

**YOUNG CHILDRENS' LIVES IN THE CONTEXT OF HIV AND AIDS:
LISTENING TO THE VOICES OF GRADE 3 LEARNERS IN
KWAZULU- NATAL**

by

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DECLARATION

This Masters dissertation is the original work of the author and has not been submitted in any form to another university. Where use has been made of the work of others, it has been acknowledged and referenced in the text.

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DEDICATION

This thesis is dedicated to my dad

**GONSEEL GOVENDER
(1945 – 2004)**

*You were there at the start of this degree but not at the end
Yet somehow I feel sure that you have been with me every step of the way
I will love you always*

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ABSTRACT

Since HIV/AIDS is closely connected with adult sexuality, children in early schooling are often overlooked in debates around the pandemic. However the growing number of children who are infected or affected by HIV/AIDS cannot be ignored. This qualitative study gives voice to young childrens' experiences and understanding of HIV/AIDS in Savannah Park, province of KwaZulu-Natal. The study also explores how HIV/AIDS intersects with other barriers to learning and development and the effect this has upon childrens' lives. Twenty learners between the ages of 8-9 years who come from low income families were selected as participants in this study. They were interviewed using focus group interviews. During the focus group interviews, various participatory research techniques such as drawing, story telling, projection, games and movement evaluation exercises were employed. One of the key findings that emerged was that the participants consistently identified HIV/AIDS as a deadly disease. There was also a deep sense of fear amongst participants that their family members will contract HIV/AIDS rendering them vulnerable to the devastating impacts of the disease. Another important finding was that many participants were able to correctly identify symptoms of the disease revealing intimate knowledge and personal experience of the disease. Some modes of transmission of HIV/AIDS were also particularly well known amongst participants such as touching blood and sharing infected needles. This study however highlights the need for children in early schooling to be given accurate information on the sexual transmission of HIV/AIDS. Participants were also restricted in their knowledge of preventative measures against the HIV/AIDS virus and did not have any specific knowledge of anti retroviral drugs. Another key finding was the high levels of awareness amongst participants of the challenges experienced by HIV/AIDS infected and affected children. Lack of money, food, clothing and support coupled with sickness and high rates of absenteeism within a HIV/AIDS context impeded learning from their perspective. The views participants express also reveal that HIV/AIDS affected and infected children are still subject to prejudice, isolation and stigmatization within educational settings. However there is hope in that many participants expressed warmth and friendship towards HIV/AIDS infected children. Support structures such as family members, neighbours, teachers, social workers, church and medical personnel were also regarded as having a positive effect on the lives of HIV/AIDS affected and infected children.

LIST OF ACRONYMS USED

AIDS - Acquired Immune Deficiency Syndrome

EPC - Education Policy Consortium

HIV - Human Immunodeficiency Virus

HSRC - Human Science Research Council

UNICEF - United Nations International Children's Emergency Fund

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION	1
CHAPTER 2: LITERATURE REVIEW	
2.1. Introduction.....	5
2.2. Researching Children and Childhood.....	5
2.3. Empirical Research on the lives of children within a HIV/AIDS context.....	11
2.3.1. Child Health and Wellbeing.....	11
2.3.2. Children, Poverty and Under- development.....	14
2.3.3. Schooling in the Context of HIV/AIDS	16
2.3.4. Constructions of HIV/AIDS in Communities.....	20
2.3.5. Social Policy and Reality.....	21
2.4. Other Studies Concerning Learners' Perceptions on HIV/AIDS.....	23
2.5. Summary.....	26
CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN	
3.1. Context of Study.....	27
3.2. Research Participants.....	27
3.3. Key Research Questions.....	27
3.4. Research Process.....	27
3.5. Research Methodology.....	29
3.6. Methods of Data Production.....	31
3.6.1. Structured Interview.....	31
3.6.2. Focus Group Interviews.....	31
3.6.3. Participatory Techniques.....	33
3.7. Data Analysis.....	37
3.8. Ethical Issues.....	37
3.9. Limitations of the Study.....	38
3.10. Summary.....	39
CHAPTER 4: DISCUSSION AND ANALYSIS	
4.1. Knowledge, Experience and Understandings of HIV/AIDS.....	40
4.1.1. What is HIV/AIDS?.....	40
4.1.2. "He is so thin".....	41
4.1.3. Transmission: Choosing to know and not to know?.....	42
4.1.4. Preventing HIV/AIDS: What should we do?.....	44
4.1.5. "You can't do anything about it".....	45
4.2. The Social Face of HIV/AIDS.....	47
4.2.1. "They will not love him".....	47
4.2.2. "It will spread to us and we gonna die".....	48
4.2.3. "I am scared"	51
4.3. Hearing about HIV/AIDS.....	52
4.3.1. The Media.....	53
4.3.2. Public Icons.....	53
4.4. Schooling in the Context of HIV/AIDS.....	54
4.4.1. "She didn't come to school"	55
4.4.2. Intersection of HIV/AIDS and other Barriers to Schooling	56

4.4.2.1. “I was very sick”	56
4.4.2.2. “We must go to the funeral”	57
4.4.2.3. “He got something that they don’t like”	58
4.4.2.4. “I don’t have any food to eat”	59
4.4.2.5. “My father didn’t have any money”	59
4.4.2.6. “My dad was drunk”	60
4.4.2.7. No School Uniforms	61
4.4.2.8. No Transport	61
4.5. “If Lindiwe’s mother died ...”	62
4.6. Who Cares?	64
4.6.1. The Family	64
4.6.2. What can the Neighbours do?	64
4.6.3. Teachers and Care	66
4.6.4. Social Workers: What is their Role?	67
4.6.5. “They will take you to Childline”	67
4.6.6. “The church will give you money”	67
4.6.7. Experiencing Medical Help	68
4.6.8. Others in the Community?	69
4.7. Summary	69
 CHAPTER 5: CONCLUSION	
5.1. Implications	70
5.2. Researcher Reflections	72
 REFERENCES	74
 APPENDIX A	84
APPENDIX B	86
APPENDIX C	87
APPENDIX D	88
APPENDIX E	92

CHAPTER 1: INTRODUCTION

HIV/AIDS is a pandemic of growing proportions. South Africa is one of the hardest hit countries in the world. Of the 40 million people who are living with HIV/AIDS worldwide, between 4.7 million and 6.6 million are from South Africa (Soul City, 2004). Thus more than 10 % of the world's HIV population is living in South Africa. Whilst much research, foregrounding adult voices, has been conducted in the medical, socio-economic, legal, educational and psychological fields on the impact of HIV/AIDS, the voices of children have been noticeably absent.

Education White Paper 6: Building an inclusive education and training system (Department of Education, July 2001) names HIV/AIDS as a potential barrier to learning in the South African context. However, HIV/AIDS cannot be viewed in isolation of the socio economic, race, class, gender, political and environmental context of the learner. There is also little localized knowledge of dealing with HIV/AIDS affected and infected learners in South Africa. Research has mainly focused on macro levels within a quantitative approach. Coombe (2000) called for detailed, qualitative micro level research to complement macro studies.

Cohen (2002) also points out that there is little firm data to explain declining school drop out rates and how these relate to increases in household poverty which has arisen as a result of HIV/AIDS. Cohen (2002) goes on to describe the lives of children who are infected and affected by HIV/AIDS as often hopeless, poverty stricken and surrounded by death and disease. This description raises many questions: How has the pandemic impacted on schooling and if so, are there gender implications? How does this resultant low morale impact on learners' achievements at school given their circumstances. These are issues that need to be investigated.

The aim of this study was to find out how HIV/AIDS is understood and experienced by grade 3 learners. The study provides valuable insights in a local context. Savannah Park is situated in KwaZulu-Natal, a province in South Africa which has a HIV prevalence rate of 11.7% (Nelson Mandela Foundation/ HSRC Study of HIV/AIDS, 2002). Through the scope of this research, this particular schooling context was

analysed and the concrete experiences and responses of learners regarding HIV/AIDS were examined.

My study also investigated the link between HIV/AIDS and other barriers to learning and the resultant impact upon learner performance. My aim was to map the extent to which HIV/AIDS acts as a destabilizing force in creating fear, discrimination and exclusion of young learners. The study also focused on the extent to which HIV/AIDS affects the treatment of children by their families, schools and communities and the effect this has upon their learning. By participating in this research, young children were given a platform to share their thoughts on HIV/AIDS and the effect it has on their lives.

Children, in early schooling, are of particular interest because of their vulnerability. They are not viewed as autonomous beings and their plight and experiences have been mainly voiced through adults who act and speak on their behalf (Oakley, 1994). A description of their needs, concerns and aspirations was seen as more relevant if taken directly from children themselves. This study provided an opportunity for children to describe their understanding and experiences of HIV/AIDS.

Children, in early schooling, are also at a receptive stage in their lives. The age group that I selected is 8-9 years. Bhana, Farook Brixen, MacNaughton and Zimmermann (2006a) note that in this phase of childhood, most children adopt ways and dispositions that will stand with them throughout their adult lives. Therefore it was seen as valuable to find out what children know about HIV/AIDS and how this knowledge can be further enhanced. Interventions as Baxen and Breidlid (2004b) note are more successful before children become sexually active and should be aimed at the primary school because this is often the site where children construct their sexual identities.

Parents and teachers also often do not discuss sex with children (Lovelife, 2000). Children tend to imbibe images from television, advertisements and the media that titillates their growing awareness of sex. The standards and values they gain from these sources may compromise how they deal with their emerging sexuality (Kelly, 2000b). There is also an assumption that children at this age are asexual (Tobin, 1997;

Bhana et al, 2006a). However contrary to this, there have been newspaper articles which show that children as young as 6 years old in KwaZulu-Natal have been involved in penetrative and coercive sex (Daily News, 2 May 2006). Unbeknown to them, they are dicing with sickness and death.

My personal interest in researching on HIV/AIDS and young children arises from my vocation. As a foundation phase educator, I work with young children daily. Whilst I have not consciously taught learners who are infected by HIV/AIDS, I believe that doing this piece of research in a localized context will prepare me and other teachers for this eventuality. Mvulane (2003) found that 89000 (7.5%) of children born in South Africa in the year 2002 were HIV positive. These statistics are further backed by the Nelson Mandela Foundation/ HRSC study of HIV/AIDS (2002) which found that 5.6% of children in the 2-14 years age group were HIV positive. Thus in the foreseeable future many teachers will need to be equipped to cope with the needs of HIV positive learners in their classrooms.

Furthermore at the beginning of this year, there were two incidents at my school that really stood out in my mind. The first was when a young learner rushed up to me with tears in her eyes waving a little piece of paper in her hand. On the piece of paper was a drawing of the learner and the words "Nosipho has AIDS" under it. Whilst I comforted the learner and assured her that it would not come true simply because others had written it (as this is what she believed), I began to wonder what exactly goes through the minds of children when they are confronted by the words HIV/AIDS. I felt a need to understand how children see HIV/AIDS as potentially affecting their lives and probe the extent to which they have the capabilities and knowledge to deal with this pandemic.

The second incident that really got me thinking about HIV/AIDS was when despite being repeatedly warned in Life Skills lessons at school about playing with sharp instruments, two learners went around piercing other learners with a sharp compass for fun. The thought of HIV/AIDS spreading and infecting innocent children through this type of reckless behaviour immediately crossed my mind. I resolved to talk to the children specifically in this regard. From the discussion that ensued it was obvious that the learners viewed HIV/AIDS as a disease that could not affect them. It was

someone else's disease. A similar attitude was observed in a parent as well. One aggrieved parent came to school to complain that her daughter had been pierced by the compass and enquired who else had been pierced before her daughter. She was also concerned about the risk of HIV infection. Her relief was almost palpable when it was evident that only Indian children had been involved in that incident. This othering of the disease as mainly a Black person's disease is a common belief of many members of the Indian population (Mail and Guardian, 2003). This is in spite of the rise noted in the number of Indian people who are infected in South Africa (Carnie, 2006).

Now more than ever, with the escalating impact of HIV/AIDS it is imperative for us educators to understand the meanings children construct about HIV/AIDS. This will enable us to cope and meet the needs of these children in our classrooms. Kelly (2002) points out that it is the education sector's responsibility to equip learners with knowledge, skills, attitudes and values to reduce the possibility of falling prey to or transmitting the HIV infection. We need to construct programmes aimed specifically at meeting the diverse and challenging needs of affected and infected children. In view of this, I believe that my study provides a basis for improving practice related to the Life Skills learning programme in the foundation phase of schooling. It will also assist in informing school policies by providing valuable, in depth and context specific information on the extent to which HIV/AIDS is impacting on young learners, and how it intersects with other barriers to participation in schools. With this in mind, my key research questions are:

1. What are learners' experiences and understandings of HIV/AIDS?
2. How does HIV/AIDS intersect with other barriers to learning and development to impact on learners' lives?

In the chapters that follow a literature review will be done to place this study on HIV/AIDS in context, the theoretical framework will be discussed within the review to ground this study, the research design and methodology will then be outlined followed by a detailed and descriptive analysis of findings and possible implications.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

HIV/AIDS is a disease that has spiraled out of control in the past 20 years. Whilst the sexual nature of the disease mainly links it to adults, children are not immune to it or its dreaded effects (Cornia, 2002). My literature review will examine how children understand and experience HIV/AIDS. The first part of my literature review will highlight the need to conduct research on children within an HIV context. The latter part of my review will examine perspectives and empirical research on the lives of children in the context of HIV and AIDS. Finally, I will examine other studies that view HIV/AIDS from the perspectives of children.

2.2. Researching Children and Childhood

Children are more vulnerable to the impact of HIV/AIDS than other social groups (Walker, Reid & Cornell, 2004). Their lives are generally touched by the virus in the following ways: Some children may be infected by the virus, some may have parents who are infected by the virus (HIV/AIDS affected children) and some children may have lost one or both parents to the disease (HIV/AIDS orphans). Children are also increasingly being left to fend for themselves in the wake of adult sickness and premature deaths related to HIV/AIDS. However their voices have been noticeably absent from the literature on HIV/AIDS (Giese, Meintjies & Proudlock, 2001).

During the 1980s social scientists expressed dissatisfaction at the way in which research on children was conducted (Prout, 2005). Research as a mirror to society portrayed two traditional outlooks on the child. One painted the child as innocent and in need of protection. The other outlook depicted the child as inherently evil and as such a threat to society, who therefore had to be controlled (Jenks, 2005; Shipman cited in Mills, 2000; Gittins, 1998). What these outlooks had disguised under the caption of child is that there are differences amongst children in terms of social class, gender, race and culture. It is these differences that warranted further reflection and probing to define a child at a particular moment in time (Gittins, 1998).

Jenks (2005), Mayall (1994) and James and Prout (1997) also note that sociologists were notorious for viewing socialization as a largely one way channel of knowledge

from adult to child. The adult was tasked with teaching children knowledge relevant to taking their place in society. As such children were conceptualized as being lesser than adults and denied personhood in their own right (Mayall, 1994). Canella (2002) states that adult constructions of knowledge were privileged whilst the knowledge children possess was subjugated and denied.

To throw off this yoke of oppression and to redress imbalances, a new way of studying childhood was born. Childhood as a social construction offers greater insight and ascribes greater value to the social factors that make up our knowledge of children and childhood. Mills (2000) states that the social construction of childhood provides children with a voice. It acknowledges children as experts who are capable of relating to us their lived experiences. It attempts to demystify children's social relationships, voice their fears and aspirations and to take their ideas seriously (Mills, 2000). There is now a growing body of research with children sharing their viewpoints and experiences on important political and social issues (Boswell, 2002; Giese et al, 2001; Wade & Smart, 2002; Daycare Trust, 1998). It is within this theoretical framework of childhood as a social construction that my study on HIV/AIDS is located.

Childhood is viewed by James and Prout (1997) as more than biological immaturity. They define it as “ an actively negotiated set of social relationships within which the early years of human life are constituted” (James and Prout, 1997: 7). It is a separate domain from adulthood and not merely a point in the continuum of the child's journey to adulthood. Jenks (2005) states that the passage from childhood to adulthood is not solely dependent on physical growth. This is now becoming apparent by the rise in child headed households where the HIV/AIDS epidemic is further weakening the boundaries between adulthood and childhood (Walker et al, 2004). Often HIV/AIDS affected children take on responsibilities that are far beyond their years and there is a dire need to capture their views and understanding of their predicament.

Children must be regarded as people in their own right rather than adults in the making. Lee (2001) points out that this being/ becoming division is a dichotomy that permits only two ways of being human. It asserts the adult as the standard and the

child as the deviant. Age is used as a marker and human beings are accorded with dignity, respect and independence accordingly (Lee, 2001). These unjust attributions on the basis of age have been further exposed by the HIV/AIDS pandemic. Older siblings who care for their younger brothers and sisters when their parents succumb to HIV/AIDS suffer financially and are often doomed to poverty because of their age. They cannot access grants because they themselves are deemed to be legally underage to care for their siblings (Walker et al, 2004). These children work as contributors to family income and to gratify their own needs, shredding childhood's fallacy of incompleteness, inadequacy and weakness (Morrow, 1994). These HIV/AIDS affected children contest the notion that children are unable to care for themselves and their voices must be heard.

However Lee (2001) also cautions that the social constructionist approach to childhood tends to deny all differences between adults and children in the hope of removing the possibility of unjust bias on the basis of age. This creates tension in that human variation needs to be recognized. Differences may exist between adults and children, without robbing children of the right to be treated equally in terms of being given recognition that they have worthwhile opinions and perspectives. Thus whilst human variation is acknowledged, age based discrimination must be resisted (Lee, 2001).

