

Exploring the National HIV/AIDS and Lifeskills intervention programme and policy implementation in a primary school in South Durban, KwaZulu-Natal.

by

R. B. Syed Nazim

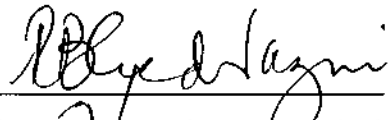
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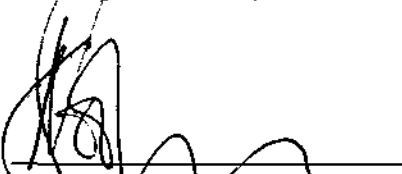
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Year: 2008

DECLARATION

I, R.B SYED NAZIM do hereby declare that this dissertation, which is submitted to the university for the Master of Education Degree, has not been previously submitted by me for a degree at any other university, and all the sources I have used or quoted have been indicated and acknowledged by means of a complete reference.


R. B. Syed Nazim (Researcher)


Professor R. Sookrajh

DEDICATION

This dissertation is dedicated to my beloved parents, the late Mr. Nazim Syed, the late Mrs. Ayesha B. Syed and my beloved sister, the late Nafiza B. Syed. May Almighty grant you the highest abode in Heaven.

Ameen.

ACKNOWLEDGEMENTS

I would like to thank my Creator, Almighty God for blessing me with good health, courage and wisdom which enabled me to persevere in my studies.

To my late sister Nafiza B. Syed, who passed away on 14th March 2009, for her unwavering love, help and support without which it would not have been possible for me to pursue my studies. Nafiza, you are simply the best and I know in my heart that you are in Heaven.

To my supervisor Prof. R. Sookrajh for her guidance and support.

To the rest of my family, for their encouragement, especially my nephews and nieces who constantly assisted me whenever I encountered computer glitches.

To the Life Orientation educators and grade 7 learners (2007) at Birchwood Primary¹ who willingly participated in this study.

¹ Birchwood Primary is a pseudonym

ABBREVIATIONS AND ACRONYMS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
LO	Life Orientation Learning Area
HSRC	Human Science Research Council
KZN	KwaZulu Natal
S A	South Africa
SDCEA	South Durban Community Environment Alliance
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organisation
ARVs	Antiretrovirals
DoE	Department of Education
TRA	Theory of Reasoned Action

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ABSTRACT

HIV/AIDS has probably become the most dreadful of all diseases, as no other disease has managed to threaten civilization as HIV/AIDS. It is capable of destroying large sections of humanity (Schoub, 1999). South Africa has the highest number of people living with HIV/AIDS in the world, while KwaZulu-Natal is the worst affected province in this country (Kaufmann, 2004). There is a high incidence of HIV infection that is reported in younger people between the ages of 15 to 29 years, which suggests that many were infected in their teens. These statistics underline the central position that young people play in South Africa's HIV/AIDS epidemic.

Mandela (2005)² states that in confronting the severe threat of HIV/AIDS, fellow South Africans have to jointly take responsibility to save this nation. The experiences in other countries have taught us that HIV infection can be prevented by investing in information and lifeskills development for the youth.

This study focuses on the implementation of the National HIV/AIDS policy and HIV/AIDS and Lifeskills intervention programme at a public primary school in the South Durban region in KwaZulu-Natal. It examines:

- The perceptions of the Life Orientation (LO) educators towards the HIV/AIDS policy and intervention programme.
- The impact that the intervention programme has had on learner awareness and knowledge of the epidemic.

The population consisted of 5 Life Orientation educators and 30 grade 7 learners. Information and data was gathered by qualitative methods viz: the use of semi-structured and focus group interviews.

² President Nelson Mandela, the first democratically elected Black president of South Africa, cited in the *Foreword*, in Abdool Karim and Abdool Karim (2005).

Some of the findings that emerged from the study suggest that:

- The National HIV/AIDS policy and intervention programme *is* being implemented at the school.
- The LO educators have a good knowledge and understanding of the contents of the National HIV/AIDS policy. However, training is lacking in the teaching of HIV/AIDS education.
- The learners have a fairly sound knowledge about how the virus is transmitted and how it can be prevented.
- Learners also have a positive attitude towards those with HIV/AIDS with regards to acceptance, providing assistance, showing them love, and respect and by being supportive.

An important challenge faced by the school is to ensure that learners continue to receive salient information and knowledge about the epidemic and that educator's get the necessary training especially with counselling of learners who are infected and affected by the virus. This will help to enhance the quality of the teaching of HIV/AIDS and Life Skills education during the Life Orientation learning area.

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CHAPTER ONE

INTRODUCTION AND ORIENTATION TO THE STUDY

1.1. Introduction

The devastating impact of HIV/AIDS is well documented by social researchers and in the public and government media. According to Irwin, Millen and Fallows (2003) HIV/AIDS is not only a deadly disease; it is the greatest scientific, political and moral challenge of our era. Schoub (1999) states that no other disease has so menaced civilization as AIDS. It has a huge potential for mass destruction of large sections of humanity. In this chapter, as a background to this study, the problem of HIV/AIDS is examined globally, nationally and locally. Secondly, this chapter focuses on the factors that have contributed to making South Africa the epicentre of the HIV/AIDS epidemic. Thirdly, it examines the crucial role the primary school has in informing children about the facts and dangers of HIV/AIDS. Finally, the purpose of the study, the critical questions, the rationale and an overview of the study are stated.

1.2. The Context:

1.2.1. The impact of HIV/AIDS globally

Globally, there has been a rapid increase in the number of people infected with HIV, from just a handful of cases in the early 1980's to about 33.4 million to 46 million living with HIV/AIDS in 2005. An estimated 4.1 million people became newly infected with HIV and about 2.8 million died as a result of AIDS (UNAIDS, 2006). The number of people living with HIV has continued to rise, partly due to population growth and now more recently to life prolonging effects of antiretroviral therapy. According to Abdool Karim (2005) 20 million people have already died of AIDS. Kelly (2000) states that AIDS is killing more people worldwide than any other infectious disease. The continent of Africa has experienced as many AIDS related deaths in the last two decades of the twentieth century as Europe experienced during the bubonic plague era in the 14th century. It is undoubtedly,

the world's most devastating epidemic, the deadliest that humankind has ever experienced and its impact has been far worse than anyone first predicted (Abdool Karim, 2005).

1.2.2. HIV/AIDS and Sub-Saharan Africa

More than seventy five percent of all AIDS deaths occurred in Sub-Saharan Africa. This region has the largest burden of AIDS. The epidemic in this region is highly diverse and especially severe in Southern Africa, where some of the epidemic is still expanding. In 2007, this sub region accounted for approximately 32% of all new HIV infections and AIDS related deaths worldwide (UNAIDS, 2008). Contributing to these statistics is South Africa: the HIV/AIDS Capital of the World.

1.2.3. South Africa: the HIV/AIDS Capital of the World

Since the first AIDS case was diagnosed in 1982 in South Africa, the prevalence level has increased from less than one percent in 1990 to nearly 25 percent ten years later. According to UNAIDS (2006), an estimated 5.5 million South Africans were living with HIV in 2005 and this makes South Africa, the country with the largest number of infections in the world. Approximately 1.8 million people have died of AIDS related diseases since the epidemic began. From all the deaths that occurred in South Africa from 1997 to 2005, it is estimated at least 40% of these deaths were AIDS related. Rising death rates have contributed to the decline in the country's population growth rate from 1.25% in 2001 to 2002 to slightly more than 1% in 2005 to 2006 (UNAIDS, 2007).

South Africa's AIDS epidemic is one of the worst in the world and has thus far shown no evidence of a decline (UNAIDS, 2006). According to the Development Bank of South Africa, more than 7.6 million South Africans are HIV positive (Daily News, 2008)¹. Of the 5.5 million people living with HIV in 2005, an estimated 18.8 % fell in the age group 15-49 years. Furthermore, according to a national household survey done in 2005, there are high levels of HIV infection among the young people aged between 15-24 years; a sign that the

¹ (Daily News, 06/05/2008): Editorial: AIDS Stats Getting Worse.

epidemic has not lost momentum (HSRC, 2005). That the epidemic has spread so rapidly in South Africa is not surprising (Dorrington and Johnson, 2002). Whiteside and Sunter (2000) concur that the South African public is highly susceptible to the spread of HIV and extremely vulnerable to its impact. Van Graan (2003)² asserts that the struggle against apartheid in South Africa was a 'struggle for human dignity, for life, for democracy, for non-racialism, for gender equity....' He equates these struggles with this country's battle against HIV/AIDS.

Several factors have contributed to making South Africa the epicentre of the HIV/AIDS epidemic. These include government policies, women's' vulnerability, economic conditions and incorrect information.

Abdool Karim (2005) suggests that a lack of economic conditions and poverty are more pronounced in rural and isolated areas and influence men and women to migrate in search of employment and better economic opportunities. When men are away from home for prolonged periods, conjugal stability and social cohesion are disrupted and this increases the risk of HIV infection. They also establish new sexual networks that can create a greater risk of them acquiring HIV, and the risk of them infecting their spouses or partners on their return home. These circumstances place women in a very vulnerable situation of HIV infection. HIV in mobile couples is two three times higher than that of more stable couples.

According to Dorrington and Johnson (2002) there remains a large portion of the population that, as a result of illiteracy, geographical isolation and incorrect information, are still ignorant of the basic facts regarding HIV/AIDS, although a large number of public HIV/AIDS awareness and education campaigns have been launched. One of the greatest obstacles to a broad mobilization against HIV/AIDS is misinformation about the epidemic. Ignorance breeds passivity, pessimism, resignation, or a sense that HIV/AIDS is someone else's problem. To act effectively, people must have a sound knowledge. Tools to contain the spread of HIV and prolong the life for people with HIV/AIDS do exist. Accurate

² Van Graan. (2003). Struggle the beloved artist.
(<http://www.hivan.org.za/network/ArtistsAction.asp>) downloaded on 13/9/2007

knowledge about the epidemic may awaken a sense of urgency to the threat of HIV and may enable effective action (Irwin et al, 2003).

The increase in AIDS mortality has been borne disproportionately by women especially young women. There has been a sharp increase in the number of deaths of South African women in their twenties over the past five years. This is due to:

- a function of the biology of HIV infection;
- women are more easily infected than men
- the social and economic disadvantages experienced by women (Walker and Gilbert, 2002)³.

This pattern of increased vulnerability to HIV infection is replicated across Africa according to Baylies and Bujra (2001)⁴.

Van der Vliet (2004) spells out that the policies pursued by the last two Ministers of Health in South Africa, as well as by other government officials, have stymied efforts to make antiretroviral drugs available to AIDS patients, blocked the distribution of Navirapine to pregnant HIV positive mothers, and also delayed the disbursing of millions meant to pay for the prevention, education and treatment programmes.

Van der Vliet (2004), further states that, many of their policies have sown confusion among the general public as to the medical link between HIV and AIDS, and have obstructed both prevention and treatment efforts. Formal institutions in South Africa have done little to prevent the rapid spread of the virus, infact; they may have actually accelerated it. Given that my study is located within the province of KZN⁵ in South Africa; the next section examines the prevalence of HIV/AIDS in KZN.

³ Walter and Gilbert, cited in Natrass, 2004

⁴ Baylies and Bujra, cited in Natrass, 2004

⁵ KZN is an abbreviation for KwaZulu-Natal

1.2.4. HIV/AIDS in KwaZulu-Natal

According to the Department of Health (2007), more than 55% of all South Africans infected with HIV reside in KwaZulu-Natal and Gauteng province. The epidemic varies from province to province but HIV prevalence among pregnant women is highest in KwaZulu-Natal and lowest in the Northern Cape. KZN having the highest prevalence rate is a trend that has been sustained since the first ANC HIV prevalence survey in 1990. In the same year KZN had a prevalence rate that was twice that of the national level, and has since sustained a prevalence rate that is approximately ten percent of the national average (WHO, 2004). According to a report compiled by the South African Institute of Race Relations, KZN has the highest HIV infection rate of just over 1.5 million in 2008 and an AIDS related death count of 115483, making it the highest infected province in this country (Natal Mercury, 2008)⁶. The province of KwaZulu-Natal enjoys the dubious distinction of being the worst HIV infected sub-region in the world with very high prevalence within certain parts of KwaZulu-Natal (Badcock-Walters, 2002).

According to the Department of Health (2007) 47% of women who attended antenatal clinics tested positive in the Amajuba district. In the rural village of Umkhanyakude in the north of KwaZulu-Natal, an HIV survey revealed that 51% of the women aged 25 to 29 years, who had participated in the survey, tested positive. In keeping with current trends and in the absence of effective preventative programmes, it is estimated that two thirds of the 15 year olds in this district could be infected with HIV, by the time they reach their 35th birthday according to UNAIDS (2007).

⁶ Newman, L. (2008). Health Education Backlog: Research shows that KZN lags behind. (Natal Mercury, 15/05/08).

1.2.5. The South African Government's stance on HIV/AIDS

The management of HIV/AIDS in this country is a sad one, and to some extent explains the high prevalence levels in this country. However, when the first democratically elected government came into power in 1994, the issue of transformation was its main priority and the AIDS issue was not its primary concern. While the attention of the South African people was focused on the recent political and social changes taking place in the country, HIV was spreading rapidly. As a result, the rapid spread of the virus was not given much attention, nor was the impact of the epidemic acknowledged. If prompt action was given, it is more likely that the severity of the epidemic could have been less (Pembrey, 2008).

President Thabo Mbeki also questioned the widely held view that HIV causes AIDS, in his speech at the International AIDS Conference in Durban in 2002; he avoided referring to HIV as the cause of AIDS and instead focused on the issues of poverty, creating suspicion that he saw poverty as the main cause of AIDS, rather than HIV. This created much controversy and confusion among the people in South Africa (Pembrey, 2008). Hence a perception has developed that the government is doing very little about the epidemic (Whiteside and Sunter, 2000).

