

**HIV/AIDS AS A BARRIER TO LEARNING:  
EXPLORING THE LIVES OF AFFECTED CHILDREN  
IN THE RICHMOND DISTRICT**

**by**

**SILOCHANA NAICKER**

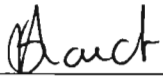
**Dissertation submitted in partial fulfillment of the Master of Education (MEd) in  
the discipline Psychology of Education, School of Education and Development,  
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**SUPERVISOR: Dr P. Rule**

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## DECLARATION

I declare that this dissertation titled, **HIV/AIDS AS A BARRIER TO LEARNING: EXPLORING THE LIVES OF AFFECTED CHILDREN IN THE RICHMOND DISTRICT** is my own work and that all the sources that have been used or quoted, have been indicated and acknowledged by means of complete references.



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**Silochana Naicker**

Reg. No.: 202001057

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## ABSTRACT

Currently in South Africa much emphasis is being placed on minimizing barriers to learning and maximizing participation to learning. *Education White Paper 6 of 2001* draws attention to the barriers to learning in South Africa and highlights HIV/AIDS as one of the barriers to learning. This study, therefore, seeks to ascertain what barriers to learning impact on the lives of children affected by HIV/AIDS and what support exists for children affected by HIV/AIDS. Further, this study is part of a larger project commissioned by the NRF on the impact of the HIV/AIDS pandemic on learning in the Richmond District.

A participatory research framework was employed in this study using qualitative methods of gathering data. A structured participant interview schedule was devised using projective and drawing exercises to get participants to volunteer information. Six children from a Day Care and Support Centre in Richmond were selected purposefully as research participants. Three focus group sessions were held to gather the data from the participants.

The data that was gathered was subjected to stringent content analysis from which topics and categories emerged which were used to report on the data. The data was analysed using critical theory in general and Young's theory of oppression in particular. The findings of this study confirm that poverty, issues pertaining to family responsibility, the emotional trauma of losing loved ones and the crime, violence and abuse that affected children are exposed to, all serve as barriers to learning. Further, the findings indicate that children are aware of the agencies from which assistance could be accessed. However, the financial assistance in terms of child support grants is not being fully exploited by those who qualify for it.

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## ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CAPRISA	Centre for the AIDS Programme of Research in South Africa
CBO	Community Based Organization
GEAR	Growth, Employment and Redistribution Strategy
HIV	Human Immuno-Deficiency Virus
NGO	Non-Governmental Organization
NRF	National Research Foundation
SGB	School Governing Body
SMT	School Management Team

## CHAPTER ONE

### BACKGROUND AND ORIENTATION TO THIS STUDY

#### 1.1 INTRODUCTION

Deadlier than war, deadlier than tyranny, deadlier even than malaria, AIDS is silently tearing Africa apart. The pandemic is throwing millions of households into turmoil. Often the middle generation is wiped out and children and the elderly are left to fend for themselves (Guest 2001: ix). This is the stark reality of the HIV/AIDS pandemic and its effect on society.

The pandemic in South Africa is so intense that no one can ignore the reality and every life in the Republic is influenced by it. As at 2003, it was estimated that over 5 million South Africans were infected with HIV/AIDS. Projections for the future indicate that between 5.3 and 6.1 million South Africans would be HIV positive by 2005, and between 6 and 7.5 million by 2010. It is further estimated that a sixth (3 million) of South African children will be orphans by 2010 as a result of the pandemic (Van Vollenhoven 2003:242).

The rising prevalence rates worldwide indicate that most strategies to contain the disease have not been effective. As HIV/AIDS spreads, individuals, families, communities and nations must learn to live with the disease. But HIV/AIDS is no longer just a disease. It is now a pandemic, an entirely different though clearly linked phenomenon. The pandemic is a complex set of related problems which together constitute a phenomenon that needs understanding in very broad geographical, demographic, environmental, psychological, cultural, economic and social terms (Coombe 2002:vii).

In this new context, education can definitely no longer be 'business as usual'. Learning institutions in an AIDS-infected world cannot be the same as those in an AIDS-free world. Challenged by this pandemic, the paradigm of education is shifting. It is necessary to change educational planning and management principles, curriculum development

goals, and the way we do education if the quality and level of education provision are to be sustained at reasonable levels, and the hard-won gains of the *Education for All* era retained (Coombe 2002:vii).

The education sector has a special responsibility with regard to the HIV/AIDS pandemic. General agreement, at both national and international levels, has emerged over the past three years that there are four principal areas of concern for sector partners:

- *Prevention*: helping prevent the spread of AIDS
- *Social Support*: working with others to provide a modicum of care and support for learners and educators affected by HIV/AIDS, including orphans and other vulnerable children
- *Protection*: protecting the education sector's capacity to provide adequate levels of quality education - by stabilizing the teaching service and improving educator skills, and responding to new learning needs, and
- *Management*: harnessing, acquiring, and developing capacity to manage the sector's response to this crisis (Coombe 2002:viii).

## **1.2 FOCUS OF THIS STUDY**

This study was part of a larger research project commissioned by the NRF and conducted by the School of Education and Development, Faculty of Education and the School of Psychology, of the University of KwaZulu-Natal. This larger project, which was conducted in the Richmond District, focused on the extent to which HIV/AIDS is a barrier to learning and participation in basic education for adults and children in non-formal and formal educational settings, and the interrelationship between HIV/AIDS and other socio-economic factors linked to exclusion.

The focus of my research study, however, is on children affected by the HIV/AIDS pandemic. Children affected by HIV/AIDS are uniquely at risk, and are vulnerable at all points in their lives: how they are treated in their families, communities and in schools; under what conditions they are able to remain or participate in these structures; the extent to which HIV/AIDS creates fear, discrimination, exclusion; whether they are forced into

sporadic non-attendance by having to assume responsibility for family income and child care (School of Education & Development 2003:9).

Further, in this study there is a focus on the barriers to learning experienced by children affected by the pandemic. This focus actually stems from the larger research project outlined above. However, in this study learning includes both schooling as well as educational support at home and in the community.

### **1.3 AIMS OF THIS STUDY**

The aims of this research study are thus:

- To add to our knowledge about the ways in which HIV/AIDS is a barrier to learning in respect of affected children.
- To add to our knowledge about the ways in which HIV/AIDS interacts with other barriers to learning.
- To determine what support the school and community as systems offer to HIV/AIDS affected children.

### **1.4 MOTIVATION AND RATIONALE FOR THIS STUDY**

Research into the HIV/AIDS pandemic has always been viewed as a health concern within education. However, it should also involve understanding the nature of the pandemic and its influence on the education community and responding creatively to a much more complex teaching and learning environment in order to maintain quality education (Coombe 2000c:6).

The research literature on HIV/AIDS in education has generally focused at the macro-level of national education systems within a quantitative research approach. Little attention has been given to the micro-level of analysis of the effects of HIV/AIDS on particular schools and communities, and the concrete experiences and responses of educators, learners and parents regarding HIV/AIDS (School of Education & Development 2003:7-8).

Currently in South Africa much emphasis is being placed on minimizing barriers to learning and maximizing participation to learning. *Education White Paper 6 of 2000*, aims to draw attention to the barriers to learning in South Africa. One of the barriers highlighted is that of the HIV/AIDS pandemic (Republic of South Africa 2001).

From the literature reviewed by the researcher, the focus of much of the research on HIV/AIDS was on the infected child. Not much research has been done in respect of learners affected by the pandemic and how this impacts on their schooling.

The researcher was also motivated to pursue this study because in the area where the researcher serves as a school-based educator, the incidence of the pandemic, though not very high, is beginning to increase. This has aroused an interest in the researcher to determine how the pandemic affects the schooling of children who are affected by the pandemic.

## **1.5 KEY RESEARCH QUESTIONS**

The study seeks to answer the following key questions:

- What barriers to learning impact on the lives of children affected by HIV/AIDS?
- What support systems exist for children affected by HIV/AIDS?

## **1.6 DEFINITION OF TERMS**

In order to facilitate a common understanding, broad definitions of key terms used in this study are provided.

### **1.6.1 AFFECTED CHILDREN**

In order to ensure a common understanding of the term ‘affected children’ it is important to define the term. A widely accepted definition of ‘affected children’ includes one or more of the following:

- Children from households with infected family member/s, e.g. where a parent or parents are sick or dying of AIDS and the children often have to care for the sick and/or assume adult responsibilities before they are ready to do so.

- Children orphaned as a result of HIV/AIDS (Republic of South Africa Department of Health 2001:4).
- Children infected through mother-to-child transmission or rape.

It is often the contention that all children will be affected by the HIV/AIDS pandemic. However, there is agreement that some children will be more adversely affected than others. The healthy children of HIV-positive parents will be adversely affected during their parents' illnesses and will usually be faced with severe consequences once one or both of their parents die. The children of those families which take in orphans, often in very resource constrained situations to start with, will be adversely affected as fewer resources are available for their care and development. Even those children from unaffected households will be affected because of the probability of their playmates leaving school due to the destruction of their households following the death of their parents (Gow, Desmond & Ewing 2002:4).

### **1.6.2 ORPHAN**

'Orphan' is a socially constructed concept and varies among cultures and countries. For some it refers to children who have lost one parent, (maternal/paternal orphans) while to others, the term is reserved for those who have lost both. While quantitative data are important, statistics on orphans do not measure the full impact of AIDS on children or the magnitude of the problem caused by AIDS. For example, orphan statistics do not track the number of children who are caring for a sick parent and experiencing physical and psychosocial stress similar to their orphaned counterparts. As a result, it is widely acknowledged by many experts that interventions and programmes designed to assist children should not seek to serve only those orphaned by AIDS, but all children affected by AIDS, including orphans and other vulnerable children (Hepburn 2002:88).

Thus, as the pandemic progresses and the infected get sick and die, the burden of care and the social implications of HIV tend to fall on the children and the elderly. The socio-economic status of families and communities will determine the impact of the disease on children and their educational opportunities (Moletsane 2003:9).

## **1.7 REVIEW OF LITERATURE**

The literature that was selected for review was obtained from a comprehensive search of national databases such as the NEXUS database on current and completed research in South Africa and international data bases such as ERIC and EBSCO. The majority of the books and journal articles consulted in this study were obtained from the libraries at the Westville, Edgewood and Pietermaritzburg campuses of the University of KwaZulu-Natal. Information was also obtained from provincial and national newspapers.

## **1.8 RESEARCH DESIGN AND METHODOLOGY**

A summary of the research methodology employed in this study is presented.

### **1.8.1 METHODOLOGICAL APPROACH**

This research is located within a participatory research framework and uses qualitative methods. Qualitative research, according to Uys (2003:118), refers to collection of data that reflects the quality or nature of a particular phenomenon in the form of description. Generally, qualitative methods are used when depth is required (Bertram 2003:45). Like much qualitative research, it is interpretative in that it deals with the perceptions of ordinary people in their daily lives (McBride 2002:141).

McBride (2002) argues that in-depth research has been neglected by those involved in education. Further, it also has been argued that much of the work done in the area of HIV/AIDS and education has used more quantitative rather than qualitative methods (School of Education & Development 2003:13). In terms of this study, qualitative methods enabled the researcher to gather in-depth information and understanding of how HIV/AIDS acts as a barrier to learning as experienced by affected children. Further, it also enabled the researcher to probe what support systems exist for these learners at school and in the community.

### **1.8.2 THE RESEARCH SITE**

The research site selected for this study is a small district called Richmond situated 35km south of Pietermaritzburg. It has a number of semi-formal and informal settlements which

house about 70 000 people (School of Education & Development 2003:10) According to Whiteside and Sunter (cited in School of Education & Development 2003:10), it is an area with high rates of HIV infection. My justification for selecting the Richmond district as my research site is as follows:

- accessibility of the institutions
- its range of settings including urban, peri-urban and rural
- high infection rate in terms of HIV/AIDS.

### **1.8.3 SAMPLING**

The purposive sampling technique was used to select informants because the researcher had to make specific choices about which people to include in the sample (Bertram 2003:71). Specifically, the researcher chose learners in the 9-12 year age group located at a Day Care and Support Centre at Ndaleni in Richmond. Given the veil of secrecy surrounding the HIV/AIDS pandemic, identification of affected children proved to be extremely difficult. However, at this centre volunteers have disclosed that there are children affected by the pandemic.

### **1.8.4 METHODS AND TECHNIQUES**

A participatory approach to data collection methods was used. Such an approach enables a production of knowledge in an active partnership with the participants who are affected by that knowledge (Babbie 2002). Participatory approaches are useful because they reduce the power imbalances that exist in traditional research methods between the researcher and the researched. Further, participatory methods allow for the analysis of a number of different perspectives and dimensions regarding the extent to which HIV/AIDS is a barrier to learning and participation as well as its embeddedness within various social, political and symbolic contexts (School of Education & Development 2003:14).

Data was obtained from six participants using focus group interviews. Various projective techniques and drawings were employed to gather data.

### **1.8.5 ETHICAL ISSUES**

Gray, Lyons and Melton (1995:6-7) identify respect for persons and their privacy as key ethical issues in HIV/AIDS research. This is accentuated because those affected and infected by HIV/AIDS are often the most vulnerable and marginalised social groups. Since this research study involved entry in the private spaces of participants in a community, it was particularly sensitive to issues around confidentiality and anonymity. Agreement was reached with participants and their guardians about the limits to accessibility of information and the process of dissemination of the findings (School of Education & Development 2003:14).

### **1.9 CHAPTER OUTLINE**

This research study is divided into five Chapters.

**Chapter One** provides a general background and overview of the key aspects of this study. The study is introduced by pointing out the incidence and prevalence of the pandemic in South Africa and its consequent impact on the education of children. The focus of this study, the aims of this study and the motivation and rationale for pursuing this study are presented. The key research questions to be explored are listed followed by the definition of key terms used in this study. A brief outline of the methodology employed in this study brings this chapter to conclusion.