Central to the social construction of childhood is the belief that the child at any given time has to be defined in his social context. The child is shaped by the cultural and social values upheld in the community in which the child grows up. Jenks (2005) points out that the meaning we place upon children and childhood differs from culture to culture and also within a culture itself due to the passage of time. The difficulties of defining what childhood is and who children are explodes the myth of a universal childhood. There can be no doubt that in parts of the world ravaged by the HIV/AIDS pandemic the nature of childhood has significantly changed (Walker et al, 2004).

Globalization has also made visible the diversity of variable circumstances in which children grow up (Prout, 2005). Researchers point out that childhoods are linked to variables such as culture, race, social class, gender and time (James & Prout, 1997; Mills, 2000; Foley, Roche & Tucker, 2001). Often research tries to impose the

western conceptualization of the child on all children. This has been found to be unsuitable in developing contexts such as South Africa. Diverse legal, cultural and social contexts make it unsuitable to transfer practices between countries since researchers are subject to different constraints (Craig, 2003). Thus universal solutions to the HIV/AIDS pandemic do not exist and it is necessary to develop local responses to specific situations (Coombe, 2002a). Walker et al (2004: 21) note the most important contribution of social scientists' research on the HIV/AIDS pandemic "is to situate the individual in relation to his or her social, cultural and historical environment; in other words to locate 'AIDS in Context'". The social construction of childhood as a theoretical framework is therefore vital to researching the child in a HIV/AIDS world.

Prout (2005) however cautions that childhood is not a purely social phenomenon in that social relations themselves are hybrid and are made up of a variety of material, cultural and natural resources. Culture and nature are simultaneously part of childhood and each entity should not be viewed as pure or distinct. Material artifacts and technology which are hybrid in nature also influence the lives, experiences and actions of children. Children often construct meanings about HIV/AIDS from the messages they receive from various media. The biological, social and cultural aspects of childhood should not be separated (Prout, 2005).

Gittins (1998) concurs and states that the idea of the social construction of childhood is itself in danger of being reduced to an essentialist argument if we persist in stating the biological, the body and embodiment are entirely socially constructed. Rather we should recognize that children are born into particular contexts as embodied beings whose bodily needs are controlled and mediated by society. Thus biology can be changed by interacting with social and environmental factors (Gittins, 1998).

Mitchell and Reid-Walsh (2002) point out that a perspective such as the social construction of childhood highlights key challenges in terms of methodology. Prout (2005) concurs noting that contemporary childhood is constantly changing and challenging us to find new ways of viewing and understanding children. It therefore requires an open ended process of enquiry. Prout (2005) maintains that research activity within this framework taps into children's active social participation and their

agency in their individual and collective social lives. With this in mind, my study on HIV/AIDS uses child participatory research activities in an effort to research with children rather than on them.

Phiri and Webb (2002) also state that child participation has to be at the centre of any response to HIV/AIDS concerning infected or affected children. They differentiate between child centred and child focused responses. Child centred responses involve looking at the child's needs and understanding them from the child's perspective. Child focused responses however go a step further by including children's participation in decisions being made about their lives. Mayall (1994) states that it is possible to ensure full child participation in research design, implementation and evaluation procedures and to redress the power imbalance through the use of enabling data collection techniques. O'Kane (2000) argues that participatory techniques and methodology are very useful in providing young children with a platform from which they can talk about issues that affect them.

The social construction of childhood also defines children as autonomous beings. The United Nations Convention on the Rights of the Child – Article 12 states that children and young people have the right to express their views on anything that affects them and their views must be given due consideration in relation to the age and maturity level of the child (UNICEF, 1989). Sometimes adult interventions on behalf of children lead to more harm than good. The following example by Prout (2005) illustrates this clearly. Prout (2005) cites a study by Boyden, Ling and Myers (1998) of the Bill introduced in 1993 in the USA which threatened to prohibit the import of commodities that had been produced by child labour. This Bill was designed to reduce child labour which was used as a cheaper alternative by employers. Consequently thousands of children in the Bangladesh garment industry were laid off work. The child workers fought against this saying they could combine work with education as their families desperately needed their income. In this case, the voices of the child workers were ignored. A subsequent survey done on a sample of the children that had been fired revealed that none of them had gone back to school and some had now found even more hazardous occupations.

Prout (2005) maintains that the above is a clear example of the problematic consequences that can arise when children's opinions are devalued and their interests are thought to be best articulated by adults. This could also explain why HIV/AIDS intervention programmes designed by adults entirely seldom work. Giese et al (2001) note that policy makers need to engage with HIV/AIDS infected and affected children if they are to address the needs of these children appropriately.

Baxen and Breidlid (2004b) also found that there was a lack of correlation between learners' knowledge about HIV/AIDS and their sexual behavior in many such intervention programmes. However when children were consulted and incorporated in the process there was a measure of success. The Stay Alive programme in Botswana managed by Berkhof (2003) is an example of a consultative AIDS awareness programme. Learners from a secondary school were given updated information about HIV/AIDS and participated in discussions revolving around sexuality issues with open and frank educators. The result was a drop in sexual activity amongst learners and an increase in knowledge about HIV/AIDS.

This notion of children as experts may be disconcerting to some especially when pitted against the expertise of adults. Jenks (2005) notes that children's words are often viewed with suspicion. Other researchers (Craig, 2003; Foley et al, 2001; Mayall, 1994; Morrow, 1994) concur noting that the capacity of children to articulate their views is questioned. Children are often seen as being unable to distinguish fact from fiction, they make up things to please the researcher thereby threatening data reliability and they do not have enough knowledge to report usefully on their experiences. However Mayall (1994) and Oakley (1994) point out that these shortcomings in research apply to adults as well.

Griffiths and Kandel (2001) caution that there is a possibility that to outsiders children may skirt issues of discussion on difficulties they face due to conflicting loyalties especially if it exposes one or both their parents in a negative manner. They cite the case of a boy who was unwilling to give reasons for his truanting from school because he truanted at the request of his disabled mother. She wanted him at home to provide her with emotional and physical support. This argument could also extend to HIV/AIDS affected learners. Some may be forced to stay at home and care for

afflicted relatives (Kelly, 2000a). They may not want to report on their plight to outsiders for fear of being removed from their families. However Aubrey and Dahl (2005) who conducted an extensive review of studies that had young and vulnerable groups of children as research participants found that young children were not necessarily upset or emotional when questioned about sensitive issues.

Now faced with the increasing needs of children affected and infected by HIV/AIDS researchers, policymakers and practitioners have shown growing interest in the notion that children need to be listened to (Aubrey & Dahl, 2005).

2.3. Empirical research on the lives of children within a HIV/AIDS context

This section highlights literature on childrens' lives within the context of HIV/AIDS so as to provide a frame of reference when analyzing the concrete responses and experiences of participants in this study. The meanings children construct about HIV/AIDS are not neutral or universal but are rather constructed in particular contexts. Research has shown that when HIV/AIDS touches the lives of children, the impact of the disease worsens the socio economic status of the families and the communities with direct bearing on the educational opportunities for children in these settings (Moletsane, 2003). Desmond and Gow (2002) note that no child in South Africa will escape the impact of HIV/AIDS since the virus has changed the nature of the society in which they develop.

2.3.1. Child Health and Wellbeing

HIV/AIDS is more than a medical disease. The pandemic has serious psychosocial, economic and educational ramifications for HIV/AIDS infected and affected children. Issues such as death, illness, bereavement, crime and abuse which affect a child's physical, emotional and mental stability cannot be ignored in the context of HIV/AIDS (Coombe, 2002b).

Illness and Nutrition

Ebersohn and Eloff (2002) describe the virus as a chronic and debilitating stressor in the lives of affected and infected children. HIV/AIDS infected children are often prone to severe and frequent bouts of illness (Moletsane, 2003). Exposure to

opportunistic diseases also takes its toll. Hospitals and health care services may be difficult to access, leaving the child to cope alone with illness (Ebersohn & Eloff, 2002). Poor health status and malnutrition often leads to stunted growth and poor, early childhood development.

However, many schools in South Africa are now working with other support structures to assist children affected or infected by HIV/AIDS. Nutrition programmes have been implemented in many schools to help provide children with healthy food and to boost their immunity (HSRC/ EPC, 2005). Food gardens have also been started at schools to supplement these programmes and these have provided learners with much needed income generating skills. Kelly (2002) suggests that schools should become multi functioning welfare and development centres pulsating at the heart of affected communities in response to the virus.

Death and Bereavement

Children who are HIV/AIDS infected or affected also become depressed and they fear death for themselves or that of their relatives (Moletsane, 2003; Ebersohn & Eloff, 2002). Studies in Sub-Saharan Africa (Kelly, 2000b; Walker et al, 2004; Desmond & Gow, 2002) have shown that women have higher HIV infection rates and mortality rates. Thus the death of a mother can have a profound impact on a child's wellbeing. It may also result in disrupted schooling if the child is sent away to distant relatives. Often families are so poor that they cannot care for an orphaned family. They will have to separate siblings in order to care for them (Kelly, 2000b). Thus many orphaned children are dealt with a double blow of loss and separation. Emotional and psychological support is needed for these traumatized children.

A study in Tanzania on the effects of orphanhood found that children coped better with being orphaned when their dying HIV infected parents talked to them about dying and they appreciated the opportunity of being able to talk to their parents and listened to their advice about how to go on with their lives after their parents died (Phiri & Webb, 2002). In view of this, many organizations also have put forward the Memory box approach to help children cope with the imminent loss of a parent. The box generally has a letter from the parent containing their hopes for the child, photos

and other small momentos that give the child a sense of rootedness and belonging, long after the parent has departed (Barnett & Whiteside, 2002; Walker et al, 2004).

Violence and Crime

In Sub-Saharan Africa, HIV/AIDS has resulted in fractured families causing many children to run away and become street children, thus opening themselves up to the risk of infection, abuse and neglect (Kelly, 2000a). Freeman (2004) hypothesizes that these children are likely to develop anti social personality disorders since they lack a caring, stable environment and childhood bonding which are adaptive factors to emotional stability. The presence of a father is often a potent weapon against delinquency (Schonteich, 1999). Denis and Ntsimane (2004) found of 33 families affected by HIV/AIDS, only 27% of the fathers regularly resided with their children and only 34% were giving material or emotional support to their families. The researchers give cause to ponder on how boys who have never experienced the presence of a caring father will learn how to become caring fathers themselves. What will they give back to a society that has not met their needs or provided them with role models?

Schonteich (1999) takes up this issue further by stating that HIV/AIDS orphaned children will be greatly at risk to engage in criminal activity since most of them lack positive role models in their lives. Schonteich (1999) found that 57% of children who had committed violent crimes in the United Kingdom had death or loss of contact with a significant other such as a parent. It is estimated that by 2015 orphans will form 9-12% of South Africa's total population (Ebersohn & Eloff, 2002). Schonteich (1999) warns us that this boom in the orphan population may result in an increased crime rate in the future. Wayward youth will not shy away from disrupting a society that they have no stake in.

Sexuality and Abuse

Walker et al (2004) note that young people are becoming sexually active at increasingly younger ages with sex often being forced on them. This growing culture of child sexual abuse in South Africa is borne out by police crime statistics. Child Rape statistics in South Africa for the year 2000 (January to December) indicate that 13540 children under 17 years were raped. Of these children, 7899 were under the age

of 11 (Walker et al, 2004). These shocking statistics indicate the vulnerability of children to being infected by the HIV/AIDS virus.

Research conducted in KwaZulu-Natal by Morrell, Unterhalter, Moletsane and Epstein (2001) amongst 15-19 year olds who are mostly still at school has estimated that over 15% of African schoolgirls are HIV positive in comparison to 2.58% of African boys of the same age group. The disparity of race and gender can be clearly seen when these infection rates are compared to other race groups. The same study found that 1.25% of White schoolgirls, 0.26% of White schoolboys, 1.29% of Indian schoolgirls and 0.26% of Indian schoolboys of the same age were likely to be infected (Morrell et al, 2001: 51). Thus, it is evident that the rate of infection is highest amongst young African females. These women who are mostly still at school are often unable to negotiate safe sex due to unequal power relationships with their partners. Walker et al (2004: 56) note that 'sugar daddies' (wealthy older men who lure young school girls into sexual relationships by offering them cash and gifts) control sexual relationships and often are members of larger sexual networks. Thus, these school girls are more susceptible to teenage pregnancy and infection by the HIV/AIDS virus. Such emerging trends such as these have caused important stakeholders such as the government, academics and non government organisations to prioritise young people at school to be on the receiving end of HIV/AIDS risk intervention strategies (Morrell, Moletsane, Karim, Epstein & Unterhalter, 2002).

2.3.2. Children, Poverty and Under-development

Hunter (2003) defines poverty as a loss of freedom, dignity and the ability to shape one's future. Poverty results in physical hardship, lack of basic necessities, loss of economic and social opportunities and anxiety. Richter, Manegold and Pather (2004) state that due to poverty many children are denied access to health, education and welfare services which are basic human rights. Two thirds of the 16.3 million children in South Africa today survive below the poverty line (Walker et al, 2004). Research (Moletsane, 2003; Ebersohn & Eloff, 2002; Kelly, 2000a) indicates that when a family member falls prey to HIV/AIDS, the family rapidly descends into poverty. Additional funds are required to care for the sick person, pay for their treatment and provide nutritious food for them. Sick, HIV/AIDS infected adults cannot work and healthy adults often have to divert their productive energy into becoming caregivers.

Walker et al (2004) state that the loss of income due to prolonged illness and medical and funeral expenses often deplete an already destitute family. HIV/AIDS and poverty feed into each other creating a monster that shadows the lives of children and all those who are touched by it.

Child Headed Households

Often when parents have died and there is no support from others, the burden of running the household falls on children. Walker et al (2004) state that children as young as 5 perform household chores such as cooking meals, taking care of crops and collecting water and firewood. They often leave school early to support siblings and earn money by begging or performing menial tasks such as washing cars. South Africa is facing a growth of child headed households. Children now have the daunting task of managing the family resources (Walker et al, 2004). These children also have a reduced ability to maintain and repair their homes. Often homes leak during heavy rains and could be unsafe (Hunter, 2003).

Orford (2004: 30) cites Zandile Nkompela an HIV/AIDS co-ordinator in South Africa working with The Social Change Assistance Trust as saying

“There are child heads of households. People are faced with this in the villages and they have to deal with it. A woman who works for the advice office was telling me a story about children stealing food from her house. One day she saw these children stealing and then she calls them over and then she walks with them to their home and when they get to the home there's no elder, nothing to eat. It's just the kids and no adults to link them up with welfare”.

This is the sad reality of many South African households.

To alleviate this phenomenon of child headed households there is now a concerted effort being made to harness community resources to come to the assistance of these families in need. For example, community members who have time are now assisting in taking care of HIV/AIDS stricken individuals and preparing meals. They provide practical and emotional support. They also provide day care for children who are below school age. This enables older children in the household, who may be taking care of younger siblings, to attend school (Walker et al, 2004). Richter et al (2004) state that local communities are devising their own initiatives to help HIV/AIDS

children and their families by utilizing communal land for crop production. Communal labour is also being used to repair houses and schools and provide home based care for sick people.

The Economies of Low Income Countries

Hunter (2003) notes that poor countries have budgets that are largely consumed by debt repayment so that little is left over for basic health care. The poverty of health care systems has led to many HIV/AIDS people being refused treatment. Hunter (2003: 38) quotes Tony Moll, head of a 350 bed hospital in South Africa as saying

“We have no medicines for AIDS. So many hospitals tell (AIDS victims) – you have got AIDS. We can’t help you. Go home and die”.

Poor countries also do not have the capacity and resources to ensure that children infected and affected by HIV/AIDS have basic necessities. HIV/AIDS is lethal in that it strikes mainly at people in the prime of their lives who are the backbone of the economy. A reduced number of taxpayers will result in a reduced national income with fewer resources and money to spend on education, health and welfare with funds being diverted to service the demands created by the effects of the HIV/AIDS pandemic (Kelly, 2000a; Richter et al, 2004). A diminishing tax base results in children and the elderly having to shoulder responsibilities that are way beyond them. Often their only hope of survival is the child support grant that is given to care givers of poverty stricken children in an attempt to address the essential needs of these children (Hall, Muthukrishna & Ebrahim, 2005).

2.3.3. *Schooling in the Context of HIV/AIDS*

HIV/AIDS has had a significant impact on school drop out rates, barriers to schooling and the role of teachers in providing pastoral care at schools. These aspects will be discussed below.

School Dropout and HIV/AIDS in Sub-Saharan Africa

Kelly (2000b) states that teachers interviewed in Lusaka who had HIV/AIDS orphans in their classrooms all reported that these children drop out when the adult dies because they cannot meet the cost of schooling.

Williamson (no date) discusses a study in Kenya which compared the status of children orphaned by HIV/AIDS where one or both parents had died from the disease to a control group who had both parents living or who had lost one of their parents to causes other than HIV/AIDS. The study found that whilst only 2% of the control group was not at school, 52% of the HIV/AIDS affected group was not at school. A higher number of this percentage were girls. Coombe (2002b) found that in Mozambique only 24% of orphans attend school in relation to 60% of children with living parents attending school.

Ainsworth, Beegle and Koda (2000) offer a different perspective. They conducted a study on the effect of orphan status and adult deaths on primary school children in Tanzania. They found that adult deaths delayed enrollment into primary schools but it did not stop it altogether since these orphaned children came to school to be enrolled when they were older. They also could not establish a direct correlation between the death of an adult and orphans dropping out of primary schools. However the weight of the research seems to suggest that orphans are more likely to lose their access to schooling without support or compassionate caregivers.