According to the World Bank (2002), the importance of commitment by the government and its willingness to invest in early prevention strategies is crucial to containing the epidemic. Dorrington and Johnson (2002), state that without significant, effective interventions and changes in sexual behaviour, fifteen percent of all children who are under the age of fifteen will be orphaned by the year 2015 and this country will inherit an orphaned generation.

Many young people lack basic information about HIV and AIDS and seem unaware as to how infection can occur and how it can be prevented. Schools serve as an excellent point of contact for young people, especially since most young people attend school at some part of their childhood and while there, they can obtain new information about the epidemic and would be more receptive to it than they might in another environment (Berry, 2008).

1.3. The primary school

The primary school has a crucial role to play in informing children about the facts and dangers of HIV/AIDS. It can enable young people to protect themselves and is a crucial tool in the battle against HIV infection. In this section, it is argued that the assumption that the interactive, high risk sexual activity between learners or between learners and others does not occur in the primary phase of education maybe badly misplaced. The age profile of pupils in this phase of education does not necessarily coincide with what might be expected in more normalized conditions. Over age learners are a common feature of the school system from the first grade (Badcock-Walters, 2004). The gravity of the situation maybe further illustrated by the rise in HIV prevalence among girls in South Africa aged 15 to 24 that is 12% in 2002 compared to 16.9% in 2005. The prevalence in females is almost four times that of males that is 16.9% versus 4.4%. These results confirm the findings of the RHRU Youth Survey ('Love Life Survey') conducted in 2003 which found similar HIV prevalence in males and females, 4.8% and 15.5% according to the HSRC (2005). Thus the congregation of young people in a learning environment led by respected and influential educators continues to represent an exceptional opportunity to provide practical information and knowledge to the very young (Badcock-Walters, 2004).

The HIV/AIDS epidemic is a global crisis which demands urgent attention and committed, continuous action by individuals, organizations and sectors. The importance of education as a transformative force in social and economic terms is clear. The sheer size of the global school system, which enrolls approximately 20% of the world population, leaves little doubt that the education sector constitutes a primary site for the containment or disaster of the disease according to Badcock-Walters (2004). In the following section I outline the purpose of the study.

1.4. The purpose of the study:

This study attempts to explore the HIV/AIDS policy and intervention programme that is being implemented at a primary school in South Durban, KwaZulu-Natal.

1.5. Critical Questions

The following critical questions were formulated to provide a basis for the study:

- 1) What are the Life Orientation educators' perceptions about the Department of Education's National HIV/AIDS policy and the HIV/AIDS and Lifeskills intervention programme?

- 2) How has the HIV/AIDS and Lifeskills intervention programme impacted on the grade 7 learners' level of awareness and knowledge of the epidemic?

1.6. Rationale for the study:

The rationale for the study is derived from 3 perspectives namely: personal, contextual and policy.

Firstly, I have a personal interest in the lives of the learners as I have been teaching for over twenty years, and as an educator I have observed and have become aware of the risky sexual behaviours of the young teenagers at my school.

Secondly, from a contextual position it is estimated that there are five and a half million South Africans who are HIV positive, with one thousand AIDS deaths occurring everyday (UNAIDS/WHO, 2006). The highest prevalence rate of 16.2% is among females aged 15 to 24 and the prevalence rate among young adults is 16.2% according to the HSRC (2005). According to Coombe (2002), 40% of the South African public is less than 15 years of age; hence one recognizes that HIV/AIDS represents a devastating epidemic among the youth of South Africa.

Thirdly, from a policy perspective, the South African government formulated the National HIV/AIDS Policy for learners and educators in public institutions (1999), the HIV/AIDS/STD Strategic Plan 2000-2005 and the Tirisano Plan of Action 2000-2004 (Department of Education:1999, 2000) in trying to prevent the spread of the disease. It was against this policy orientated background that the Department of Education introduced Life

Orientation as part of the formal curriculum in schools with Lifeskills, Sexuality and HIV/AIDS Education as its components. It is against this background that my interest in conducting research about the National HIV/AIDS policy and intervention programme was developed.

1.7. Overview of the chapters

This study is divided into five chapters. In this chapter (chapter one) an overview of the HIV/AIDS epidemic internationally, nationally and locally was presented. I also discuss reasons why South Africa is known as the HIV/AIDS capital of the world and why the primary school has a crucial role to play in informing young people about the dangers and facts of HIV/AIDS.

Chapter Two reviews the literature on the impact of HIV/AIDS on adolescents, HIV/AIDS and education, the senior primary phase learners perceptions of HIV/AIDS, the HIV/AIDS and lifeskills programme offered at public primary schools, the problems experienced by educators in the implementation of the HIV/AIDS education and lifeskills programme, a review of policy documents and describes the theoretical framework for the study.

Chapter Three describes the research design and research methodology which was employed in this study viz: sample selection, document analysis, focus group interviews, as well as the context, ethical considerations, challenges and limitations, etc.

Chapter Four introduces an analysis of the findings from the semi-structured interviews that were employed to answer the first critical question and an analysis of the findings from the focus groups that were employed to answer the second critical question. A biographical data of the participants in this study is also presented.

Chapter five presents the research findings, and the recommendations for the study.

1.8. Conclusion

In chapter one, I gave an overview of the HIV/AIDS epidemic globally, nationally and locally and why South Africa is regarded as the HIV/AIDS capital of the world, and reviewed reasons why the primary school has a crucial role to play in informing young people about the facts and dangers of HIV/AIDS.

In the next chapter (Chapter Two) I explore the available literature on issues such as the impact of HIV/AIDS on adolescents. It also offers a critical review of literature related to HIV/AIDS and education in South Africa and offers the theoretical framework for the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. Introduction

In this section, the following is explored: the impact of HIV/AIDS on adolescents throughout South Africa; the implementation of the Lifeskills programme as it has been experienced in schools; a review of four policy documents is undertaken, namely, the National HIV/AIDS Education Policy (1999), the Emergency Guidelines for Educators (1999), the Implementation Plan for Tirisano (2000) and the HIV/AIDS Strategic Plan (2000-2005). The final part of this chapter engages with the following theories: the Health Belief Model of Rosenstock, Strecher and Becker (1994), the Theory of Reasoned Action (Fishbein and Ajzen, 1977) and the Social Cognitive Theory of Bandura (1992).

2.2. The impact of HIV/AIDS on adolescents

According to Mathews (2005), in South Africa, the HIV/AIDS epidemic is driven mainly by sexual behaviours that expose individuals to risk of infection. In tackling the epidemic, the deepest and most difficult problem of all is trying to change sexual risk behaviour. She further believes that young South Africans begin to be sexually active between the ages of 12-24, and that by age 18 half would have had sexual intercourse. According to Hartell (2005), more than a third of adolescents in South Africa are sexually active and that they commence sexual activity at an early age. He continues to state that the average age of onset of sexual activity with several partners is 15 years. Reasons may include peer pressure, curiosity, and particularly for young girls, coercion and material gains. The literature suggests that although they appear to have high level of awareness about HIV/AIDS, this has not translated into substantial behaviour change.

Hartell (2005) further states that few perceive themselves to be at risk; few take the need for safer sex seriously, and do not see AIDS as a personal threat, although most adolescents acknowledge the disease's severity. General knowledge among adolescents about transmissions of the disease was found on the whole, to be inadequate to provide a foundation for developing positive attitudes and safer sexual behaviour. Many young people receive conflicting messages about sex and sexuality; most adolescents make decisions about engaging in sex without having accurate information and access to support and services; they lack negotiation skills in sexual relationships and many do not acknowledge that the disease to be a problem in their area or race group.

According to Abdool Karim (2005) early sexual initiation has been associated with subsequent sexual behaviour and risk of HIV/AIDS in several studies in Africa and elsewhere. Women who become sexually active between the ages of 10 and 14 were more likely to have had sex with men who were at increased risk for HIV and STDs. They are also more likely to have greater number of partners than those who become sexually active at a later age. Younger age of first sexual intercourse is associated with increased risk of infection.

Throughout South Africa, the AIDS epidemic is affecting large numbers of adolescents, leading to serious psychological, social, economic and educational problems. A staggering 71% of deaths among those aged 15 to 49 are caused by AIDS (South African Medical Research Council and Actuarial Society, 2006). Over half of the 15 year olds are not expected to reach the age of sixty. HIV/AIDS has unfortunately become "a disease of adolescence, a period which is often characterized in our own society by its own unique logic, moments of sudden growth and regression, of open search, of personal power and extreme susceptibility to the influence of others"(Silin, 1995:241). Hence one recognizes the seriousness of the epidemic (HSRC, 2005). The scale of the AIDS epidemic among the youth is enormous as HIV/AIDS continues its deadly course.

2.3. HIV/AIDS and Education

Heywood (2001)⁷ points out that the South African Constitution guarantees that young people have the right to protect themselves through access to appropriate information about their own sexuality. Silence about sex, a lack of practical and social knowledge, is perhaps the greatest conduit to spreading AIDS. Young people are at an age where they experiment with sex and are most in need of information about sexuality and HIV/AIDS and if young people are not properly equipped with the knowledge of how to protect themselves if and when they do embark on sexual relations, they face the real threat of contracting HIV (UNAIDS/WHO, 2000).

All teenagers regardless of age, sex or whether or not they are sexually active want to know more about sexual issues (Ganczak, Boron-Kaczmarsha, Leszczyszyn-Pynka and Szych, 2005). Hence, this situation is ideal for educating teenagers about sexuality education and HIV/AIDS. The Minister of Education (2001:1)⁸ states “that the primary means of preventing the disease is by promoting awareness and by educating our young people”. According to Singh, Bankole and Woog (2005), sexuality and HIV/AIDS education should precede, and if possible be provided well in advance of sexual initiation.

The World Bank (2002) has proposed that education offers a window of hope unlike any other for escaping the grips of HIV/AIDS. It offers a ready made infra structure for delivering HIV/AIDS prevention efforts to large numbers of the uninfected population, such as school children as well as youth who in many countries are the age group most at risk. It is also cost effective as a prevention mechanism, because the school systems, parents and the community, and preventing AIDS through education, avoids the major AIDS related costs of health care and additional education supply.

HIV infection in children who attend primary school, which is the age group 5 to 14, is found to be comparatively rare. This group is often referred to as the “window of hope”.

⁷ Heywood, cited in Mitchell, Walsh and Larkin, 2005

⁸ (Kader Asmal, Minister of Education (2001) in the booklet “How AIDS affects me” cited in Mitchell et al., 2005)

They represent one window of hope because they are the least likely ones to be infected with HIV. Considering these learners AIDS free status and their developmental stage at primary school, schools have a responsibility to ensure that they remain uninfected while at school and educated about HIV/AIDS before they reach their peak vulnerable years. This will protect them, and this protection will be reinforced by early training that promotes healthy lifestyles and avoidance of risky behaviours (World Bank, 2002). The impact of education on behaviour is strongest amongst the young, which may reflect the relative effectiveness of ensuring that a child grows up to practice good healthy behaviours, versus efforts to achieve behaviour change amongst adults with established risky behaviours (Kelly, 2000).

It is proposed that since, there is no cure or vaccine for HIV, prevention is the only way in which we can place any limits on the epidemic. One of the most economical and effective means of preventing HIV infection is through education, and enabling primary school learners to be involved in the HIV prevention effort themselves. As a result, HIV/AIDS education has been included in the formal curriculum. As stated in the Lifeskills and HIV/AIDS Education Programme Guide (1999:5) "Education authorities contend that since children want to know about sexual issues, informing them about it would enable them to make more informed choices". According to Badcock-Walters (2002:95) schools can serve as the 'key strategic place on which the battle to mitigate the impact of HIV/AIDS can be won or lost'.

2.4. The primary school learners' perceptions of HIV/AIDS

Children in the age group, nine to twelve, think mostly in concrete terms and not in abstract terms but are still capable of operational thinking. They still find it difficult to think in terms of abstract hypothesis according to Piaget and Inhelder (1969)⁹. However, they are able to distinguish between the causes and symptoms of a disease. They know that HIV can be transmitted through sex, blood, by using drugs and from mother to child. It is also

⁹ Piaget and Inhelder, cited in Van Dyk, 2001

possible for them to make distinctions such as that ‘not all drugs’ and ‘not all types of sex’ can lead to HIV infection (Walsh and Bibace, 1990)¹⁰.

According to Peltzer and Promtussananon (2003)¹¹ children who fall in the age group thirteen to nineteen have a much better understanding of HIV/AIDS than do younger children. Their more advanced cognitive development is reflected in their understanding of HIV/AIDS. They understand the concept of a syndrome and have a clear idea of the causes as well as the effects of HIV infection.

A study¹² was conducted by UNISA students in 2008, to gauge the perceptions of South African children to HIV/AIDS. This study involved participation from nine provinces including children from six to nineteen, yielded the following results. The schools who participated in the study were very knowledgeable about HIV/AIDS in general. Most were able to give a basic explanation of what AIDS is and how HIV is transmitted and how it could be prevented. The depth of the children’s understanding of HIV/AIDS increased with age and their cognitive developmental level. Children who knew more about HIV/AIDS indicated that they had learned about the epidemic from school (Van Dyk, 2008).

When children aged between nine and twelve in UNISA study were asked questions about AIDS, the majority gave concrete answers which were based on external features of the disease that they could observe. Very few children in this age group were able to give an in depth understanding of the concept of the illness. Their responses mirrored their developmental differences in their perceptions of the condition. Children in this age group also showed a fear of blood as a way of transmitting the disease. This fear was linked to the children’s own subjective frame of reference, namely the school situation.

However, the report on the abovementioned study further suggests that the children who fell in the age group thirteen to nineteen had a more advanced understanding of HIV/AIDS.

¹⁰ Walsh and Bibace, cited in Van Dyk, 2001

¹¹ Peltzer and Promtussananon, cited in Van Dyk, 2008

¹² Students who enrolled for an HIV/AIDS counselling course at the University of South Africa acted voluntarily as field workers for this study.

