

THE EXPERIENCES OF AN HIV POSITIVE
LEARNER IN A SECONDARY SCHOOL IN
KWAZULU- NATAL

“There is no hope for me.”
An HIV positive learner’s
dilemma of schooling...
‘THE SOUNDS OF SILENCE’

P. NASAREE

MASTER OF EDUCATION

(SOCIAL JUSTICE AND EDUCATION)

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**“There is no hope for me: An HIV positive learner’s dilemma of
schooling”
‘THE SOUNDS OF SILENCE’**

**HOW DOES AN HIV POSITIVE LEARNER EXPERIENCE
SCHOOL?**

P. NASAREE

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SUPERVISOR: DR. L. RAMRATHAN

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ABSTRACT

This study focused on how an HIV positive learner experiences her formal school. The purpose of this study was to understand and document the experiences of the HIV positive learner in the environment of the school. Her experiences in responding to the total school curriculum were recorded.

The participant was an HIV positive learner from a secondary school in Kwa Duguza. This study is a case study using qualitative methods of data collection. With the use of observation, interviews and document analyses, I was able to gather data on the HIV positive learner's experiences in school. The participant was observed in her school environment, she was interviewed and her academic and attendance records were analyzed.

The Data collected revealed that remaining in school for an HIV positive learner, who does not disclose her positive status to any one in the school environment, becomes increasingly difficult. The infected learner struggles to cope with the disease, the stigma attached to it and the demands of school.

The findings of this study outlines the challenge for schools to cope with the increasing numbers of infected and affected learners. The study concludes with fresh insights gleaned, implications and recommendations for all stakeholders involved in the process of education.

DEDICATION

*This dissertation is dedicated to my late
grandmother,
Mrs. A. A. Chetty,
who instilled in me
a deep
love of learning,
the value of
selfless service
and
compassion
for all living beings,*

And,

*To all the HIV positive female learners who
suffer in silence
and bear
their mental anguish
with
quiet
dignity.*

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To my parents, Mr and Mrs B Chetty for their unwavering support and encouragement.

DECLARATION

I, Padmani Nasaree, declare that this dissertation is my own work, and has not been submitted previously for any degree in any university.



RESEARCHER

SUPERVISOR

JANUARY 2005

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"You never really know a man until you stand in his shoes and walk around in them."

Atticus Finch – *To Kill a Mockingbird*, Harper Lee

CHAPTER ONE

1. ORIENTATION

1.1 INTRODUCTION

South Africa is in the grip of a devastating HIV/AIDS epidemic. Epidemiological studies, conducted by the Reproductive Health Research Unit of the University of Witwatersrand, South Africa, shows that the peak incidence of HIV/AIDS occurs in young people aged between 15 and 24 years. Research reports from the Department of Health from 1998 to 2003 reveal that the HIV/AIDS epidemic in South Africa is among the most severe in the world and it continues to increase at an alarming pace. According to the Government Gazette (10-08-99), in the ante-natal survey conducted then, the prevalence of HIV/AIDS among pregnant women under the age of 20 years had risen by a frightening 65.4%.

Not much has changed over the years as the research study, conducted by the Reproductive Health Research Unit of the University of Witwatersrand, on 'HIV and Sexual Behaviour among Young South Africans: A National Survey of 15-24 Year Olds', in 2003, has indicated that prevalence was higher among females in the 15 to 24 year old group than males. The research also indicated that 77% of young female South Africans are living with HIV/AIDS. According to Lovelife (2003) the province with the highest prevalence of HIV/AIDS infections is Kwa - Zulu Natal.

* Given the established fact as revealed by the research that 15 to 24 year olds are most at risk of being infected with HIV/AIDS and given the fact that many 15 to 20 year olds are still at school, South Africa has the challenge to reverse the course of the epidemic over the next five to ten years. The challenge calls for a committed effort from the government in all its sectors to develop strategies to cope with the epidemic. The epidemic challenges the education sector very especially to develop strategies to manage with the infected and affected learners in school (Department of Education Handbook on HIV/AIDS for Educators 2002).

* This however had not been an easy task to accomplish as when the new Mandela – led government came into power in 1994, funds and an action plan on HIV/AIDS were immediately mobilized. However the implementation of the AIDS policy has been characterized by a lack of progress and a breakdown of trust and co-operation both within government and between government and the non- governmental organizations contracted to implement the action plan. Hence not much was done to stem the tide of the pandemic, except conjecture (Abdool- Karim 1998). In the meanwhile infection rates continued to escalate in the 15 to 24 year old group (Lovelife 2003).

In 1999 the then Minister of Education, Professor Kader Asmal, launched a five year plan, 'Tirisano', to transform the education system in South Africa. This programme aimed at addressing educational, health and social needs of learners and included programmes of sexuality, gender, school safety, health and skills development. The Minister identified nine priorities, which have been organized into five core- programmed areas in the implementation plan. The scourge of HIV/AIDS was the first of the five core programmes. This programme was translated into policy that was to be followed by the schools in the Life Orientation learning area. As a result of the increasing number of infected and affected learners it became the responsibility of the education sector to deal urgently and purposefully with the HIV/AIDS emergence through life skills and sexuality education. According to Badcock-Walters (2000), medically, hope seemed a long way off, education and prevention are the only recourse in this present time of crisis. He contended that education can not produce a medical solution but it can help manage the problem by converting schools from high risk to low risk environments in which behaviour change and choice can be addressed and properly communicated. The view that the so called education vaccine means that education together with strong political commitment could become the strongest weapon against HIV/AIDS was shared by many (The Sunday Times, 2002). Thus education became the most important sector in the fight against the epidemic.

In 2001 the National Policy on HIV/AIDS was translated into practice at schools. Schools seemed to have been the most logical ground to counter the spread of the HIV/AIDS epidemic through extensive educational programmes on sex and sexuality education. To this end various workshops were held provincially in numerous districts by the Department of Education on HIV/AIDS and sexuality education for educators. Educators were required to return to their respective schools and develop an HIV/AIDS policy with all stakeholders for their school.

• Various challenges arose with the implementation of such a policy, viz, parental objections to sex and sexuality education, lack of educator knowledge, lack of training for educators to facilitate learning on sex and sexuality education, lack of resources and a general apathy to the HIV/AIDS epidemic by some educators. The programme was implemented in some schools and not in others. The implementation of the life skills programme varied between and within provinces. In largely rural provinces the implementation was less successful compared with the urban areas, for instance, the implementation of life skills was severely constrained in rural disadvantaged schools whilst in urban areas of the same province the implementation was promising (The Department of Education HIV/AIDS Workshop 2001).

Whilst there is a hopefulness of the Department's policy to prevent HIV/AIDS, the implementation, translation and practice of the policy was marred by challenges inherited by the apartheid system of education (The Department of Education 2002). However, many workshops organized by the Department of Education continued in its endeavour to workshop educators on the seriousness of the pandemic. Whether these workshops are successful or not in cascading the information to the schools is not followed up by the Department of Education.

The policy currently in practice in schools is a formal education on HIV/AIDS, sexually transmitted diseases, sex and sexuality which forms part of the syllabus requirements for the Life Orientation programme for grade eight and nine learners. The message of the syllabus requirements include among others that:

- ✓ HIV/AIDS is very much the result of intentional sexual behaviour.
- ✓ Sexual behaviour, which is both a need and a lifestyle, can be changed to reduce the risk of contracting HIV/AIDS.
- ✓ Behavioural change can at least limit the spread of HIV/AIDS whilst medical 'cures' are being tested.

It was hoped that by presenting learners with the facts on sex and sexuality, HIV/AIDS, and the fear of the disease learners will alter their sexual practices. The syllabus further propounds the notion that HIV/AIDS need not be a disease of epidemic proportion if informed, responsible and reasonable learners take the necessary precautions in their personal and sexual behaviour. However this attempt to legislate for the conscience failed dismally as in the year 2001, according to the Department of Education's, HIV/AIDS Programme for Secondary Schools, 95 000 learners between the ages of 6 to 15 are living with HIV or AIDS (HIV/AIDS Life Skills Resource Guide for Educators 2003). Clearly the reality then, in our South African schools is very different. The programmes implemented in schools are very hopeful in deterring and delaying learners from engaging in their first sexual experience but these programmes do not cater for the learner in school who has already been infected with the HIV/AIDS virus. No programme has been formulated that effectively supports the infected and affected learner within the school environment. The crises continues to affect schools as more and more learners are HIV positive as the research statistics indicate (Department of Education, A Guide for Educators, 2003.)

✧ The Department of Education and the Department of Health have a comprehensive policy on HIV/AIDS knowledge and prevention, targeting schools, community-based, regional and national organizations, and the general public, yet, there still seems to be an alarming statistics of infected adolescent and young adult learners in schools (Department of Education, Handbook for Educators 2002).

Children and adolescents below the age of 19 years make up half of the South African population of 44.8 million. The transition to democracy has made schooling compulsory which means that large numbers of young people are now engaged in the process of learning. A large number of forces encourage youth to engage in sexual activity (e.g. changing hormones, emotional and physical needs and desires, peer pressure, norms promoting sexual risk –taking and the omnipresent inaccurate portrayal of sex in both visual and verbal media). In addition, in my experience, it is known that significant underlying factors such as the many manifestations of poverty and family and community disorganization are related to sexual risk-taking behaviour. Therefore the programmes implemented by the Departments of Education and Health face daunting challenges.

Thus it may not be reasonable to expect that a relatively short educational programme will overcome all of these factors and have a very dramatic impact upon sexual behaviour. Further it should be understood that most educational instruction is evaluated by assessing the impact of instruction upon knowledge, not upon behaviour outside of school. Therefore many of our adolescent learners are vulnerable to risk taking behaviours and many engage in such behaviours. Whilst HIV is a non-notifiable disease, the challenge now lies for educators to manage the HIV positive learner in school. The purpose, therefore, of this study is to explore how an HIV positive learner experiences school.

1.2 AIMS OF THE STUDY

The study aims to explore how an HIV positive learner experiences formal schooling.

1.3 CRITICAL QUESTION

1.3.1. How does an HIV positive learner experience school?

1.4 RATIONALE

I have been an educator for the past eighteen years. I have taught in the ex- House of Delegates (associated with the past political dispensation of South Africa) schools for a period of nine years and my interaction was with learners from the Indian background. The school that I taught in was classified as an advantaged school with a learner population coming from the average to upper socio-economic backgrounds. When measured against other Indian schools in the House of Delegates era our academic and non-academic successes were many and our socio-economic challenges were few.

However in 1994 with the coming of democracy the demographics of public schools in South Africa changed. The school that I taught in was changing to keep up with the principles of our fledging democracy. Gradually the demographics of each class in my school began to change and it was in the year 2001 that I had a fully representative class of our new democracy. This was a milestone in my teaching career.

My experiences in this class were somewhat different from my experiences with my previous learners. I was faced with a different reality. A new set of factors both, positive and negative, penetrated the reality of school and teaching for me. These included, on the positive side, greater sporting achievements, multi-cultural interactions, better race relations and understandings, new ways of thinking and behaving, new customs and traditions, shared rules and ideas, bridging modules for lessons, new habits of dress, diet and daily routines, a revision of the language policy document and greater participation in cultural and ethnic events. On the negative side issues of poverty, absenteeism, teenage pregnancies, sexual and physical abuse, lower socio-economic realities, language barriers, sickness and behavioural problems reared its ugly head challenging all role players involved in education at the school to work together on issues for the betterment of the learners and the school. Slowly but surely I was able through a process of continuous

reflection to fully immerse myself in the role that I had to perform as an educator in the new South Africa.

The HIV/AIDS workshops began in 2001 and I was fortunate that I was selected to attend a four day workshop on the HIV/AIDS pandemic that affected our schools. Subsequently I was to cascade the information to staff at a staff-meeting at school. Educators had to inform learners on the HIV virus and prevention strategies. Various programmes were held to observe Aids Day as a calendar event at school. Personnel from the Department of Health and Welfare lectured our learners on the pandemic and stressed abstaining from sexual activity.

In 2002 the Department of Education continued with the programme of informing educators on HIV/AIDS and its effects. In 2003, the Department of Education with the aid of Non Governmental Organisations preached abstinence to learners emphasizing the message that true love waits. Learners at my school were asked to sign pledges supporting the message that true love waits.

Only towards the latter half of 2003 did the Department realize the theoretical knowledge of HIV/AIDS is not having an effect on learners as learners were still engaging in sexual behaviour as revealed by the (The First African National Youth Risk Behaviour Survey 2002).

In 2001 I was nominated as lay counselor and the HIV/AIDS co-ordinator at my school and after attending the workshops it was my task to set up a peer counselling support group at school. The Department of Education's Psychological and Guidance Services trained the peer counselors. Together we were empowered to offer our services and demystify the disease on a small scale through intensive campaigning, vigorous discussions, lunch- time theatre activities and visual and literary displays in our counseling room. We were initially viewed with scepticism and gradually a few of our senior learners disclosed their status to us and we duly referred them to the local clinic and welfare department for further help.

It was interesting to learn from the HIV positive learners of a shroud of secrecy and silence coupled with the widely held belief that if one is HIV positive, one is bewitched, cursed by God or one is evil and promiscuous. These beliefs together with fear and intimidation prevented learners from seeking our assistance or help in general. Further it was learnt that HIV/AIDS is an attempt by the Whites to get rid of the Africans and it is cured by sleeping with a virgin or drinking a bitter medication from the root of the African Potato plant. In our interactions with learners it was difficult to dispel such myths. What emerged though was a frighteningly simplistic understanding of the cure and the impact of the AIDS pandemic. It seemed as though in the infected and affected learner's desperation to search for answers learners were willing to believe anything.

