

**AN EXPLORATION OF TEACHER
ENGAGEMENT WITH HIV/AIDS
EDUCATION: A CASE STUDY**

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**AN EXPLORATION OF TEACHER ENGAGEMENT WITH HIV/AIDS
EDUCATION IN PRIMARY SCHOOL: A CASE STUDY**

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ABSTRACT

The purpose of this study was to determine teacher engagement with HIV/AIDS education in primary school. Since the emergence and acknowledgement of the HIV/AIDS epidemic in South Africa, the national education department's policy has advanced HIV/AIDS education as a priority. The new curriculum has opened up opportunities for HIV/AIDS education to be inserted in the curriculum especially in the learning area Life Orientation in the primary school, which previously did not exist.

There is a paucity of research documenting teachers' experiences on the implementation of the HIV/AIDS curriculum. The manner in which teachers engage with the HIV/AIDS curriculum is not known. This study focused on 9 teachers in the intermediate and senior phases in a particular primary school in KwaZulu Natal who have had experience in the implementation of the HIV/AIDS curriculum over the past four years in their school. A survey questionnaire was administered to all educators in the study. The three intermediate educators participated in face-to-face interviews as well as a focus group discussion. An interview was conducted with the member of the management team who was part of the sample.

The results from the survey, interviews and focus group discussion suggest that teachers were strongly implementing the HIV/AIDS curriculum in their classrooms while experiencing some practical challenges. This study also suggests that the educators found the Department Of Education's implementation plan suppressive. All three intermediate phase teachers used creative methods to assist in the implementation of the curriculum. The respondents claimed that the workshops and meetings that they had attended were invaluable to them. They however preferred seeing the community more closely involved in the fight against HIV/AIDS, as this was not an issue confined to the school exclusively. Teachers would also liked to have had HIV/AIDS education implemented across the curriculum, as the task to empower learners in this regard was a mammoth one.

The unique and challenging experiences of teachers implementing the HIV/AIDS curriculum must be documented before any theoretical positions can be articulated about the implementation of HIV/AIDS education in primary schools in South Africa. This study has contributed to research on the implementation of HIV/AIDS education in primary school by providing some insight into a group of educators' experiences.

DEDICATION

...to my mum and in the memory of my dearest dad and gran...

ACKNOWLEDGEMENTS

“O LORD, MY ROCK AND MY REDEEMER”

I am indeed indebted to the Lord for blessing me with the capacity to persevere ...

TO MY MUM

For being my wellspring of strength and inspiration...

TO MY PRECIOUS DAUGHTER RIYONA

For your enchanting spirit and helping me, doll, to believe in tomorrow...

TO MY SISTER LORRAINE & BROTHER IN LAW STANLEY

For your patience and tolerance and for accessing information at a moments notice across the province!

TO MY BROTHER PREGGIE

For your countless prayers of better things still to come...

TO MY FRIENDS AND RELATIVES

For your unconditional support and belief in me...

TO DESIREE` ERICA LEAFE & RUSSELL KETTLE

For your invaluable assistance and selfless nature...

TO MY SUPERVISOR RESHMA SOOKRAJH

For your dedication, counsel and friendship...

TO DAISY PILLAY

For your sensitivity, compassion and guidance...

TO DEEVIA BHANA

For challenging everything I believed in and leading me to the door of empowerment and enlightenment...

DECLARATION

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

.....

Researcher

Rajashprey Pillay

.....

Supervisor

Professor Reshma Sookrajh

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Chapter 1

1.1 Introduction to the study

HIV/AIDS has grown into a pandemic that presents a plethora of challenges of unprecedented proportions to the world at large today. Nations are being stalked by a pandemic that is even more lethal and devastating than the plagues of the past (Campbell and William 2000). HIV/AIDS is 'different' from other diseases and epidemics in profound ways partly because biomedical science has not yet produced a vaccine or cure for this predominantly sexually transmitted disease. In addition the disease is expanding more rapidly than any other epidemic and has a grip on men, women and children alike (Campbell & Williams 2000:176).