Barriers to Schooling

HIV/AIDS infected children who are frequently absent from school due to sickness and disease often find it difficult to cope in schools. This failure to thrive and sporadic school attendance often results in poor performance in school and these children are likely to leave school at an early age. Parents are also often afraid to invest in their educational future because they fear that their HIV/AIDS infected children may die before they can reap the benefits of their educational investment (Hepburn, 2002; Kelly, 2000a).

HIV/AIDS also results in over stretched resources. In afflicted homes there is often little or no money left for school fees, books and uniforms for children (Loewenson & Whiteside, 2001; Ebersohn & Eloff, 2002; Hepburn, 2002). Very often, learners from these homes dropped out of school. If they did remain in school then there was an adverse effect on their achievement. Such children may also be forced into child labour and tend to enter the working world much earlier than their peers to assist their families (Kelly, 2000a; Loewenson & Whiteside, 2001; Moletsane, 2003; Hepburn,

2002; Walker et al, 2004). Thus they miss out on important life skills training that they need to protect and support them later on in life.

HIV/AIDS also poses another barrier to schooling in that HIV/AIDS affected children often do not have time to attend school. The time that constitutes the school day directly co-incides with the time when they are needed to care for infected relatives and younger siblings as well as perform household chores (Moletsane, 2003). Thus, schooling may become impossible for them. They and their parents may also deem education to be a waste of time as they see little in the curriculum that connects to the reality of their lives (Kelly, 2000a; Moletsane, 2003; Hepburn, 2002). The HSRC/EPC report (2005) found that some parents from rural, HIV/AIDS stricken contexts in South Africa question the importance of schooling:

“We have children here and they attend school up to matric, but when they finish you don't see any difference because they do nothing and you just wonder what the point of studying was” (Caregiver, HSRC/EPC, 2005: 20).

Williamson (no date) however states that many communities in Africa value education and are now opening their own schools to provide education for these children who cannot go to regular schools. Hepburn (2002) concurs and states that this has been a popular approach in countries such as Mali, Malawi, Uganda and Zambia since no fees and uniforms are required and educational materials are provided. However, these community schools are reliant on donor funding which is at best unpredictable. Thus, they may be difficult to sustain in the long run.

HIV/AIDS infected and affected learners may also be stigmatized and isolated in schools (Moletsane, 2003). These learners will most likely leave school because school has become another harsh environment they must contend with. However policies have been drawn up to protect learners against discrimination in schools. The National Policy on HIV/AIDS For Educators and Learners and Students in schools (1999) clearly states that “No learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly, Educators should be alert to unfair accusations against any person suspected to have HIV/AIDS”. These policies offer some measure of protection against discrimination to vulnerable groups.

Families are also more wary of sending girls to school because of the wide spread sexual abuse that occurs on the way to and in schools. Leach (2002) argues that schools have become sites of gender violence and rape. She states that some male teachers who regularly proposition school girls are deemed to be potential sources of the HIV/AIDS virus. Walking alone to school also makes girls easy prey. This perceived threat results in many girls being kept out of school as parents fear that sexual abuse by teachers and classmates can result in them being infected by the HIV/AIDS virus.

However not all teachers are painted with the same brush. A study undertaken by Bhana, Morrell, Epstein and Moletsane (2006b) found that most teachers were an important source of pastoral care in the battle against HIV/AIDS. Bhana et al (2006b) conducted a study to understand the pastoral care provided by teachers for learners who are infected or affected by HIV/AIDS. They interviewed life orientation teachers from four contextually different schools in Durban. They found that learners from under resourced schools had the greatest need for support and pastoral care. In these cases, schools may be the only sanctuary that learners whose lives have been wracked by HIV/AIDS, poverty, orphanhood and violence have and teachers are their only source of care (Bhana et al, 2006b).

Teachers in the 2 township schools recounted how they started feeding programmes using their own money and collected clothes and uniforms for learners. Bhana et al (2006b: 12) quote a teacher as saying

“ ... when the child has been hurt... abused physically by whoever. When the child has found out they are HIV (positive) ... you've got to, he's crying, he's desperate, thinks the whole world is falling, and you've got to be there”.

Learners often did not have anywhere else to go so the teachers felt that they could not turn their backs on them. One teacher at a township school describes how he counseled a HIV positive learner who confided in him through his depression and incapacitating fear of death. This study shows that teachers offer resilience and hope for their learners in the face of HIV/AIDS.

Whilst the nature of schooling has changed in the context of HIV/AIDS education is still referred to as the “social vaccine” of the HIV/AIDS pandemic (Kelly, 2002: 2). Moreover schools are important sites for the dissemination of information on HIV/AIDS and they are in the best position to reach children between the age of 5-13 years who are deemed to be in the window of hope age (Badcock-Walters, 2000). A concerted effort must thus be made to keep children in schools by minimizing the effects of barriers to participation in schools.

2.3.4. Constructions of HIV/AIDS in Communities

Walker et al (2004) report that because HIV/AIDS initially appeared in marginalized groups such as gay men, intravenous drug users and prostitutes it has been strongly associated with moral judgements. Those who carried the deadly disease were scorned as victims of their own immoral or antisocial behavior. The silence surrounding HIV/AIDS also added to the social stigma pervading it. HIV/AIDS has become almost synonymous with hopelessness, debilitation and death (Walker et al, 2004).

Many people are afraid to disclose their HIV/AIDS status because they fear being isolated and shunned by society. HIV positive parents are reluctant to appoint guardians or make plans for their children’s future in the event of their deaths for fear of disclosure to other members of the community that they are carrying the AIDS virus (Richter et al, 2004). Children in particular are very vulnerable especially if they or their parents are HIV/AIDS infected (Moletsane, 2003; Ebersohn & Eloff, 2002). They may be excluded from community resources, support and be a painful witness to their parents being insulted by neighbours and relatives on account of their status (Alliance, 2003).

Leclerc-Madlala (2001) states that although the death rate in KwaZulu-Natal has sharply increased the silence around HIV/AIDS is pervasive. There is a denial that it is AIDS related. Discussions on HIV/AIDS are avoided because it exposes sensitive issues such as gender violence, rape, transactional sex and infidelity. Kelly (2000a) observes that this silence around HIV/AIDS must be broken to deal with the disease constructively. Orford (2004: 95) quotes Victoria Nquindi, a HIV/AIDS activator with The Social Change Assistance Trust as saying

“Some families used to reject infected family members. Before if there was a funeral of a HIV- positive person then it was hidden but that is no longer the case. So many people are sick now that you cannot hide it. There was a lot of stigma but education and workshops have changed peoples minds to a certain extent”.

Richter et al (2004) state that the resilience and strength of communities have now been utilized to cope with the impact of HIV/AIDS. Traditionally, the family and community played a great role in the education of the child and in particular the care of orphans. There is now a strong move back towards these practices with neighbours and kin taking on affected HIV/AIDS families and orphans. Therefore any funding that is available needs to be channeled in their direction to build their capacities and pave the way for longer term solutions (Williamson, 2000). However Barnett and Whiteside (2002) warn that the extended family support mechanism is being increasingly weakened as more and more families are affected by the HIV/AIDS pandemic.

Phiri and Webb (2002) state that the community family model type of institutional care is now widely used in South Africa to create an approximate environment to that of the family. With the increasing rise in the orphan population due to HIV/AIDS, there is an even greater need for it. Phiri and Webb (2002) define it as a model where a house is purchased and furnished and up to six children are placed in it with a foster mother. The foster mother is paid an allowance and collects foster grants for the children. She is given part time help by a relief mother. This system has been shown to be beneficial as it is established as part of the community and the children go to regular schools and join in all other community activities. Thus with the expected boom in the orphan population due to HIV/AIDS this type of model will be increasingly needed as the safety net of extended families wears too thin to cover an ever increasing number of children who are orphaned by HIV/AIDS.

2.3.5. Social Policy and Reality

Social policies must be aimed at ensuring care and protection of rights for children (Richter et al, 2004). Children are guaranteed the right to education as enshrined by our Bill of Rights in the Constitution of South Africa (Act 108 of 1996). This implies

that all children have the right of equal access to the widest range of educational opportunities. However, education is not free in South Africa and many other parts of the world. Thus, children whose families' meagre resources have been eaten away by the HIV/AIDS virus, stand very little chance of exercising this right to education (Kelly, 2000a). More distressingly, children who do not attend school compromise their rights of living productive economic and social lives "through education" (HSRC/EPC, 2005: 65). .

Children infected and affected by HIV/AIDS also need adequate nutrition to develop normally. The Primary School Nutrition Programme is an initiative by the South African government aimed at alleviating hunger in the lives of poverty stricken children (Hall et al, 2005). The HSRC/EPC report (2005) states that 14% of children in South Africa go to school in the morning eating nothing or only having a cup of tea.

" I don't understand the lessons at school because we eat nothing at home "

Learner voice (HSRC/EPC, 2005: 54).

" They come without food and eat here at school... "

Teacher voice (HSRC/EPC, 2005: 54).

99% of school principals surveyed felt that school meals were vital and children came to school because of the food provided. Provision of food also improved concentration levels and improved performance in the classroom offering some measure of relief in these HIV ravaged contexts (HSRC/EPC, 2005).

HIV/AIDS infected children also often require expensive medication and the cost of anti retrovirals often put them beyond the reach of many families who are in desperate need of them. In November 2003 the HIV and AIDS Care Strategy was adopted by the South African government to set up HIV service points (Soul City, 2004). Existing hospitals and clinics were to be used as service centers and each health district was given a service point. These service points now in operation provide free medication, counselling, information, assessment and care to HIV positive people. The service points also refer clients to organizations and volunteers in their communities that complement the services of service points (Soul City, 2004). Hall et

al (2005) state that the HIV/AIDS- Home and Community-based Care and Support Services is another important initiative on the part of the government in partnership with other organizations to help HIV/AIDS afflicted homes. These services make use of community resources to assist HIV affected and infected children and their families.

Social welfare grants are also available to alleviate poverty. Since 49% of adults in KwaZulu-Natal are unemployed there is a high dependency on social grants and pensions. This is the only form of income on which entire households including children have to survive on (HSRC/EPC, 2005). Sithole (2004) reports on a KwaZulu-Natal granny, Mrs Lili Ndlovu of Clermont who supports a family of 13 on her monthly pension of R740. Two sons, nine grandchildren and two great grandchildren live with her. Six of the school going children do not have birth certificates. Thus they cannot get the child support grants. Walker et al (2004) note that as many as 70% of births in Sub-Saharan Africa are not registered thus robbing these children of their rights as citizens.

HIV/AIDS orphans are also eligible for child support grants. A child support grant of R170 is available to children under the age of 9 who are poverty stricken (Hall et al, 2005). In some orphaned households it is possible for the eldest sibling to become a foster parent to the other children enabling older children within this household to receive a R500 per month foster care grant. However in most child headed households older siblings cannot become foster parents because they are under the age of 21 and the “primary adult care giver” to whom child support grants are payable must be 21 years or older (Walker et al, 2004; Hall et al, 2005). This lack of certification and poor design of policies on the part of law makers is impeding the process of social welfare grant applications and making it impossible for HIV/AIDS infected and affected children to access grants which could improve their lives drastically.

2.4. Other Studies Concerning Learners' Perceptions on HIV/AIDS

Taylor, Jinnabhai and Dladla (1999) undertook a study at macro level to gauge learners' perceptions of HIV/AIDS. They conducted research with 691 learners from grades 3-7 to determine the learners' knowledge and behaviours regarding HIV/AIDS.

They used a questionnaire in Isizulu to gain this information from two rural schools in KwaZulu-Natal. Their study found that there were many misconceptions with regard to learners' knowledge and behaviour surrounding HIV/AIDS. Their findings were as follows: 15% of the learners were unaware of the threat of HIV/AIDS as a disease, 21% were ignorant of the ways in which it was transmitted and 55% believed that the virus could be transmitted by playing with an infected person. 43% feared sitting next to an infected person. 48% did not want to use the same toilet and an even greater 59% did not want to share utensils with an infected person. 35% were scared to touch an infected person.

This study shows that many children are still ignorant of the dangers of the HIV/AIDS virus and many are still unaware of how this disease is transmitted. The phobia present in the attitudes that the learners have reflected in this study will no doubt adversely affect the way in which they relate to HIV/AIDS infected or affected learners. The Taylor et al (1999) study is quantitative in nature and a gap can be perceived here. Due to the large number of learners surveyed, each child's particular understanding of HIV/AIDS can only be guessed at. My study will try to address this gap by using qualitative methods to gauge young learners' understandings and experiences of HIV/AIDS.

In 2004 a project aimed at mapping the effects of the HIV/AIDS pandemic on barriers to learning from learner perspectives was undertaken by a team of researchers from the University of KwaZulu-Natal. This qualitative study using participatory methodology was undertaken in schools in the Richmond area. Participants were selected from grades 3, 6 and 9. The study found that poverty, inadequate resources and infrastructures at schools, high rates of mortality, crime, violence, sickness, stigma and poorly designed social policies within an HIV/AIDS context were some of the factors that impeded learning from the learners' perspectives (Van der Riet, Hough, Killian, O'Neill & Ram, 2006). These researchers also noted that resilient factors such as community networks, significant others, spiritual groups and good home backgrounds uplift these children. They also found that most participants were able to identify symptoms of HIV/AIDS accurately and were aware of the modes of transmission of the virus. This study was conducted in both urban and rural schools. My study undertaken in an urban school will add to this research.

The Emerging Voices project was commissioned by the Nelson Mandela Foundation to look at poverty and schooling in a rural context (HSRC/EPC, 2005). This qualitative study used surveys and participatory action research. It incorporated 595 households and 144 primary schools spread across rural areas of KwaZulu-Natal, Eastern Cape and Limpopo. These provinces were chosen for their high learner populations and because they were ravaged by problems of adult illiteracy, unemployment and HIV/AIDS. Voices of all stakeholders in the communities were elicited to map out the relationship between rurality, poverty and schooling. This study found that in rural contexts poverty, the need for child labour, household chores, distance to and from school, school fees, cost of uniforms, lack of food, sickness, HIV/AIDS, disability, teenage pregnancy, bullying and sexual harassment are some of the barriers to schooling and children's participation in schools. My study will focus on an urban context and solely on the learner voice when exploring how HIV/AIDS intersects with other barriers to learning and impacts on the learner.

On 22-24 August 2001, the National Children's Forum on HIV/AIDS was held in Cape Town. Ninety HIV/AIDS infected and affected children were brought together under the banner "Children can make a change- hear our voices". Drawing, drama, writing, painting and discussions were some of the participatory activities employed by facilitators to empower children to talk about the challenges they faced in their daily lives as a result of HIV/AIDS. On the final day of the event the children also engaged with policy makers from the government to voice their views on relevant issues concerning HIV/AIDS. Key themes that emerged from this forum were poverty, child headed households, limited access to education and health care services, discrimination, inadequate social security measures and child sexual abuse. A report on the National Children's Forum on HIV/AIDS was drawn up by Giese, Meintjies and Proudlock (2001) to illustrate these themes in full and give voice to the child participants. The National Children's Forum on HIV/AIDS enabled children to insert their voices into the debate on HIV/AIDS in South Africa. My study seeks to add to these voices by giving children a platform to share their views, knowledge and experiences of HIV/AIDS.

2.5. Summary

Since HIV/AIDS touches the lives of all children in various ways, an important starting point would be to enquire how children understand and perceive HIV/AIDS in their particular context. Baxen and Breidlid (2004a) state that new research has to probe and develop an understanding of how this knowledge is produced in order to contribute to learners making informed choices about their sexuality in an HIV/AIDS stricken world. My study inserts itself into this debate by capturing participant's frames of references, local knowledge and lived experiences within their particular context to understand the meanings they construct around HIV/AIDS. In the following chapter, the research methodology which facilitated this research study will be discussed.

CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN

3.1. Context of Study

KwaZulu-Natal is a region heavily burdened by HIV/AIDS (Nelson Mandela Foundation/ HSRC Study of HIV/AIDS, 2002). This study was conducted at a combined school situated in an urban area in KwaZulu-Natal. The school caters for learners from grade R-12 and has 1250 learners. The medium of instruction is English. The educators are predominantly English speaking and the school has adequate resource facilities. Presently the school's sports fields are not used because of a high crime rate in the area. Learners regularly report being mugged on the way to school and the school itself was a scene of an armed robbery in the past year. The school caters for African and Indian learners from the surrounding areas and is situated within a working class community who have accessed low cost housing. The area is in a state of development as more houses are continually being built.

3.2. Research Participants

Since my study focuses on children in early schooling, the sample consisted of 20 grade 3 learners. All participants were between 8-9 years placing them within the window of hope age range in the battle against HIV/AIDS (Badcock-Walters, 2000). Learners were divided into 2 groups and gender was purposively used in that 5 girls and 5 boys were selected in each group. Since the school had a mixture of African and Indian learners both these population groups were reflected in the sample. All the learners came from working class backgrounds and lived with their families. Two learners lived in a foster care unit as outlined by Phiri and Webb (2002).

3.3. Key Research Questions

The following are my key research questions:

1. What are learners' experiences and understandings of HIV/AIDS?
2. How does HIV/AIDS intersect with other barriers to learning and development to impact on learners' lives?

3.4. Research Process

Since I am an educator at the school gaining access to the school posed no difficulties. The school also has a vibrant culture of teaching and learning and the staff members

are encouraged to develop themselves professionally. With this in mind I confidently approached the principal of the school to gain permission to conduct the research at the school. The nature of the research as well as the research process was outlined to him. He granted permission subject to the approval of the Department of Education. I then made contact with the Department of Education by writing a letter to them. The letter outlined the focus of the research and how the research process would be handled in terms of ethical standards. Written permission was granted by the Department of Education to use the school as a research site. The University of KwaZulu-Natal also granted ethical clearance to proceed with the study (ethical clearance number: HSS/05227A).