With the information disseminated at school one learner from grade eleven approached me and was terrified about the disease that she had, had for four years. She had sores that were oozing throughout her body. She had been to the local doctor who confirmed that she was HIV positive and she was terrified and devastated as she could not inform her parents that she had been ill. She had to endure the trauma of non- disclosure for four years during which the disease developed into full- blown aids. Her drastic weight loss and frequent absenteeism caused much concern and suspicion from other learners who often ridiculed and threatened her. She failed and did not return to school. Another HIV positive female learner from grade ten succumbed to the same fate. The research that was conducted on the latter learner could not be published as she feared for her life and received death threats from her community. The research conducted on the former learner could also not have been published as the guardian of the learner prohibited such research for fear of death threats to the learner and the social stigma to her sibling who is still at school.

From the above experiences my curiosity was aroused and I wanted to understand the practicality of the Department of Education's policy that stated, that learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability

(HIV/AIDS Document 1999). With HIV positive learners enduring non-disclosure, hostile communities, ridiculing peers, the demands of schooling, unforgiving parents and guardians and the medical and psychological consequences of the illness- how does such a learner experience formal schooling?

With the establishment of our peer- counseling group at school I was introduced to Angel (not her real name) who agreed to be a part of my research study. I was introduced to Angel by Audrey, my student counselor at school. Angel attends our sister school in Kwa Duguza. Our relationship was strengthened by our willingness to assist her in all facets of coping with her illness. Angel was willing to reveal her experiences as an HIV positive learner, in the senior phase, at a secondary school. Angel is an adopted pseudonym, a name change had to be done to assure the participant of confidentiality. Whilst the name of the learner had to be changed the impact of the disease on the experiences of the learner at school must not be diminished.

In 2004 the National Improvement Plan, (NIP), initiated by the Department of Education found it necessary to aggressively inform educators on the care of infected and affected learners at school since many infected and affected learners attend school as revealed by the (Department of Education, Handbook on HIV/AIDS for educators 2002). The reason is that the Department of Education acknowledges the seriousness of the epidemic and sees education as the only means of supporting the HIV infected and affected learner. The legislation passed had made it compulsory for schools to implement an HIV/AIDS policy at schools modeled on the National Policy Document. The National Policy on HIV/AIDS prevents unfair discrimination on the grounds of HIV/AIDS status. The Department of Education via the policy seeks to contribute towards promoting effective prevention and care within the context of the public education system. The policy on HIV/AIDS reinforces that sexuality, morality and life skills education be provided by educators. Sexually active persons should be advised to practice safe sex and to use condoms (National Policy on HIV/AIDS, August, 1999). The policy legally assures the positive learner's right to a full education but

does not stipulate how HIV positive learners must be supported in schools. Information gathered from the workshops that I attended in 2002 and 2003 was that various problems arose with the interpretation and implementation of the National Policy on HIV/AIDS. Many schools currently do not have an HIV/AIDS policy as yet. There are no means for evaluating the successes of policy implementation by the Department. So in essence then, a policy is only as good as it is implemented and HIV positive learners continue to remain marginalized by unimplemented policies, social stigmas and non- disclosure.

Therefore this study attempts to present an analysis of how the HIV positive learner experiences school so that it may influence how the policy can be implemented contextually. All research and policies reviewed are not from people experiencing HIV, therefore this research gives me the insider's perspective on how an HIV positive learner experiences school. It provides me with a unique window to see school through the eyes of a positive learner so that I see problem areas within the school organization, educator interaction, learner interaction that will allow me to correct, advise policy formulators, school managers educators and learners.

In our South African society HIV/AIDS has a stigma that no other disease or illness shares. Apart from the social stigma HIV/AIDS is transferable and the consequences of transference is potentially fatal. It is a social disease transferred predominantly through sexual intercourse. Statistically the most affected group are school going teenagers who are exploring and discovering their own sexuality. Therefore it is necessary to research this area with a view towards understanding sex and sexuality as viewed by the learner and to design policies that will influence effective teaching at school. The research aims at managers and educators at school to destigmatize HIV/AIDS and most of all to restore the dignity of the HIV positive learner.

1.5 WHY THE SENIOR PHASE LEARNER?

The senior phase learner is generally the mid to late adolescent or the young adult. Adolescence, according to Ornstein & Levine (1989), is a period characterized by emotional, mental and moral confusion and it is a crucial period of development for the learner personally. Psychosocially, the concerns reign over identity versus role confusion, sex roles and occupational choice. Cognitively, this stage is characterized by the increasing ability to engage in mental manipulations, understand abstract thought and test hypotheses. Morally the development is concerned with the increasing willingness to think of rules as mutual agreements – co-operation- and to make allowances for intentions and extenuating circumstances. Achievement of sexual maturity has a profound influence on many aspects of behaviour. Peer group and reactions of friends are extremely important. Concerns with issues of life after school begin to manifest itself. There is an awareness of the significance of academic ability and the importance of grades for certain career paths. There is a need to make personal value decisions regarding sex, peer influences and a code of ethics. In addition to this the senior phase is characterized by personal course selection and preparation for exit from school (Biehler & Snowman 1990). The senior phase learner's academic, curricular and co-curricular programme is crammed with both formal and informal, academic and social activity within the school. Therefore if the infected population falls largely within the mid to late adolescent and young adult learner, it becomes necessary to research and to understand how an infected learner experiences school.

1.6 RESEARCH METHODOLOGY

A case study methodology was adopted in this study. Case studies usually detail in depth the phenomena under exploration. It is usually context bound. The study adopted the case study approach as it attempts to document an in depth analysis of an HIV positive learner's experience of schooling. Research with regards to this study was conducted by examining the relevant literature, and the use of qualitative research methods comprising of observations, semi-structured interviews and document analysis.

1.7 LIMITATIONS OF THE STUDY

This research study is dependant on a learner willing to disclose his/her HIV status. Therefore, this study is a case study of one learner from a neighbouring school in Kwa Duguza who disclosed her positive status. This learner did not disclose her status to any one in her school, except that, she believed that her geography educator indirectly knew of her problem. Her non- disclosure of her HIV status to any educator in her school, together with the stigma and fear of the disease added further constraints to the research study. Agreements with regards to the anonymity and safety of the learner, time constraints and availability of the learner for interviews had to be negotiated and re-negotiated to ensure participation in the research study. These factors made collecting data extremely difficult and challenging. The sensitive nature of the research study is a limitation in itself as it is dependant upon disclosing ones positive status which is difficult to do.

1.8 CHAPTER OUTLINE

Chapter one introduced the study. Chapter two provides an overview of the literature perused for the study. It also presents the theoretical findings and discusses the conceptual framework adopted for the study. Chapter three presents the methodological choices guiding the study. The interpretive paradigm allowed me to structure the observation schedule and the semi-structured interviews necessary for the study. Chapter four presents the findings of the study with a discussion of the observation schedule and common themes that emerged from the interviews. It also presents a discussion of the learner's academic performance based on the academic records of the learner. Chapter five presents the insights of the study and sets out the recommendations for the Department of Education, educators and policy planners. It also presents the conclusion to the study.

1.9 CONCLUSION

This chapter gives the reader the background information and rationale for the study. The next chapter presents the literature review and the theoretical and conceptual framework for the study.

“The HIV/AIDS epidemic as it is unfolding in our schools and learning institutions, and higher education right across the entire sector, can no longer be treated as we have done in the past. We need to place education at the heart of the entire national response to HIV/AIDS because education represents the only hope for the future of AIDS-free society.”
Professor Kader Asmal, MP and Minister of Education (June 2002)

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter a comprehensive review of the literature will be discussed to enable me to understand the impact of HIV/AIDS internationally, within the African continent and South Africa. I also attempt to examine educational initiatives in countries in Africa and South Africa in responding to the pandemic. It also allows for a critical discussion on policy implementation and the development of a theoretical and conceptual framework.

2.2 CONTEXTUALISING HIV/AIDS AND THE ADOLESCENT

When AIDS emerged from the shadows two decades ago, few people could predict how the epidemic would evolve and fewer still could describe with any certainty the best ways of combating it. We are now past the stage of conjecture and we have read from both the visual and verbal experiences that AIDS can devastate whole regions, knock decades of national development, widen the gulf between the rich and poor nations and push already stigmatized groups closer to the margins of society. Just as clearly as it destroys, the right approaches applied quickly and with enough courage and resolve can and do result in lower HIV infection rates and less suffering for those already infected and affected by the disease (UNAIDS 2001).

Media reports in South Africa, indicate that our efforts are just not enough and unless drastic action against the epidemic is scaled up drastically, the damage done will seem minor in comparison to what lies ahead. Twenty years after the first clinical evidence of the Acquired Immunodeficiency Syndrome was reported, HIV/AIDS has since become the most devastating disease humankind has ever faced. Since the epidemic began HIV/AIDS is the leading cause of death in Sub-Saharan Africa. At the end of 2001 an estimated 40 million people were globally living with HIV/AIDS (van Dyk 2001).

According to UNAIDS (2002), in many countries throughout the world, sexually transmitted disease and unplanned pregnancies have always occurred among adolescents. However during the last few decades, the onset of puberty and initiation of sexual intercourse occurred at decreasing ages in many industrialized and developing countries. Thus many adolescents began having sexual intercourse with multiple partners at an early age, and this, of course facilitated sexually transmitted infections and HIV (McWhirter et al 1993).

According to the UNAIDS (2000) report, in many parts of the developing world new infections occur in young adults with women being especially vulnerable. Globally an estimated 11.8 million young people aged 15-24 were living with HIV by mid 2002. In South Africa about one third of those currently living with AIDS are those aged between 15 to 24 years. About half of all new infections worldwide, or approximately 6000 per day occur among young people. Because many HIV infected adolescents and young adults have not been tested for HIV and their HIV status is not known, and also because of the typically long latency period before the development of clinical AIDS, many cases of HIV/AIDS that are identified among people in their 20s have been acquired during their teen years (UNGASS 2001). Many of them do not know that they carry the virus for various reasons and many millions more know nothing or too little to protect themselves against it (UNAIDS 2001/2002). Adolescents in general are at risk of contracting HIV through sexual transmission because a large majority engage in sexual intercourse, have multiple partners over a period of time and fail to consistently use a condom during every act of intercourse. In addition many young people also become infected with other sexually transmitted infections that facilitate the transmission of HIV. There are also some adolescents who engage in unprotected sex for drugs thereby becoming high- risk individuals for HIV. In some countries because of the escalation of physical, emotional and sexual abuse of females, HIV transmission is common (UNAIDS 2002).

2.2.1 Educational implications on adolescents infected and affected by HIV/AIDS

The patterns presented above (2.2) have important implications for educational programmes. First they suggest that there should be effective HIV education programmes for young people. Furthermore they suggest that there should be additional, more focused programmes targeting those adolescents who are more vulnerable to HIV. Programmes must also cater for the sexual orientation, culture, background and behavioural patterns of adolescents.

According to Barnett and Whiteside (2002), several countries around the globe have implemented successful HIV/AIDS education policies. In these countries the total commitment of government and strong, leadership together with effective implementation and evaluation of policies on HIV/AIDS resulted in curbing the spread of the disease. For example in the United States, sexually transmitted diseases and HIV education programmes have been implemented in a variety of settings including schools, family planning clinics, churches, youth serving agencies, housing projects, homeless shelters, detention centers and in communities. In addition aggressive social marketing and media approaches were used. Regular evaluations of the successes of the programmes were undertaken by various organizations and this reduced the transmission of HIV. Evidently there is hope through educational interventions (National AIDS Policy, Washington 1996).

The African countries south of the Sahara have some of the best HIV surveillance systems in the world. They provide solid evidence that the HIV infection rates has stabilized at a relatively low level in Senegal and that the extremely high rates in Uganda have been reduced. However in most sub-Saharan countries adults and children are contracting HIV infection at a higher rate than ever before. About 71% of the world's HIV infections occur in sub-Saharan Africa (van Dyk 2001).

Currently there are 16 countries in sub-Saharan Africa in which more than one – tenth of the population aged 15 to 49 is infected with HIV. In seven of these countries at least one adult in five is living with the virus. South Africa has the largest number of people living with HIV/AIDS in the world. Studies conducted in 11 African countries including South Africa between 1995 and 1998 found that prevalence rates of infection among teenagers and women in their early 20s are frighteningly high. In 7 of the 11 countries more than one woman in five in her early 20s was infected with the virus. A large portion of them will not live to see their 30th birthday. Close to 6 out of 10 women in the 20 year old age group in the South African town of Carletonville tested positive for HIV. Recent antenatal clinic data showed that several parts of Southern Africa have now joined Botswana with prevalence rates among pregnant women exceeding 30% (van Dyk 2001).

According to Barnett and Whiteside (2002), since the early 1990s it has been clear that HIV would undermine development in countries affected by the virus. Falling life expectancy, increasing numbers of orphans, extra costs for businesses and the total devastation of family and community structures are becoming increasingly visible in South Africa. HIV/AIDS has become a full-blown developmental crisis. Its social and economic consequences are felt widely not only in health but in education, industry, agriculture, transport, human resources and the economy. This destabilizing effect also affects fragile and complex geopolitical systems. According to the United States Census Bureau the population pyramid will be greatly affected by the deaths of the adolescent and young adult population as a result of the HIV/AIDS pandemic (van Dyk 2001).

According to the UNAIDS report (2002), the premature death of a large part of the young adult population, typically at an age when they can contribute to the economy, start their own families and become economically productive can be expected to have a radical effect on every aspect of economic and social life. The AIDS epidemic has a profound impact on growth, income and poverty. It is estimated that the annual per capita growth in half the countries of sub-Saharan Africa is falling by 0,5% to 1,2% as a direct result of AIDS. As an index of

existing social and economic injustices the epidemic is driving a ruthless cycle of impoverishment. People at all income levels are vulnerable to the economic impact of HIV/AIDS but the poor suffer most acutely.

The few surveys of the impact of HIV/AIDS on households reveal a dramatic decrease in household income. In hard hit rural areas in South Africa, rural families experience a decrease in their agricultural output which threatens their food supply. Children are often taken out of school to take care of the elderly and themselves. Households headed by orphans are becoming common in South Africa (UNAIDS 2001).