Majority of the children in the senior phase, when asked to give a definition of AIDS, gave a simple definition, that AIDS is a disease. Younger children seldom referred to AIDS as a sexually transmitted disease, adolescents were more ready to define AIDS as such. The drawings of adolescents (aged thirteen and over) also illustrated a higher level of thinking and reasoning. The majority of adolescents were able to name all the primary modes of HIV transmission. A preoccupation with blood as was seen with the younger children was not evidenced in this age group. Adolescents had a much clearer perception of HIV prevention than children in the middle childhood years (Van Dyk, 2008).

The findings in the UNISA study show that HIV/AIDS has become an important part of the lives of many South African school children. Although many school going children have a basic knowledge about HIV/AIDS, many still feel vulnerable and have misconceptions about HIV/AIDS. Schools can play a vital role in empowering children and adolescents with knowledge, attitudes and lifeskills needed to protect them against HIV and to cope with HIV/AIDS in the family and community (Van Dyk, 2008). In the next section the HIV/AIDS Education and Lifeskills programme that is offered at public primary schools is described.

2.5. The HIV/AIDS Education and Lifeskills Programme offered at public primary schools

Public schools are open to all children between the ages 5 to 17 in South Africa, and as such offer an important opportunity for mass based, state and other interventions, that can impact beyond the immediate target population of learners and educators. Schools that conduct interventions for this age group have an opportunity to bring changes to reduce vulnerability to HIV through fostering and developing more equitable, safe, democratic and joyful norms of behaviour. In the last decade, the South Africa government, academics and non governmental organizations have rightly identified young people in school as a priority group for receiving HIV risk reduction interventions (Morrel, Moletsane, Abdool Karim, Epstein and Unterhalter, 2002).

According to Van Dyk (2001) HIV/AIDS education should never concentrate on the dissemination of information about HIV/AIDS alone, as it is insufficient by itself to bring about low risks behaviour. Children will only be able to make responsible decisions if the knowledge which they receive is firmly based on healthy values, norms and attitudes and if they have the necessary skills to make responsible decisions. There must be a balance between knowledge, lifeskills, values and attitudes in order for the HIV/AIDS programme to be successful in schools.

Dealing with HIV/AIDS is the one priority in the national Department of Education's Corporate Implementation Plan, 'Tirisano' that the Minister of Education (2000), Kader Asmal, referred to as "the priority that underlies all priorities, for unless we succeed, we face a future full of suffering and loss, with untold consequences for our communities and education institutions that serve them" (Western Cape Education Department, 2003: 1).

The new education policy, Curriculum 2005, which implements Outcomes Based Education, was launched in 1997. It installed Lifeskills, Sexuality and HIV/AIDS education, as part of the Life Orientation learning area. The reason for its inclusion was the rise in the HIV/AIDS epidemic in South Africa as is evident from this statement that was issued by the Department of Health / Education (1999)

"The HIV/AIDS epidemic in our country compels us all to become involved. Research indicates that in order to curb the spread of HIV/AIDS, it is crucial to reach children before they become sexually active. The increased incidences of sexual abuse, also stresses the urgency to work with children from a very young age. Since, HIV/AIDS is mainly spread through sexual contact, HIV/AIDS education needs to be presented in the context of sexuality education together with lifeskills".

This rationale will be further elaborated in the next section.

2.5.1. The Department of Education's HIV/AIDS Education and Lifeskills Programme

The Department of Education's HIV/AIDS Education and Lifeskills programme was based on the rationale that HIV/AIDS prevention education is most effective when learners have the opportunity to:

- Acquire knowledge about HIV/AIDS,
- Consider choices that support healthy behaviour related to HIV/AIDS and
- Develop and practice skills that support those choices.

As most HIV/AIDS infections occur through sexual intercourse, the programme was developed in the context of sexuality education. According to Vergani and Frank (1998) sexuality education is not the same as sex education. It is about 'much more than sex'. The goals of sexuality education are to:

- Enable learners to like and respect themselves, to enhance their self-esteem and self-awareness
- Provide accurate information on prevention and transmission
- Teach the skills to enable learners to make informed and responsible decisions
- Help learners to act in accordance with the values of society
- Teach understanding, tolerance and respect
- Teach learners the core components of good relationships, namely caring, respect and responsibility
- Teach learners to protect themselves from abuse.

The goals of this programme are to guide learners to:

- Abstain or postpone sexual activity
- Change their lifestyle if they are already sexually active

- Be responsible if they do not want to change their lifestyle, for example by using condoms, etc
- Accept people living with HIV/AIDS without discrimination (Lifeskills and HIV/AIDS Education: Primary school programme for grade 7, Teacher's Guide, 1999).

The emphasis of the Department of Education's Lifeskills programme is on facilitating behavioural change through providing life enhancing (life saving) skills within the curriculum. This programme imparts basic information but with an understanding that sexual responsibility flows out of self-esteem and self-knowledge and not just the acquisition of information and seeks to provide students with the skills to gain such qualities (Western Cape Department of Education, 2003). The counseling component of the programme is of high importance in the "post HIV/AIDS awareness era" (Ngcobo, 2002). The Lifeskills programme targeted at young people in the school represent one of the identified key priority strategies of the South African Government's National AIDS Programme since 1995. Some of the problems experienced by Life Orientation educators are discussed below.

2.6. Problems experienced by educators in the implementation of the HIV/AIDS Education and Lifeskills Programme

According to Ngcobo (2002), the following are some of the barriers that are experienced by educators in the implementation of the HIV/AIDS Education and Lifeskills Programme.

- The learning support material does not take into account local contexts.
- The local community is not always involved.
- Educators are expected to teach Lifeskills to learners but this is problematic.
- The educators themselves went through a school system that did not offer Lifeskills.
- Educators themselves hold conservative values, and some educators may be implicated in gender based abuse.
- Educators need to first grapple with their own issues, before they can facilitate Lifeskills for learners.

- The 'values and norms' bias of the programme raises some awkward questions in the mind of many community members who do not yet understand the life skills context of the Sexuality and HIV/AIDS education, and who feel that something other than community values is being discussed.
- Some ordinary people, including educated ones, equate lifeskills and sexuality to sex talk. This poses problems for educators who become suspected of ulterior motives.
- Educators are not always supported when they return to school after training, and some principals are opposed to the programme.
- Educators often feel demotivated to continue.
- There is also a chronic shortage of trained staff.

Ngcobo further states that a Lifeskills, HIV/AIDS Care and Support and Counselling Programme is needed for educators, this might improve and increase implementation. In the next section a review of four policy documents is undertaken.

2.7. A review of policy documents

Due to the seriousness of the HIV/AIDS epidemic, the South African government formulated national policies and strategic plans to create an enabling environment. These are: the National HIV/AIDS Education Policy (1999), the HIV/AIDS Emergency Guidelines for Educators (1999), the Implementation Plan for Tirisano (2000-2004) and the HIV/AIDS Strategic Plan (2000-2005). A brief outline of these policies is undertaken below as my study draws from these policies especially the National HIV/AIDS policy.

2.7.1. The National HIV/AIDS Education Policy for learners, students and educators in public schools (1999)

The Ministry of Education has recognized the gravity of the HIV/AIDS epidemic and since local and international evidence indicates that there is a great deal that can be done to curb the impact of the epidemic. The Ministry has committed itself to minimize the social, economic and developmental impact of HIV/AIDS to the education system and to provide leadership to implement an HIV/AIDS policy. This policy seeks to contribute towards

promoting effective prevention and care within the context of the public education system. Kader Asmal, who was the Minister of Education in 1999, launched the National Policy on HIV/AIDS for learners in public schools in 1999 (National HIV/AIDS Education Policy for learners, students and educators in public schools, 1999).

I outline the following procedures that are prescribed in the National HIV/AIDS policy:

- Ensuring a safe school environment.
- The prevention of HIV/AIDS during play and sport.
- A continuous HIV/AIDS education programme must be implemented at all school.
- The duties and responsibilities of learners, educators and parents.
- The Governing Body of a school may develop and adopt its own policy on HIV/AIDS. The policy of the school may not deviate from the basic principles of the National policy.
- Where community resources make this possible, it is recommended that each school should establish its own Health Advisory Committee as the Governing Body.
- The constitutional rights of all learners, students and educators must be protected on an equal basis.
- Learners and students must receive education about HIV/AIDS and abstinence in the context of Lifeskills education on an ongoing basis.
- Lifeskills and HIV/AIDS education should not be presented as an isolated subject but should be integrated in the whole curriculum. It should be presented in a scientific but understandable manner.
- The purpose of HIV/AIDS education is to prevent the spread of the disease, to reduce excessive fears of the epidemic, to instill a non discriminatory attitude towards infected persons and to reduce stigma attached to it.

I offer a critique of the Department's of Education's National HIV/AIDS policy for educators and learners in the next section.

2.7.1.1. The National HIV/AIDS policy: A critique

This document plays a pivotal role in public schools as it provides a clear account of the measures that need to be taken in order to ensure that learners and educators are protected against HIV infection. The document begins with an account of statistics regarding HIV infections, which are now outdated. These statistics need to be updated and an appropriate form of reporting on these statistics needs to be found.

According to Simbayi, Skinner, Letlape and Zuma (2005) although the policy is very clear on the constitutional rights of learners especially on issues such as confidentiality, non-discrimination, however, little mention is made of the increasing number of children and educators who are affected. They further state that no mechanisms have been put in place to help schools when educators are absent for long periods of time.

The section on 'definitions' is fairly good but needs to be clarified in a more simpler way so as to enable younger children especially in primary schools to understand these concepts. The policy also states that all educators should be trained to give guidance on HIV/AIDS. However, in practice not all educators are given opportunities to attend workshops. Often when workshops are held, the notice inviting educators to attend workshops usually specifies that two educators must attend. Selection is done by the principal in some schools.

Simbayi et al (2005) state that there is no clarity on issues such as if an educator is exposed accidentally to possible HIV infection while on duty whether the Department of Education will cover the costs of treatment of the educator or whether the educator will be entitled to monetary compensation because they were infected while on duty.

They further state that this policy adopts a scientific approach and works through issues clearly and methodically. However, the policy is ambitious in its orientation. Finally, structures need to be put in place by the Department of Education to ensure that the policy is being implemented in schools. In the next section the main features of the HIV/AIDS Emergency Guidelines for Educators is described.

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

This document is based on the National Policy on HIV/AIDS (1999) for learners and educators. It outlines the following:

- Facts about HIV/AIDS.
- Eight key messages about preventing HIV/AIDS.
- Questions educators ask about sexuality education.
- Ways of preventing disease transmission in schools.
- The building of an enabling environment and a culture of non-discrimination and
- The Declaration of Partnership against AIDS by President Thabo Mbeki.

2.7.3. The Implementation Plan for Tirisano (2000-2004)

The implementation plan outlines the key objectives that are necessary for successfully achieving the Minister of Education's nine priorities. The nine priorities have been organized into five core areas in the implementation plan. Of these five core areas, the first programme is on HIV/AIDS.

The main priority of this programme is that the education sector must deal urgently and purposely with the HIV/AIDS emergency in and through the education and training system. I outline three projects which are discussed in this program:

Project 1: Awareness, information and advocacy

To increase knowledge and awareness of HIV/AIDS amongst educators, learners and students in all institutions in the education and training sector. To promote values, that inculcates respect for girls and women and to recognize the right of girls and women to free choice, in sexual relationships.

Project 2: HIV/AIDS within the curriculum

To ensure that lifeskills and HIV/AIDS education are integrated into the curriculum at all levels of the education and training system. Every learner must understand the causes and consequences of HIV/AIDS. All learners must lead healthy lifestyles and make responsible decisions regarding their sexual behaviour.

Project 3: HIV/AIDS and the education system

To develop planning models for analyzing and understanding the impact of HIV/AIDS on the education and training sector. (Implementation Plan for Tirisano, 2000-2004). In the next section, the HIV/AIDS/STD Strategic Plan is outlined.

2.7.4. The HIV/AIDS/STD Strategic Plan (2000-2005).

This is a national strategic plan to guide the country's response to the epidemic. It is a statement of intent for the country as a whole, and not a plan for the health sector only. Since no single sector, ministry, department or organization is by itself responsible for addressing the epidemic, all government departments, organizations and stakeholders must use this document as the basis to develop their own strategic and operational plans so that all the initiatives in this country can be harmonized to maximize efficiency and effectiveness (HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005).

The primary goals of the Strategic Plan for South Africa are outlined as follows:

- To reduce the number of new infections especially among the youth and
- To reduce the impact of HIV/AIDS on individuals, families and the community.

The Strategic Plan is structured according to the following four areas:

- Prevention;
- Treatment, care and support;

- Human and legal rights; and
- Monitoring, research and surveillance.

According to this plan the youth will also be broadly targeted as a priority population group, especially for prevention efforts (HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005).

2.8. Theoretical Framework for this study

2.8.1. Introduction

According to Mathews (2005) theories help us to explain why people behave in ways that put their health at risk and why they adopt health protective behaviour. They point us towards the factors and mechanisms that may influence health behaviour. Mathews further states that theories with the ability to identify factors that influence behaviour can lead to more efficient intervention programmes with the potential to reducing sexual risk behaviour and improving public health.

According to Fishbein and Middlestadt (1989)¹³ we need to do more than supply people with information, if we hope to change behaviour of vulnerable groups. The theories that govern behaviour change need to be first understood, if behaviour change is to be effected. There are several major theories that have been used to understand HIV risk behaviour. These include the Health Belief Model (Rosenstock, Strecher and Becker, 1994); the Theory of Reasoned Action (Ajzen and Fishbein, 1977) and the Social Cognitive Theory (Bandura, 1977; 1992).

These models view values, beliefs, perspectives, attitudes and ways of thought as characteristics of individuals including educators and learners. Interventions that have been based on them have been useful in helping gay males, drug users and others to understand

¹³ Fishbein and Middlestadt, cited in Van Dyk, 2001

their risks and their alternatives and have already led many individuals to take positive action to reduce their risks of becoming infected with HIV (Becker and Joseph, 1988)¹⁴.