The next step was to select the research participants. A group of 20 learners were selected from the class registers using gender and race purposively. A meeting was then held with these learners in which I outlined to them in child friendly terms and easily understandable language what the research was going to be about. Participation was voluntary and they could leave at any stage of the research process. At this stage 2 learners decided that they did not want to participate. These learners were replaced from the register by two more learners who expressed an eagerness to participate. I reiterated to the learners that they could leave at any stage of the research process. All the learners indicated that they were enthusiastic about participating in the process. At this meeting I also encouraged the learners to ask me questions about the research. A lively discussion ensued. The learners were then given letters to take home to their parents informing them of the study in English and Isizulu. These letters also contained requests for informed parental consent to allow their child to take part in the research. Both participants and parents were made aware that all information would be kept strictly confidential and participation was voluntary.

Once parental consent has been obtained participants were then interviewed individually using a structured interview schedule. At the outset of this interview informed consent was sought from each participant individually and issues of confidentiality were explained to them. The questions used, responses and other biographical data that emerged were recorded on an interview schedule. Participants were then placed in two groups of 10 (sample 1 and sample 2). Each group formed an independent focus group and was interviewed separately. However the data from both

these groups were analysed collectively and differentiations were only made between the samples if the need arose.

Three inter related focus groups sessions were then held with each group. The first focus group interview was aimed at building communication and trust with participants whilst exploring the impact of barriers to learning on children. The last 2 sessions focused specifically on HIV/AIDS. Embedded within these focus group interviews were participatory techniques aimed at seeking out and voicing individual and collective experiences. The activities, drawings and discussions elicited rich response from the participants. The focus group interviews were taped and then transcribed using the tape recordings. The children's drawings, written extracts and transcripts all fed into the data in keeping with participatory methodology. Attendance records of the participants were also studied.

During the research process I was an insider adult as opposed to an outsider adult. This made the establishment of rapport easier. MacNaughton, Rolfe and Siraj-Blatchford (2001) note that children are more thoughtful, clear and expressive when they are in the company of familiar adults in well known surroundings. A further advantage of being an insider adult was that I could understand their behaviour better and was more alert to changes in their behaviour which could be have been effected by the research process.

Farquhar cited by Oakley (1994) notes that physical position is important to the power dimension of research. During the research process I seated myself on the same type of chair that participants were seated on. This brought me to the same level as the participants so they could easily establish eye contact with me and they did not have to look up to me. I also gave myself a codename "Aunty Devi" which they thoroughly enjoyed calling me. This codename also helped them relate to me as a friend and a researcher rather than a teacher.

3.5. Research Methodology

As I wished to examine the experiences and understanding of young learners with regard to HIV/AIDS, I worked within an interpretivist paradigm. My framework was

exploratory and qualitative in nature. Neuman (2000: 71) defines the interpretivist approach as

“the systematic analysis of socially meaningful action through the direct detailed observation of people in natural settings in order to arrive at understandings and interpretations of how people create and maintain their social worlds”.

Thus social action is assigned meaning in relation to unique features of particular contexts. Knowledge too is derived from everyday concepts and meanings within a specific context. Working within this framework enabled me to capture participants' frames of references and their context so I could understand how they constructed their meanings around HIV/AIDS.

In qualitative research, human behaviour is described and understood from the perspectives of the social actors rather than explained (Babbie & Mouton, 2001). Neuman (2000) states that an interpretivist researcher seeks to provide detailed description of social settings, interactions and phenomena thus enabling the reader to step into another's social reality. By researching with children rather than on them I was able to enter their everyday world in order to grasp the socially constructed meanings and understand their actions in the way that they themselves do. I was able to access how they experienced schooling in their everyday lives and their perspectives on barriers in the schooling context.

Qualitative research also holds that social reality is not a phenomenon to be discovered but develops from continuous processes of interaction, communication and negotiations (Neuman, 2000). Children are active conscious beings who make choices. Within this qualitative framework I was able to access what knowledge children take for granted about HIV/AIDS and what are their assumptions about the disease. The knowledge and assumptions they have derived will greatly determine their interactions, behaviour and choices when dealing with the pandemic.

Contemporary society is complex, constantly changing and multi faceted. Interpretivist social sciences view facts as fluid and embedded within cultural and social meaning systems. The use of an interpretivist paradigm is therefore compatible

with studies on HIV/AIDS since the pandemic is culturally and socially embedded itself enabling it to change its face in different contexts.

3.6. Methods of Data Production

Data in this study is regarded as produced rather than collected in that children were actively engaged in meaning making throughout the research process. Data was produced by means of a structured interview and focus group interviews. Embedded within the focus group interviews were participatory techniques which enabled me to achieve my intention of giving children voice.

3.6.1. Structured Interview

At the outset, a structured interview was used to gain biographical data on the learners as well as information on the school and home background of the learners. The questions were listed on an interview schedule. Learners answered orally whilst I made notes on the schedule of their responses. The interview was also an opportunity for participants and the researcher to build rapport. It gave participants an opportunity to bring up personal matters which they might feel sensitive to speak about in a focus group situation. One participant (Donita) eagerly confided in me during this interview of the abuse her father inflicted on her mother. Her pain at seeing the domestic violence in her home and meeting her “dad’s girlfriends” was graphically described. She spoke unhesitatingly about how she and brother often sought refuge in the neighbour’s house to escape her father’s alcoholic rages. This information, however, did not surface in the focus group interviews as she did not want others to know of her home situation. Other personal information which participants may be reticent to divulge in the group format was also tapped into. These included age and educational level of family members, financial status of the family, housing conditions, the type of health and nutrition received by each child and the child’s perception of the school and the community.

3.6.2. Focus Group Interviews

Three focus group interviews were held with learners. As part of participatory methodology focus group interviews were chosen because they empower participants to make their voices be heard. Schurink, Schurink and Poggenpoel (1998) define the focus group interview as an open conversation, a purposive discussion on a specific

topic by individuals of common interests or similar backgrounds. Each participant may make comments, responses or reflections enabling a smooth exchange of ideas, opinions and perceptions. It is based on dialogue, and as such, encourages open rapport. Focus group interviews are particularly useful when working with children because some young children need support from their peers to embolden themselves to express themselves freely (Glesne & Peshkin, 1992).

Wilkinson and Birmingham (2003) state that the intimacy of the group setting, combined with the flow of discussion and neutrality of the researcher make focus groups an ideal instrument to generate data on sensitive and difficult issues such as HIV/AIDS. At the beginning I noticed that learners were afraid to express different points of view and preferred to echo what a few were saying. However when they saw that I was listening intently to their views without being critical or judgemental, they were more willing to participate. Participation grew as the sessions progressed. Participants were given an opportunity to talk as “experts” addressing specific issues that concern them and their relationships with others. My participants felt affirmed and important because I was genuinely interested in what they were saying.

The intimacy of the group setting also provided a warm and friendly environment. Group dynamics were carefully negotiated. Since there were few participants there were more opportunities for them to speak as well as sufficient diversity of experiences. Sometimes a participant’s experience served as a trigger for other participants to share similar experiences. Focus group interviews enabled my participants to add to responses, build on and address the input of others thus generating information they might not have thought of had participants been interviewed separately (Schurink et al, 1998; Wilkinson & Birmingham, 2003).

Pattman and Chege (2003) found that focus group interviews improves inter-subjective and dialogical relationships among research participants and between the participant and the researcher. Kelly (1999) defines intersubjective experience as experience shared by a community of people. By researching with my participants through a focus group, I was able to access their collective experiences as well as understand differences between people who could be perceived to be homogenous because of their similar age and background.

The focus group interview also allows for a considerable amount of probing to be done in order to bring to the fore, relationships in the field, phenomena and social processes that we know little about (Schurink et al, 1998). It allows for flexibility to explore if other pertinent issues arise. Indeed, I was often able to probe participants further on points of interest. These types of discussions are not possible with other research instruments such as questionnaires, surveys and structured interviews. Schurink et al (1998) point out that the focus group topics are predetermined and sequenced so that the discussion flows naturally. Wilkinson and Birmingham (2003) also point out that because participants are not forced to answer all questions it minimizes the possibility of lying. Data is also a more honest reflection since participants mainly answer when they feel strongly about something.

Facial gestures, nods of assent, and other gestures captured during focus group interviews enrich data (Wilkinson & Birmingham, 2003). Doherty –Sneddon (2003) states that non verbal communication offers a wealth of information as to how children feel and what they are thinking. An important advantage of using focus group interviews lay in the fact that I could also take note of how issues were being raised, the emotions expressed as well as accompanying body language and gestures. For e.g. when the word ‘sex’ was mentioned, I noticed some learners becoming self conscious and nudging each other indicating that they were sexually aware but regarded sex as a taboo subject for discussion. Thus I was able to note and make meaning of verbal and non verbal behaviour in this context.

3.6.3. Participatory Techniques

Participatory techniques offer opportunities for learner participation in childhood research (Karlsson, 2001). Johnson and Mayoux (1998: 151) state that participatory techniques enable participants to

“make their voices heard, increase their own awareness and understanding and have a determining role in policy development which is directed towards- or is likely to affect- them”.

There is a move away from researching on children to researching with children (O’ Kane, 2000). Participatory techniques were used to capture the voices of the learners in my study.

Participatory techniques can be used even with young children (see, for example, Muthukrishna & Ebrahim, 2006). Craig (2003) states that given appropriate, age consistent research design and knowledgeable researchers who are sensitive to their needs children are articulate, energetic and eager to participate. The researcher's role is to free the child's abilities and creativity within a negotiated framework of rights and responsibilities. Thus the use of participatory techniques builds capacity in children, allows them to set the agenda and engages them constructively (O'Kane, 2000).

In socially disadvantaged settings where children's voices have been neglected researchers are challenged to create space and techniques that enable children to be heard (O'Kane, 2000). Participatory techniques were used in this study as an attempt to address the power imbalance that is often present between the researcher and the participants and in this case between adult and child.

I adopted a participatory approach to data production as this enabled me to involve and actively engage children in the research process. I was able to see through the lens of children how HIV/AIDS is constructed in their lives. Their concrete experiences and responses regarding HIV/AIDS were carefully analysed to create a picture of their knowledge on how to deal with this pandemic. However participatory techniques do have limitations in that the process of data production can be messy. Nevertheless this is offset by the richness of the data that it yields. Participants were actively involved in the research process. Participants were asked to draw, write and tell their own stories in response to various scenarios related to HIV/AIDS.

Participatory techniques are also particularly beneficial in that they do not emphasise reading and writing skills but rather center on visual imagery and graphic representations of ideas (O' Kane, 2000). This allowed for varied literacy skills on the part of the learners. The use of participatory techniques also enabled children to relate the complexity of their experiences through preferred ways such as drawing and game playing. The participatory techniques that I used in the focus groups interviews are listed below.

Drawings

Nieuwenhuys (cited in O’Kane, 2000) found that methods such as games, storytelling and drawing enabled children to be more descriptive of the complexities of their experiences. The drawings produced by the participants provide us with a picture that can be described. They were used to initiate discussions and access feelings about people and events depicted. Participants were involved in drawing sick people to access their perceptions on illness and possible sources of support during illness. Drawings of their school and drawing the effects of HIV/AIDS on families led to rich discussions. By the participant explaining the drawing the researcher gained a sense of their reality. All the participants were absorbed in these tasks and appeared to take them seriously.

Games

Icebreakers were used at the beginning of each focus group to create a friendly atmosphere. Games such as the Pots and Beans Activity outlined by O’ Kane (2000: 146) were adapted to gain a quantifiable measure of children’s viewpoints. Participants listed their fears about HIV/AIDS on pieces of paper and they were given 2 beads each to place on the fears they felt most strongly about. In the first focus group the game “Lets Rock and Rose” where children associated a rock or a rose with good or bad things that happened in their lives respectively also lent itself to quantification as well as discussion about these events. A brainstorming game was also done to see what associations participants made with the word HIV/AIDS. A True and False game was also played where participants discussed statements on HIV/AIDS in same sex groups in an attempt to overcome any inhibitions. These games led to the production of valuable data.

Projection

MacNaughton et al (2001:166) state that persona dolls and puppets provide children with opportunities to “act out” their emotions and they also assist in building a “narrative or scenario about a more ‘real’ personality”. They cite studies by Brown (1998) and Bosisto and Howard (1999) in support of this. A doll “ Karabo” was used to help the participants voice their attitude and feelings regarding children infected by HIV/AIDS by projecting it onto the doll. A doll Mafuse was used to role play the

reasons why children did not attend school. Participants projected their reasons upon the doll. In this way, projection techniques assisted in the production of data.

Story Telling

Children were encouraged to tell stories as well. Engel (1995) states that children tell a wide range of stories that offer portals into the inner workings of a child's mind, personal experience and creativity. Participants were asked to tell the story of why Lindiwe, a HIV/AIDS affected child, did not come to school for a whole week. This led to data being produced in an open ended way.

Movement Evaluation

O'Kane (2000) states that children in 8-12 year age group like to be actively involved in communication activities rather than simply talking. She identifies movement evaluation as a useful technique. Participants were asked to position themselves around the doll who represented a learner with HIV/AIDS according to how comfortable they felt to be around her. The researcher then questioned each participant about the position they had taken and the reasons for it. Another movement evaluation activity was used to find out how different sectors of the community are viewed as assisting children who are affected or infected by HIV/AIDS. A line was set up in the room. One end represented very helpful whilst the other end represented not helpful at all. Midway represented moderate helpfulness. Participants were asked who are the various people who can assist children with HIV/AIDS. Their replies were written on cards. Each card was then held up and participants took their positions on the line according to their evaluations. Further questions with regard to their positions were asked to elicit discussion.

Vulnerability Matrix

Matrices are useful research tools which can be used for basic comparative analysis. The elements are listed on one side and the criteria is listed across the top. Each element is then judged in terms of each criteria. This activity was used to note the vulnerability of various categories of children to barriers children commonly experience to schooling. A blank matrix was provided by the researcher. Participants wrote down various categories of children on one side of the matrix and listed all the factors that they saw as barriers to schooling on the top of the matrix. Participants

then coloured in the vulnerability matrix using red to denote strong links, green to denote possible links and left the block unshaded if there was no link. This helped to identify vulnerable children. It also served to reflect patterns of relative vulnerability between categories of children and barriers to schooling. Whilst the children were actively involved in this activity the researcher clarified why the blocks were shaded or unshaded by asking probing questions.

Diamond Ranking Exercises

This activity focused on the reasons for social inclusion and exclusion. Participants identified factors that may influence their attitude towards peers. What makes children popular and what makes them social outcasts. Participants then ranked the popularity factors on a diamond shaped grid from most important which was at the top to least important which was at the bottom. They then did the same for the factors leading to unpopularity on a separate grid. This activity was adapted from O' Kane (2000). It was useful in that it allowed participants to give equal weighting to some factors by placing them side by side.

3.7. Data Analysis

In keeping with the qualitative nature of the study, data was analysed thematically. Thematic analysis involves seeing, understanding and interpreting phenomena. Themes were identified by searching for patterns when analyzing the transcripts of the interviews (Boyatzis,1998). The results are presented under each theme. Self analysis was also done by participants who explained their drawings and the positions they had taken up during movement evaluation.

3.8. Ethical Issues

Karlsson (2001) notes that in dealing with disadvantaged contexts learner vulnerability is increased in the power dynamics of the research relationship. Therefore the researcher must be more cautious when dealing with issues of consent, confidentiality and validity of responses. HIV/AIDS is a sensitive issue with stigma and shame attached to it. In certain cases, children may not feel comfortable to talk about this issue. An effort was made to put participants at ease. Participants were given the option to withdraw from the discussions, should they be discomforted at any stage without negative outcomes. Children, if not willing to talk were not forced to

participate and if a child showed signs of distress then focus was shifted away from the child.

Written permission and informed consent was gained from all stakeholders such as the school principal, Department of Education, parents and participants. Ethical clearance for the study was also granted by the University of KwaZulu-Natal (ethical clearance number: HSS/05227A). All participants signed confidentiality pledges to ensure that they did not divulge information shared in the group sessions to others. Codenames were chosen by all participants to ensure anonymity and to protect their identities. These code names were written on name tags and collected from the participants as they left the room. Participants appeared to value the confidentiality provided by the codenames. One participant had put his name tag on before the start of a focus group when he had to be excused to visit the toilet. No sooner had he reached the door when he was summoned back by the others who reminded him to remove his name tag. Group rules were also used to reinforce confidentiality.

3.9. Limitations of the Study

In qualitative studies the researcher is the research instrument. As a human being it is impossible to be completely value free and detached from process. However by consciously acknowledging my own subjectivity I was able to keep it in check. There is also a possibility of participant bias in that children may have said what they thought were good answers. However this was minimized in the sense that a variety of different responses was invited and affirmed.

According to Neuman (2000) triangulation in social sciences involves looking at data from multiple angles and viewpoints. As I was the sole researcher there was limited room for additional perspectives. Neuman (2000:125) state that triangulation of observers is beneficial in qualitative studies. If there is only one researcher then “the limitations of the one observer become the limitations of the study”. To counteract this my data was verified by both my supervisor and co-supervisor. I also engaged in peer debriefings with my colleagues to gain multiple insights on the data.

Finally the size of the sample in this study is also relatively small. Hence the study cannot be generalized. However this is not an obstacle in qualitative research which seeks in depth context specific information rather than general trends.

3.10. Summary

This chapter dealt with the research methodology and design that underpinned this study. In the following chapter I will discuss the main findings of this study.