Given the proportion of young adults infected with HIV and dying from associated diseases in Africa it is inevitable that the business, agriculture, health, education, families, schools and other sectors will feel the cost. Education is an essential building block in a country's development. In areas where HIV is common, HIV related illnesses is taking its toll on education in a number of ways. Firstly it is eroding the supply of teachers and thus increasing class sizes, which is likely to detract from quality teaching. Secondly it is depleting family budgets, reducing monies for school fees and increasing school dropouts Thirdly it is adding to the pool of learners of AIDS orphans (Department of Education Handbook 2003). In Swaziland, according to van Dyk (2001), school enrolment is reported to have fallen by 36% due to aids, with girls most affected because they have to take care of ill family members. In many parts of Africa, teachers are also becoming too sick to work and they die of HIV related illnesses long before retirement. In the Central African Republic, AIDS was the cause of 85% of the 300 teacher deaths that occurred in 2000 (van Dyk 2001).

HIV/AIDS exposes, according to Fleishman (2003), the connections between gender inequality, violence sexuality and poverty against women. According to statistics in sub-Saharan Africa women make up 57% of the HIV infected population. Physiologically women are more prone to HIV but added to this are a whole host of social, economic and personal inequities that make women more

vulnerable to HIV infections. Compounding the problem against women is the factors of male myths and machismo, poverty and discrimination, infection by husbands and ignorance. The social and economic empowerment with governmental support and strong leadership of women, is key to curbing this inequality (UNAIDS 2002).

Clearly from the literature reviewed it is evident that HIV/AIDS has reached epidemic proportions in sub-Saharan Africa. It is a sign of crisis and also of opportunity, a sign of desperation and also of hope. It is easy to get caught up in the negativity and hopelessness of the HIV/AIDS pandemic as it manifests itself around us and yet the challenge to us in every sector is profound. Research, in countries like India, The United States, Russia and many African countries have shown that there are effective measures that the various sectors can take to respond to the epidemic. A study cited in van Dyk (2001), revealed that Zimbabwean factories demonstrated that strengthened prevention efforts in the workplace can reduce HIV transmission. Workers in these factories were given information about preventing HIV infections and were offered voluntary counseling and HIV testing. The factories also made peer counselors, condoms and sexually transmitted infection treatment available to its workers. Uganda has brought its estimated prevalence rate down to around 8% from a peak of close to 14% in the 1990s by means of extensive education and vigorous prevention campaigns directed by a determined government to curb the epidemic. There are encouraging signs that Zambia maybe following the signs chartered by Uganda. The HIV prevalence rate among 13 to 19 year girls in Uganda has fallen significantly over an eight year period. Sexuality education and the distribution of condoms is partly responsible for the decline (UNAIDS 2001). According to Barnett & Whiteside (2002), the key feature of Uganda's response was leadership. This ensured that AIDS was constantly on the agendas and people were not stigmatized. It began with President Museveni's talking frankly and openly about AIDS as early as 1986. The Ugandan president insisted that AIDS be on the agenda at all levels including religious leaders- Protestant, Catholic and Muslim –were brought into the process and played important roles in prevention processes. Botswana followed the same

political commitment as Uganda and was able to reduce HIV infections drastically. The research reviewed revealed that stronger political leadership is necessary and it should cascade to all government departments to fight the scourge of this epidemic. Research also reveals that higher education levels correlate with lower infection rates among the youth and adults. Therefore according to Badcock- Walters (2000), schools are in an ideal position to reach children in the window of hope age group of 5 to 13 years.

2.2.2 Educational initiatives in South Africa in responding to the epidemic

According to Badcock- Walters (2000), HIV/AIDS is a development issue and the largest single management challenge facing education. It will directly or indirectly impact almost every aspect of management, teaching and learning for a very long time to come. Education cannot produce medical cures but it is the only vaccine we have against HIV/AIDS. The Impact can be reduced by developing practical, systemic responses to be implemented at all levels. It is possible to design policy and practical counter-measures to mitigate the impact of HIV/AIDS. South Africa is a middle- income developing country, with a mixture of First and Third world economies and a large gap between the rich and poor. The extremes of wealth and poverty are due to 350 years of colonialism and apartheid (Department of Health survey 2002). Prevention of initial infection is one of the biggest challenges a marginalized society faces. Many programmes have often failed because of the lop-sided approach taken to address the HIV/AIDS issue. The message of government was often misguided. In essence many messages boiled down to 'have sex as long as you do it safely.' What is it about human nature that has people engaging in risky behaviours rather than avoiding it at all costs? The AIDS statistics soared as a result of this kind of message. Although Apartheid is no longer the declared enemy, some of its consequences are still with us, viz, poverty, the effects of inferior education, poor health care, power inequities, gender inequalities, domestic violence and sexual abuse. The government realized that there is no room for complacency and prevention work needs to continue vigorously to address people in groups who remain vulnerable and further the

AIDS issue is an issue of social justice and involves the protection of everyone. Thus multi-sectoral approaches needed to be employed with education being the fore runner in saving vulnerable members of our communities. This is evident in political statements like the five year Tirisano Plan for Education which gave the HIV/AIDS issue special priority.

The AIDS world prior to 1994 was characterized by strong networks between non-governmental organizations, researchers, sympathetic health workers, an infrastructure of AIDS counseling and information centers in metropolitan local governments and the anti-apartheid political groupings. The expectation was that enlightened forces in civil society would work together with the new government to steer the rapid implementation of a well formulated and rights-oriented National AIDS plan. Yet by the end of 1998 little of this rationalist idea materialized (Abdool-Karim 1998).

In 1990 as a consequence of multiple pressures a first series of annual national surveys in antenatal clinic attendees found an HIV prevalence of 0,8%. By 1991 the figure had doubled. It had become abundantly clear that South Africa was in the early stages of a rapidly growing virus. In October of 1992 The ANC and the Department of Health convened a conference on AIDS in South Africa. It led to the launching of the National AIDS Committee of South Africa an umbrella body whose duty it was to co-ordinate the aids plan in the country. A creative period of policy development followed by the task team. The policy was a broad mobilization, consensus on the need for a non-discriminatory approach to aids and the formulation of an AIDS Plan with an immediate set to be implemented over two years. Thus the AIDS Plan emerged with government playing a central role (Abdool-Karim 1998).

However the incidence of HIV still continues to rise at alarming proportions. In 1994 the new government immediately developed the AIDS plan and set about mobilizing resources and establishing an AIDS Programme. Along with twenty other social priorities AIDS was declared a "Presidential Lead Project." This gave

the HIV/AIDS project special status and early access to resources set aside for reconstruction and development. However lack of political will or commitment is a reason for the successful difficulties in implementing the policies in South Africa. After many controversies, there was a huge outcry from all sectors for accountability from senior government on the crisis developing from HIV/AIDS. What was needed was an attempt by both the formal and informal sectors to work together on the epidemic proportions of HIV/AIDS. What developed were initiatives to target educating the public on HIV/AIDS through massive advertising and media campaigns. However this planned programme did not have the desired effect that it was envisaged to have as it was not reaching the most affected part of the population. Thereafter a multi-disciplinary approach was needed spearheaded by the government, including all government departments to counter the spread of HIV/AIDS. It became evident that with the rapid spread of the disease Education was the only means to counter the spread (Soul City 1997).

Despite early resistance and ongoing debates and contradictions various community –based and media (both visual and verbal) programmes had been introduced. Recently, Lovelife, a national campaign on youth sexual health started a mass media campaign to address and advise on issues of sexual health, the underlying causes of HIV, gender issues and sexual coercion. Unfortunately these campaigns only reach the majority of the urban population and neglects the rural areas where the incidence of HIV is greater.

Until late 1999, according to Coombe (2002), The Department of Education had no policy on HIV/AIDS. In August 1999 The Department's Corporate Plan 2000-2004 identified five priorities with HIV/AIDS being one of them.. The objectives related to HIV/AIDS were highlighted, viz:

- ✓ Raising awareness about HIV/AIDS among educators and learners,
- ✓ Integrating HIV/AIDS curriculum,
- ✓ Developing models for analyzing the impact of HIV/AIDS on the Education system (Coombe 2002).

The problems of policy implementation still continues to hinder the Life skills curricula from province to province. There is evidence according to Coombe (2002), that only 15% of schools have a policy on HIV/AIDS. In 2000, the new minister prioritized HIV/AIDS in his 'Tirisano' plan of action (Guidelines for Educators, 2000). The 'Tirisano' document sees education more particularly schools as the most logical ground to counter the spread of the epidemic via extensive educational programmes on sex and sexuality. This was an holistic approach as it focuses on gender issues, developing self esteem, conflict resolution, building a democratic school culture and securing schools against violence. Hence in 2000 and 2001 the Department of Education legislated that sex and sexuality education be part of the formal curriculum in the Life Orientation learning area. But, according to Ngcobo (2002) the co-ordination of the programme is still being improved within departments and districts. There have been problems with co-ordinating workshops to train educators and providing support materials. The absence of local communities in the design and implementation on the training programmes had a negative effect on the success of HIV programmes at school. Parental objection to sex and sexuality education also affects the programme. Therefore many hurdles have to be overcome before a successful programme can be implemented.

The challenge remains, for us as educators to formulate our own policies to counter the spread of the HIV virus and to provide the best service we can with our own innovations, in our school sites, to our learners in this time of AIDS. The National Youth Risk Survey (2002), reveals that while discussions continue, our youth are still being infected in alarming proportions. The survey indicates that 63.6% of our learners have reported having treatment for sexually transmitted infections. Learners 19 years and over that have had sex, reported a significantly higher rate of having a sexually transmitted infection than all learners aged 17 years and younger. The reported prevalence of having had a sexually transmitted infection among Kwazulu –Natal learners (14.6%) who have had sex was significantly higher than the national prevalence, while Gauteng learners (3.4%) who have sex reported the

lowest prevalence. The survey also revealed that grade 8 learners nationally also reported that they were less able to protect themselves against HIV, and felt it was more likely that they would get HIV in their lifetime than learners in other grades (The 1st South African National Youth Risk Survey 2002). This finding is important when considering that perception of vulnerability is fundamental to understanding precautionary behaviour. We as educators need to understand what informs such behaviour and adapt our teaching strategies to make for effective learning in this time of crisis. The curriculum packages introduced in schools advocate safe sex, but as early as 1991 research according to Van Niekerk (1991), revealed that learners know very little about HIV/AIDS and parents do not want to give their children the necessary information or guidance, that there is no cure for aids in the near future, the disease will have to be stamped out through education and prevention and even if existing ignorance and doubts can be eradicated, attitudes and behaviour towards the disease will not necessarily change.

Therefore the programmes and policies assume that by providing learners with sex and sexuality education we can sufficiently hope for behavioural changes. However over the decades and with several sexuality education programmes, the prevalence rates have not stabilized.

In all of the discussion on Education for prevention for HIV, we have to deal with the reality that there are HIV positive people amongst us. More specifically, as educators, we have to deal with the reality that there are HIV positive learners in our schools and classrooms. How do we respond them? More importantly, how do they experience schooling and education? This study then, attempts to explore the experiences of the HIV positive learner through a case study of an HIV positive learner's experiences in school.

2.3 THEORETICAL CONSIDERATIONS FOR THE STUDY

Research done at the University of California, Center for AIDS Prevention Studies in 1996 reveal that the problem of HIV/AIDS is deeply rooted not only in the form

of the disease but also in the lifestyle of the learner. The learner's view of life and his/her ethical approach to the values she/he considers important in his/her life will influence his/her priorities and decisions. Sexuality is part of our needs and it is dictated by various factors (University of California, Center for AIDS Prevention Studies 1996).

Therefore can theory help in our prevention of HIV? Whether or not it is stated, some form of theory is already the basis of prevention planners, who seemingly know their population and plan accordingly. This hands- on knowledge is informal theory. Formal theory is made up of principles and methods about prevention and behaviour change that have already proven useful in some areas of disease prevention and behaviour change. The question is how effective is the theory used to sustain the spread of the virus?

In the absence of formal assumptions within the South African context of what informs sexual behaviour among adolescents it is only logical that we look to already established theories to provide a framework for the goals of intervention, or help explain aspects of risk-taking behaviour when working with our learners. There are various theories that can assist with HIV prevention but for the scope of this research the social cognitive theory and the theory of reasoned action which forms the basis of the life skills curriculum and which is taught through the outcomes based theory of learning will be discussed. Although these theories support the National Policy on HIV/AIDS, they do not allow for contextual factors of each school site to design its own policy on HIV/AIDS. Therefore it is necessary to look for other theories that will assist schools in drawing up effective policies on HIV/AIDS to suit the needs of individual school sites and learner populations. The Symbolic Interactionist theory will also be discussed as it provides the framework to tailor make policies to suit individual schools.

2.3.1 The Social Cognitive Theory and the Theory of Reasoned Action

The social cognitive theory as espoused by Albert Bandura views learning as a social process influenced by interactions with other people. In Social Cognitive Theory, physical and social environments are influential in reinforcing and shaping the beliefs that determine behaviour. A change in any one of the three components – behaviour, physical or social environments influences the other two. Self-efficacy, an essential component of the theory, is the person's belief that s/he is capable of performing the new behaviour in the proposed situation. Evaluation research according to Valdisseri (1989), indicates that Social Cognitive Theory can be behaviourally effective in a number of ways within the HIV domain. According to Social Cognitive Theory effective intervention must consist of four components, viz,

- ✓ Information related to perceived vulnerability and self efficacy;
- ✓ Development of self regulatory and risk reduction skills;
- ✓ Further development of these skills and the self efficacy to use them; and
- ✓ Development and use of peer group support (Bandura 1992).

The Social Cognitive theory enforces self- regulation and mental competence in behaviour change when addressing HIV.

