YOUNG CHILDREN'S RESPONSES TO AIDS

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DECLARATION

I, Dhanasagrie Jewnarain declare that the research reported in this dissertation, except where otherwise indicated, is my original work.

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Acknowledgements

ABSTRACT

This study explores the ways in which Grade Two boys and girls (aged 7-9) in a predominantly Black school construct their knowledge of HIV and AIDS. The study also seeks to explore how young children, in giving meaning to HIV and AIDS, position themselves as gendered beings in the context of HIV and AIDS. By focussing on the construction of young children's identities in response to AIDS, this study demonstrates how children, in responding to AIDS, do gender and sexuality. There is very little work around gender and young children, let alone gender, HIV and AIDS, and sexuality. This is because of the ways in which children are perceived to be nonsexual, degendered and without the capacity to think beyond a certain stage of development (See Bhana, 2006; 2007a; 2007b; 2008; Silin, 1995; MacNaughton, 2000 as exceptions). By drawing upon qualitative and feminist methodological approaches, this study positions young children as having their own identities, as active participants who are capable of making meaning. This study shows that AIDS is embedded within social, economic, cultural, political and ideological contexts and that the ways in which these children give meanings to HIV and AIDS are embedded within these contexts. In responding to AIDS, the children in this study inform us of their relationship to AIDS within social processes including sexuality, gender, race and class, and they show us how these are actively acted upon. This study also shows the children positioning themselves as gendered beings with the capacity to think, feel and enact their sexuality. In doing so, they dispel many notions which position young children as unknowing, asexual beings.

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CHAPTER 1: INTRODUCTION TO THE STUDY

1.1. Introduction

This study explores the ways in which Grade Two boys and girls (aged 7-9) in a predominantly Black school construct their knowledge of HIV and AIDS. The study also seeks to explore how young children, in giving meaning to HIV and AIDS, position themselves as gendered beings in the context of HIV and AIDS. By focussing on the construction of young children's identities in response to AIDS, this study demonstrates how children, in responding to AIDS, do gender and sexuality. There is very little work around gender and young children, let alone gender, HIV and AIDS and sexuality. This is because of the ways in which children are perceived to be nonsexual, degendered and without the capacity to think beyond a certain stage of development (See Bhana, 2006; 2007a; 2007b; 2008; Silin, 1995; MacNaughton, 2000 as exceptions). By drawing upon qualitative and feminist methodological approaches, this study positions young children as having their own identities, as active participants who are capable of making meaning. This study shows that AIDS is embedded within social, economic, cultural, political and ideological contexts and that the ways in which these children give meanings to HIV and AIDS are embedded within these contexts. In responding to AIDS, the children in this study, inform us of their relationship to AIDS within social processes including sexuality, gender, race and class, and they show us how these are actively acted upon. This study also shows the children positioning themselves as gendered beings with the capacity to think, feel and enact their sexuality. In doing so, they dispel many notions which position young children as unknowing, asexual beings.

In this thesis I argue that children are gendered and sexual beings and, therefore, it is important to understand the way young children make meaning of HIV and AIDS. I also argue that young children know about HIV and AIDS but they know about it unevenly because they give meaning to AIDS in terms of gender, sexuality, race, culture and their social location. Having introduced the study and discussed the need to explore the rationale for this study, I continue this chapter firstly by reflecting personally on my experiences with HIV and AIDS as a school teacher in early childhood development and then I briefly explain my rationale for engaging young children in research. I also advocate the importance of HIV education in early childhood education.

1.2. HIV and AIDS – A Personal reflection

The motivation for this study derives from my involvement with teaching learners in the Foundation Phase from 2003 onwards. In this year, I transferred from a majority Indian school to a majority Black school which is situated in a middle-class Indian suburb. The children attending the school reside in the nearby township and in the shacks within the urban suburb. Many of the children come from poverty-stricken homes, their school fees are unpaid, they lack basic stationery, they lack proper school uniforms and many of the children are fed by the community members who sponsor sandwiches on a daily basis. My first experience with childhood gender violence happened in the same year. In the shack settlement, poverty, crime and abuse of all kinds are prevalent. A child in Grade Two came to school one day, looking tired, dirty and sad. I offered her sandwiches, but she refused. I went out with her during the break. We chatted… correction; I spoke, I questioned. She began to cry. I found out that she had been and was being raped by an older person from the settlement. We called the police in, and they went to the settlement to make an arrest. The matter was referred to the authorities. When the alleged rapist was arrested, he disclosed to the police, the principal of the school and the gathering crowd his HIV status – he was HIV positive.

It is now 2008; I asked my research participants to draw me a picture about HIV and AIDS. I asked them to draw me a picture of how they saw HIV and AIDS. I was taken aback by the very pretty drawing of a child and her mother. I asked the child to explain the drawing to me. The child said, "This is a picture of baby helping mum". "Why does baby have to help mum"? I asked. The child responded, "because mum is sick; mum has HIV (AIDS)". I later discovered that the mother had died two weeks before the interviews.

In 2007, when I was in charge of a Grade One class, one of the learners had prolonged periods of absenteeism. One day he came to school and he held onto me. He kept on saying, "mama ifele, mama ugula' (mummy died… mummy sick). I made contact with the grandparent, and discovered that the child had lost his mother due to a 'sickness'. The child was subsequently sent to live on a farm.

In 2003, a parent came in to pay school fees. When I explained to her that I was concerned about her child's absenteeism the woman looked at me and tears started to

slowly roll down her cheeks. She whispered "….was raped". She told me that she had to be hospitalised for a while and that during her hospitalisation, her daughter was sent to live with relatives. She then explained that it was during this time that her daughter was raped by a family member. She saw me again in 2005. She told me that her daughter was diagnosed as being HIV-positive and that she was on anti-retrovirals. The man who raped her had since died. The child was six years old at the time of the abuse.

These are just some of my experiences; however, I was struck by the similarities in the gendered violence and its relation to HIV and AIDS. I was also affected by my learners' grief and anguish at the passing away of a loved one due to AIDS. Suddenly, HIV and AIDS seemed to dominate my classroom. It dawned on me that I was doing an injustice to the Life Skills programme and I realised that I was prejudiced when it came to dealing with sex and sexuality in young children. I began to introduce HIV and AIDS education in the Life Skills programme, however, I could not bring myself to talk about rape. The children's experiences were very vivid in my mind and I found myself having sleepless nights. After a few months, I began to gradually phase in sex and sexuality education in my lessons. 'Stranger Danger' took on a new meaning as I explained to the children aspects of personal safety, good touch/bad touch, the right to say no, etc. I gradually became stronger through the support of the children: I soon discovered that the children were able to identify with what I was saying. The children knew about sex (they spoke of it as sleeping with the boy/girl), some could identify rape and they linked it to 'kidnapping', and they also knew about HIV and AIDS. I discovered that children were very gendered in their thoughts and their behaviour *(The girls preferred to hang around me, and while some of the boys did come to me, it was usually with a prefect in tow!).* My experiences have brought me to the realisation that HIV and AIDS is widespread in the schooling context and that knowledge of the disease is not confined to older children only. It consequently became important for me as an early childhood educator in the Foundation Phase (Grade R–Three) to explore young children's understanding of HIV and AIDS. The study was further driven by the urgency to discover how young children position themselves, their gender and HIV and AIDS, given their social location and their social context.

In order to do this study, it was necessary to posit this study in the new sociology of childhood that allows the researcher to see children as agents, being able to make

meanings of their lives. The new sociology of childhood draws from a social constructionist perspective. It also accentuates childhood as a distinct and important phase where the construction of human experience has value in its own right (Prout & James, 1997). Children, as temporary members of childhood, are seen as fully formed, complete individuals who are social actors in their lives (James, 1998; Lee, 2000). According to Christiansen and Prout (2000), it is the children themselves that are seen as experts who are knowledgeable about their lives and provide information as experts about their lives as they "act, take part in, change and become changed by the social and cultural world they live in".

Having drawn on my personal experiences with HIV and AIDS, I continue this chapter by focusing on the gendered nature of HIV and AIDS. I draw on the social aspects which exacerbate HIV and AIDS and which also exacerbate vulnerability in terms of gender. Further to this, I investigate the stigma, shame, silence and discrimination which surround the disease and I also draw attention to the racialising of HIV and AIDS. In the next section I focus on the influence of culture, class and poverty in the context of the HIV and AIDS pandemic. I continue this chapter, now focussing on the myths, misconceptions and taboos that emerged in the wake of HIV and AIDS. I proceed to explore sexuality, gender and young children and here, I draw from the new sociology of childhood that argues that children must be understood and accepted as sexual beings rather than for their sexuality to be ignored and hidden. I then describe in great detail the context and the research site of this study. The aims of this study, together with the research questions and the organisation of this study conclude Chapter One.

1.3. The gendered nature of HIV and AIDS

Understanding HIV and AIDS through a gendered prism is very important because HIV and AIDS is gendered and as such, men, women and children are highly vulnerable to AIDS, with women, however, bearing the impact and scourge of the disease. We are now more than 20 years into the disease; and women account for nearly half of the people living with HIV worldwide, with an even higher population living in developing countries. According to UNAIDS (2007), since 1995, women have constituted

approximately half of all adults living with HIV globally. Statistics in 2007 revealed that today, women account for 15,4 percent of the 30.8 million adults (ages 15+) currently living with HIV. According to UNAIDS (2007) in many of the world's most affected regions, women are increasingly at risk. According to UINAIDS (2007), the number of women living with HIV globally increased by 1.6 million from 2001 to 2007. In 2007, an estimated 2,900 new HIV infections occurred each day among women (ages 15+). It has also been established that young people, especially young women, are disproportionately at risk. According to IPPF/UNFPA (2007), among young people (ages 15-24) in South Africa, 14,8 percent of young women are living with HIV and AIDS, compared to 4,5 percent of young men. Women's vulnerability has been increased due to their gender roles, sexuality and differential power relationships with men, in the context of racial and class relations, which are embedded in the culture of most societies.

In the context of poverty and HIV and AIDS, girls are often deprived of educational opportunities. Mutangadura (2005) asserts that in many instances, young girls are removed from school to become caregivers to sick family members or to take care of younger siblings. According to Mutangadura (2005) and Gupta (2000) girls are frequently socialised to be submissive, yielding, dependent and emotionally more demonstrative, whilst the cultures of almost every society socialise boys to be strongly masculine, dominant and emotionally self-possessed. Girls, therefore, become the ideal candidates for care-giving and as a result, girls are more likely to remain or be kept away from school because of AIDS trauma (Mutangadura, 2005). This exacerbates the vicious cycle of poverty and further discriminates against girls, denying them the opportunity to educate themselves and escape poverty (Mutangadura, 2005). According to Human Rights Watch (HRW) (2001), HIV and AIDS has motivated older men, especially 'the sugar daddy' type, to turn to young girls for sex in the belief that they are HIV free and also that such an encounter would provide a cure for HIV infection. HRW (2001) says that it is not uncommon to find young girls in the context of poverty, trading their body for the creature comforts or just to ensure food on the table. According to the report HRW (2001), in some cases, young girls are even encouraged by their parents to engage in liaisons with older rich men in order to supplement the income in a poverty-stricken home. Weisman et al. (2006) adds that motivation for

accepting gifts of material goods and money is complex including needing money for survival, desire of material goods and possessions and perception of social status conferred. Both however, exacerbate vulnerability to HIV and AIDS and places young girls at enormous risks.

In the context of gender, it is also important to acknowledge men's vulnerability to HIV and AIDS. Unequal power balances in gender relations increase men's vulnerability to HIV infection, despite or rather because of their greater power. According to UNAIDS (1999) prevailing norms of masculinity expect men to be more knowledgeable and experienced about sex. This puts men at risk because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and coerce them into experimenting with sex in unsafe ways from an early age. Mane, Gupta & Weiss (1994) point out that in many societies worldwide, it is believed that a variety of sexual partners is essential to men's masculinity that they seek multiple partners for sexual release, which in turn challenges fidelity.

1.4. Stigma, shame, silence and discrimination in HIV and AIDS

According to Parker and Aggleton (2002), stigma and discrimination remain among the most poorly understood aspects of the pandemic. In 2000, Peter Piot, executive director of UNAIDS, identified stigma as a 'continuing challenge' that prevents concerted action at community, national and global levels (Piot, 2000).

Weeks, J (1981) point out that in order to understand the ways in which the HIV and AIDS-related stigma and discrimination appear, and the contexts in which they occur, we first need to understand how they interact with the pre-existing stigma and discrimination associated with sexuality, gender, race and poverty. According to Aggleton and Weeks (2002), HIV and AIDS-related stigma and discrimination also interact with pre-existing fears about contagion and disease. Early AIDS metaphors such as death, horror, punishment, guilt, shame, etc have exacerbated these fears, reinforcing and legitimising stigmatisation and discrimination. According to UNAIDS (2000), persons living with HIV and AIDS frequently experience social stigma, scorn or abuse. According to UNAIDS (2000) the belief is widespread, that infected persons deserve their fate because of their lifestyles: drug related or promiscuous sexual

behaviour. UNAIDS (2000) point out that this disease is associated with fear: fear of transmission and the accompanying death that follows one's HIV and AIDS status and also fear that one's HIV and AIDS status be known by family, friends and the community. Stigma, therefore, is a very real obstacle to both prevention and care and according to UNAIDS (2000) in many of the worst hit countries, government and ordinary citizens, including those most affected by the pandemic, often continue to look the other way because of rejection, discrimination and shame attached to AIDS.

According to Parker and Aggleton (2002) and UNAIDS (2000) discrimination against people who live with HIV and AIDS extends further than social and community spheres. Parker and Aggleton (2002) point out that there have been authenticated cases of people being denied medical care because of their HIV and AIDS status, employment being terminated and children excluded from school because of HIV and AIDS in their families. According to these authors, stigmatisation and discrimination may be greater against women than against men, which contributes to the silence around the disease and, as a result, in many communities, there is no sincere acknowledgement of the disease which results in a wall of silence around it. HIV and AIDS is referred to by innuendos and half suggestions and is concealed as TB/pneumonia, etc. This silence reinforces the sense of shame and this, in turn, leads to stigma and discrimination. Shame in being infected or affected often leads to silence that causes the disease to become stigmatised. Unfortunately, stigma leads to an even greater or deeper shame that reinforces greater silence and isolation that results in people behaving as if AIDS does not exist. This denial of the disease creates an atmosphere that provides a dark, secretive breeding ground for the spread of the virus.

Young children's constitution of stigma is deeply intertwined and tied to contagion and the reproduction of power inequalities, both in HIV and AIDS and sexuality (Bhana, 2006; 2007a; 2007b; 2008). Jewkes (2006) notes that whilst South African scholars have contributed to the growing literature on stigma and the social exclusion of people with HIV and AIDS (Shisana et al, 2005; Kalichman et al, 2005; Campbell et al, 2005, Campbell et al, 2007), a serious omission in this work is that it fails to seriously consider the divergent nature of responses to HIV and AIDS. Bhana (2008) adds that young children's constitution of stigma features rarely in HIV and AIDS research. This

study, like Bhana (2006), seeks to illustrate how young children stigmatise HIV and AIDS. Whilst contagion has featured strongly in HIV and AIDS stigma, this study, by allowing young children the opportunity to be active participants and by engaging them as 'knowers' in matters related to HIV and AIDS, show that young children are powerful in controlling and contesting their agency in HIV and AIDS.

Aggleton and Warwick (1999) further point out that HIV and AIDS stigma and discrimination is also linked to gender-related stigma. The impact of HIV and AIDS-related stigma on women reinforces pre-existing economic, educational, cultural and social disadvantages and unequal access to information and services. In settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behaviour that is not consistent with gender norms; for example, prostitution is associated with female sexual behaviour that is not consistent with gender norms. Female sex workers are identified as 'vectors' of infections, whilst men are blamed for heterosexual transmission, hereby making assumptions about male sexual behaviour, such as men's preference or need for multiple sexual partners (Aggleton & Warwick, 1999).

A significant characteristic of HIV-related stigma is that the disease has to do with Black people who are constructed as inherently diseased and promiscuous (McClintock, 1995). Parker and Aggleton (2002) concur, adding that race, ethnic stigma and discrimination also interact with HIV and AIDS-related stigma and that the pandemic has been characterised by racist assumptions about 'Black (African) sexuality". This characterisation of HIV and AIDS can and must be blamed on the structural violence in South Africa. In spite of the post-apartheid government's promise to alleviate poverty in South Africa, the majority of poor people in South Africa are Black. As a result, Blacks bear the brunt of the social injustices and apartheid structural violence which continue to dominate the people who have suffered and who still suffer. Whilst we all know that poverty does not cause HIV and AIDS, there is no denying that HIV and AIDS is exacerbated by poverty. The children in this study are located in poverty stricken environments, and their knowledge is, therefore, drawn from their context.

The media is, however, also responsible for stigmatising Black people in the context of HIV and AIDS. According to Bhana (2008), the ways in which the media represents

HIV and AIDS is important, particularly in the South African context where Blacks receive a great deal of coverage, suggesting that Blacks are more at risk as compared to other race groups.

1.5. Myths, misconceptions and taboos

Myths, misconceptions and taboos have promoted stigmatisation, gender violence and ignorance in the wake of HIV and AIDS. The belief that having sex with a virgin will cure AIDS is a widespread myth. According to Rose-Innes (2007), increasing numbers of rapes of female children may represent men's attempt to seek sexual relations with young girls to avoid HIV infection or because of the belief that sex with a virgin will cure AIDS.

The misconception that Black people are inherently diseased must be addressed in the context of education. It is important that young children, like the children in this study, are helped to dispel harmful notions about HIV and AIDS, especially the belief that Black people are inherently diseased with HIV and AIDS. All race groups in South Africa and in the world are susceptible to HIV and AIDS. According to the South African National HIV Prevalence Incidence Behaviour and Communication Survey, 2005, commissioned by the Nelson Mandela Foundation, a total of 10.8% of South Africans were infected with HIV. However, statistically, many more Blacks are infected than other races. Infections across racial categories, taken from the South African National HIV Prevalence Incidence Behaviour and Communication Survey, 2005, show that 13. 3% of the Black population to be infected with HIV and AIDS as compared to the infection rates amongst other groups: Whites – 0.6%, Coloureds – 1.9% and Indians – 1.6%. The same study also revealed that the infection rates are highest in South Africa's poorest communities, in informal and rural settlements, where more Black people live than Whites, Coloured or Indians. This survey serves to confirm that HIV and AIDS impacts more on the poor than on the rich.

It's clear that AIDS is about sexuality and therefore AIDS is a taboo subject. Whilst the children in this study seemingly deny an association with HIV and AIDS, their knowledge about sex and sexuality is nuanced and given away in their construction and exploration of their own sexualities. Failure by teachers and parents to address HIV and

AIDS and sexuality with children has impacted on the belief that HIV and AIDS is a taboo subject.

1.6. Culture, class and poverty

HIV and AIDS is a social phenomenon that it is embedded within ideology, race, gender, class and sexuality – all of those meanings are conjured when one thinks about HIV and AIDS. According to Rose-Innes (2006), South Africa is considered to be one of the countries worst affected by HIV and AIDS in the World. Rose-Innes (2006) asserts that certain socio-cultural factors have been identified as responsible for the rapid spread of HIV and AIDS. These factors include gender inequality and male dominance, violence and sexual violence, stigma and discrimination, poverty, cultural beliefs and practices together with lack of knowledge and misconceptions about HIV and AIDS. Cultural practices and attitudes play an important role in increasing the vulnerability of women to infection. In the majority of societies, women lack complete control over their lives and are socialised from an early age to be subordinate and submissive to men, particularly men who command power such as father, uncle, husband or male guardian. According to Rose-Innes (2006), South African culture is generally male-dominated, with women being accorded a lower status than men are. Men are socialised to believe that women are inferior and should be under their control, and women are socialised to over-respect men and act submissively towards them. Socially promoted male dominance and lack of self-assertiveness on the part of women make it very difficult for them to refuse sex or to insist on the use of condoms with a partner who may be HIV infected. Albertyn (2000) adds that it is widely held that men have the right to make all decisions regarding sexual relations. According to Albertyn (2006), not only is women's vulnerability to HIV and AIDS rooted in their sexual, social and economic inequality, but this gender inequality is further fragmented by factors such as race, class, urban/rural location, sexual orientation, religion and culture. The children in this study do the same – they harness meanings around AIDS that reflect who they are, where they come from and within the situated context of HIV and AIDS and situated meanings that they give.

South Africa counts amongst one of the worst affected countries for HIV and AIDS. Whilst apartheid and migrant labour is to blame for the racialisation of HIV and AIDS

amongst the poorest people, who happen to be Black in South Africa, the new democratic government's delay and failure to provide housing for the poor has exacerbated the racialisation and the prevalence of HIV and AIDS in the context of poverty. Whilst HIV and AIDS affect rich and poor alike, poverty seems to facilitate the spread of the disease and worsens its impact. That poverty and disease is inextricably linked is a widely accepted fact. Poverty creates situations of vulnerability to HIV infection by lowering the nutritional status of poor people and contributes to the poorer state of general health. People in poverty-stricken environments often lack access to adequate health services and information, and the means of protecting themselves during sexual encounters. Poverty also contributes to overcrowded situations in which many people live, thereby exposing young children to environments where sex, drugs, violence and alcohol abuse is rife (Jewkes, 2006). Many shacks in the informal settlements are characterised by a single room. In this room, children eat, play and share sleeping space with adults. In such close confines, children are exposed to sex, sickness and death. In poverty contexts, responding to immediate short-term survival or satisfaction needs assumes greater importance than protecting long-term benefits. Survival needs cause poor women and girls to enter into sexual relationships, whilst economic needs propel many young men from poor families to leave home and migrate from one high-risk environment to another in search of work. Very often, the female heads families in informal settlements and the lack of a father figure is not uncommon. Informal settlements characterised by low levels of education, low marketable skills, lack of knowledge and information regarding the risk of infection and lack of resources to act on this knowledge, lack of capacity to negotiate sex and high population mobility create a 'fertile terrain' for HIV and AIDS to flourish (Alban, 2001; Wojcicki, 2005). The children in this study are located in this context. Bhana (2006) points out that these settlements have the highest rates of infection and that children here are at most risk of HIV and AIDS.

Having discussed, in great detail, the gendered nature of HIV and AIDS in a very broad context, affecting men, women and children, I now move on to explore how young children construct meanings around sexuality and gender in the context of HIV and AIDS.

1.7. Sexuality, gender and young children

Many commentators in the new sociology of childhood argue that children must be understood and accepted as sexual beings rather than for their sexuality to be ignored and hidden (Weeks, 2000). Bhana (2006) asserts that there is little literature on sexuality and early childhood in South Africa and existing literature constructs children as being in need of protection, despite laws which uphold the competency and rights of young children. In this study, children demonstrate their understanding of gender, sexuality and HIV and AIDS. In the process of demonstrating such knowledge, the children themselves challenge myths about childhood innocence and they also dispel adult misconceptions of young children. They assert the right to talk sexually about HIV and AIDS. Their knowledge on issues regarding sex compels us to question the source of their knowledge. Whilst the dominant view in the construction of childhood is that children and sex should be kept apart, the children in this study challenge this adultist view, revealing a far sophisticated knowledge base than we, as adults, would have thought. This study provides evidence that young children's knowledge is socially constructed and that the social context and the social location of children impacts and determines, to a large extent, their gendered behaviour. It is therefore, imperative that children be given a voice and a space to exercise their rights on issues of gender, sexuality and HIV and AIDS. Bhana (2006) explains that young children assert their right to talk about HIV and AIDS and sexually but also adopt adult stances on the matter, distancing and rejecting child sex. She points out that in this way, children adjust and accommodate children's rights to know sexually.