CHAPTER 4: DISCUSSION AND ANALYSIS

This chapter gives voice to learners' experiences and understandings of HIV/AIDS. It also examines the barriers noted by participants to their schooling and the effect of the intersection of HIV/AIDS on these barriers. Participants detailed their knowledge and experiences of HIV/AIDS and spoke about the challenges experienced by HIV/AIDS infected and affected children. They also gave their views on the effectiveness of the support structures that are available to these children. Upon analysing the data several themes emerged which are discussed below.

4.1. Knowledge, Experience and Understandings of HIV/AIDS

The participants had a good knowledge of HIV/AIDS and had more accurate information about the virus in comparison to other common childhood diseases such as chicken pox and measles. Some of the participants also revealed lived experiences of having relatives with HIV/AIDS and profound understandings of the disease as will be outlined below.

4.1.1. *What is HIV/AIDS?*

All the participants easily recognized the words HIV/AIDS and were able to identify it as a deadly disease.

Sam: HIV/AIDS is a very bad sickness

Brenda: HIV/AIDS is a big disease that can kill you and you can ... and you can sleep in bed for many months

Zola: HIV can kill anybody

Some participants had even more sophisticated understandings of the disease and could define it more comprehensively as a result of being exposed to media campaigns.

Danny: HIV/AIDS means that it's a very bad diseases that kills your white blood cells

Harry: HIV/AIDS is a sickness and like its starts on by first ... sickness and like ... your blood has some uh ... You have flu or something and then it gets worse ja HIV is something that could kill you and ja that's what I want to say

Maria: HIV is germs that causes AIDS. It can stay in your body for a long, long time. Although you may not look ill or sick but you can die of it. I heard of HIV in the newspapers and in the news

From the above definitions, it is apparent that the participants associate HIV/AIDS with death. This finding is supported by literature on HIV/AIDS which found that most children see HIV/AIDS and death as almost synonymous (Giese et al, 2001; Walker et al, 2004) Words such as “die” and “kill” are common in these definitions. Not surprising since many of these participants even at this early age have experienced deaths amongst their families and friends due to HIV/AIDS.

Brenda: I heard about HIV/AIDS in the news and my mother tells me that my uncle died with AIDS

*Zola: I took 1 stone and 1 flower
I took one stone, my mother died
I: okay
Zola: he was sick
I: Okay, what sickness she had
Zola: she was coughing*

*Blessing: His mother died and he's staying with her dad
I: Okay, how did his mother die?
Blessing: She got HIV positive*

Justin: Yes, one of my neighbours are living in the homes because their family had died of AIDS and ...

4.1.2. “He is so thin”

Participants appear to have a very good understanding of the symptoms of HIV/AIDS suggesting close involvement with the disease. These findings are similar to Van der Riet et al (2006) who found that learners could accurately describe symptoms of HIV/AIDS.

Phindile: He feels sad and because his body is so small

Usher: Sometimes they are not eating food then they'll get thin

Beyonce: He is so thin and he don't look like other people

Usher: and he's thin and he got sores

Brenda: This is my uncle. He has AIDS and he get AIDS by coughing and flu and ...

I: Okay, how do you know that he has HIV/AIDS. What are some of the symptoms that he had?

Justin: coughing, wheezing and diarrhoea

The severity of the symptoms experienced by some HIV/AIDS patients is simply but poignantly reflected in Brenda's remarks. Whilst playing the game "Lets rock and rose" she carefully selected a rock to represent a hardship in her life and a flower to represent a happy event in her life

Brenda: I take the 1 flower and 1 stone. I take the stone because my uncle died. He got AIDS and I took the stone because ... I took the flower because it was all over

Death is no doubt an escape and a restoration of dignity for many HIV/AIDS sufferers. There is a sense of relief in Brenda's words which is common to most people who watch loved ones die a slow and agonizing death. Similar sentiments were expressed in the National Children's Forum by children living with HIV positive parents who witnessed the suffering and death of their parents (Giese et al, 2001).

4.1.3. Transmission: Choosing to know and not to know?

The participants have a good knowledge of how HIV/AIDS is transmitted and the various modes of transmission. This finding is similar to Van der Riet et al (2006) who found that learners in their study were very knowledgeable about how HIV/AIDS is transmitted. The spreading of HIV/AIDS through touching infected blood is particularly well known amongst the participants in this study.

Justin: This is my picture. This is my friend. He has HIV/AIDS. He has touched somebody's blood, that is how he has got AIDS

Usher: HIV, you can get it if you touch someone's blood, if he get HIV

Akon: HIV is gonna kill you, if you touch the other person's blood and you can go to hospital and sleep for many months

Sharing of needles was also well known amongst participants as a means of transmitting the HIV/AIDS virus.

Danny: When you have HIV, you will stay for a few months, then you will die. HIV/AIDS is spread by sharing needles and touching someone's blood

*I: How do you know that Mike has HIV/AIDS?
Danny: he put the needle on his arm that he found down*

Most participants were aware of sex as a means of transmission of the HIV/AIDS virus but were reluctant to articulate it. When it was verbalized by a few participants the others nudged each other and smiled. This could be attributed to the fact that discussions around sex at this age are avoided by parents and educators who view this as a sensitive and awkward issue (LoveLife, 2000). Rather educators prefer to concentrate on blood and needles as a source of infection in their lessons.

Blessing: HIV starts when you are sleeping with somebody who have HIV and when you love him and you sleep with him, then that time when you get HIV

Usher: you have sex with somebody

Blessing: when you sleep with somebody who have HIV positive when you touch him when you kiss him and when you make sex with him you can get disease

Maria: sharing, when you are sharing food, you cannot get HIV/AIDS and kissing when someone got AIDS and you kiss her, you can't get HIV and sex when you get in protected sex, you get HIV/AIDS

Maria, however, appears to be confused about protected and unprotected sex and misconceives protected sex as leading to the transmission of HIV/AIDS. This is not surprising since children in early schooling are assumed to be asexual so little or no knowledge is imparted to them on the value of contraception and the protection it affords (Bhana et al, 2006a; Lovelife, 2000).

Many children are infected by the HIV/AIDS virus at birth or from breast feeding (Mvulane, 2003). However very few participants were aware that HIV/AIDS can be transmitted from mother to child in the uterus or through breast feeding.

Usher: If the mother has HIV and the baby too will get HIV because the mother will have HIV too

The possibility of HIV/AIDS transmission through blood transfusion was only brought out by one participant and he appeared to be confused over the correct terminology.

Justin: A person who has HIV and you translate their blood, you will get it

However, like the Van der Riet et al (2006) study, participants on the whole had a very good knowledge of how HIV/AIDS could enter their bodies. This is surprising since they appeared to be struggling with the modes of transmission of other common illnesses such as sugar diabetes and chicken pox.

Beyonce: If someone had sugar, she will spread the sugar on to other people

I: What sugar?

Ps: sickness

Tina: This is my cousin. She has chicken pox. She had it when she bit something, she drank something when it was poison. She went for help by the nurse

Sam: This is Pinky. She has chicken pox. She got chicken pox from eating cold things then after that one day that it just came to her .. the chicken pox

A possible explanation for this could be that media campaigns are gaining ground in raising awareness on the transmission of HIV/AIDS.

4.1.4. Preventing HIV/AIDS: What should we do?

Contrary to the findings of Van der Riet et al (2006) where even grade 3 learners were aware of condom usage, participants in this study were restricted in their knowledge of preventative measures. Wearing of gloves when touching blood was a common prevention method noted by participants to safeguard oneself against HIV/AIDS.

Usher: and HIV can you get if you are playing with somebody and you get hurt and you touch his blood and you must wear a gloves

Maria: sharing, when you are sharing food, you cannot get HIV/AIDS and kissing when someone got AIDS and you kiss her, you can't get HIV and sex when you get in protected sex, you get HIV/AIDS

Aside from Maria's mention of protected sex which is misconceived by her as resulting in the spread of HIV/AIDS, participants did not mention the word condom. There was no mention of it as well in the word association activity which centred around the words HIV/AIDS. This may be partly due to the fact that children still regard sex as a taboo subject in front of elders and my adult presence could have closed off this avenue of discussion. However it could also point to the fact that children are largely ignorant of this form of protection.

Traditional knowledge is vital to sustain communities. However the premature death of adults and the progressive orphaning of children at an early age due to HIV/AIDS will result in a loss of traditional knowledge that is passed from generation to generation (Richter et al, 2004).

Participants also did not have any knowledge of anti retroviral drugs programmes which can halt or slow down the progress of the HIV virus to full blown AIDS. This is similar to the findings of Van der Riet et al (2006) who found that whilst learners were aware that they could take medicines for HIV/AIDS, they did not have specific knowledge of anti retroviral drugs. The idea that a cream can assist HIV/AIDS infected people was however raised by the participants in this study. This notion of a cream was first raised by Justin and the others quickly grasped it.

Justin: It means that HIV/AIDS is a very bad disease and you can stay in hospital for months and they give you a cream to get it a little better.

Justin: Needle is the same thing as injection. If you poke it in you, you can get AIDS and die is for HIV. If you have HIV and you don't put the cream you will die. Sickness is you can stay in the hospital for many months and you will get very sick

I: Now tell me about ... a little bit more about this cream. Have you seen this cream?

Justin: no

I: then who has told you about this cream?

Justin: eh I have heard it in the news and in the paper and my mother told me

Sam: blood, if someone has HIV and if you touch their blood, you will get HIV too.

Hospital, if you go to the hospital they will give you one medicine cream

I: What cream is this

Sam: drug cream ... no I don't know the name

I: Okay, thank you Sam

Alicia: the hospital ... if you have HIV/AIDS and you go to hospital they will give you a cream to put on it.

In the true and false activity Brenda reasons:

Brenda: Number 4, there is a cure for HIV/AIDS – false because there is only a cream to take a little bit out

The idea of the cream illustrates to us how powerful the peer network is in the dissemination of information. Peer education can be a valuable tool if the correct information is handed to influential youngsters to be spread amongst their peers.

The participants' persistence in referring to anti retroviral drugs as a cream also suggests that children make meaning on their own terms instead of using adult terminology. This is not surprising since HIV/AIDS is commonly associated with language jargon.

4.2. The Social Face of HIV/AIDS

HIV/AIDS has changed the social context of children's lives. The data from this study reflects the harsh manner in which children living with HIV/AIDS are treated. The prejudice and phobia present in some participants responses will certainly affect the way they interact with HIV/AIDS infected and affected learners.

4.2.1. "They will not love him"

A life size doll was used to portray a HIV/AIDS infected learner, Karabo. Discussions were then held with participants to determine their understanding of the treatment of HIV/AIDS infected children at schools. The scene painted is harsh and uncompromising. Since most learners are aware of the fate in store for them at school it is not surprising that they would rather leave school when they become HIV/AIDS affected or infected (Moletsane, 2003).

Usher: They said they don't scare of them and hit him, that you got HIV you must get out of this school and you must go to the xxxxx(name of an LSEN school)

Blessing: They will abuse him

Fiona: They will laugh at her because she has spots on her body

Donita: They won't play with her because she got AIDS

Ranger: They'll throw stones and all

Malaika: They'll hit him

Maria: They will not love him and they will not share their lunches with him

Brenda: They will not like Karabo because she have HIV/AIDS and then they will leave him alone ...

From the above excerpt, it is evident that HIV/AIDS infected learners are shunned and subjected to violence, abuse, discrimination and mockery. The harsh treatment meted out to HIV/AIDS infected and affected learners is also confirmed by HIV/AIDS affected learners in the National Children's Forum who report that bullying, teasing and isolation are the biggest problems that they and other HIV/AIDS

infected children face on a daily basis at school (Giese et al, 2001). Learners in the study by Van der Riet et al (2006) also note that children with HIV/AIDS are mocked, isolated and disrespected on account of their status.

Participants display an awareness of the effects of this type of behaviour towards Karabo. They attribute negative emotions such as despair, anger and fear to Karabo.

Donita: she gonna cry

Desigan: she gonna feel bad

Malaika: angry

I: Why angry?

Malaika: because they said he must come out from this school

Beyonce: She's going to be afraid because they took her out of the school

However when participants themselves are faced with the challenge of carrying HIV/AIDS themselves, they expect better treatment.

Fiona: They must treat you nice like how they treat their other friends

Harry: They must care for you and they must also treat you like a human being ...not like an animal and ja

Akon: I want people to take care for me and they must give me the food and they must play with me. They must be my friends

From the above excerpt it is evident that participants expect equal treatment based on common humanity and compassionate care from peers when living with HIV/AIDS. This finding is similar to the hope of acceptance and expectations expressed by HIV/AIDS infected and affected children who participated in the National Children's Forum (Giese et al, 2001).

4.2.2. "It will spread to us and we gonna die"

HIV/AIDS is often associated with stigma and prejudice (Moletsane, 2003). One participant, Danny deliberately lowers his voice when he confirms that the person he has drawn has HIV/AIDS suggesting that he may be aware of the high levels of secrecy surrounding the disease.

I: okay what sickness is he having?

Danny: uh ...HIV (whispers)

Participants were also asked to situate themselves around Karabo to indicate how comfortable they were to be around her. Some of the participants stood far away not wanting any physical contact with the doll for fear of becoming infected. The prejudice evident in the attitudes of some participants in this study will no doubt affect the way in which they interact with children living with HIV/AIDS.

Beyonce: If Karabo has AIDS, we cannot play with her or eat her lunch cause it will spread to us and we gonna die

Beyonce: People who have HIV, they don't look like other people. They are so thin

Beyonce: I cannot play with her because she had HIV/AIDS and it will spread to me and if I eat her lunch the HIV will spread to me in my mouth

Phindile: because if I play with the doll or eat her lunch, it is gonna spread to me

This finding is similar to Van der Riet et al (2006) who found that fear and discrimination was also prevalent in some learners towards their HIV/AIDS infected and affected peers. Participants at the National Children's Forum also spoke movingly of the exclusionary practices and the stigma they were subjected to by their peers and community (Giese et al, 2001).

Some participants seem to be paying lip service to the "My friend with AIDS is still my friend" motto whilst hiding deep seated uneasiness about contact with an HIV/AIDS infected person.

Fiona: and if someone has it, you can still play with them because it doesn't spread when you play with them

Having said this Fiona later demonstrates uneasiness and prefers to remain far away when confronted by the doll Karabo who has HIV/AIDS.

Fiona: it will spread

I: How will it spread?

Fiona: When I hold her hand and play with her

These attitudes will not be changed easily in some participants. Simply telling them the correct information about HIV/AIDS will not bring about desired results in all participants (Baxen and Breidlid, 2004b). This is evident in that after being told in a focus group how HIV/AIDS is transmitted Malaika still reports:

Malaika: You must not use the spoon which one ... if someone have HIV if they eat with that thing you must not eat with it ...start and wash it first

I: After you wash the spoon, can you eat with it?

Malaika: no

What this highlights is that knowledge will not automatically result in a change of behaviour. Leclerc-Madlala (2001) notes that this is true of the very nature of the virus in South Africa where adequate knowledge is still coupled with high risk behaviour. Thus whilst learners may be aware of the politically correct way to treat other learners with HIV/AIDS there is no guarantee that they will be able to overcome their own instincts and beliefs.

All the participants in this study deny knowing any learners at the school with HIV/AIDS. However some participants do acknowledge that there may be some learners who have it.

Harry: I don't know anyone but there must be someone in the school that has it

On the positive side many of the participants reacted with warmth and friendship towards Karabo. In the movement evaluation exercise, many of them stood closely by her, touching her dress, holding her hand or putting an arm around her shoulder. They mentioned that HIV/AIDS infected learners must be incorporated into the circle of friends and cared for.

Harry: If someone has HIV you must play with them ... play with them ja so you must care for them and help them ja

Sam: I am standing next to Karabo. I am standing next to her because I care about people who has AIDS

Brenda: I stand by Karabo because I want to help him

Akon: I standing next to him because I came to see him

Danny: I am standing right next to her because I care about people with AIDS. I like to help them

Jenny: I am standing next to Karabo because she has no friend but I am gonna be his friend

4.2.3. "I am scared"

The fear of death reflected in the data is overwhelming. Participants feared death for themselves. This finding is consistent with the research of Van der Riet et al (2006) where participants also feared dying. This is not surprising due to the sharp rise in the mortality rates of many communities to an extent that Leclerc-Madlala (2001) notes that attending funerals has become a primary activity on weekends in many townships.

Maria: I am worried ... I am scared because the AIDS could get in me and I could die

Blessing: I am scared of when I got HIV I can die ... I can die anytime

Justin: I am worried because I might get AIDS and I could die

Most participants were also very worried that close family members could become infected with HIV/AIDS and the effect this would have on their lives if their caregivers died.

Harry: The thing that I am scared of ... like if someone dies that have HIV/AIDS that's important to me. Like someone that's left, that's taking care of me ... and dies I am scared that I won't have no one to take care of me anymore .

Sam: I am frightened if my father gets AIDS and he dies, I am frightened if we don't have no money, what we are gonna do

Akon: I am frightened because when my father got AIDS, he can't go to work

Some of the participants are afraid that members of their families will pass away in their absence. The fear of death of close family members could have a gripping effect on a child's life (Moletsane, 2003; Ebersohn & Eloff, 2002).

Usher: I am scared if no one at home then if no onenot get HIV... if they don't tell us that his gonna die if I went to school ... no one at home and if I come back to school and I'm gonna tell ...if he died

Blessing: When you left them with no one and when you come back to school, you see the ambulance parking by his house and he telling that they told him he has HIV and he died

Phindile: and me too ... if ... if someone at home have HIV and if my father got HIV or my mother ... or my mother and if they go to work and then they die at work

HIV/AIDS affected learners who attended the National Children's Forum also report an intense fear of coming back home to find their HIV/AIDS infected mother/father had died. (Giese et al, 2001).