In my study, I review the principles and concepts that underpin the following theories: The Health Belief Model, The Theory of Reasoned Action and The Social Cognitive Learning Theory as these theories are commonly used in health promotion and HIV prevention (Mathews, 2005). They are also successful in helping to evaluate and understand behaviour in terms of HIV prevention risk (Eaton, Flisher and Aaro, 2003). I have chosen these models as they all deal with issues that relate to attitudes and behaviour change which is necessary in HIV prevention. My study is based on the National HIV/AIDS policy and the HIV/AIDS education and Lifeskills intervention programme of which the main focus is to ensure that learners are taught about the facts and dangers of HIV/AIDS and to enable them to acquire skills and attitudes that will help them to adopt positive behaviours that will prevent them from getting infected with HIV. In the next section I present the main features of the Health Belief Model.

2.8.2. The Health Belief Model

The Health Belief Model is one of the most widely used frameworks for understanding health behaviour. This model asserts that learners will change their behaviour based upon their knowledge and attitudes. In the 1980s the element of self-efficacy was added, that is the perceived ability of any individual to bring about change (ReCapp, 2008).

The Health Belief Model is based on the understanding that a learner will take a health related action if that learner:

1. Feels that a negative health condition can be avoided (i.e. get infected with HIV).

¹⁴ Becker and Joseph, cited in DiClemente and Peterson, 2004

2. Has a positive action that by taking a recommended action, he or she will avoid a negative health condition (i.e. the use of condoms will be effective in preventing HIV infection and

3. Believes that he/she can successfully take a recommended health action (i.e. he/she can use condoms comfortably and with confidence) according to ReCapp (2008).

The Health Belief Model can be used to motivate young learners at primary school to take positive health actions that use the desire to avoid a negative health consequence as the prime motivation. For example, HIV is a negative health consequence and the wish to avoid HIV infection can be used to motivate sexually active learners into practicing safe sex. An important fact to remember is that avoiding a negative health consequence is a key element of the Health Belief Model (ReCapp, 2008).

According to this model, a young learner must hold the following beliefs in order to be able to change behaviour:

- Perceived susceptibility to a particular health problem: i.e. ones belief of the chances of getting a condition ('I am at risk of HIV infection').
- Perceived severity: ones belief of how serious a condition is and its consequences are ('AIDS is serious. My life would be difficult if I got it').
- Perceived benefits: ones belief in the efficacy of the advised action to reduce risk or seriousness of the impact ('the belief that the recommended action of using condoms would protect his/her from getting infected with HIV').
- Perceived barriers: ones belief in the tangible and psychological costs of the advised behaviour. This includes the potential negative aspect that may result from performing the preventable behaviour ('I don't like using condoms').

- Cues to action: includes strategies to activate readiness and environmental action ('e.g. youth receive reminder cues for action in the form of incentives, media coverage, etc or physical symptoms of a health that motivates people to take action for example witnessing the death or illness of a close friend or relative due to AIDS).
- Self efficacy: refers to ones confidence in ones ability to take action (AIDS Quest, 2008).

The Health Belief Model can be an effective framework to use when developing health education strategies for young learners at primary school level. However in planning programmes to influence the behaviour of large groups of young learners for long periods of time, the role of the Health Belief Model including self-efficacy must be considered in context. Permanent changes in behaviour will not be realized by directing attacks solely on beliefs systems. Where the behaviour of large groups of learners is targeted, interventions at the individual as well as the societal level will most likely prove more effective than interventions that target one level only according to Rosenstock, Strecher and Becker (1994). In the next section, the Theory of Reasoned Action is presented.

2.8.3. The Theory of Reasoned Action (TRA)

According to Lipppa (1990) the theory of reasoned action is commonly used to help understand human action and behaviour. This theory has been used to develop models to reduce risky behaviours that lead to HIV infection. It was named a 'theory of reasoned action' because it holds that attitudes predict behaviour primarily when behaviour is conscious, voluntary and thus reasoned. Learners are defined as reasonable beings that process and use information that is available to them in a systematic way. Educators in a school setting cannot change learners' risky sexual behaviours if they do not understand and appreciate the individuals' beliefs, attitudes and subjective norms. Ajzen and Fishbein (1980)¹⁵ believe that once these factors are taken into consideration, behaviour from attitudes can be predicted.

¹⁵ Ajzen and Fishbein, cited in Forsyth, 1987

The theory of reasoned action works well for predicting behaviours that are under a person's volitional control. However, according to Stahberg and Frey (1988), Ajzen and Madden (1986) discovered some limitations to the TRA. They found that if behaviour is not under a person's volitional control, then they can have difficulty in performing the intended behavioural goal. The TRA is based on the ability to predict intentions from attitudes and subjective norms; however, sometimes a person's intentions or goals are not fully under his/her control.

Finally, this theory can be used as a framework to analyse the particular beliefs and attitudes that lead to undesirable behaviours, for example, drug abuse, engaging in dangerous sexual practices, then school intervention programmes can be directed at the identified causal beliefs or attitudes according to for example, if research suggests that teenagers generally hold negative attitudes towards unprotective sex (it is dangerous and can lead to HIV infection) but strong subjective norms that favour unprotective sex ('all my friends are doing it and I think I should'), then school intervention programmes should be directed at changing teenagers subjective norms and not their attitudes according to Fishbein and Ajzen (1980)¹⁶.

2.8.4. The Social Cognitive Theory

According to Bandura (1992), in order to prevent HIV infection, learners are expected to exercise influence over their own behaviour and their social environment. Efforts that have been designed to control the spread of HIV/AIDS have centred mainly on informing the learners about how HIV is transmitted and how to safeguard against such infection. It is a common assumption that if the youth are informed adequately about the threat of HIV/AIDS, they will take the appropriate action to protect them. However, Bandura (1992) asserts that information alone does not have much influence on changing risky health behaviours. He further, states that in order for learners to change, they need to be given much more than only reasons to change; they must be given the resources and social supports to do so. Bandura (1992), further states that effective self regulation of behaviour

¹⁶ Fishbein and Ajzen, cited in Lippa, 1990

is not achieved through an act of will but it requires skills in self motivation and guidance. These skills need to be taught during the Lifeskills and HIV/AIDS intervention programme by the Life Orientation educators at primary school. Learners must also be taught that in order to succeed they requires a strong self-belief in their own efficacy to exercise personal control over their behaviour.

Perceived self efficacy is concerned with people's beliefs that they can exert control over their own motivation, emotional state and behaviour patterns. Numerous studies have been conducted linking perceived self-efficacy to health promotion and health impairing behaviour (Bandura 1992). The results show that perceived self-efficacy can affect every phase of personal change.

Bandura (1992) further states that in order to translate health knowledge into an effective self protection action against HIV/AIDS infection requires social and self-regulative skills and a sense of personal power to exercise control over sexual activities, one of the main modes of transmitting HIV infection. According to Bandura (1992), the major problem is not teaching people safe sexual practices, which is easy to achieve but rather to equip them with skills and self beliefs that enable them to put these guidelines into practice even though there are extenuating influences.

In spite of their contributions, according to Friedman, Des Jarlais and Woods (1994)¹⁷ to the fight against the spread of HIV/AIDS, individual models, have several limitations that make it necessary to develop more social theories of how to combat the spread of HIV/AIDS and other dangers to public health. As many people have gone through programmes based on individualistic models, they still continue high risk behaviour. Whereas, others have reduced or for a while eliminated risky behaviours, they have none the less returned to risky behaviours such as unprotected sex or unsafe drug habits.

According to Eaton et al. (2003) these theories (Health Belief Model, Theory of Reasoned Action and the Social Cognitive Learning Theory) have been found to be valid and useful,

¹⁷ Friedman, Des Jarlais and Woods, cited in DiClemente, 1994

especially within the contexts in which they were designed for, that is the Western societies. However, they cannot be applied haphazardly in all situations and to all problems. This is apparent particularly to developing countries, such as Africa, where factors beyond an individual have a serious impact which warrants special attention. Eaton et al. (2003) further state that these theories recognize that there are factors that are beyond the control of the individual. However, they tend to place more emphasis on personal processes and subjective influences to the neglect of the objective aspects of social influence and the distal and cultural context. According to Mathews (2005) it is crucial that in South Africa, HIV/AIDS intervention programmes must take into account the broader social and environmental factors, where the collective health of communities can be enhanced by processes, structures and policies that foster individual health promoting actions or reduce health hazards in the social and physical environment.

2.9. Conclusion

In Chapter Two I have presented a comprehensive discussion on the impact of HIV/AIDS on adolescents, which makes the research important in the context of HIV/AIDS education. The implementation of the HIV/AIDS education and Lifeskills intervention programme as it has been experienced in schools was examined, an outline of four policy documents was given, and the final section of this chapter engages with the three theories that have been applied to understanding HIV risk behaviour.

In the next chapter (Three) the research design and methodology is described.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

In the previous chapter I reviewed literature which was related to this study. This was done to explore a variety of issues that surround HIV/AIDS education with emphasis on the grade seven learners. This study also explores the perceptions and experiences of five Life Orientation educators in the realm of HIV/AIDS education at a primary school. Furthermore, the study hopes to gauge the impact of the HIV/AIDS intervention programme on the grade 7 learners, a qualitative study consisting of focus groups and semi-structured interviews were used.

In this chapter I shall describe the interpretive paradigm which was used to contextualize the study. The chapter also explains the research methodology that was adopted, the sample selection, the type of instruments employed to select data and ethical considerations. The research methodology employed in this chapter consists of a qualitative analysis of focus groups, semi-structured interviews and tape recorded interviews with five Life Orientation educators and approximately thirty grade seven learners in a primary school in South Durban.

3.2. Research Aim

This study aims to explore and describe the Life Orientation educators' perceptions of the National HIV/AIDS policy and the Department of Education's HIV/AIDS and Lifeskills intervention programme. It also aims to gauge the impact of the HIV/AIDS and Lifeskills intervention programme has had on the level and awareness of the grade seven learners to the epidemic.

3.3. Research Design

The present study will be conducted within the qualitative paradigm. This research design is exploratory, descriptive and contextual in nature as it seeks to describe a particular phenomenon thoroughly (de Vos, Strydom, Fouche' and Delpont, 2005). Babbie and Mouton (2001:74) define a research design as a “plan or blueprint” of how the researcher intends conducting the research. Creswell (1998:2) defines a research design as “the entire process of research from conceptualizing a problem, to writing the narrative”. The research design that is used in this study is explorative in nature, as the goal is to explore and describe the five Life Orientation educators’ perceptions of the HIV/AIDS intervention programme and the impact that the National HIV/AIDS policy has had on them. The researcher has chosen to employ a qualitative approach as it allows her to assess the level of awareness and knowledge of grade seven learners about this epidemic.

3.4. Qualitative Research

I have conducted research based on qualitative inquiry in order to answer the research questions. The qualitative paradigm according to Henning (2004) is known for understanding and in-depth inquiry. Qualitative studies usually aim for depth rather than ‘quantity of depth’. Henning further attests that these studies are conducted in settings that are bound by the theme. She also states that in a qualitative inquiry the researcher wants to understand and explain in argument by using evidence from data and from literature what the phenomenon that we are studying is about. The qualitative researcher interprets and makes meaning of the evidence that he/she has collected.

I adopted the tenets of a qualitative approach for the following reasons:

Strauss and Corbin (1990)¹⁸ state that the task of qualitative research is to understand and uncover what lies behind any phenomenon about which, little is yet known or to gain novel and fresh slants on things about which quite a bit is already known. They also claim that

¹⁸ Strauss and Corbin, cited in Jarrat, 2005

qualitative methods can give intricate details of phenomena that are difficult to convey with quantitative methods.

According to Denzin and Lincoln (2003) a qualitative inquiry is also effective in capturing the process and developing a rich understanding of contextual factors. It can also be defined as a research that is a situated activity that locates the researcher in the world of the researched in my case it would be the school and consists of interpretive practices such as interviews, focus groups that make the world visible. They further state that qualitative researchers also study people in their natural settings and attempt to make sense of the phenomena in terms of the meanings people bring to them. Such an approach was used as it afforded me the opportunity to explore the perceptions of the Life Orientation educators to the National HIV/AIDS policy and intervention programme and to assess the level of awareness and knowledge of the grade seven learners in respect of HIV/AIDS. It was also used as it enabled me to explore phenomena and to provide a 'thick description' i.e. a detailed description of the phenomena being studied (Durrheim, 1999:43).

Durrheim (1999) further asserts that qualitative research is necessary where the purpose of the research is to study phenomena as they unfold in real world situations without any manipulation. Qualitative research is also inductive, holistic and naturalistic as the researcher begins by exploring genuinely open questions, and looks at the whole phenomena which is under study as a complex system and studies real world situations as they unfold naturally with openness to whatever emerges. A study that aims at understanding and interpreting the perceptions of five Life Orientation educators, lends itself to the interpretive paradigm.

3.5. Interpretive Paradigm

I have positioned my research in the interpretive paradigm because in this paradigm there is a necessity to interpret and make meaning of the data collected. According to Denzin and Lincoln (2003), there is a need for the researcher to understand and make sense of what has been researched. Researchers working in this paradigm assume that people's subjective

experiences are real and should be taken seriously, that we, the researcher can understand others' experiences (the experiences of the Life Orientation educators and the grade seven learners) by interacting with them and listening to what they tell us, that is their responses and stories in relation to the questions asked, and qualitative techniques such as interviews are best suited to the task. Rather than "translating the stuff of everyday experiences into a mathematical formula, as we would do if we were following a positivist approach, the interpretive approach tries to harness and extend the power of ordinary language and expression, to help us get a better understanding of the social world in which we live" (Terre Blanche and Kelly, 1999: 123).

The interpretive paradigm is characterized by the researcher's concern for the individual. The central purpose in the interpretive paradigm is for the researcher to understand the subjective world of the people involved. In order to gain the integrity of what is being investigated, the researcher must make every effort to get inside the participants heads and to understand from within. The interpretive researcher tries to begin with the individual and then tries to understand their interpretations of the world around them (Denzin and Lincoln, 2003). Further, interpretive research relies on first hand accounts, tries to describe what it sees in rich detail and presents its findings in engaging language (Terre Blanche and Kelly, 1999).