**Chapter Two** focuses on the literature reviewed with regard to the key research questions generated in chapter one. The review commences with an account of the barriers to learning experienced by learners affected by the HIV/AIDS pandemic. The impact of socio-economic factors, social discrimination, challenges to family responsibility, health, violence, gender and abuse are highlighted. An account of the appropriate support to those affected by the pandemic is then presented. This chapter concludes with an account on critical theory and oppression which were the theoretical tools employed in this study.

**Chapter Three** focuses on the research design and methodology of this study. After presenting a brief discussion on the methodological approach to this study, the methods used to gather data are presented. The research instrument, including its design and trialing, is discussed. Accounts of the research site, sampling techniques employed and ethical issues pertinent to this study are then presented. A brief narrative follows on the biography of the research participants in this study.

**Chapter Four** focuses on the presentation, analysis, findings and discussion of the data gathered from the focus groups. The data is presented in terms of the topics extracted from the focus group schedule. Based on the data obtained on each topic, the researcher grouped the data into categories. The emerging trends and patterns from the presented data are then outlined. Pertinent findings of this study and a discussion of the findings in terms of the theoretical and conceptual tools are then presented.

**Chapter Five** presents the main conclusions and recommendations of this study. After a careful consideration of the findings of this study, certain clear conclusions are drawn and pertinent recommendations are made.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

The previous chapter outlined the background and introduction to this study. This chapter focuses on the literature reviewed with regard to the key research questions formulated in chapter one.

This review commences with an account of the barriers to learning experienced by learners affected by the HIV/AIDS pandemic. The impact of socio-economic factors, social discrimination, challenges to family responsibility, health, violence, gender and abuse are highlighted. An account of the appropriate support to learners affected by the pandemic is then presented. This chapter concludes with an account of the theoretical tools, namely critical theory and Young's theory of oppression, which were used in this study.

#### **2.2 BARRIERS TO LEARNING**

The barriers to learning experienced by learners affected by the HIV/AIDS pandemic, as indicated in the literature, are multifarious and include socio-economic factors such as poverty and the high cost of education; challenges posed to family responsibility; social discrimination; health; violence; gender and abuse.

##### **2.2.1 DEFINITION OF THE TERM 'BARRIER'**

A barrier is something which prevents access or causes hindrance or impediment or obstacle (The New Choice English Dictionary 1999, s.v. 'barriers'). In the context of this study the term barrier is used to denote any factor impeding or serving as an obstacle to learning for HIV/AIDS affected children.

## **2.2.2 THE SOCIO-ECONOMIC IMPACT OF HIV/AIDS**

The socio-economic barriers to learning experienced by learners affected by the pandemic include poverty and high cost of education.

### **2.2.2.1 POVERTY**

Researchers are in agreement that the pandemic has a significant impact on household income (Giese 2002; Moletsane 2003; Malaney 2000; Ebersohn and Eloff 2002). Giese (2002:60) and Moletsane (2003:9) point out that when a family member has AIDS, the average household income will fall while expenditure increases owing to the costs of special medical treatment, transport to health facilities, nutritional requirements and ultimately, funeral costs. When money is available, most of it is spent on medical and nutritional care of the sick and dying. With the decline in the number of economically active people, children, most of whom are orphans and/or live in child-headed households, are left to fend for themselves. Under these circumstances, unable to access resources for their basic needs, education becomes either a nuisance or a luxury. Thus the possibility of successfully educating children becomes remote, and that of keeping them in school, almost impossible. The result is high failure and low retention rates and eventually high dropout rates from school.

Children who are orphaned as a result of AIDS more often than not, grow up as street children or in child-headed households, with very little income and, therefore, no possibility of attending school. Some are brought up by grandparents, mostly grandmothers, and survive on monthly social security payments of about R700.00. This suggests that while these children have been orphaned, the reason they either withdraw or are excluded from school is linked to economic status – their own and that of their caregivers (Moletsane 2003:10).

Researchers also concur that the death of the parents has a significant impact on family finances (Malaney 2000, Giese 2002 and Moletsane 2003). Malaney (2000:5) avers that as children are orphaned they often lose their primary source of financial support. Young

children are often forced to find work to support themselves and their younger siblings, consequently causing them to drop out of school.

Giese (2002: 60) further points out that the financial impact of an AIDS-related death on the average family is greater than the financial impact of any other cause of death. The financial burden of HIV/AIDS adversely affects the living standards and quality of life of all household members, leading to food insecurity, malnutrition, poor hygiene, loss of opportunity and other factors related to poverty.

An example from Guest (2001:135) illustrates this point:

*My father stopped working in June when he got sick. June, July, August, we had to ask neighbours for food. Sometimes we were hungry. Sometimes we'd go to sleep without eating because we didn't have money to buy food.*

Further, it is important to note that the nature of the family structure in sub-Saharan Africa is changing, because the number of households headed by children is increasing in the wake of the pandemic. Malaney (2000:5) points out that in many cases orphans are taken in by their extended families. Once again, family structures are being modified across the entire region as grandparents find themselves in the position of taking care of young grandchildren, or couples find themselves raising many more children than they had planned because they take in the children of dead siblings or cousins. This places considerable financial burden on families, and they often cannot afford to keep all these children in school.

#### **2.2.2.2 HIGH COST OF EDUCATION**

Whilst the *Constitution of the Republic of South Africa Act, 108 of 1996* states that education is free, the reality in South Africa is that education has become a commodity. Parents are expected to pay for their children's education through school fees. Researchers have established links between parents/caregivers inability to pay school fees

and their children being excluded from schooling (Badcock-Walters 2002; Moletsane 2003; Williamson 2004).

Badcock-Walters (2002:97) points out that in order to improve the quality of education, schools are imposing user fees (school fees) which parents have to pay. Parents who are unable to pay school fees run the risk of their children being expelled from school, being held back a grade, having report cards withheld, being threatened by teachers, being excluded from the school feeding scheme and being embarrassed and teased. Badcock-Walters (2002:98) and Williamson (2004:1) concur that the inability to pay school fees may indeed prohibit the entry of the child to school. While there is clear and articulate national policy insisting that every child has the right of access, school principals and school governing bodies are faced with issues of institutional viability and routinely turn away learners unable to pay fees. Even if the school was to permit entry, the fact is that the child would be hard pressed to pay for stationery and textbooks, as well as for transport and food at school. Williamson (2004:1) emphasizes that school fees are only a small part of the expenses families face to send a child to school. Other expenses include uniforms, books and supplies. The additional expenses and loss of cash income from employment, that comes with illness, force families to redirect their financial resources. Children are often forced to drop out of school before they are orphaned, and school expenses may no longer be affordable when children have to leave school to care for ailing parents and take on adult work responsibilities.

Contrary to the *South African Schools Act, 84 of 1996* that promises every child access to quality education in their own locality regardless of the child's socio-economic background, many schools in the country still exclude non-payers from school activities. An evaluation of a science education project in 34 schools in one rural district in KwaZulu-Natal province, the worst hit by the HIV pandemic, indicates that the annual average fees charged per child per school is about R62.00 in primary schools and R140.00 in high schools (Moletsane and Volmink 2003). Moletsane (2003:11) adds that while this is very low by national and international standards, many of the children in this area are unable to pay, leading to their exclusion or withdrawal from school. Compulsory

school uniforms, the cost of which has been found to be beyond reach for many of the families in rural and township schools, is another stumbling block to children's access to education. For HIV-infected and affected children, the burden of paying for education is, therefore, considerable. To supplement household income, children often have to drop out of school in order to engage in income-generating activities, or care for the sick and dying, as well as the surviving siblings.

In commenting on education in sub-Saharan Africa in general, Hepburn (2002:91) has observed that primary education is not universally free. Families, through locally imposed fees, must pay a substantial proportion of the costs of operating a school. In addition to school fees, families are often required to pay for teaching materials and supplies, uniforms, recreational activities and levies for school development, maintenance and construction. While paying these expenses is difficult for many families, it is particularly burdensome for households seriously weakened by AIDS. Reasons for this include the loss of income from employment and other activities, in rural areas a reduction in farming which decreases income generating potential, high costs for health care and medication and a growing number of households affected by AIDS are headed by children.

### **2.2.3 THE CHALLENGES TO FAMILY RESPONSIBILITY**

Researchers concur that children in South Africa who are affected by the pandemic are increasingly assuming adult responsibilities at a very young age. This results in them not being able to engage in normal developmental activities, including schooling (Moletsane 2003; Kelly 2000a; Bernard 2000; Malaney 2000). Moletsane (2003:11) and Kelly (2000a:2) point out that with the illness of parents and other adult caregivers, educational involvement is often curtailed. Children who should be in school are needed in the home to provide care or to substitute for adults. The burden falls mostly on girls, as they are more likely to be kept at home to care for sick relatives and younger and/or male siblings.

Malaney (2000:5) reinforces this point by stating that as parents fall ill and die as a result of the disease there are likely to be many strong and lasting effects. The extended illness

that infected parents experience will place an increased demand on the time of children for caretaking. With the loss of parents, older siblings may also be expected to take on caretaking responsibilities for younger siblings. Rates of absenteeism can be expected to rise. Extensive absenteeism leads to poor academic performance and increases the likelihood of premature dropout. Once again, there is likely to be a disproportionate impact on girls, as there are asymmetric expectations with respect to caretaking responsibilities.

The following excerpt illustrates this point:

*Nombulelo is a 16 year-old girl who is taking care of her father, Thomas, who is sick with AIDS. She also looks after her sister and brother, Zanele and little Thomas. She often has to stay away from school to get her father's medicines from the clinic. She never has time to play or enjoy being a young girl (Soul City as cited in Moletsane 2003: 10)*

Moletsane (2003:10) poignantly points out that for an increasing number of children in South Africa's townships and rural villages, Nombulelo's story is commonplace. With parents either sick or dead from HIV/AIDS, life for children is a continuing struggle for survival, their own and that of younger siblings and relatives. Absenteeism from school, poor academic performance and ultimately dropout are inevitable as children scramble for scarce resources and take on responsibilities that even adults find difficult to fulfill in impoverished, fragmented and demoralized communities.

Moletsane (2003:11) further adds that the demand for child labour tends to go hand in hand with absenteeism and tardiness, and may impact negatively on the child's ability to learn and/or stay in school. With family responsibilities on their shoulders, attending school or doing well in their studies becomes impracticable. Bernard (2000:63) agrees with Moletsane (2003) by stating that children affected by HIV/AIDS are forced into sporadic or non-attendance by having to assume responsibility for family income and childcare.

#### **2.2.4 SOCIAL DISCRIMINATION**

There is agreement among researchers that children affected by the HIV/AIDS pandemic face varying degrees of social marginalization and discrimination (Hepburn 2002; Badcock-Walters 2002; Giese 2002; Webb undated). HIV/AIDS is impacting tragically on children's rights to be protected by and participate in their society, and on their ability to protect and manage themselves. One of the enduring traumas for affected children is that the discrimination associated with HIV/AIDS can put certain of their rights (of access to care and learning) in jeopardy (Bernard 2000:19).

One of the forms of social discrimination experienced by children affected by the pandemic is that of stigmatization. Hepburn (2002:93) avers that the stigma associated with AIDS is very real and tangible. Community members who fear orphans are HIV-positive or believe that their families have brought shame to their community, often discriminate against the children and deny them social, emotional, economic and educational support. Orphaned children may also be treated poorly or abused in their new home furthering their emotional distress and contributing to poor mental and physical health. Further, research suggests that two often-overlooked impacts of AIDS are the increasing number of children who do not wish to attend school because of the stigma and scorn they experience coming from AIDS-affected households and the psychological trauma and shock they feel after the death of a family member (Hepburn 2002:93).

Badcock-Walters (2002:98) poignantly emphasize that the issue of stigmatization in the community and marginalization in the school is a very real barrier to access and participation. While levels of awareness of HIV/AIDS are patently high, so too, are levels of suspicion and fear. Thus a child coming from a home in which infection is perceived to be HIV linked, may be stigmatized or even physically deterred from entry to school by his or her peers, or simply so traumatized by the reaction that they themselves opt to stay away. Further, Giese (2002:62) emphasizes that affected children are forced to endure teasing and she is in agreement with Badcock-Walters (2002) and Webb (undated) that these children are marginalized by their peers and other members of their community. Webb (undated:181) projected that the growing number of street children in urban

Kenya, for example, can be attributed to the increase in AIDS orphans, who are forced to move, due to either ostracisation and/or the lack of community support in their home areas.

As Avhaphani from Northern Province says:

*Before this tragedy struck my family, I had a lot of friends and we lived in close community with our neighbours. But after my parents died, and it became known that AIDS had killed them, they all started to drift away. Today we can't even ask our neighbours for a pinch of salt because when we approach them, they demand to know what we want and don't allow us to enter their yard (Giese 2002:64).*

The other form of social discrimination experienced by children affected by the pandemic is related to the trauma and distress they undergo when they lose their loved ones (Whiteside and Sunter 2000; Hepburn 2002; Malaney 2000 Ebersohn and Eloff 2002). Ebersohn and Eloff (2002:79) indicate that children's psychosocial distress and trauma are often not as visible as that of their health, education and economic needs, but they are of fundamental importance. The psychosocial challenges children face include coping with grief, loss of identity (self-, family- and cultural identity), coping with shame, stigmatization and fear of abandonment, rejection and death.

\*

Whiteside and Sunter (2000:95) and Malaney (2000:5) point out that those children who lose a parent to AIDS suffer loss and grief and results in them having deep psychological effects. Their loss is further exacerbated by prejudice and social exclusion, and can lead to the loss of education and health care. Moreover, the psychological impact on a child who witnesses his or her parent dying of AIDS can be more intense than for children whose parents die from more sudden causes. There are typically months or years of stress, suffering or depression before a patient dies. There is increased time spent by children in mourning for loved ones, and the long-term effects of such trauma on children's ability to learn.

Hepburn (2002:93) agrees that the psychosocial effects of losing a parent to a debilitating illness are severe and can have long-term effects on a child's behavioural development. As they endure the loss of parental support and nurturing, many orphans experience anxiety, depression and despair. Further complicating these emotions, siblings are often divided among several households within an extended family to mitigate the economic burden of caring for the children. Relatives or neighbours who have agreed to care for the orphans may contribute to the despair by taking their property or inheritance and leaving them more vulnerable to exploitation.