Bhana (2006) asserts that sexuality is nuanced by other social differences. According to Bhana (2006), within the context of danger and poverty in which children live, young girls' sexualities are framed by the discourse of heterosexual danger, both real and imagined, being vulnerable to HIV and AIDS, to older men and rape.

In this study, the children attend this school for two reasons: one being that this school is in an Indian suburb and the belief is that the education offered by an Indian school is better than the education in township schools nearer their homes; and the second being that the school fees are lower compared to four other schools in the same suburb.

En-route, children are exposed to many dangers as the children in this study reveal. They talk about messages scribbled inside the taxis and they also talk of strangers taking children to their homes and raping them. The children in this study reveal their innate fear of men and strangers and they also reveal their vulnerability in terms of their gender (fear of rape). I, therefore, argue the need to include young children in discussion in order to empower them with defensive protective mechanisms to afford them safety and to create spaces for them to become aware of their rights in terms of their sexuality and their gender in the context of HIV and AIDS.

It is extremely important we acknowledge that young children are far superior in knowledge than we believed them to be. As this study shows, the children undergo constant struggles to present themselves as unknowing in matters relating to sex, sexuality, gender, race, poverty, HIV and AIDS , despite the richness of their knowing about these matters. These contradictions show very clearly the constant struggle that young children have to endure in trying to present themselves as the 'ideal' children. This study argues that young children need to be viewed as social beings, with the power and the ability to construct knowledge. If we, as adults and teachers, give young children this space to air their views and opinions and if we adopt a stance where we recognise that young children are gendered beings, capable of thought, action and of making meaning related to their situated contexts then, I believe we, as adults and teachers, would help young children realise their rights. It is impossible to argue that children are ignorant of sex, sexuality, gender, race and poverty. The children in this study come from a poor socio-economic climate. Their experiences and knowledge positions them as knowing despite the contradictions. HIV and AIDS, poverty, racialisation of the disease and gender inequalities has denigrated our society. This study argues for change: whilst as adults and teachers, we try to pretend that children are ignorant and we denounce them as brazen or errant when they speak of or allude to prohibited knowledge, we need to take cognisance of our accountability to young children, especially in the context of HIV and AIDS.

The children in this study come from a largely African context. Their lives, their experiences and their gender are influenced and shaped not only by the context of poverty in which they live, but also by the social, economical, cultural and political

factors prevalent in their community. There is no disputing that HIV and AIDS is feminised. In 2002, The New York Times/International Tribune reported the former United Nations Secretary General, Koffi Annan as saying that "increasingly, the face of HIV and AIDS is a woman's face". In South Africa, women and girls disproportionately bear the burden of the epidemic. According to the Commission on HIV and AIDS and Governance in Africa (CHGA), (2004), women and girls make up an increasing proportion of people infected and affected by HIV and AIDS. CHGA (2004) point out that within South Africa, in five out of the nine provinces, at least 25 percent of pregnant women are HIV positive. Ndinga-Muvumba and Pharoah (2008) add that gender is indisputably one of the most significant factors in determining how HIV is transmitted. According to these authors, the confluence of poverty and gender has feminised HIV and AIDS. They point out that women are poorer, on average than their male counterparts whilst social expectations which govern relations between men and women, continue to underpin the vulnerability of girls and young women to HIV. In addition to this women and girls are victims of stigmatisation. Furthermore, in the wake of the pandemic, women and girls are often the principal caregivers for people living with HIV and AIDS. In feminising the disease, the young children in this study draw on their experiences that shape their knowledge. Whilst many factors have been responsible for the feminisation of HIV and AIDS, in the context of poverty, young children construct their knowledge according to their experiences. Young children also give meaning in terms of gender and sexual narratives. That the children, as young as they are in this study, positioned women as the reservoirs of infection, informs us that they are already condemning women, positioning women as the subordinate other. By positioning women as the vector in the spread of the disease these children are inscribing into the discourse in which AIDS is feminised. Yet at the same time, the boys in this study reveal their agency and their power as sexual beings, boasting multiple girlfriends whilst the girls, even at age 7 and 8, are aware of their sexuality and reveal that they have no qualms in using their sexuality to attract the boys.

1.8. HIV education: Why is it important?
Schools are now entering a new arena, which was taboo in the past. Schools have now been identified as a locus for HIV and AIDS education, sexuality education and

reproductive health education and, as such, the role of the school is now changing. Increasingly, the school is seen as having a major role to play in fostering sex-related attitudes and in developing behaviour patterns that will protect against HIV and AIDS.

The main aim of HIV and AIDS education policy is to prevent the spread of the disease and to reduce stigma and discrimination. In order to do so, AIDS education initiatives must begin early, within the elementary Grades, to be effective. Schools must provide opportunities for children from inception (Grade R), essential knowledge about their bodies, sexual health, HIV and AIDS and also equip children with skills to protect themselves against HIV infection. I concur with Bhana (2006) and Silin (1995) that we should no longer underestimate the capacity of young children to understand and benefit from this instruction. In addition, we should not overestimate the impact of brief interventions, and should plan for continued AIDS prevention instruction throughout the school years, involving sequential, developmentally appropriate curricula that respond to the preadolescent's and adolescent's changing cognitive capabilities, social skills, and expanding exposure to sexual experiences.

1.9. The Context of the Study
This study is positioned in a former all Indian primary school which is situated in the heart of a middle-class Indian suburb. The school is surrounded by big, beautiful homes, with pretty gardens and tall trees which offer much shade to the learners who wait for their afternoon taxi to take them home. The roads are very busy as people are continuously driving in and out of their residences to the large and many shopping complexes situated in the residential area. The school is also served by the local community which supplies lunch to approximately 250 learners on a daily basis. The children look forward to these sandwiches and soup on a daily basis.

1.9.1. The research site
Durwest Primary School is a co-educational primary school. This school was built almost 40 years ago, in the apartheid era. During this time, schools in non-White areas were built without much attention to detail. The school buildings resemble a barracks, with very little ground space for play. Unlike schools that were built later, this school lacks amenities and infrastructure to enhance learning and development and to provide

opportunities for extra-curricular activities. This explains the low school fees charged at this school. The Annual Athletic Meeting is always held at Kings Park Stadium, as the school does not have any ground for training or hosting a sporting event or fixture. Recently, there have been efforts to improve the appearance of the school. Murals have been painted on the walls, classroom walls have also been painted and vegetable gardens have been established. In 2008, the school was the proud recipient of a R5 000 donation and was adopted by a well-known franchise to receive food donations on a fortnightly basis. The school has since established a market garden and sells vegetable to the teachers and community members. In 2007, the school won a fully equipped computer centre (30 computers were installed in the school and training was offered to educators). The centre is also fully serviced on a regular basis by the donor. There isn't a strong religious ethos at the school. We have a general assembly on a Monday morning. We say a universal prayer (Father we thank thee…) and our assembly concludes with the National Anthem. The Foundation Phase has a special assembly on a Wednesday morning and the Intermediate Phase has their assembly on a Thursday morning. There are 660 learners in this school, which is the second highest enrolment in the schools in the suburb. Teaching and learning begins in Grade R and continues up to Grade Seven. The learner population comprises 90% Black children, 8% Indian children and 2% Coloured children. Whilst the language of teaching and learning is English, when outside the classroom, the majority of the learners revert to their mother tongue, isiZulu. Learners at this school follow Outcomes Based Education and the Revised National Curriculum Statement. The medium of instruction is English. Other languages offered at this school include Eastern languages, isiZulu and Afrikaans. In November this year (2008), all learners from Grade One to Grade Six were required to write the National Standardised Assessment in Literacy and Numeracy. The school does not have security. The gates are electronic and are opened and closed by the school secretary or any other school personnel in her absence.

1.9.2. The Management and teaching staff

The school has a staff of 26 educators, comprising 24 Indian teachers and 2 Black teachers. There are 24 females and 2 males on the staff. The school has a fully female

management staff comprising a Principal, a Deputy Principal, two Intermediate (Senior Primary Heads of Department) and one Acting Head of Department in the Foundation Phase. I am presently occupying the Acting Head of Department Foundation Phase post. The Foundation Phase has a learner enrolment of 285 learners. There are eight units altogether: two in each Grade (Grade R – Gr 3). The age of the learners in the Foundation Phase ranges from 5 years (Grade R) to 10 years (Grade Three)

1.10. The learners

The learners at this school come from the informal settlements situated in and around the outskirts of the suburb, the suburb and also from the townships bordering the suburb. The majority of the learners are poor, and many of them reside with mothers only or a caregivers/grandparent. Whilst some of the learners do not have mothers due to the mother being deceased, others live with grandparents and relatives because their parent/s have relocated due to job opportunities. The children who reside in the informal settlements walk to school whilst the children who live in the townships travel via school buses and taxis. In wanting to send their children to this school, sacrifices have been made. It is evident that parents/grandparents/caregivers cannot afford to pay school fees (R550 for 2008) and the travelling costs (R250). The majority of the parents/caregivers opt to pay the travelling costs instead. The community provides lunch on a daily basis to the indigent learners. As mentioned earlier, donated food hampers from the local franchise store also help to feed the children.

1.10.1. The aim of the investigation

The aim of this study is to investigate the meanings that children aged 7-9 in a public co-educational primary school context give to HIV and AIDS.

1.10.2. Objectives of the study

The following objectives have been identified and will serve to provide guidelines in the course of the study:

1. To examine young children's (7-9 years) construction of knowledge about HIV
 and AIDS.

2. To explore young children's (7-9 years) agency relating to HIV and AIDS.

3. To develop guidelines and frameworks of appropriate learning programmes in Life

Skills education relating to HIV and AIDS.

1.10.3. The research question

This study investigates the ways in which Grade Two learners in a working-class school in greater Durban ascribe meaning to HIV and AIDS. To do this, the study embarked upon qualitative research methodologies including group and informal interviews, observations and field notes as methods of data collection. This study is significant in that it seeks to investigate young children's knowledge of HIV and AIDS in the current context in South Africa. It is important for us as educators to understand what knowledge young children have of HIV and AIDS and also to understand how young children position themselves in the context of HIV and AIDS because it is through understanding that we can develop implementation programmes to address and build upon what young children know about HIV and AIDS. This study also seeks to build on the children's positive insights as well as to develop appropriate teaching methodologies or intervention programmes at Grade Two level which are currently absent in the country.

The study will be guided by the following research questions:

1. What knowledge do young children aged 7-9 have of HIV and AIDS?
2. What are the implications for working with young children in addressing HIV?
 and AIDS?

In answering these questions, the following two sub-questions, which are embedded in the above, will be answered:

- How do young children aged 7-9 position themselves in the context of HIV and AIDS?
- What are their gendered experiences of HIV and AIDS?

1.11. Conclusion

In this chapter, I have described my motivation and I have justified the need to explore young children's understanding of HIV and AIDS. In doing this, I drew focus on the

child as a gendered being, thereby acknowledging that children have agency and power and I maintain that young children construct their knowledge using this. I also maintain that the social context and the social location influence the construction of knowledge in young children. I have also narrated a few of my own experiences related to HIV and AIDS, gender and sexuality.

1.12. Organisation of the study

This dissertation contains five chapters.

Chapter 1 has provided an overview of the study. This chapter has described the problem and the context of the research as well as the intended design and methodology to be followed.

Chapter 2 explores literature related to the study.

Chapter 3 presents the research design and methodology. It also discusses the sampling procedures and data collection techniques, reliability and validity and concludes by discussing the limitations and ethical considerations.

Chapter 4 presents the analysis of the data. In this chapter, I present the data in its originality by drawing on the transcripts and the participants' drawings.

Chapter 5 presents the recommendations and conclusions.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

This research investigates the meanings that children in a largely Black primary school context give to HIV and AIDS. This study illustrates how 7-9 year old children actively construct complex gender identities and meanings of sexuality within the context of race, class and HIV and AIDS. Further to this, this study also shows how sexuality is embedded within the doing of gender and points out that in constructing meanings around HIV and AIDS, the children in this study are not only doing gender but sexuality as well. Throughout this thesis, I argue that the discourses that are most central to HIV and AIDS are sex, sexuality, gender, poverty and stigma and that these discourses have served to feminise HIV and AIDS. Furthermore, HIV and AIDS is about sex and young children give meanings to HIV and AIDS and sex unevenly (Bhana, 2008). The children, as this study illustrates, inscribe into this discourse.

This thesis will also show that young children's construction of HIV and AIDS is socially located and bound by their social context from which they emerge. The children in this study come from the lower socio-economic level of society. The meanings they ascribe to the disease surface from their experience with HIV and AIDS. It is further argued that young children are sexual beings who have agency and their responses are located and determined by this agency. This study will show how young boys and girls exercise their sexuality to attract attention to themselves and also to 'tease' in the same age group.

The literature focusing on HIV and AIDS is accompanied by how social factors such as gender, class, race, age and sexuality influence the construction of meaning. I begin this literature review by looking at children in the context of HIV and AIDS in South Africa and I draw focus to how HIV and AIDS affects children in the different spheres of their lives. I also draw attention to the fact that is it is Black children living in contexts of social and economic deprivation that are most vulnerable, infected and affected by HIV and AIDS in South Africa. This study focuses largely on Black children who come from a poor socio-economic background and I maintain that in a poor socio-economic context, vulnerability is exacerbated by gender.

I continue by briefly discussing the South African context of gender and HIV and AIDS and how women and children bear the brunt of the pandemic.

2.2. The context of children and HIV and AIDS in South Africa

HIV infections are alarmingly common amongst children in South Africa. According to UN, there were around 280 000 children aged below 15 living with HIV in South Africa in 2007 (UNAIDS, 2008). Children who are living with AIDS are highly vulnerable to illness and death. As well as many children being infected with HIV in South Africa, many more are suffering from the loss of their parents and family members from AIDS. UNAIDS estimated that there were 1. 4 million South African children orphaned by AIDS in 2007 (UNAIDS, 2008). According to UNAIDS (2008) once orphaned, these children are more likely to face poverty, poor health and a lack of access to education.

Given the scale of the pandemic in South Africa, it is safe to say that most children are in some way affected by HIV and AIDS. However, certain categories of children are more affected than others:

- Being born to a mother who is HIV-positive
- Living with sick parents, caregivers or others who are sick
- The illness or death of someone who provides financial or other support
- Living in communities with high rates of illness and death

Being orphaned

According to the UNAIDS (2008), the most direct way for HIV to affect a child is when they themselves are infected. HIV and AIDS impacts directly on children in the domains of material problems affecting poverty, food security, education and health, as well as non-material problems related to welfare, protection and emotional health. The material problems include the following:

i). Livelihood

The child is placed in a situation in which he/she has to deal with increased poverty. In some instances, children are also deprived of their property and inheritance in the wake of their parent/parents' death. Such a situation often leads to loss of food security and even loss of shelter (UNAIDS, 2008).

ii). Health

Children who are orphaned as a result of HIV and AIDS may be subjected to lower nutritional status. Since there is no parent, a sick child is given less attention and furthermore, children living with caregivers are also less likely to be immunised and

thus face increased vulnerability to disease, less access to health services and increased vulnerability to HIV and AIDS. As a result, child mortality is higher and children have a higher exposure to opportunistic infections (UNAIDS, 2008).

iii). Education

Children may discontinue education for a number of reasons. There might be insufficient funds for school fees, books, uniforms, stationery, transport, etc. Children who are affected or infected by HIV and AIDS may also experience diminishing capacity to concentrate and interact with other learners and/or educators at school. There might be further need for child labour at home for household tasks, caring for ill adults or siblings (UNAIDS, 2008).

According to Von Donk (2002), although there is no official data on the HIV prevalence by income groups in South Africa, local evidence suggests that HIV and AIDS is concentrated in townships and informal settlements. The children in this study come from the surrounding townships and the informal settlements in the suburb. These children, already disadvantaged by poverty, are further vulnerable to HIV and AIDS. Foster (1998) contends that AIDS-induced poverty among survivors leads to deterioration in the child's health and increased vulnerability. Therefore, in the context of poverty, children are affected by HIV and AIDS before they are orphaned. Furthermore, Foster (1998) asserts that their vulnerability is exacerbated by gender. According to Foster (1998), children living in such contexts may experience a reduction in their quality of life as finances in the home decrease (a result of unemployment due to illness or extended support to other family members affected and infected by HIV and AIDS). When parents become ill due to AIDS, children often shoulder new responsibilities which include domestic chores, becoming caregivers to sick parents and siblings or supplementing an income (Foster & Williamson, 2000). Coombe (2000) points out that this would entail increased absenteeism or dropout from school.

According to Gow and Desmond (2002), South Africa has had, and to an extent continues to have a unique level of gender equity in its schooling system. According to Gow and Desmond (2002), one obvious implication is that girls will be more affected than boys. These authors point out that among the many reasons for this is the fact that girls are more likely to be withdrawn from school than boys, in the event of economic hardship and deprivation, and more likely to be held back to provide care both for the

infected party and for siblings now without care themselves. Girls are also more likely than boys to become victims of sexual exploitation and may be driven to this course as a means of personal survival and household support (Gow & Desmond 2002). In such instances, young girls cannot insist on safe sex and as a result, their vulnerability to HIV and AIDS is increased. In the context of HIV and AIDS, it thus becomes very clear that vulnerability to HIV and AIDS is exacerbated by poverty and gender. Having looked briefly at the ways in which vulnerability is exacerbated by gender, I now turn my attention to the South African context of gender and AIDS. This is followed by a discussion on children's knowledge on disease and it is continued with a look at children's knowledge of HIV and AIDS. The study then focuses on the theoretical underpinnings of social constructivism theory and in doing so, I adopt a feminist post structural view in which I explore its central tenants of identity, discourse and agency. I then introduce a brief discussion on the absence of research involving young children as constructors of knowledge in topics such as HIV and AIDS, gender and sexuality. At the end of this chapter, the study examines the South African context in which the children in this study are located and in doing so, I draw on some of the literature from South African authors that has informed areas of this research.

2.3. South African context of gender and HIV and AIDS

At the end of 2007, there were approximately 5. 7 million people living with HIV in South Africa and almost 1 000 AIDS deaths occurring every day (UNAIDS, 2008). According to UNAIDS (2008), amongst the many factors blamed for the increasing severity of the AIDS pandemic in South Africa, gender issues have featured predominantly in the rise and spread of the AIDS pandemic. Avert (2008) maintains that whilst HIV prevention campaigns focuses on 'abstinence, be faithful, and condomise' (ABC) with regard to HIV and AIDS, many women and girls are unable to negotiate safe sex and are frequently involved with men who have several sexual partners. Furthermore, women, young girls and girl children are particularly vulnerable to sexual abuse and rape and are economically and socially subordinate to men. Women often face more severe discrimination than men if they are known to be HIV-positive. This can lead to physical abuse and the loss of economic stability if their partners leave them.

According to Tadria (2004) and UNICEF (2004), HIV and AIDS is redefining the meaning of childhood for millions around the world, depriving children of their basic human rights such as the care and love of their parents, an education, future opportunities and protection against exploitation and abuse. Tadria (2004) and UNICEF (2004) point out that orphanhood exacerbates gender inequalities: girl orphans are overworked and often sexually exploited by their caregivers, they are more likely to drop out of school, and they are more often dispossessed of their parents' property (Tadria, 2004; Unicef, 2004).

Tadria (2004) and UNICEF (2004) concur that gender discrimination and challenges to orphans reinforce each other in a number of ways. Girl orphans are doubly vulnerable and particularly exposed to sexual abuse and other forms of exploitation. However, all orphans are at greater risk of marginalisation in the household since they also from part of the communities and are greater risk of poverty. Children affected by HIV and AIDS and the families that care for them endure terrible suffering and deprivation. According to HRW (2005) children also suffer discrimination in access to education from the moment HIV and AIDS affect their families. HRW (2005) point out that children (especially the girl child) may leave school to perform household chores, to become caregivers or because of lack of finances for schooling. As a result orphan children who leave or dropout of school for the reasons mentioned are exposed to a life-cycle of poverty and abuse. Orphan children face a high risk of sexual exploitation, hazardous labour and living on the street. Tadria (2004) says that taken together, this increases orphans, and particularly orphan girls', vulnerability to HIV infection.

Women traditionally play a major role in the care economy and this means that caring for the sick, as well as for orphans, falls within their domain. For Black women, taking in orphans therefore increases the already overwhelming burden of care (UNICEF, 2004). According to UNICEF (2004), female-headed households are not only more likely to be poor; they are also more likely to take in orphans than male-headed households. Female-headed households affected by HIV and AIDS are therefore more likely to enter into an irreversible downward spiral of increasing expenses, contributing to the present feminisation of poverty. This process is thus insidious, as poverty is considered one of the main factors fuelling the pandemic (UNICEF, 2004).

Accompanying the pandemic is the issue of stigma and the ensuing discrimination. Both women and orphans face more AIDS-related stigma, discrimination and marginalisation than men. This exacerbates their already disadvantaged position and lower access to testing, treatment and care (Parker & Aggleton, 2003; Tadria, 2004; UNICEF, 2004).

Tadria (2004) asserts that women's control of their own bodies and sexuality is considered key to prevention. She maintains that to date, HIV prevention efforts have focussed on individual behaviour modification (ABC's) and chastity. However, Tadria (2004) argues that this approach generally fails to take into account women's, particularly that of young women and adolescents, lack of control over their own sexuality. Orphan girls are in a particularly vulnerable group, as they face increased risk of violence and sexual exploitation. Invisible, uncounted and unaccounted for, the orphan girl continues to be marginalised, sexually abused and exploited (Tadria, 2004).

The high levels of violence against women and children, particularly sexual violence, intensify the subordinate situation for women and girls as well as creating situations where, if the perpetrator is HIV-positive, the risk of transmission of the virus is higher. The existing high social tolerance for violence against women and children increases their vulnerability to HIV infection and forms part of the dynamics that underpin the spread of HIV in South Africa (UNAIDS, 2008; UNICEF, 2004; Tadria, 2004).

Abuse of children, with girls being particularly vulnerable, is one form of sexual violence to which orphans are susceptible, as they do not have the protection that parents would normally provide. Some sexual violence, for example rape of young girls may even be spurred by HIV, as in some cases some infected men still believe that sex with a virgin will 'cleanse' and cure them of AIDS.

Bhana (2006) point out that in South Africa, 6-9 year olds actively construct complex gender identities and meanings of sexuality within the context of race, class and HIV and AIDS. According to Bhana (2006), in the second Grade, young girls may express a fear of boys, older men and rape. The girls are aware of their vulnerability to HIV infection and this awareness has a significant effect on their gendered identity.

Having looked briefly at the South African context of gender and HIV and AIDS, I now shift my attention to examine firstly, young children's knowledge of disease and secondly, young children's knowledge of HIV and AIDS.

2.4. Young children's knowledge of disease

According to Siegal and Peterson (1999), contamination and contagion are likely to be the disease process most familiar to young children. Most of the illnesses that affect children involve infections e.g. colds, chicken pox and measles. Many of the rules children know surrounding causes of illnesses relate to a process for example, "Wash your hands before eating". Young children see germs as a mechanism of infection. Siegal and Peterson (1999) point out that consideration on literature on how children's conceptualisation of health and illness develops reveal diverse perspectives with seminal work heavily influenced by the work of Piaget (1973) and a belief that the understanding of younger children may be minimal (Van Dyk, 2008).