In my study knowledge regarding the implementation of the Lifeskills and HIV/AIDS intervention programme as well as the National HIV/AIDS policy will be constructed through an analysis of educators describing their intentions, values, reasons, perceptions and understandings. I have used a case study, semi-structured interviews with open ended questions, focus group interviews and qualitative data analysis. In the next section a motivation is presented arguing for the use of a case study in this study/thesis.

3.6. Case Study

A case study is described as a research genre that is part of a qualitative methodology (Henning, 2004). Stake (2003) states that the sole criteria for selecting cases for a study should be the opportunity to learn. When a case study is explored and described, it will take

place through detailed, in depth data collection methods, involving multiple sources of information that are rich in context. The researcher needs access to the confidence of the participants, as well as access to them. The LO educators and grade 7 learners were from the same school and were promised confidentiality and anonymity at all times. Although the researcher situates this case within its larger context, the focus will remain on the case or the issue that is illustrated by the case according to Cresswell (1998). According to Babbie and Mouton (2001), case study researchers seek to enter the field with a prior knowledge of the relevant literature before conducting the field research. I am informed by the relevant literature prior to conducting my research.

A case study can provide a unique example of real people in real situations, enabling readers to understand ideas more closely. Stuurman (1999) argues that an important feature of case studies is that human organizations have a wholeness or integrity to them, rather than being a loose connection of traits, which necessitates an in-depth investigation. He further states that contexts are unique and dynamic, as every primary school is different from the other; hence case studies report and investigate the complex and dynamic interactions of events, human relationships and other factors in a unique instance as cited in Cohen, Manion and Morrison (2000).

I chose a case study because it has the following hallmarks according to Hitchcock and Hughes (2000)¹⁹:

- It is concerned with a rich and vivid description of events that are relevant to the case and provides a chronological narrative of events that were relative to this case. Therefore to understand and interpret this case, I described the context in detail and provided information about the participants including the LO educators and grade 7 learners. Conceptual issues such as the purpose of the study, the critical questions as well as the literature review were provided.

¹⁹ Hitchcock and Hughes, cited in Cohen, Manion and Morrison, 2000

- It focused on individual actors or groups of actors, such as the LO educators and the grade 7 learners. The intention was to explore the perceptions of the LO educators towards the National HIV/AIDS policy and to gauge the level of awareness and knowledge of the learners to the epidemic.
- It highlighted specific events that are relevant to the case such as the teaching and learning of HIV/AIDS education, the attitude of learners towards people with AIDS.
- The researcher is integrally involved in the case as the researcher is also an educator and is involved in the education of the learners.
- It blends in the description of events with an analysis of them. An attempt was made to portray the richness of the case in writing up a detailed report about the findings.

According to Geertz (2000:182)²⁰ case studies, strive to portray what it is like to be in a particular situation, to catch the “close up reality” and “thick description” of participants lived experiences, thoughts and feelings for a situation.

3.7. The context

Birchwood Primary is the school under study. It is a public school which is located in Merebank, a community in the South Durban Region. South Durban,²¹ located on the Indian Ocean, is the largest industrial centre of Durban, which is the largest city in KwaZulu-Natal²². It has a population of approximately 2.3 million and is predominantly made up of Black communities. The South Durban Region is made up of low income communities namely; Merebank, Merewent, Wentworth, Isipingo, and Umlazi. During the apartheid era, these communities were segregated and designated as Indian, Coloured, White and African. South Durban also has the largest concentration of petrochemical industries as well as a paper manufacturing plant and a multitude of other chemical

²⁰ Geertz, cited in Cohen et al., 2000

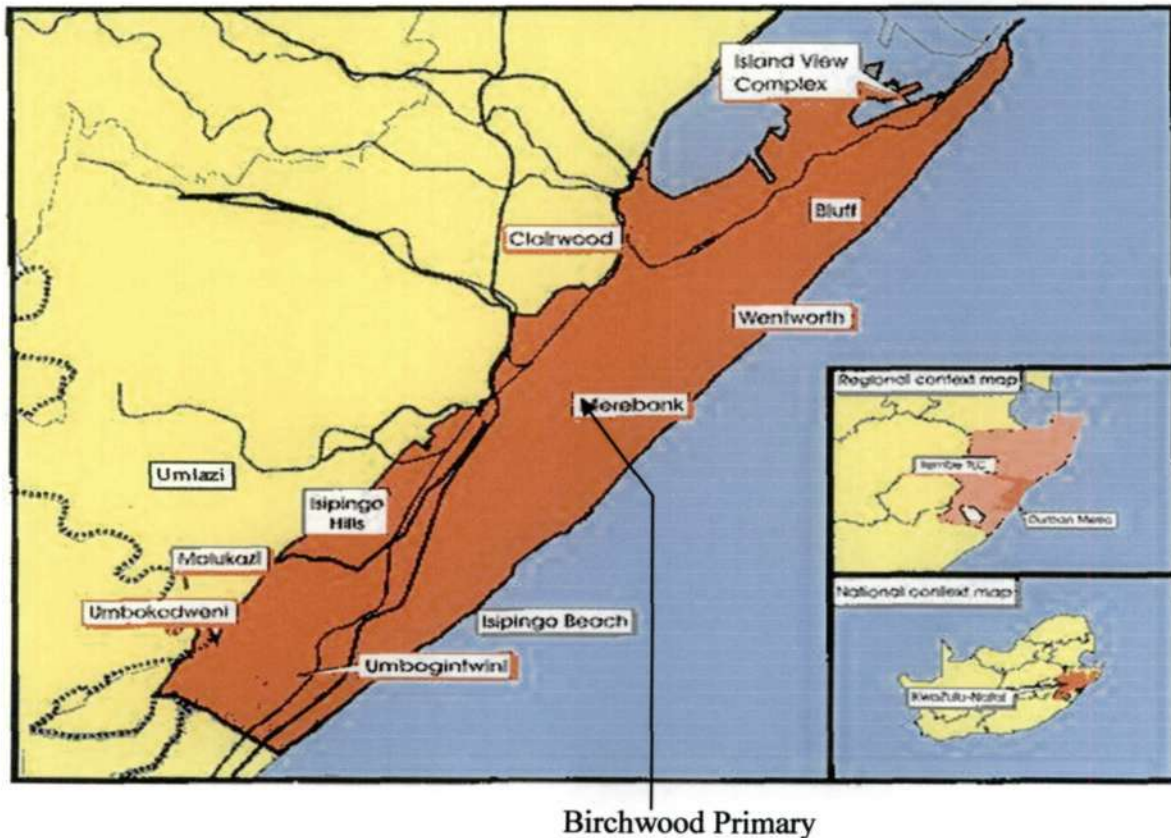
²¹ South Durban extends from the Harbour Point south along the Bluff, through the Happy Valley Vlei wetlands to the Isipingo Estuary.

²² Located on the east coast of South Africa, KwaZulu-Natal is the country's largest province, with a population of almost ten million.

industries. In the South Durban Basin the residential communities and industries are in close proximity to one another. (SDCEA, 2008)²³.

Most of the learners are from two neighbouring townships and the surrounding area. A small percentage of learners live in squatter camps. The learners range from age five to fifteen. Some grade seven learners have been known to be sixteen and over. Although English is the medium of instruction, most learners are isiZulu speaking. The learner population in my sample is made up as follows: fifty five percent Black, forty five percent Indian and approximately five percent Coloured.

MAP OF SOUTH DURBAN DEPICTING THE AREA IN THE STUDY



Source: <http://www.h-net.org/esati/sdcea/30/08/2008>

²³ SDCEA is the South Durban Community Environment Alliance

3.8. Sampling

Van Vuuren and Maree (1999) state that sampling is the process that is used to select cases for research in a research study. As all empirical research is conducted on a sample of cases which can be individuals, groups, organizations, documents, etc. The main concern in sampling according to Durrheim (1999) is representation. The aim must be to select a sample that will be representative of the population that the researcher aims to draw conclusions from. Where the research is interpretive and is concerned with detailed in-depth information, purposive sampling is used.

Arkava and Lane, cited in de Vos et al. (2005) attest that the sample comprises the elements of the population that is considered for actual inclusion in the study. We study the sample to enable us to understand the population from which it is drawn. A sample is selected on purpose to yield the most information about the focus of interest (Merriam, 2002).

In view of the above the researcher used purposive sampling to select five educators who are involved in the teaching of Life Orientation from grade four to seven, and thirty grade seven learners. The grade seven learners fall into the age group 12-13. The five Life Orientation educators participated in face to face semi-structured interviews. The thirty grade seven learners participated in focus group interviews. I used a small sample, since one advantage of purposive sampling is that a few participants are able to yield many insights about the phenomenon under study (McMillan and Schumacher, 2001).

The sampling procedure consisted of the following steps, which are listed below:

Step one: was to get written permission from the KwaZulu-Natal Department of Education to conduct research in a public primary school (The University did this on my behalf).

Step two: I had to choose and establish a public primary school to which I could get access.

Step three: I had to get written permission from the principal to conduct my study at his school with the least amount of disruption to the learners and educators.

In response to my critical questions I chose semi-structured interview schedules and focus group interviews. An interview is a more natural form of collecting data and interacting with people and therefore sits well with the interpretive approach (Terre Blanche and Kelly, 1999). As a researcher I can get an opportunity to get to know the people such as the educators and learners well so I can really understand how they feel and think about HIV/AIDS issues.

3.8.1. The educators

The school has a policy of specialization in grades 6 and 7. In grades 4 and 5, the class teacher teaches Life Orientation as class based teaching is implemented in these grades. I chose educators from each grade but the grade 6 educator declined to be a part of the study after initially agreeing to participate.

3.8.1.1. Biographical details of the educators who teach Life Orientation in the Senior Primary Phase which included educators from grade 4, 5 and 7.

The following table is a representation which provides the biographical details of the Life Orientation educators. The sample comprised of five Life Orientation educators, all of whom were females. However, of the fourteen educators who teach in this phase, three are males who teach Life Orientation but were not of the study. The participants teaching experience ranged from sixteen years to twenty one years. They are all Indians with two educators belonging to the Hindu faith and the other three to the Christian faith. All educators are State employed on permanent basis.

Table: 1. Life Orientation educators' profile

Educator's	Age	Religion	Gender	Teaching experience
1	39	Hindu	female	16
2	43	Christian	female	20
3	41	Hindu	female	19
4	42	Christian	female	20
5	39	Christian	female	17

3.8.2. Biographical details of the learners

The total population of the grade 7 learners comprised of 120 learners. The majority belong to the Hindu faith, approximately 10 belong to the Christian religion and a small percentage belong to the Black Tribal Religions. I handed out consent forms to 60 learners in three grade 7 classes. Thirty five consent forms were returned to me with a positive response. The sample consisted of 30 learners. All learners who participated were 13 years of age with the exception of one learner who was 12 years old. Twenty five participants were females and five were males. Nineteen participants were Indians and ten were Blacks with one Coloured. Learners who fell in the fourteen year age group did not agree to take consent forms home.

Table: 2. Learners' profile

Learners'	Age	Race	Religion	Grade	Gender
1	13	Indian	Hindu	7	female
2	13	Indian	Hindu	7	female
3	13	Black	Christian	7	female
4	13	Coloured	Christian	7	female
5	12	Black	Christian	7	female
6	13	Black	Christian	7	female

7	13	Black	Christian	7	female
8	13	Black	Christian	7	female
9	13	Indian	Hindu	7	female
10	13	Indian	Hindu	7	female
11	13	Indian	Christian	7	female
12	13	Indian	Hindu	7	male
13	13	Indian	Hindu	7	male
14	13	Indian	Hindu	7	female
15	13	Black	Tribal Religion	7	female
16	13	Black	Christian	7	male
17	13	Indian	Hindu	7	female
18	13	Indian	Hindu	7	male
19	13	Indian	Hindu	7	female
20	13	Indian	Hindu	7	female
21	13	Black	Tribal Religion	7	female
22	13	Indian	Hindu	7	female
23	13	Indian	Hindu	7	male
24	13	Black	Tribal Religion	7	female
25	13	Indian	Hindu	7	female
26	13	Indian	Christian	7	female
27	13	Indian	Hindu	7	female
28	13	Black	Christian	7	female
29	13	Indian	Hindu	7	male
30	13	Indian	Hindu	7	female

3.9. Interviews

I chose the interview method as a means of producing data for the following reasons:

- The interview has the potential to provide rich and rather illuminating material.
- It is a flexible and adaptable way of finding things out.

- Face to face interviews offer the possibility of modifying one's lines of inquiry, following up interesting responses and investigating underlying motives.
- The use of non-verbal cues may give messages which help in understanding the verbal responses (Robson, 2002).

Kvale (1996) regards an interview as an interchange of views between two or more people on a topic of mutual interest, and sees the centrality of human interaction for knowledge production. According to Seidman (1998) at the root of interviewing is an interest in understanding the experiences of other people in this case learners and educators and the meaning that they make of that experience. Terre Blanche and Kelly (1999) state that interviewing is a more natural way of interacting with learners and educators instead of asking them to fill out a questionnaire or conduct an experiment and therefore fits well with the interpretive approach to research.

Tuckman (2000)²⁴ asserts that "one of the purposes of the interview is that, it may be used as the principal means of gathering information, which can have a direct bearing on the research objectives. By providing access to what is inside a person's head, it makes it possible for the researcher to measure what a person knows (information), a person's likes and dislikes (values and preferences) and what a person thinks (attitudes and beliefs)".

The interview can also be defined as a conversation between two people which is initiated by the interviewer for the main purpose of obtaining relevant information which is focused on specified research questions according to Cohen et al. (2000).

Two types of research interviews were used namely:

- Semi-structured interviews
- Focus group interviews

²⁴ Tuckman, cited in Cohen et al. (2000:269).