Gow, Desmond & Ewing (2002:5) state that in HIV/AIDS- affected families, relevant factors include bereavement and psychological depression in the surviving parent caregiver, which tends to incapacitate them in child rearing, and to impair their ability to work, obtain food, and provide adequate meals for their children. There are severe psychological health impacts for children of bereavement due to AIDS – and indirect impacts from being cared for by someone who is exhausted, distressed and desperately poor. The effects of bereavement on children and on the way that AIDS-related illness and death is being explained (or not) to children can be devastating.

The pandemic also has a deleterious effect on the social capital of families. Whiteside and Sunter (2000:95-96) point out that for a child living with a parent who has AIDS, the disease is especially cruel as HIV is sexually transmitted. Consequently, once one parent is infected, he or she is likely to pass it on to the other parent. Children who lose one parent to AIDS are thus at considerable risk of losing their remaining parent as well. For children AIDS will, over time, cause a major diminution in social capital in the form of lack of social skills, knowledge and unclear expectations. It will also lead to detectable and quantifiable declines in levels of formal education.

### **2.2.5 HEALTH**

Researchers have discovered startling evidence concerning the effect that the HIV/AIDS pandemic has on the health of children where a parent/s or caregiver is HIV positive and

on those children who are AIDS orphans (Giese 2002; Piwoz and Preble 2000; Ebersohn and Eloff 2002).

Giese (2002:61) concurs with Piwoz and Preble (2000) that poor health and increased rates of stunting among children living in HIV-infected families, are common. Children living in households with HIV-infected persons are more exposed to opportunistic infections, such as tuberculosis and pneumonia. With caregivers sporadically sick or absent, the child is less likely to get the medical attention s/he needs and more likely to have repeat infections. Food security in HIV-infected households is affected by reduced household income and increased expenditure on healthcare which leaves less money available to purchase appropriate food. Preparation of food is also affected by compromised care giving. The child may also be unable or unwilling to eat due to a range of physical, emotional and psycho-social factors which play a role in appetite suppression.

Ebersohn and Eloff (2002) are also in agreement with Giese (2002), and Piwoz and Preble (2000) that children living in infected communities suffer from poor nutrition and ill- health, and show signs of failure to thrive. Children's nutritional status suffers in rural areas that are dependent on household labour for subsistence agricultural production. Where social services, hospital and home-care systems are stretched or absent vulnerable children have inadequate access to health care.

Researchers aver to the fact that childhood malnutrition is one of the most severe and lasting consequences of parental death (Piwoz and Preble 2000; Giese 2002). According to Giese (2002:65-66) children who have been orphaned are more likely than their peers to be malnourished and sick. They are at greater risk of dying from preventable diseases and are less likely than other children to be fully immunized. As immunization coverage decreases, the herd immunity declines and all children become more susceptible to common childhood illnesses. With limited resources and inadequate adult supervision, orphans are more likely than their peers to drop out of school, leaving them with fewer opportunities for growth and development. They are also denied the benefit of the

monitoring and support of teachers and peers and the nutritional support offered through the primary school nutrition programme which targets poor children at schools.

Piwoz and Preble (2000) agree with Giese (2002) that the impact of HIV on the nutritional status of a child is felt long before the parent's death and, if ongoing and severe, it can have a long-term impact on the development of the child.

### **2.2.6 VIOLENCE/CRIME**

Researchers project that AIDS and age will be significant contributors to an increase in the rate of crime in South Africa over the next ten to twenty years (Schonteich 1999; Whiteside and Sunter 2000).

Schonteich (1999:1) postulates that there will be a boom in South Africa's orphan population during the next decade as the AIDS pandemic takes its toll. Growing up without parents, and badly supervised by relatives and welfare organizations, this growing pool of orphans will be at greater than average risk to engage in criminal activity. Moreover, in a decade's time, every fourth South African will be aged between 15 and 24. It is within this age group where people's propensity to commit crime is at its highest. Whiteside and Sunter (2000) concur with Schonteich (1999) that an increasing number of AIDS orphans, who grow up without parental support and supervision, may turn to crime. Crime will increase because of the disintegration of the fabric of society. It will be made worse by the lack of guidance, care and support for HIV-positive people, including children. Children orphaned by AIDS will have no role models in the future and they will resort to crime to survive.

Schonteich (1999) further points out that the absence of a father figure early in the lives of young males tends to increase later delinquency. Such an absence will directly affect a boy's ability to develop self-control. An insecure attachment will lead to lower levels of empathy and self-control, and to an increase in violent behaviour.

### **2.2.7 GENDER**

South Africa has had, and to some extent continues to have, a unique level of gender equity in its schooling system (Badcock-Walters 2002). One implication of the impact of HIV/AIDS on the home and school environment is that girls will be more affected than boys. There are a number of reasons for this, and include the fact that girls are more likely to be withdrawn from school than boys, in the event of economic hardship and deprivation, and more likely to be held back to provide care both for the infected party and for siblings now without care themselves. Girls are also more likely than boys to become the victims of sexual exploitation in these circumstances and may in fact be driven to this course as a means of personal survival and household support (Badcock-Walters 2002:103). This view on the impact of the pandemic on females is also supported by Kelly (2000a:2), Malaney (2000:5/9), Williamson (2004:1) and Moletsane (2003:9).

### **2.2.8 ABUSE**

A number of researchers have established a link between HIV/AIDS and the vulnerability of children to abuse (Smart 1999; Guest 2001; Ewing 2002; Moletsane; 2003). One obvious impact of the illness and death of adults from AIDS-related causes may be the large numbers of children who grow up without adult attention, supervision or love (as orphans and/or in child-headed households). The growing numbers of street children and other abandoned and destitute children in homes and other care centres are evidence of this. Many of these children are vulnerable to abuse (physical, emotional and sexual) from extended family members and other members of their communities (Moletsane 2003; Guest 2001; Smart1999).

Some researchers have identified reasons why these children are vulnerable to abuse. According to Ewing (2002:85) the abuse and neglect of children in AIDS-affected households is an indicator of the reduced ability of adults to cope. Guest (2001:158) concurs that more children will be abused; because they lack shelter and protection or because selling sex is their only means of survival. Abused children are more likely to take greater sexual risks or find themselves in abusive relationships in adulthood. The trauma of rape can destroy a person's self-esteem. Orphaned girls are particularly

vulnerable to sexual abuse because they've assumed adult responsibilities, such as caring for dying parents or raising siblings, without the maturity to understand quite what has happened to them.

Smart (1999:30), agrees that the abuse of young girls and children within families is on the rise highlighting three myths or theories apparently linking child sexual abuse and HIV/AIDS. The prevention theory is based on the assumption that all sexually active people are likely to be HIV infected and, in order to be 'safe', one must choose a partner who is not yet sexually active. The cleansing theory suggests that having sex with a child will cleanse the infected individual of the virus. Finally, the retribution theory is linked to the deliberate spreading of infection to all sectors of society.

## **2.3 SUPPORT SYSTEMS FOR AFFECTED CHILDREN**

The support available to children includes school-based support and community-based support.

### **2.3.1 SCHOOL-BASED SUPPORT**

As the crisis of HIV/AIDS grows, school and education systems have no option but to take responsibility to care for and support children affected by the pandemic. According to Bernard (2000:63-64) schools must give support to the human resource capacities of families of affected children, as well as to the children themselves. Non-formal, community-based and formal education programmes are needed to work together in strengthening the capacity of those affected to adapt to the psycho-social, work and home management changes confronting them. They are needed to help children develop the knowledge and skills to access support networks, those which can give them guidance in dealing with the health aspects of the infection, and also with the human rights and ethical dilemmas related to issues such as expulsion from school or denial of medical care.

Hepburn (2002:93) states that while the psychosocial needs of children are well documented, they regularly go unmet in school settings. While the need for counselling

and support is obvious, few schools have the resources to offer services and care for these children. Smith (2003:10), in his study on school disaffection, looked at the various impacts of HIV/AIDS on school disaffection. Apart from the loss of qualified teachers and school principals which teacher training institutions are unable to keep up with, it is Smith's contention that school systems have not been able to respond to the educational needs of such children, let alone their emotional needs. He argues that children become disaffected from schooling when they see that their teachers are a source of infection, that schools are not geared to counsel them in their grief and that nothing exists to help them through this most difficult period of their lives.

Educators will need to develop an awareness of and sensitivity to barriers to learning and development and will have to be trained to do so. They need to form part of a school-based support team. Educators have to take responsibility to identify learners who have problems. Each school will have to develop its own model of support in terms of the needs of that specific school. Teams should be flexible enough to cater for different needs at different times. The task of the teams will be to support the learning and development process by addressing the needs of individual learners and needs within the system. The teams could be strengthened by expertise from the community and district level services (Republic of South Africa Department of Health 2001:76).

Researchers have emphasized the importance of integrating the HIV/AIDS education content in the school and in teacher education (professional development) curricula. Owing to the increasing infection rates, researchers have identified education as playing a key role in establishing conditions that render the transmission of HIV/AIDS less likely (Moletsane 2003; Kelly 2000b).

Kelly (2000b:4) further points out that the formal education system must do better what it is supposed to be doing in terms of access and real learning achievement; integrate sexual health and HIV/AIDS education into the curriculum for all education levels; ensure that every school member is adequately equipped with the relevant life skills, and that adequate learning takes place in the fourth 'R' , that is, relationships with oneself and

with others; manifest an improved human rights profile – in terms of its own procedures and actions and in terms of the curriculum; extend its mission beyond the strictly academic to include more attention to counselling and care for its members and to promoting care and compassion for people with HIV/AIDS. Moletsane (2003:12) also suggests that a coordinated and integrated effort may involve guidance and counselling for orphans and other vulnerable children and their families, working with service managers, education planners and curriculum specialists on implementing HIV and education activities in schools.

Programmes that prepare learners for the caring roles they assume in their families and communities are also needed. Teachers must also be trained for their roles as educators and caregivers for children who, in many cases, will increasingly be living without any adult caregiver. This means that effective professional development programmes for teachers and organizational development for schools should be developed and implemented. Such programmes may include counselling, nutrition and pastoral care (Moletsane 2003:12).

True ‘caring’ for pupils is the heart of schooling, for enabling the child to develop as a person is essential for happiness in school; the best chance of success across the curriculum; and for preparation for adult life in all its aspects. Thus the caring is not merely reactive, coping with sadness, difficulties and problems, but is positive – enabling a rewarding experience of life, an understanding of others and a sensitive exploration of self (Marland 2001:25). Waghid (2004:49) concurs that when education institutions become intensely concerned about “tragic predicaments and their prevention” *vis- a-vis* HIV/AIDS in the country, such institutions embody compassion, since they rely on compassionate learners and educators to keep alive the essential concern to attend to the well being of others – a matter of balancing their responsibilities and emotions.

Baxen and Breidlid (2004:17-18) state that education is vital in the prevention of the spread of HIV/AIDS. Education has a powerful effect on the degree to which young people engage in risky sexual behaviour. Therefore, in finding ways to increase

awareness of and suggest preventative measures against the disease, life skills and sex education programmes have been developed within the formal school sector. These programmes have been aimed at providing children with accurate information about the disease.

### **2.3.2 COMMUNITY-BASED SUPPORT**

Researchers indicate that it is essential to mobilize the whole community to address holistically the fundamental needs of parents, families, the school and the community regarding HIV/AIDS because it is unrealistic to think that the school alone can address all the problems surrounding learners who are affected by HIV/AIDS (Republic of South Africa Department of Health 2001; Coombe and Kelly 2001; Coombe 2000a; Williamson 2004).

Coombe and Kelly (2001:8) emphasize the centrality of community participation to every innovation aimed at adjusting the education delivery system in response to the challenges of HIV/AIDS. The most immediate effects of the disease are experienced at household and community levels. These levels have already seen an unprecedented manifestation of different coping strategies, including self-sacrificing home –based care for the sick and the integration of orphans into already stressed extended families. In coping with the disease and its impacts, communities are showing that the real potential for combating HIV/AIDS lies in the resourcefulness, strength and courage of the people themselves. For education to be proactive in combating HIV/AIDS and in managing its impacts, it must also be proactive in establishing linkages with the communities being served.

Coombe (2000a) and Williamson (2004) agree that that in many communities there are already established community committees. In others there is little structure and co-ordination. However, in most communities, there are CBOs, religious organizations, and NGO's that are rendering a service, often despite the absence of official strategy in that area. Some NGOs have supported community efforts to repair or construct needed infrastructure in return for a commitment by the school to allow needy children to attend. Communities are providing counselling and support to principals and educators by training learners and educators in peer education, teaching the lessons of safe sexual

behaviour, and working hard to reduce abuse and violence. They are saving lives and form the core of care and support in those communities, even though what they are doing is often not structured or coordinated.

An approach being piloted in Tanzania mainland and Zanzibar is the involvement of local communities in school HIV/AIDS programmes. In the School Youth HIV/AIDS programme being implemented in Magu District in Tanzania, local communities are represented in school HIV/AIDS committees (Rugalema and Khanye 2002:34). The active involvement of communities has played a part in strengthening school-based HIV/AIDS programmes. Instead of having parents as antagonists they are actually playing a part not only in contributing resources for the programmes but they are also supportive of the teachers responsible for guidance and counselling. The strengths of School Health Clubs (in which HIV/AIDS is the significant part) lie in the support they get from local communities. Parents support their children to participate in club activities but the most exciting finding is that children are increasingly sharing HIV/AIDS information with their parents and siblings. Such experiences are few yet they provide evidence that school-community collaboration in HIV/AIDS programmes is necessary and would be mutually beneficial. (Rugalema and Khanye 2002:34)

A lack of a coherent National Policy with regard to support and care of the estimated 250 000 AIDS orphans in South Africa is a source of much criticism by opposition parties in the South African government. Mike Waters of the Democratic Alliance, in calling for community-based support makes the point that there must be adult supervision over child-headed households by community members or welfare officials. He believes that the government must put in place policy that empowers community organizations and welfare agencies to assist AIDS orphans (News 24.com 2005).