In addition, the Theory of Reasoned Action as espoused by Ajzen and Fishbein in 1967, is a well -tested model that has provided the theoretical basis for effective intervention targeting HIV. The Theory of Reasoned Action, (TRA), sees intention as the main influence on behaviour. Intentions are a combination of personal attitudes towards the behaviour as well as the opinions of peers, both heavily influenced by the social milieu. The TRA based intervention will focus on addressing:

- ✓ An individuals attitudes towards preventative behaviour;
- ✓ The perception of subjective social norms related to preventative behaviour;
- ✓ The behavioural intention to practice the preventative behaviour (Ajzen 1998).

Both the Social Cognitive Theory and the Theory of Reasoned action argue for behaviour change amongst learners. The Social Cognitive theorists focuses on the human mind to make sense of the social world the learner inhabits. It calls for self-regulatory behaviour and believes that controlling our own behaviour is the key to survival (Bandura 1994). The Theory of Reasoned Action focuses on the learner's rational ability to make systematic use of information available to them. Both theories encourage the development of the self to rationalize situations before acting.

When applied to the health education of the learner the theories are used to predict and understand healthy and unhealthy behaviours and the outcomes of such behaviour. It has important implications for HIV/AIDS education in that it advocates examining health related behaviours and developing health prevention programmes. Both the theories form the theoretical background that support the teaching methods that most effectively encourage behaviours that will enhance sexual health. The Life skills policy implemented in schools uses the Social Cognitive Theory and Behavioural theories of Reasoned Action as its basis for behavioural change. It is hoped that firstly all effective educational programmes designed to impact on sexual health behaviour should incorporate elements of information, motivation and behavioural skills. Secondly information, motivation and behavioural skills are basic concepts that are easily understood by a diverse array of educators and programme audiences. Thirdly that such theories are supported by research demonstrating its efficacy as the foundation for behaviourally effective sexual health.

2.3.2 Limitations of the theories

- ✓ The theories are based on the assumption that human beings are rational and make systematic decisions based on available information. Unconscious motives are not taken into account.
- ✓ The assumption is made that perceived behavioural control predicts actual behavioural control. This is not always the case.
- ✓ Contextual factors of people are not taken into account.
- ✓ Self-regulatory behaviour may be easy for some and difficult for others.

Therefore it becomes necessary to search for theories that will influence effective HIV/AIDS education at schools. Constantly theories arise from a variety of sources, often from the community that sees the need (Valdiserri 1989). Collaborations between service organizations and researchers need to be encouraged so that the best programme is found. A comprehensive HIV strategy uses multiple elements to protect as many of those at risk as possible. Whilst these theories undergird our Life skills curriculum the research statistics reveal a different scenario. It becomes necessary then to question whether borrowed theories alien to the African continent will be sufficient to address the epidemic facing our learners or should we not attempt to search for more applicable theories to make an impact on the life of the infected and affected learner?

2.3.3 The Outcomes Based Theory of Learning

The current Outcomes Based Theory is the theory adopted to teach our learners. We, the educators know the difficulties inherent in the Outcomes Based Theory of teaching, yet we have to translate the policy and communicate these life sustaining skills meaningfully to our learners so that it can enable them to overcome the challenges of changing hormones, emotional and physical needs, desires to be adult and take risks, ambivalence about pregnancies, peer pressure, norms promoting sexual risk taking and the omnipresent inaccurate portrayal of sex in the media. In addition it is a known fact in South Africa that underlying factors such as

poverty and family disorganization and a lack in the belief of a future hampers our learners.

The Outcomes Based Theory, hereafter referred to as OBE, advocates equity in terms of educational needs and to develop learners to think critically. OBE encourages life-long learning, is people centered and is designed to develop people to their full potential. The focus is on teachers and learners achieving outcomes. Educators must facilitate learning and learners must acquire knowledge, skills and attitudes in a constructive way. However OBE has been plagued with criticism since its inception – from interpretation and implementation of the policy, from the lack of training of educators, poor resources through to whether the outcomes in different contexts will mean the same thing (Jansen 1998). The life skills curriculum on sex and sexuality education is taught at my school in an academic fashion, with the learner's being given formal tests and examinations to assess whether they have internalized the content. The impact or the desired effect of the content on the cognition and behaviour of the learner is lost because it is divorced from the realities of the learner. The content is presented in a vacuum totally devoid from the experiences of the learner. It then becomes necessary to search for other theories that work within the context of AIDS in our schools.

2.3.4 Symbolic Interactionism

If learning according to Mazur (1990), cited in Slavin (1997), is defined as a change in an individual caused by experience, then surely learning cannot be done in isolation. It needs to take into account the realities of the learner. I believe that knowledge must relate to the reality of the learner and the learner must be empowered to cognitively deal with those realities. To this end I subscribe to the view that learning must be able to allow learners to cope with real choices. My perspective on learning in these times of HIV/AIDS and social inequities is supported by 'Symbolic Interactionism', which focuses according to Wallace & Wolf (1991), on the individual with a self and on the other hand, the interaction

between a person's internal thoughts and emotions and his/her social behaviour. Symbolic Interactionists see the individual as taking an active role in interpreting and defining his/her actions rather than being a passive individual who is influenced by external forces. The self is a creative and vibrant force. Development of the self is essential so that individuals can respond to the actions of others and set up goals for themselves and plan for the future. Symbolic Interactionists also see the individual as reflective, an individual who is capable of standing back and reflecting on his/her experiences. Teaching and learning in schools today lose this need to empower and to develop the learner's sense of self. Instead it concentrates on pushing content and achieving the highest pass rate per grade.

Symbolic Interactionists also see human interaction as human beings actually creating the social environment and being shaped by it (Haralambos & Holborn 1991). The individual cannot be divorced from society because the individual can grow and become fully human in that environment. Thus an individual constructs meaning of his/her world through the interaction with others.

The world of reality for the individual is perceived only in the symbolic form and as social reality changes, new perceptions form. Symbolic Interactionism makes learning meaningful to the individual, it deals with the individual's reality. This approach attempts to understand, by examining 'everyday activity', since every aspect of society is built on how people act in everyday life. It is the day to day activities of learners, educators and all other role players in education that form the focal point, as any changes in these components will bring about changes in education and society. This theory is pertinent in understanding the HIV positive learner's perception of reality in school. It provides a basis to understand how the learner interacts with peers and educators, engages with learning, participates in curricular and co-curricular activities and relates to the school environment as a whole. Symbolic Interactionism encourages research that will explore the human experience. Thus the Interpretive approach to human inquiry is suitable for my research.

2.4 THE INTERPRETIVE APPROACH

The interpretivist approach shares the goal of understanding the complex world of lived experience from the point of view of those who live it. This goal is spoken of as an abiding concern for the life world, for the emic point of view that is the world of lived reality and situation specific meanings (Schwandt 1995).

Interpretive Social Science can be traced to Max Weber who argued that social science needed to study meaningful social action with a purpose. The goal of such research is to develop an understanding of social life and discover how people construct meaning in natural settings. The researcher is interested in knowing what individuals experience in daily life. The interpretive approach sees human social life as an accomplishment. It is intentionally created out of the purposeful actions of interacting social beings. Social life exists as people experience it and give meaning to it (Neuman 1997).

This implies that for interpretive researchers social reality is based on people's definitions of it. A person's definition of a situation tells her/him how to assign meaning in constantly shifting conditions. It accounts for differences in experiencing social or physical reality. The key question is, how do people experience the world? Social reality is seen as consisting of people who construct meaning and create interpretations through their daily social interaction.

The interpretive approach is ideographic and inductive (Lincoln 1995).

Ideographic means the approach provides a symbolic representation or thick description of something else. An interpretive analysis is rooted in the meaningful experiences of people being studied. Interpretive theory gives the reader a feel for another's social reality. The theory does this by revealing the meanings, values, interpretive schemes and rules of living used by people in their daily lives.

Interpretive researchers want to discover what actions mean to people who engage in them. It makes little sense to deduce social life from abstract logical theories that

may not relate to feelings and experiences of ordinary people. Researchers need to learn the reasons people use for their actions. Individual motives are crucial to consider even if they are irrational and carry deep emotion. For interpretive social science a theory is true if it makes sense to those being studied and if it allows others to understand deeply or enter the reality of those being studied. The theory or description is accurate if the researcher conveys a deep understanding of the way others reason, feel and see things (Neuman 1997).

An interpretive researcher's description of another person's meaning system is a secondary account. The interpretive approach is the foundation of social research techniques that are sensitive to context, that use various methods to get inside the ways others see the world, and that are more concerned with achieving an empathic understanding of feelings and world views rather than testing laws of human behaviour (Guba and Lincoln 1994).

Thus the interpretive paradigm supports my research study as it enables me to research how an HIV positive learner experiences her schooling. It allows for me to explore her social reality using a variety of qualitative methods in order to understand how she makes sense of her world. Her subjective experiences forms the basis of my research.

2.5 CONCLUSION

The literature review reveals that it calls for very a special commitment on the part of educators to assist our positive learners during this period of HIV/AIDS. It further reveals that we as educators have no time to wait for solutions from policies, we have to seize every moment and act accordingly for the benefit of our learners within our school sites.

In the next chapter, the process of collecting and obtaining data is discussed. De Vos (1998) argues that qualitative research is concerned with people's perspectives of the world; insights sought rather than statistical analysis. My research study is a

qualitative one using the case study approach and various qualitative methods of data collection.

CHAPTER THREE

3.1. INTRODUCTION

The literature study revealed the horrifyingly high rates of HIV/AIDS infections among our adolescent and young adult learners aged between 15 to 24. The literature study also revealed that while life skills education was disseminated via the school's curriculum there still is an alarmingly high HIV infection rate amongst our adolescent and young adult learners. This research is a case study using only qualitative methods of data collection and analysis to help address the critical question of:

HOW DOES AN HIV POSITIVE LEARNER EXPERIENCE HER SCHOOLING?

3.2 WHY QUALITATIVE RESEARCH?

Qualitative research affords me the opportunity to understand the social and human behaviour from the insider's perspective, as it is experienced by the participant (Arkava & Lane 1983.) It allows me to understand the social and psychological phenomena from the perspective of the people involved. According to Welman & Kruger (1999), the person derives his or her meaning from his/her life world and by existing s/he gives meaning to the world. Hence the interaction between the reality of school and the HIV positive learner becomes the central focus.

3.2.1 Why a case study?

According to Welman & Kruger (1999), the term case study pertains to the fact that a limited number of units of analysis, (often only one), such as an individual, a group or an institution are studied intensively. In case studies the researcher is directed towards understanding the uniqueness and the idiosyncrasy of a particular case in all its complexity. By this we mean that the researcher conducts the

investigation under natural circumstances. The emphasis in a case study is on understanding and no value stance is assumed (Anderson 1977.) Case study research is highly data based and strives for the same degree of reliability and validity as any good research. The choice of a case implies a knowledge of some interesting issue or feature that sets the general parameters for the important 'why' question. The most important themes relate to how things are taking place and why. The emphasis in case study is on explanation and these types of questions help to do that (ibid.)

According to Arkava & Lane (1983), a case study is an 'in depth investigation to portray the complex pattern of what is being studied in sufficient depth and detail so that one who has not experienced it can understand it.' A case study also allows for the observing of behaviours of the participants in naturally occurring environments and researchers must gather data about the participants present state, past experiences, environment and how these factors relate to one another (Arkava & Lane 1983.) Thus in my study, I attempted to observe how the HIV positive learner experiences her schooling using multiple data sources. The use of a case study allows me to be involved in collecting all kinds of data and in interpreting, analyzing and recasting the issues and questions as the data collection unfolded.

3.2.2 Sampling

According to Welman & Kruger (1999), purposive sampling is the most important kind of non- probability sampling. Researchers rely on their experience to deliberately obtain units of analysis in such a manner that the sample they obtain, maybe regarded as being representative of the relevant population. With the establishment of our peer counseling service at school, I was introduced to Angel via my peer counselor, Audrey. Audrey and Angel were very close friends and they attended the same church and lived in the same area. Audrey was also assisting Angel by counseling her. Angel admitted with medical proof, that she was HIV positive and that she was a learner at our sister school. After my informing her of my concern and intention to assist HIV positive learners in

schools she had agreed to be a part of my research study. Thus, Angel was chosen as she had been the most suitable participant for the research study based on her positive HIV status and the fact that she was 16 years old at the time. Angel agreed to participate under the following conditions:

- ✓ That she remain anonymous,
- ✓ That interviews be confidential and conducted at my school and not at hers, early in the morning or after school hours or in public meeting places of a social nature.
- ✓ That interviews be conducted with her mother in the presence of Audrey my peer counselor or by Audrey herself.
- ✓ That my observation of her in school be done by her subject educator whom she would inform me of.

Criticisms of this kind of sampling is that different researchers may proceed in different ways to obtain such a sample and thus it is impossible to evaluate the extent to which such samples are representative of the relevant population.

3.3 THE RESEARCH INSTRUMENTS

3.3.1 Observation

The theoretical framework concentrates on the behaviour of the participant and on how the participant relates to and interprets her world. Therefore this research study created the opportunity for the observation of Angel in her school setting for a period of one week. General information on the agreed upon criteria had to be noted by the educator observing her. The criteria agreed upon were as follows:

- ✓ The number of days Angel attended school in that week,
- ✓ Her interaction with her friends and peers during the first and second break,
- ✓ Her participation in any lunch- time activities,
- ✓ Her general demeanour during the breaks and lesson time.

Such observations were not intensive or overt because of the sensitive nature of the research and the fact that she did not disclose her positive status to anyone at her school except her subject educator who indirectly knew of her problem. Further my agreement with her that no attention would be drawn to her within her school environment was binding.

3.3.2 The semi-structure interviews

A semi-structured interview schedule was used to obtain relevant information on how an HIV positive learner experiences school. The interviews were conducted by me with the aid of my peer counselor. I believed that this was the best method of obtaining the relevant information for the following reasons:

- ✓ Semi-structured interviews are usually used in qualitative research.
- ✓ Semi-structured interviews are flexible
- ✓ One can gain insight into the character and intensity of the respondents attitudes, motives, feelings and beliefs and can detect underlying motivations and unacknowledged attitudes (De Vos 1998).