3.9.1. Semi-structured interviews:

The semi-structured interview was used for the following reasons:

- To gain an understanding of the participants feelings, ideas, thoughts, opinions, experiences and understanding of the HIV/AIDS education and policy at a primary school and Henning (2004) concurs when she says that the main aim of this type of interview is to bring to our attention what individuals think, feel, and do and what they say about a particular topic.
- Since these interviews are flexible and explorative, educators felt free to talk about issues relating to training and workshops that they attended (Cohen et al. 2000).
- I was also able to collect and formally capture information regarding barriers that disenable educators from effectively teaching in class and this was captured on tape recorder after obtaining permission from the educators (Terre Blanche and Kelly, 1999).
- The schedule was unstructured enough to allow the interviewees to fully articulate their views about the impact and effectiveness of the HIV/AIDS intervention programme but was structured enough to allow me to introduce limits on the direction of dialogue (de Vos et al. 2005).
- It enabled me to notice and correct the educators' misunderstandings, to probe inadequate or vague responses, and to answer questions and allay concerns and this enabled me to collect rich and meaningful data.
- Since it was a face to face interview, a certain amount of rapport was established and this motivated the educators to answer fully and accurately, this helped to improve the data (Kidder and Judd, 1986).

The interview questions were discussed with participants as the interview went along. I was responsible for making sure all relevant topics were covered. The semi-structured interview allowed me to focus on collecting and formally capturing details about the questions. I had a list of questions on my schedule and when the interviewee moved away from the topic, I was able to bring their attention back to their original focus (Terre Blanche and Kelly, 1999).

A familiar setting was used and this put the interviewees at ease. I tried to ensure that I received relevant information and was able to conduct the interview within the prescribed time of approximately forty five minutes each (de Vos et al. 2005).

3.9.2. Focus group interviews

According to Robson (2002) the focus group interview is a group interview on a specific topic, this is where the focus comes from. My focus was based on the awareness and knowledge of HIV/AIDS by the grade seven learners. It was an open ended group discussion which was guided by me, the researcher.

The sample consisted of thirty grade seven learners of both sexes from the three race groups. There were four groups, each comprising approximately seven to eight learners. The groups were picked heterogeneously since difference in race, background and gender can stimulate and enrich discussion and may inspire other group members to look at the topic in a different light (Robson, 2002).

The focus group interview was selected for the following reasons:

- They were a means of better understanding how people feel or think about an issue; in this case the issue discussed was on the grade seven learners' level and awareness of HIV/AIDS. This type of interview allowed me to get a closer understanding of the learners understanding of HIV/AIDS issues than I would have been able to do by other methods such as questionnaires or observation (Seidman, 1998).
- Participants were selected because they had certain characteristics in common that related to the topic of the focus group. They were in the same grade, fell into the same age group and were peers.

- The purpose of focus groups is to promote self-disclosure among participants. It is to know what the learners think and feel about the topic (Krueger and Casey, 2000). The learners had an opportunity to answer questions that related to HIV/AIDS.
- They are economical on time and produce a large amount of data in a short period of time. Since, I was interviewing learners who had a limited time in school, this kind of interviewing suited my study (Cohen et al. 2000).
- There was a continual communication between the facilitator and the participants, as well as among participants themselves. The larger process of communication between researcher and the participants connects the world of the researcher and the participants. Focus groups create a process of sharing and comparing among participants. In this way they spark of a range of new ideas in each other and they consider different views. Thus this type of interviewing enabled group members to share their experiences and to reach some kind of consensus about the topic (Bless and Higson-Smith, 2000). Learners had an opportunity to share information that they knew about HIV/AIDS and make comparisons of what they knew.
- They were a powerful means of exposing reality and of investigating complex behaviour and motivation. It was also a method that was friendly and respectful. It conveyed a willingness to listen. There was an easy going rapport between learners as they were all familiar with one another. They listened and respected the views of their peers (de Vos et al. 2005).
- Focus groups have shown, that learners maybe more likely to self disclose or share personal views and experiences in groups, instead of alone. The learners felt relatively empowered and supported in a group setting where they were surrounded by others. They were more comfortable to share feelings and experiences in the presence of people they thought more like themselves in some ways (Farguhar, 2005)²⁵.

²⁵ Farguhar, cited in de Vos et al. 2005

- A classroom that the learners felt comfortable in was chosen so as to create a tolerant environment that encouraged participants to share perceptions, points of view, experiences, wishes and concerns without pressurizing participants (Krueger and Casey, 2000).

The learners' met during the Sports Activity period. Although the setting was a contrived one, the participants were focused on a particular issue and therefore yielded insights that may otherwise not have been available in a straightforward interview. They sat in a semi-circle with the researcher in the front of the group with the tape recorder. This facilitated participation and communication between the learners and with the researcher. The interaction in the group led to data and outcomes.

Participants were briefed as to the nature of the interviews, in an attempt to make them feel at ease and this offered them some sort of security to talk freely (Cohen et al. 2000). Since interviews have an interpersonal interaction and produce information about the human condition, they have an ethical dimension. Three main areas of ethical issues can be identified here, i.e. informed consent, confidentiality and the consequences of the interview, all are problematic here according to Kvale (1996).

3.10. Ethical Considerations

According to Durrheim and Wassenaar, (1999) research designs should always pay careful attention to the ethical issues embodied in a research project. The essential purpose of ethical research planning is to protect the welfare and rights of research participants which in my study included adults and children.

The following ethical guidelines were taken into consideration by me:

- Firstly, as the researcher, I had to respect the autonomy of all participants in the research project. I was required to address issues such as voluntary and informed consent; the freedom of participants to withdraw from the research at any time and the participants rights to anonymity at all times (Durrheim and Wassenaar, 1999:66).

- Secondly, participants were made aware that the information will remain confidential and private at all times, their names will not be mentioned and in the transcripts their initials will be written. They were assured of anonymity at all times (Punch, 2005). They were also made aware that the interviews will be audio taped and they agreed to this.
- Thirdly, since the children were all younger than the age of 18, I had to obtain informed consent from the parents; I sought the 'assent' from the children but sought 'permission' from the parents (Seidman, 1998).
- Fourthly, all participants were made aware that by participating in my research study they were helping me to complete my thesis which was a requirement for me to complete my Master's Degree.
- Finally, all participants were made aware that they could withdraw from the interview at any time this, should they feel uneasy and uncomfortable in any way (Punch, 2005).

3.11. Challenges and Limitations

It was necessary for me to receive the Department of Education's letter of permission, without the letter I was not granted access to start my fieldwork. Data could only be gathered in the third term, but this was immensely difficult as educators and learners were busy with a fundraiser and with IQMS. I was allowed to interview learners during the Sports Activity period only, which is two half hour periods a week. More time would have enabled me to collect more data.

One of the main limitations of this study was the sample size was small and was drawn from one public school only. However, since the study was conducted in a public school, it could be replicated in any other public school in this country, since individual schools have their own unique culture and characteristics.

The second limitation was the lack of interest on the part of the boys to participate in the study. Their participation could have enhanced the quality of the data produced.

The third limitation is that the study focuses on primary school educators and learners only. It is therefore limited in that it does not address issues that maybe pertinent to secondary schools.

Finally, the chosen sample was not representative of the entire population of KwaZulu-Natal. The study was limited racially to Indian educators and learners who were mostly Black and Indian. Therefore, the results cannot be replicated.

3.12. Reliability and Validity

Validity and Reliability are important keys to effective research. If a piece of research is invalid then it is useless. Validity is thus a requirement of both quantitative and qualitative research. It enables the researcher to know whether a piece of data accurately describes what it intends to describe (Lowe, 2007). In qualitative research validity must be addressed through the honesty, depth, richness and scope of the data achieved, the participants approached, the extent of triangulation and the objectivity of the researcher according to Cohen et al. (2000). Mishler (1990)²⁶ suggests that we, as the researchers are part of the world that we research and we cannot be completely objective, hence other people's perspectives are equally as valid as our own, and the task of research is to uncover this. Validity then attaches to the accounts of the participants, not to the data or methods. According to Hammersley and Atkinson (1983), it is the meaning that participants give to the data and inferences drawn from the data that are important.

According to Silverman (1994) reliability is defined as the degree with which the same methods used by different researchers and or at different times will produce the same results.

²⁶ Mishler, cited in Cohen et al., 2000

To ensure reliability and validity of the research the following was undertaken:

- The researcher conducted all the interviews. This eliminated the risk of misunderstandings and misinterpretations.
- There were ongoing consultations with my thesis supervisor.
- The tape recordings and notes taken are kept as well as the transcripts for perusal. The use of the tape recorded responses of the participants helps to eliminate researcher bias and manipulation.

3.13. Conclusion

In this chapter, the following methodological components used to conduct the research were discussed: research instruments, the methodological plan, context of the school, population and sample, ethical considerations.

The next chapter will examine the responses of all participants in relation to the critical questions and will present a discussion of the findings.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF DATA

4.1. Introduction

This chapter focuses on the analysis and discussion of the data findings pertaining to the perceptions of educators on the implementation of the National HIV/AIDS policy and the impact the lifeskills intervention programme has had on the knowledge and awareness of the grade seven learners. In analyzing qualitative data, the methods of analysis are less structured than quantitative data. As outlined in the previous chapter, data was collected through the use of semi-structured and focus group interviewing. The educators were interviewed once and the data revealed their perceptions of and the impact the National HIV/AIDS policy and the intervention programme. The grade seven learners were interviewed in groups of six to nine, the interview was carried over two sessions, lasting thirty minutes each. Here the data revealed the impact the intervention programme had on the learners' knowledge and awareness of the epidemic.

4.2. Findings

The semi-structured and focus group interviews were tape recorded and then transcribed. After transcribing, the data was analyzed, where themes and similarities emerged. I also looked for units of general meanings within and across the interviews. I then looked for units of meanings that were relevant to the research questions which were developed before the start of the research. The data was discussed and presented according to the themes that emerged from the interviews.

4.2.1. Emergent Themes

- Educators' perceptions of the National HIV/AIDS policy.
- Implementation of the National HIV/AIDS policy.
- Training and workshops.
- Impact of the intervention programme on learner awareness.

- Problems that disenable educators from effectively teaching the intervention programme.
- Learners' knowledge and awareness about HIV/AIDS.
- Attitude of learners towards people with AIDS and their families.
- Stigmatization and discrimination.

4.2.1.1. Educators' perceptions of the National HIV/AIDS Policy

In response to the question of familiarity with the document, all five Life Orientation educators had indicated that they had read the policy and were informed of its contents. In order to ascertain the depth of their understanding, they were asked to elaborate on aspects discussed in the policy and to discuss the salient features that existed in the policy.

Educator 2 responded by saying:

I think it is comprehensive and allows the infected person to live a normal life with dignity and confidentiality. No one is allowed to discriminate against any person who has HIV/AIDS.

Section 3.1. The National HIV/AIDS Policy (1999:11) clearly states “no learner, student, or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly”.

Educator 2 indicated that she taught that educating learners about HIV/AIDS should start at an early age at primary school level and learners should be taught about the precautions that should be taken to prevent transmission. Educators agreed that it was informative, practical and it helped in the school situation.

Educator 4 indicated that she felt the policy needs to elaborate more on infection control since it is an essential aspect of controlling the spread of HIV/AIDS. The educator also felt that all educators should be workshopped more on the policy and on HIV/AIDS on a much greater level as everyone is not aware of the contents of the policy and the disease.

Educator 5 stressed that although the policy is a 'good thing' and is there to protect everyone, however, there are no structures to help learners who are infected, she said:

the policy just says what the school must do, that teachers just have to protect the learners if they reveal their status but it does not say how, it does not list the ways the school can protect these learners as learners often get ostracized when their status is revealed.

The educator was critical of the policy as it did not give details about the process. It would appear that although the idea of "protection" is significant, no details as to how to protect learners have been given.

When educators were questioned on the impact that the policy has had on them, all educators responded that it had a positive impact on them. Educator 3 stressed that it has helped her tremendously, *'initially when I heard of this HIV/AIDS thing, I was very sceptical teaching children who may be HIV positive'*.

However after reading the policy and other literature, she is not uneasy about teaching Life Orientation and HIV infected learners and is no longer scared that she will contract the disease. Reading the policy has enabled this educator to become more informed and knowledgeable of the ways in which HIV is transmitted and this has helped to allay her fears.

Educator 3 indicated that she has become very knowledgeable now that she has read the policy and Educator 1 indicated that she has taught learners what precautions to take when caring for infected learners. Educator 1 responded that she has learnt a lot from the policy. She said that it outlines everything pertaining to educating those who are infected and those who are not. She further stated that it also outlines how one should care for oneself, the precautions that learners should take on how to prevent HIV transmission and how they should protect themselves from those who have it. It has allowed her to incorporate HIV/AIDS education into the Life Orientation learning programme. Educator 4 said that it has made her aware of how to help and treat infected learners in her class. Another

educator responded that it has been helpful in that it has helped her to teach learners but also to educate herself as she had an HIV positive learner in her class. She has now become aware of what precautions to take and how to take care of the learner in her class as he was always sick, more especially since the parents were not very co-operative and did not help the child to do extra homework when it was sent home.

However, Educator 3 indicated that it was important that the policy stressed, that all HIV positive educators, learners and students should be respected. Section 3.2 and 3.4²⁷. states that “learners, students, educators and other staff should be treated in a just, humane and life-affirming way and learners should be educated about fundamental human rights as contained in the Constitution of the Republic of South Africa, 1996”. However, she felt that the effect was still not there. She believed that more needs to be done to bring awareness and as a Life Orientation educator, there is insufficient time and not all lessons focus on HIV/AIDS education. There are other lessons that need to be taught during the Life Orientation lesson. She stated that:

More and greater awareness needs to be created considering what a devastating effect the epidemic is having on the country.

With regard to the effectiveness of the policy, some educators felt that it was effective as it listed ways of how to prevent HIV/AIDS and it clearly outlines issues regarding non-discrimination of infected people including learners and educators. However, Educator 2 felt that there was a ‘*downfall*’, as educators were not aware if pastoral care was given to learners and educators and if infected persons were receiving ARVs at hospitals. There appears to be a “silence” in the policy about identification and help to learners. Educator 5 indicated that she believed that the policy was only 70% effective as she felt she can only discuss little aspects of the policy as part of it does not really involve the school. Educator 2 indicated that a copy of the national HIV/AIDS policy should be given to all the educators thereby creating greater awareness of the epidemic.