To quantify participants fears related to HIV/AIDS participants were given two beads to place on two separate cards that reflected their worst fears. Prior to this all the fears related to HIV/AIDS which emerged during the focus group discussion had been recorded on cards by the researcher. In sample 1 of this study participants most feared dying from HIV/AIDS. 6 beads were placed on this card during a game. This was closely followed by people who are important to us dying from HIV/AIDS (5 beads). Thus the fear of death accounted for 11 of the 20 beads given to participants. In Sample 2 there was also an overwhelming fear of death amongst participants. 12 out of the 20 beads given to them were placed on fears related to death. This fear of death due to HIV/AIDS is also validated by the word association exercise where participants in both samples frequently associated the words death, disease, sex, needles, blood and hospital with the words HIV/AIDS.

Other fears involving HIV/AIDS include mainly being excluded from activities and resources.

Usher: I am scared if I have HIV that the other people... my friends they don't want to play with me

Alicia: I am frightened because they won't be my friends

Tina: I am frightened of AIDS because when I don't have lunch, nobody will share with me lunch

Brenda: I am frightened that all people can't go to school because they get AIDS

4.3. Hearing about HIV/AIDS

The data in this study reveals that participants have heard about HIV/AIDS through the media, family members and teachers. They also associate well known public figures such as Nelson Mandela and Nkosi Johnson with the pandemic.

4.3.1. The Media

Most of the participants in this study have heard of HIV/AIDS through the media. This is not surprising as 74% of the population in South Africa has access to television, radio reaches 93% and 40% have access to newspapers (South African Advertising Research Foundation, 1999). Thus the media is a powerful tool in the battle against HIV/AIDS. Participants state that the television, newspapers, radio and magazines have provided them with information regarding HIV/AIDS.

Justin: I have heard many things in the newspapers, magazines, radio and news that people are saying AIDS is a very bad disease that is spreading through all the whole country and they are saying that we must not take needles and poke ... old needles and poke us and touch anyone's blood

Maria: I have heard of HIV in the newspaper so that we must take care of people who have HIV. We must not leave them alone, we must share them lunch when they don't have lunch and we must not take needles and put it in someone's hand

Tina: I heard HIV in the newspapers that telling HIV is a bad sickness. It will kill everybody and it will bugger our blood cells up and we will die

Participants also report hearing about HIV/AIDS from teachers and their parents.

Fiona: on tv and my mum and dad told me

Ranger: in school eh our mam told us

Brenda: I heard about HIV/AIDS in the news and my mother tells me that my uncle died with AIDS

4.3.2. Public Icons

Many of the participants were able to associate icons such as Nelson Mandela and Nkosi Johnson with HIV/AIDS. These icons have been at the forefront of the battle against the pandemic and participants readily acknowledge the part that Nelson Mandela has played in assisting children who are HIV/AIDS infected or affected. Nelson Mandela has commissioned studies on HIV/AIDS to highlight the path of this disease in South Africa (Nelson Mandela Foundation/ HSRC Study of HIV/AIDS, 2002). The Nelson Mandela Childrens Fund also aids children in distress and has now directed its resources to assisting AIDS orphans and child headed households (Garson, 2003). Participants in this study seem to feel a personal connection to him although he is a public figure. This is not surprising since Nelson Mandela is widely regarded as the 'father of the rainbow nation'.

I: Okay, where does he get help from?

Phindile: from uh from some peoples

I: which people?

Phindile: Like uh Nelson Mandela

Ranger: Nelson Mandela

I: Nelson Mandela... how will he help?

Ranger: He can help them, he can ask people who want children. They can't have children he can ask them if they want to adopt them

Harry: He takes care of you ... he loves children and he takes care of you

Malaika: he helps children

Blessing: and Nelson Mandela is very kind

Usher: Nelson Mandela can give you food and can sit with you and can take you to the hospital

Nkosi Johnson who succumbed to HIV/AIDS after a long personal battle is also known amongst participants showing that they have benefited from media exposure on HIV/AIDS. Nkosi Johnson was a child activist who raised awareness and fought for the rights of HIV positive people in South Africa. His address at the 13th International AIDS Conference in Durban helped to raise funds and ease the stigma surrounding the disease (Nkosi Johnson Foundation, 2006).

Usher: This is Nkosi Johnson

I: mmm

Usher: He got HIV

4.4. Schooling in the Context of HIV/AIDS

Education White Paper 6: Building an inclusive education and training system (Department of Education, July 2001) states that learners face many barriers to learning in South African schools. An effort must be made to minimize barriers and maximize participation in educational institutions. One of the key potential barriers to learning in the South African context is HIV/AIDS. Data in this study reflects that HIV/AIDS also intersects with other barriers to learning to the detriment of the child.

4.4.1. “She didn’t come to school”

Moletsane (2003) states that the HIV/AIDS pandemic has adversely affected the motivation and ability of HIV/AIDS affected and infected learners to attend school. Giese et al (2001) state the schooling context is unique in that it provides an opportunity to identify and support HIV/AIDS affected children and if need be refer them to other agencies for additional assistance. Thus a wholehearted attempt must be made to keep HIV/AIDS infected and affected learners in schools. However many HIV/AIDS affected learners are frequently absent from school or withdraw from school to become caregivers (Richter et al, 2004). Most participants in this study attributed Lindiwe’s (a HIV/AIDS affected child) absence from school to a need to care for her family.

Danny: Lindiwe didn’t come to school because he was taking care of his family that that they have ...dying of HIV

Beyonce: She was going to the shop and when her mother sent her to the shop and she was cooking food for them

I: Why couldn’t the mother go to the shop to buy the bread herself?

Usher: because he was sleeping on the bed. ... he can’t go with his self to the shop and Lindiwe cooked for him and he was washing the dishes and he was wash his clothes

Blessing: (school siren sounds) she didn’t come to school because she must wipe all the floors and help his mother. If she want to go to the toilet and carry him up and go to the toilet and put him back to his bed

Besides the physical needs of the family, participants also mention that she sees to their emotional needs. Lindiwe’s presence seems to be a reassurance to the mother that help is at hand. This in keeping with research that shows that many children in HIV/AIDS affected homes experience a role reversal where they are forced to take on adult responsibilities in the face of parents’ illness and incapacitation as a result of HIV/AIDS (Lorey & Sussman, 2001; Moletsane, 2003).

Usher: because if the mother died no one will get help

Maria: Lindiwe didn’t come to school last week because she need to go the funeral and she needs to take care for his mother and his baby brother and she needs to wash the dishes and love them and take care them, hug them and bring them food and wash their clothes and iron their clothes

Participants are aware that Lindiwe's absence from school will be to the detriment of her schoolwork and life chances. These findings are in accordance with that of Richter et al (2004) who found that some of the direct impacts of HIV/AIDS on children are lower educational achievement and fewer vocational opportunities.

Ranger: When they are learning new work they... she will miss out on it and and when she comes mam gives them the work she won't know it and she will get zero for it

Maria: Lindiwe will affect her learning because she will come back at school, she will not know nothing at school. Did not write her work and she will only think about his father and she will not write her work, not learn and when her teacher says she must write something down, she will not write it

Harry: If she doesn't go to school she won't get a better job when she grows up

Maria's account in particular reveals a knowledge that HIV/AIDS affected children are traumatized as a result of death of loved ones and this adversely affects their performance in the classroom.

4.4.2. Intersection of HIV/AIDS and other Barriers to Schooling

During the roleplay activity participants projected their reasons for not coming to school onto a doll called Mafuse. Participants were also asked to give reasons for school absence in the vulnerability matrix activity. Most participants indicated that sickness, bereavement, stigmatization, poverty, hunger, family instability and lack of school uniforms and transport were barriers to schooling with HIV/AIDS infected and affected children being the hardest hit. These sub themes will be discussed below.

4.4.2.1. "I was very sick"

When roleplaying, many participants cited sickness as a reason for not coming to school.

Donita: I didn't come school because I was sick and I was vomiting

Alicia: Hello, my name is Mafuse. I never come to school last week because I was very sick and I was very sick and I went to the hospital and after the one week I came back to school and all my friends asked me why did I not come to school

In the vulnerability matrix exercise both samples included sickness as a barrier to learning at school and shaded in red the blocks that corresponded to children infected

by HIV/AIDS and children whose parents have HIV/AIDS denoting a strong link between these categories and sickness. Thus the participants seem to view sickness as having a strong presence in the lives of HIV/AIDS infected and affected children. This in turn could result in them being absent from school more frequently than other categories of children. This finding is in accordance with literature on HIV/AIDS which shows that in homes where HIV/AIDS is prevalent lower nutritional status and increased vulnerability to opportunistic diseases results in sickness and high rates of absenteeism from school for many learners (Richter et al, 2004; Lorey & Sussman, 2001).

The importance of access to medical care is also reflected in the data. Participants seem to be aware that good medical care and access to doctors, nurses and hospitals is vital to combat sickness and disease.

Phindile: I like to be a doctor because....when I grow up I like to be a doctor because when my child when I have a child .. when my child gets sick I can take him to me

Beyonce: and my third flower, I am so happy because my mama is a nurse

I: Does that help you to have your mother being the nurse?

Beyonce: yes

I: How?

Beyonce: because when I am sick, she gives me medicine

Justin: and I took the flower because my mother has a new job... in a hospital

This is not surprising since Lorey and Sussman (2001) note that the climate of HIV/AIDS has resulted in a weakening of access to quality health care systems.

4.4.2.2. "We must go to the funeral"

During the role play activity it emerged that a death in the family was also a reason that some children were absent from school. This finding concurs with Van der Riet et al (2006) who found that many of the learners had experienced multiple deaths in their immediate families resulting in them being absent from school because they were attending funerals and observing a period of mourning.

Brenda: Hello, my name is Mafuse. I never come to school because my uncle died of AIDS and we had to do all the work, wash dishes and we must go to the funeral

Sam: Hello, my name is Mafuse. I didn't come last week because my mother died and we had to go buy all the funeral things and all and then we had to come home the next week and we had to do all the housejob and all the prayers

When drawing up the vulnerability matrix participants in sample 2 also included this category as a barrier to their schooling. They viewed HIV/AIDS infected and affected children, orphans, poor children and sick children as being very vulnerable to experiencing death in the family which in turn could result in them being absent from school more frequently than other children.

4.4.2.3. "He got something that they don't like"

Some of the participants in this study are adamant that they will not play with other learners who are sick. In the diamond ranking exercise which centred around factors of social inclusion and exclusion participants say Sifiso is not well liked because he is sick with a disease and this is superseded only by the fact that he carries weapons to school. Usher offers the following reason for Sifiso being unpopular.

Usher: because he got something that they don't like and he's hitting other people and...

I: Okay you said he got something that they don't like. What something he's got that they don't like?

Usher: They don't like but he is sick and...

I: he's sick

Usher: ja

When the disease is HIV/AIDS, participants note that learners are made to feel even more isolated. As a result many learners who are HIV/AIDS infected and affected do not want to attend school. Schooling is not a priority when they are excluded and teased by their peers (Moletsane, 2003).

Phindile: This is Sifiso and Sifiso got AIDS and her mother says that she must go to school and Sifiso says that I don't want to go to school because they gonna .. the people some people are going to laugh at me and then her mother says that if they laugh at you, you must come and tell me. I am going to come to your school and tell the teachers

Beyonce: He is just walking alone and other people say they ..they ...they do not like him because because he have HIV/AIDS

Brenda: If you have HIV, it's hard for you to come to school because some children will laugh at you

The data is consistent with high levels of discrimination and stigmatization that learners who are infected or affected by HIV/AIDS spoke about in the National Children's Forum (Giese et al, 2001). The vulnerability matrix did not reflect this category as a barrier to schooling.

4.4.2.4. "I don't have any food to eat"

Participants also felt that a lack of food in the home was another barrier to schooling and they voiced this through role playing activities.

Beyonce: Hello children, my name is Mafuse. I didn't come to school last week because I was so sick and I didn't come to school last week because there was lots of problems in my house. I had no any food to eat in the morning when I woke up and in the ... in the afternoon I don't have any food to eat and I didn't come to school because my father didn't give me money to eat and I was so hungry

In the vulnerability matrix exercise both samples included no food as a category which posed a barrier to schooling. Participants coloured the blocks red for both HIV/AIDS infected and affected learners. Thus participants perceive children as being prone to experiencing a lack of food when there is a presence of HIV/AIDS in the home. In support of this HIV/AIDS affected children at the National Children's Forum also relate how their ability to concentrate at school is impaired due to hunger (Giese et al, 2001). Moletsane (2003) also notes that in HIV/AIDS prevalent homes children have a reduced access to food.

4.4.2.5. "My father didn't have any money"

Williamson (1995) states that HIV/AIDS forces children into poverty and holds them there by denying them access to schools, and cutting them off from formal training and transfer of important life skills from parents. Poverty which is linked to unemployment was also regarded by participants in this study as a barrier to their schooling. During the role play exercises participants commonly cite it as a reason why they are absent from school.

Phindile: Hello, my name is Mafuse. Last week I didn't come to school because my granny ... my granny was sick and my mother said that I mustn't come to school and my father didn't have any money. At work they told him that he mustn't come back to work and then I didn't come to school because my father didn't have any money and my mother is not working

In the vulnerability matrix no money and unemployed parents have mostly been shaded in red by participants when connecting it to children whose lives are infected and affected by HIV/AIDS. Thus participants perceive that children who come from poverty stricken homes that have also been gripped by HIV/AIDS experience a strong barrier to their schooling. This is in accordance with the literature which notes that HIV/AIDS stricken homes have less labour to utilise in income generating tasks and thus little or no money for fees, books and uniforms thus resulting in children from these homes withdrawing from schooling (Lorey & Sussman, 2001; Loewenson & Whiteside, 2001; Ebersohn & Eloff, 2002; Hepburn, 2002).

4.4.2.6. "My dad was drunk"

Desmond and Gow (2002) found that domestic violence was prevalent in many homes that were HIV/AIDS afflicted. Parents fighting with each other and alcohol abuse by parents were also regarded by participants in this study as another barrier to schooling.

Malaika: Hello, my name is Mafuse. I didn't come to school on last year because my dad was drunk and I didn't have money to come to school and my father came back he was drunk and he came to me and he asked me why I didn't go to school and I tell him what am I I tell him and you was drunk isn't and my ... Mafuse his dad hit him because he didn't go to school

Usher in describing a person he knows who is in the same situation as Lindiwe (a HIV/AIDS affected learner) describes the lack of care that is present in some HIV/AIDS infected homes.

Usher: The boys and girls sometimes they don't eat everyday

I: Okay

Usher: and some people they are helping them to give him food and they are going to school

I: Are there any adults in that house ... are there any big people in that house?

Usher: yes

I: There are

Usher: yes

I: Are they working?

Usher: no but everyday they are going to drink alcohol and they don't take care of them

It is apparent from this excerpt that these children mentioned above are able to attend school as a result of outside interventions. However the majority of the participants in

this study do not view parents fighting as adversely affecting the schooling chances of HIV/AIDS affected learners as they left this block blank in the vulnerability matrix.

4.4.2.7. No School Uniforms

A lack of school uniform was also noted by participants as a barrier to schooling in the role playing exercise.

Danny: Hello, my name is Mafuse. I didn't come last week because my uniforms were very wet. And it was raining so they asked my mother why didn't I come to school and my mother told them because my uniform was wet

In the vulnerability matrix activity participants coloured the block red when depicting the strength of this barrier in the lives of HIV/AIDS infected and affected learners. Thus participants perceive the lack of a school uniform to be a strong barrier to schooling in homes that are infected or affected by HIV/AIDS. This is supported by evidence from the National Children's Forum where HIV/AIDS affected learners report being denied their right to schooling because they do not have money to buy uniforms (Giese et al, 2001). Harley (2006) who conducted research in the Richmond area with community members on barriers to basic education also notes that the lack of school uniforms is becoming an obstacle to impoverished children in their quest for education.

4.4.2.8. No Transport

A lack of transport was also noted by participants in the vulnerability matrix exercise as posing a barrier to their schooling. Participants shaded this block in red for HIV/AIDS affected children denoting that participants perceive these children as being strongly subjected to this barrier. This finding is supported by Giese et al (2001) who note that many HIV/AIDS affected children who attended the National Children's Forum report that the journey to school is often long and tiring. They are also exposed to danger as they walk through unsafe areas. Thus many of these children find it difficult to attend school.

4.5. “If Lindiwe’s mother died ...”

Participants were asked to draw a picture and discuss what would happen to Lindiwe (a HIV/AIDS affected learner) and her siblings if her mother dies of HIV/AIDS bearing in mind that her father has also succumbed to the disease. This activity was designed to access participants’ understandings of child headed households. Phiri and Webb (2002) state that the increasing number of orphans can no longer be covered by the safety net of the community. Many children are left to fend for themselves and the burden of care to look after siblings when parents have died is often shouldered by the eldest female child (Walker et al, 2004).

Participants in this study seem to have a very good understanding of the consequences of orphanhood due to HIV/AIDS. The stories they tell of what happens to Lindiwe and her siblings after both their parents die of HIV/AIDS bears close resemblance to the fragmented families and child headed households that the literature on HIV/AIDS reveal (Nelson Mandela/ HSRC Study of HIV/AIDS, 2002, Giese et al, 2001). The need for compassionate caregivers who support and care for HIV/AIDS infected and affected children is apparent in the participants’ accounts.

Fiona: (pointing at drawing) This is the place where they put their mother's body and this is the car and there's the brother and there's Lindiwe and her two sisters They cry and they don't have money to pay rent and lights and water... they will go live by their aunty and uncle and their aunty and uncle will look after them

Brenda: I draw sentences and picture. If Lindiwe mother died, the little sister and her family will cry. If her mother died, they will no money and they must have a person that will keep them safe. Please help us

Participants are also aware that without protective adults HIV/AIDS orphans are very much at the mercy of unscrupulous relatives and strangers who may cheat them or forcibly remove them from their homes because of debts.