According to Bibace and Walsh (1980), findings reveal six developmentally ordered categories of explanation of illness have been articulated. They point out that the categories are consistent with Piaget's three stages of cognitive development. Van Dyk (2008) also follows Paiget (1973) in positing a progression of moral development based on cognitive theory about children's stages of development. According to (Piaget, 1973; Quackenbush & Villarreal, 1988; Walsh & Bibace, 1990) a child's perception of illness is very concrete and typically defined in terms of external, observable features, without any reference to internal processes or feelings. According to these authors, young children are positioned as being unable to construct abstract ideas and thus do not reason about hypotheses but only in terms of observable reality. Whilst previous research (Bibace & Walsh, 1980; Van Dyk, 2008) have suggested that beliefs about health and illness develops through a series of systematic stages and that children are unable to understand explanations in advance of their own cognitive level, Siegal and Peterson (1999) and Silin (1995) refute such beliefs, suggesting that children may have far more potential to understand complex illness concepts that they have previously been given credit for. Silin (1995) argues that in order to gage what children know of disease, we have to return to children themselves to uncover what it is that seems to

matter, to grasp how they make sense of experience. Silin (1995) further develops this argument by arguing that in order to do this, we have to abandon the safety of science that allow us to know children from the privileged position of distanced adults. His argument contradicts with the Piagetian theory, which adopts an adultist approach to doing research with children. According to Silin (1995), dirt and germs serve as important symbolic role in the social organisation difference. He points out that dirt and disorder have been associated with poverty and sin, both punishable by disease. In this study, I examine theories alternate to the Piagetian theory in order to investigate the meanings poor young Black children give to disease, illness and HIV and AIDS. Having considered young children's knowledge of disease, I now draw focus to a very significant and important section which is central to this study and that which seeks to understand young children's knowledge of HIV and AIDS.

2.5. Young children's knowledge of HIV and AIDS

Young children are perhaps the most vulnerable to the vague fears, fantasies and misconceptions surrounding AIDS. Children receive information about AIDS from educational programmes intended for more mature audiences, from parents and other adults, from television and from their peers. Silin (1995) tells us that children have distorted knowledge about disease. He gives an example of his own experience – 'the 1st Grade teacher told how pandemonium broke out in her classroom when the principal announced over the inter-com the subject (AIDS) of the afternoon staff meeting. Children spoke of the disease and linked it to the 'other' and warned her not to attend in fear that she may contract AIDS from the guest speaker'. Children refer to AIDS as the disease of the 'other', meaning that it is a disease of people we do not know and in whose lives we are not implicated (Silin, 1995). Silin (1995) points out that by viewing AIDS as a disease of the 'other', it creates a distance between us and AIDS-hence it allows us to feel safe. Silin (1995) further explains that for young children and for many adults as well, fear needs to be replaced by understanding, and misinformation by facts. HIV is part of daily life and should be treated as such in schools (Silin, 1995).

South African studies (Bhana, 2006; 2007a; 2007b; 2008; Bhana & Epstein, 2007) which sought to explore young children's construction of HIV and AIDS, shed light on how young children perceive the disease. These studies confirm that whilst children in

middle-childhood years do not clearly understand what illness is, many children in South Africa do because of their social location.

Studies (Bhana, 2006; 2007a; 2007b; 2008; Bhana & Epstein, 2007; Silin, 1995) reveal that young children's emergent understanding is closely associated with knowledge of related topics like sex or drug use: 'you can get AIDS when you go to bed in the same bed' 'sex' is described as 'going to bed' and it is believed that 'you get AIDS when you smoke'.

In their studies, Bhana (2006; 2007a; 2007b; 2008) and Silin (1995) discovered that children also saw drugs, rather than infected blood as the source of HIV infection and they clearly equated AIDS with death. Silin (1995) explains that children related smoking to drugs and the emergent understanding is that children are aware that HIV and AIDS can spread through drug use, thus the reference to smoking.

In South Africa, the pandemic is driven largely by poverty and gender discrimination; it is a reality that the Black child in South Africa is more affected by the disease, given the social location, the low socio-economic status and a patriarchal society in which the Black male is dominant.

Whilst I agree that children develop in ages and stages, I find that the Piagetan theory is insufficient in exploring the construction of meaning that young Black children emerging from a deprived socio-economic class in South Africa give to HIV and AIDS. In the South African context, HIV and AIDS is very prevalent in poverty-stricken communities. I concur with Bhana (2006; 2007a; 2007b; 2008) in that the meanings young children give to HIV and AIDS are shaped by their social context, their gender, race and culture.

 Having looked at the way in which young children understand disease and HIV and AIDS, the study now focuses on the theoretical underpinnings of social constructivism theory and in doing so, I adopt a feminist post structural view in which I explore its central tenants of identity, discourse and agency.

In this section I am also going to explore and contrast Piaget et al's (1969; 1973) theory of childhood development, as this remains a dominant view of understanding young children's ability to make sense of abstract issues, to the new sociology of childhood which advocates a discrete field of theory and practice permeable to a wider variety of influences (Silin, 1995), which is where I position my study.

2.6. The theoretical location of the study

Dominant pedagogical theory in early childhood has consistently maintained the view that curriculum should be informed by understandings about the developmental levels and interests of each child (Spodek, 1986; Farquhar, 1990). Subsequently, the curriculum traditions and expectations of the early childhood profession have been fundamentally pre-occupied with the individual child's natural development (Canella, 1997; Jipson, 1998; Silin, 1995; Walkerdine, 1984).

Jean Piaget (1954), a biologist, explored the development of children's understanding through observing them, talking and listening to them while they worked on exercise sets. His view of how children's minds work and develop has been enormously influential, particularly in educational theory. His particular insight was the role of maturation in children's increasing capacity to understand their world: they cannot understand certain tasks until they are psychologically mature enough to do so. He proposed that children's thinking does not develop entirely smoothly; instead there are certain points at which it 'takes off' and moves into completely new areas and capabilities. He saw these transitions as taking place at about 18 months, 7 years and 11 or 12 years. This has been taken to mean that before these ages children are not capable (no matter how bright) of understanding things in certain ways, and this theory has been used as the basis for scheduling the school curriculum. However, whilst it is acknowledged that children do grow and develop in ages and stages, accumulating evidence reveals that this scheme is too rigid (Van Mannen, 1995). Many children manage concrete operations earlier than he thought and some people never attain formal operations. Van Mannen (1995) and Silin (1995) urge us to return to the children themselves to uncover what it is that seems to matter, to grasp how they make sense of experience. Piaget's approach is central to the school of cognitive theory known as 'cognitive constructivism. Whilst I agree that the Piagetian theory which argues that

children learn in stages and ages is useful, I do not think that it is sufficient when exploring children's knowledge in controversial issues such as HIV and AIDS. If based on the Piagetian theory, children at age 6 or 7 would be perceived as 'unknowing' on issues relating to their sexuality and would not be able to position themselves in discussions relating to their sexual nature. Children would then be viewed as asexual beings, devoid of having agency in addressing issues pertaining to their lives. The Piagetian theory premises that children at age 6-7 are at the pre-operational age and thus do not and cannot have knowledge of controversial issues such as HIV and AIDS. However, I argue this premise by drawing on research studies (Bhana, 2006; 2007a; 2007b; 2008; Bhana & Epstein 2007; Silin, 1995). This study, in exploring children's knowledge of HIV and AIDS seeks to establish that whilst children develop in ages and stages, their experiences shape their cognitive ability to construct meaning. In this thesis, I present findings to support this belief. This study, which is based on largely Black children from the lower socio-economic class, draws attention to the influence of social determinants which determine the children's experiences and the construction of knowledge around HIV and AIDS, gender, class and sexuality.

Researchers (Paplia et al, 1998) point out that Piaget did little research on the emotional and personality development of children and possibly would have been more accurate to view cognitive development as gradual and continuous rather than having definite demarcation stages. According to these researchers, Piaget's information processing approach provides a good way of assessing intelligence and gathering information about memory development and other cognitive processes, but it does not take into account the importance of creativity and social interaction.

Whilst a major source of inspiration for the Piagetian theory was Piaget's observations of his own three children, the children in Piaget's small research sample were all from well educated professionals of higher socio-economic status. In his research studies, it would appear that Piaget also tended to underestimate the effects of other factors such as social, motivational and educational influences of cognitive development. His theory also does not adequately address any of the distinctly social problems confronting education today like poverty, gender roles, HIV and AIDS, and abuse. Some of Piaget's theories remain dormant in understanding childhood development. Silin (1995) also

adds that many of the interview questions Piaget posed to children assessed the possession of specific information but not the ability to reason. My study shows that young children are resilient, knowledgeable and agents in giving meaning to HIV and AIDS. Hence, I argue that Piaget's theory is inadequate in dealing with my study.

Bowman (1993), an internationally recognised authority on early childhood education and a pioneer in building knowledge and understanding of the issues of access and equity for minority children through teaching, research, and advocacy, has been a powerful advocate for children and those who have made them their life's work. Bowman (1993) draws our attention to the difficulty of defining developmentally appropriate practices in a multicultural society. According to Bowman (1993), various groups differ regarding the ages for achieving appropriate objectives as well as in the translation of developmental principles to specific practices that will determine how various communities organise interpersonal and material relationships to achieve similar results. According to Silin (1995), in recent years, a growing critique of developmentally appropriate practice directs us to sources for renewing early childhood education. Kessler (1991) suggests that developmentally appropriate practices should no longer be the endpoint of our work but must be subsumed under a broader set of goals.

The idea of a universal state of childhood was challenged toward the turn of the 21st century through an increasingly globalised perspective which accompanied scholarly questioning through ethnographic, cultural and anthropological studies. The shift toward a recognition and acceptance of children's voices in determining their own worldview brought about a fragmented view which questioned the structural norm of childhood and brought about a theoretical position about pluralities of childhoods. For such theorists as Chris Jenks (1996) and Jens Qvortrup (1994), it is more accurate and helpful to talk of many childhoods or a plurality of experience both across cultures and within them. According to Jenks (1996) and Qvortrup (1994) diversity of experience according to class, ethnicity, gender, culture, place of residence, health, or disability rather than one common childhood is emphasised. Unlike the older conceptualisations of children, Prout and James (1997) argue that the new sociology of childhood borrows the ideas of children as agents as well as products of social processes. These authors point out that in the new paradigm, childhood is understood not as preparatory or a marginal state but

as a component of the structure of society (James & Prout, 1990; Prout & James, 1997; James et al., 1998; Jenks 1996; Mayal, 2000; Qvortrup, 2004) and therefore it is necessary to acknowledge that childhood is a social institution in its own right (Ebrahim, 2006). According to Ebrahim (2006), race, class, ability and gender are some of the conditions that bring about differences in childhood. Furthermore, the concern with interactions in situations acknowledges that people are active beings in networks of relations which would mean that there is nothing natural about childhood. Her argument is substantiated by Prout & James (1997) who aggress that children must no longer be viewed as passive beings, nor be seen as empty vessels to be socialised for childhood. At this stage, I reflect that the absence of research on young children and HIV and AIDS might be related to the construction of children as passive, asexual beings, incapable of constructing knowledge around issues such as HIV and AIDS. In the following section, I delve into the absence of research on young children and HIV and AIDS.

2.7. Absence of research on young children and HIV and AIDS

There is sparse work around HIV and AIDS and children's ability to understand the disease. This is both a national and an international trend. There seems to be a lack of information on what children themselves think they need in order to avoid contracting HIV and AIDS and an unwillingness to act on these needs even when they are expressed. (UNFPA, 2005). This seems to be the case in South Africa. Whilst much research on HIV and AIDS and children has been conducted in South Africa, research which places children as constructors of knowledge is however sparse (see Bhana, 2006; 2007a; 2007b; 2008; Bhana & Epstein, 2007) as exceptions.

According to researchers (Bhana, 2006; 2007a; 2007b; 2008; Bhana & Epstein, 2007; Silin, 1995), the construction of the child as an asexual entity and the consequent denial that young children have any awareness of sexual matters is responsible for the lack of acknowledgement and as contributed to the delay in the gender dimension of the AIDS pandemic relating to young children. These authors point out that as a result, children have learnt that sex and sexuality is something to hide and repress and they do so by drawing on affective conventions of disgust to confirm the narrative of childhood

innocence and in doing so, resist the right to know about HIV and AIDS and sexuality more broadly and this is how children negotiate sexuality.

Bhana's study (2008) argues that much of the neglect surrounding research into HIV and AIDS and early childhood stems from a preoccupation with the conceptualisation of children and childhood as innocent. This argument is supported by Peltzer and Promtussananon (2003) in that older children are made vulnerable by adults through a lack of access to information about HIV and AIDS. Peltzer and Promtussananon (2003) state that one major reason that children under 15 years have been overlooked in HIV and AIDS programmes is likely due to the difficulty for adults to accept children's sexuality. Peltzer and Promtussananon (2003) agree that children are vulnerable to HIV and AIDS for economic, social, political and biological reasons, many of which are directly or indirectly caused by adults. Peltzer and Promtussananon (2003) explain that children express their sexuality differently depending on their cultural background, access to information, social and economic status and their experience of sexual abuse.

Van Dyk's study (2008) maintains that that children's ability to comprehend information about HIV and AIDS to which they are exposed will depend on their cognitive, emotional, social, moral, sexual and self-concept development. This informs us that young children (approx 6-9) in the middle-childhood years do not well understand what illness is, mainly because they are unable to think operationally, especially since that particular developmental phase was the strongest predictor of a child's understanding of HIV and AIDS, thereby aligning the study to Piaget's theory of cognitive development. However, this theory is refuted by Peltzer and Promtussananon (2003) and Bhana (2006; 2007; 2008) who argue that young children between ages of 5-8 do make sense of AIDS. They give meaning to it, they know about the link between sex and AIDS and are aware that HIV and AIDS is very gendered.

Bhana (2007a; 2007b; 2008) concurs with Peltzer and Promtussananon (2003) in that sexuality is a fundamental notion among children as early as 6 years of age and that children have definite ideas about male and female roles and this is significant among the components that boys and girls use to build their identities. However, there is recognition that there needs to be more studies into children aged below 15 (Peltzer &

Promtussananon, 2003). According to Peltzer and Promtussananon (2003), sexuality needs to be addressed very early in a child's life, in order to enable the child to engage in critical thinking and decision making. Van Dyk (2008) points out that although younger children in the primary school phase (aged 6-9) do not really understand sexual issues, they have developed fixed sex-role identities and are often curious about sex. Bhana (2007a; 2008) explains that sex role identities are built on fundamental notions of sexuality. She advocates that working with this group of children, using age-appropriate information and methods of communication could provide them with skills they need to meet these challenges. Peltzer and Promtussananon (2003) draws our attention to children by saying that the interpretation of what children want and need is not provided by children themselves, but by well-meaning adults. Furthermore, Peltzer and Promtussananon (2003) claims that the information that adults provide about children's needs is often expressed in terms of risk and vulnerability rather than by opportunities and resources.

Concerns with ethical and moral implications of researching children have been widely discussed (Amos Hatch, 1995; Hood Kelly & Mayall, 1996; Mahon Glendinning, Clarke & Craig, 1996; Mathews, Limb & Taylor, 1998). These concerns have been related to the appropriateness and desirability of involving children directly in research, in terms of their competence and vulnerability as research subjects (Mahon, et al., 1996). Based on adultist assumptions, the view of children as incompetent and in need of protection and control has underpinned much research involving children (Hood et al, 1996; Mathews et al, 1998). In this regard, the research focus governed by adult interests has resulted in children being perceived as 'either at the mercy of or posing risk to adult social worlds' (Hood et al, 1990:118). To these ends, children's own interests, experiences, and knowledge have been perceived as poor informants, not able to fully understand 'many of the issues which confront their daily lives' (Mathew et al, 1998:34). While the validity and accuracy of children's responses have been questioned in conjunction with debate over the issues of protecting children from researcher exploitation in the form of intrusive or potentially distressing questions, there is now strong consensus that 'children's views can and ought to be taken seriously' (Mahon et al, 1996: 46).

Having surveyed the absence of research on young children and HIV and AIDS, I now look at the need for new understanding of the children in South Africa.

2.8. Need for new understandings of children in South Africa

Dominant pedagogical theory in early childhood has consistently maintained the view that the curriculum should be informed by understandings about the developmental levels and interests of each child (Spodek, 1988; Farquhar, 1990). According to Canella (1997) this produced an approach to curriculum that became known widely as Developmentally Appropriate (DAP) and which was based on the theories of Piaget (1954). However, some reconceptualists (Mallory and New, 1994; MacNaughton, 2000) argue that DAP has contributed to social inequality and injustice because:

- It offers a necessary but insufficient framework for guiding educational practices for children with disabilities.
- The traditional child development theoretical and empirical knowledge base it rests on is ethnocentric.
- Its values, beliefs and goals are middle class.
- Of its processes and principles and sexist early childhood practices (Mallory & New, 1994; MacNaughton, 2000).

According to Mallory & New (1994) and MacNaughton (2000), some reconceptualists argue that DAP offers little guidance on the values and goals that should guide our curriculum work with young children. It was also argued that DAP guidelines were based on outdated understandings of child development which denied the role of social contexts and social relationships in children's learning (Mallory & New, 1994; MacNaughton, 2000). In feminist post structuralist terms, the reconceptualists are calling for new discourses of early childhood teaching and learning, within new understandings of what constitutes good and/or appropriate early childhood practice. Silin (1995) points out that reconceptualists are producing new ways of understanding early childhood. This allows us to examine the social practices that constitute masculinity and feminity in our society such as dressing, acting, thinking, feeling and being. MacNaughton (2000) explains that we need to highlight the gendered nature of

children's lives, our own part in this and the possibilities of freeing children from the constraints and inequalities that gender places on them.

MacNaughton (2000) says that we need to experiment with changing lenses through which we read children. Teachers should look for the relationships between children, race, class, ability and sexuality and how these influence the children's experiences in and contributions to the groupwork. MacNaughton (2000) asks us to examine how gender is lived and experienced by children and how this shifts over time and different spaces and adds that we need to examine how the above impacts on children's educational lives. She also points out that the challenge is to find ways of understanding it that help us to create greater opportunities for equity and justice in all children's lives. Keeping MacNaughton (2000) in mind, I now explore how gender is lived and experienced by children in South Africa. I also examine the results of other studies which posit children as constructors of knowledge in the context of HIV and AIDS. In order to do so, I review studies undertaken by Bhana (2006; 2007a; 2007b), Bhana & Epstein (2007) and Van Dyk (2008). In doing so, I shall focus on the following areas:

- What do young children say about disease?
- What do young children say about sex and disease in terms of stigma and gender?
- How is social context related to their knowledge?
- How do young children express their sexuality?

2.9. South African research on children on HIV and AIDS

In a recent study, Van Dyk (2008), explores and describes South African school children's perspectives of HIV and AIDS and links this to their respective cognitive development stage. Van Dyk's (2008) study highlights developmental differences in the children's perceptions of HIV and AIDS and makes specific recommendations for improving HIV and AIDS education in school. Van Dyk (2008) discloses that the school children that participated in the study were very knowledgeable about AIDS in general. In her study, 57.8% in the Foundation Phase and 61. 6% in the Intermediate Phase defined AIDS as a disease, an illness or a sickness. Her study also revealed that almost half of the 6-12 year olds (48. 3% in the Foundation Phase and 46. 9% in the Intermediate Phase could name at least one way in which HIV is transmitted. Most of

the children mentioned blood (25% and 17. 8% in the Foundation Phase and Intermediate Phase respectively) or sex (21. 7% and 35. 8% in the Foundation Phase and the Intermediate Phase respectively), while 19. 2% of the children in the Foundation Phase and 34. 6% in the Intermediate Phase named more than one way in which HIV can be transmitted (such as sex, blood and mother to child transmission). Whilst Van Dyk (2008) concludes that the children were very aware of HIV and AIDS and the depth and complexity of their understanding was linked to their cognitive developmental stage, I argue that whilst some children do not know about AIDS and it is abstract, many of them actually do know because they are able to associate that knowledge with their social location. I argue that all of us are socially located and that the factors of our social location empower us differently. We may be powerless or powerful, depending on where we are and the people with us, the institutions we occupy and the values that society attaches to all these areas. The importance of social location is that it determines our experience in society and the world, it determines what happens or does not happen to us, and what we see and hear and how we see and hear it, or conversely, what we do not see or hear.

Another point worth mentioning is that methodology one engages in when working with young children will actually impact on the data gathered from researching young children and controversial issues like HIV and AIDS. Van Dyk's (2008) sample consisted of 1 904 children aged 6 to 19 years and the instrument was a questionnaire of mainly open ended questions and the research was conducted by university students from University of South Africa (Unisa).

I concur with researcher, Bhana (2006) in that using deep interviews, where the researcher looks for meaning and interacts actively with the participants and also links the experiences of the participants with real life, closed focus methods, and ethnographic methods allow the researcher to get a better sense of the children. In my study, I had adopted a similar approach in my methodology and I was able to interact with my participants and elicit data which related to the real life experiences of the participants. Bhana (2006) argues that exploring children's understandings of HIV and AIDS from the perspective of 'rights' can open a space through which to move beyond commonly found representations of the Black child as either simply a victim of HIV

and AIDS or as a subject instrumentally exerting new 'rights' brought by South Africa's democracy. The article is based on a study of seven and eight year old children's understanding of AIDS in a black township school in KZN, South Africa. Through the use of ethnographic methods and group interviews, the research explores the extent to which sexuality characterised young children's narratives in a context of a severe AIDS pandemic. Bhana (2006) argues that by allowing children to talk about such sensitive issues, children are enabled to express themselves as sexual agents.

According to Bhana (2006) even research which is informed by a concern for children's rights often addresses children as relatively passive, desexualised beings without the capacity to formatively and constitutively engage with sexual matters. According to Bhana (2006), there is very little information on the ways children themselves constructed their knowledge of HIV and AIDS and sexualities, their freedoms and lack of freedoms and whether and if so how they draw on the right discourses.

Prout (2000) points out that child rights discourse calls for children to be treated as autonomous individuals. Whilst they may benefit from adult protection, this discourse views them as capable, interactive social agents who engage with people and institutions.

In South Africa Bhana (2006; 2007a; 2007b; 2008) studies show how young children in different social contexts give meaning to the disease. According to Bhana & Epstein (2007) young children's meanings of HIV and AIDS are not simple. These researchers point out that young children's understanding of HIV and AIDS is socially constructed through class/race and gender and these forms of social relations provide the framing and reference points for children's constructions of meanings around HIV and AIDS. According to Boler & Jellema (2005) besides providing an environment in which children can be educated about AIDS, basic school education has the capacity to reach large numbers of young people with information that can save their lives and help to reduce stigma and discrimination, which is a major problem for people infected or affected by the disease. Chase and Aggleton (2006) explains that putting the young person first and promoting participation of the child and addressing issues around social justice and equality within the specific content of the young person's social

circumstance is key in understanding the complex mediation of HIV and AIDS related stigma and developing strategies to combat stigma. Parker and Aggelton (2003) suggest that HIV – related stigma is complexly connected to existing inequalities of race, gender and class and involves the language of power, inequality and exclusion. Berry (2008) informs us that stigma and discrimination often starts early as name-calling amongst children. Amuzu (2007) concurs with these researchers by saying that misconceptions about HIV and AIDS are widespread among young people and that they vary from one culture to another and that particular rumours gain currency in some populations both on how HIV and AIDS is spread (eg by mosquito bites or witchcraft) and how it can be avoided (eg. by eating a certain fish or having sex with a virgin) and prejudices resulting from ignorance eg "Can I get it from toilet seats?" (Berry, 2008). According to Bhana (2007) the early school association with HIV, AIDS, sexuality and gender is particularly significant given that education systems have a critical role to play in the fight against the pandemic.