Cooperation and trust must characterize South Africa's response to HIV/AIDS. That means:

- breaking the current impasse between politicians, government officials, NGO and institutional activists, academics and the media about what to do, and who is responsible;
- involving communities, parents and local leaders in any campaign through the school governing body, and using the school as the ultimate community-based organization and the nerve-centre for local response;
- listening to what teachers and district officials say about what needs to be done, how it can be done, and what they need to do it;
- pushing unions to get the message out to their members; and
- making better arrangements with international development cooperation agencies in support of both Government and local initiatives (Coombe 2000b).

## **2.4 THEORETICAL FRAMEWORK**

Critical theory is employed as an over-arching framework in this study with Young's (1990) theory of oppression being used as a specific framework.

### **2.4.1 CRITICAL THEORY**

Critical theory refers to a specific theoretical tradition which has its roots in the *Frankfurt School* in Germany. It is not a unified theory, but rather it embraces a family of theories and theorists. This heterogeneity in theories and theorists notwithstanding, there are nevertheless, some commonly shared assumptions.

Critical theory aims to provide enlightenment as to the actual conditions of social life. According to Gibson (1986:5), enlightenment consists of the disclosure of the true interests of individuals and groups. 'Interests' here refers to the needs and concerns of particular groups, but especially to the disadvantages (or advantages) they possess in the sense of 'self-interests' or 'vested interests'. In the context of this study, affected children have an interest in change which entails the removal of the barriers to learning their affected status confers on them. This process may, therefore, bring them in conflict with other groups which may directly or indirectly lead to various forms of oppression and struggle.

Critical theory acknowledges the sense of frustration and powerlessness many oppressed groups, such as those affected by the pandemic may feel as they see their destinies are out of their own control and in the hands of others. Gibson (1986:5) makes the point that critical theory attempts to reveal those factors which prevent groups and individuals from taking control of, or even influencing those decisions which crucially affect their lives. Critical theorists seek to emancipate those who are downtrodden by those in power and to be a voice for the voiceless. They aim to empower the members of oppressed groups. Their goal is the total emancipation of each and every human being from all forms of oppression be it class, race, gender or political (Higgs & Smith 1997:157). In this study the researcher proceeded from the premise that HIV affected children are in fact a voiceless grouping, who are subjected to various forms of oppression by those individuals and groupings in society who wield power.

According to Higgs and Smith (1997:157), critical theorists claim that the most pervasive and pernicious form of oppression is that imposed on people without their knowledge – the basis of this form of oppression, they claim, is the fact that all human societies are structured on certain power relationships which then leads to domination. It explains to all of us how social domination works, even in a democracy such as South Africa, and why we tolerate it. Therefore, critical theory is aimed at decreasing domination and increasing freedom in all their forms.

From an educational perspective, critical theorists have, according to Gibson (1986:44), three things in common. They begin from a concern to map the inequalities and injustices of education. Next, they claim to trace those inequalities and injustices to their source, showing the educational processes and structures by which they are maintained. Finally they seek to propose remedies to those injustices. Consequently, this study attempts to expose the injustices in education that learners affected by the HIV/AIDS pandemic experience and it also attempts to demonstrate how these injustices are maintained. Recommendations (see chapter 5, page 59) are also proposed as to how some of the injustices experienced by HIV/AIDS affected learners can be remedied.

## **2.4.2 OPPRESSION**

The concept oppression as used in this study is defined, followed by an elucidation of Young's theory of oppression.

### **2.4.2.1 THE CONCEPT 'OPPRESSION'**

In its traditional usage, oppression means the exercise of tyranny by a ruling group and it carries connotations of conquest and domination. However, in this study oppression is seen as a broader concept. It refers to the disadvantage and injustice some people suffer not because a tyrannical power coerces them, but because of the everyday practices of a well-intentioned society. Further, it refers to systemic constraints on groups that are not necessarily the results of the intention of a tyrant. Oppression in this sense is structural, rather than the result of a few people's choices or policies. Its causes are embedded in unquestioned norms, habits, and symbols in the assumptions underlying institutional rules and the collective consequences of following those rules. It refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions in the normal processes of everyday life (Young 1990:41).

### **2.4.2.2 THE THEORY OF OPPRESSION**

According to Young (1990) all societies have groups of people who are denied access to the rights and privileges enjoyed by some on account of certain traits. Accordingly, every society has one-up groups and one-down groups. The one-down group members often receive negative treatment that may include negative beliefs, exclusion, denial of basic human rights and overt acts of violence. The one-up group may use prejudice, stigmatisation and discrimination to maintain its control or power.

In an HIV/AIDS context, individuals infected or affected by the pandemic can be construed as the one-down group. They often suffer prejudice from the one-up group not on the basis of facts but rather on the basis of stereo-types and misinformation. Moreover, both affected and infected individuals are stigmatised and are considered as someone with a 'spoiled identity' who is rendered 'unworthy' by others.

The one-down group becomes the oppressed group. Young (1990) identifies five characteristics (faces) - exploitation, marginalisation, powerlessness, cultural imperialism and violence - of the oppressed group. However, the researcher, borrowing from Muthukrishna (2005) extends the characteristics to six by including vulnerability as a characteristic of oppression.

#### **2.4.2.2.1 EXPLOITATION**

The central insight expressed in the concept of exploitation is that this oppression occurs through a steady process of the transfer of the results of labour of one social group to benefit the other. Social rules about what work is, who does what for whom, how work is compensated and the social process by which the results of work are appropriated operate to enact relations of power and inequality (Young 1990:49-50).

Brown (cited in Young 1990:51) points to gender exploitation in contemporary society where men have removed themselves from the responsibility for children. Women bear nearly total responsibility for childrearing and many have become dependent on the state for subsistence.

#### **2.4.2.2.2 MARGINALISATION**

Marginalisation refers to the process where individuals or groups of people are permanently confined to lives of social marginality (Muthukrishna 2005:3). Young (1990:53) views marginalisation as the most dangerous form of oppression and results in people being expelled from useful participation in social life and being subjected to severe material deprivation. In capitalist societies, the material deprivation marginalisation often causes is unjust, especially where others have plenty.

Marginalisation results in the marginalised becoming dependent on others in society such as welfare agencies etc. This results in them being subjected to patronizing, punitive demeaning, and arbitrary treatment by individuals and institutions who exercise power over their lives. Young (1990:54) adds that one cannot imagine a society in which some people would not need to be dependent on others at least some of the time: sick people

and children have the moral right to depend on others for subsistence and support. However, such dependency should not deprive one of choice and respect.

#### **2.4.2.2.3 POWERLESSNESS**

Young (1990:56) argues that in many societies not all people participate in the decision making processes that affect their lives because people lack significant power. These are the powerless individuals or groups in society who are situated so that they must take orders and rarely have the right to give them. They lack the authority, status and sense of self. Owing to the status of the powerless, these individuals or groups are often subjected to disrespectful treatment.

#### **2.4.2.2.4 CULTURAL IMPERIALISM**

Cultural imperialism, according to Young (1990:59), involves the universalization of a dominant group's experience and culture, and its establishment as the norm. Consequently, the experiences, values, goals and achievements of these groups are most widely disseminated. The dominated groups which become marked as 'Other' are viewed as being deviant and inferior. The 'Other' undergo a paradoxical oppression, in that they are both marked out by stereotypes and at the same time rendered invisible.

#### **2.4.2.2.5 VIOLENCE**

Members of some groups live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no motive, but to damage, humiliate, or destroy the person. Included in this category are incidents of harassment, intimidation or ridicule simply for the purpose of degrading, humiliating or stigmatizing group members (Young 1990:61).

According to Young (1990:62), violence is regarded as a phenomenon of social injustice because of its systemic character. Violence is systemic because it is directed at members of a group simply because they are members of that group. The oppression of violence consists not only in direct victimisation, but in the daily knowledge shared by all members of oppressed groups that they are liable to violation solely on account of their

group identity. Living under the constant threat of violence deprives the oppressed of freedom and dignity.

#### **2.4.2.2.6 VULNERABILITY**

Vulnerability as outlined by Solnit (cited in School of Education and Development 2005:38) is the ‘actual and latent susceptibilities and weaknesses immediate and delayed’ that an individual child may be subject to. Vulnerability makes a child susceptible to a negative outcome. When investigating the vulnerability of a child, one is accounting for the entire effects of the risk factors of the child. The risk factors are those factors that challenge a child biologically, environmentally and psychosocially and lead to the likelihood of a detrimental outcome.

#### **2.5 SUMMARY**

This review has highlighted some of the salient barriers to learning as experienced by learners affected by the HIV/AIDS pandemic. Moreover, it has pointed out that these barriers do not act in isolation to one another but often interact with each other. Further, this review pointed out the possible school and community-based support programmes that could assist affected learners. An account on the theoretical framework utilized in this study brought this chapter to a close.

The next chapter outlines the research design employed in this study.

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

The previous chapter focused on the literature reviewed around the critical questions formulated in chapter one and the theoretical framework of this study. The focus of this chapter is on a discussion on the research design and methodology of this study.

After presenting a brief discussion on the methodological approach to this study, the methods used to gather data are presented. A discussion on the research instrument including the design and trialing of the instrument follows. An account on the research site, sampling techniques employed and ethical issues pertinent to this study is then presented. A narrative then follows on the biography of the research participants in this study.

#### **3.2 METHODOLOGICAL APPROACH**

The methodological approach to this study locates it within a participatory framework.

##### **3.2.1 LOCATING THE STUDY**

In order to obtain data on the issues related to the critical questions formulated in Chapter One, namely:

- What barriers to learning impact on the lives of children affected by HIV/AIDS?
- What support systems exist for children affected by HIV/AIDS?

the researcher chose to locate this study within a participatory research framework using qualitative methods for the collection of data. The researcher was not interested in quantifying data as is the case with quantitative approaches to research but was rather more interested in reflecting on the quality or nature of the barriers to learning experienced by children affected by the HIV/AIDS pandemic which qualitative approaches allow (Uys 2003:118). Further, in the field of HIV/AIDS and education, much work has been done using quantitative rather than qualitative research methods.

Huber and Gould (2003), therefore, suggest that qualitative, participatory methods can provide different data and alternate interpretations of existing data.

### **3.2.2 PARTICIPATORY METHODOLOGY**

HIV/ AIDS is a difficult area of exploration, given the ‘veil of secrecy’ around the pandemic owing to the stigma and myths attached to the pandemic. Therefore, those infected and those directly affected by the pandemic are often reluctant to talk about their experiences. However, according to Babbie (2002) and Willig (2001), the use of participatory approaches allows for greater exploration. It enables the researcher to obtain rich descriptions that would provide an understanding of HIV/AIDS as a possible exclusionary factor and a barrier to learning.

Participatory approaches also enable children and young people to talk about issues that affect them. O’ Kane (2000:137) asserts that it enables the researcher to gain ‘a clearer understanding of the perceptions and cultural constructions of young people’. In the research process, there is a shift from viewing children as ‘objects of concern’ to ‘active participants in the collection of data’. They are active in the construction of their experiences, other people’s lives and the community in which they live. In other words, the research is conducted *with* children rather than *on* children. Consequently, the differences in the power relations between the researcher and the researched are removed.

Moreover, participatory approaches are sensitive to the literacy levels of participants. They are, according to O’ Kane (2000:138), ‘particularly advantageous in communities where there are low levels of literacy’ because the methods of data collection do not rely heavily on reading and writing skills, but place greater emphasis on the power of visual impressions and the active representation of ideas.

Participatory approaches also have their limitations. In this particular study the participants were not involved in the construction of the questions in the interview schedule. Further, they played no role in the analysis of the data. Participation was thus restricted to participatory methods of data collection.

### **3.3 METHODS OF DATA COLLECTION**

Two data collection techniques were used. Firstly, each learner was interviewed using a structured questionnaire that focused on biographical and background information. This helped to build rapport with the participants whilst it simultaneously enabled the researcher to access sensitive information about the learner.

The second data collection technique was a three-stage focus group process. Van der Riet, Hough and Killian (2005:85) describe focus groups as encouraging communication especially around difficult issues, allowing for the exploration of differences as well as similarities in experiences and in thought. The group format of focus groups also potentially decreases the power dynamics between the researcher and the participants rather than having to always respond individually to an interviewer.

#### **3.3.1 METHODS USED IN THE FOCUS GROUPS**

A multiplicity of techniques and strategies were used in the collection of the data. These included icebreakers, projective techniques, diagrammatic mapping, drawing activities and activities which drew the focus group sessions to a close with positively affirming activities.

The icebreakers, used at the commencement of each focus group, created an environment conducive to the formation of group cohesion, promoting participation and helping the participant to relax (Van der Riet, Hough & Killian 2005:87). Further, at the end of each focus group session there was a little activity which the participants had to engage in, in order to express something affirming about themselves. Van der Riet, Hough and Killian (2005:88) postulate that part of being able to build resilience is the ability to articulate positive things that one is, one has, or one can do.

#### **3.3.2 TECHNIQUES USED IN THE FOCUS GROUPS**

Van der Riet, Hough and Killian (2005:88) make the point that children, particularly younger children, respond better with techniques that encourage more than just verbal

discussion. This study, therefore, employed projective techniques and drawings in order to facilitate the active involvement of the participants.

### **3.3.2.1 PROJECTIVE TECHNIQUES**

The projective techniques used asked the participants to reflect on a picture of a child in relation to particular issues. Pictorial aids, according to O' Kane (2000), helps younger children's participation and ability to enter into discussions. Further, Van der Riet, Hough and Killian (2005:89) make the point that enabling children to project onto a picture circumvents them having to talk directly about potentially anxious and stigma provoking personal issues. The participant's real feelings are then inferred from what she/he says about others.

### **3.3.2.2 DRAWING EXERCISES**

Drawings are widely used as psychological assessment tools to explore developmental maturity, group values, perceptions of self in relation to others and personality (Van der Riet, Hough & Killian 2005:89). Two types of drawings were used in this study, namely, 'A road of life' and body mapping. In 'A road of life' drawing children share their life stories through the metaphor of their life as a journey or road, and to expose significant life events, including whether the children had experienced loss and/or illness of others during their lives. The body map entailed the participants pairing off and drawing an outline of each others body. The participants then had to fill in on the outline of their body map their feelings and experiences about HIV/AIDS.