Justin: they had no money to pay the light bill and the water account and the electricity

I: and then

Justin: and so they ... they were renting so they had to come out from the house

Brenda: they will live ... they will live at the streets because they have strangers and then they will take the house and then they will be on the streets

These findings match the reality of the situation in child headed households as Richter et al (2004) note that the death of parents due to HIV/AIDS often results in the loss of shelter, property and inheritance for the children they leave behind.

Participants are also very aware of the hardships of orphan life that Lindiwe and her siblings must endure. Participants' accounts match the way in which HIV/AIDS orphans from the National Children's Forum who live in child headed homes described their lives (Giese et al, 2001). The Nelson Mandela/ HSRC Study of HIV/AIDS (2002) also notes that children from child headed households lacked food, clothing, shelter, guidance and support.

Sam: I drew ... I drew a picture of Lindiwe begging for money from people so she can get money and buy food for her sisters and her and her baby brother

I: Why does she need to beg now?

Sam: to buy food and to pay the accounts because they have to use water

Zola: This is Lindiwe's family, they stay in the street

Jenny: Since Lindiwe's mother died and the children will not have no money and they will have no food to eat and they will get poor they ... the children will cry. They will not go to school. Please help us (reads from drawing)

Richter et al (2004) state that when family care is unavailable for HIV/AIDS orphans, foster care and residential projects must be put in place. Barnett and Whiteside (2002) point out that new types of alternate households such as grandparent headed households, child headed households, cluster foster care and large households with unrelated children are now becoming a reality of the HIV/AIDS pandemic. Harley (2006) also cites cases of pensioners who despite their own poverty take in orphans from different families simply because these children have nowhere to go. Participants in this study were also aware that foster homes and foster care can help HIV/AIDS orphans.

Fiona: I know someone down the road. They had HIV and their mother and father died and then they called the homes and they put them in the homes

4.6. Who Cares?

To access participants' understandings of family and community assistance towards HIV/AIDS infected and affected children, movement evaluation activities were done. In this activity, participants positioned themselves on a line reflecting their view on the degree of helpfulness of different sectors of the community to children living with HIV/AIDS. The line ranged from not helpful to very helpful.

4.6.1. The Family

The family is the primary unit of care and nurture for any child. All participants considered the family to be very helpful towards HIV/AIDS infected and affected children in the movement evaluation exercises.

Harry: Families take care of them and when they want things the family buys for them the things that they need like clothes, food, to eat lunch, money to spend at school

Ranger: The family helps them when they have to go to school. They pay school fees and they buy school clothes for them

Maria: The family members are very helpful if you have HIV/AIDS. They will take you to the hospital and you will get medicine

However contrary to this, some HIV/AIDS infected and affected children at the National Children's Forum spoke of the abuse and neglect that was inflicted on them by relatives who had taken them in after their parents died. Some of them report being made to do all the household chores and being given leftover food to eat. There were however affirming accounts as well of the love and care relatives provided to HIV/AIDS orphans (Giese et al, 2001).

4.6.2. What can the Neighbours do?

Neighbours were viewed by most participants as being second only to family in providing assistance to HIV/AIDS infected and affected children. Most participants felt certain that neighbours would provide material resources for orphaned families such as food and shelter as well as assistance with domestic chores.

Beyonce: They can bath the babies and they can cook and they can wash dishes and go to the shop

Phindile: (pointing at drawing) This is her two sisters and ... (hesitant) Lindiwe and they are crying ... they are crying because their mother died and this is next door, the

people that are next door ... they asking why are you crying and they said ... they told them that my mother died and then they said don't cry don't worry. I will take care of you'll and then they bought them juice and Rama and milk and rice and bread and eggs and they gave them R10

I: How will the neighbour help them?

Jenny: to keep them safe

I: How will the neighbour keep them safe?

Jenny: to take them and live with them

Some participants felt that the assistance of the neighbours would allow HIV/AIDS orphans to continue with their schooling. This is in accordance with the findings of Richter et al (2004) that communities are devising ways of sharing labour and relieving caregivers in HIV/AIDS afflicted homes so children can attend school.

Fiona: They can look after the childrens when Lindiwe goes to school

Harry: They can give them something to eat and then they'll make the children sleep

I: And where will Lindiwe be?

Harry: in school

In the movement evaluation exercise most participants considered the neighbours to be most helpful. However, as one participant notes, neighbours can also be very limited in their capacity to help.

Ranger: because ... because they can see for you and they are your neighbours

And they can't only help you they have to see for them too because they don't have much money to help you

This data is similar to the views expressed by HIV/AIDS infected and affected children in the National Children's Forum. Giese et al (2001: 23) quote an HIV/AIDS affected learner from the forum as saying:

" I need food, clothes. At the moment I am given these by mummy (neighbour who has taken them in). But I do not have food. You should understand that she also has got children of her own and is struggling".

Thus it is evident that though many neighbours may wish to help HIV/AIDS orphans their efforts may be constrained by their own impoverished circumstances

4.6.3. Teachers and Care

Most of the participants regarded teachers as instrumental in providing a lot of assistance to learners who are infected or affected by HIV/AIDS. Most participants believed that teachers would pay home visits and give food and money to families that are in need.

Harry: They can take grocery and money and then give it to her and some homework

Phindile: If they are going to go to her house and they gonna give him food and some money to go and buy and all the things

Participants also view the feeding scheme run by the school and teachers as very helpful.

Maria: The teachers can help Lindiwe feel good and giving him lunch so his brain can open and he can concentrate on his work

However contrary to this HIV/AIDS affected children report in the National Children's Forum that they are sometimes excluded from feeding schemes because they have not paid their school fees. Their teachers were often unaware of their personal circumstances and punished them for coming late, not doing their homework or falling asleep in class. Teachers who were aware of learners HIV positive status disclosed this information resulting in stigmatization by other learners (Giese et al, 2001). Other HIV/AIDS affected children at the National Children's Forum noted, however, that teachers were a vital source of support in that they provided food for them, introduced interventions to improve their performance and put them in touch with social workers. Bhana et al (2006b) also note that many teachers especially those in under resourced schools are providing pastoral care to HIV/AIDS infected and affected learners. Although their work is not often recognized they offer a vital service to learners who are gripped in the claws of the HIV/AIDS pandemic.

Data from this study also showed similar findings. Some participants indicated that teachers could intervene and put learners who were orphaned in touch with welfare services.

Usher: They can call the social worker

Blessing: They can help her with ... he must get a new mother that he will stay with when her mother dies

4.6.4. Social Workers: What is their Role?

Majority of the participants considered the social worker to be very helpful in assisting children who are infected or affected by HIV/AIDS during the movement evaluation activities. Blessing, who is in foster care, is very positive about the care given to HIV/AIDS infected and affected learners by social workers.

Blessing: The social worker can help you give you money and give you food and give you a new mother and give you a new family

Justin: I am standing right next to this very helpful because a social worker is very helpful ... It helps you to be good and when you live in the street eh they will take you to a good home

4.6.5. “They will take you to Childline”

Most participants viewed Childline as very helpful towards children who are HIV/AIDS infected or affected as reflected in the movement evaluation exercises. Childline in KwaZulu-Natal offers a 24 hour toll free helpline and crisis counselling to children as well as therapy for abused children (Childline South Africa, no date). However some participants seem to have some misconceptions with regard to the actual services Childline provides.

Justin: Childline is very helpful because if you have AIDS they will take you to Childline. Maybe your neighbour will phone Childline and they will take you to the Childline and Childline will keep you there for a month so you can get better

Sam: Childline can give you medication and they can give you food and water and they can put you in the bed

Ranger: It helps you little bit by giving you tablets and giving you medicines

4.6.6. “The church will give you money”

Most religions incorporate caring for the less fortunate and needy as part of their religious doctrines. Foster (2003) states that faith based organizations care for more than 140 000 children in six Southern African countries who are orphaned or vulnerable due to HIV/AIDS. Volunteers from faith based organizations provide these children with spiritual, material, educational and psychosocial support. Most of the participants in this study considered the church to be very helpful towards HIV/AIDS infected and affected learners. However this only extended to material things such as money, food and clothes. Participants did not mention the church’s involvement in the

spiritual upliftment and provision of comfort towards HIV/AIDS orphans who have lost their parents.

Justin: Lindiwe's family can go to the church where they go on Sunday and they will give ... the church will give them money

Maria: The church is very helpful because when you are poor, the church can give you money to buy some food, some water, something to drink and everything and clothes

Alicia: The church is very helpful if you got HIV and you got no money to go to the hospital, they will give you money

4.6.7. Experiencing Medical Help

Medical personnel such as doctors and nurses were regarded by most participants as being very helpful towards children who are infected and affected by HIV/AIDS. This was also reflected in the movement evaluation exercise. Doctors and nurses were mainly seen as sources of care, expertise and medical help.

Jenny: The doctor is very helpful because he can take care of you if you have HIV/AIDS and she will give you medicine

Justin: The doctor takes care of you and he tests your blood and the doctor gives you an injection and medicines

Maria: nurse ... the nurse is very helpful because she can give you injection and medicines

Danny: The nurse is a very kind person because she takes care of you and and when you are sick, she give you medicine

However HIV/AIDS affected and infected children at the National Children's Forum gave a mixed response to the treatment they received from doctors and nurses at health care facilities. Some participants were positive about the care and medication they received from medical personnel. Others mentioned that nurses were rude to them and often ignored them. Some nurses even spoke about the child's HIV positive status in the presence of others (Giese et al, 2001). A similar attitude was glimpsed in a participant in this study. One participant was adamant that nurses are only moderately helpful during the movement evaluation exercise and stood in the middle of the line. She reasoned that nurses sometimes spoke to adults bypassing children.

Tina: because the nurse sometimes when the children have HIV, they don't worry about the children. She go and first talk to the adults and she not paying interest to the HIV children

I: Do you think it is important for her to pay attention to the HIV children

Tina: Yes

This need for children to be heard and listened to forms the crux of this study. It is an idea that is steadily gaining momentum and growing interest (Aubrey and Dahl, 2005).

4.6.8. Others in the Community?

The Mayor was largely considered by participants to be of little help to children who are infected or affected by HIV/AIDS.

Usher: because the mayor he can't help you to to get the things that you want everyday

Lawyers were also considered to be moderately useful as a majority of the participants stood in the middle of the line during the movement evaluation exercise. Participants were divided over the helpfulness of the police towards children with HIV/AIDS.

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4.7. Summary

In this chapter I have focused on the presentation, discussion and interpretation of data. The main findings of this study have been presented in themes giving voice to how learners' experience and understand HIV/AIDS. The intersection of HIV/AIDS and other barriers to schooling was also discussed. Learners' views on support structures that assist children infected and affected by HIV/AIDS were also explored and found to be mostly consistent with data from other studies. In view of the findings, several implications can be drawn from this study. These I will present in the next and final chapter.

CHAPTER 5: CONCLUSION

This chapter presents the implications of this research study as well as the personal reflections of the researcher.

5.1. Implications

From the findings it is apparent that learners have a good knowledge of HIV/AIDS and some of the common modes of the transmission of this disease such as touching infected blood and sharing needles. However they need to be given more information as to other modes of transmission such as breast feeding, mother to child transmission and blood transfusions. Sex as a mode of transmission needs to be discussed more openly and in depth to dispel misconceptions. Learners must be given accurate information about the sexual transmission of HIV/AIDS. Preventative methods such as the use of condoms and the use of anti retro viral drugs in the treatment of HIV/AIDS also need to be explained fully to learners. Parents within a school community must also be educated on the need to advise young children on sexual matters so as to gain parental support for sex education in schools.

This dissemination of information can take the form of life skills lessons. Themes such as 'Healthy Living', 'I am special' and 'Child Abuse' lend themselves to discussions around sexuality and HIV/AIDS. Care must however, be taken to avoid the high language jargon that is commonly associated with HIV/AIDS as participants in this study had to be assisted with HIV/AIDS related jargon. Lessons on HIV/AIDS must be planned so that appropriate knowledge is built on firm foundations. Child friendly language must be used. Learners must be made aware of the interconnections between behaviour and the spread of the disease so that they can make life saving choices. They must be provided with a comprehensive picture of the disease rather than isolated facts. Edutainment in the form of dance, song and drama should be used to raise awareness on HIV/AIDS.

Learners will also benefit from peer teaching. Influential children who are role models can be used to disseminate the correct information about HIV/AIDS to their peers. Justin's notion that a cream is used to assist HIV/AIDS infected people which was quickly grasped by the others is an example of how learners look to more influential

peers and take their cues from them. The peer network is a powerful tool which must not be underestimated in the battle against HIV/AIDS.

Various people living with HIV/AIDS can be invited to schools to give talks on their lives. This will remove some of the phobia surrounding the disease. Attaching faces to the disease will have a greater impact on learners when they realize that ordinary people like themselves have become infected. Learners through school programmes can also assist people living with HIV/AIDS so that they develop responsibility, understanding and compassion when relating to people infected with HIV/AIDS.

From this study it is also very apparent that learners who are HIV/AIDS infected and affected look to teachers for support. Teachers who are more knowledgeable about the disease are able to offer better support (Giese et al, 2001). The scale of the pandemic is such that HIV/AIDS training must be integrated into initial and continuing teacher development and education. Higher education institutions and the government must take responsibility for these initiatives. Teachers must be trained to face their own fears about HIV/AIDS and to recognize symptoms of abuse, neglect and depression in children. They must be prepared to assess situations by making home visits and take an active interest in learners. They must also be trained to respond appropriately with techniques to counter stigmatization and ways to provide psychosocial support to children in early schooling. Teachers must also respect confidentiality regarding the status of HIV/AIDS positive children as this will encourage other children to open up to them.

Another important finding of this study was that children are very fearful of death for themselves and their loved ones. Some of them have already experienced death in their families due to HIV/AIDS. It is imperative therefore to teach learners coping skills and how to handle grief and loss. Income generating skills must also be taught to learners as a survival skill and to give them a sense of independence. Since many of the learners regard hunger and poverty as a barrier to their schooling and strongly link it to homes where HIV/AIDS is prevalent, food gardens and nutrition programmes must be established in schools to help alleviate hunger. Some impoverished schools have also now become fully subsidized by the government. Learners who attend these schools do not pay school fees and are provided with stationery. This is a positive

move which must strive to encompass all schools in an attempt to overcome the barrier of poverty to schooling.

From this study it is also apparent that most participants see the extended family as a source of care when children are orphaned due to HIV/AIDS. Care of orphaned children by relatives is a favoured model by welfare services (Giese et al, 2001). However the capacities of these families need to be built as the intake of additional children in already impoverished homes leads to stress and neglect (Williamson, 2000). Grants should therefore be made available to the caregivers of orphaned children and extended up to the age of eighteen since it is most likely that by this age orphans would have completed their schooling. This may lead to better care of orphans.

Participants in this study spoke about how HIV/AIDS infected and affected children are turned out of their homes when they become orphaned. Policies and laws that protect children's inheritance must therefore be put in place. Policies such as the child support grant also need to be changed in order to meet the needs of child headed households. To this effect, the age of caregivers can be lowered so more child heads of households can access these grants. Finally policy makers need to engage with HIV/AIDS infected and affected children to determine how best to meet the needs of these children. This can be done by holding open forums and meetings with children living with HIV/AIDS.

5.2. Researcher Reflections

Before I started this study I was convinced that none of the learners at my school had personal experience of HIV/AIDS. To my surprise, I learnt that some of the participants had family members who died of the disease. I had encountered many of these participants before on a daily basis yet prior to the research process I had no idea of the challenges they faced in their lives. Doing this research has now caused me to be more alert to the children around me as many of them are suffering in silence. I have changed my agenda to actively encourage casual chats with children to make myself more approachable to them so that they will be able to turn to me should the need arise. I am now acutely aware of the need for educators to form solid relationships with young learners in a HIV/AIDS context.

During the study I also developed a tremendous amount of respect for the young participants and was awed by their honesty. As they were all young children, they could easily have been perceived to be homogenous in their views. However the module 'Perspectives and Practices in Early Childhood Education' in my Masters course work caused me to believe otherwise. My expectations were more than met. The learners expressed diverse opinions about a range of experiences. They were profound in their world views and displayed a high level of maturity in their thinking.

Finally doing this study enabled me to see HIV/AIDS as more than a disease. A global picture emerged of the often untold suffering HIV/AIDS brings to children when it enters their lives. As an educator I am now acutely aware of the power I and others hold to change the lives of the children we touch. It is a power that must be put to good use. I consider my thesis as a tool in this crucial direction.

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APPENDIX A

The Directorate of Education
Department of Education and Culture Services
25 May 2005

Dear Sir

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT SCHOOL

I am a foundation phase educator currently teaching at Savannah Park Secondary. As part of my professional development, I am presently enrolled for a Masters Degree in Psychology of Education. I have completed my first year courses and am now required to do a dissertation.

My research will focus on HIV/AIDS as a barrier to learning and how it intersects with other barriers such as poverty and crime and impacts on the learner. I will be gauging learner's understanding and knowledge of HIV/AIDS through focus group interviews with the children. My sample would be a random group of children in grade 3 from Savannah Park Secondary.

Before conducting my research I would obtain parental consent for all the participants. All information given would be kept strictly confidential and participants will be free to withdraw at any stage of the research. I give you my undertaking that I will follow research ethics in handling the data as well.

My research is aimed at giving children a voice on this issue. I hope that you will consider my request favourably and grant me permission to conduct my research at my school.

I look forward to your reply and thank you for your time and consideration.