Children at this age understand more complex issues about health, disease, and sexuality. They are interested in birth, families, and death. They have probably heard about AIDS from television, friends, or adults.

They may have questions or fears about HIV/AIDS. They may have heard that people get AIDS from being bad. They understand basic answers to questions based upon concrete examples from their lives.

2.9.1. What do children say about the disease?

Bhana & Epstein (2007) embarked on a study that examined young South African school children's understanding of HIV and AIDS. This study explored the impact of HIV and AIDS on the ways in which gender and sexuality are articulated against the backdrop of race and class specific contexts. Bhana & Epstein (2007) argue young children inscribe themselves within particular gendered, raced and classes discourses of sexuality and HIV. The study (2007) which was conducted in two separate schools, one being a Former Model C School and the other, a public school in a poor Black township area, reflect how social context impacts on the social location of HIV and AIDS. Model C schools were during apartheid, schools for Whites only. While in the new South

Africa, this has fallen away, we still use this term to distinguish schools, as former Model C schools tend to have better facilities than other government and public schools. The children at the former Model C school were aware of the relationship between sex, sexuality and HIV and AIDS. Furthermore, they ascribed the disease to the 'other'. This is revealed in the following extract from an interview with children from the said school, *'They look very sick', 'They can't read, write and speak properly'* (Bhana & Epstein, 2007). The children notably link the disease to dirt and to the poor (Bhana & Epstein, 2007), '*Maybe they get born in dirty places'.* And also how their perceptions of HIV and AIDS were influenced by their stereotyped attitudes towards race and social class, *'Some Blacks dig in the black bins and eat all the rotten food… like White people walking and taking walks with their dogs and the Black is walking right next to him, he could infect the Whites… they have germs… they don't have cream… they don't have everything else to keep their bodies clean.'* Bhana & Epstein (2007).

In the Black township school, HIV and AIDS was a reality for the children since it was something they lived with on a daily basis. According to Bhana & Epstein (2007), the children connected HIV and AIDS to disease, sex and gender. The children had superior knowledge about the disease: they knew that AIDS can make one very ill, they had an awareness and knowledge of sex, protective sex (they spoke of condom use) and of reproduction. The children also displayed knowledge of sexual violence as was revealed in the interview transcript *'from rape you get AIDS. AIDS is rape'.*

The study also revealed that young boys and girls associated promiscuity as a risk factor for HIV and AIDS. The researchers point out that young children's meanings of HIV and AIDS are not simple and these meanings are produced through social and cultural differences that constrain and create meanings in ambiguous ways.

2.9.2. What they say about sex and disease in terms of stigma and gender
Whilst children in the study (Bhana 2008) were aware that one way of contracting HIV is through contact with infected blood, the study also revealed that they were able to link sex to HIV and AIDS. In their responses, children were able to engage in matters concerning sex and sexuality. They expressed their sexuality and their desire in their responses, which were punctuated by laughter and giggles when they began talking

about sleeping (sex) and kissing, they spoke pleasurably about boyfriends and girlfriends and about the games they played. In engaging so, Bhana (2008) says that the children functioned not only to reproduce their sexual identities but also to break down gender boundaries.

Furthermore, the studies (2008) revealed that HIV and AIDS were regarded as diseases of Black people. Parker and Aggelton (2003) suggest that HIV-related stigma is complexly connected to existing inequalities of race, gender and class and involves the language of power, inequality and exclusion. Germs were regarded as *'catchy' Bhana* (2008), children expressed fear of blood and contagion, black people, poverty, The children associated HIV infection with dirt (Silin, 1995) and disease and located it in the lower socio-economic groups in South Africa. Poverty and its relation to race in South Africa is captured by the following response *'Africans living on the street and stuff'* (Bhana, 2008). Black men were also seen as vectors in the spread of disease; a perception which is reinforced by dominant Black masculinities which shape men's control over women and celebrate multiple partners, *'Her boyfriend slept with one girl and made her pregnant and then came and slept with her'* (Bhana, 2008), which drive the gendered nature of the pandemic (Hunter, 2005).

2.9.3. How social context is related to their knowledge

Bhana (2008) explains that social class makes available not only different versions of masculinity and feminity, but also different versions of sexuality. In the studies, children positioned men, especially Black men as perpetrators and girls, especially Black girls, as victims of the dominant Black masculinity, which advocated multiple partners, sexual violence and harassment. The ways in which girls from a working-class context make meaning of their sexuality will be contextually specific (Hey, 1997). Men are featured as dangerous. The material and social circumstances in South Africa's townships make Black girls more vulnerable to rape and abuse. Furthermore, Bhana (2008) argues that girls' vulnerability and status as victims is 'reinforced' by parents who warn them of men. Violence and sexual violence have featured prominently in South African society (Hunter, 2005). Black men have been problematised in the context of the HIV pandemic, with campaigns and literature addressing them, especially

as people with multiple partners who engage in forms of sexual harassment and violence.

2.9.4 How do children express their sexuality?

Bhana (2008) confirms that young children are sexual agents and capable of establishing links between HIV and AIDS and sex. Bhana's (2008) study explains that the deployment of childhood innocence is a strategic tool in the manufacture of the adult's version of childhood. However, she points to the following contradictions which show very clearly the constant struggle that young children have to endure in trying to present themselves as the ideal child.

'Are we supposed to talk about AIDS?'

'No… it wouldn't be right, sex is not to be discussed by small children…. . because its old people's stuff…we'll get smacked…by the teachers'

She further notes that by asserting the right to talk sexually about HIV and AIDS,

'How exactly is AIDS spread?

By kissing… they're naughty…they take off their clothes and have sex'

In this study (2008), children are revealed as active makers of sexuality whilst resisting and locking into discourse of innocence. According to Bhana & Epstein (2007) children, whilst resisting the right to talk about issues related to sex and sexuality, show how markedly sexual matters feature in their constructing of sexual rights in the context of HIV and AIDS. Bhana & Epstein (2007) also explain that children give meaning to sex and sexuality in a variety of forms that include talk about boyfriends, girlfriends and heterosexual games. This is highlighted in the following excerpts taken from the study (Bhana & Epstein, 2007):

'I had a boyfriend in grade One', ' I kissed Grant in grade One', 'Kyle and Carl were fighting over who was going to be my boyfriend', 'He loves me so much, he was holding my hand in assembly', 'We kissed on the lips a thousand times before', 'We played hide and seek', 'While we were waiting for her to find us…we picked these little white flowers and we played "I love you, I love you not" and it kept on landing on "I love you" and we kept on kissing all the time'.

Bhana's (2006) study, which positioned children (7-8 years) as 'knowing', explores how young children give meaning to HIV and AIDS. In studies conducted by Bhana (2006; 2007a; 2007b; 2008), findings revealed that young children's discursive frameworks for understanding HIV and AIDS, gender and sexuality are marked by class, race and gender. My study is inserted here since I, too, am exploring young children's responses to AIDS. My work, which seeks to explore what meaning young children under 9 in a largely Black populated public primary school give to HIV and AIDS, adds to this knowledge.

2.10. South African education responses to primary schooling and HIV AND AIDS
In South Africa human rights are protected and guaranteed by the Bill of Rights of the Constitution. The Constitution guarantees the right to freedom of access to information and freedom of conscience, thought, religion, belief and opinion. The Constitution gives special protection to children's rights and it puts a duty on everyone to act always in the best interest of the child. The Constitution (1996) further states that children have the right to information about sexual health and HIV prevention. This is their constitutional right and our constitutional responsibility as educators (South African School's Act 1996).

The Department of Education (2002) in South Africa stipulates that the Life Skills programme in the Foundation Phase needs to be designed to contribute to the full personal development of young learners and to provide them with some knowledge, skills and values needed for wider social and economic development and involvement. It must enable learners to make sense of and integrate things they learn at school into daily life, so that they are able to make skilled and informed life decisions. The Life Skills programme must also be designed to enable young learners to develop the skills, knowledge, attitudes and values that will enable them to identify and solve problems, and make decisions. The learning outcomes in the Life Skills programme have been formulated to help the learners to apply critical and creative thinking skills and to organise and manage themselves and their activities responsibly.

Silin (1995) emphasises that for many children and for many adults as well, fear needs to be replaced by understanding, and misinformation by facts. HIV is part of daily life

and should be treated as such in schools. Silin (1995) points out that in order to be meaningful, HIV and AIDS information should not be delayed until fourth grade science curriculum or sixth grade health class, where it may seem too abstract, and removed from students' lived experience.

Schools have also been tasked to provide correct information and to make people aware of the situation. Schools also need to support learners who resist peer pressure to engage in sexual relationships and/or drugs. Schools have also been tasked help children to understand healthy and positive sexual relationships and to build self-worth. This includes correct information about a healthy lifestyle, for example, hygiene, good nutrition, how the body works and sexual health. In order to ensure that this happens, the Department of Education (1999) has introduced sexuality and HIV and AIDS education from Grades R-12. Contrary to popular understanding of teaching about HIV and AIDS and sexuality education, Bhana (2006) calls for the need for sexual literacy and openness in early childhood education and for children to be treated in rights-respecting ways in which teachers respect their rights to think about sex and sexuality, their rights to talk about sex rights and their rights to act. Bhana (2006) encourages teachers to treat young children as speaking, knowing and experiencing sexual subjects, and this entails taking their concerns, pleasures and fears seriously in order to create the space to enable young children to recognise and exercise their rights.

Peltzer, K & Promtussananon (2003) supports the Department of Education's stance by adding that programmes should seek to understand and promote children's and youth's own strategies for avoiding HIV and AIDS and help them to develop their capacities for decision-making and critical thinking. Silin (1995) adds that it would be far more helpful to ground the curriculum in the issues that children themselves find challenging, rather than creating elaborate instructional guides based on formal ordering of facts. According to Silin (1995), "a curriculum that is permeable to the impact of students, one through which they can learn the skills of responsible citizenship, lays the groundwork for AIDS education".

The South African Education Department has also responded by conducting in-service workshops for educators, and training is being provided to enable educators to

implement the learning programmes for life skills education. However, Peltzer & Promtussananon (2003) explain that while teachers should be trained to be able to provide appropriate and interesting sexual education to children, the success of such training programmes will probably require that teachers receive training regarding their own sexuality. Bhana (2006) adds to this, emphasising that while policy makes it clear that teachers should drive information on HIV and AIDS, many teachers lack HIV and AIDS training. Furthermore, Bhana (2006) points out that there is unevenness in training and information around HIV and AIDS education in early childhood. Weeks (2000) adds that many childhood teachers in South Africa can finish a degree without taking a single course on human or childhood sexuality. She advocates the need for such courses in order for teachers to recognise that sexuality is an integral and positive part of young people's life. The results of Silin's (1995) study further indicate that HIV and AIDS pose multiple challenges to traditional ideas about teachers and teaching in early childhood. To be effective, teacher education programmes must address the changing nature of childhood, the value of integrated curricula, the role of teachers as advocates and more flexible approaches to understanding young children.

Silin (1995) concurs with Bhana and adds that what teachers think about childhood also influences how or even if they will approach HIV and AIDS with their students. However, the responsibility does not lie solely on the teacher. Bhana (2007a) points out that teachers and parents should reflect critically together on their own investments in concepts of gender and that teachers should be prepared to assist parents in seeing the contradictions, the dangers and the meanings behind gender discrimination. Bhana (2006) explains that while the teachers saw no necessity for engaging with the children on matters of sex, sexuality or even HIV and AIDS and displaced this responsibility onto the parents, the parents do not take on the sex education role. This was revealed in the findings which showed that the children at 'Bullwood' (the school in the study), had no clear knowledge about HIV, the vectors of transmission or sexual practices whilst at Kwa Dabeka the teachers felt that children should be taught about HIV but not sex (Bhana, 2007).

Silin (1995) points out that the school is a safe place to make sense of complex and confusing realities. Furthermore, he states that teachers who believe in this approach are

more likely to provide opportunities for critical social issues to become part of the curriculum.

Silin (1995) states that questions about HIV and AIDS undermine the mutual pretence with which children and teachers fulfil their socially prescribed roles. The presumption that children are ignorant and innocent is belied by their concerns about a disease that we wished they did not know about.

2.11. CONCLUSION

Boys and girls are thinking, feeling people who actively and independently negotiate their own personalities and identities. Much of this development has already occurred by the time a child has reached 8 years of age. In view of this, early childhood education programmes should seek to support children in this process. They can also take advantage of this characteristic of early childhood to provide children with adequate space to challenge and resist narrow, stereotypical constructions of gender and avoid gender bias. (Bhana, 2006; 2007a; 2007b; Silin, 1995). This entails addressing programmes which can supply children with an environment conducive to positive, sustained learning about safe behaviour and which operate largely around helping children to obtain the attitudes and skills they will be able to use at critical times as they grow in order to make wiser decisions (Bhana, 2006).

In Chapter 3, I discuss the research design and the research methodology for this study. I also discuss the steps I took to ensure the validity, reliability and trustworthiness of study. I also explain in detail the ethical considerations since this study positioned young children as constructors of knowledge.

CHAPTER THREE 3: RESEARCH METHODOLOGY

3.1 Introduction

This study investigates the ways in which Grade Two learners in a working-class school in greater Durban ascribe meaning to HIV and AIDS. To do this, the study embarked upon qualitative research methodologies including group and informal interviews, visual methodology which incorporated asking children to explain their drawings observations and field notes as methods of data collection. This study is significant in that it seeks to investigate young children's knowledge of HIV and AIDS in the current context in South Africa. In electing to use qualitative research methodologies such as group and semi-structured interviews, together with visual methodology, the study aims to explore and to understand what knowledge young children have of HIV and AIDS and also to understand how young children position themselves in the context of HIV and AIDS. It is through understanding how children position themselves in the context of HIV and AIDS, that we can develop implementation programmes to address and build upon what young children know about HIV and AIDS. This study also seeks to build on the children's positive insights as well as to develop appropriate teaching methodologies or intervention programmes at Grade Two level.

This chapter presents the research design and methodology selected in answering the following key questions:

1. What knowledge do young children aged between 7-9 have of HIV and AIDS?
2. What are the implications for working with young children in addressing HIV?
   and AIDS?

In answering these questions, the following two sub-questions, which are embedded in the above, will be answered:

- How do young children age 7-9 position themselves in the context of HIV and AIDS?
- What are their gendered experiences of HIV and AIDS?

In the first section of this chapter, I present the research methodology which I decided will best fit this study. Using the qualitative approach, I chose group interviews, individual interviews and visual methodology (using participants drawings to elicit information on the topic 'Young children's responses to HIV and AIDS'. I also draw on

previous research to authenticate the need to view and engage young children as agents, as actors and as producers of knowledge. Included in this chapter is the process of data collection as well as the data analysis. In this chapter, I also document how I overcame participant bias (which is often associated with qualitative research), together with details and explanations on methods I used to lend validity, reliability and trustworthiness to this study.

3.2 Research design and method

3.2.1 A qualitative approach

According to Cresswell (1994), "A qualitative study is defined as an enquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting.

The main reason underlying my choice for a qualitative approach was my interest and experience with the phenomenon being studied. My study, which is somewhat ethnographic in nature, relates to my teaching background and experience. Banister, Parker, Taylor & Tindall (1994) and Denzin & Lincoln (1994) agree that one undertakes qualitative research in natural settings where the researcher is the instrument of data collection who gathers words or pictures and analyses them. Having been a Foundation Phase educator for 23 years, I have experience in issues relating to gender violence, sexual abuse and rape of young girls, and I have witnessed the effects of HIV and AIDS in the lives of young children. I have also observed young boys and girls within the school context displaying and enacting their gender and sexuality in talk, in play and in their learning. This experience, and knowledge gave me the confidence to proceed with the study and involve myself as the research instrument. Good qualitative research also has special value for investigating complex and sensitive issues which is why I thought it would 'fit' (Henning, 2004) my study perfectly. Qualitative methods permit the researcher to study selected issues in depth and in detail (Mouton & Marais, 1988, Patton, 1990). In order to obtain a deep understanding of how children think about HIV and AIDS, I used qualitative methods such as group and individual interviews to derive data. By engaging in qualitative research, I was able to describe the phenomena of interest in great detail, in the original language of the research participants.

3.2.2 Locating the study: interpretative paradigm

This study is positioned in an interpretive research paradigm and adopts group and individual interviews which are methods used to derive data in qualitative research. The interpretive paradigm aims to understand the subjective world of human experience (Cohen, Manion and Morrison, 2000). In an interpretive paradigm, knowledge is constructed not only by observable phenomena, but by also descriptions of people's intentions, beliefs, values and reasons, meaning making and self-understanding (Henning, 2004). Phenomena and events are understood through mental processes of interpretations which are influenced by and interpreted within social contexts to look for ways in which people make meaning and what meaning they make (Trauth, 2001). The interpretative researcher looks for frames that shape the meaning (Neuman, 2000). This allows the researcher to be extremely sensitive to the role of the context, in this case the school and the learners. In my study, children were viewed as having inner capabilities that allow for individual judgments, perceptions and decision-making (agency).

3.2.3 Qualitative methodology: group and individual interviews

Cooper & Schindler (2001) state that an exploration typically begins with a search of published data. In addition, researchers often seek out people who are well informed on the topic. Secondary data was informed by Bhana and Epstein (2007) and Bhana (2006; 2007a; 2007b; 2008).According to Bhana (2007a; 2007b) ethnographic studies, loosely structured discussions and informal interviews elicit thick, rich data. Since this was exactly the kind of data I was pursuing, I held that I would achieve the similar findings using similar data collecting methods.

Bhana's (2006) study engaged ethnographic methods and group interviews to explore the extent to which sexuality characterised young children's narratives in a context of the severe AIDS pandemic. This research shows how, in exercising, negotiating and adjusting what they see as their rights, children can be encouraged to raise and discuss issues about sexuality and about rights (Bhana, 2006). The article argues that by allowing children to talk about such sensitive issues, children are able to express themselves as sexual agents. Bhana's study (2007a) is also based upon work with two Grade Two classes in a well-established, affluent and formerly White-only suburb. About 50 children participated in this study. The study positioned itself within the

young-person centred research, which argues that young children are active agents with multiple identities, with the capacity to think, to know and to feel (James et al (eds), 1998; MacNaughton, 2000; Renolds, 2005). The group discussions were informal and were structured around questions such as: 'What is AIDS?', ' How do you know who has AIDS?', ' How do you catch it?', etc. My study, in many ways is related to this study as it also sees children as active beings, as having agency with the capacity to think, to know and to feel.

Bhana's (2008) work also explores the specific circumstances under which 7 and 8 year olds understand HIV and AIDS. The study also sought to investigate how primary school teachers construct children's right to HIV and AIDS education focusing on the regulatory force of childhood innocence. Studies conducted by Bhana (2006; 2007a; 2007) were based on group interviews. These studies were conducted with the Grade Two's in a former Model C school. The study engaged in a young-person-centred approach (Kehily, 2004), which recognises the right of the child to set the agenda and to determine ways in which the conversations are held. In these studies, the researcher informed the participants that should they feel uncomfortable, distressed or wanted to discontinue participation, they could withdraw from the research at any time and the children were shown examples of how this could happen. I followed the same in my study, especially since my study was also of a sensitive nature and I was also engaging the children in group and individual interviews.

In the study ('I don't want to catch it', boys, girls and sexualities in an HIV environment), Bhana & Epstein (2007) examine questions of gender, violence and HIV and AIDS in two KwaZulu-Natal schools. The study also looked at the discursive framing of gender, sexuality and the pandemic amongst much younger children. Whilst group interviews were used, the methods for collecting data differed in both schools. In one school, the researcher collected data with the help of a translator because she was not conversant in isiZulu and in the other school; the interviews were conducted very informally, in a variety of informal settings. According to Bhana and Epstein (2007), the translator impacted on the data collected in different ways: translation changed things in the data and since the translator was not a researcher, she phrased questions less open-ended. I took note of this and I decided that since I have conversational

isiZulu, I would be able to conduct the interviews and extract the information I needed for my study. Furthermore, I decided that should I experience problems, I would reframe my questioning in order for children to understand and I would also get other children in the group to help me with the translation should it be necessary.

As explained earlier, a qualitative approach was used to explore the topic: Children's responses to AIDS. This approach enabled me to gather information to gain an understanding of how learners aged 7-9 respond to AIDS. Their responses enabled me to address the research questions and to understand the deeper meanings of their responses to HIV and AIDS. Because measurement is fallible, the qualitative researcher encourages varieties of data and uses different sources and analysis methods in order to strive for validity (Henning, 2004). In order to gather the relevant data, I selected group interviews, as it encourages interaction amongst the group, providing a setting in which children are given a voice and a setting in which children feel comfortable and is as close to a natural surrounding as possible, (Cohen, Manion & Morrisson, 2007). I also engaged in semi-structured individual interviews within the qualitative paradigm to get children to explain their drawings in order to get this insider perspective. Cohen and Manion (2001:272) claim that Tuckerman described the interview as one of the best tools that allows the researchers to access what is in the participant's mind. Morgan, cited in Babbie and Mouton (2001:292) furthermore observe that the advantage of group interviews lies in the ability to observe a large amount of interaction within a shorter duration of time and also because group interviewing is low cost and rich in data, Uwe Flick (2006:190). Although qualitative research allows for a number of data gathering methods, I tailored my techniques to my specific research question and to my particular site of research. These techniques were used in the study: the group interview, individual interview, drawings, participant observation, field note taking and secondary data analysis (prior research studies). These techniques made it possible for me to provide informed judgments because issues were viewed from different angles and it allowed for a more informed understanding of the topic.

3.2.4 The research site
My study was conducted in a public primary co-educational school which is situated in a middle class formerly Indian suburb in Durban. I was purposeful in choosing to

locate my study in this context since the aim of the research was to investigate the ways in which Grade Two learners in a working class school in greater Durban gave meaning to HIV and AIDS. Whilst there are four other public primary schools in the suburb, feasibility was a strong determining factor in my decision to conduct the study in this school. I lived and worked near the school, I shared a strong ethical and cordial relationship with the principal, staff and learners in the school. Furthermore as Acting Head of Department, I have contact with all the children in the Foundation Phase and I therefore knew that the children would be comfortable with me during the interviews. I also choose this school as a research site because I felt comfortable to conduct the study in the school in which I taught. The familiar surroundings meant that I could navigate my way around the school, choosing sites which I thought would be most comfortable and conducive to conduct the interviews in. Furthermore, in choosing this school I knew that I would have daily contact with the grade teacher and that the interviews, especially the individual interviews, could be scheduled at the children's convenience should time present a problem.

Being a teacher in the school also meant that I would have ongoing interaction with the participants in the study. Should any of the participants endure trauma/stress in the course of the study, I knew that I would be able to provide comfort and counselling immediately and even after the study was completed.