## **3.4 THE RESEARCH INSTRUMENT**

### **3.4.1 DESIGN OF THE RESEARCH INSTRUMENT**

The Participant Interview Schedule (see Annexure A, page 68) comprised four sections.

#### **Section A: Biographical Data and Background Information**

This section consisted of largely close-ended questions. However, in a few instances the participants were required to elaborate on some of their responses. The questions in this section centred around the personal details of the participant, their family details,

household membership, sources of income, housing issues and household resources, health and nutrition, school issues and community issues.

### **Section B: Focus Group Interview One**

This section commenced with an icebreaker which was used to build trust and rapport with the participants. The ground rules for communication were also laid. A series of open-ended questions was posed covering the following themes: family responsibility; social discrimination; road to life; and discussion of likes and dislikes.

### **Section C: Focus Group Interview Two**

This section commenced with refreshing the groups about the rules to be followed and an icebreaker. The focal theme in this section was sickness and health issues. Various open-ended and closed ended questions were posed covering the sub-themes sickness, HIV/AIDS in general and HIV/AIDS in your area.

### **Section D: Focus Group Interview Three**

This section commenced with a review of the rules and an icebreaker. The main focus of this section was on HIV/AIDS and personal experience. Open and close-ended questions were posed on the sub-themes accessing support, emotions about HIV/AIDS, absenteeism and coping with death.

## **3.4.2 TRIALING OF THE INSTRUMENT**

An instrument is useful only to the extent that it is able to measure that what it intends to measure. The researcher, therefore, wanted to test to what extent the Participant Interview Schedule would elicit the data required by the research questions. This proved to be extremely challenging to the researcher. Given the ‘veil of secrecy’ around the pandemic it was difficult for the researcher to identify a group of participants to pilot the instrument. However, the researcher was able to submit the instrument to one Master’s student, one Doctoral student and a University professor for comment. Based on inputs from these persons, the researcher was able to improve the quality of the instrument.

### **3.5 THE RESEARCH SITE**

This study was carried out at a Day Care and Support Centre which is located in a small rural town called Richmond. Richmond is about 35km south of Pietermaritzburg. It serves the farming and forestry communities and is surrounded by semi-formal and informal settlements. During the 1980's and 1990's it was characterised by large scale political violence and it is estimated that some 20 000 lives were lost since 1984. One of the effects of the violence in Richmond was the high population mobility, with thousands of refugees leaving the area and later returning when peace was restored. Population mobility and the disruptions caused by political violence are associated with high rates of HIV infection (Whiteside & Sunter 2000).

### **3.6 SAMPLING TECHNIQUES**

Drawing a sample for this study was indeed a challenge. Given the stigma associated with the pandemic, identifying participants proved difficult. The researcher, therefore, had to enlist the help of the principal of the Day Care and Support Centre.

The principal was briefed on the sampling criteria, namely, affected children in the age cohort 9-12 years. Based on the purposive sampling technique, the principal identified the six participants for this study.

### **3.7 ETHICAL CONSIDERATIONS**

Research into HIV/AIDS involves participants volunteering highly personal and sensitive information. Researchers, therefore, need to exercise respect and circumspection when engaging with participants. Gray, Lyons and Melton (1995) make the point that respect for persons and their privacy are key ethical issues in HIV/AIDS research. Given the stigma and discrimination associated with the pandemic, the researcher was extremely sensitive to issues around participation in this study, confidentiality and anonymity. Therefore, special attention had to be paid to ways in which informed consent could be obtained from the parents/guardians and the child participants.

Owing to the fact that the participants in this study were children, the researcher sought the permission of their parents/guardians in order for them to participate in this study. A letter (see Annexure B, page 82) in IsiZulu (home language of the parents/guardians) outlining the purpose of the study, the nature of the activities their children would be engaged in, an assurance of anonymity of the identities of their children and confidentiality of all information furnished by their children was given by the researcher. Further, the manager of the Day Care Centre (who is an IsiZulu first language speaker) explained to the parents/guardians the aims and objective of the study. All six parents/guardians gave full consent for their children to participate in this study.

A second letter (see Annexure C, page 84) was directed to the participants. This letter written in IsiZulu (home language of the children) also outlined the purpose of the study, the nature of the activities they would be engaged in, an assurance of anonymity of their identities and confidentiality of the information furnished. In addition, it was made abundantly clear to the participants that if at any time they felt uncomfortable with any aspect of this research project, they were free to withdraw from the project. All six participants willingly consented to participating in this study.

Owing to the fact that the data gathering was to occur through focus groups where the participants would be exposed to the individual stories of the other participants, the researcher had to ensure that the concept of confidentiality was fully understood. The researcher, therefore, had to establish group norms and use confidentiality pledges. At the commencement of each focus group the group norms were highlighted which reinforced the need for all information to be regarded as highly confidential. Further, all participants made verbal pledges at the commencement of the project to keep all information divulged during the focus groups confidential.

### **3.8 THE RESEARCH PARTICIPANTS**

The six participants in this study were asked to choose *nom de plumes* in order to protect their identities. A brief narrative on the biography and background of each participant is presented.

**Participant One: Ntombi**

Ntombi is nine years old. She is in grade four at Magoda Primary School. Both her parents are deceased due to illness. Ntombi's grandmother takes care of her and her brother. Two uncles, an aunt and two cousins also live in the household. Ntombi's aunt is responsible for buying food and paying the accounts. The family also receives a child care grant for Ntombi's six-year old cousin. Ntombi's grandmother has applied for a grant for her brother and her but nothing has come through as yet. They have their own home. It has five rooms, a separate kitchen and an outside pit toilet. There is no piped water so they rely on the communal tap. They have electricity and a television. Ntombi shares her room with her grandmother and cousins. She attends school regularly. She sometimes stays away if she is sick. Ntombi loves to learn and play at school.

**Participant Two: Mbesuma**

Mbesuma who is eleven years old is a grade four learner at Gagisa Primary School. Both his parents are deceased. They were ill. Mbesuma lives with his grandmother who takes care of him, his brother and his sister. His brother and sister have both dropped out of school. His grandmother receives a child care grant which she uses to buy food and pay the accounts. The older brother works but the income is not regular. The grandmother has her own home which has three rooms. The house has a separate kitchen, and an outside pit toilet. They do not have piped water and use the communal tap. They have electricity and a television. Mbesuma shares his room with his brother. He tries to attend school regularly but he is absent on most Wednesdays when he has to go to the hospital. He is often late for school because he has to take medication at 07:00 in the morning. He is only able to leave home after taking his medication. Mbesuma loves to learn at school and enjoys it when they watch videos at school. The school fees are forty rand per annum which his grandmother has not paid because she cannot afford it.

**Participant Three: Lumka**

Lumka is eleven years old and she is in grade five. She attends Ndabikhona Primary School. Her mother died after a long illness. Lumka lives with two aunts and her grandmother. Her cousins also live there. Her grandfather, who does not live with them,

buys the food and pays the accounts for the household. Lumka's grandfather sells clothes in Pietermaritzburg. The family also receives a pension and child care grant. They have their own home which is made of brick. The house has six rooms. It has an inside toilet and piped water. They have electricity and a television. Lumka shares a room with her aunt. She does not attend school regularly because she is sick. She stays away when she coughs and has a runny tummy. Lumka loves learning and playing netball at school. The school fees are thirty-five rand per annum which her grandfather has paid.

#### **Participant Four: Sibusiso**

Sibusiso who is ten years old is a grade three learner at Gagisa Primary School. Both his parents are deceased. His mother was ill with tuberculosis. His father was also ill but Sibusiso was not aware of his illness. He lives with his grandmother who takes care of him, his three brothers and three sisters. His uncle is responsible for buying food and paying accounts in the household. He is not aware if any kind of grant is received. They have their own home. It has two rooms, a separate kitchen, and an outside pit toilet. There is no piped water and they rely on the communal tap. They have electricity and a television. Sibusiso shares a room with his brother. He does not attend school regularly. He stays away when he is sick with the flu or if he has a runny tummy or if he is vomiting. He also stays away to take care of his younger siblings if nobody is available to take care of them. He sometimes goes late to school because he has chores to complete at home before leaving for school. Sibusiso loves to learn at school. He likes reading and writing. He also likes the food the school gives them.

#### **Participant Five: Tau**

Tau is ten years old. He is in grade five at Magoda Primary School. Both his parents are deceased due to illness. Tau's grandmother takes care of him and his sister. Two uncles, an aunt and two cousins also live with them. Tau's aunt buys food and pays the accounts for the family. The family also receives a child care grant for Tau's six-year old cousin. Tau's grandmother has applied for a grant for his sister and him but nothing has come through as yet. They have their own home. It has five rooms, a separate kitchen and an outside pit toilet. There is no piped water so they use the communal tap. They have

electricity and a television. Tau shares his room with his grandmother. He attends school regularly. He sometimes stays away if he is sick or if he has to accompany his grandmother to Illovu to check on the grant. Tau loves to learn and play ball at school.

### **Participant Six: Shoes**

Shoes is eleven years old. He attends Ndabikhona Primary School. Shoes loves to learn and play with fellow grade four learners. Both his parents are deceased after a long period of illness. Shoes lives with his grandparents who take care of him and his sister. There are three cousins who also live with them. The grandmother receives a pension which she uses to buy food and pay accounts for the household. His grandparents have their own home. It is a big house which has four rooms. There are also two rondavels. The house has a separate kitchen. There is an outside toilet which has a pit system. There is no piped water so they use the communal tap. There is electricity. They have a television but it is now broken. Shoes does not have his own room but shares a room with his grandmother, sister and cousin. His attendance at school is regular. The school fees are thirty-five rand per annum which his granny has paid.

### **3.9 ADMINISTERING THE INSTRUMENT**

All six of the research participants' home language was IsiZulu. This was problematic for the researcher in the sense that the researcher was not well versed in IsiZulu. Consequently, the researcher had to enlist the help of co-researchers who could speak the language. One co-researcher, who was fluent in IsiZulu and highly skilled in interview techniques, administered the instrument with the assistance of the researcher.

Getting the participants to the research site was a challenging task because the data could only be gathered over the weekends or during the school vacation so as not to disrupt the schooling of the participants. Notwithstanding the timeous notification being given to all concerned (the manager of the Centre, parent/guardians and participants), when a first session was convened over the July school vacation period, only one participant turned up. Therefore, all that could be done was to obtain the biographical and background information of this participant.

In order to ensure that all participants were present at the next session, the researcher decided to enlist the help of the volunteers at the centre. After explaining the aims and objectives of the project to the volunteers they were extremely forthcoming in volunteering their assistance in ensuring the presence of the participants at the next session. The next session was scheduled for a weekend (over two days). At this session all six participants were present. After accessing the biographical and background information of the remaining five participants by the co-researchers, the focus group sessions were conducted. The focus groups were divided into three clearly demarcated sessions. The one session was conducted on the Saturday and the other two on a Sunday.

### **3.10 ANALYSIS OF THE DATA**

The focus group sessions were audio and video-taped and then transcribed. The transcripts were then subjected to content analysis. The substantive points made by the participants were then classified into topics and categories. The reporting on the data (see chapter 4, page 44) is presented under topics and categories.

### **3.11 LIMITATIONS OF STUDY**

Owing to the small size of the sample (six children) and the specific geographical area selected for this study, the findings cannot be generalised to the population as a whole. Further, owing to the fact that the children have not disclosed the cause of death of their parents, this study assumes that the death of the parents is HIV/AIDS related. It is likely that the deaths were HIV/AIDS related given the prevalence of the pandemic in the province, the prematurity of their deaths and the circumstances inferred from the interviews.

### **3.12 SUMMARY**

This chapter highlighted how the research was planned and executed. A detailed account with regard to the methodological approach, research site, sampling techniques and research participants was presented.

The next chapter deals with the presentation, analysis and discussion of the data.

## **CHAPTER FOUR**

### **DATA PRESENTATION, ANALYSIS, FINDINGS AND DISCUSSION**

#### **4.1 INTRODUCTION**

The previous chapter outlined the research design and methodology employed in this study. This chapter focuses on the presentation, analysis, findings and discussion of the data gathered from the focus groups. The data is presented in terms of the topics extracted from the focus group schedule. Based on the data obtained on each topic, the researcher grouped the data into categories. Further, in presenting the data, the researcher wanted to ensure that the voices of the participants were not lost. Therefore, *verbatim* quotations are also used in the data presentation.

The emerging trends and patterns from the presented data are then outlined. Pertinent findings of this study and a discussion of the findings in terms of the research questions and the theoretical and conceptual tools outlined in chapter two are then presented.

#### **4.2 PRESENTATION OF DATA**

The data from the focus groups was grouped into topics as reflected in the focus group schedule. Based on the responses of the participants to the activities associated with each topic in the schedule, the researcher grouped the responses into categories.

##### **4.2.1 BARRIERS TO LEARNING**

The barriers to learning that emerged from the data are presented under the categories poverty, social exclusion, family responsibility, crime and violence, abuse and emotional trauma.

###### **4.2.1.1 POVERTY**

Participants pointed out that owing to the absence of adults to provide food; children are sometimes left to fend for themselves. With food not being readily available, children

sometimes have to sacrifice their schooling in order to seek out food. One participant, in responding to his personal situation articulated the following:

*'My mother and my father passed away... At home there is no one and we are living in poverty and we are hungry...'*

Another participant made the point that some children end up becoming street children. They end up looking for hand-outs and resort to begging for money. He commented:

*'She could go and live on the street with strangers... she would beg for money from people.'*

In responding to a story centred on a boy who did not go to school, a participant made the point that owing to the lack of food at home, children may have to go scavenging for food:

*'There will be no food... You will eat from bins.'*

Another participant, in responding to the same story, indicated that as a result of the unavailability of food at home, children will be reluctant to attend school because a hungry child will not be able to learn. He stated:

*'Maybe he wasn't getting food in the morning... He will not be able to learn if he is hungry'*

It is interesting to note that among the participants themselves, one participant indicated that at one time she went without food for a period of 1-2 days. Two other participants indicated that that they went without food for a period between 2-4 days.