According to Patitu (2000), the researcher has the ability of analyzing both verbal and non- verbal responses. In face- to- face meetings an investigator is able to encourage subjects and to help them probe more deeply into a problem particularly an emotionally laden one. By establishing a proper rapport with Angel I could obtain more rich information. In a face to face interview the nonverbal behaviours can help as an indicator for the need to further clarify questions.

With respect to the construction of the interview schedules, I was guided by the critical question in eliciting responses from Angel, her mother and her subject educator. According to Bogdan and Biklen (1992), an interview is a purposeful conversation between two people that is used to gather descriptive data in the subject's own words so that the researcher can develop insights on how the subject

interprets his/her world. I was able to probe further and get answers in the order that I wanted to. I was aware of receiving socially desirable responses but I rephrased the questions to get the response I desired.

The semi- structured questions do not have a predetermined structured response. The question is open ended yet specific in intent, allowing for individual responses. The questions allow for probing, follow up and clarification. Semi-structured questions were suitable for my research because the sensitivity and the social stigma surrounding HIV/AIDS required that questions had to be phrased and re- phrased to ensure further probing and clarification (Welman & Kruger 1999).

The interview was conducted in a pleasant, friendly, relaxed, safe and secure environment. The safety and the security of my school environment provided Angel with the comfort and protection that she required for fear of being found out. This type of setting and arrangement was conducive to Angel being honest and less inhibited in her responses. The atmosphere was friendly and permissive and this directed the discourse and encouraged Angel to reveal the desired information. However, because of the personal and emotional nature of the interview, Angel preferred that I note down her responses as opposed to having them recorded. Interviews were conducted in the presence of my peer counselor, Audrey. Audrey was Angel's crutch when issues were emotionally charged. Immediately after the interview was over I had to expand on my note- taking.

Interviews were also conducted with her mother and her subject educator. The interview with her subject educator was based on his general observation of her as she did not disclose her status to him formally but she believed that he knew what was wrong with her as she often told him that she was sick, and that he knew what kind of sickness she was suffering from. The interview with Angel's mother was conducted by Audrey in the informal settlement that she resided in. Audrey is both a trusted friend and counselor to Angel and Audrey often assists Angel's mother in the process. Therefore, Audrey was trusted by Angel's mother as she believed that Audrey would only help them. Audrey is a trained peer counselor, who received

her training from the Psychological and Guidance Services from the Department of Education. Audrey has been interviewing and counseling learners for the past three years at my school. Audrey had to be briefed on what information was required from the interview before it took place. I also brushed up on Audrey's interviewing skills by enacting a mock interview with her. The secrecy of this research and the agreements reached initially, resulted in Audrey being the only means I had to secure the interview with Angel's mother.

3.3.3 Document Analysis

Document Analysis was my next primary method of collecting data. Documents are written records. The documents were primary sources. They were Angel's academic records and school records. The purpose of the analysis was to ascertain if any significant changes occurred, after Angel was infected with the HIV virus.

3.4 MY ROLE AS RESEARCHER

My role as the researcher in this study was severely hampered by the constraints imposed by society on the HIV/AIDS sufferer. Non-disclosure by Angel to authorities within the school environment severely hampered my ability as the researcher to enter her school environment. My role in the research process was restricted even further as agreements were reached prior to the actual conducting of the research. The agreements were binding because of the fear of Angel being found out by anyone that she was HIV positive. The sensitive nature of The HIV problem forced me as the researcher to often ask the question, how does one conduct research on such a sensitive and life threatening issue? My first two attempts at conducting a research of this nature at my school failed because the participants revealed an unnatural terror at being HIV positive and feared for the safety of their lives. After months of research and a lack of consent to publish the findings, the research was aborted. This particular case study could have gone the same route had I not agreed to the conditions. Angel provided me with a response

in one of our meetings when she answered that, ‘ being HIV positive is a death sentence through slow torture and it only magnifies the terror of being found out that you are the carrier of a deadly virus - your life is doomed and you are sentenced to a life of ridicule and condemnation by the rest of those around you.’ Armed with a determination to make a difference in the lives of HIV positive learners at school I pursued.

Because of the personal nature of the information I required, my relationship with Angel was one based on mutual respect and a deep commitment on my part to listen and to understand her experiences. Often, my own identity as researcher had to be diluted at times as the situation called for offering advice from a variety of perspectives. At times I had to assume the role of a mother, educator, counselor, friend and confidante offering emotional and mental support. Therefore it was impossible at times not to become emotionally involved in the research especially if you are an adult listening to a young child.

3.5 PROBLEMS ENCOUNTERED

The sensitivity of the research, the problem of non-disclosure and the fear of being the focus of attention for Angel created additional challenges that had to be taken care off viz:

- ✓ The observation had to be conducted by the educator of her choice. The educator had to be briefed on what to look for and discussions had to take place on a daily basis to update information thus not compromising the theoretical and conceptual underpinnings of the research. My role in this type of observation was passive as the subject educator was guided in detail to observe criteria already agreed upon. This type of arrangement created greater demands on the subject educator whose programme in school had to be re-arranged to accommodate me. Sometimes because of the demands of professional duties, it was not possible to accommodate me, especially if workshops were scheduled in the educator’s turn for ground duty. This

resulted on time delays. Observation could only be done when the educator was on ground duty, discreetly.

- ✓ The interview had to take place at my school after scheduling and re-scheduling. Time constraints were a difficulty always because of Angel's prolonged absence, her visits to the hospital and clinic and traveling arrangements after school.
- ✓ The interview with Angel's mother had to be conducted by Audrey as I was not allowed by Angel to visit her home for fear of being questioned by neighbours and relatives. This resulted in much time being spent with Audrey in preparation for the interview. The notes made at the interview had to constantly be expanded upon with Audrey, Angel's mother and myself. This was time consuming.

3.6 LIMITATIONS OF THE METHODOLOGY

The study was constrained by a few limitations of the methodology employed. The fact that, I, the researcher was the passive participant in the observation could have compromised the accuracy of the information that was observed and recorded. Although the criteria for the observation was discussed with the observer, the possibility could have existed where information and details were left out depending on the viewpoint of the observer. As a result of non-disclosure by the learner, the fear of being the focus of attention and the preference of a particular educator to observe, created problems with regards to time frames. Observation could only be done when the educator was on ground duty in a cycle of once every five weeks. The observation of the learner during instruction time could not be done at all because on non-disclosure.

Interviews have their limitations as participants are not always honest. Socially desirable responses may have been given. Further my deep desire to complete my

research could have affected my tone and influenced the responses of the study. Finally, my preconceived notions on HIV positive learners could have also influenced my study.

Because the number of disclosed positive cases of learners are so few the purpose of the case study was to extensively examine the case that was available, and the concern is, whether one can generalize sufficiently based on the findings that this case study revealed with all the agreements and criteria used. Will different researchers get the same results?

3.7 VALIDITY OF THE STUDY

Reinhartz (1992), points out that the use of multiple methods in research work enhances understanding both by adding layers of information by using one type of data to validate or refine another. Thus in this study three methods of data collection were used to increase the validity of the findings. Thus in my study I was able to compare the findings yielded by the observation with the interview and the analysis of the documents. According to Denzin and Lincoln (1998), no single method ever adequately solves the problem of causal factors, multiple methods of data collection must be employed. This is termed triangulation. I was also able to get a variety of responses from the three methods of data collection on a single issue. I was also able to pose similar questions in all three interviews to validate certain responses. This allowed me to constantly cross reference data collected with that being collected. This, in turn facilitated the emergence of similarities, common trends and themes. This triangulation made it possible for the data to be more credible.

Assuring the anonymity and confidentiality of the research participants, resulted in a relationship based on mutual respect and trust where Angel often treated me as her confidante and this facilitated the easy dissemination of information. The use of Audrey as an intermediary in the research strengthened the research process and contributed to the ease with which Angel responded to issues especially the

emotionally charged ones. Whenever telephonic contact with Angel failed, Audrey was instrumental in establishing and maintaining contact with Angel whenever the need arose for me to meet with her.

Angel was assured of the confidentiality of the imparted information both verbally and in writing and this influenced her in her providing very appropriate, sincere and honest information on her experiences in school.

Angel was invited to read the transcripts and the research report at any time. Furthermore, if at any time, Angel felt threatened she could withdraw from the research totally.

3.8. HOW THE DATA WAS ANALYSED?

The data was analyzed on an ongoing basis, where similarities and themes emerged. The data will be discussed and presented according to the themes that emerged from the observation, interviews and document analysis.

3.9. CONCLUSION

The research topic dictated that a qualitative research approach be used to collect the data for the critical question of, how an HIV positive learner experiences school. This chapter focused on the research methods that were used in the study and concludes the discussion on methodology. The next chapter discusses the findings of the study.

“It is not the HIV-virus which is killing me or making my life not worth living, but the bad attitudes of people towards me and their rejection of me.”
(Evians, 2000)

CHAPTER FOUR

4.1 INTRODUCTION

In the previous chapter the general approach of the study, the different methods of collecting data and a motivation for the use of a case study were presented. In this chapter I will discuss the data generated through the various methods and instruments used for data collection. After the data had been read and re-read, the data had been codified according to similarities that emerged from the interviews conducted with the educator, parent and learner. The data from the observation was summarized from the field notes observed at that time in October. The data from the interviews were transcribed, read and analysed many times. The themes that emerged out of this process were then subsequently explored. The data from the interviews is then presented under common themes that emerged while the data was being analyzed.

4.2 ANALYSIS OF FINDINGS

4.2.1. Summary of observation

The following are notes made of the observation of Angel for a period of one week, at her school, by her geography educator who was on ground duty during that week of the observation. The fact that the appointed educator was on ground duty alleviated the problem of Angel being targeted, as when educators are on ground duty they walk all around the school campus. The agreed upon criteria was that Angel will be observed during the mornings i.e. from 07h45 to 08h00, during the first interval break at 10h20 to 10h35 and during the second interval break from 12h35 to 13h 10. It was difficult to observe Angel during lesson time, as she had not disclosed her positive status to any other educator or member of management. She informed me that she trusted her geography educator because he had all their interests at heart.

MONDAY: Angel attended school at around 07h 30 and she dispersed among the girls in her class. The girls left their bags against the corridor walls outside their

classroom and slowly made their way to the assembly area. Angel was accompanied by one girl friend from her class whom she would always be with. Angel together with her friend made their way to the girl's cloakrooms and then to the assembly area where she remained until the buzzer sounded. Once assembly was over Angel made her way to her classroom. A noticeable difference between Angel and the other girls was that the other girls from her class were talking garrulously and enjoying the sight of their friends, while Angel appeared quiet, pensive and gravitated towards the one friend she was always with.

FIRST INTERVAL BREAK: During the first interval Angel would be with her friend in a shady spot having her lunch. She would sit on a bench and chat with her friend. She would make her way towards the tuck-shop and would return to the bench under the tree. She continued to eat her chips and chat to her friend. Once the buzzer sounded, she would amble back to her classroom, late.

SECOND BREAK- LUNCH TIME: During the lunch breaks the school is pulsating with activity. Some of the learners are participating in all kinds of sporting activities, inter-class competitions in soccer, cricket, netball and basketball, other learners support their classmates and the noise is overwhelming. Angel is very passive preferring to sit on the bench in the shade with her friend. She seemed to chat to her friend. A group of girls came up to Angel and her friend and chatted to them and then left to go to the tuck-shop. Angel continued to sit in the shade until the buzzer sounded for registration.

TUESDAY: A similar pattern as Monday was followed. Angel arrived at school at 07h30. She went to the female cloakrooms with her friend before they made their way to the assembly area. After assembly she made her way to her classroom.

FIRST INTERVAL –BREAK: Angel and her friend made their way to the bench under the tree. During the first break Angel's friend shared her sandwiches with her. They then made their way to the cloakroom and returned from there, when the buzzer sounded. They then made their way to their classroom. An interesting feature was that Angel's school bag was almost always carried by her friend. Angel seemed somewhat pale and frail today, and she walked slowly towards her classroom. She was quieter and talked less.

SECOND BREAK- LUNCH TIME: Angel continued in much the same way as Monday with the exception that she went to the secretary's office for a headache tablet. She then sat in the sick room where she remained until the end of the day. I was able to ask her friend what had happened because she was not present in my geography lesson in class. I was told that she had, had a severe headache and was in the sick room.

WEDNESDAY: Angel did not attend school.

THURSDAY: Angel did not attend school. When I enquired about her absence I was told by her friend that she was sick and she had to go to the hospital.

FRIDAY: Angel came to school at approximately 07h45. She was absent from the assembly area and did not come to the assembly. During the first break Angel sought leave from school because she was feeling unwell as I discovered later on in the day during my geography period with the class.

A summary of the observations indicated clearly that Angel preferred a quiet, sedentary life at school. She preferred to remain with just one friend most of the time. She did not participate in any activity during the breaks. Her demeanour was always quiet and reserved. She chose to remain in the sick room when she felt ill rather than return to her classroom even after obtaining medication from the secretary. She was absent for two days of that week and she took early leave on one day of that week.

In my discussion with her geography subject educator during the period of the observation, I discovered that Angel was a vibrant scholar who was average in class and passed grades 8 and 9 on her own strength. She was part of an energetic group of friends in her class that socialized during and after school. However in 2000 (her first attempt at grade ten) he noticed a drastic change in Angel. Almost overnight she lost her youthful, precocious teenage behaviour and became weighed

down and depressed, talking and laughing less and putting her head down on the desk very often. She frequently absented herself from school. Her participation in sport ceased. Upon enquiring from her friends he discovered that she was pregnant. The pregnancy placed a tremendous burden on her and she had to leave school. She returned after giving birth and had to repeat grade ten with not much success. In the two years that followed he noticed that her health had deteriorated and she was absent from school very often. Attempts to discover why she was away from school so often was met with the stock response that she is sick, when the word 'sick' was mentioned it was always followed by 'you know the sickness, sir,' with no affirmation on the exact nature of the illness.