HIV/AIDS, like other epidemics has been documented to have a differential impact on each region but the statistical reality of HIV/AIDS in South Africa specifically, is especially alarming as research statistics place South Africa at the epicentre of the epidemic (Morrell et al 2002). According to Campbell & Williams (2000:176) the prevalence of HIV/AIDS in South Africa is still increasing, despite various attempts at intervention, with the youth emerging with the highest rates of infection. At the end of 1999, in South Africa alone 420 000 individuals were living with HIV/AIDS. Of this number, 95 000 were children whose ages ranged between 0-15 years! (Louw et al 2001:3).

In South Africa, while infection through contact with HIV infected blood, intravenous drug use and homosexual intercourse, does occur, it constitutes a very minimal proportion of all infections (Whiteside and Sunter 1999). Research has revealed that in the spread of HIV "the primary mode of transmission in South Africa is through heterosexual sex" (Campbell & Williams 2000:176; Latham 1992:1). It was also found that the highest rates of HIV infection, due to sexual activity, were found to exist amongst youth between the ages of 15-29 years. These statistics underscore the central position that the youth occupy in South Africa's HIV/AIDS epidemic (Whiteside 1998; Louw et al 2001:3).

The epidemic forced immediate and effective strategies from planners and policymakers in the highest echelons of government to try to mitigate the disease in the hope of circumventing its worst consequences. Amongst those responding to the epidemic was the Department Of Education. They recognised the need for educational programmes for the prevention of HIV/AIDS. Given the extent of the epidemic in South Africa in 1998 the ministry of education acknowledged the seriousness of the epidemic and initiated a classroom -based curriculum to influence the course of the epidemic (Government Gazette, 1999).

At the same time international organizations, governmental, non- governmental agencies and faith-based organisations emphasised the critical role of educational activities as an integral component of the global fight against the disease (Department Of Education 1999). Given that the only effective policy to limit the spread of HIV/AIDS infection is through awareness campaigns and sex and HIV/AIDS education, it was acknowledged that in order to prevent the spread of this disease, it was crucial to identify young people in school as a priority group and empower them with HIV risk reduction interventions so that they could make informed and educated choices to negotiate and explore their sexuality (Morrell et al 2002).

Ngcobo too (2002:14) contends, "Since schools are where knowledge is produced, defined, taught, measured and examined, they offer a suitable environment for AIDS prevention programmes". In addition, schools as public institutions, inhabited by young children between the ages of six and sixteen in South Africa, offer an important opportunity for mass-based state sexual health and AIDS interventions that can impact beyond the immediate target population of learners and educators to connect with the diverse world beyond the school walls to initiate changes to reduce vulnerability to HIV.

Against the backdrop of these strong arguments and with the introduction of Curriculum 2005, the new national curriculum in South Africa that embraces the principles of critical thinking, rational thought and deeper understandings, the task to advance HIV/AIDS education was made easier (Curriculum 2005- National Department Of Education).

The modus operandi of Curriculum 2005 was to address the reduction of HIV from a variety of angles: technology (condoms), the body (biology and sex education), diseases (STI's), and sexuality (communication skills) through the life skills programme (National Policy on HIV/AIDS 1999). Life skills refer to certain core skills (for example, negotiation, problem solving, critical thinking etc.) that are critical to every individual in order to live his/her life in the best possible way. These skills are basic to all parts of our lives and do not relate exclusively to sexuality (Vergnani & Frank 1998). The purpose of school-based intervention was based on the premise that once individuals displayed increased knowledge about HIV/AIDS, its modes of transmission and range of risk factors implicated in the transmission of HIV and the development of AIDS, this would in turn initiate changes in safer sexual behaviour thereby preventing HIV transmission.

The state initiative into education via the curriculum was acknowledged as the most logical, comprehensive and wide-reaching tool for advocacy and prevention of the disease (Ngcobo 2002). Teachers were identified as a key link in promoting and maintaining the good health of all learners based on the following reasons: learners indicated that they would prefer to learn sexuality education from their teachers as opposed to other adults namely, parents and nurses; numerous teachers were already involved with HIV prevention programmes in their schools after having received training in the Life Skills Curriculum or other programmes and finally teachers were natural sources of support for the youth given their daily contact with learners and their specialized training as educators and mentors (Harrison 2002).

In the implementation of Outcomes Based Education- OBE (the international term for the education style used to implement Curriculum 2005), the Life Skills Programme was installed within the learning area Life Orientation. The Revised National Curriculum (2003) states that the vision of Life Orientation is to facilitate individual growth so as to contribute towards the creation of a democratic society and improved quality of life in the community.