Poverty also manifests itself in the non-payment of school fees. In responding to a picture of a learner who did not attend school, one participant indicated that the probability existed that this learner did not pay his school fees and, therefore, was forced to stay at home by the school. The fact that his parents have not fulfilled their obligations in terms of the payment of school fees has resulted in this child's non-attendance at school. Two of the participants in commenting on their own situation indicated that though the school

fee was a paltry sum at their schools, their care-givers could not afford to pay the school fees. One participant went on to talk of the humiliation experienced of non-payment of fees where school progress reports were withheld.

#### **4.2.1.2 SOCIAL EXCLUSION**

A reason participants provided for a child's non-attendance at school was the issue of excluding certain children from particular groups because of victimization. A participant, in commenting on a story of a child who would not attend school, pointed out that the victimization at times results in overt violent behaviour. He stated:

*'The other children were victimizing him... they were hitting him.'*

#### **4.2.1.3 FAMILY RESPONSIBILITY**

Attending to family chores was another reason provided by a participant for school non-attendance. This participant, in responding to a story of a boy who did not attend school, pointed out that the possibility existed that this child wants to offer his labour to others so that he could make some money. This participant stated:

*'He was sent to get water... Perhaps he wanted to work for other people... so they could pay him...'*

Participants, in responding to a picture of a girl who lived in a home with HIV/AIDS infected family members, made the point that when the mother is ill, older children are forced to stay home, sometimes for prolonged periods, in order to take care of the sick parent. The one participant even spoke of taking care of younger siblings. This is illustrated by the following comments:

*'If someone [children] wants food...she feeds him or her.... And if she [the sick parent] is sweating she wipes her with the towel.'*

*'If mother wants to go to the toilet, she help[s] her to go to the toilet. If she wants to take a bath she helps them.'*

*'... he must look after the person and nurse him.'*

*'He has to nurse the person and give him water to drink.'*

Owing to the death of their parents, all six of the participants in this study indicated that they have to live with other care-givers namely, grandparents. Due to the old age of the grandparents and other commitments they have, some of the participants indicated that they have to take on added responsibilities in the home. One participant pointed out that when her grandmother goes away to collect her pension, the task of preparing the meals becomes her responsibility. She stated:

*'Now I have to go home and cook... the ones who get home first cook.'*

Having to care for a sick family member impacts on a child's attendance and schoolwork. Two participants pointed out that the affected child won't be able to go to school owing to the fact that a family member is ill. The guilt feelings of knowing that somebody at home is seriously ill make concentration on schoolwork difficult. These children, in responding to a question as to how the pandemic will impact on a child's schooling owing to a family being ill at home with HIV/AIDS, stated:

*'He will not want to go to school because he is feeling bad.'*

*'... he will not be able to concentrate because he is thinking of the sick person.'*

*'... She will think of the sick person when she is writing.'*

#### **4.2.1.4 CRIME AND VIOLENCE**

When children do not attend school, they sometimes engage in criminal activity in order to obtain money and food. Some resort to stealing. Others engage in the taking of drugs and the consumption of alcohol. Females even run the risk of being raped. One participant, in commenting on a story of a child who did not want to go to school, made the point the child will engage in criminal activity. This participant stated:

*'... the boys will teach them to steal... she will join boys that smoke... She may even smoke drugs and drink liquor and then they rape her.'*

#### **4.2.1.5 ABUSE**

In order to obtain money, these children are extremely vulnerable. One participant indicated that sometimes females resort to prostitution. This participant, supported by another, indicated that the female runs the risk of contracting HIV/AIDS which could subsequently lead to her death. She stated:

*'She will get germs.... She will get the germ and then she will get sick... Maybe she will die.'*

#### **4.2.1.6 EMOTIONAL TRAUMA**

Participants were asked to reflect on some of the experiences in their lives with the aid of drawings (map of our lives). A conspicuous feature of each of the drawings was that each drawing had a picture of a coffin with a mother in it. Further, participants were also asked to reflect on changes in their lives over the past five years. Almost all the participants spoke of the death of their mothers. In some instances their fathers also died. This was indeed a trying time for all participants emotionally. Apart from the period of mourning, many of them had to cope with radical readjustments to their lives. They had to move in with members of the extended family. One participant stated:

*'...in 2002 my father died... he was admitted to hospital. I feel sad and then in 2003 my mother passed away.'*

Given the emotional trauma associated with death, one participant indicated that if he could change anything in his family, it would be the reversal of death in his family. Another, when asked what he would like to change in his family, expressed the fervent wish for his family to be together and live harmoniously with healthy food to eat. The emotional trauma undergone by these participants was further reflected when one participant indicated that it pains him to walk past his father's grave daily on his way to school.

#### **4.2.2 ACCESSING SUPPORT FOR AFFECTED CHILDREN**

The participants were asked to speak about the support an affected child could access as a result of this the child's school attendance and schoolwork being affected.

#### **4.2.2.1 MULTI-SECTORAL SUPPORT**

Almost all participants spoke of the help from clinics and hospitals, traditional healers, faith healers, church organizations and family members. The response from one of the participants to a question as to where a sick person can get help, sums this up:

*'They can get help at the hospital and by the sangomas and at the church. They can also get help from the family [members].'*

The participants were aware that assistance can be accessed from the Department of Welfare. They spoke of the help provided by social workers. In some instances social workers even assisted in the placement of orphaned children in homes. Some of the participants articulated the following:

*'Social workers... social workers took them [orphaned children] to stay in children's homes.'*

*'The social worker can take care until she [the orphaned child] can take care of herself.'*

In terms of the affected child accessing support with regard to his or her schoolwork it was interesting to note that none of the participants spoke of educators being a source of help. However, a few of the children alluded to peer support. One participant mentioned the following:

*'She [the affected child] needs to ask her friend to help her catch up the work she has missed.'*

Another participant also supported this by stating:

*'They [the affected child's peers] can show her what work she has missed...There is a child next door that I showed the work.'*

#### **4.2.2.2 FINANCIAL SUPPORT**

The participants made the point that sometimes collections are organized to assist destitute families. In some instances these collections are initiated at school. One

participant also alluded to the accessing of financial help from the state by mentioning the following:

*'Thabo Mbeki government can help these children by giving them money...'*

Whilst all six participants are orphans, not all the care-givers are accessing the child support grant. Only three of the participants indicated that their grandparents are receiving the child support grant.

### **4.3 EMERGING TRENDS AND PATTERNS FROM THE DATA**

After a thorough scrutiny of the data, the following findings emerged from the data.

#### **4.3.1 POVERTY**

**Finding One:** *The poverty experienced by these children serves as a barrier to their learning.*

The data arising from this study indicates that poverty denies children their basic right to education. Owing to infected parents at an advanced stage of the pandemic not being able to work and consequently derive an income, infected parents are unable to provide food for their children. The death of one or both parents also results in food insecurity especially when the dead parent is the breadwinner. Hunger in its self is a serious barrier to learning in that hunger results in exhaustion and diminished attention (Giese, Meintjies and Proudlock 2001). Thus, the affected child, in order to provide for his physiological needs is forced to miss school in order to obtain food. Evans (2002) points out that a major force that leads children to leave their homes was that their families were unable to meet their basic needs, such as providing them with their basic nutritive needs.

Owing to poverty, infected and affected families are unable to meet their financial commitments to schools in the form of school fees. Whilst the *South African Schools Act, 84 of 1996* provides for the exemption of fee payment for parents who are poor, the reality of the matter is that school governing bodies seldom allow such exemptions and make it mandatory for all parents to pay. The result is that parents whose school fee

payments are in arrears run the risk of having their children's report cards being withheld and being denied participation in the school's extra and co-curricular programme. Such children face humiliation from their peers. One of the reasons for such oppression is the powerlessness of individuals to access the social rights embedded in policy instruments and legislative frameworks. The end result of such powerlessness is the affected child not attending school and ultimately dropping out of school. Huber and Gould (2003) concur that the reason most often cited by affected learners for non-attendance at school was the lack of money.

In terms of Young's (1990) faces of oppression, the poverty trap results in the marginalization of children <sup>whose fees are not constantly or fully paid</sup> affected by the pandemic. This marginalization is particularly harmful since it means both being expelled from useful participation in social life and being subjected to material deprivation. In capitalist societies such as South Africa such deprivation caused by marginalization, from a social justice perspective, is unjust given the fact that there are others who have plenty. In noting that South Africa's economic policies since 1994 were overtly aimed at equity and redress, these policies in reality have not done much in elevating the standard of living of those living in poverty. Consequently, the material deprivation suffered by those affected by the pandemic <sup>those who cannot pay are systematically deprived to enjoy their rights of schooling</sup> makes them dependent on others in society.

As a consequence of poverty, the marginalization of children <sup>who cannot pay school fees</sup> affected by the pandemic may result in the exclusion of children <sup>of these parents</sup> from participation in effective learning experiences at school. When school fees are not paid, children are subjected to various exclusionary practices at school. The irony of such exclusion is that whilst the *Constitution of the Republic of South Africa Act, 108 of 1996* guarantees all children the right to education, the pandemic <sup>school fees</sup> works to deny <sup>poor</sup> affected children such rights. The parents/caregivers of the affected children are powerless to question their children's exclusion despite legislation which supports their inclusion. Their status as marginals in society results in them lacking authority to question and even challenge those authority. This contributes to their continued oppressive treatment by those in power.

#### **4.3.2 FAMILY RESPONSIBILITY**

**Finding Two:** *Having to meet the needs of the family often results in affected children not attending school.*

The data from this study suggests that when parents are ill owing to the pandemic, the responsibility for taking care of the family falls on the children. The affected child has to take on added household chores. In some instances, children will have to seek work in order to meet the financial costs of running the home. When parents become too ill, the nursing of the parent becomes the responsibility of the child. Even when children are orphaned and are forced to live with care-givers such as grandparents, added family chores become a reality. Owing to the old age of caregivers and their need to visit hospitals and collect social grants, the basic household duties become the responsibility of the children. Under such circumstances the affected child can hardly be expected to attend school.

This study confirms that some children affected by the pandemic undergo a face of oppression which Young (1990) terms exploitation. In order to obtain money, they are forced into child labour and engage in menial labour in return for paltry sums of money as payment for their labour. Whilst the *Child Care Act* precludes child labour in South Africa, unscrupulous employers are aware of this cheap labour market and thus exploit this grouping in order to maximize their profits.

These children also experience a sense of powerlessness in that they have no say in the decisions that affect their lives. Since there may be no adults around they are forced to stay home to provide care to the sick parent and complete household chores. Thus the decision to attend or not attend school under such circumstances is not one of their own volition, but rather one that is thrust upon them.

#### **4.3.3 CRIME, VIOLENCE AND ABUSE**

**Finding Three:** *Affected children are exposed to the world of crime, violence and abuse which impacts negatively on their schooling.*

This study suggests that being affected by the pandemic results in the vulnerability of children to the risk factors of crime, violence and abuse. Children affected by the pandemic are often forced into crime and violence in order to obtain money and food. Female children resort to prostitution in order to obtain money and material things they desire. Moletsane (2003:9) points out that young schoolgirls often form relationships with much older, working men referred to as 'sugar daddies' for economic support and status. The Centre for the AIDS Programme of Research in South Africa (CAPRISA) have noted that teenagers with sexual partners who are older than 24 are six times more likely to contract HIV (Sunday Times 2005:13). These individuals thus become vulnerable to teenage pregnancy and infection by the HIV/AIDS virus.

Apart from the experience of vulnerability as a face of oppression, these children are susceptible to an extremely degrading and humiliating face of oppression in the form of violence. The data has shown that females run the risk of being raped (see 4.2.1.4, page 47) and children become the victims of overt violent behaviour (see 4.2.1.2, page 46). The risky behaviour that these affected children engage in, in order to obtain money and food, exposes them not only to overt acts of violence on their person but also to covert acts of violence which includes incidents of harassment, intimidation or ridicule. Young (1990:61) states that these less severe forms of violence have the effect of degrading, humiliating or stigmatizing oppressed people. When these oppressed people come to fear violence, Young (1990:61) points out that violence then functions to keep the oppressed groups subordinate.

#### **4.3.4 EMOTIONAL TRAUMA**

***Finding Four: The emotional trauma that affected children have to endure impacts on their schooling.***

The children exposed to the pandemic in this study also experience another cross cutting face of oppression termed vulnerability. The emotional trauma experienced by the children affected by the pandemic make these children extremely vulnerable to

psychosocial distress, stigmatization and discrimination. The children in this study spoke of the sadness they experienced when loved ones passed away and the subsequent trauma they experienced associated with the death. In some instances they had to cope with radical readjustments to their lives where they had to move in with members of the extended family (see 4.2.1.6, page 48).

Children burdened by the HIV/AIDS virus, often experience a wide variety of negative emotions. The death of one or both of the parents results in feelings of despair and insecurity over the future. Lewis (1995:57) points out that when children are exposed to the death of a parent because of AIDS, the child may react to the loss with marked protest, despair, and detachment, as well as helplessness and hopelessness. In addition, the child will also try to conceal the death by going through extra-ordinary measures to keep the death a secret from other members of the community, all because of the stigma associated with the pandemic. This then places an added burden on the child.

Apart from having to deal with issue of death itself, the prospect of having the family broken up and having to live with distant relatives adds to the trauma. Kelly (2000b) points out that for young children who do not as yet understand the ways of the world; this can be an insurmountable source of rejection, confusion and despair. The morale of these children is lowered as they experience sickness, poverty and death intertwined with hopelessness.

Apart from the trauma associated with the issue of death, caring for a sick parent alone is an emotionally charged experience. Ebersohn and Eloff (2002) point out that this becomes a chronic and debilitating stressor in the lives of affected children. Such children, when they attend school, often cannot cope with the expectations and demands made on them owing to the constant worry and guilt feelings associated with the sick parent.