²⁷ In the National HIV/AIDS Policy (1999:11)

The National HIV/AIDS Policy (1999) seeks to contribute towards promoting an effective prevention and care programme within the public education system. Hence, there is a great need for educators to read and understand the contents of the national policy as this can assist them to implement the policy and intervention programme at school.

4.2.1.2. Implementation of the school HIV/AIDS policy

In response to the question of whether this school had its own HIV/AIDS policy, all educators stated that this school had its own HIV/AIDS policy which was formulated by the HIV/AIDS Committee. Educator 2 indicated that she believed that the staff was divided into policy groups and one group decided to work on the HIV/AIDS policy. However the other educators indicated that a team of educators got together and drew up the policy.

In respect of the procedure that was followed in the drawing up of the policy, Educator 1 indicated that the team of educators had looked at the National HIV/AIDS policy and drew up the school HIV/AIDS policy. However, Educator 2 indicated that they looked at HIV/AIDS policies from other schools and at the National HIV/AIDS Policy and took ideas and then drew up the policy.

In response to the question regarding the implementation of the HIV/AIDS policy all five Life Orientation educators indicated that they are implementing the policy. However, Educator 2 responded:

I feel more needs to be done to create awareness, the school can have assembly talks, essay writing and art competitions which should be initiated by the educators and this will help to cut down on the transmission of the virus.

When asked about the salient features of the school HIV/AIDS policy, educators responded that it covered all aspects such as confidentiality and non-discrimination of infected learners, educators and non teaching staff including cleaners. They also indicated that the

policy is very clear on issues such as safety measures²⁸ which need to be taken in school when learners are injured. That education about HIV/AIDS should be ongoing. It must also be age appropriate and must be taught as a component of sexuality education. Educators also indicated that parents are also not obligated to reveal their children's status when filling out admission forms. If a teacher is aware of a child's status then he/she must inform the principal. However, if a parent reveals to the principal, then he/she has to inform the class teacher and the teachers who teach that class. The child must be treated as normal and must not be discriminated against. They also stated that when new educators are employed at the school, they are also not required to reveal their status. Universal precautions are also mentioned briefly in the school policy.

Educator 3 felt that counseling should be emphasized in the policy as educators are not all trained to counsel learners and they need to be trained, as this will enable them to help the learners.

The National HIV/AIDS Policy and the school HIV/AIDS policy are important as they guide what educators are supposed to do in respect of HIV/AIDS education. However, there is a constant message in literature that policy does not directly translate into practice. The lack of fit between policy and education practice is commonly explained in terms of the lack of resources, the dearth of capacity to translate official vision into contextual reality (Jansen, 2001).

According to McLaughlin (1998) policy implementation is also affected by how it is interpreted and the response of the individual who has to implement it, in this case the Life Orientation educators. The local expertise, organizational routines and resources available to these educators also helps them to execute, and sustain the implementation of the National HIV/AIDS Policy. Furthermore, the Life Orientation educators will and motivation is also dependent on the attitudes of the school management team and district officials. While the Life Orientation educators in this school may be eager to implement the

²⁸ Safety measures are discussed in detail in Section 7. A Safe School and Institution Environment (National HIV/AIDS Policy, 1999: 15).

National HIV/AIDS policy, because of a lack of support from the school managers, the implementation process may be derailed. Local implementation of the National HIV/AIDS policy is a process of mutual adaptation between educators and the management team. McLaughlin further states that educators who successfully implement the National HIV/AIDS policy do so because they belong to a collegial learning community which enables them to work together to discover new knowledge and understandings as opposed to those educators who work in environments which are characterized by professional isolation and an absence of a shared sense of practice.

According to Kiely (1998) it is possible that this policy maybe in conflict with some of the training that educators received. According to the LO educators support needs to be provided by the Department of Education as well as teacher unions and school management members.

Educators play a fundamental role in the implementation of the National HIV/AIDS Policy, especially with regard to disseminating messages across to the adolescent population. This is the national focus, as it is seen as being instrumental in the long term reduction of the epidemic.

4.2.1.3. Training and Workshops

When asked whether they had attended any workshops on HIV/AIDS, the response was varied. Educator1 said that she had attended a one week workshop in 2003 and thoroughly enjoyed the experience. She had gained a lot of information but since has not heard of anyone going in recent years. It would seem that there is eagerness to attend workshops but there is a general lack of such programmes over the years.

Educator 2 believed that not everyone has an opportunity to go on workshops as it's the same educators who go, either because they do the planning for the Life Orientation lessons or they have already attended other HIV/AIDS workshops. Sometimes educators who have experience in counseling would go. However, she believed that there are times when the

workshop notice is sent around to the staff, which gives all educators an option to choose whether they want to go. This educator felt however, that more educators should be allowed to go to these workshops for example a rotation basis should be followed, i.e. if two educators go this year, then another two must be allowed to go the following year as the workshops are very informative and educators get an opportunity to be trained by professionals.

With regard to the issue of the cascading of information, to the staff after attending workshops. The educators responded in the following ways. Educator 1 said

I do not believe in cascading of information as the information is cascaded in 20 to 30 minutes, this is too rushed especially if educators had attended a one week workshop. Educators also neglect to cascade the information and usually do so if they are forced. Cascading of information is also not done timeously in this school.

Another educator stated:

“Information regarding HIV/AIDS should be cascaded to educators once annually or twice a year so as to keep educators informed to create greater awareness. There are also limitations regarding the cascading of information in the afternoons as educators are busy with other activities”.

Educator 5 agreed *“All educators should be trained and equipped with information regarding HIV/AIDS, even if they do not teach Life Orientation as all educators teach in a class and need to be equipped to handle situations”.*

It would appear that training and workshops are held in order to provide information for use by educators in their role as HIV/AIDS educators in their institutions. Since HIV/AIDS is taught during the Lifeskills component of the Life Orientation learning area, it was recognized that teachers needed to be trained to fulfill this role. A cascading model was used since the scale of the challenge was so vast. This meant that in KwaZulu-Natal

approximately 1000 educators were trained and were then expected to cascade their knowledge to the other educators at their schools. Evaluations of this project suggested that this model was not successful (McBride, 1989). The Department of Education is presently looking at a system of peer educators with respect to HIV/AIDS education. The advantages of this new system will have to be evaluated (Simbayi et al. 2005). In the context of this study the idea of cascading did not happen regularly and was unsuccessful.

4.2.1.4. The impact of the lifeskills intervention programme on learners in terms of knowledge and awareness of HIV/AIDS.

All educators agreed that the intervention programme is having a positive impact on learners. According to the educators the learners are becoming more aware of the disease but one educator indicated

I think it is sad that young children have to be exposed to such sexual terms as some of them are quite sensitive although there are learners who are quite aware of these terms.

The educator did indicate that they used terms, that the learners could understand, which were age appropriate. Section 9.3.²⁹ clearly states that “education and information regarding HIV/AIDS must be given in an accurate and scientific manner and must be in language and terms that are understandable”.

The educators also found that the learners are becoming more knowledgeable and they are learning to be more compassionate towards family members and friends who are infected. Learners are learning about HIV/AIDS and how it is transmitted and how transmission of the virus can be prevented. The belief is that this knowledge will help the learners make the correct choices. One educator also indicated

In the primary school the younger children are also more eager to learn and listen to educators. However, another educator said that “Although the children are learning about

²⁹ In the National HIV/AIDS Policy (1999: 22)

the disease and are quite knowledgeable about it, I do not think that they are really equipped to deal with it". According to her "They do not want to associate with people who are infected or share anything with that person.

This shows that although learners have been educated as to how the virus is transmitted they are not willing to put into practice what they have learnt. She felt that more emphasis should be placed on teaching young children to show love, respect and caring towards those who are infected instead of just concentrating on imparting knowledge about the disease.

4.2.1.5. Problems encountered by educators in the teaching of HIV/AIDS education

Some of the barriers that were discussed by educators included a negative attitude by parents. One educator indicated that many parents have a negative attitude about the epidemic and this is passed on to the learners. This becomes a '*stumbling block*' and she found it hard to continue with her lessons. Another educator indicated when she was teaching a grade 4 class, some parents had come up to her and told her that they felt that their children are a bit too young to learn about such things but now that she is teaching older children in grade 5, she has had no such problem with parents.

The data elicited from educators suggests that that most children do not discuss with their parents what is taught in class. Most parents are also not discussing with their children issues regarding sexuality or HIV/AIDS. Section 2.6.5.³⁰ clearly states that "Besides sexuality education, morality and life skills education being provided by educators, parents should provide their children with healthy morals, sexuality education and guidance regarding sexual abstinence until marriage and faithfulness to their partners". However, according to educators most parents have abdicated this responsibility and passed it on to the school. The educators believed that it would make things a lot easier for educators if parents discussed such issues with their children at home.

³⁰ In the National HIV/AIDS Policy (1999: 9)

In response to the question of gender, educators responded that this issue does not pose a problem as most educators prefer to teach mixed classes, with both boys and girls at the same time. However, there were two educators who indicated that they would prefer to teach certain topics separately to boys and vice versa but their timetable did not provide for such a concession.

In response to the question of learners' maturity levels, the grade 4 and 5 educators indicated that although the topics are age appropriate, they find that learners are still too young and immature to learn about such topics. However, educator 5 indicated that the learners in her class are quite mature. They do not feel shy to ask questions pertaining to HIV/AIDS and sexuality issues as they seem very aware and have gained a lot of information from the media, but she did say that those who are immature are usually 'molly coddled' by their parents and make up 60% of the learner population in her class.

4.2.1.6. Learners knowledge and awareness about HIV/AIDS

From the focus group interviews it was found that with regard to the question "What do the acronyms HIV and AIDS mean?" indicates that the grade 7 learners have a fairly good understanding of what the acronyms HIV/AIDS mean. They responded that HIV means Human Immunodeficiency Virus, although a few kept referring to it as human immune virus which is actually quite close. Most of them knew that AIDS means Acquired Immune Deficiency Syndrome, although there were some learners who were unable to get this correct. They were aware that humans are infected by the virus. Some learners indicated that a person gets infected with the virus first, which then leads to AIDS. The term 'acquired' according to the learners means "*a person can get the disease but one is not born with it*" meaning a person does not genetically inherit the disease. They stated that "*HIV is transmitted from one person to another*".

The learners were very aware of how the virus is transmitted in adults and children. They were able to mention the various ways such as

“Unsafe / unprotected sex, through blood to blood contact”. “A pregnant woman who is HIV positive can pass it to her baby through childbirth or breastfeeding”.

They also mentioned *“through rape and sexual abuse”*. This can also take place in schools.

“When people take drugs and share needles. It was also mentioned that “youngsters go clubbing and get involved in drug taking and alcohol consumption, this could lead to behaviour that could lead to unsafe sex”.

“Blood transfusion” was also mentioned, “if someone is bleeding a lot and needs blood, the virus can be passed on if the blood has not been tested properly”.

4.2.1.7. Attitude of learners towards people with AIDS and their families

It was found that the learners have a very positive attitude towards people with AIDS and their families. This can be deduced from the statements that were made by them, such as

‘I will be kind and friendly towards them’, ‘I will take care of them and get someone to counsel them’, ‘I will remind them to take the right medication’, ‘and I will treat them with love and respect and will be supportive towards them and their families’.

According to Quackenbush and Villarreal (1988) senior primary school learners describe people with AIDS in more general terms and do not see it in specific or personal terms. Since they have a decreased sense of egocentrism, learners at this age have the ability to see things from another point of view and they understand that the points of view of various people may be different. They are often very deeply moved by the stories of people with AIDS especially children. This helps them to acquire a greater understanding of compassion for people with HIV/AIDS. They are also more tolerant of uncertainties.

4.2.1.8. Stigmatization and discrimination

The learners seemed very aware of how people generally treat people with HIV/AIDS. They mentioned some ways in which people generally discriminate against AIDS victims. According to the learners the following are some of the ways in which people discriminate against people with AIDS;

“people do not want to go near someone who has AIDS, they do not want to sit next them, or lend them things, they can spread rumours that the person is bad because they are infected, their own families may reject them”,

However, mention was made that *“some families will still remain loving and giving”*. They also mentioned that *“children will tease children who are infected or who have AIDS, they will make funny comments about them and will not want to play with them”*.

They also indicated that *“some adults will not want to hire a person, who has AIDS, certain employers will fire them and some employees may not want to work with them”*.

There is a high level of awareness amongst learners in the ways that people with AIDS are generally discriminated against. They also mentioned that *“some people still think that one can get infected with HIV if one touches an infected person”*. This indicates that the learners are aware that there is a great deal of ignorance on the issue which can lead to discrimination and stigmatization.

Visser (2007) states that HIV/AIDS stigma can be seen as prejudice and discrimination that is directed at people who are perceived to be HIV positive, and towards people and communities that they associate with. People manifest stigma towards people living with HIV or AIDS because they are afraid of the illness, afraid of contacting it and are also afraid of death. Stigmatization inflicts suffering on people and interferes with attempts to fight the AIDS epidemic. Visser (2007) further states that in this regard research has found

that people prefer not to know their HIV status instead of knowing it. By displaying this kind of behaviour the transmitting of the virus can continue.

According to Frohlich (2005) in South Africa, stigma has been combined with discrimination. Discrimination against HIV positive people depends on a variety of perceptions and misconceptions of their gender, their race, their HIV positive status and their sexuality. Stigma induces discrimination. When people are afraid to speak openly about their HIV status, there is a climate of denial. This in turn discourages health seeking behaviour among those who think that they may already be infected with HIV and may delay health seeking benefits. Frohlich (2005) further states that the issue of stigma and discrimination is tied to ignorance, informing people about the virus are not enough to eradicate it. Preventive education must also embrace serious education about discrimination.

4.3. Conclusion

In response to critical question one, educator participants (LO) indicated that they had a good understanding of the National HIV/AIDS policy and that they had found it was very useful and informative. It enabled them to effectively implement the HIV/AIDS and Lifeskills intervention programme.

On the second critical question, the learners had displayed a sophisticated level of awareness of the epidemic and were very aware of the ways in which the virus is transmitted and not transmitted. Knowledge about the facts and dangers about the epidemic appears to be high amongst the grade seven learners.