3.2.5 Description of the sample

The sample comprised learners from the Foundation Phase. I looked at the age group 7-9 years and in doing so, I was able to draw participants from Grade Two. Whilst some of the participants selected reside in the suburb in which the school is situated, most of the participants reside in the township outside the suburb. The end of apartheid era (1994) brought about radical changes in South African education. Durwest Primary School, a formally all Indian school, situated in a middle-class Indian suburb, opened its doors to admit children of colour (Blacks, Whites and Coloureds). Being the oldest school in the suburb, built in apartheid times, this school had a small playground, two blocks of classrooms for Foundation Phase and two blocks of classrooms for the Intermediate Phase. Very soon the classes were overflowing and as a result, three new schools were built. The new schools in the suburb boasted large playgrounds,

swimming pool, hall, sporting facilities and much more. Many Indian parents who were able to afford the new school fees transferred their children to these schools. Whilst the Indian population at this school dropped drastically, the Black learner population steadily increased. It must be noted also that the school fees at this school was, and still is payable, as compared to the newly built schools. The school fees at the research site was set at R550 for 2008 and was increased to R650 for 2009. Taxi fees for children travelling from the townships amounts to approximately R280 per month. However, despite the added cost of travelling, the majority of our learners are from the surrounding townships. The school offers stability, a good education and over the past few years, the school, has acquired funds to improve the learning environment for the learners.

Many children residing in the suburb emerge from contexts characterised by poverty, violence, theft, alcohol and drugs. The eight percent Indian children attending this school are poor and are tenants in the majority middle-class Indian properties in the community. A large number of the children are Black and many live in the informal shack settlements situated in the suburb. These learners walk to school and many depend on the school for resources for learning, for example books, pencils, crayons and many of the learners are part of a feeding scheme set up by the community at the school.

3.2.6 Sampling Techniques

A purposive sampling technique was employed to select participants for the study.
In purposive sampling, researchers handpick cases to be included in the sample on the basis of their judgement of their typicality. In this way, they build up a sample that is satisfactory to their specific needs (Cohen, Manion and Morrison, 2000). Cresswell (1994) says that the purposeful selection of participants represents a key decision point in qualitative research. With this in mind, sampling was done according to the following criteria:

Participants for the study were selected from the Grade Two class. I chose Grade Two because I was exploring the responses of children within the 7- 9 age group and the ages in Grade Two ranged between 7-9 years. The research sample comprised 40 boys and girls. I issued consent letters to parents informing them of the study and requesting permission to include their children. From the 40 forms issued, 22 forms were returned,

20 were signed with consent, whilst 2 learners had been refused permission. The 20 learners with approved consent became the participants in the study.

Table 1: Details of the participants

No.	Name	Age	Race	Sex	Resides with				Resides in		
					Mom	Dad	Grand parent	Care giver	Town ship	Suburb	Informal settlement
1.	Ntando	8	B	G				✓			✓
2.	Penny	7	B	G				✓	✓		
3.	Thuli	7	B	G	✓				✓		
4.	Nelly	7	B	G			✓				✓
5.	Saheen	8	B	G			✓		✓		
6.	Zama	7	B	G			✓				✓
7.	Lindiwe	8	B	G			✓			✓	
8.	Neo	8	B	G	✓						✓
9.	Angel	8	B	G	✓				✓		
10.	Zabe	7	B	G				✓	✓		
11.	Melody	7	B	G				✓	✓		
12.	Mbali	7	B	G	✓				✓		
13.	Nhlanhla	8	B	B	✓	✓					✓
14.	Allan	7	B	B	✓					✓	
15.	Nkosi	7	B	B	✓						✓
16.	Sandile	7	B	B	✓	✓			✓		
17.	Njabulo	7	B	B	✓						✓
18.	Matthew	8	I	B	✓					✓	
19.	Ncedo	7	B	B			✓		✓		
20.	Mhlengi	7	B	B	✓					✓	

3.2.7 Participants Background

All the participants were Grade Two learners. Whilst 3 of the participants were fluent in English, the remaining 17 had a relatively good knowledge of English and were coherent in responding to questions. All learners came from the working-class and

lower working-class socio-economic group. All the participants were of Christian background. Seven participants resided in the informal settlements, four participants were tenants in the suburb and nine participants lived in the nearby township

Participants were informed about the purpose of the study and the intention of the researcher regarding the desired responses before they participated in the interviews. Participants were also guaranteed of anonymity and assured that their responses would be held in the strictest of confidence.

3.2.8 Procedure of obtaining data

"Permission to carry out an investigation must always be sought at an early stage" (Bell, 1987 cited in Cohen and Manion, 2001:53). The first stage of any research project involves obtaining official permission to carry out research in a specific community. For the purpose of this research, I contacted the Principal and the Department of Education. The research was explained to the relevant authorities and a copy of the research proposal was forwarded to the Department of Education. Both officials granted permission (See Annexure1 and Annexure 2). Permission was also sought from the class teacher, the parents and the learners themselves. A letter outlining and explaining the research was sent to parents together with the consent form(See Annexure 3 and Annexure 4). The class teacher and the participants were also briefed of the study.

Data was gathered in the following ways:
- Voice recording of group and individual interviews
- Participants drawings
- Field notes of the interviews
- Participant Observation, which entailed the observation of verbal and non-verbal interactions and responses of participants to the issues at hand.

3.2.9 Data sources

The selected children were the key informants in this study. The children produced data collected for this study during the group and individual interviews.

3.2.10 The Research Instrument

The researcher is the primary research instrument in this study. I elected to use myself as a tool for eliciting data from the children because of my past and present experiences with learners who are affected and infected with HIV and AIDS. Whilst I have previously had a trusting relationship with the learners in the school, my position as Acting Head of Department in the Foundation Phase allowed me more opportunities to interact with the learners, along with their parents, grandparents and caregivers. With 23 years of teaching experience in the Foundation Phase and the knowledge I had gained from working with young children, I felt confident to embark on this study, knowing that the learners would not feel threatened or uncomfortable by my presence during the interviews. Moreover, I knew that they would respond openly and without inhibition to questions that might come up during the interviews. I also knew that the subject of HIV and AIDS was not foreign to the children, since HIV and AIDS education is incorporated into life skills education at school. The Department of Education had provided guidelines to implement a range of topics to be included in the life skills programmes. Some of the topics included HIV and AIDS facts, for example, modes of transmission, understanding one's body and also keeping the body safe and healthy. Other topics which focus on HIV and AIDS and sexuality education include self-esteem and self-awareness, relationships with family, peer groups and the community attitudes and values, rape and abuse, and decision-making. These topics are accompanied by a range of methodologies teachers can use to help our children to make meaningful decisions in their lives, now and later. Such methodologies include group work, role playing, drama, etc. I was the primary interviewer, but I also assumed the role as an observer. Whilst I interviewed the children, I also took down field notes, noting their responses in facial expressions, their posture, their interaction with other members of the group as these responses would otherwise be absent since I was using a voice recorder to record the interviews. Observations and recordings took place in a very informal manner and the children were not disturbed or threatened in any way during the interviews.

3.2.11 Examples of questions

Whilst the interviews were semi-structured, most of the questions were open ended which allowed children to position their responses and their arguments in ways that they

deemed fit. Through the use of open-ended questions, participants were reassured by reframing of the questions and the children were also given time to answer and to express themselves freely.

Examples of questions asked: (Annexure 5)

1. Group interviews:

1.1. What is AIDS?

1.2. Who gets AIDS?

1.3. How can you tell if a person has AIDS?

1.4. Should your teacher talk to you about HIV/AIDS in school? Why?

2. Group work: I asked each participant to draw me a picture about AIDS.

3. Individual interviews: I asked the participants to explain their pictures to me.

3.2.12 The actual research process: conducting the interviews

According to Silin (1995), in order to understand what children know of disease, we have to return to children themselves to uncover what it is that seems to matter, to grasp how they make sense of experience. Silin (1995) points out that in order to do this, we have to abandon the safety of science that allows us to know children from the privileged position of distanced adults. The purpose of the interviews was to establish the learners' responses to HIV and AIDS.

For the purpose of this study, I engaged the children in four sessions. In the first session, I called all the participants together and I invited them to sit with me in the discussion corner of my classroom. I explained to them very simply the purpose of the research. I also spoke about myself as a student of the university and the need for me to do the research as part of my study. I proceeded to tell them about the study. I explained to the children that whilst the school, the Department of Education, their parents and themselves have given me permission to conduct the research, they were not obligated to participate in the research. I explained to them that should they decide that they were uncomfortable any time during the interviews, they were free to leave the interview setting and no questions will be asked. I provided them with ways to leave the interview setting. I also explained that they are not compelled to answer questions if they did not want to. I explained and stressed the matter of confidentiality and anonymity in order to reassure the children that their names and their responses would not be divulged to their

teachers, the Principal, their parents or to their friends. After having established trust and ground rules, I found the participants to be relaxed and comfortable with me and the other children in the group. More so, I sensed excitement, cheerfulness and liveliness in the children. They were very keen to participate and felt very important that they were considered for selection. This session lasted 30 minutes.

In the second session, I engaged in three group interviews. The children were divided into two groups seven and one group of six. Before the start of the interviews, I asked the children if they were comfortable to participate and they reassured me by displaying cheerfulness, which was underlined by a sense of self-importance. The interviews were conducted in an informal manner, with the participants again being informed of the purpose of the study and the confidentiality of the responses. There were three group interviews and each session lasted approximately 20 minutes.

In the third session, I met with the group as a whole and I asked them to draw me a picture about HIV and AIDS. I chose to incorporate drawings into the study because I felt that I needed alternate methods to get these young learners' perspectives on HIV and AIDS. I also wanted to use this method in the event that the participants felt uncomfortable or found that they could not express themselves freely. Furthermore, it must be noted that the majority of the children are second-language learners and I felt that this was an alternate method to elicit rich, thick data on their knowledge about HIV and AIDS. I explained to them that they could draw anything related to AIDS. I explained to the children that the picture must tell a 'story' since I was going to ask them what they had drawn, they must be able to tell me about their picture. I also mentioned that I was going to use their drawings in the thesis. This session took longer than I expected. In order to complete the individual interviews, in my non-teaching time I arranged with the class teachers to allow me access to individual participants. In this way, I managed to complete all my interviews.

3.2.13 Process of data analysis

Qualitative data analysis is the range of processes and procedures whereby we move from the qualitative data that has been collected into some form of explanation, understanding and interpretation of the phenomenon we are investigating (Lewins,

Taylor and Gibbs 2005). In this study, all the interviews were audio taped with the exception of the first meeting, which outlined the purpose of the study and dealt with issues of consent, participation, confidentiality and anonymity.

The process of qualitative data analysis involved writing and the identification of themes. Notes and interviews were transcribed and transcripts were copied. In order to establish themes, I had to code the data. I used different coloured highlighters to code the recorded transcripts. I also identified passages of text in the transcripts and applied labels to indicate that they were examples of some thematic idea. This labeling or coding process enabled me to quickly retrieve and collect all the text and other data that were associated with some thematic idea and I was able to examine them together and compare the different themes that emerged. I then used folders to gather together material that were examples of similar themes. Field notes from the observations during the group interviews were also documented. Participant's responses were documented using pseudonyms. Data was then checked against tape recordings for accuracy. At this point, I revisited the theory and the literature review sections and I tried to establish links between the theory section and the findings in order to see if there was a relation between the theory, the literature and the themes. I revisited the interviews again to check if there was any other important response I might have overlooked or neglected.

I found that the data sets used in qualitative data analysis to be very large even though the sample was small as compared to those used in quantitative research.
The following themes emerged from the analysis of the data:
- Stigma, fear of contagion, myths and mysteries
- Social class, race, culture and gender
- Sex and sexuality in young children
- HIV and AIDS and adulthood
- How children see disease
- How children see AIDS

3.3 Design limitations
Purposive sampling techniques used in this study had limitations in that they allowed the researcher to select participants, thereby making the representation of the sample to

the larger population rather questionable. For this study, I had specifically chosen Grade Two learners in the age group 7 –9.

3.4 Researcher bias

I was aware that since I am an educator at the school, I would have, to a certain degree, influenced the data I gathered. In order to reduce or eliminate this bias, I decided to research participants from the other Grade Two class, since I am also a Grade Two teacher. I also conducted my study in this class because I have not taught any of these learners in the Junior Primary phase. Further bias was offset by ensuring that the data collection was voice recorded and by verifying that detailed transcripts represented the actual words of the research participants, thus minimizing researcher bias.

3.5 Validity and reliability

Validity is an important key to effective research (Cohen, Manion and Morrison, 2007). According to Silverman (1994), research has to be intellectually challenging, vigorous and critical, and the researcher's reliability and validity must determine the rigor. Tests for validity seek to establish the accuracy of the research findings. In qualitative research, validity tends to look into content and construction of the research instrument,

In this qualitative study, validity is addressed through honesty, depth, richness and scope of the data achieved, the participants approached, and triangulation. In order to ensure validity in this study, the following precautions were taken:

- I kept a detailed research journal.
- Interviews were voice recorded and transcribed and are available for perusal
- The different data gathering techniques (group interviews, individual interviews, drawings field notes and participant observation) serve to alleviate inconsistencies in the data.
- I engaged in ongoing debriefing and consultation sessions with my research supervisor.

Reliability refers to the dependability of a measurement instrument, meaning the extent to which the instrument yields the same results (Terre Blanche & Durrheim, 1999).

Reliability is therefore defined as the degree with which the same methods used by different researchers and/or at different times produce the same results.

Reliability in this study is assured by making available transcribed data and field notes so that references can be made to them. In addition, the use of the voice recorder made available original data with the actual voices of the participants that served to eliminate researcher manipulation and bias. Furthermore, the context and process of the study is fully described. If another researcher was interested in a similar kind of study, she/he will be able to do so based on the detailed research design and methodology in this study.

3.6 Trustworthiness

According to Lincoln & Guba (1985), truth is the first criterion used to establish trustworthiness. According to Lincoln & Guba (1985) truth value asks whether the researcher established confidence in the truth of the findings for the participants and the context in which the study was undertaken. In my study trustworthiness was achieved through the following techniques:

- Triangulation: different methodologies such as group interviews, individual interviews, field notes and participant observation were employed to ensure credibility of the study.
- Observation: verbal and non-verbal cues were observed in order to better understand the data generated.
- Reflexivity: Krefting (1991) defines reflexivity as assessment of the influence of the investigator's own background, perceptions and interests on the qualitative process. Reflexivity in this research was enhanced through the use of the voice recorder and detailed note taking.
- Peer examination: I discussed the research process and findings with a colleague who is simultaneously undertaking qualitative research.
- Field journal: I kept a field journal throughout the research process in order to record any relevant findings at any time during the research period.

3.8 Ethical Considerations

Concerns with the ethical and moral implications of researching children have been widely discussed (Amos Hatch, 1995; Hood Kelley & Mayall, 1996; Mahon Glendinning, Clarke & Craig, 1996; Mathews, Limba & Taylor, 1998). These concerns have been related to the appropriateness and desirability of involving young children directly in research, in terms of their competence and vulnerability as research subjects. Based on adultist assumptions, the view of children as incompetent and in need of protection and control has underpinned much research involving children. However, while the validity and accuracy of children's responses have been questioned in conjunction with debate over the issues of protecting children from researcher exploitation in the form of intrusive or potentially distressing questioning, there is now strong consensus that 'children's views can and ought to be taken seriously'. (Mahon et al, 1996:46).

For the purpose of my research, I adhered to the following ethical guidelines laid down nationally and internationally:

- Accessing the school: A formal written request was made to the school Principal and the Department of Education for permission to conduct the research in the school and with the participants. The aims and objectives of the study were outlined to the Principal, and The Department of Education. The Principal was thoroughly apprised of the aims of the research and its methodologies. Being in the physical context of the research, i.e. the school, the teacher and the Principal had the opportunity to talk to me during the data generation period and to raise any ongoing concerns about the progress of the study.

- Parental consent: The parent was provided with details of the study, its aims and projected outcomes and details of what interviews involved. Their children's confidentiality and anonymity in any publication proceeding from the study was guaranteed. Parents were required to sign an informed consent form allowing their children to participate in the study.

- Participant consent: Only children for whom formal consent from a parent had been obtained participated in the study. The purpose of the research was

explained to the participants in order for them to be informed and to obtain their voluntary consent. Whilst children in the school have knowledge of English, I have a working knowledge of isiZulu. When the need arose, I attempted to clarify questions and answers through other children in the group. Fortunately, I did not experience problems in deciphering what the children said. As a result, there was no need for me to get the assistance of a translator. I ensured, as far as possible, that the children who participated in the study understood the issues in my study. I also ensured that the questions asked were age appropriate and relevant to the study. I tried my best to adhere to the duration of participation requested. As a researcher and as a teacher, I was alert to any indication that a child was unwilling to proceed. I looked constantly for signs of discomfort, uneasiness, and of participants creating distances from other learners or myself. Before the interviews, I facilitated ways ' role playing' (Bhana 2007) and the use of pre-arranged signals to facilitate withdrawal without drawing attention to the participant.

- I avoided asking sensitive questions to the learners, bearing in mind that the participants may be affected/infected with HIV and AIDS. I also consulted with the class teacher to gain background knowledge on the sample. The knowledge I gained from the teacher informed me as to the suitability and the vulnerability of the sample. In the course of the study and during the interviews, I drew on my own notions of morality and ethical values to guide my conduct during the interviews. In the line of my duty as an educator and as Acting Head of Department in Foundation Phase, I have offered counselling and care to many learners affected and infected by and with HIV and AIDS. As such, I was aware of the kind of information I wanted to elicit and I ensured that I did not ask questions of a sensitive nature, which might have had the capacity to cause children distress, grief or to become saddened. Whilst I had mechanisms in place in the event of secondary trauma, I was fortunate that all the participants participated freely and with 'light spirits', which made our interviews very carefree and informal. However, should any secondary trauma have occurred in the course of this study or during the interviews, I would have stopped the study and assessed how best I could offer counselling and care to the participant. We

have an institutional support system at school, which I am part of, and its function is to offer counselling, treatment and care to children in need. My involvement in the Youth and Learner Development Programme instituted by the Department of Education and in the Community Youth Desk that is being set up by the Reservoir Hills Policing Forum guided my interaction with affected learners.

- Confidentiality: Data collected was recoded using pseudonyms and the identities of the participants were thus concealed. I respected the dignity and the worth of all the participants involved. As an educator in the school, I was involved in ongoing negations in the course of the study; there was a process of continuous interaction between researcher and participants rather than a one-off case of getting a form signed. This approach assisted in reducing the power differential between the participants and myself and contributed to the development of trust.

- Storage of data: appropriate data storage security measures were taken to minimise the possibility of any parties gaining access to the study data. After submission of the thesis, the data will be stored in a secure location by arrangement with my supervisor. Thereafter, data will be disposed of through shredding of documents.

3.9 Difficulties encountered

Initially, my study was going to be based on Grade Three and Grade Two learners' perceptions of HIV and AIDS. I identified learners aged 7-9 in both grades and decided that these learners would comprise my sample. However, I decided to pursue the study with the Grade Two's only due to difficulties encountered. One of the biggest difficulties that I encountered was the time factor. Initially, when I planned my study, I intended using my non-teaching periods to conduct the interviews. The study would encroach into the Life Skills period and this was acceptable since the study was related to the Life Orientation learning area. However, much to my frustration, many of my non-teaching periods were utilised to do relief teaching at the school. This impacted on the times I had selected for the interviews. I could not ask the participants to remain after school hours since some of them travelled by bus and school transport to and from

school. I could not conduct the interviews during intervals since there is only one break during the teaching day, and the children needed that time to eat their lunch, visit the toilets and play with their friends. It was thus easier for me to conduct the interviews with the Grade Two's. Since I was also a Grade Two teacher, I made internal arrangements with the other Grade Two teacher. When I was given free time. I conducted my interviews. If the children missed out on a lesson, I included them when I was teaching a similar or same concept to my learners. In this way, I ensured that the participants were not disadvantaged. I found the interview setting to be very challenging. There were many disturbances from other children, other educators and, most annoyingly, from the heavy traffic which prevailed outside the school.

3.10 Response rate

Out of a sample of 40, 22 learners brought back a signed consent from issuing me with permission to include the learner in the study. Two learners from Grade Two were refused permission to participate in the study. No reasons were given. Eighteen forms were not returned. Seven learners said that their parents said they could not take part so they did not bring in the letters. Three learners said that they had lost the form and eight learners returned the forms unsigned.

3.11 Conclusion

This chapter explained the research design, the methodology, the group and individual interview, the data collection method and the instrument that was used, and the process engaged in to analyse the data. It must be noted that the greater part of this chapter was written after the interviews and once I started working with the data. This chapter also outlines the necessary steps that were taken in order to render the findings of this study reliable, trustworthy and valid. In the next chapter, the data is presented and analysed.

CHAPTER 4: FINDINGS

4.1 Introduction

Ignorance in children is equated with innocence and precocious sexual knowledge with defilement and culpability (Tobin 1977). The children in this study emerge from environments where HIV prevalence rates are high. Through the interviews, the children kept slipping in and out of what is known as 'childhood innocence'. The children's response in the interviews attested to their knowledge of HIV and AIDS, and in doing so, revealed themselves as sexual beings. Their knowledge also alluded to them being very aware of the sexual nature and transmission of HIV and AIDS. However, whilst children positioned themselves as 'knowing', as having agency and of being agents in producing their gendered and sexual identity, many in the study resisted their right to know about HIV and AIDS, casting HIV and AIDS into the domain of adulthood. This, as you will see in the course of the findings, proved to be contradictory, given the rich data the interviews generated.

In this chapter, I present the learners responses to HIV and AIDS. The results are based on the data gathered from the group and individual interviews with the learners. In the individual interviews, children were asked to explain their drawings, whilst the group interviews focused on children's understanding of HIV and AIDS. Findings, incorporating the children's drawings will be presented thematically.

According to Parker & Aggelton (2003) HIV related stigma is complexly connected to existing inequalities of race, gender and class and involves the language of power, inequality and exclusion. The children in this study come from low socio-economic backgrounds. Whilst many of them live in the bordering townships, an equal number of children reside within the context of the school in the informal settlements that characterise urban areas. The children drew pretty, colourful pictures. The drawings revealed a combination of emotions: when the child related the sexual nature of the disease, they drew boyfriends, girlfriends, they depicted them as happy people, however, when they drew people infected or affected by HIV and AIDS there was an accompanying sadness in the picture. The findings also reveal that the children's

responses were located in their social context and their knowledge was socially constructed.

4.2. Findings : Children's construction of AIDS

4.2.1. Feminisation of HIV and AIDS

"The face of HIV/AIDS is a woman's face" (Annan, K. 2002).

Studies suggest that the feminisation of HIV/AIDS in South Africa is driven by gender power inequities, which are embedded in a complex matrix of socio-cultural, economic and political factors (Castro, 2008). In this study, many children perceived HIV and AIDS as a girl's disease. This perception of HIV and AIDS as a girl's disease is embedded in socio-cultural, economic and political factors which prevail in the current context of HIV and AIDS in South Africa and features strongly in the situated meanings the children ascribed to HIV and AIDS. In this study, the situated meanings prevail from a working class, largely African, context with high HIV and AIDS prevalence. The feminisation of HIV and AIDS have also led to wide scale gender and sexual violence against women and children, especially the girl-child.