Having a parent die of the pandemic also sometimes becomes a source of ridicule and negative treatment by one's peers. Moletsane (2003) points out that children living under

the stigma of HIV/AIDS are often subject to humiliation and taunts due to ignorance and fear on the part of their peers and teachers. Sometimes some of these children suffer overt discrimination and are left out of activities and isolated from the general hub of the class. In essence, the affected children experience a sense of powerlessness in trying to belong because the decision as to who is in and who is out, rests with those with status and power. Such treatment of affected children is bound to affect them emotionally and have a negative impact on their self concept.

Young (1990:58-59) also points out that as a result of cultural imperialism, children who are stigmatized (as a result of their dead parents assumed HIV status) undergo a kind of paradoxical oppression in that they are marked out as 'Other' by stereotypes, and at the same time rendered invisible by the dominant groups (those unaffected by the pandemic). These groups often use harsh labels to describe those marked out as 'Other' and they become reconstructed largely as being deviant and inferior.

These affected children often experience another face of oppression called violence. Affected children experience social exclusion and become targets for violence simply because they are members of a stigmatized group. The oppression of violence, according to Young (1990:62), consists not only of direct victimization, but in the daily knowledge shared by all members of oppressed groups that they are liable to violation, solely on account of their group identity. Just living under the threat of attack on oneself, deprives the oppressed of freedom and dignity.

#### **4.3.5 MULTI-SECTORAL SUPPORT**

***Finding Five: There was a satisfactory understanding of agencies that could be approached in accessing support for affected children.***

The children in this study were able to clearly articulate the various agencies from which support could be accessed. However, when it came to assistance with schoolwork, a conspicuous omission was the school and educators as a source of support and help. The accessing of support by both those affected and infected by the pandemic exposes people

to a face of oppression termed marginalization. Because of their (affected and infected individuals) increasing dependence on the bureaucratic state, NGO's and CBO's for support and services they are in fact expelled from useful participation in social life and confined to lives of social marginality. Young (1990:54) points out that these individuals are then subjected to the patronizing, punitive, demeaning and arbitrary treatment by the people and policies associated with these organizations. Being dependent on these organizations implies being legitimately subject to the often arbitrary and invasive authority of social service providers and other public and private administrators, who enforce rules with which the marginal must comply. Further, in the dependency relationship with support organizations, power relations are also at play. Because of the dependency of affected and infected individuals on the support agencies, many individuals are stripped off their rights, freedoms and their self esteem. This then results in feelings of powerlessness among these individuals.

#### **4.3.6 FINANCIAL SUPPORT**

***Finding Six: The financial support offered by the Department of Social Welfare is not being fully exploited by affected individuals.***

The data in this study suggests that the accessing of child support grants by care-givers in order to financially support affected children is not being fully exploited. Given the powerlessness, marginalization and stigmatization of individuals affected by the pandemic, those in authority are not doing enough to empower affected individuals with regard to their rights in seeking financial support from the state. Moreover, state policies are not designed so as to make it simple for affected individuals to access financial support. The dominant and powerful groups in society (those with greater cultural and economic capital) determine not only the processes and procedures to be followed with regard to accessing of the financial assistance from the state, but it is these groups that determine how much should be made available in terms of social welfare grants through their influence over the states macro-economic policy.

South Africa's adoption of neo-liberalism as the states' ideology, as expressed through the macroeconomic Growth, Employment and Redistribution (GEAR) strategy works against those living in poverty in the country. The economy contributes to the oppression of those individuals marginalized as a result of the pandemic. In neo-liberal politics there is a push towards a 'lean and mean' state. A 'lean and mean' state is neither a producer nor a deliverer of services. The government in a neo-liberal state has to practice fiscal discipline – spending less in order not to compete with the private sector (Pape 1998:2). What this in essence translates into is a trimming of government expenditure on social welfare and other social services. With the trimming of social welfare budgets, the need for social welfare grants often outstrips supply. Given such a scenario, the interests of government are served by not empowering individuals who qualify for such grants. From a social justice perspective, this exacerbates injustice and confines the lives of affected children to deepening poverty.

#### **4.4 SUMMARY**

In this chapter the data obtained from the focus groups was presented under topics and categories which were generated after subjecting the data to content analysis. The emerging trends and patterns from the data were then presented using the theoretical and conceptual frameworks outlined in chapter three.

In the next chapter, the main conclusions of this study are presented and certain pertinent recommendations are made.

## **CHAPTER FIVE**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

The previous chapter dealt with the presentation, analysis and discussion of the data. In this chapter the main conclusions and recommendations are presented. After a careful consideration of the data, certain clear conclusions emerge in terms of the critical questions formulated in chapter one. Based on the findings outlined in chapter four and the conclusions of this study, pertinent recommendations are then made.

#### **5.2 CONCLUSIONS**

This study has suggested that the HIV/AIDS pandemic has a negative impact on affected children's schooling. The poverty that results as a consequence of the pandemic seriously hampers a child's access to and participation in formal education. Owing to the poverty that prevails, children are often forced to abandon their schooling in order to take on the duties of adults because the adults have either become incapacitated due to the pandemic or have perished because of the pandemic. The burden of caring for sick adults and taking care siblings become the responsibility of older children. Some are forced to enter the world of work in order to provide for themselves and their siblings. When children find themselves in such circumstances they become the objects of oppression and are reduced to the roles of marginals in society. In instances where they enter the labour market they are subject to exploitation by their employers.

Affected children, in their attempt to satisfy their nutritive needs often miss or drop-out of school and engage in criminal activity in order to obtain money to purchase food. These children then become vulnerable to violence and abuse. To live constantly under the threat of violence and abuse, impacts on a child's freedom and dignity.

The emotional toll of the pandemic has a debilitating effect on the affected child's schooling. Apart from coping with the emotional trauma of the loss of a parent to the

pandemic, the pressure on the child to conceal the cause of the death of the parent owing to the stigma associated with the pandemic becomes too burdensome on the child. When the child's peers do become aware of the death, the affected child is discriminated against, marginalized and sometimes subjected to overt forms of violence as well as covert forms of violence such as victimization and harassment. Under such circumstances the child's schooling is impacted upon negatively.

These barriers impacting on the schooling of children affected by the pandemic do not act in isolation to one another. They are in fact intertwined and sometimes have a cumulative effect as a barrier to learning of the affected children.

The children in this study had a satisfactory understanding of the multi-sectoral support that is available to affected children. However, schools and educators could do more in assisting affected children to cope with the schoolwork they may have missed owing to their absence from school. Whilst financial assistance is available to the care-givers of affected children in the form of child support grants from the Department of Welfare, not all care-givers exploit such assistance. Given the neo-liberal economic policies of the state, budgets for such grants are often inadequate. Consequently, the need for such grants far outstrips supply.

This study has also elucidated the injustices that affected children have to endure through no fault of their own. They are subjected to all six faces of oppression *viz.* exploitation, marginalization, powerlessness, cultural imperialism, violence and vulnerability. The worrying feature of this oppression is that the 'oppressors' have no interest in changing the situation in which the affected children find themselves.

### **5.3 RECOMMENDATIONS**

The following recommendations have implications for:

- The Department of Education
- Educators and SMTs
- SGBs

- State Officials

### **RECOMMENDATION ONE**

In noting the broad philosophy underpinning *Education White Paper 6 of 2001* which aims to minimize barriers to learning and to promote inclusivity, schools should become more aware of how the HIV/AIDS pandemic serves as a barrier to learning. The time that constitutes the school day also coincides with the time that affected children are needed at home to care for ill parents, younger siblings as well as perform household chores. This thus makes attending school impossible. The schooling system as a whole needs to take cognizance of this and needs to become more flexible in order to accommodate affected children. Failure to do this will exacerbate exclusion which will run counter to the spirit of inclusion as espoused in *Education White Paper 6*.

### **RECOMMENDATION TWO**

Given the fact that schooling is not free in South Africa, children affected by the pandemic should be protected from exclusionary practices instituted by some schools on account of the parents/guardians inability to pay fees. The school fee issue, coupled with poverty and its attendant consequences can be overcome by the state engaging in a vigorous advocacy programme on how child support grants could be accessed. This will ensure that the affected children have the financial means to take care of their needs. Further, the budget for such grants needs to be increased substantially so as to ensure that more people can benefit. The copious documentation required for accessing such grants needs to be relaxed so as to ensure that the application for such grants do not become a tedious and onerous task which may result in deterring those who qualify for such grants from applying.

### **RECOMMENDATION THREE**

Given the emotional trauma of losing a parent to the pandemic there is dire need for bereavement counselling of affected children. Schools should become nodal points where such counselling can be accessed. If the Department of Education is serious about

minimizing the barriers to learning caused by the pandemic, then the appointment of adequately trained counselors at schools becomes something mandatory.

#### **RECOMMENDATION FOUR**

In order to ensure that an affected child's schoolwork does not suffer when the child has to be away from school for any particular period of time, SMTs should be creative in arranging an academic support programme for the affected child. Affected children could be allocated a teacher-mentor who supervises the child's work and who provides guidance and support to the child.

#### **5.4 RECOMMENDATION FOR FURTHER RESEARCH**

This study was a small scale study confined to a small geographical area involving only six participants. It was largely qualitative and aimed at uncovering meaning and generating insight. Consequently, no generalizations could be made about all children affected by the pandemic. It is therefore, strongly recommended that a large scale quantitative study be conducted so that certain firm generalizations could be made.

#### **5.5 SUMMARY**

This chapter outlined the main conclusions drawn in this study. Further, based on the findings and the conclusions drawn in this study, relevant recommendations are made.

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**ANNEXURE A**

**PARTICIPANT INTERVIEW SCHEDULE**

**BIOGRAPHICAL DATA AND BACKGROUND INFORMATION**

**1. Personal Details of Learner**

Code Name of Learner: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

**2. Family Details of Learner**

2.1 Are both your parents living? Yes / No

2.2 If not who is deceased? \_\_\_\_\_. How did this happen? \_\_\_\_\_

2.3 Do you live with both your parents? Yes / No

2.4 If not, which one or who do you live with? \_\_\_\_\_

2.5 How many other people live in your house? \_\_\_\_\_

2.6 Who are these people? \_\_\_\_\_

**3. Household Membership: Age and Educational Level**

3.1 How many people who live with you are aged below 2 years old? \_\_\_\_\_

3.2 Who cares for them? \_\_\_\_\_

3.3 How many people who live with you are between 2 and 7 years old? \_\_\_\_\_

3.4 Do they go to school or daycare or stay at home? \_\_\_\_\_

3.5 How many people who live with you are between 8 and 12 years old? \_\_\_\_\_

3.6 Do they go to school? What grade are they in? \_\_\_\_\_

3.7 How many people who live with you are between 13 and 20 years old? \_\_\_\_\_

3.8 Do they go to school? What grade are they in? \_\_\_\_\_

**4. Sources of Finance**

4.1 How does your family get money to buy food and pay accounts? \_\_\_\_\_

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4.2 Who is responsible for paying accounts and buying food for the family? \_\_\_\_\_

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4.3 Does anyone in your family collect any of the following:

(circle where applicable)

Child care grant	Yes	No
Foster care grant	Yes	No
Disability grant	Yes	No
Pension	Yes	No

**5. Housing Issues and Household Resources**

5.1 Do you have your own home? (circle applicable choice) Yes / No

5.2 Describe your home (what is the building made of; how many rooms; etc.) \_\_\_\_\_

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

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

5.4 Do you have your own room? (circle applicable choice) Yes / No

5.5 If not, who do you share your room with? \_\_\_\_\_

## 6. Health and Nutrition

6.1 What meals did you have yesterday? (breakfast/lunch/supper) \_\_\_\_\_

6.2 What did you eat in those meals? \_\_\_\_\_

6.3 Do you take lunch to school? (circle applicable choice) Yes / No

6.4 If not, why? \_\_\_\_\_

6.5 Do you buy food from the school tuck shop? (circle applicable choice) Yes / No

6.6 If yes, who gives you money? \_\_\_\_\_

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

Never

1-2 days

2-4 days

A week

6.8 Are there any other people who provide food for you? \_\_\_\_\_

## 7. School Issues

(Circle where applicable)

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

7.2 If not, who bought your stationery for you? \_\_\_\_\_

7.3 Did you receive textbooks at school this year? Yes / No

7.4 What else did you get from school this year? \_\_\_\_\_

7.5 Do you have a desk and chair to use? Yes / No

7.6 How many of you sit at your desk? \_\_\_\_\_

**8. School Attendance**

8.1 Do you go to school most days? (circle applicable choice) Yes / No

8.2 When do you stay away from school? \_\_\_\_\_

8.3 Why do you not go to school? \_\_\_\_\_

8.4 How many times were you absent from school in the last term? (circle applicable choice)

Never

More than five times

More than ten times

8.5 What were the main reasons you were absent from school? \_\_\_\_\_

8.6 Are you ever late for school? (circle applicable choice) Yes / No

8.7 Why do you come late to school? \_\_\_\_\_

**9. School Fees**

9.1 How much are your school fees? \_\_\_\_\_

9.2 Did you pay your school fees? (circle applicable choice) Yes / No

9.3 If no, why? \_\_\_\_\_

9.4 Does the school take any action if your fees are outstanding? (circle applicable choice) Yes / No

Tell you to stay at home (circle applicable choice) Yes / No

Deprive you of text books (circle applicable choice) Yes / No

Treat you differently from the other learners (circle applicable choice) Yes / No

Other (Specify) \_\_\_\_\_

9.5 What do you like about your school? \_\_\_\_\_

**10. Community Issues**

10.1 What do you think are the problems that children in your community have?

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10.2 Are children in your community experiencing any of the following problems?(Tick where applicable)

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

10.3 Have you ever experienced any of these problems? (circle applicable choice)

Yes/ No

Specify \_\_\_\_\_

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10.4 What do you like about your community? \_\_\_\_\_

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**THANK YOU FOR SHARING THIS INFORMATION WITH ME**

## **FOCUS GROUP INTERVIEW ONE**

**AIM:** To build rapport and trust with learners

**SAMPLE:** 9 – 12 years old

### **ICEBREAKER**

The facilitator introduces herself. Learners are asked to choose a code name for himself/herself. Eg. My name is Lindiwe and my code name is Pretty. Explain to learners that their code name is their research name and that any information they speak about will be recorded under their code name so no one else will know who said it. Name tags are made for each learner.