According to Ngcobo (2002:96), co-ordinator for the Life Skills Programme in KwaZulu-Natal, the Department Of Education's reasoning behind this decision was that since we live in a rapidly evolving society, the acquisition of skills related to

critical thinking, clarifying norms and values, positive self esteem and skills that underscore the importance of negotiating safer sexual behaviour are critical components since these skills would assist in the facilitation of healthy lifestyles and behavioural changes needed to cope with the host of ongoing challenges one has to face in daily life (Louw et al 2001:5).

1.2 The focus and context of the study

The following study attempts to explore the experiences of teachers of HIV/AIDS in the learning area Life Orientation. It also attempts to gain an understanding of educator engagement with HIV/AIDS education and prevention programmes via life skills education in a primary school in the greater Durban area in KwaZulu-Natal, South Africa. Data for this study was obtained through semi-structured interviews, focus group interviews and a survey questionnaire.

1.3 The purpose of the study

The central purpose of the study was to generate an understanding of how teachers are engaging with HIV/AIDS education in schools in the realm of HIV prevention work. In addition, the study attempts to identify any gaps/silences that may exist in HIV/AIDS education.

1.4 Critical Questions

The study explores the following critical questions:

- What are the gaps/silences that exist in the teaching of HIV/AIDS education in schools?
- Why do such gaps exist?

1.5 Rationale for the study

The motivation for this study was spearheaded during my studies and training as an HIV/AIDS facilitator. I discovered that the main thrust of most literature surveyed on the discourse of HIV/AIDS was located within a biomedical model of the disease. The main focus was on the aetiology of the disease, origins of the disease; modes of transmission; symptoms and prophylaxis (preventative) treatment. There seems to be

a paucity of research in terms of engagement with HIV/AIDS education, specifically within the school site.

1.6 Policies informing this study

The study was conceptualized against the landscape of the Implementation Plan for Tirisano, with a specific focus on educator engagement with the HIV/AIDS policies that are currently being implemented by the Department Of Education in KwaZulu-Natal in terms of managing 'the scourge of HIV/AIDS' (Implementation Plan for Tirisano 2000:6). The Implementation Plan for Tirisano, expects that educators should be implementing its plan. It provides for this in two ways: it defines a broad set of outcomes that are to be relevant to national life and sets those outcomes into a framework that requires local interpretation. In both aspects the policy exhorts curriculum designers and educators to recognise HIV/AIDS as priority.

Before providing an illumination of the Implementation Plan for Tirisano, I think it is imperative that I provide a synoptic overview of the context that led to the birth of this plan in July 2003.

Africa was the product of a historical process characterized by decades of conquest, capital expansion and colonization with significant historical ramifications. It left in its wake a legacy of exploitation, hierarchically ordered societies, bureaucracy, male hegemony and processes of exclusion and marginality (Cohen & Kennedy 2000). Nowhere was this more apparent than during the apartheid regime in South Africa when the government of the day promoted white hegemony through its many policies that infiltrated and permeated literally every sphere of society to endorse and more importantly, protect the coveted interests of the leading players (Cohen & Kennedy 2000).

The construct 'Apartheid' is considered to be an extreme form of segregation and was the means by which Afrikaners sought to achieve a multi-state settlement that would enable them to reclaim sovereignty over the main body of South Africa (Sparks 2003). The ideologists of the apartheid regime embraced racial categories for discriminatory practices. Thus the apartheid regime was underpinned by structural

inequalities that operated along the main axes of gender, race/ethnicity and class (Cohen & Kennedy 2000).

The South African education system was no exception. It too was expertly moulded and manipulated by the philosophy of the apartheid regime. This was clearly illustrated by the disparate levels that existed in terms for example, the level of government spending on education, access to education and the content of the school curriculum across the racial divide. The focus in South African education was on knowledge rather than skills and the national education system did not take into account learners' immediate needs.

Thus the apartheid curriculum, fraught with a system of racist ideologies, norms, values and cultural beliefs was instrumental in legitimizing unequal social, economic and political power relations that were founded on Christian National Policies.