My mother says "don't talk to anybody you don't know"

Children are exposed to all forms of violence on a daily basis, be it in the media, their homes, to and from school or just in their context. In this study, violence and gender violence is known to the children. The children talk of kidnapping, of rape and of being cautioned by their mothers to be wary with strangers. According to Bhana and Epstein (2007), sexual violence has featured prominently in South African society with Black boys and young men being constructed as the perpetrators. These researchers however, make it known that in South Africa it is more likely that Black girls will be victims of Black male violence. The following transcript bears reference:

R: Should we speak to strangers?
Zama: No…They lie and say your mummy say that I must take you home and they kill you..
Asanda: When you are going on your own and the people take you into the house and then they take you and put you in the bed and then you get HIV.

Angel: My mother say don't talk to anybody you don't know... I said ja, I will do that.

On closer inspection, the following phrase "*put you in bed and then you get HIV'* hints or should I say implies some reference to rape. However in the following transcript, the children were very clear about rape:

R: Rape you? What is rape?

Nkosi: When you take the girl to your house and rape it… sleep with it

*Nhanlha: Somebody who has HIV and they touch you in the private and then
 you are gonna get HIV.*

Mothers concern, worry and protective instincts are very apparent in this response **'my mother says don't talk to anybody you don't know'**. This again alludes to the gendered lives of many females in the context of poverty, where the mother has to protect the child from danger, including sexual danger.

The girl is going to give the boy AIDS

It became quite clear in the interviews with the children, that whilst both boys and girls believed that boys spread the disease, they were very clear that it was the girls who had the disease and that the boys get HIV and AIDS from girls. Again, this perception would link their response to their social and cultural context where women are seen as the infector and responsible for the disease. In attributing the disease to women and the manner (sleep implies sex) in which it was passed to the man, it became clear that the children had sexual knowledge of the disease.

These are some of the responses to *'Who do you think spreads the disease'* and *'how is the disease spread?'*

Nelly: The boy is touching the girl… the boy will get HIV from the girl.

Mbali: The boys don't know that the girl has AIDS and they kiss… he gets AIDS.

R: So you are saying that if you kiss you can get HIV?

Nkosi: Yes. When you kiss other people and when you sleep with it.

In the following drawing, the child's perception that HIV and AIDS is passed on by the girl is very explicit. In the drawing below, the child drew a line with an arrow at the end

of the line. The line originates from the girl and points to the boy. An interesting aspect emerging from this drawing is the adult status ascribed to HIV and AIDS. Both people in the drawing are portrayed as young adults, note especially the female; she is depicted in full form (note the breasts) and the 'red lips' which alludes to her as an adult and enhances her sexuality. It becomes very clear here that young children construct HIV and AIDS as an adult disease and also that they see the disease emanating from heterosexual relationships and not as a 'gay' disease.

Figure 1: The girl is going to give the boy AIDS

The disease is further feminised because of mother-to-child transmission (MTCT) during pregnancy and childbirth. Mother to child transmission is a well-established mode of HIV transmission. It is well documented that infection may occur during pregnancy, during labour and from breastfeeding. Children in this study were able to make the link between sex, pregnancy and childbirth. One boy in particular displays astounding knowledge as he goes on further to inform us that HIV is prevalent in pregnant woman and draws our attention to many babies who die as a result of being infected during pregnancy and childbirth. The high levels of HIV and AIDS infections

prevalent in pregnant women during antenatal testing fearfully remind us of the gender vulnerability of young women and girls.

The following transcripts bear reference:

R: Who do you think spreads the disease?

Nkosi: Girls.

R: The girls? How do they spread it?

Sandile: When they have the baby…

Nkosi: When you kiss other people and when you sleep with it and then you have a baby and then you are going to get HIV and then the baby will die.

4.2.2. Race, Social class, culture and gender

Bhana and Epstein (2007) maintain that the South African HIV and AIDS epidemic is profoundly gendered, classed and raced and that young children inscribe themselves within particular gendered, raced and classed discourses of sexuality and of HIV. These researchers argue that gender, race and class are important in understanding the high levels of HIV prevalence that have mainly affected Black, South African men and women. My study, like Bhana (2006, 2007), took place in KwaZulu-Natal where the prevalence of HIV and AIDS is very high and where a large number of Blacks live in the informal settlements and are at high risk to HIV and AIDS. The children in this study come from similar locations as explained in the context. Aggleton and Weeks (1981) concur and elaborate that in order to understand the ways in which the HIV and AIDS related stigma and discrimination appear, and the contexts in which they occur, we first need to understand how they interact with the pre-existing stigma and discrimination associated with sexuality, gender, race and poverty.

The findings in this study prove that the South African HIV and AIDS epidemic is indeed gendered, classed and raced and that young children inscribe themselves within particular gendered, raced and classed discourses of sexuality and HIV (Bhana and Epstein, 2007).

4.2.2.1 Racialising the disease

This study, like Bhana and Epstein (2007) showed that the racialisation of AIDS was a significant means through which knowledge was expressed.

Children seemed to have a strong sense of where HIV and AIDS is located. Whilst many of their responses alluded to the social structures in society, for example, poverty; children also racialised the disease. McClintock (1995) point out that a significant trait of HIV-related stigma is that Black people are inherently constructed as diseased and promiscuous. In this study, the children's response that Black people are the vectors in the spread of HIV and AIDS is premised upon their knowledge of Black men and women which is located in their social context. The transcripts below attest to children's perception of the disease.

R: Who spreads the disease… who gives the disease?
Nelly: Some people… like black one… they give the disease.

However, some children were also adamant and took exception to Nelly's answer and quickly pointed out that *'Some ma'am… not all'* black people were vectors in the spread of HIV and AIDS. The children's response draws attention the high prevalence of HIV and AIDS infections amongst Blacks in Southern Africa. Bhana (2006) asserts that in South Africa, AIDS is gendered and racialised. According to Bhana (2006) apartheid, strong political governance, the dominant Black masculinity and social and cultural factors have all contributed to the AIDS onslaught. In many Black cultures, dominant Black masculinities shape men's control over women and celebrate multiple partners that drive the gendered nature of the pandemic (Hunter 2005). Bhana (2006) asserts that the children's responses and understandings of AIDS is racial and sexual; this assertion draws our attention to the children's knowledge about sex and sexual matters in this study and forces us to reconsider the myth of 'sexual innocence' in young children.

4.2.2.2 Child- headed households
In the following transcript, the child's explanation of Figure 2 drawing is very poignant and hits hard at the reality of child-headed households due to the lack of male support in the context of poverty and family life. The child in this interview draws our attention to the gender dimensions relevant to HIV and AIDS which encompass many aspects of society including economic, legal, cultural, religions, political and the sexual status of women. In the context of poverty, women are often the only parent the child knows and

relates to. As in this picture, the absence of the father is obvious, both in him not being in the drawing and also the child's failure to acknowledge him in the caring of the infected mother. The structure of the house (simple box and the black smoke emanating from the chimney) alludes to the low socio-economic context in which this child is situated in, which gives meaning to this child's understanding of HIV and AIDS. In the context of poverty, the absence of the father figure is not uncommon. Whilst many men are driven to seek employment outside their community, Black culture has been dominant in encouraging heterosexual prowess and men are constantly proving their masculinity and heterosexuality by engaging in many casual encounters, putting them and their partners at risk of contracting HIV and AIDS and unplanned pregnancies. This drawing also draws our attention to child-headed households. In the face of the AIDS pandemic, roles have been reversed: children are now called on to take care of the sick adult.

Figure 2: Baby is helping mum

R: You have a very pretty picture. A very pretty picture. What can you tell me about your picture?

Melody: This one has AIDS. (Points to the adult female)

R: Who is this?
Melody: Mummy.
R: And who is this here?
Melody: Baby.
R: and what is wrong with baby?
Melody: He is helping the mum.
R: Why is he helping the mum?
Melody: 'Cause his mother is having HIV.

This drawing was especially profound. Two weeks later, I received notification that the child's mother had died. I realized then that the drawing was interconnected with the child's personal realities. I went back to this drawing and now, the sadness in the picture takes on a deeper meaning for me. This child, only 7 years old, has been a caregiver. The sadness is indicative of the trauma, the loneliness and the burden this child had to endure during her mother's illness. Moletsane (2003) concurs that the HIV and AIDS pandemic affects children in South Africa in many ways. This is further supported by Malaney (2000) who states that watching a parent die can be expected to have deep psychological effects on children**.**

4.2.2.3 Poverty

Hunter (2006) informs us that informal settlements express a great variety in terms of rates of employment, gender breakdown, resident's place of origin and types of building structure. According to Hunter (2006), informal settlements tend to be occupied by the poorest South Africans and according to available statistics, HIV prevalence rates tend to be at their highest in these spaces. The children in this study are poor, many live in the informal settlements and share a room with other siblings, adults and their partners, and they also watch television together. In such a context, children are exposed to intimate relationships between young adults, their parents or relatives and to television programmes which have an age restriction. In such a context, child abuse is also rife. Many children are left unsupervised and are often sexually abused. Jewkes et al (2002) point out that in low socio-economic contexts and informal settlements, sexual abuse often goes unnoticed as no one really pays attention to such matters. In this study the children also display knowledge that 'sex with lots of girls will give one AIDS'. This

response is situated in the impoverished context from which many children in this school come. Multiple sexual partners, transactional sex and the high crime rate, which characterizes informal settlements, provide the context for young children to give meanings to abuse, gendered violence, violence, alcohol and drug abuse and HIV and AIDS.

R: What about you Ntando. Do you know what AIDS is?

Ntando: The people who stay in the jondolos... they got AIDS and they go in the hospital and they die.

The children in this study are socially located and have knowledge that exceeds their years and stages of development. This is evident in the above response, which shows how children construct and connect HIV and AIDS to inequalities in class and the stigma and discrimination they subscribe to. Nkosi's response, *"when you kiss other people and when you sleep with it"*, page 76 and Neo's response, *"he is HIV positive and he wants to give it to the girl...he wants to sleep with the girl"*, page 84, serves to strengthen and provide strong support in that children are socially located and have knowledge that exceed their years and stages of development.

4.2.2.4. Culture

The children in this study come from a dominant Black patriarchal society in which dominant Black masculinity is revered and celebrated. This draws attention to the patriarchal societies existing in South Africa that encourage and validate multiple sexual partners in and out of marriage. Women are viewed as asexual beings without the capacity to make informed decisions regarding their welfare, their health and their choices in sexual matters. The negativity towards condom use increases the risk of HIV transmission and unplanned pregnancies. This exacerbates the social circumstances of the child and the absence of a father figure to provide protection and emotional and financial support increases young children's vulnerabilities towards HIV and AIDS (see figure 2: note the sadness in the picture and the lack of the father figure in the picture and in the conversation that follows. This insubordination of women in African societies has rendered women vulnerable and at risk to HIV and AIDS. The children in this study draw into this kind of discourse and 'favour' multiple *'girlfriends'*. This is noted in the following excerpt:

R: So you're saying that if a boy has a lot of girlfriends then that boy probably has AIDS?

All: yes ma'am!

R: How can it kill you?

Nkosi: Because when you got five girlfriends you can die

R: Is that so?

Nkosi: Yes.

R: Why would you die if you have five girlfriends?

Nkosi: Because they have HIV and AIDS.

R: The girls have HIV and AIDS?

Nkosi: Yes.

4.2.2.5. Gender inequality and male dominance

Aggleton and Warwick (1999) state that HIV and AIDS stigma and discrimination is also linked to gender-related stigma. The impact of HIV and AIDS related stigma on women reinforces pre-existing economic, educational, cultural and social disadvantages. South African culture is generally male-dominated, with women being accorded a lower status than men. Men are socialised to believe that women are inferior and should be under their control; women are socialised to over-respect men and act submissively towards them. The resulting unequal power relation between the sexes, particularly when negotiating sexual encounters, increases women's vulnerability to HIV infection and accelerates the pandemic. In the explanation of the following drawing, the child alluded to coercion in sexual relationships. This is evident in the following transcript

Figure 3: The boy wants to go with the girl to his house

Neo: The boy's picking the girl's skirt up.

R: Why is he doing that? Can you get AIDS in that way?

Neo: No… The boy wants to go with the girl to his house.

R: Okay... why does he want to go with her to his house?

Neo: He is HIV positive and he wants to give it to the girl.

R: And how will he give it to the girl?

Neo: He wants to sleep with the girl.

This discussion, based on the drawing, compels us to take note of what the child is saying. The child makes it very clear that HIV and AIDS is a sexual disease, the picture suggests knowledge of coercion. The following excerpt bears reference:

'***The boys picking the girl's skirt up'*** and '*the boy wants to go with the girl to his house'.*

In our social context, men are seen as the ones who coerce females into having sexual relationships. Men are also seen as being responsible for passing the disease. The following excerpt bears reference:

'He is HIV positive and he wants to give it to the girl'

The children respond clearly, displaying knowledge on issues such as kissing and sex and there is the awareness that the disease can be spread by adults engaging in adult sexual relationships. Whilst they are not very descriptive in their responses, their knowledge alludes to their knowing of the transmission of HIV/AIDS through sexual relationships, again forcing us to reflect on the myth of 'childhood innocence'.

3. Myths, Misconceptions and Taboos

According to Aggleton (2003), HIV and AIDS related stigma and discrimination also interact with pre-existing fears about contagion and disease. Early AIDS metaphors such as death, horror, punishment, guilt and shame have exacerbated these fears, further reinforcing and legitimising stigmatisation and discrimination.

The findings below revealed that myths, misconceptions and taboos were very prevalent in the lives of young children.

"They might come and touch me and then I will get AIDS"

Stigma, fear of contagion and ignorance featured strongly in the children's responses to HIV and AIDS. A popular belief regarding HIV and AIDS as highly infectious have played an important role in stigma and has remained steadfastly impervious to pubic messages (Delius & Glaser 2005; Petros et al 2006). Campbell et al (2007), and Delius & Glaser (2005) point out that whilst the sexual connection with the disease remains an important source of stigma, evidence suggests that popular understanding of contagion constitute a relatively unyielding and significant element in the multidimensional sources of HIV and AIDS related stigma. This is indicative in the following response.

R: Would you play with someone that has got AIDS?
Nkosi: No. When she is touching me like this…when you are playing…I'm gonna die … she is gonna give me too.
R: So you will not play with a person who has HIV or AIDS?
Nkosi: No... because I will die

Figure 4: We don't play with people who have AIDS

Many participants felt that they would die if they came into contact with an AIDS infected person. The idea of touching reflects an important element of children's construction of HIV stigma. In refusing to play with someone who is infected, children also reveal their vulnerabilities and fear in contracting HIV and AIDS and ensuing death which again alludes to their experience and knowledge that death accompanies HIV and AIDS. The 'HIV-positive child' is a striking feature in this drawing. The child is portrayed as a colourless entity, as having no identity, whilst the other children in the drawing are bright and beautiful. The short arms, the short legs, the sparse hair and the simplicity of the facial features as compared to the other children in the drawing, draw our attention to the manner in which children perceive HIV and AIDS.

In contrast to the fear of contagion, some children revealed compassion, caring and love towards children infected and affected by HIV and AIDS. Whilst many children distanced themselves from HIV and AIDS infected people, others displayed empathy and caring for children who have HIV and AIDS. Children spoke of offering comfort to infected children because they would be lonely. They also spoke of sharing food and providing the infected child with food when going on 'excursion'. Very important here

is the mention that no one must 'tease' the child. Again this directs our attention to how children negotiate their involvement and participation with HIV and AIDS infected learners. It also points to children's power (agency) as agents in deciding when it is suitable for them to become involved. The following transcript bears reference:

R: Would you be friends with a person who has AIDS?
Saheen: yes… I will take care of him.

Nelly: I would be his friend.

R: Sure?

Nelly: yes ma'am… because he would be lonely.

Angel: I would try to comfort him… by going to talk to her

Zabe: …and give him food.

Zama: Take care of him… maybe we're going on excursion, maybe I will give him food when he is going.

Angel: Maybe when we go to the beach we are supposed to play with him.

Saheen: You must make sure that no one must tease him… he will get sad and he will cry.

Children also showed much insight as to how they would negotiate play with the infected person. The following excerpt reveals this:

Penny: I would be her friend but I would be careful.
Mbali: If he is coughing I would go this side and then he coughs… then I will come back and I play with her…
Lindiwe: I'm going to play with him because he will want to cry.
Zama: I will teach her how to take care of herself.

The following drawing is an expression of kindness and consideration. In the text, the child explains how she will navigate her relationship with an infected child. In using bright colours to illuminate the message, the child's perception of HIV and AIDS is not morbid; the message suggests hope and happiness.

Figure 5: I care for people who have HIV and AIDS

Text: I care for people who have HIV and AIDS

Allen: 'HIV and AIDS'

'I care for people who have HIV and AIDS. I give them water to drink and food to eat. I play with them everyday. We jog everyday so they will be healthy. They eat fruit and vegetables and porridge. I take care of them when they are sick. I take them to hospital'.

Sharing juice and toothbrushes will give you AIDS!

Popular myths such as sharing food and personal items will spread the disease also surfaced, reinforcing the fear of contagion and again pointing to the social circumstances where material and cultural factors interact with popular understandings of contagion in mediating knowledge about the disease (Bhana, 2002). The following response bears reference:

R: How do people get AIDS?

Matthew: By drinking juice.

R: People who drink juice get AIDS?

Mathew: Yes… people who are drinking everybody's juice…

R: How else can a person get AIDS?

Matthew: if you brush with another's brush in your teeth, you get AIDS (sic)

Whilst we acknowledge that it is unhealthy to share personal items eg. a toothbrush, the mere fact that mention is made about sharing a toothbrush alludes to the social context in which the learner and many others live. In many homes, poverty and lack of education led to family members sharing the available personal resources at home.

Taboos

Inspite of South Africa having one of the highest rates of new HIV infections in the world currently (UNAIDS 2007), AIDS and its implications are still largely taboo subjects among the majority of the population. As a result, people with HIV and AIDS are often shunned or worse, killed. In one such example, Gugu Dlamini was stoned to death in 1998 for admitting she had AIDS (Cullinan, 2001). According to Cullinan (2001), Dlamini was kicked, beaten and stoned to death by a group of men outside a KwaMashu shebeen in December 1998 because she had apparently admitted to being HIV positive.

Recent official figures suggest that almost 4 million South Africans are HIV positive and more than 1,500 new people are infected by the virus every day (UNAIDS, 2007). In rural South Africa, there have been several incidents of individuals being ostracised, beaten and occasionally killed by members of their community after they admitted to being HIV positive.

The children in this study are adamant that they should not talk about HIV and AIDS. The children believe that if they were to talk about AIDS, then they would be susceptible to the disease. A very interesting point that came out in the conversation is the following:

R: And what will happen if we talk about AIDS now?

Nelly: We are going to get it.

R: You are going to get it? You will get AIDS if you talk about AIDS now?

Nelly: Yes… because we are going to think the AIDS and we are going to do the

AIDS.

The children believed that talking about HIV and AIDS will result in them thinking about AIDS which will cause them to be 'get' AIDS. The children traipse in and out of childhood consciously denying knowledge of HIV and AIDS, affirming that they are too small to talk about HIV and AIDS, thus positioning themselves in the safety of childhood, whilst unconsciously confirming their construction of HIV and AIDS, all the time, subtly alluding to their awareness of the sexual aspect of the disease. Bhana (2006) explains that by resisting the right to know about HIV and AIDS and about sex, the children were drawing upon discourses of childhood innocence despite the richness of their knowing. This is revealed in the following transcript:

R: Why should you not learn about AIDS now? Are we supposed to talk about AIDS in school?

All: Nnnnoooo…

R: No? Why?

Sandile/ Nkosi/Nelly: Because we are small.

R: What did dad say to you?

Sandile: He say that the HIV is not for the babies.

R: Is not for the babies? Who is it for?

Sandile: It is for the big people.

In the drawing below, the child's response that HIV and AIDS is for big people is clearly illustrated. The participant drew a picture depicting two happy adults and a symbol of love is attached to the lady. The man is equally happy. The picture is bright and happy, alluding to happiness, well-established persons; note the fancy house in the background. This drawing also suggests that HIV and AIDS is not confined to poverty only. However, the HIV signs seems to be a reminder that HIV and AIDS is prevalent in 'love' relationships between man, woman. The flower and heart are placed at

strategic places, denoting the child's awareness of sex and sexuality which further emphasis the child's construction of HIV and AIDS as a disease which is passed on by adults in heterosexual relationships. The following excerpt bears reference:

R: Can you tell me about your picture?
Mercy: This is a man and a lady.
R: Who are they?
Mercy: Mum and dad?

This discussion not only speaks of heterosexual relationships but also places the disease firmly in the family context , in saying it is a disease for mom and dad. As much as it is no longer a homosexual disease, the children see HIV and AIDS very much as a disease of the family and of the parents specifically.

Figure 6: AIDS is for big people.

The children also agreed that boyfriends and girlfriends was for grown-ups and expressed their distaste in noting that the Grade Seven boys in the school liked girls, adding further that boyfriend and girlfriend relationships are for when one has completed school. They further prophesise that such kissing is going to render the boy

vulnerable to HIV and AIDS. Note again the reference that the boy will contract the disease by kissing the girl and not the other way around, implying once again that girls have HIV and AIDS. This is evident in the following transcript:

Mbali: I saw this boy in Grade Seven… he is kissing the girls… after school he is kissing the girl in Durban Heights.
R: And you all saw that?
All: Yes ma'am.
R: And what do you think of that?
Nhlanhla: Stupid thing…He is going to get HIV.

Figure 7: AIDS is for big boys and girls

Again, this knowledge of sex and sexuality matters in young children defies the myth about childhood innocence and instead positions children as knowing. In the drawing above, the people are portrayed as youngsters. The girl is sexualised: the heart and the flower are symbolic of the ways in which people speak of girls and women's sexuality. This picture was explained as follows:

Zama: AIDS is for big boys and girls.

In attributing the disease to 'big boys and girls', the participant, like other children in this study, has distanced herself from HIV and AIDS. The children in this study make reference to the sexualised behaviour of the Grade Seven learners in the school and out of the school which they have witnessed.

4.4. How do young children see disease?

Children linked observable symptoms to being sick or having a disease. Most times, these symptoms were physical. Children spoke of disease being identifiable by *'coughing, red/brown eyes, thinness, sadness, loss of speech'* and isolation: *'he is lonely and like nobody cares about her'*

R: How would you know if someone has a disease?
Matthew: When you cough a lot and then you die.
Melody: Maybe when she… she… she… when she sleeps a lot and when
she… she… coughs alot.
Njabulo: If he's like uuuhhh… if he's…. mmmm… thin and he's coughing
Nkosi: If he has red eyes or brown eyes.
Mbali: and when he is like… uuuhhh… thin and sad ma'am and he don't know how to talk.
Zabe: like when he is lonely and like nobody cares about her.

Some children also drew people in wheelchairs, implying that people who are in wheelchairs are sick or diseased. The following picture is however contradictory as the people depicted in the drawing appear to be happy. However, further questioning revealed that the child had drawn people with physical disabilities and that their disabilities were the result of them suffering a 'stroke'. This picture draws our attention to young children's perception of sickness and AIDS. Whilst some children in the study spoke of HIV infected people being sad and lonely, this picture depicts people who have suffered a 'stroke'. This drawing alludes to the child's perception that whilst HIV and AIDS is a disease associated with death, stroke (sickness/illness) is seen in a more positive light and it does not appear to be life threatening to the participant.