From the information gleaned from the observation it became necessary to understand the behaviour patterns of HIV positive learners. According to the Department of Health's, HIV/AIDS: Care and Support of Affected and Infected Learners, A Guide For Educators (2001) it is common for infected learners to isolate themselves from friends and peers. It is also common for learners to exhibit feelings of despair and hopelessness. The thought of impending death causes severe feelings of anxiety and trauma. These learners can experience many different emotions such as guilt, fear, shamefulness and extreme despair. These learners even withdraw from all forms of activity and give up on life. Depression is very common and suicidal tendencies tend to occupy the learner's mind. Mood swings are very common and occur very frequently. Angel exhibited some of the behaviour patterns herself. She chose to be with just one friend, to visit the sick – room often, she did not participate in any social activities in school and she was absent very often. It is important to highlight the common behavioural patterns in infected and affected learners so that educators need to be aware of these signs, intervene as soon as possible and lend care and support in the most effective way possible.

From the information gathered from the observation it became necessary to employ another instrument of data collection to get more appropriate information on how Angel experienced her formal schooling. The method selected to elicit this

information was the semi -structured interview with Angel, her mother and her educator.

4.3.ANALYSIS OF THE SEMI – STRUCTURED INTERVIEWS

The data that emerged from the interviews were characterized into a few common themes. Similarities that emerged from the three interviews were then categorized into themes for discussion. These themes will form the sub-headings for the discussion according to the three perspectives that emerged from the interviews. Thereafter a summary of the individual responses to questions asked, will be discussed from the individual's perspective.

4.3.1 Attendance at school

4.3.1.1 Educator's perspective: *“Angel's attendance at school was very poor. She attended school sometimes just once a week. On average she was absent for three days a week. She would also be absent from lessons as she would be in the sick room. Her absenteeism from year mark tests, assessments, tutorials and controlled tests was very frequent. She was also absent from major social events at school. Poor attendance severely hampered her performance in tests, and examinations. Surprisingly was her absence from sporting events organized by the school.”*

4.3.1.2 Mother's perspective: *“I noticed a change in Angel from a girl who would go to school even in the rain to a girl who was staying at home- not going to school. I knew something was wrong but honest to God I didn't suspect it was HIV. Her changes in her behaviour, someday very sick and some days not worried me about her not going to school. My concern was that Angel hardly went to school and being away for such long time results in failure. I had no choice because sometimes she would be so ill that she just could not go to school.”*

4.3.1.3 Angel's perspective: *“There is no hope for me. Bad attendance equals failure. I cannot tell my situation to any other teacher because I am so embarrassed. I cannot explain my illness as no-one would understand. I just cannot go to school and be as before because I cannot cope with the work like before. I cannot tell my friends that I am sick as they won't help me. Therefore it's*

easier to be home. My teachers see me as the girl who is a problem. I cannot answer their questions truthfully and I miss a lot of work and I do badly in my work so I stay at home.”

Thus it can be clearly seen that poor attendance in school is a cause for concern for all three but, as a result of non- disclosure, the stigma of being positive and the fact that the learner cannot confide in anyone truthfully or readily allows her to endure a life of no hope and condemnation. The desire to keep the illness a secret inhibits the mother and child from seeking for help openly. The educator, although trusted by Angel assists her in a very indirect way, as she did not tell him directly that she is HIV positive.

According to Goodyer and Fourie, cited in the Department of Health’s HIV/AIDS Care and Support of Affected and Infected Learners (2001), frequent absenteeism and illnesses can disrupt the formation and maintenance of peer relations and friendships. A few weeks absence could mean exclusion from the group. When the infected learner feels ill or down, the infected learner could reject social contact totally. Communication with friends and peers becomes extremely difficult. The infected learner feels she/he is different and has difficulty in socializing with the group and this may lead to isolation, withdrawal and introversion. Angel felt that she was condemned to a life of no hope and despair. This self- imposed isolation was her way of dealing with her inability to communicate with her friends and peers. She chose to stay in the sick bay instead of coming to class. She chose to isolate herself from mainstream activities. She chose to stay at home at times. She assumed that there is no help for her and resigned herself to a sense of hopelessness and helplessness.

4.3.2 Participation in co-curricular and extra-curricular activities

4.3.2.1 Educator’s perspective: *“Angel ceased to participate in any activity at all. Alarmingly was her total absence from sporting activities that she loved.”*

4.3.2.2 Mother's Perspective: *“Of concern is the total change that occurred in my child from an active school going child to a child who shows no interest in anything at all. She does not go to any function. The illness drained my child's energy, and there is the problem that in her weak state if she exerts herself she will get more ill.”*

4.3.2.3 Angel's Perspective: *“I cannot take part in any event because I feel tired easily and dizzy. I do not want to arouse any suspicion from my friends when I play sport and fall ill. My grade eleven year was the most hurtful when all the symptoms were showing and I felt that I was becoming the clown of the school. I just couldn't take part. This meant giving up all the things that I liked. The disease affects your energy levels and I feel tired most of the time. I just cannot function normally in school anymore.”*

The school curriculum is both overt and covert. The overt curriculum being the manifest or formal curriculum that which is content based and the covert or the hidden curriculum being that, that the school promotes to socialize the learner. In this case both the actual/ formal and the hidden curriculum ceased to exist for Angel as she sees herself as being unable to cope in the total school environment because of her illness. Once again this self imposed despair and hopelessness stems from the inability to disclose the illness openly. Research by the Department of Health (2001), revealed that disclosing your HIV status is tantamount to giving permission to discriminate, more so that people still associate being HIV positive with reckless behaviour. Therefore it becomes understandable why Angel chose to withdraw from both extra and co- curricular activities. It is evident that she did not want to be discriminated against.

According to the Department of Health, Managing HIV in Children 2000, emotional stress can have severe adverse effects on the infected learner. Social stress may become apparent by not adapting well to the change in the infected learner. The infected learner will experience severe illnesses and show a lack of motivation to be a part of any social interaction. It is expected that disclosure among infected and affected learners is very difficult because of the ignorance surrounding HIV/AIDS. The fear of being disowned by family, friends and peers,

the fear of loss of normal bodily functioning and the stigma attached to HIV/AIDS contributed to Angel feeling that she was the clown of the school. By Angel viewing herself differently intensified her feelings of being different and further contributed to her feelings of inadequacy and helplessness. She was supported in this by her mother who felt that if she exerted herself she would become more ill. Contrary to that research from the Department of Health (2000), reveals that HIV infected persons should be encouraged to eat healthily and exercise regularly. However a belief in the myths of the disease seems to prohibits any form of positive action being taken to help Angel. The challenge for schools remain then to create situations that encourage disclosure by creating atmospheres of hope and encouraging learners who are infected and affected.

4.3.3. Interaction with peers / friends:

4.3.3.1 Educator's perspective: *“A noticeable difference was observed in Angel's interaction with her peers. There was no longer that raucous, jovial behaviour that characterized Angel and her friends before. Angel seemed to have drifted from her friends although they seemed ready to shout out that Angel was sick therefore she was absent. Prior to this there was a close bond that existed with Angel and some selected friends both in and out of school. Now all that has changed.”*

4.3.3.2 Mother's perspective: *“Friends are the first ones that desert you. They spread the message that we are bewitched, dirty and cursed by God. The friends that used to come to my home and have meals at my home no longer even care to come. They don't want to be seen anywhere around us. Her only friend is the pastor.”*

4.3.3.3 Angel's perspective: *“No I have no friends anymore. I was living in a world where I was the outcast. My sudden weight loss, feeling unwell all the time led to me being viewed with suspicion and my so called friends drifted away from me more and more each day. I found it very hard to believe that there was anything called friendship. You slowly have no friends as the word spreads that you are unwell so often. Further the*

fainting and dizziness makes friends stay further away from you. School is a lonely place then. I wanted to be in school because of my friends but friends are the first people to hurt you when you are ill with this kind of disease.”

From the data it is evident that as the disease worsens there is no support from peers or friends. Associating with an HIV person leads to further condemnation from society as experienced by Angel. The disappointment as evidenced in the mother's retort can only be summed by the ignorance around us of the HIV/AIDS virus. Sadly enough for Angel when she requires all the support she can get, she is isolated even more to bear the burden of being infected by the virus by herself. For the mother being HIV positive arouses deep feelings of fear. The myths within the community reflect strongly in the mother's preference for Angel's non- disclosure. According to the HIV and AIDS Life Skills Resource Guide for Educators (2003), the situation exists because infected persons fear stigmatization, isolation and discrimination. Infected people would rather attribute the disease to being bewitched rather than owning up to the truth. The issue of denial is so rife in our communities that very few people acknowledge suffering from the disease. To worsen matters HIV/AIDS is not called by its proper name- but it is referred to by several euphemisms such as the 'the slimming disease.' Friends and family members desert infected people because the stigma attached to HIV/AIDS is so detrimental to ones acceptance in the community. Thus for Angel the aspects such as friendship and collegiality had to be re-examined as she experienced desertion and ostracizing by her friends. She felt an outcast and withdrew from all forms of contact with her friends. Educators need to encourage disclosure among infected learners. The word disclosure is often associated with sensational events or those events accompanied by shame, guilt and secrecy. These associations are not helpful when applied to a learner's knowledge of his/her diagnosis. Terms such as 'talking about the diagnosis' or 'sharing information' are less threatening. Talking about 'special' or 'private' information instead of secrets in the explanation dispels the connotation of something to feel ashamed and guilty about (Melvin 2000).

4.3.4 Performance in tests and examination

4.3.4.1 Educator's perspective: *“Absenteeism affects performance in year mark tests, assessments, tutorials and examinations. In the senior phase at school there is an average of 2 to 3 tests a day. Policy documents for each subject demand a certain number of formal and informal assessments for the year mark purpose. Whilst policy documents ask for scheduling and re-scheduling of tests in the case where learners are absent- this is not practical when one can see that a learner is not well and can't manage to write a test on the day s/he returns to school. The situation is further compounded by the fact that on the day the learner arrives at least two more tests are scheduled for the day. Although tests are planned according to the testing programme of the school, testing overload cannot be helped because of the number of assessments each subject requires in the senior phase. All of these, formal and informal assessments are for the year mark. If a learner is absent continuously, the learner is almost always at a disadvantage because assessed marks also have criteria that must be followed. Attendance, attitude to subject, performance in class-work exercises and general behaviour are factors to consider when assessing marks. If a learner is absent and very little or no work is given in, then that learner is severely disadvantaged and surely fails. In Angel's case she found it very difficult to cope with schoolwork. There was a decline in academic performance. The high absentee rate and inability to submit work on time in all her subjects resulted in very poor performance. Angel did have the potential to pass as she had done in previous years. Being pregnant and suffering visible mental anguish as evident in her expression all the time made it extremely difficult to cope.”*

4.3.4.2 Mother's perspective: *“It is very difficult knowing that your child is unable to get up the next day and get ready for school- let alone write a test or examination. Coping is the hardest part. You watch your child's life and dreams fade into nothing. On some days you think the body is fighting the sickness and then all of a sudden things take a turn for the worse. The disease slowly turns your child's world upside down. I knew my Angel would have passed all her tests if she*

wrote them but now I have to give up the idea and help her to cope with her illness myself. My husband still does not know that Angel is so sick. I just cannot tell him. He has still not accepted the situation, so I have to help her by myself. I know it will be nice if Angel can write her exam but sometimes it just cannot be helped. I worry about my child's future which seems unreal and the most difficult part is just waking up every morning and making sure your child has not left you as yet. God willing, she is young and can write more tests but now I just want her to get better any way I can.”

4.3.4.3 Angel's perspective: “I did not even realize the need for school- tests or exams. Because I knew that I was going to die. I knew that I was going to be no more and my time had come. I was just counting the days. One morning I would be wide -awake and be on top of the world and the next the world would be on top of me. My grades dropped and I just couldn't cope or care anymore. Before I was a normal child going to school. I looked forward to going to school very much and writing my tests and exams were a big thing for me. I would make sure I had all my stationery and I would study so that I could be a fashion designer one day and make my parents proud of me. I used to pass comfortably. Children knew that I could pass comfortably. My life was going perfectly smoothly and it was great but after I fell pregnant and started getting ill everyone knew me because I was a danger to the school. I stayed away, got sick often and my life was turned upside down. I missed many tests and exams because I could not concentrate at all. I only focused on the hopelessness of my life and count the number of days to my grave. My life was a living nightmare. I did not have the ability to concentrate on my schoolwork. My mind was wrecked and life didn't matter to me any more. I even thought of committing suicide. My baby is a constant reminder of my mistake and I have to take care of the baby as well. Therefore I gave up on the thought of school.”

From the data it is evident that prolonged absence from school makes passing more difficult. However surviving is a greater issue than passing tests or exams for Angel. The emotional, mental and psychological anguish that HIV imposed on

Angel and her mother made the normal activities seem of little or no consequence. The struggle to live and see things in their normal perspective was extremely difficult for Angel as she continually experienced hopelessness and despair with a deep regret for her pregnancy and the effect it had on her life. Perhaps the testing overload heightened Angel's despair as continued absence disrupts continuity in learning. Angel's sense of future will be seriously affected. Infected or affected learners may not plan for the future. They regret their loss of health and future. They experience severe guilt and despair (Melvin 2000). Angel could not inform her father as well as he does not believe in the disease. Therefore she believes that coping with the disease is extremely hard. The emerging issues from both the individual and community perspectives that education has to deal with is firstly to encourage disclosure and secondly to demystify the disease and dispel the ignorance surrounding the disease.