With protracted negotiations and the election of Nelson Mandela as President of South Africa in 1994, the system of apartheid was firmly dismantled at full throttle. Moreover, the election of a democratic government and the consequent adoption of the new Constitution heralded a new chapter in the history of our country. Since the transition into democratic governance in April 1994, the Government of National Unity has made significant attempts to quash the forces of discrimination, oppression and inequality (for example, the repealing of discriminative legislature; putting into place structural mechanisms to deal with gender bias and inequality) to build a non-racist society which affirms and embraces the democratic values of human dignity, equality and freedom and prosperity for all.

One such key challenge spearheaded by former Minister of Education, Professor Kader Asmal, was the provision of an educational system contingent on the mobilization and commitment of South Africans from all walks of life, which would further the development of our country and thereby satisfy the aspirations of all South Africans. In reality this vision translated into the birth of the Implementation Plan for Tirisano that embraces the spirit of '*working together*' (Implementation Plan for Tirisano 2000:2). An integral component of this plan is the HIV/AIDS component.

Nine priorities were identified and a time frame of five years was set within which they would be realized. The priorities were actually the basic building blocks for the development of a fully functioning education and training system to drive South Africa into the 21st century and contribute to the overall health and prosperity of the nation at large (Implementation Plan for Tirisano 2000:7).

These priorities were further re-organised into five core programmes areas in the implementation plan namely,

1. HIV/AIDS
2. School effectiveness and teacher professionalism
3. Literacy
4. Further education and training and higher education
5. Organisational effectiveness of the national and provincial department of education.

My focus will specifically embrace the HIV/AIDS policy and implementation framework (Implementation plan for Tirisano 2000:8-13). In terms of HIV/AIDS, the implementation plan has been divided into three core projects which are as follows:

Project 1: Awareness, Information and Advocacy

The main thrust of the above project is to:

- Initiate increased awareness, understanding and level of knowledge and sensitivity of the causes of HIV/AIDS amongst educators and learners
- Eradicate any non-discriminatory policies against HIV/AIDS infected individuals with the purpose of quashing any myths and fallacies about the disease
- Formulate non-discriminatory HIV/AIDS policies at educational and training institutions
- Promote values to initiate changes of attitude and behaviour towards sexuality including an increased respect for females as well as recognizing the right of females to free choice in sexual relations

- Foster an increased acceptance of the need to practise safe sex

Project 2: HIV/AIDS within the curriculum

Project two's central aim is to:

- Ensure the integration of life skills and HIV/AIDS education into the curriculum at all levels
- Increase the understanding of learners about the causes and consequences of HIV/AIDS
- Change attitudes towards sexuality and HIV/AIDS among learners
- Reduce the incidence of HIV/AIDS among learners by instilling the adoption of healthy lifestyles and responsible decision making skills with regard to their sexual behaviour

Project 3: HIV/AIDS and the education system

The main goal of Project 3 is to:

- Develop plans and strategies to respond to the impact of HIV/AIDS with regards to the sustainability and human resource needs of the education and training system and the country at large
- Establish care and support systems for learners and educators affected by HIV/AIDS
(Implementation plan for Tirisano 2000)

The preceding discussion has clearly and categorically outlined the emphasis that the national department of education is placing on HIV/AIDS education. It recognises that HIV/AIDS is a major challenge to South Africans and that an urgent and co-ordinated response is necessary to help intercept the rapid transmission of the disease. The challenge for the education department is to ensure that the projects as presented above are being implemented at school level and is partly what this study aims to do.

1.7 Scope of the study

The research was carried out at only one site namely a primary school in KwaZulu-Natal. Permission was obtained from the principal to interview the participants. The teaching experience of the educators who participated in the focus group interview ranged between eight to twenty years, while the member of management, a research participant in the semi-structured interview, had twenty years of teaching experience.

This study was undertaken with:

- Three primary school teachers who taught Life Orientation in either the Intermediate or Senior Phase (focus group discussions and semi-structured interview)
- A member of the School Management Team (Head of Department who also taught Life Orientation in the Intermediate Phase)
- The remainder of the staff complement (9 educators participated in the survey)

1.8 Significance of the study

The findings of this research could be useful in the context of the development of primary school institutions and the HIV/AIDS programmes on offer.