Figure 8: The people in the wheel chairs have suffered from 'stroke'

4.5. How do young children see AIDS

The children in this study related AIDS to blood, sores, disabilities and drug use. Many children in the study expressed fear of contagion with regard to blood. They displayed knowledge that the mixing of blood can lead to one becoming infected with HIV and AIDS. The following except bears reference:

Zama: HIV and AIDS is bad for you so that is why I drew a HIV person having blood and another having blood and they are touching and their blood is getting mixed up.
R: Is that the way HIV and AIDS can spread?
Zama: Yes
R: Do you know what AIDS is?
Mhlengi: AIDS is about… uhhh… when somebody got blood in the hand or somewhere… you must not touch because if you touch, then you gonna get AIDS and then you die.

Children expressed fear and revealed their vulnerable selves when they spoke of contracting the disease and then dying from it. It was obvious that the children associated HIV and AIDS with death and they expressed a conscious desire to avoid touching the blood of other people.

Children identified HIV and AIDS as a debilitating disease, and mentioned that people with HIV and AIDS can be identified by the sores on their faces, as is depicted in the drawing below.

Penny: You can tell the people you have AIDS because you got some sores in your face.

Mbali: Maybe you have AIDS and you are coughing, coughing…

Njabulo: You can see if they are sick or something… if they have a disease… you can see they have AIDS or TB… they have AIDS.

Figure 9: You can tell by the sores on the face

This participant's responses allude to the context in which she is located which is a low socio economic context. In such a context, the prevalence of HIV and AIDS is high.

Whilst I have mentioned earlier in the study that HIV and AIDS does not cause poverty, poverty does however exacerbate HIV and AIDS. The participant's description of the picture alludes to the loneliness and rejection many AIDS sufferers experience because of the misconceptions, stigma and myths about AIDS. A popular stigma is one about contagion: you can AIDS by touching an infected person. Many AIDS sufferers experience utter loneliness, rejection and desolation as this participant and the drawing reveals. Another interesting aspect also surfaces in this drawing. The participant has drawn the person with sores on the body. This is a symptom of AIDS: AIDS sufferers often develop 'Kaposi's Sarcoma', a skin disease associated with AIDS. This picture and the participant's response alludes strongly to the child's ability to construct meaning around HIV and AIDS.

The following transcript bears reference:

R: What about this picture? Can you tell me what you have drawn?

Penny: He was going to die, then his cat came to see him… he didn't walk… he didn't do nothing… he was going to go to the hospital but he had no money to go to the hospital… he slept on the sun… he had a bed outside… he got more sick"

Figure 10: AIDS is a debilitating and crippling disease

In this drawing, the child portrays HIV and AIDS as a debilitating and crippling disease. Very often, with the onset of AIDS, people experience difficulty in mobility. People with AIDS are usually given walking sticks by the hospitals to help them to be mobile. It is obvious that the children in this study have seen and experienced AIDS and they therefore connect the walking stick and the wheelchair to the HIV and AIDS. When people have reached this stage of the infection, they undergo a lot of pain, ostracisation and their lives become very difficult. This pain and suffering is very evident in the above drawing: the people are portrayed with great sadness (notice the tears on their faces).

Children also saw AIDS in drug use. Again in making the connection between drug use and AIDS, children force us to accept that they do know about AIDS and that they do make the connection between adult behaviour, HIV and AIDS and drugs. The following excerpt reveals young children's knowledge and thinking in drug related AIDS issues.

Allen: If you have an injection and you share that injection, you can get AIDS.
Ntando: If you take the injections and put it to someone is AIDS.
Thuli: Because you mustn't pick up a needle and poke yourself.

In the context of poverty and informal settlements, drug and alcohol abuse is often not shrouded by mystery. Children are exposed to adults and teenagers indulging in drugs and alcohol.

4.6. Sex and Sexuality in young children

The data generated in the following interviews draw our attention to preconceived ideas of children as innocent, incapable of constructing knowledge in their social context and threatens many other notions about early childhood. In the following transcripts, we see how children exercise and negotiate their rights in ways that allow them to hide, display and deny their sexuality.

In the conversation below, the learners become very frivolous, happy, shy, hesitant and confident as we progress with the interviews. Bhana (2006) says that laughter acquires a symbolic significance in this context. She points out that not only does it allow for

validation and support of childhood sexual cultures, it also allows them to speak of transgression. At this stage in their development, these children aged 7-8, are able to record and express their feelings, and hence their sexuality.

Letter, cards and pink glasses

In these interviews, the children are eager to share to their knowledge with me. They talk of love letters, writing in the sand and of receiving presents from boys. However, as the interviews progress, I am made aware of the deeper meanings the children attribute to their childish games. In sharing their thoughts and experiences with me, it becomes very plain to see that these children are able to make meaning of HIV and AIDS and they also show how they negotiate their sexuality and gender in the context of play.

The children first talk of inking 'love letters' to inform a certain person of their 'love'. The letter written is very simple, *"I love Angel"*. I observe during the interviews that the recipient of the letter smilingly denies having received such a letter. Further evidence of childhood sexuality and heterosexual attraction is demonstrated in the following excerpt:

> *Angel: "I was going to Siminikiwe... and I don't know… we were in the sand… waiting for our sisters and brothers. Tami came… Lindiwe said I must write… I write all the boys names. I asked: who do you love in these boys"*

Children (boys) also expressed their desire to have girlfriends. In their talk, they made mention of not one, but of having two and five girlfriends. It also became clear that children had a strong sense of their heterosexuality. In one instance, it was made very clear that the participant was heterosexual and the implication that he liked boys made the other participants laugh and he was annoyed.

Zama: Nkosi…has the boyfriend.
R: Boyfriend?
Nkosi: No! Girlfriend ma'am

Nhlanhla: He has five girlfriends!
R: Do you have girlfriends?
Sandile: I have…two is for here. (Meaning this school.)

It is interesting to note Sandile's contradictions. He is very adamant that he should not learn about HIV and AIDS because it is for '*big people*' and he is a baby (see page 90: he says that HIV is not for babies….it is for big people), however, he takes much pride in announcing that he has two girlfriends in the school. This suggests that children are actors and are powerful in controlling their agency. They decide what is the preferred way to demonstrate childhood knowledge and act accordingly.

Boys and girls also make the association between gifts, girlfriends and their desires. *Shaheen: "Faith says that she loves that boy and that boy gave Faith the glasses… that pink glasses".*

Writing in the wall
It became obvious that the children in this study had knowledge, which was inherent and socially located. The children spoke of the school toilet as a place of secrecy and alleged that **'stupid things'** were done in the toilet. By **'stupid things'**, I assumed that they were referring to using the toilet for other than what it is intended for. My assumptions proved correct as is revealed in the following transcript:

Neo: Yes ma'am... I see Sani, Thabiso, Nadia playing together in the toilet... and hugging each other… they are making stupid things
R: In the toilet?
Nelly & Zabe: Yes… they making stupid things… (laughter)

Laughter again points to their knowing that they have transgressed the boundaries of childhood into adult-domain.

Again, the children reveal their sexuality. One of the boys apparently writes that a certain girl is '*sexy*' on the toilet wall**.** Whilst writing on toilet walls is a common occurrence in public spaces and communal toilets, what is interesting is that these 7 and

8 year olds are able to relate their feelings in words 'sexy' and in their 'behaviour'. The following transcript bears reference:

Saheen:….. pull her and take her in the boys toilet and I don't know what they do.

However, 'pulling her' indicates forced sexual behaviour. It is likely that the children may have observed forced sexual behaviour in their social context and they relate or connect coercion or force to sex.

Such behaviour also alludes to observed behaviour from their social context. In informal settlements and in poor socio-economic communities, children are exposed to such behaviour: seeing boys and girls going into the toilets, seeing and reading writing on communal toilets, etc, exposes children to elements, which many would consider undesirable and unsuitable for young children. However, children coming from such backgrounds are exposed and can relate to matters of sex and sexuality and in the process, enact their own sexuality.

Crossing the line

In the following transcript, the children indirectly reveal that fear of punishment and grown-ups were often the deciding factor in their behaviour and that in the absence of such, they are unafraid to pursue their sexuality:

Angel: I don't like to have the boyfriends. My mother will smack me and Ndumiso, my brother in Grade Six will know that and he will tell my mother.
R: So if Ndumiso was not here then…
Lindiwe: She can do… she can talk with the boys… because today Ndumiso is absent... she is going to talk with the boys… **(Smiles)**

As the interviews progressed, it became very clear, that the children enjoyed talking about their feelings and about the opposite sex and about things relating to sexuality issues. This revealed below:

Zabe: Ma'am wrote in the board I gave my girlfriend a… And ma'am said a "ring". And Zama laughed and laughed, laughed and Tami laughed with Lindo.

Angel: I was writing the test and ma'am said that if we finished, we must close our books and come to the front. I sit with Simi and Tami (boy) *came and sit on this side and Lindo* (boy) *came and sit this side and I said no, no, stop, move this side* (we all laugh… much laughter).

What is interesting it also that children regard love, issues to do with love and the opposite sex as something that is happy and pleasurable to talk about and they are happy to express themselves. This is very evident in the constant giggles, smiles and laughter that accompanied this aspect of the interviews. The children appeared free and wanted to pursue the conversations in length about boyfriends and girlfriends and the toilets, etc.

In the following transcript, we discover how boys and girls positioned themselves within heterosexual cultures, laughing and expressing joy and pleasure whilst talking about kissing and flirting.

Nelly: I was coming out in the gate and Tami say, did you see Mnotho and Faith and Witness was kissing there?
R: Where?
Zama: In the corner.
Nelly: And Lindo kissed Witness in here, (pointing to the cheek) *and Witness, she laughs.*

Little angels or precocious devils

In the following excerpt, the children reveal the seductive behaviour of their classmates while they wait for their taxis.

> *Lindiwe: Ma'am, I see Alleta all the time, when she sees the boys, she takes the uniform and she pulls it like this* (demonstrates… lifting the dress to show the panty line) *and Zama, Faith, Nosipho and Alletas are doing like this and… the panty… and the boys are seeing… The boys are laughing at them… And ma'am then he calls her and she goes like this* (demonstrates a walk)… *and the boys they are following them… They are going with them.*

They are aware of certain behaviour patterns which makes them attractive to boys and in doing so, the girls also reveal that they are aware of the power of their sexuality and the effect it can have on the boys now and later on in life. In addressing and acknowledging this power differentials between girls and boys, girls can come to benefit this awareness to escape the effects of HIV and AIDS, gendered violence later on in their lives.

4.7. Should children be taught about HIV and AIDS in School?

Silin (1995) points out that very little is known about how young children give meaning to AIDS. Silin (1995) argues that in the early childhood sector silence persists around these areas particularly as HIV and AIDS deals with matters that are not considered appropriate for children. At the heart of HIV and AIDS is sex and putting sex, HIV, and AIDS together with young children is considered to be problematic.

There were different views on whether young children should be taught about HIV and AIDS in school and these findings reveal the inconsistencies in children's knowledge with regard to HIV and AIDS. Whilst some children supported the need for HIV and AIDS education on the basis that knowledge is power, many children seemed to be at conflict with what they know, see and experience. This latter group appeared afraid to express their thoughts on HIV and AIDS because they felt the topic was taboo, or because they may have been feeding into the image of what they are expected to know and how they are expected to behave. This is evident in the following transcript.

Matthew: AIDS is very important… Everybody has to know…
Zabe: Because it is dangerous…You can touch other people's blood without knowing.
Thuli: You must be careful with your body.

Others shared a completely different view on the need for HIV and AIDS education, arguing that this information is necessary because:

> *'Nhlanhla: you must learn about AIDS because when you grow up you will know that if you have a lot of girlfriends, you gonna get AIDS"*

It is important to note here, that the boys still perceive HIV and AIDS as a girl's disease and they link the disease to adulthood, saying that when 'you grow up, you will know that if you sleep with many girls you will get AIDS'. It is very evident that the boys, as young as they are, are able to construct women as the vector of HIV and AIDS. The following response reinforces the stigma that people living with HIV and AIDS have to live with.

R: Do you think your teacher should talk to you about AIDS?
Allan: Yes.
R: Why?
Allen: Because I will learn not to go by HIV/AIDS people.

Others argued that they were too small to learn about HIV and AIDS in school. This is noted in the following transcript:

R: Do you think you should learn about AIDS in school?
All: No.
R: No? Why?
Sandile: Because we are too small.

The data and analysis presented in this study draws from the group interview and individual interviews with the children which seeks to explore children's understanding of HIV and AIDS. This study, like Bhana and Epstein (2007), explored the impact of HIV and AIDS on the ways in which gender and sexuality are expressed against the background of race and class, specific to a primary school context. The study also explored the ways in which young children establish the connections between HIV and AIDS and sex and sexuality. The particular focus of this study was to investigate how children position sexuality and negotiate the right to know about HIV and AIDS. Farquhar (1990) offers that children's emergent understanding of HIV and AIDS is closely related with the knowledge of related topics like sexual behaviour and drug use. This study bears reference.

4.8. CONCLUSION

The results of this study highlight the ways in which children understand HIV and AIDS; in the process, we become aware of how children understand sex and sexuality.

The study importantly reveals how children construct and give meanings to their understanding of HIV and AIDS, sex and sexuality. These, in turn, compels us as adults and teachers to reflect on our teaching and to ask ourselves a crucial question.: In ignoring the young child's request to be acknowledged as agents in constructing knowledge , who are we protecting? Are we protecting the child, or are we protecting ourselves in allowing ourselves to believe that our children will remain untouched by this pandemic?

I agree with Bhana (2007) that the paucity of research literature on children's account of HIV and AIDS and sexuality may reflect the failure of researchers to investigate this topic and to develop the kind of person-centred relations with children to enable them to talk in the way they did in her study and in this study. Farquhar (1990b) confirms that children's knowledge is variable in the extreme and he asserts that this is so because most researchers using the developmental frameworks suggest that knowledge is primarily age-dependent.

With reference to this study, chapter five attempts to make suggestions and recommendations with regard to providing children with:

- the practical knowledge that will prevent them from getting AIDS;
- opportunities for them to grapple with the social implications of the disease; and
- opportunities to valorise their experiences in order for them to be better able to understand the sources of pleasure and danger in their own lives.

Chapter 5: CONCLUSION OF THE STUDY

5.1. Overview of the study

This study focuses specifically on the ways in which young children in Grade Two, aged 7-9, position themselves in their responses to HIV and AIDS. The study also looks at how young children construct their knowledge around the topic 'AIDS'. This study also illustrates how, in responding to AIDS, 7-9 year old children in Grade Two do gender and furthermore how the association with AIDS underpins the way in which these children construct their knowledge and agency. This study provides crucial evidence showing how sexuality is embedded within the doing of gender and how in responding to AIDS, children are not only doing gender, but sexuality as well.

The motivation for this study came from my personal experiences as a Foundation Phase educator and a gender student, and stemmed from numerous readings of journal articles and books which centred on the social construction of childhood in the context of the HIV and AIDS pandemic in South Africa (Silin, 1995; Peltzer & Promtussananon, 2003; Bhana 2006; 2007a; 2007b, 2008 ; Bhana & Epstein, 2007; Van Dyk, 2008) Through numerous readings of Gender, HIV and AIDS, I began to eventually understand the unfolding of sexuality in early childhood, and I became aware and could make the connection between early childhood, gender and sexuality

My decision to work with the Grade Two children was twofold. Firstly, being a foundation phase teacher, I wanted to understand how young children saw AIDS given that HIV and AIDS is very prevalent in the largely Black lower income context in which these children are located. Whilst poverty does not cause AIDS, it is a common fact that HIV and AIDS is exacerbated by poverty. However, the second reason is personally the most important: in my years of teaching children, I was affected by the rape and gendered violence which some of my learners experienced. I found it very traumatic to be in the classroom with children who were raped and sexually violated. Every time I looked at the victims, I questioned myself as an educator; I began to contemplate the children's lives and their experiences in their social context. Soon child protection phrases like 'stranger danger' and 'my body is my body' became very meaningful in our classroom discussions, and I found that once children felt

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comfortable to talk about sensitive issues, they revealed a far superior and sophisticated knowledge base than what we as teachers and adults imagined them to have. Once they understood that I would not judge them or become angry with them for possessing knowledge related to sex and sexuality, the children astounded me with their capacity to construct meanings around sensitive issues such as AIDS, sex and sexuality. The children in my class spoke freely about HIV and AIDS, race, class, gender, sex and sexuality. This realisation motivated this study as I decided to document the meanings these young children in a largely Black populated public school gave to AIDS.

In this chapter, I draw together the meanings the children give to HIV and AIDS. Firstly, drawing on qualitative, post structural feminist research approaches, I summarise my answers to the following research question:

1. What knowledge do young children aged between 7-9 have of HIV and AIDS?
2. What are the implications for working with young children in addressing HIV
 and AIDS?
In answering this question, the following two sub-questions, which are embedded in the above, will be answered:

- How do young children age 7-9 position themselves in the context of HIV and AIDS?
- What are their gendered experiences of HIV and AIDS?

A number of findings emerged from this study and in the next section I discuss these findings thematically. I continue by considering the implications of this study and conclude with a brief discussion about its limitations.

5.2.   Synthesis of the argument

Throughout the study I argue that whilst some children do not know about AIDS and it is abstract, many of them actually do know and are able to associate that knowledge within their social context. I argue that all of us are socially located and that the factors of our social location and context empower us differently. We may be powerless or powerful, depending on where we are and the people with us, the institutions we occupy and the values that society attaches to all these areas. The importance of social location

is that it determines our experience in the society and the world; it determines what happens or does not happen to us; what we see and hear and how we see and hear it, or conversely, what we do not see or hear.

Boys and girls are thinking, feeling people who actively and independently negotiate their own personalities and identities. Much of this development has already occurred by the time a child has reached 8 years of age. In view of this, early childhood education programmes and teachers should seek to support children in this process. They can also take advantage of this characteristic of early childhood development to provide children with adequate spaces to challenge and resist narrow, stereotypical constructions of gender and sexuality. (Bhana, 2006; 2007a; 2007b; Silin 1995). This entails addressing programmes which can supply children with an environment conducive to positive, sustained learning about safe behaviour and which operates largely on helping children to obtain the attitudes and skills they will use to make wiser decisions at critical times as they grow (Bhana, 2006).

5.3. Implications of the study

5. 3.1. Young children's knowledge of disease and AIDS

Children in this study identified physical and emotional symptoms in identifying people with sickness or disease. The children spoke about red eyes, coughing, sleeping etc. when referring to sick people. They also spoke of sadness and loneliness accompanying sick people. However, the children in this study revealed themselves to be very astute in their perception of HIV and AIDS. They spoke about sores, blood, tuberculosis and referred to AIDS as a debilitating disease. Their ability to link these symptoms to AIDS alludes to a social circumstance in which HIV and AIDS is highly prevalent. The children also, in drawing people in wheelchairs and using a walking stick to gain mobility, draw our attention to their exposure to people with AIDS. Whilst all people in wheelchairs and who use a walking stick cannot be generalised as HIV-positive, the correlation the children make between AIDS and loss of mobility is an important one as it rings true for many poverty stricken people suffering with AIDS. Children also see AIDS as sex. In this study, the children allude to sex by using the word 'sleeping'. Silin (1995) states that '8 year olds belief that you could catch AIDS when you go in the

same bed' is not surprising given that the child in this study describes 'sex' as going to bed with somebody as well. This connection between sex and AIDS informs us that the children in this study have identified the gendered aspect of HIV and AIDS; in saying that 'you can get AIDS by sleeping with girls'. The children in this study are also very firm in their belief that AIDS is spread through heterosexual sex. This knowledge is inscribed in their contexts, as children in informal settlements are often privy to adult liaisons, which are generally heterosexual relationships. It is also important to note here that the children in this study do not ascribe HIV and AIDS to homosexuals. A determining factor could be the stigma that is attached to homosexuality and the resistance of Black cultures to acknowledge homosexuality.

5.3.2. How do young children position themselves in the context of HIV and AIDS, Sex , Sexuality and young children.

In this study, the children challenge our preconceived ideas of children as innocent and incapable of constructing knowledge in their social context. The children in this study draw on conversations that are punctuated by laughter, shyness, denial and raised voices when they become excited as they speak of boyfriends, girlfriends, kissing and flirting. The children's construction of gender and sexuality compels us to view children as having agency, as sexual beings and as knowing. We cannot ignore young children's construction of knowledge in matters of sex, sexuality and gender. It is interesting to note the children's reaction when they realise that they have transgressed the 'boundaries of childhood'. They retreat into a 'safe corner' stating that knowledge about HIV and AIDS is not appropriate for them since they are too small to know, hereby adopting society's prescription for childhood. Bhana (2006) asserts that by resisting the right to know about HIV and AIDS and about sex, the children were drawing upon discourses of childhood innocence determined by adults, despite the richness of their knowing. She points out that these contradictions show very clearly the constant struggle that young children have to endure in trying to present themselves as the ideal children. As children meander in and out of childhood, it becomes very clear that the children in this study are actors and are powerful in constructing and controlling their knowledge.

What emerged in this study is also the impact of poverty in the children's construction of sexual knowledge. In informal settlements, bathroom and toilet facilities are communal and situated outside the home. It is obvious that the children in this study have witnessed sexually enticing behaviour most probably amongst older boys and girls and adults in the informal settlements because they resort to similar behaviour in the school. Constructing children as asexual beings and the consequent denial that young children have any awareness of sexual matters can be held largely responsible for the lack of acknowledgement of the gender dimensions of young children in the context of the AIDS pandemic. As a result, children have learnt that sex and sexuality is something to hide and repress and they do so by drawing on affective conventions of disgust to confirm the narrative of childhood innocence and in doing so, resist the right to know about HIV and AIDS and sexuality more broadly.

Bhana's study (2008) supports this, and explains that much of the neglect surrounding research into HIV and AIDS and early childhood stems from a preoccupation with the conceptualisation of children and childhood as innocent. Peltzer & Promtussananon (2003) states that one major reason that children under 15 years have been overlooked in HIV and AIDS programmes is likely due to the difficulty for adults to accept children's sexuality. Peltzer & Promtussananon (2003) explains that children express their sexuality differently depending on their cultural background, access to information, social and economic status and their experience of sexual abuse.

5.3.3. What are young children's gendered experiences of HIV and AIDS?
5.3.3.1 Feminisation of HIV and AIDS
What emerged is that whilst both boys and girls contested who 'gives' AIDS, the general consensus was that boys get AIDS from girls. This was revealed in the discussions when both boys and girls alluded to boys getting AIDS because of multiple relationships. A disturbing finding in this study was that the boys and some of the girls, as young as they are, were being drawn into the belief that girls spread AIDS.