4.3.5 Curriculum intervention on HIV/AIDS

4.3.5.1 Educator's perspective: *"Recently with the introduction of OBE and Life Orientation, sex and sexuality education became compulsory and examinable in the grade 8 and 9 syllabus. My opinion is this programme was a bit too late for some of our learners. Many learners are teenagers and they are still experimenting with sex even in this dangerous time of HIV and AIDS. It is clearly evident in my school that the message intended to empower our learners, is falling on deaf ears because of the large number of teenage pregnancies at our school. The problem is much bigger than we educators perceive. There are a number of learners who are HIV positive, but they are too scared to reveal their status for fear of being rejected. In my grade 11 class there were two aids orphans caring for their siblings something many educators were not aware of. They passed grades 11 and 12 despite trying circumstances. Assistance was given to these learners both in cash and kind, because they were too afraid to reveal their plight for fear of being labeled. Curriculum interventions only guide educators on the content but for the content on life skills, sex and sexuality to be imparted effectively, I believe every educator should receive some training to help our learners. It is common*

knowledge that learners will choose different educators on the plant for assistance, depending on whom the learner trusts, it therefore imperative that educators be trained or work-shopped to help our learners. Some form of training is essential to assist our learners in coping with HIV and all other related problems at school. At present the Life Orientation educator is targeted, for training but the reality is that children may not choose that educator for guidance and help therefore I am of the opinion everyone of the adult population involved in the education of the child be trained to assist the child. In my experience I found that some educators have a phobia for HIV positive learners, probably because of non- disclosure, and the fact that the academic work is not done, frustrates the teacher- however I cannot begin to understand how a learner who displays behaviour that is not normal, e.g. prolonged absence, always putting his/her head on the desk, sleeping in class from the first period, always asking the secretary for a tablet, remaining in the sick room during lesson time, not completing class and homework escapes the attention of any educator. The problem in school is much bigger than we think, e.g. I also had a learner in grade eight who was gang raped on her way home from school. This problem was discovered when I made enquiries about her long periods of absence. As a result of the medical strain of the virus she contracted during the rape she died of tuberculosis a year later. Another grade eleven male learner returned to school after a prolonged absence. He had lost considerable weight and stated that he was suffering from tuberculosis and was hospitalize for a long period of time. He was known as the 'glamour boy', and he was so popular with many females and he often bragged about his girlfriends. His illness resulted in him leaving school and to date his fate or whereabouts are unknown. So coming back to curriculum interventions then, my opinion is that it can only be effective if it is applied to the life experiences of our learners and it must be adapted to suit the experiences of our children rather than focusing on it being an exam subject. Educators must receive some form of in- service training at all levels to help our learners cope. We have to be direct and attack this problem head on at school level. We need to have walk in HIV/AIDS centers in schools where information is readily available to our learners so that they can get the necessary help.”

4.3.5.2 Mother's perspective: *"I know children are taught sex and sex education at school but I do not think the message is making a difference to our children. It is not in our culture to discuss sex with our children. The large age gap between Angel and myself prevented me from talking to her about sex. I relied on the school and the television to teach her. Angel loved to be with her friends and attend parties and go dancing, she did not believe that such a thing will happen to her. My other children are more educated about the disease and they know the precautions and everything about the disease from watching and helping Angel. I cannot explain why Angel did not listen to the messages about HIV/AIDS but I cannot blame her, I have to help her."*

4.3.5.3 Angel's perspective: *"I was fully aware of the HIV/AIDS virus and the death and destruction that it causes but I did not think that I would get the virus. I used to be a party animal. I was not an outcast and though I was not the queen I was one of the tribe. I had my life perfectly planned and I had no worries. I had a boyfriend and I was a virgin at that time. Peer pressure forced me to have sex as it is the in thing in schools to have sex and to have a boyfriend. In one night of passion all logic escaped me and I let my stupidity take control of me and I had unprotected sex. It was the first time that I had, had sex with my boyfriend that I had known for long. I just wanted to have fun because everyone was doing it and to top it all I got pregnant. So although I was aware of the dangers of HIV, in the moment of passion nothing matters. I can say that I was in denial because I never thought that I could get HIV. I also knew that this kind of disease never affected my family so why would it affect me . I also thought that it was impossible to get HIV for the first time although all reports say so."*

From the information presented above it is imperative to note that while formal curriculum interventions are implemented in schools it requires more efficient and informed delivery to create an impact on our learners. Therefore educators have to receive some kind of in-service training to increase their knowledge of the pandemic nature of the HIV/AIDS virus for the benefit of our learners. Learners choose educators they can trust and educators who show a caring attitude towards

them. The response from Angel's mother revealed that parents are dependant on the school to impart sexuality education to the learner. However she also believes that education on sex and sexuality is not having an effect on our learners. Angel reports that although she received sexuality education at school, but when caught in the moment of passion all rational thought was lost. Therefore the school plays a vital role in educating learners on sex and sexuality. This era of AIDS calls for educators to take a special interest in learners and not only help learners with academia but challenges associated with coping with life as well. Learners need to be taught other life skills to help them deal with compromising situations that they face.

4.3.6 Re-action to peer counselling services at school

4.3.6.1 Educator's perspective: *"Realistically speaking learners do not like seeking help from other learners. Although we offer this service in our school the idea of it is not well received by the learners. As a result of rationalization and right sizing the post of the guidance counselor was dissolved and this was the biggest blunder in my school. I know that in some other schools this service is very successful probably due to the educator in charge. But in my school learners do have a problem in approaching other learners with personal problems. They readily discuss problems of a general nature with the representative council of learners but personal problems are generally imparted to educators. Learners have problems with peer counselors who do not observe confidentiality. Peer counselors are generally grade ten to twelve learners and these counselors also become traumatized when learners disclose their personal problems to them. Counseling sessions are held during the breaks and no learner wants to go the peer counselor during the break because of the suspicion of being seen as suffering from HIV. Learners have difficulty trusting peer counselors, so in my opinion the programme can be effective if implemented properly with effective management and educator support."*

4.3.6.2 Mother's perspective: *' No telling peers or friends makes matters worse. They poke fun at you. I know because Angel could not tell anyone, even her friends were passing rumours of what they thought was happening to Angel rather than the truth. Peers are still not mature and they are friends in the school environment and there is no guarantee that they will keep your secret. So it is best not to tell anyone. Audrey is our friend and she does some good work in the church therefore I trust that she will help Angel.'*

4.3.6.3 Angel's perspective: *"I could not trust anyone at school to keep my secret. I had no friends anymore and I could not risk telling a peer counselor at my school for fear of being identified and rejected by the general school population. My grade eleven year was the most hurtful where all my symptoms were showing and I could not trust anyone so I had to leave school. Although some of the peer counselors are good I do not think they can be trusted with such a big secret."*

It is abundantly clear that trusting peer counselors is a major concern for infected learners, parents and educators. The peer counseling programme was an initiative by the Department of Education to assist HIV positive and other learners to cope with challenges that they encounter, but clearly it is not effective in some schools where trust which forms the bed rock of counseling is compromised and cannot be observed. Further the social stigma of the HIV/AIDS virus is a further inhibiting factor that prevents disclosure and trusting someone to keep that information a secret. It is clearly evident from Angel's experiences that you do become the focus of attention when symptoms start to show and you are isolated as a result of that.

4.3.7 School strategies to keep HIV positive learners in school

4.3.7.1 Educator's perspective: *"We, all role players in the school environment need to tackle this problem aggressively. The escapist assimilationist view of treating all learners as being infected is just not working. A more nurturing environment must be developed to encourage disclosure and learners must be*

supported by the school making conscientious effort to link up with other service providers in the interests of the welfare of the learner. The loss of Angel is the loss of one learner too many and such a situation must stop because anti- retroviral drugs are now being distributed and there is life after being diagnosed as HIV positive. Angel was not taken seriously by many educators. The learner did not trust many educators who often ridiculed her because of her long periods of absence. It is sad that for many educator's a child's worth is still measured by academic excellence. Management and educators need to prioritize the pandemic and make concerted efforts to help learners. I think Angel trusted me because of the following reasons:

- ✓ *The geography syllabus allows for an in-depth discussion of the pandemic*
- ✓ *Learners are given many opportunities to express their opinions on social issues i.e. teenage pregnancies, drug abuse, HIV/AIDS, teenage sexuality etc through discussions, debates, assignments, and tutorials.*
- ✓ *Honesty and confidentiality are guaranteed to all learners with no fear of being ridiculed.*
- ✓ *Discussions are frank and to the point.*
- ✓ *Learners will turn to you as long as you have their interests at heart.*
- ✓ *One has to be sympathetic and a good listener and observer.*
- ✓ *The success of a lesson is not measured by the content taught but by how you have contributed to making the learner a better human being.*

I am not advocating that we should have a fan club at school, but I do firmly believe that in this time of the pandemic, educators need to reflect on their roles and serve learners. Management and educators alike need to be more sympathetic towards learners and instead of viewing learners who are absent frequently, absconding from lessons and truanting as problem learners or trouble shooters, we need to understand why such behaviours persist and refer them to the necessary service providers.”

4.3.7.2 Mother's perspective: *“Principals and educators must help our learners to remain in school. They must support them because like Angel society has no regard for them. I see the school as the only place that can support HIV positive learners. Educators need to teach children to accept HIV positive learners in our communities to care for and support them and not to throw them away. In Angel's case I could not speak to the Principal of the school because Angel did not want me to. I still cannot speak to my husband because he has not accepted the situation. This illness devastates the family and I have no help. Educators have to make learners understand that HIV positive people are still people and they have a right to life. Educators need to tell learners that casual sex is dangerous and HIV education needs to be looked at directly even if it means taking learners to HIV/AIDS wards in hospitals. Learners are not mature and do not understand the consequences of this illness.”*

4.3.7.3 Angel's perspective: *“The management and educators must have a sympathetic approach to learners. They must be good listeners and be humane to us. They must not criticize us if we are not in school for long periods of time, they must ask us what the problem is. They must care for us like my geography educator did and have our interest at heart.”*

Thus it can be clearly seen that management members, educators and all role players have a very significant role to play in this period of HIV/AIDS. Educators need to re-think their roles as defined by the norms and standards document and provide the best service they can for our learners. Educators need to demystify the disease, create atmospheres that encourage disclosure and support HIV positive learners in schools. Schools must support learners who experience rejection on all fronts.

4.4 SOME PERSONAL RESPONSES TO THE HIV/AIDS PANDEMIC FROM THE PERSPECTIVES OF THE MOTHER AND ANGEL

4.4.1 Angel's mother: *“On being told that Angel was HIV positive, my first reaction was that it was a dream. I was shocked and I was very scared. I thought that God will take this disease away but that did not happen. I was so afraid because there was nothing that I could do to help because medicines cost so much. My husband does believe in this disease, the only thing that I could do was to be with her and help her when she gets sick, but that kills me inside knowing that her days are numbered. This disease kills me inside and I suffer internally. My dreams and hopes for my child disappeared in seconds and I feel a failure. I could not resent Angel and it did not help to blame her because what's done cannot be undone. This illness affected my whole family. It changed our lives completely. It taught me to understand more things about teenagers. I still feel that I need to understand modern youth. I believed that God made me care for an HIV positive child because I could handle it. I now rely on my pastor for guidance because this illness tears me up inside every time I look at my daughter. I manage to get some traditional medicines to help Angel and I know that she will be able to go to night school when she is stronger.”*

4.4.2 Angel's thoughts: *“I do have regrets and I do not want to talk about the father of my child who infected me. It is too painful as he is also a learner who is positive as well. But this illness destroyed my dreams and sometimes I only wish that I had waited for the right time and there are many things that I wish I could have done differently. I miss school the most. I recall the first day I went to secondary school. I was so excited and my future looked so bright but now things are really changed. My secondary school was known for its cute guys and girls and I remember that I felt that I had just come to paradise. I waited for this day all my primary school days. However when I became ill, I wanted to still go to school to escape my father because I was so ashamed of myself. School became a battlefield for me, than a place of education. I could not cope with schoolwork and the whole school programme of tests and exams. The high expectations of the*

educators pressurized me and I felt trapped because I could not concentrate. My mind was always concerned about the illness I have. I always thought about my child and I realized that it is best to quit school and spend my days with my child. I could not live with the rejection of my friends as well. They avoided me and were afraid of me, perhaps thinking that I might hurt/ infect them as well. I knew that they knew that I was HIV positive because I could just sense all the time that they were talking about me. This was mental agony for me. I just had to quit. My symptoms in my grade eleven year made it impossible for me to stay in school. My relationship with my mother was strengthened and I found comfort in talking to my brother. I am trying to live positively now and am trying to live healthier as well. I am currently taking traditional medicines which really helps. Western medicines are too expensive and to get them is a long wait at the local clinic but I am still trying. I miss my old school very much. It hurts when I talk about my school days. I look forward to church very much and with the help of my pastor I am trying to manage this disease. I want to finish school and I attend night school when I can because I feel more comfortable there. I chose the name Angel because angels are messengers from God who have jobs to do and it is my job to warn teenagers of the dangers of casual sex, that HIV/AIDS kills and to convince them that they must change their minds towards sex because as teenagers we think we know everything but we don't. My one mistake cost me my life and that is a tragedy.”

Thus it can be seen that attending school was very difficult for Angel. Coping with the demands of schoolwork, the rejection from friends and peers and her inability to concentrate caused by the pressures of being HIV positive forced her to leave school. In spite of all the trauma and anguish Angel and her mother endured there was a glimmer of hope in their responses, that one day she will get better. There is a hope for a brighter future for her once she gets well, as revealed by her mother. Her new- found friend and confidante is her pastor. This spiritual bond can be seen as the agent of change in Angel's life as she looks forward to going to church. This spiritual renewal enables Angel to see herself as God's messenger wanting to educate teenagers on the dangers of HIV/AIDS.

4.5. DOCUMENT ANALYSIS

An analysis of the attendance register from 2000 to 2001 revealed that Angel had a particularly high absentee rate. This resulted in her failing grade ten in the year 2000. She had to repeat grade ten. She succumbed to the same fate in grade eleven. Grade eleven was particularly traumatizing because the disease was progressing rapidly into AIDS. She was hardly present at school and she was absent on average for about twenty days a month. The exact figures for 2002 and 2003 could not be traced as there were problems with securing attendance figures for those years from the school. However in my discussion with her geography educator, I was able to confirm her attendance records verbally.