A learner will say their code name and then call another person by their code name and throw the ball to that person. That person says his/her name and calls another person, and so on. Encourage everyone in the circle to have a turn. The facilitator also joins in.

### **GROUP RULES**

The facilitator and the learners will discuss together the rules which should be followed. The facilitator poses the following question: *What things will help this group to talk freely and openly and to make this a safe space to share?* Get learners to share their ideas. Ensure that the following points are covered:

- One person to speak at a time
- Do not laugh at what someone says
- Everyone must have a turn, participation is important
- What we say is confidential – that means that we do not tell other people about what someone says, what we say stays in this room.
- Punctuality is important
- Encourage learners that if anything upsets them, to talk about it in the group (preferably as probably it is worrying others too) or to come and see you afterwards.
- Learners to sign a confidentiality pledge

## **TOPIC 1: FAMILY RESPONSIBILITY**

**Purpose:** to identify the extent to which learners assume responsibilities in the home.

1. Show learners a picture of a boy. This is Siphso. He didn't go to school. Tell me a story about why he didn't come to school. (Probe for more reasons). Elicit a list of possible reasons.
2. What happened to him when he didn't come to school?
3. What did he do during the time that he was not at school?
4. What did his family do (about him not going to school)?
5. Show learners a picture of a girl. This is Thandi. She didn't go to school. Tell me a story about why she didn't come to school. (Probe for more reasons). Elicit a list of possible reasons.
6. What happened to her when she didn't come to school?
7. What did she do during the time that she was not at school?
8. What did her family do (about her not going to school)?
9. Have you ever not been to school? Why did you not go to school?

## **TOPIC 2: SOCIAL DISCRIMINATION**

**Purpose:** To discern what factors children use to stigmatize or discriminate against some children.

Learners are shown a photograph. This is Vusi. He is well liked by his peers. What are some of the reasons for his popularity? List the reasons.

Learners are shown a photograph. This is Douglas. He is not well liked by his peers. What are some of the reasons for this? List the reasons.

### **TOPIC 3: ROAD OF LIFE**

**Purpose:** To identify the obstacles experienced by learners in their lives.

Give learners paper and pens. Ask learners to put their code name and grade at the top right corner of the paper.

Learners must think about a road. It goes up and down hills, it is sometimes bumpy, it sometimes has rocks in it, it sometimes winds, it has potholes.

Think of your life as a journey on this road, from when you were born, to now. Try to draw it. Show the important things that have happened in your life. Show the good things and the bad/hard things. Perhaps the hard things are rocks on the road. You can draw pictures of things on the road, or on the side of the road. There is no one correct way of doing this, just draw how you want to.

After drawing, tell the learners about the things on your road, and how you felt about them. Each learner then talks about and explains his/her road of life.

### **TOPIC 4: DISCUSSION OF LIKES AND DISLIKES**

**Purpose:** To determine the emotional well-being of learners.

What do you like about your life?

What would you change?

What do you like about your family?

What would you change?

What do you like about yourself?

What would you like to change?

What has been the greatest change in your family in the last 5 years?

## **CONCLUSION**

Ask learners to close their eyes and think about what they liked today. Tell us what you liked about today. Was there anything that was difficult?

Thank learners for their participation.

## **FOCUS GROUP INTERVIEW 2**

**AIM: to focus on sickness and health issues**

**SAMPLE: 9 – 12 year olds**

Welcome learners. Ask learners if they could remember the rules of the group.

### **ICEBREAKER**

Greet each other: elbow to elbow, back to back, foot to foot, very softly, as if you were a bit sad, or as if you are a bit sad or as if you are happy, as if you are very excited. Then ask them to greet each other calmly.

### **TOPIC ONE: SICKNESS**

**Purpose:** To identify infected members in the family.

Learners are given each a piece of A4 paper and crayons. Learners must write their code names on the top right hand corner. Learners must draw someone who is sick. After 10 minutes, ask learners to talk about their drawings. The following questions can be used to prompt learners:

- Tell us about your drawing
- Who is the person?
- What sickness has the person got?
- What happens to them with this sickness?
- How/Where did they get this sickness?
- What does this person do when they are sick? (Do they go to someone for help? Do they stay at home? Does someone look after them?)

## TOPIC TWO: HIV/AIDS

### Purpose:

- To determine what fears learners have about HIV/AIDS
- To identify how HIV/AIDS affects learning.

### 1. Group Discussion:

- What is HIV/AIDS?
- What do people here in Ndaleni call HIV/AIDS?
- Why do you think that they use these words?
- Where did you hear about HIV/AIDS? (ask learners individually).

2. Give each learner a piece of paper and a pencil. Ask them to write down what they fear most about HIV/AIDS.

Collect the responses and hand them out again so that each person gets someone else's response.

Discussion of each response – fears. If the group wants to say something about these fears, eg. yes, I also have that fear, lots of people have that fear.

What happens when a person has HIV/AIDS? ( There are different dimensions of this, eg. what happens to them physically; how do people respond to them?)

### 3. Use pictures from last session (Sipho and Thandi)

- Show them a picture of Sipho
  - Sipho has someone in his family that has HIV/AIDS
  - Does this affect his learning? How?  
Will Sipho be forced to stay at home to take care of the sick person?
- Show them a picture of Thandi
  - Thandi has someone in her family that has HIV/AIDS.
  - Does this affect her learning? How
  - Will Thandi be forced to stay at home to take care of the sick person?
  - Do you think that Sipho being a boy will have different responsibilities as compared to Thandi being a girl in a HIV/AIDS household?

How do people treat a person with HIV/AIDS?

- What do people say about them?

- Why?
- What do they do to them(people with HIV/AIDS)
- Why?
- How do people treat the family members of the person with HIV/AIDS?
- Why?
- Is this fair? Is it right?
- Why? /Why not?

### **TOPIC THREE: HIV/AIDS IN YOUR AREA**

**Purpose:** To determine the support systems that exists in the area for children affected by the pandemic.

We have been talking about HIV/AIDS, and now we want to find out about HIV/AIDS and your area, Ndaleni.

Discussion based on the following questions:

- Does HIV/AIDS happen here in Ndaleni?
- What makes you think it is here?
- What do you see that makes you think it is here
- Does HIV/AIDS happen in your school?
- What do you see that makes you think it is here?

Give out pieces of paper and pencils to each learner.

Please answer this question, by writing on the piece of paper:

*If someone in your family has HIV/AIDS, where and how can you get support*

### **CONCLUSION**

Ask learners to think and talk about the things that were nice today. Ask learners: What do you want to be when you grow up?

Thank learners for their participation.

## **FOCUS GROUP INTERVIEW 3**

**AIM: To focus on HIV/AIDS and personal experience**

**SAMPLE:** 9 – 12 year olds

Welcome everyone back to the session. Remind learners of rules of the group

### **ICEBREAKER**

Learners will stand in a circle. If facilitator shouts RIVER, the group must jump forward and if she shouts BANK, the group must jump backward. If anyone makes a mistake, they sit out.

### **TOPIC ONE: ACCESSING SUPPORT**

**Purpose:** To determine the support systems that exists in the area for children affected by the pandemic.

Use the same pictures from session one. Show the picture of the girl.

This is Thandi. Her mother has HIV/AIDS and is very sick.

1. Where and how does Thandi get help?

Introduce the Children's Bill of Rights:

- All children have the right to learn and education.
  - All children have the right to basic protection and care
2. How could we the learners, teachers and the school help Thandi to achieve these rights?
  3. Now, imagine that Thandi's mother passes away. Where and how does Thandi get help?
  4. How could we learners, teachers and the school help Thandi now?

### **TOPIC TWO: BODY MAP DRAWING**

**Purpose:** to understand learners experiences and feelings about HIV/AIDS

Two people are to work together in pairs. One person to lie on a piece of paper, the other person draws around their body to get an outline of that person on the paper. Then swap

around. Now each person has an outline of himself or herself. Now fill in the outline of the drawing of yourself, which show in your body how you feel about HIV/AIDS, your experiences and your feelings about HIV/AIDS. You can draw things realistically and symbolically, i.e A big heart if you have a lot of love , or a broken heart if you feel pain.

### **TOPIC THREE: ABSENTEEISM**

**Purpose:** to identify the extent to which HIV/AIDS affects learning.

Learners are shown a picture of a girl. This is Thobeka. Her father has died recently and her mother and baby brother are very sick with HIV/AIDS. She has 2 younger sisters who are 3 and 5 years old. She hasn't been to school the whole week. Learners are then asked to give reasons why Thobeka didn't go to school. The following could be some questions which can be asked:

- What do you think she was doing at home?
- Will this impact on her learning at school?
- Why is it important for her to be at school?
- Can the teachers and school assist her? How?
- Can the community help? How?
- Have you been in a similar situation as Thobeka where you were not able to attend school? Explain your situation.

### **TOPIC FOUR: COPING WITH DEATH**

**Purpose:** to determine the extent to which HIV/AIDS related deaths affects children

Ask learners to imagine what would happen if Thobeka's mother dies. Learners must draw what they think would happen. Each learner then describes and talks about his/her drawing. Probe aspects of the picture. Further questions can be asked:

- Where can Thobeka get help if her mother dies?
- Do you know anyone else in Thobeka's situation? How did he/she cope? What help did he/she receive?

## **CONCLUSION**

Ask learners to think about a happy moment in their lives. Share this moment with the rest of the group.

Thank learners for their participation.

## ANNEXURE B

7 Rameshvar Drive  
Harinagar Township  
Queensburgh  
4093

08 July 2005

Dear Parent/Guardian

### **Research Programme at Richmond Day Care and Support Centre**

We, as research students at the University of KwaZulu-Natal are conducting research into the factors that may assist or create difficulties for children in terms of their education. We believe that there may be various ways in which children's learning may be affected. We want to try to understand these factors so that we can provide the government and others with information to assist with policy development and intervention. We hope that the information that we obtain during the course of this research will help to lessen the difficulties that some children experience in accessing education and progressing with their schoolwork.

The Richmond area has been selected as the site where the research will be conducted. The Mayor of Richmond and other key stakeholders have expressed their support for this programme. We have selected a group of learners from the Richmond Day Care and Support Centre to participate in this research programme.

We want the children to take part in an individual interview with a trained assistant, and three or four group discussions about the factors that affect children's school progress. The individual interviews will last about twenty to thirty minutes and the group discussions will be about one and half hours each. These will take place when your child is at Richmond Day Care and Support Centre. We would like to do all of these activities during July 2005.

All information will be kept confidential. Any articles that are published from this research will ensure that the anonymity of the community, school and individuals is maintained by not using any identifying information. It is unlikely that your child will find the discussions distressing in any manner. However, if they feel a need to deal in more detail with any stressful situations, we will ensure that they are put in touch with the appropriate service agency.

By chance your child has been selected to participate in the research. We are asking for your permission for him or her to take part. With this in mind, we ask that you give us permission for your child to participate by signing and returning the attached form to the Richmond Day Care and Support Centre as soon as possible. We will also be asking

your child individually if they would be willing, but obviously need your permission as a first step.

Yours sincerely

\_\_\_\_\_  
Silochana Naicker  
(Researcher)

083 886 5989 ©  
031-4095707 (H)

I, (Please write in your full name) \_\_\_\_\_

agree

disagree

Child's name \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_

Understand all the issues in the letter, and agree to participate in the research process.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## ANNEXURE C

7 Rameshvar Drive  
Harinagar Township  
Queensburgh  
4093

08 July 2005

Dear Learner

### **Research Programme at Richmond Day Care and Support Centre**

We are research students at the University of KwaZulu-Natal, and we want to find out about the difficulties learners have in their education. We want to find out about these problems because it can help us and the government to make plans to address these problems.

The Richmond Day Care and Support Centre is one of the sites which we have chosen to work in. We cannot work with all the learners, so we chose a few names from the learner list in the centre, and you were one of the chosen learners. We would like to tell you about the research, so that you can decide whether you want to participate in it or not.

We want to focus on why you go to school, what you like about it and what is difficult, what might be some of the problems you have in attending school, and problems you know that other learners have. We would like to find these things out by talking to you on your own (in a short interview, 20 minutes), and then also to meet with you and a group of learners. These groups are called focus groups. We would like to have four meetings with you in this group. Each of these meetings will take about 1 and a half hours. We will discuss with you what would be the best time to have these meetings.

In the interview, we will ask you about your family, where you live, your school, and some of the problems you might have there. In the groups we will ask you about why you attend school, why some learners don't attend school, what you enjoy about it, what you don't like about school. We will also ask you about your family life and responsibilities at home. In the groups we will also play games and do some drawings. In the groups we will also ask about what you know about sickness, and illnesses like HIV/AIDS.

It is very important for you to know that what you say in the interviews and the focus groups will be kept confidential. This means that if you tell us something, no one else will know what it is that you tell us. We will not tell your parents/guardians or your teachers, that it is you who has said something. In fact, in the groups, we will play a game where you give yourself another name. If there are things which people talk about in the groups which you find upsetting, we will talk about these things.

It is also important to know that when you hear things in these groups, you must not go and tell other people who was not part of the group. This means that you are keeping the group discussion confidential, and this helps all the learners in the group.

We want to make sure that we record exactly what you say, so we would like to use tape recorders and a video camera in the group discussions. These will be kept very safe and will not be shown to anyone outside of the research team.

If you agree to be in this process, you may also withdraw at any time if you don't want to be part of it any more. If you have understood all of these things, and if you want to be part of this research project, then please read the next sheet.

Yours sincerely,

\_\_\_\_\_  
Silochana Naicker  
(Researcher)  
083 886 5989 ©  
031-4095707 (H)

I, (Please write in your full name) \_\_\_\_\_

- Agree
- Disagree

I am in Grade \_\_\_\_\_ at \_\_\_\_\_ School.

Understand all the issue in the letter and agree to participate in the research process

Signature: \_\_\_\_\_

Date: \_\_\_\_\_