The children are able to link pregnancy and childbirth to AIDS, saying quite emphatically that the baby can gets AIDS when the baby is inside the mother or when the baby is born. It is a well-documented fact that whilst there has been a decrease in

MTCT, not all women are able to access the medication available, especially women living in poverty stricken conditions. The fact that these young children are able to make the link, points to a number of very important factors: these children have knowledge and experience regarding pregnancy and infected babies. It alludes to the way in which the children construct knowledge albeit grown-ups belief that children are unaware of such issues. It also points to the social context in which the children in this study exist, a context which has rendered the child knowledgeable of the link between pregnancy, death and AIDS. The children's knowledge also reflects their innate ability to perceive matters beyond their age and stage of development (Bhana 2006, 2007a, 2007b; 2008). We, as adults and teachers of children in early childhood need to accept that children born into this generation are far superior in terms of knowledge, maturity, experience and exposure. We have to adopt new lenses when we work with young children, we cannot deny that the children in this study are 'knowing', they know about HIV and AIDS, they are able to make meaning in matters relating to sex and sexuality and yes, their social context has influenced and shaped these young children's knowledge of disease, HIV and AIDS and sex. This study further identifies that the children's sexuality is brought to the fore and further developed within the socio-economic contexts in which they live.

It is clear that these young children, especially the boys, are drawn into the discourse where AIDS is feminised. The young boys in this study mention that the boys can get the disease by 'sleeping with the girls'. The association of the disease with female partners is reflective of the gendered dimension attributed to this disease. In any society multiple masculinities exist, reflecting factors like race, class, age, religious affiliation, stoicism and geographic location (Morrell, 2001). In South Africa, like many other African countries, dominant masculinity in Black cultures promotes multiple female partners. The number of girlfriends a man has, is a defining feature of what it means to be a man (Wood and Jewkes, 2001). Furthermore, ideals of masculinity define avenues for achieving manhood. It would appear that the boys in this study draw into this discourse, revealing the sexual elements of their masculinity hence the affirmation that 'I have five girlfriends' and 'I have two… I like it'.

5.3.3.2. Gender Violence

Children in this study are aware of the inherent dangers in their environments and in the prevailing context of South Africa. The children in this study either walk to school or travel via the Thokomala (Municipal Buses)/taxis. It becomes very clear that whilst parents aspire to send their children to a school outside their townships and zones, both parents and young girls are aware of the inherent dangers existing en route. The young girl in this study, although only seven years old, is able to link the words written on the taxi to something sinister. *'Say goodbye to your mother and your father, you are going home, ... the windows are black'* causes fear in the children and this is reflective of the society in which we and these children live. The children in this study talk of rape, a topic which was once, and in some homes, is still taboo. Children are not supposed to know about such issues. However this study compels us to review our perceptions of young children. The finding in this study is consistent with Bhana's (2006) study in which children show their vulnerabilities and demonstrate their lack of rights in the context of violence and rape.

Bhana (2006) writes that within the context of danger and poverty in which they live, the young girls sexualities are framed by the discourse of heterosexual danger, being vulnerable to HIV and AIDS, to older men and to rape.

5.3.3.3 Race, Social class, culture and gender

The children in this study draw on their personal knowledge in understanding HIV and AIDS. I concur with Bhana (2007a; 2007b) that impoverished children show themselves to be resourceful, knowledgeable and confident navigators of what many in the overdeveloped world regard as unchildlike contexts. Bhana (2007a; 2007b) states that the poor children at KwaDabeka, drew on much personal knowledge of the disease. Not only did they know how it was transmitted through sexual activity, but they also had a very clear idea of its impact. This rings true in my study: the children know how the disease is transmitted and they know that AIDS manifest itself in pain, suffering, loneliness and death. Class, race and gender mark their understanding of AIDS, gender and sexuality. In speaking of multiple girlfriends, the children implicate themselves, revealing that they know that the disease is spread through sexual contact; *'sleeping'* with the boy/girl, is the term they use to talk about sex. Given their social context and

the environment in which these children exist, their response to HIV and AIDS are thus comprehensible. According to the children in this study, Black people have the disease and they are responsible for spreading the disease. In South Africa, a country characterised by large differences in social class amongst the different population groups, there is a high prevalence of HIV and AIDS in poorer communities, which in South Africa, is majority Black. The children in this study come from the lower socio-economic group and reside in a Black township bordering the middleclass suburb in which the school is situated. The difference in the two communities is starkly vivid. In their social context, the children see poverty, suffering, illness, disease and death, whilst in the context of their schooling they see big homes, pretty gardens, high security, established infrastructure, a lot of fancy cars, etc, and it is within these confines, that the children connect HIV and AIDS to Black people. An important point to be noted here is that dominant Black masculinity is not confined to the rich sector of the Black population only. Dominant hegemonic masculinity models also prevail in the context of poverty hence the children's reference to multiple female partners; this understanding stemming from their understanding of the adult relationships that they are exposed to in their context. The lack of a father figure in the lives of many children in informal settlements is not uncommon. The absence of fathers in the context of illness and death is conspicuous in the child's drawing of her mother and herself. (See fig 2).

5.3.3.4 Myths, Misconceptions and Taboos

This study, similar to Bhana (2008) shows that HIV related stigma has deep social roots connected to race, class, gender, age and sexuality. Bhana (2008) draws attention to the issue of contagion and irrational anxieties that manifest in HIV and AIDS responses. In my study the children's association with contagion stems from inadequate adult attempts to educate children about AIDS. Children display irrational anxieties such as touching a person with AIDS causes infection. Whilst adopting a distancing strategy from the 'blood' of any human being is a protective factor, children at the same time need to know that there are protective mechanisms which can be adhered to in order to prevent AIDS transmission. The children's irrational anxieties arising from contracting HIV and AIDS by 'touching' is also insidious of the stigma accompanying HIV and AIDS. Sharing of personal items eg toothbrush and drinking from the same bottle stems from the ignorance that accompanies AIDS. In this school, the context of this study, I

have seen children taking turns sucking on a lollipop, I have seen children snatching juice bottles from other children and drinking from it without permission, I have seen children helping themselves to other children's lunches without permission. Whilst these issues need addressing, since children must learn habits which are conducive to good health and mannerism becoming of young children, the most important remains that young children must be relieved of associated misconceptions relating to HIV and AIDS. The children in this study also showed their ability to negotiate and navigate their involvement and association with children infected with HIV and AIDS. Whilst they described precautionary and self-regulatory practices to ensure their safety from contagion, they also expressed a great deal of care and compassion for victims of AIDS. Bhana (2008) points out that this has profound implications for efforts to stem the spread of HIV-related stigma and discrimination in South Africa as it highlights the contradictory discursive contexts within which young children give meanings to stigma.

Children are 'fluid' beings. They wander in and out of childhood, constructing their knowledge from situations arising in their social context; often seeking the safety of childhood when they feel that they have transgressed. This is apparent in the interviews with the children. Initially they were all excited to reveal just how much they knew about AIDS, but, they also realise that their knowledge, which borders the ambit of adulthood, displaces adult expectation of childhood. (See fig. 6: AIDS is for big people).

5.3.4. What are the implications for working with young children in addressing HIV and AIDS?

In this study, children adopted different stances with regard to HIV and AIDS education. Whilst some children showed resistance to being taught about HIV and AIDS, others defend their rights to know about such issues, claiming that they needed HIV and AIDS education in order to protect themselves when they grow up. The children in this study, both in resisting and advocating HIV and AIDS education, by informing us that HIV and AIDS is for big people , draws attention to the meaning they ascribe to HIV and AIDS. They see sex as HIV and AIDS, they understand that sex is something that grown ups engage in and therefore it is as an adult disease. It would be

reasonable to then understand some children's resistance to HIV and AIDS education in Grade Two.

In feminist poststructuralist terms, the reconceptualists are calling for new discourses of early childhood teaching and learning within new understanding of what constitutes good and/or appropriate early childhood practice. Silin (1995) points out that reconceptualist are producing new ways of understanding early childhood. This allows us to examine the social practices that constitute masculinity and feminity in our society such as dressing, acting, thinking, feeling and being. MacNaughton (2000) explains that we need to highlight the gendered nature of children's lives, our own part in this and the possibilities of freeing children from the constraints and inequalities that gender places on them.

MacNaughton (2000) further explains that we need to experiment with changing lenses through which we read children. MacNaughton (2000) asks us to examine how gender is lived and experienced by children and how this shifts over time and different spaces and adds that we need to examine how race, class, ability and sexuality influence the children's experiences and their educational lives. She also points out that the challenge is to find ways of seeing it that help us create greater opportunities for equity and justice in all children's lives.

Silin (1995) points out that the school is a safe place to make sense of complex and confusing realities. Teachers who believe in this approach are more likely to provide opportunities for critical social issues to become part of the curriculum. Silin (1995) states that for many children and for many adults as well, fear needs to be replaced by understanding, misinformation by facts. HIV is part of our daily lives and should be treated as such in schools. According to Silin (1995), to be meaningful, HIV and AIDS information should not be delayed till fourth grade science curriculum or sixth grade health class, where it may seem too abstract, removed from student's lived experience. Silin (1995) states that, questions about HIV and AIDS undermined the mutual pretence with which children and teachers fulfil their socially prescribed roles. The presumption that children are ignorant and innocent is belied by their concerns about a disease that we wished they did not know about.

5.4. Recommendations

With these authors in mind (Silin, 1995; MacNaughton, 2000; Bhana, 2006, 2007a; 2007b; 2008) and in the light of the findings of this study, the following recommendations relating to young children and HIV and AIDS are suggested:

1. There is sparse work around HIV and AIDS and children's ability to understand the disease. This is both a national and an international trend. There seems to be a lack of information on what children themselves think they need in order to avoid contracting HIV and AIDS and an unwillingness to act on these needs even when they are expressed. (UNFPA, 2005). This seems to be the case in South Africa. Whilst much research on HIV and AIDS and children has been conducted in South Africa, research which places children as constructors of knowledge is however sparse (see Bhana, 2006, 2007a; 2007b, 2008) as an exception. In the light of this, I recommend that further research, which positions young children as gendered beings and as being able to construct knowledge, be given priority. This is especially needed in South Africa, where HIV and AIDS is rampant and where violence against women and children is fuelling the pandemic.

2. In order to explore young children's agency relating to HIV and AIDS, it is necessary that class teachers engage children in issues relating to sexuality. Children must learn that it is normal to have feelings, know how to protect themselves from situations that can threaten their health and their lives. To date, HIV prevention efforts have focussed on individual behaviour modification (ABC's) and abstinence. In adopting this approach there has been, and still is, a general failure to take into account young children's lack of control over their own sexuality.

3. It is imperative that teachers in early childhood develop guidelines/frameworks of appropriate learning programmes in Life Skills relating to HIV and AIDS. Whilst the Department of Education has outlined a framework to address gender, sexuality and HIV and AIDS in school, it is necessary that each school creates its own learning programmes appropriate to age and gender. Furthermore, the learning programmes must take into consideration the social context of the children attending the school in order

for such programmes to be effective. However, it must be noted that these programmes can only be effective if the teacher firstly, is committed to equality in terms of gender; secondly, if the teacher is prepared to acknowledge that young children have agency and that young children are sexual beings with the capacity to think, feel and behave sexually. It is recommended that teachers of early childhood utilise opportunities presented by young children to educate them in order for children to grow up responsibly, respectfully and who can make choices later in life that can help them negotiate their way and protect themselves against HIV and AIDS.

4. The Life Skills learning area provides opportunities for teachers and learners to overcome fear, stigma and discrimination towards females and also towards people affected and infected with AIDS by engaging in the following:

- We instill in our children, both boys and girls, respect and tolerance. Children need to learn that HIV and AIDS is not passed on by girls specifically and therefore females should not be seen as vectors in the spread of the disease. Children need to understand that by feminizing the disease, we are discriminating against females.
- We, as teachers need to foster an understanding in young children that violence against women and children is wrong and unacceptable. Furthermore, that violence against women and children increases their vulnerability to HIV and AIDS, since most violence against women and children is gendered i. e. sexual violence and rape.
- We need to create a conducive teaching and learning environment in which the rights of all children are protected. In such an environment, we, as teachers of young children, need to dispel any form of AIDS-related stigma and discrimination in order to promote the inclusion of all children regardless of race, class or gender. In fostering such an environment, myths, misconceptions and taboos surrounding the disease can be dispelled. Children will instead be empowered with knowledge and choices that will help them to negotiate their individuality and identity as they grow up.
- Children's fears need to be allayed. Fear needs to be replaced by understanding, misinformation by facts.

5.5. Limitations of this study

- This study was done on a small scale in one school in the Durban area only. What is needed is more longitudinal research in the middle-class ex-Model C schools, predominantly Indian, predominantly Coloured and predominantly White populated schools that explores young children, age 7-9 response to AIDS. This kind of research will engage us in and enlighten us about young children's construction of knowledge in the context of HIV and AIDS. Such research will also provide information of the influence of the social context in the construction of knowledge in young children.

- This study could have also included teachers and their perceptions of early childhood education linked to HIV and AIDS.

- Language might have been a problem, since the participants were second language English speakers. Participants might have responded better if they were interviewed in their mother tongue.

5.6. Conclusion

This study explored the ways in which Grade Two boys and girls (aged 7-9) in a predominantly Black school constructed their knowledge of HIV and AIDS. The study also explored meaning is created in relation to HIV and AIDS and young children position themselves as gendered beings in the context of HIV and AIDS. By focussing on the construction of young children's identities in response to AIDS, this study demonstrated how children in responding to AIDS, enact their gender and sexuality. There is little work around gender and young children, let alone gender, HIV and AIDS and sexuality in children. This is because of the ways in which children are perceived to be nonsexual, degendered and without the capacity to think beyond a certain stage of development (See Bhana, 2006, 2007a; 2007b; 2008; Silin, 1995; MacNaughton, 2000 as exceptions). By drawing upon qualitative and feminist methodological approaches, this study positioned young children as having their own identities, as active participants who are capable of making meaning. This study show that AIDS is embedded within social, economic, cultural, political and ideological contexts and that the ways in which these children give meanings to HIV and AIDS is embedded within these contexts. The children in this study in responding to AIDS, informed us of their relationship to AIDS within social processes including sexuality, gender, race, class and

they showed us how these are actively acted upon. This study also showed that children positioned themselves as gendered beings with the capacity to think, feel and enact their sexuality and in doing so, they dispelled many notions which position young children as unknowing, asexual beings.

ACRONYMS

ABC: Abstain, be faithful, condomise (HIV and AIDS prevention message)

HIV: HIV stands for human immunodeficiency virus. It is the virus that causes
AIDS. It is passed from one person to the other through infected blood
and body fluids.

AIDS: Acquired Immune Deficiency Syndrome. AIDS is caused by infection with a
virus called human immunodeficiency virus (HIV). This virus is passed from
one person to another through infected blood and body fluids through
unprotected sex and sharing needles. People with AIDS are highly vulnerable to
life-threatening infections.

DAP: Developmentally Appropriate

HRW: Human Rights Watch

IPPF: International Planned parenthood Federation

MTCT: Mother To Child Transmission

UNAIDS: Joint United Nations Programme on HIV and AIDS

UNFPA: United Nations funds for population activities

UNICEF: United Nations International Children's Emergency Fund

WHO: World Health Organization

KEY CONCEPTS

APARTHEID: Apartheid was the system of racial separation that existed in South Africa until 1993. It was a policy developed to oppress dominate and control Blacks. Apartheid means separateness in Afrikaans. During apartheid black South Africans could only live in certain areas, were required to use separate trains, beaches, attend separate schools, etc.

CULTURE: Culture can be defined as all the ways of life including art, beliefs and institutions of a population that are passed down from generation to generation. Culture has been called "the way of life for an entire society. As such, it includes codes of manner, dress, language, religion, rituals, games norms of behavior such as law and morality, and systems of belief as well as the art.(Wikipedia)

DISCRIMINATION: According to the Joint United Nations Programme on HIV and AIDS, discrimination is any measure entailing any arbitrary distinction among persons depending on their confirmed or suspected HIV sero-status of health. Discrimination takes the form of unfair treatment based on colour, race, sex, religion or an illness,

Gender: refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. "masculine" and "feminine" are gender categories

INFORMAL SETTLEMENTS: Informal settlements (often referred to as squatter settlements or shanty towns) are dense settlements comprising communities housed in self constructed shelters under conditions of informal or traditional land tenure. They are common features of developing countries and are typically the product of an urgent need for shelter by the urban poor. As such they are characterised by a dense proliferation of small, make-shift shelters built from diverse materials, degradation of the local ecosystem and by severe social problems.

ORPHANS: The definition of 'AIDS orphan' used by UNAIDS, WHO and UNICEF is of a child who loses his/her mother to AIDS before reaching the age of 15 years. Some of these children have also lost, or will later loose, their father to AIDS. A child whose father dies typically experiences serious psychological, emotional,

social and economic loss. However, because reliable data on the number of paternal orphans are not available in many countries, the orphan statistics used by UNAIDS and UNICEF do not include children who have lost only their fathers.

Sex: refers to the biological and physiological characteristics that define men and women. Male" and "female" are sex categories. Sex also refers to the act of sexual intercourse.

SEXUALITY: refers to who we are as males or females, the way we dress, our behaviour, attitudes and our relationships.

SEXUALITY EDUCATION: Encompasses education that aims at developing young children from an early age to become responsible boys and girls and later on in life to become adults who are warm, caring and who can have satisfying relationships with other people. In sexuality education, children are also taught skills which will help them cope with life and especially difficult situations. Important values and attitudes are also established in children.

STIGMATIZATION: According to Bruce(2003) HIV-related stigma refers to all unfavorable attitudes, beliefs, and policies directed toward people perceived to have HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups, and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities--especially those of gender, sexuality, and race--that are at the root of HIV-related stigma.

APPENDIX 1: Request to Principal to conduct research at the school.

Consent Letter

The Principal: Durwest Primary School

1 McLarty Road

Reservoir Hills

Durban

4091

Dear Mrs R. Gobindlal

Re: Consent for learners to participate in Research Study.

I am currently studying for a Masters degree at the University of KwaZulu Natal. It is the requirement of the faculty of Education to undertake a research study. My research topic is : Young Children's responses to AIDS. The aim of this study is to explore the learners' understandings of AIDS. This letter seeks your permission to allow the learner to participate in the study. I am the sole researcher in this study. I have chosen this area of study because I want to know what knowledge our children have of AIDS since this pandemic has begun to influence and affect everyone in all spheres of life. This research will help educators to generate guidelines to instil knowledge, values and skills that are acceptable and desirable especially where millions of South Africans are affected by this disease. This study will also help to overcome and dispel any forms of discrimination towards people affected/infected with HIV and AIDS. This study will also provide valuable information to assist educators to support affected and infected learners.

All information gathered in this study shall be treated with the strictest of confidentiality. The names of the learners and of the school shall not be divulged at any stage of this research nor will it appear in the thesis. Learners have the prerogative to participate or not in this study and the learners are free to withdraw at any time during the research.

I look forward to your response.

Thanking you

Yours Faithfully

………………….

D. Jewnarain

Proposed Qualification: Masters in Education: Gender Studies

University of KwaZulu Natal

Edgewood Campus Tel: 031 (2625010) a/h 031 (2621067) b/h

Permission granted: …………………………

My Supervisor's Details are as follows:

D. Bhana, PhD

Associate Professor

School of Education

University of KwaZulu- Natal

Private Bag X03

Ashwood

3605

South Africa

Tel: 2731 2602603

Fax: 2731 2607003

Email: bhanad1@ukzn. ac. za

APPENDIX 2: Permission to conduct research at the school

APPENDIX 3: Letter to the education department requesting permission to conduct research at the school.

FOR ATTENTION: Mr S. R. Alwar
Department of Research, Strategy
Policy Development & ECMIS
Private Bag X9137
Pietermaritzburg
3200

PERMISSION TO DO RESEARCH AT DURWEST PRIMARY SCHOOL

TOPIC: YOUNG CHILDREN'S RESPONSES TO AIDS

THE RESEARCH WILL BE CARRIED OUT BY ME, MRS D. JEWNARAIN.

I WILL ENGAGE IN SEMI – STRUCTURED GROUP INTERVIEWS AND INDIVIDUAL INTERVIEWS.

PARTICIPANTS WILL BE ASKED THE FOLLOWING QUESTIONS

1. Group interviews: I shall ask the participants the following questions:
   1.1. What is AIDS?
   1.2. Who gets AIDS?
   1.3. How can you tell if a person has AIDS?
   1.4. Should your teacher talk to you about HIV/AIDS in school? Why?

2. Group work: I shall ask each participant to draw me a picture about AIDS.

3. Individual interviews: I shall ask the participants to explain their pictures to me.

MRS D. JEWNARAIN
MASTERS IN EDUCATION (GENDER STUDIES)
STUDENT NUMBER: 203520677
UNIVERSITY OF KWAZULU NATAL – EDGEWOOD CAMPUS

APPENDIX 4: Permission granted by the Department of education to conduct research at the school

APPENDIX 5: Permission granted to use the school as a research site.

APPENDIX 6: Consent letter to parents

Consent Letter

 2008-08-10

Dear Parent/Guardian

Re: Consent for learners to participate in Research Study.

My name is Mrs D. Jewnarain and I am presently teaching at your child/ward's school. I am currently studying for a Masters degree at the University of KwaZulu Natal. It is the requirement of the faculty of Education to undertake a research study. My research topic is: Young Children's responses to AIDS. The aim of this study is to explore the learners' understandings of AIDS. This letter seeks your permission to allow the learner to participate in the study. I am the sole researcher in this study. I have chosen this area of study because I want to know what knowledge our children have of AIDS since this pandemic has begun to influence and affect everyone in all spheres of life. This research will help educators to generate guidelines to instil knowledge, values and skills that are acceptable and desirable especially where millions of South Africans are affected by this disease. This study will also help to overcome and dispel any forms of discrimination towards people affected/infected with HIV and AIDS. This study will also provide valuable information to assist educators to support affected and infected learners.

For the purpose of this study, I shall engage in four contact sessions with the selected participants. The participants will also be informed as to their rights to withdraw at any time during the study . The interviews shall last approximately 20 minutes each and will be conducted during the life skills period

All information gathered in this study shall be treated with the strictest of confidentiality. The names of the learners and of the school shall not be divulged at any stage of this research nor will it appear in the thesis.

I look forward to your response.

Thanking you

Yours Faithfully

……………………… .

Mrs D. Jewnarain

University of KwaZulu Natal Edgewood Campus

My supervisor's details are as follows:

D. Bhana, PhD

Associate Professor

School of Education

University of KwaZulu- Natal

Private Bag X03

Ashwood

3605

South Africa

Tel: 2731 2602603

Fax: 2731 2607003

Email: bhanad1@ukzn. ac. za

APPENDIX: 7 Letter of informed consent for participants

Informed Consent

DURWEST PRIMARY SCHOOL

I, _____ parent/guardian of _____

In Grade Two give permission to Mrs D. Jewnarain to conduct group and individual interviews with my child/ward on the topic: Young Children's Responses to AIDS. I have been informed as to the nature of the study and I understand that my child/ward is under no obligation to participate in this study. I am also aware that my child/ward can withdraw at any stage of the interview should he/she not feel comfortable. I am also aware that all information obtained from my child/ward will be treated with the strict confidence.

Yours sincerely

_____ _____

Parent/Guardian Date

APPENDIX 8: Semi-Structured interview schedule

Examples of questions asked

1. Group interviews:

1.1. What is AIDS?

1.2. Who gets AIDS?

1.3. How can you tell if a person has AIDS?

1.4. Should your teacher talk to you about HIV/AIDS in school? Why?

2. Group work: I asked each participant to draw me a picture about AIDS.

3. Individual interviews: I asked the participants to explain their pictures to me.

ETHICAL CLEARANCE

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Notes
1. All names of the participants have been changed in line with the ethical principals of anonymity and confidentially.