Her academic record for grades eight and nine reveal a learner who passed easily from one grade to the next. Her problems began in the year 2000. Angel was studying English, Afrikaans, Business Economics, Geography Hotel Keeping and Catering and Travel and Tourism. There was a sharp decline in her grades in all of these subjects. She managed to pass geography in her first attempt at grade ten. In her second attempt, she managed to pass, just making the aggregate of 720. Poor attendance characterized grade eleven for the entire first term. She then left school.

A study of the attendance register and Angel's reports validates that her poor attendance prevented her from passing. Her illness affected her ability to continue with school.

4.6. CONCLUSION

From the analysis of the data it can be gleaned that remaining in school for an HIV positive learner is extremely difficult. A concerted effort is required by all role players within the arena of the school to work together and to approach HIV/AIDS education, supporting learners infected and affected by AIDS with vigour and resolve. HIV positive learners need to remain in school and be provided with the necessary support services to sustain a healthy mind and to live positively.

HIV/AIDS education must not be superficial. It must deal with the reality of sex and sex education within the South African environment. Educators must be trained to disseminate age appropriate sex education. According to the 'Tirisano' document HIV/AIDS education is mandatory in all schools, but sadly while it is done, the appropriate message is not communicated to our learners. Much still needs to be done and education is the only weapon left to fight the disease and the crippling mind set it creates and implies.

The next chapter will focus on my insights I gleaned from this study. This research study will also allow me to make recommendations that I will discuss in the next chapter.

CHAPTER FIVE

5. INSIGHTS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

The focus of the previous chapter was the discussion of the findings based on the research question, how does an HIV positive learner experience school? In this chapter insights will be discussed, recommendations will be made and conclusions will be drawn based on the findings obtained from the study.

5.2 INSIGHTS

5.2.1 Observation

The one- week period of observation confirmed Angel's prolonged absence from school and her lack of participation in the academic and social curriculums of the school. As I reflect on the data collected from the observation session I think educators should attempt to create an environment that encourages disclosure or encourage learners to adopt a 'buddy system' where a learner can rely on a friend or peer to tutor and help HIV positive learners with basic schooling. Home schooling should be encouraged. Informal counseling to a learner who shows signs of distress may encourage disclosure. The observation validated the findings of the interviews and the analyses of documents.

5.2.2 Interviews

5.2.2.1 Interview with educator

The insights gained from this interview were that educators are ill prepared to handle HIV positive learners in class. Educators are not adequately equipped to deal with the needs of this kind of learner. Educators need to be trained and workshopped on the latest developments in curriculum interventions in HIV/AIDS so that they can take charge of this pandemic and plan for effective education of

the learner. With the absence of guidance counselors in schools educators need lay counseling training to support and encourage infected learners. The study revealed that management teams need to show strong leadership and prioritize the seriousness of this pandemic on the academic and social agenda of the school. Educators are also troubled by the increasing numbers of HIV positive learners in their classrooms and they become traumatized by watching young learners wither away by the disease. This implies that educators also need to be counseled as well. There was also a need to look at a new pedagogy in this era of HIV/AIDS.

5.2.2.2 Interview with parent

The insights gained from this interview is that the parent has very little or no option if the infected learner does disclose that s/he is HIV positive. No help can be elicited from the school to support the learner. The social stigma of the disease is so overwhelming and encompassing that it affects every aspect of family life. The non-acceptance and denial of the infection by loved ones creates further trauma and despair. The irony of the situation is that the survival of the child is paramount than the search for proper medical intervention or counseling to prolong the learner's life. A heavy reliance on traditional medication is believed to work. There emerged a strong reliance on others to provide sex and HIV/AIDS education for their children. There was also the reflection that there was more learning after the event i.e. after Angel was infected with the virus.

5.2.2.3 Interview with learner

The study revealed that the experiences of an infected learner in a school set up is definitely traumatizing and filled with mental anguish. Angel suffered mentally as a result of non-disclosure and she couldn't risk disclosure because of the ridicule and ostracizing she would have had to endure. The irony is that she still had to endure rejection, ridicule and suspicion when her symptoms of weight loss, fainting and dizziness became more apparent. The non-disclosure weaved a web of despair and hopelessness in her situation that resulted in prolonged absences, poor performance in academia and a total withdrawal from school life which facilitated her leaving school.

5.3 IMPLICATIONS OF THIS STUDY

From the review of literature and the findings of this study it became evident that the school is the major community- based organization to manage the impact of the pandemic for our learners. This is so because a large percentage of our learners infected are still in school. The theories of learning also inform that learning in this era of HIV/AIDS has to involve the learners in planning, programming and in the implementation of programmes at school level. This calls for proper planning within the school to facilitate such programmes.

This study also implies that educators be reflective practitioners. The authoritarian educator who sees himself/ herself as the fount of knowledge is long gone. Educators have to serve the learner in many different roles as stipulated by the norms and standards for educators, The National Policy Act, 1996 (Government Gazette 2000). This act identified among others seven roles that the educator has to perform for the benefit of the learner. These include learning mediator, interpreter and designer of learning programmes and materials, leader, administrator and manager, scholar researcher and lifelong learner, community, citizenship and pastoral role, learning area specialist and assessor.

This translates into the educator creating an environment of non-discrimination against the HIV positive learner, to support the positive learner, to respect the learner's right to life, care, counseling, survival and development, to respect the choices of the infected learner and finally to restore the dignity of the HIV positive learner.

5.4 RECOMMENDATIONS

This research revealed that HIV/AIDS is definitely the sign of the times in South Africa. As a result I propose the following recommendations,

5.4.1 For the Department of Education

- ✓ Provision of regular in- service training workshops for educators on sex and sexuality, life skills education and basic care and counseling of infected and affected learners.
- ✓ The training of school managers, governing body personnel, educators and learner representatives as lay counselors to assist learners with coping strategies.
- ✓ To encourage partnerships in education between the school and the health and social welfare departments.
- ✓ To reinstate the guidance and counseling educator at schools.
- ✓ The curriculum on sex and sexuality education needs to begin from primary school with age appropriate sex education.
- ✓ To appoint a health care professional in school.

5.4.2 The Institutions of Higher Learning

- ✓ To offer courses on basic HIV/AIDS care and counselling and social justice to all students training as teachers.

5.4.3 Managers and educators at school

- ✓ That an appropriate, relevant and context specific school policy on HIV/AIDS be formulated, adopted and implemented.
- ✓ That managers and educators establish protocol for dealing with infected and affected learners.
- ✓ Establish networks with social welfare partners.
- ✓ Managers and educators create a non- discriminatory and non-judgemental environment through teaching strategies.
- ✓ That youth programmes involving learners under the guidance of a good manager or educator be implemented at school.
- ✓ That a nurturing, warm and caring environment be created to encourage disclosure.

- ✓ To establish school based support systems and teams tailored to suit the specific needs of the school to assist learners who are experiencing problems.
- ✓ That sex and sexuality and life skills age appropriate education be implemented from primary school.

5.5 CONCLUSION

As this study concludes and I reflect on the data collected I think of the emaciated figure who called out to be understood and accepted. The school is the most important community based organization regarding the care and support of infected and affected learners. It occupies a central position in the epidemic in imparting appropriate information, debunking misinformation and myths, addressing unhelpful cultural practices and taboos and building life skills and capacity since prevention on its own is an incomplete response. Let us as educators cease the moment and save lives.

I conclude this research study with a poem by Emily Robinson, which I read, at an HIV/AIDS workshop organized by the Department of Education in 2004

If I can stop one heart from breaking
I shall not live in vain
If I can ease one life the aching
Or cool one pain
Or help one fainting robin into his nest
Again
I shall not live in vain.

With that I conclude this thesis.

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APPENDIX A

OBSERVATION SCHEDULE

As a result of non-disclosure, observation was only done according to the criteria agreed upon as listed below:

- ✓ The number of days Angel attended school in that week,
- ✓ Her interaction with her friends and peers during the first and second break,
- ✓ Her participation in any lunch- time activities,
- ✓ Her general demeanour during the breaks and lesson time.

OBSERVATION SCHEDULE :

MONDAY TO FRIDAY:

MORNING: (07: 45 - 08: 00)

FIRST INTERVAL: (10: 20 – 10: 35)

SECOND INTERVAL: (12:35 – 13: 10)

APPENDIX B

SEMI-STRUCTURED INTERVIEW 1.

INTERVIEW WITH EDUCATOR

Semi-structured interview was conducted to determine the experiences of the learner from the perspective of an educator that she had recommended. The responses were used for cross-validity checks with the observation schedule and the interview with learner and parent.

The questions were a mixture of open-ended and those requiring specific details.

QUESTIONS

1. BIOGRAPHY

- 1.1. How many years have you been a teacher?
- 1.2. What is your area of specialization?
- 1.3. How many years have you been Angel's teacher?

2. INTERACTION WITH THE LEARNER

- 2.1. Describe your interaction with the learner?
- 2.2. From your interaction, how do you think the learner was experiencing school,
 - 2.2.1. Academically (i.e. school work, examinations, tests)
 - 2.2.2. Socially (her interactions with educators and learners)
- 2.3. Do you believe that educators are sensitized adequately to deal with HIV+ learners?
- 2.4. What activities did she participate in?
- 2.5. What activities did she have the most difficulty in?

APPENDIX C

SEMI-STRUCTURED INTERVIEW 2

INTERVIEW WITH THE MOTHER

Interview conducted by Audrey, the peer counselor at the mother's residence. A list of questions was given to the peer counselor and instructions on the recording of responses were outlined.

QUESTIONS

1. Describe the event when Angel told you she was HIV+?
2. Describe how Angels' illness affected the following:
 - 2.1. Her attendance at school.
 - 2.2. Her performance in tests and examinations.
 - 2.3. Her interaction with friends.
 - 2.4. Her participation in school activity.
 - 2.5. Her general attitude towards school.
3. Was there any aspect of schooling that Angel found most difficult?
Why?
4. How did the family react to her disclosure?
5. Did Angel's attitude towards school change after her disclosure?
6. How do you think that the school can assist in preventing learners from becoming HIV+?
7. How can the school support those like Angel who are infected?

APPENDIX D

SEMI-STRUCTURED INTERVIEW 3

INTERVIEW WITH ANGEL

Angel is the name my participant chose to call herself. The interview was used to generate data on how the learner experienced school. The questions were designed to fit the respondent. They were similar in content to the questions posed to the mother and the educator to ensure greater credibility of the data.

Questions

1. Describe your routine in school from the morning to the afternoon before you were HIV+.
2. Was there a change in your routine after you found out that you were HIV+? Describe the changes, if any.
3. What are the difficulties you have in school as a result of your illness? Both formal and informal.
4. How do you think schools can best assist learners such as yourself, in school?
5. Describe your relationship with other learners before you discovered you were HIV+ and after.
6. Describe your relationship with educators before you knew you were HIV+ and after.
7. What did you think of the peer counseling provided at school?
8. Is there any reason why you did not make contact with them?
9. What motivated you to attend school after you discovered you were HIV+?

P O Box 3814
Stanger
4450

25 November 2003

The Principal

Sir/Madam

My name is Padmani Nasaree and I am a student at the University of Kwa-Zulu Natal. I am currently completing my Masters Degree at the University of Kwa-Zulu Natal. I am in the process of completing my dissertation. My research focus is HIV/AIDS, and I am documenting the experiences of an HIV positive learner.

I hereby request your permission to peruse and record the academic results of your ex- student for the years 2002 and 2003. Any information that you divulge to me will be treated with the strictest confidence. Your ex- learner and your school will remain anonymous during the entire research process. The research is strictly for educational purposes only and should you require any further information you can contact me at the above address or telephonically at 032- 5544652 or 0837874677 or 032- 5511227.

Thank you for your co-operation

Yours faithfully

P Nasaree
Reg. No. 8117068

P O Box 3814
Stanger
4450
15 March 2004

Dear Angel

Thank you for agreeing to be a very significant part of my research project. You cannot imagine my delight when you agreed to participate in my research project. My intention was to record the experiences of an HIV positive learner so that together we could make a positive contribution to the HIV pandemic that affects our learners at schools. After researching my topic for two years and being told that I cannot publish the findings was completely devastating to me. I pursued nonetheless, hoping that someone, somewhere would try to understand the need for such a study. I have attended various workshops, which are held very regularly on the theory of the HIV/AIDS pandemic, but none provided us teachers with the experiences of a positive learner so that we could make a significant contribution on how to deal with this pandemic practically. Angel, you are the beacon of hope that will change the attitudes of all those who still believe that this pandemic is not as serious as we make it out to be. Your identity and the school you attended will remain anonymous. Any information that you impart to me will be treated with the strictest confidence. Your tape-recorded interview, your diary, your responses to the questions and your medical and academic reports will remain confidential.

I hope that my research will create a greater awareness of this dreaded disease and it will equip us educators with lay counselor skills to address this problem at our schools.

I thank you.

Take care

P Nasaree

Reg. No. 8117068

P O Box 3814
Stanger
4450

20 March 2004

Angel

Affirmation of intent

This is to say that I am conducting this study for educational purposes and no harm will come to you, Angel. All information given and provided to me will be treated confidentially. Angel, you may withdraw at any time you feel threatened and you will still receive a copy of my research report. You will see the data at any time.

The interview that you have agreed upon will be taped with your permission and I will transcribe the information myself. You will see the transcription upon completion.

Thanking you
P Nasaree

Reg. No. 8117068

P O Box 3814
Stanger
4450

20 April 2004

Angel

Thank you for agreeing to participate in my research project. My interest is how an HIV positive learner experiences school. I want to formalize our agreement by securing your permission in writing of your decision to participate in my research project.

Thank You

P Nasaree

I, _____ agree to participate in this research.

Signature

Date