Yours faithfully

K. GOVENDER (MRS)

Contact no : 031 4092762
031 7061826



PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI
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NHLOKOHHOVISI

PIETERMARITZBURG

HEAD OFFICE

Inquiries:
Ibuzo: Sibusiso Alwar
Ivrae:

Reference:
Inkomba: 0051/05
Verwysing:

Date:
Usuku: 29 August 2005
Datum:

RE: PERMISSION TO CONDUCT RESEARCH

TO WHOM IT MAY CONCERN

This is to serve as a notice that **Mrs K Govender** has been granted permission to conduct research with the following terms and conditions:

- That as a researcher, he/she must present a copy of the written permission from the Department to the Head of the Institution concerned before any research may be undertaken at a departmental institution.
- Attached is the list of schools she/he has been granted permission to conduct research in. however, it must be noted that the schools are not obligated to participate in the research if it is not a KZNDoe project.
- **Mrs K Govender** has been granted special permission to conduct his/her research during official contact times, as it is believed that their presence would not interrupt education programmes. Should education programmes be interrupted, he/she must, therefore, conduct his/her research during nonofficial contact times.
- No school is expected to participate in the research during the fourth school term, as this is the critical period for schools to focus on their exams.

Bhimkulun

SUPERINTENDENT GENERAL
KwaZulu Natal Department of Education

UHULUMENI WAKWAZULU NATAL
UMNYANGO WEMFUNDO DEPARTMENT OF EDUCATION DEPARTEMENT VAN ONDERWYS
2005 -08- 29
ISIKHWAMA SEPOSI PRIVATE BAG / PRIVAAT SAK X04 ULUNDI 3838
RESEARCH, STRATEGY AND POLICY DEVELOPMENT

APPENDIX B

Dear Parent/ Guardian

Greetings to you! I am writing to you to find out whether you will kindly assist me in a project that I am involved in. I am doing a small study to find out what children know and understand about barriers or risk factors that they may be experiencing in their lives, in other words, what are the things that make it hard for children to benefit from schooling and what are the things that worry them about their schooling.

These barriers or risk factors may include crime, poverty, violence, drug, alcohol abuse, and HIV/AIDS. I will be doing focus group interviews with the children, in other words, I will talk to them and discuss their experiences in a group of about 10 children. Everything the children talk about will be kept confidential. I will make sure that your child understands that his or her participation is voluntary, and that he/she can stop participating at any time during the interviews.

I think the information I get from the children will be valuable to the school, and that it can be used in future to make our life skills programmes suit the needs of all children..

I shall be grateful if you will allow me to work with your child on this project. If you do, please sign the form below to indicate that you have given me permission. If you need any more information, I shall be happy to provide it. Please call at the school or phone me at: 7061826/ 4092762.

Thanking you

Mrs K.Govender

I _____ parent/ guardian of _____

in Grade _____ give consent for my child/ward to take part in the study and interviews.

Signature

Date

APPENDIX C

Mzali othandekayo/ mbhekeli

Ngiyakubingelela. Ngikubhalela lencwadi ukuze ngithole ukuthi ungangisiza yini kulomkhankaso engiwenzayo. Ngenza izifundo zokuthola ukuthi abantwana bazi futhi beqonde ngezinkinga abangahlangabezana nazo empilweni yabo. Ngamanye amazwi izinto ezenza kube lukhuni ukufunda nalezo ezenza kufundeke kalula.

Lezo zinto eziyingozi kukhona ubugebengu, ubuphofu, udlame, izidakamizwa, uphuzo oludakayo kanye nengculazi. Ngizobe ngibuza izingane imibuzo, ngamanye amazwi ngizoxoxa nabo ngabakwaziyo. Bazoba bengamaqembu. Mhlawumbe bazoba yishumi eqembini. Okuzokhulunywa kuzoba imfihlo. Ngizoqinisekisa ukuthi ingane izozisiza ngokuzikhethela.

Ngiyacabanga ukuthi ulwazi engizoluthola kubantwana luzongisiza. Nangesikhathi esizayo lungasebenza ukuthuthikisa impilo.

Ngojabula uma ingane yakho ingangisiza kulezifundo zami. Uma uyivumela ngicela usayine leliphepha.
Uma kukhona ofuna ukukubuza ungafonela esikoleni ngalenombolo (031)706-1826 noma ekhaya (031)409-2762.

Ngiyabonga
Mrs K. Govender

Mina _____ mzali ka _____

ofunda ugrade _____ ngiyavuma ukuthi umntwana wami abekhona kuloluhlelo.

sayina lapha

usuku

LEARNER INTERVIEW SCHEDULE

1. Personal Information

Learner's Code Name: _____
Age: _____ Gender: _____
Grade: _____

2. Family Background

(Circle where applicable)

- 2.1. Are both your parents living? Yes No
2.2. If not, who is deceased? _____ How? _____
2.3. Do you live with both your parents? Yes No
2.4. If not, which one or who do you live with? _____
2.5. How many other people live in your house? _____
2.6. Who are these people? _____

3. Age And Educational Level Of Family Members

- 3.1 How many people who live with you are aged below 2? _____
3.2 Who cares for them? _____
3.3 How many people are aged between 2 and 7 years? _____
3.4 Are they at home, in school or day care? _____
3.5 How many are aged between 8-12 years? _____
3.6 Are they in school ? What grade? _____
3.7 How many of these people are aged between 13-20 years? _____
3.8 Are they in school ? What grade? _____

4. Finance

- 4.1. How many people in your family are employed full time? _____
4.2. What do they do? _____
4.3. How many people in your family have part time work or do hawking (buying or making things to sell)? _____
4.4. How does your family get money to buy food and pay accounts? _____
4.5. Does anyone in your family collect any of the following:(Circle where applicable)
Child care grant Yes No
Foster care grant Yes No
Disability grant Yes No
Pension Yes No
4.6. Who is responsible for paying the accounts and buying food for the family? _____

5. Housing Conditions

(Circle where applicable)

5.1 Do you have your own home? Yes No

5.2 What is the building made of? _____

5.3 Do you have your own room? Yes No

5.4 If not, who do you share your room with? _____

5.5 Does your family own a car? Yes No

5.6 Does your family own a cellphone? Yes No

5.7 Does your home have the following?(Tick where applicable)

	Yes	No		Yes	No
1. A separate kitchen			8. Electricity		
2. A separate bathroom			9. Telephone		
3. An outside toilet			10. Television		
4. An inside toilet			11. Newspapers/ Magazine		
5. A pit/ bucket toilet					
6. No toilet					
7. Piped water					

6. Health and Nutrition

6.1 How often do you visit the doctor? _____

6.2 What was the reason for your last visit? _____

6.3 How many meals did you eat yesterday? (breakfast, lunch, supper) _____

6.4 What did you eat in those meals? _____

6.5 Did you bring lunch to eat? Yes No

6.6 If not, Why? _____

6.7 Do you visit the school tuckshop? Yes No

6.8 Who gives you money to go there? _____

6.9 How often have you and your family gone without something to eat?(tick if applicable).

Never

1-2 days

2-4 days

A week

6.10 Which of these people have provided lunch for you this week? (Tick if applicable)

Neighbours

Friends at school

School feeding scheme

Other (Specify) _____

7. School Matters

(Circle where applicable)

7.1 Did you get stationery from the school this year? Yes No

7.2 If not, who bought your stationery for you? _____

7.3 Does your school have a library? Yes No

7.4 Does your school have computers/ fax machine/ telephone? Yes No

7.5 Does your school have sports fields? Yes No

7.6 How many learners are in your classroom? _____

7.7 Do you have an educator in your class? Yes No

8. Absenteeism

(Circle where applicable)

8.1 Does your educator stay away from school? Yes No

8.2 If yes, how often does he/ she stay away? _____

8.3 Do you go to school regularly? Yes No

8.4 When do you stay away from school? _____

8.5 How many times have you been absent from the beginning of this year?

Never

1-5 days

6-10 days

More than 10 days

8.6 Why were you absent? _____

8.7 Are you ever late for school? Yes No

8.8 If yes, how many times did you come late this week? _____

8.9 Why did you come late? _____

9. School Fees

(Circle where applicable)

9.1 What is the school fees for this year? _____

9.2 Have you paid your school fees? Yes No

9.3 Do you have a balance owing from the previous years? Yes No

9.4 Does the school take any action if your fees are outstanding? Yes No

Tell you to stay at home Yes No

Deprive you of text books Yes No

Treat you differently from the other learners Yes No

Other (Specify) _____

9.5 What do you like about your school? _____

10. Community Matters

10.1 There are many children in this community. What do you think are some of the problems faced by them? _____

10.2 Are any of the following, problems that you have seen, children in your community experiencing?(Tick where applicable)

Poverty-no money	
Deaths in the family	
Crime	
Alcohol and drug abuse	
HIV/AIDS	
Violence and physical abuse	
Child Abuse	
Witchcraft	
Other(Specify)	

8.3 Have you ever experienced any of these problems? Yes No

Specify _____

8.4 What do you like about your community? _____

Thank you for sharing information and doing this interview with me.

FOCUS GROUP INTERVIEW 1

AIM: To build communication and trust with learners.

To focus on the impact of barriers to learning on children in schools.

SAMPLE: Random sample of 10 grade 3 learners - 5 boys and 5 girls

ICEBREAKER

Facilitator introduces herself. Children are then asked to think of code names for themselves and the reason why they have selected that codename. Each child then introduces himself, together with the codename and reason. Eg. “ My name is Melusi. My codename is Fish because Mark Fish is my favorite soccer star.” The group then responds “Welcome, Fish”. Learners are then asked to think of adjectives to describe themselves beginning with the first letter of their codename eg. “Funky Fish. Name tags are made for each code name.

GROUP RULES

The facilitator and the group will then jointly discuss and set up rules to be followed during activities and discussions. Eg. Respect others in the group, agree to disagree, listen when others are speaking, only one person can speak at a time, keep the experiences of others in the group confidential. Learners will then sign a confidentiality pledge.

TOPIC 1: LETS ROCK AND ROSE

Purpose: To find out more about the child.

Have a box of rocks and roses. Ask learners to think back upon their lives and pick up rocks and roses for the good and bad things that have happened in their lives. Let them place their rocks and roses in a row. Let them elaborate on the incident that each rock or rose signifies. Researcher to make notes of how many rose and rocks each child assembles.

TOPIC 2: SCHOOL ATTENDANCE

Purpose: To find out what learners think about their school and what keeps learners out of school.

Give learners sheets of paper. Ask them to draw their school. Ask them to describe and discuss their pictures. Do they like coming to school? Why? List their reasons. Show them a doll . This is Mafuse. He did not come to school the whole of last week. Lets pretend to be Mafuse and find a reason for his absence, Facillitator will go first .Take doll and role play : Hi I'm Mafuse, last week our water was cut because there was no money to pay the account. I could not wash my uniform so I did not come to school. Give each child a turn. Are there any other reasons that you can think of that we have not spoken about here?

TOPIC 3: INCLUSION/ EXCLUSION

Purpose: To find out factors that may influence learners attitudes to peers

Show learners a photograph. This is Thando. He is well liked by his peers. What are some of the reasons for his popularity. List them. This is Sifiso. He is not well liked What are some of the reasons for this? Do a diamond ranking exercise.

What are some of the things that make you want to come to school?

I like to come to school because.....

TOPIC 4: BODY MAPPING

Purpose : To find out learners knowledge about sickness

Ask learner to draw a picture of a sick person. Let each learner explain their picture. Who is the person in the picture? What sickness are they suffering from? Discuss the symptoms this person is suffering from ? What help does he receive?

CONCLUSION

Ask learners to lie on the mat and start relaxing each part of their body eg relax your toes moving upwards. When they are completely relaxed ask them to open their eyes and tell how they feel. Thank learners for their cooperation. **Serve juice and snacks.**

FOCUS GROUP 2

Remind learners of group rules and confidentiality pledge

ICE BREAKER

Learners will play a game called “River and Bank”. Group will stand in a ring formation. If facilitator shouts river, the group must jump forward and if she shouts bank, the group must jump backwards. Anyone who makes a mistake sits out.

TOPIC 1: AWARENESS OF HIV/AIDS

Purpose: To gain an understanding of learners awareness of this disease.

Group discussion

Have you heard of HIV/AIDS?

What does it mean to you?

Where have you heard about it?

Do you think that there may be people at your school who are infected by HIV/AIDS?

Do you have any fears concerning the virus? What are they?

Facilitator writes down all the fears that learners have reported on pieces of paper and places the papers on the floor. Each learner is then given 2 beads and told to place them separately on the papers which reflect their worst fears about HIV/AIDS. The facilitator will then count the beads and make records.

TOPIC 2: ATTITUDE TOWARDS PEERS WITH HIV/AIDS

Purpose : To find out about learners attitudes towards peers with HIV/AIDS.

Random formation

The facilitator introduces to learners a life size doll. Explain to learners that the doll is a learner in their school called Karabo. She has HIV/AIDS. They must now position themselves around the doll according to how comfortable they feel to be around her. Learners stand in their positions and the facilitator questions each learner about the position they have taken and the reasons for it.

The group then comes together to discuss the following questions.

Do you know of any learner like Karabo in your school?

How are they treated? How do you think they feel?

If you were Karabo, how would you like to be treated?

What messages have you heard about HIV/AIDS?

TOPIC 3 : KNOWLEDGE OF HIV/AIDS

Purpose: To find out learners perceptions of HIV/AIDS.

Let learners form 2 groups.

Each group must discuss whether the given statements are true or false

GROUP 1

1. HIV causes AIDS.
2. A baby can become HIV positive through breastfeeding.
3. AIDS can be caused through witchcraft.
4. There is a cure for HIV/AIDS.
5. A person who looks healthy is uninfected by the HIV/AIDS virus.

GROUP 2

1. AIDS is a disease that affects the immune system of the body.
2. HIV/AIDS can be transmitted through kissing.
3. AIDS can be cured by sex with a baby.
4. The results of an HIV/AIDS test are confidential.
5. Only bad people contract HIV/AIDS.

The groups then come together and elect a spokesperson to report on the choices made by their group as well as provide feedback as to the reasons behind the choices.

The facilitator makes available the correct information to the learners as well as additional information on HIV/AIDS.

TOPIC 4: BRAINSTORMING EXERCISE

Purpose: To find out learners feelings towards HIV/AIDS

Facilitator will write down HIV/AIDS in big letters and each learner will write down words that they associate with this term on separate lists. Compare these lists to see if there are any common words. Let learners discuss their lists. Are there any positive words? If not, what positive words can we add on?

CONCLUSION

Facilitator gets learners to each think about the future? What would they like to be when they grow up and why? The group then concludes by singing Barney's Song: I love you ... Facilitator thanks learners for their participation. **Juice and snacks will be served.**

FOCUS GROUP 3

Remind learners of group rules and their confidentiality pledges.

ICEBREAKER

Learners will stand in a circle. They will each be given 5 beans in a packet. They must shake hands quickly with everyone and give the fifth person they have shaken hands with a bean. They must accept any beans they are given. The first person to finish all his beans must shout Bingo and he is declared the winner.

TOPIC 1 : DEALING WITH HIV AIDS

Purpose : To understand how children's lives are affected by HIV/AIDS.

Show learners a picture of a girl. This is Lindiwe. Her father has died recently and her mother and baby brother are very sick with HIV/AIDS. She has two younger sisters who are 3 and 5 years old. She did not attend school the whole week. Tell me a story of why she hasn't come to school. Listen to learners stories and ask more questions.

Are there any other reasons for it?

What do you think she was doing at home?

Does this affect her learning? How?

Why is it important for her to have been at school?

How can the school and teachers help her?

How can the community help so that she can spend more time at school?

Are there any learners at your school who are absent for long periods? Why?

Have you been absent for a long period of time? Why?

TOPIC2: DEALING WITH DEATH FROM HIV/AIDS

Purpose: To find out if learners are aware of how HIV/AIDS related deaths affect families

Ask learners to draw a picture of what they think would happen to this family if Lindiwe's mother dies. Let each learner discuss their picture. Probe aspects of the pictures. Ask further questions.

Where can Lindiwe get help from if her mother dies?

Do you know of anyone in Lindiwe's situation? What help did they receive?

TOPIC 3: MOVEMENT EVALUATION

Purpose: To find out how different sectors of the community are viewed as assisting children who are affected or infected by HIV/AIDS.

Set up a line in the room. One end represents very helpful whilst the other end represents not helpful at all. Midway represents okay. Ask learners who are the various people who can assist children with HIV/AIDS. Write their reply on cards. Now hold up each card and let learners take their positions on the line according to their evaluations. Ask further questions with regard to their positions.

TOPIC 4: INTERACTION OF HIV/AIDS AND OTHER BARRIERS TO LEARNING

Purpose: To find out whether HIV/ AIDS is linked to other barriers to learning
Ask learners to list to you all the factors that can be seen as barriers to learning eg sickness, alcohol abuse, crime etc. Write these down on a blank matrix. Now put down various categories of children on the other side of the matrix. Learners can suggest these categories such as orphans, children with HIV/AIDS, children affected by HIV/AIDS, wealthy children, poor children, children with both parents, orphans, Let learners draw up a vulnerability matrix using the following code: unshaded block denotes no link, green block denotes possible link and red block denotes strong link. Discuss possible reasons for the shadings.(ALT use 1-5 rating, tally scores and represent groups in order of vulnerability for further discussion.

CONCLUSION

Facilitator will conclude the session as follows: We are at the end of our session. I want you each to tell me of something important that you learnt today. Learners share ideas and facilitator does a short recap of the important issues discussed. The facilitator will then ask learners to close their eyes and think about a happy moment in their lives. Learners then open their eyes and talk about their experiences with the person next to them. The facilitator will then thank the learners for their participation and active involvement during the session.

Juice and snacks will be served to learners.