In the next chapter I focus on the findings, conclusions and recommendations of this study.

CHAPTER FIVE

INSIGHTS, RECOMMENDATIONS AND CONCLUSIONS

5.1. Introduction

This study explored the perceptions of the Life Orientation educators to implementation of the National HIV/AIDS policy and HIV/AIDS education and Lifeskills intervention programme at a primary school. It also assessed the impact that the intervention programme has had on the grade seven learners level of awareness and knowledge of HIV/AIDS. This study revealed that the Life Orientation educators found the National HIV/AIDS policy to be very informative and comprehensive. It has enabled them to implement the intervention programme with some success. However, the study also revealed that there are limitations with regards to the implementation of the policy and intervention programme as there is a lack of much needed resources and training to facilitate teaching. In this chapter I summarize the findings under the following categories; perceptions of educators towards the National HIV/AIDS policy, training and workshops, the impact of the HIV/AIDS intervention programme on learners and attitudes of learners towards people with AIDS.

5.2. Findings

5.2.1. The perceptions of the Life Orientation educators towards the National HIV/AIDS policy

The Life Orientation educators indicated that the policy was comprehensive and very informative. It allowed educators to inform themselves about the epidemic and helped them to incorporate HIV/AIDS education in their leaning programme. One Life Orientation educator who was sceptical initially about teaching HIV positive learners in her class, had a change of attitude and no longer felt uncomfortable teaching infected learners as she read the policy and became more informed of its contents. The reading of the policy helped her to allay any fears she may have had of contacting the virus from infected learners. One can

deduce from the above that the policy has had a positive impact on the Life Orientation educators.

A questionnaire based survey of educators in public schools was done by Shisana et al. (2005). The main goal of the survey was to report on the educators' level of awareness of the DoE's HIV/AIDS policy and their perceptions about the implementation of the policy. The findings were as follows: an overwhelming majority (89% to 95%) indicated that had actually read or studied the policy. These educators who had read the policy were also asked for their opinion regarding how useful the DoE's HIV/AIDS policy was. The majority of the educators (90.9%) indicated that this policy was either very useful or useful in their school environment compared to a small minority who said that the policy was neither useful nor applicable. This is in concordance with my findings as LO educators in my study indicated that the policy is comprehensive and useful as it enabled them to incorporate HIV/AIDS education into their Life Orientation learning programme.

5.2.2. Training and workshops

Most educators had not received training in the teaching of HIV/AIDS education and had to rely on getting information from a variety of sources. Educators had also stressed that all educators need to be offered opportunities to attend workshops as they need the necessary skills and information as all educators come into contact with learners who are infected and affected and being more informed will not only enable them to educate the learners but will also enable them to help the learners. The educators also felt that the cascading model of informing educators has not worked as information is not always adequately disseminated and is not done timeously. According to McBride (1989) evaluations of the 'cascading model', also suggest that the impact is not successful. Evidence from other countries also suggests that the 'cascade' models of professional development are not always effective especially with regards to sensitive topics such as HIV/AIDS. It was also found to be unsuccessful when a provincial survey revealed that only 18% of schools were found to be offering any form of lifeskills training, let alone training that concentrates on sexuality and HIV/AIDS prevention (Data Research Africa, 2000).

5.2.3. The impact of the HIV/AIDS intervention programme on learners

Educators agreed that the intervention programme is having a positive impact on the learners. Knowledge about HIV/AIDS appears to be high in this study. The learners researched have gained a great deal of information about the epidemic during the Life Orientation lessons which started from grade 4 level. They are very knowledgeable about how the virus is transmitted and how it is not transmitted. This is in keeping with what Peltzer and Promtussananon (2003)³¹ state that children who fall in this age group 13 to 19 have a much better understanding of HIV/AIDS than do younger children. Since adolescents have a more advanced cognitive development which is reflected in their understanding of HIV/AIDS. They understand the concepts of a syndrome and have a clear idea of the causes as well as the effects of HIV infection.

5.2.4. Attitude of learners towards people who have AIDS.

Learners displayed a very positive attitude towards people who have AIDS and their families. This sense of positivity can be deduced from some of the statements that they made such as that they will be kind and friendly towards infected persons. They were also very aware of how people infected with the virus are being discriminated against.

However, this is in direct contrast to research that was carried out by the University of Pretoria, with 460 grade 6 and 7 learners from four primary schools in previously disadvantaged urban areas in the Pretoria Metropolitan area. These learners attitude towards people with AIDS was very negative. Almost half (46%) stated that they would not allow learners with AIDS in their schools (Visser and Moleko, 2008).

³¹ Peltzer and Promtussananon, cited in Van Dyk, 2008

5.3. Recommendations

- All educators must have access to the school HIV/AIDS policy. It must be the management's responsibility to ensure that the policy is discussed and implemented by all educators.
- Educators, parents and community organizations must merge their resources with the intention of disseminating information regarding HIV/AIDS. Parents also need to take a more meaningful role in discussing issues of sexuality with the children and must not leave this responsibility to schools alone.
- Educators must be offered more information and skills training regarding the teaching of HIV/AIDS education. To make learners more aware of the virus and its effect on people. The school should make a concerted effort to invite people with AIDS to visit the schools and give talks to learners, educators, parents and community members. More awareness could also be created by having assembly talks, poster displays. This would create more compassion and understanding towards people infected by the virus.
- The school must also develop programmes that foster self esteem development and the acquisition of lifeskills. Structures should be set up to provide counselling and peer support groups for infected and affected learners.
- Since the cascade model of disseminating information has not worked well in this school, a system of using peer educators is advocated to inform educators about policy and background information for the implementation of the policy and intervention programme.

5.4. Conclusions

The data generated indicated that educators in this study have a good knowledge and awareness of the contents of the National HIV/AIDS policy, although most had indicated that they had not received much training in the teaching of HIV/AIDS. In order for

successful implementation of the policy and intervention programme to take place in primary schools, a number of factors are necessary including managerial capacity to co-ordinate this process. It is also essential for other stakeholders such as site stewards to disseminate information so as to enable educators to become more knowledgeable about the policy and the directives flowing from it.

The findings also show that the learners have a fairly sound knowledge about HIV/AIDS. However, research has shown that although knowledge about HIV infection is high, this has not translated in a reduction in the HIV infection rate. Hingston and Strunin (1992)³² concur when they state that despite a marked increase in public awareness of HIV transmission, there has not been a corresponding change in HIV risk behaviours. According to Visser and Moleko (2008) in three major studies undertaken on youth in South Africa, it was found that there exists a fair degree of risk proneness with regard to risky behaviour and AIDS is a major health threat facing South African youth. Of the primary school learners who participated in this study, 24% indicated that they were sexually active, however only 40% of these sexually active learners protect themselves from HIV. It also seems as if sexual activity is becoming the group norm, 46% of these learners see their friends as being sexually active.

It is essential that educators, community structures and parents play an important role in disseminating correct information about the virus. Since young people learn about HIV/AIDS from a multitude of sources. The school cannot solely take responsibility for HIV/AIDS education. Research also shows that HIV/AIDS education together with lifeskills is more effective in developing attitudes and behaviour that is necessary for preventing the spread of HIV/AIDS.

³² Hingston and Strunin, cited in DiClemente and Peterson, 1994

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HEAD OFFICE

Enquiries:
Imibuzo: M Francis
Navrae:

Reference:
Inkomba: 0267/06
Verwysing:

Date:
Usuku:
Datum: 08/05/2007

RE: PERMISSION TO CONDUCT RESEARCH

TO WHOM IT MAY CONCERN

This is to serve as a notice that Rehana Sayed-Nazim (204518607) 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 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.
- **R Sayrd-Nazim** 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.


for **SUPERINTENDENT GENERAL**
KwaZulu Natal Department of Education



**UNIVERSITY OF
KWAZULU-NATA**

Faculty of Education Research Office
Room A126
Edgewood Campus

Office: (031) 260 3524

Fax: (031) 260 7594

Email: Buchler@ukzn.ac.za

17th March 2009

Attention: To whom it may concern:

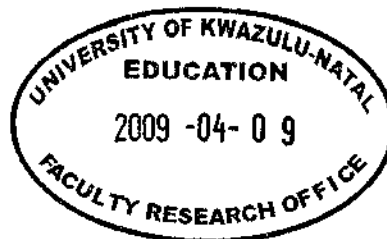
RE: Ethical Clearance Certificate

This letters serves to confirm that Syed Nazim, R - 204518607 has applied for Ethical Clearance and has been given clearance. The certificate is on file with the Faculty Office for inspection.

Yours truly,

Derek Buchler
Research Officer

cc. Prof Bhana
File



Faculty Research Office – Education

Postal Address: Private Bag X03, Ashwood 3605, South Africa

Telephone: +27 (0)31 260 3524

Facsimile: +27 (0)31 260 7594

Email: education@ukzn.ac.za

Website: www.education.ac.za

APPENDIX 3

University of KwaZulu-Natal
Edgewood
16 February 2007

The Principal
Primary School

Sir,

I am registered as a Master's student in the Faculty of Education at the University of KwaZulu-Natal, Edgewood in the current academic year. The programme is a two year degree which involves course work and a dissertation.

The dissertation would entail undertaking research in the area of HIV/AIDS education. My research topic is:

Exploring the HIV/AIDS and Lifeskills intervention programme and policy implementation in a primary school in South Durban, KwaZulu-Natal.

I request your permission and support to enable me to undertake the study at Primary School. The research study will be conducted during the school year 2007. It would be a qualitative study and will involve mainly semi-structured interviews with school based personnel and focus group interviews with grade 7 learners (30). The interviews will be conducted out of class times.

The importance of HIV/AIDS education is emphasized in the National HIV/AIDS Policy for educators and learners. It is anticipated, that the evaluation of the findings of the research project will be used to assist in the effective teaching and learning of HIV/AIDS.

Thanking you

Yours faithfully

Ms. R. B. Syed Nazim

CONSENT FORM

I _____ consent to Ms. R. B. Syed Nazim undertaking her research at Primary School during the academic year 2007.

Principal

School Stamp

APPENDIX 4

University of KwaZulu-Natal
Edgewood
16 February 2007

Dear Parent

I am registered as a Master's student in the faculty of Education at the University of KwaZulu-Natal, Edgewood in the current academic year. The programme is a two year degree which involves course work and a dissertation. The dissertation entails undertaking research in the area of HIV/AIDS education. My research topic is:

Exploring the National HIV/AIDS and Lifeskills intervention programme and policy implementation in a primary school in South Durban, KwaZulu-Natal.

I request your permission to interview your child. The interview will be conducted during the school year 2007. It will be done in groups of 5-7 for a duration of 30 minutes. The interviews will be tape recorded. Participation is voluntary and the child may withdraw at any time without any penalty.

The interviews will be based on work that is done in the class during the Life Orientation learning area to gauge the level of awareness and knowledge about the disease. The identity of the learner will remain anonymous and information passed on will remain confidential. At no time will your child's name be linked to the research as no names will be mentioned in the dissertation.

The importance of HIV/AIDS education is emphasized in the National HIV/AIDS Policy for educators and learners which was gazetted in 1999. It is anticipated therefore, that the evaluation of the findings of the research project will be used to assist in the effective teaching and learning of HIV/AIDS.

Thanking you

Yours faithfully

Ms. R. B. Syed Nazim

CONSENT FORM

I _____ consent to my child/ward _____
to be interviewed in this study. The interview the interview will take place during school time.

Signature of Parent/Guardian

Date

APPENDIX 5

University of KwaZulu-Natal
Edgewood

Dear Life Orientation Educator

I am registered as a Master's student at the Faculty of Education at the University of KwaZulu-Natal, Edgewood in the current academic year. The programme is a two degree which involves course work and a dissertation.

The dissertation would entail undertaking research in the area of HIV/AIDS education. My research topic is:

Exploring the National HIV/AIDS and Lifeskills intervention programme and policy implementation in a primary school in South Durban, KwaZulu-Natal.

I request your permission to interview you. The interview will be conducted during the school year 2007. The interview will be tape recorded. Participation is voluntary and you may withdraw at any time without any penalty. Your identity will remain anonymous and information passed on will remain confidential. At no time will your name be linked to the research as no names will be mentioned in the research.

The importance of HIV/AIDS education is emphasized in the National HIV/AIDS Policy for educators and learners which was gazetted in 1999. It is anticipated therefore, that the findings of the research project will be used to assist in the effective teaching and learning of HIV/AIDS.

Thanking you

Yours faithfully

Ms. R. B. Syed Nazim

CONSENT FORM

I _____ (full name of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

APPENDIX 6

THE SEMI-STRUCTURED INTERVIEW SCHEDULE

The following questions were explored with the Life Orientation educators in response to critical question one.

1. What are your perceptions of the HIV/AIDS policy?
What impact has the policy had on you as a Life Orientation educator?
What is the effectiveness of the policy?
2. Does your school have its own HOV/AIDS policy?
Who drew up the policy?
What are its salient features?
3. Training and workshops.
Are educators given opportunities to attend workshops?
Is the information cascaded to educators? How and when?
4. Are the intervention programmes in your school having an impact on your learners in terms of their knowledge and awareness of the disease?
Is the impact negative or positive? Describe how?
5. What barriers do you encounter in your teaching of this programme, which disenables you from effectively making a contribution?
Culture, upbringing, tradition, parental attitudes, etc.
Mixed classes-both genders and large numbers.
Age of learners and maturity levels.
6. What materials are used to teach HIV/AIDS education? Resources, etc.
7. Is there flexibility in the designing of your lessons?

Do you include your own topics or do you exclude certain topics that in your Work Schedule? ---Explain why?

APPENDIX 7

FOCUS GROUP INTERVIEW SCHEDULE

The following questions were explored with the grade 7 learners in response to critical question 2.

1. Discussion on the difference between the two terms HIV and AIDS.
2. Discuss the ways the virus is transmitted in adults and children.
3. Discuss the different ways in which the virus is not transmitted in people.
4. What are universal precautions?
5. Discuss the treatment of people with AIDS and their families.
6. Discuss stigmatization and discrimination of people with AIDS.