The study could also play a significant role in:

- Transforming and developing curricula for primary HIV/AIDS education, to equip educators for the culturally diverse and multifaceted contexts they may find themselves working in;
- Moving towards a (re) definition and (re) interrogation of HIV/AIDS education that embraces diversity
- Developing policy initiatives that are context driven

1.9 Limitations of the study

- This study focuses specifically on the HIV/AIDS curriculum at a primary institution of education. It is therefore limited to curriculum development in primary education and as such will not address issues that may be pertinent to secondary educational institutions

- The research area focuses on one primary school in KwaZulu-Natal. Therefore the analysis falls within the confines of the primary education curriculum in a single province and cannot offer generalisations.

1.10 Outline of the chapters

Chapter 1 provides an introduction to the study. It describes the personal motivation and rationale for undertaking the study and the policies that inform the study. It also states the critical questions and delineates the scope, significance and limitations of the study.

Chapter 2 provides a literary review that explores the medical focus of the disease as well as the influence of HIV/AIDS on the constructs education and power relations. It also goes on to explore the role of the media and its significance in relation to HIV/AIDS.

Chapter 3 explains the theoretical framework of the interpretive paradigm within which the study is located. It also describes and expounds the research methodology employed in the data collection and subsequent analysis of the study. It presents the qualitative data that was obtained through interviews with educators of Life Orientation and a single member of the SMT. It also describes how the data was transcribed and analysed. In addition it presents how the quantitative data was collected.

Chapter 4 presents the analysis and findings of the case study.

Chapter 5 provides a summary, recommendations and conclusion for the study.

The next chapter will explore the AIDS virus, touching on its origin, the modes of transmission and magnitude. It also provides the platform for a discussion on the following issues namely, gender, the education system and the role of the media, in relation to the AIDS epidemic.

CHAPTER 2

Literature Review

2.1 Introduction

In this chapter I will present literature reviewed in this field. This chapter will begin with a brief description of HIV/AIDS as a medical disease. It will then provide a discussion on HIV/AIDS and education, followed by the nature of HIV/AIDS education and gender and HIV/AIDS. The chapter continues with a discussion on the role of the media and HIV/AIDS and HIV/AIDS and life skills education. The chapter concludes with a discussion of who should provide the education.

2.2 HIV/AIDS –The disease

AIDS is the acronym for Acquired Immune Deficiency Syndrome. The first recognised cases of AIDS occurred in America in 1981. A rare form of pneumonia caused by *Pneumocystis carinii* (micro-organism) and Kaposi's sarcoma (a rare form of skin cancer) appeared in several patients simultaneously. Common characteristics amongst the patients were that they had compromised immune systems and the patients were young homosexual men (van Arkel 1991; Van Dyk 2001).

In 1985, a new disease, which undermined the immune system and caused diarrhoea, was identified in Africa amongst heterosexual people. The disease initially baffled scientists and doctors because it was difficult to immediately identify the causes and modes of transmission of this disease. In 1983, the virus responsible for the disease was identified as lymphadenopathy-associated virus, renamed HIV in 1986 (Alcamo 1997).

At present there are two viruses associated with AIDS, namely HIV-1 and HIV-2. All current indications are that while HIV-2 is as dangerous a virus as HIV-1, it acts more slowly. This only means that it takes longer for the symptoms of infection to manifest in an HIV-2 infected individual (Van Dyk 2001).

AIDS is caused by a virus (HIV- the Human Immunodeficiency Virus), which enters the body from the outside via infectious fluids (blood, semen, vaginal fluids, amniotic fluids, cervical fluids, cerebrospinal fluids, pleural fluids and breast-milk). Although HIV is present in saliva, tears, sweat and urine, the concentration of the virus in these fluids are minimal. When the virus is no longer in the context of body fluids, it becomes extremely fragile-especially if it is exposed to oxygen, heat or dryness in the atmosphere (Alcamo 1997).

According to Schoub (1999) what makes the disease so truly extraordinary and unique is that it exploits and capitalises on a complex set of chinks in the human immunological armour. The virus weakens the immune system of the body to such an extent that it can no longer fight the pathogen (disease causing agent) that invades the body. AIDS is a syndrome of opportunistic diseases for example chronic diarrhoea, tuberculosis (the most common opportunistic infection in Africa), cryptococcal meningitis, pneumocystis carinii (pneumonia), infections and certain cancers (like Kaposi's sarcoma, a rare form of cancer of the skin's blood vessels)- each or all of which has the ability to kill the infected person during the final stages of the disease (Schoub, 1999; Whiteside & Sunter 2000; Van Dyk 2001).

Schoub (1999) states that HIV/AIDS has four cardinal features that jointly make it a uniquely formidable disease:

- Firstly, the disease is infectious and transmissible from one individual to the next.
- Secondly, in most if not all cases once infection sets in, it follows an inexorable course that eventually leads to death.
- Thirdly, all infected individuals are able to transmit the virus to other individuals and can remain infectious for the rest of their lives.
- Lastly, the reservoir of infection can act as a source of infectious virus to other individuals, which can constantly and progressively expand as the disease spreads to encompass more and more individuals.

Whiteside & Sunter (2000) assert that in order for a person to be infected the HI-virus has to enter the body in sufficient quantities. In addition, the virus has to pass through an entry point in the skin and/or mucous membranes into the bloodstream. Whiteside & Sunter (2000) identify the following factors in order of importance which predispose particular individuals or groups of individuals, susceptible to the disease:

- **Unsafe sex-** most commonly vaginal or anal intercourse without a condom. The presence of sexually transmitted infections (STI's) like syphilis, gonorrhoea and chancroid greatly increase risk of infection.
- **Mother to child transmission (MTCT)-** infected perinatally or through breast-feeding. MTCT accounts for 90% of HIV infection in children.
- **Intravenous drug use with contaminated needles, syringes and other sharp instruments-** because needles can harbour infected blood, intravenous (IV) drug users can infect each other by sharing needles or syringes
- **Use of infected blood or blood products-** although the risk of HIV infection via blood transfusions are very low because of the screening process, there is no such thing as 'no-risk blood'.

Phases of infection:

Although HIV infection cannot in practice be precisely demarcated into individual or distinct phases, it can nevertheless be theoretically divided into the following phases:

- **The primary HIV infection phase:** this phase begins as soon as a person's HIV status converts from being HIV negative to HIV positive. This process referred to as sero-conversion, usually occurs 4 to 8 weeks after an individual has been infected with the HI virus. Most infected individuals display a 'flu-like' viral infection, characterised by symptoms such as a sore throat, headache, a mild fever and fatigue that usually last between 1 to 2 weeks.
- **The asymptomatic latent phase:** in this stage of infection the infected person displays no symptoms. Infected individuals are often unaware that they are carrying the HI virus and may go about their normal daily routine. However, the virus remains active in the body and continues to damage and undermine its victim's immune system.

- The minor symptomatic phase: during this phase of infection minor symptoms of the HIV disease begin to manifest. The infected individual will present one or more of the following symptoms- swelling of the lymph nodes in the neck, armpits and groin; occasional fevers, herpes zoster or shingles, rashes or fatigue.
- The major symptomatic phase: major symptoms and opportunistic diseases begin to manifest as the immune system continues to deteriorate. The infected individual displays the following symptoms- persistent and recurrent oral and vaginal candida infections, recurrent shingles, skin rashes, fevers and night sweats, chronic diarrhoea, significant and unexplained weight loss.
- The severe symptomatic phase: this is the final stage of AIDS. The symptoms of the HIV disease become more acute. The immune system deteriorates exponentially and more persistent and often untreatable opportunistic conditions and cancers begin to manifest. The AIDS patient is usually bedridden during this stage. While AIDS infected patients usually experience death within 2 years, anti-retroviral therapy and treatment of opportunistic infections may prolong this period (Van Dyk 2001).

Campbell and Williams (2000:176) maintain that in South Africa whilst most individuals are aware of HIV/AIDS, its symptoms, modes of transmission and the fatal implications of infection, the prevalence of HIV/AIDS is still on the increase.

2.3 HIV/AIDS and education

According to the Department Of Education (1996) in South Africa, while HIV infection does occur through contact with HIV-infected blood, intravenous drug use and homosexual intercourse, it constitutes a very minimal proportion of all infections. HIV is spread predominantly through sexual contact between heterosexuals within South Africa. Since many young people are sexually active, whether coercive or consensual, increasing numbers of learners attending schools might be infected (Oulai & Carr-Hill 1993; Department Of Education 1999:3; World Health Organisation 2000:2).

In a study (Coombe 2000) carried out in provinces around South Africa, respondents revealed that they engaged in sexual intercourse from as early as age 11. In addition in one province, research revealed that 76% of girls and 90% of boys were sexually active by the age of 12. A critical aspect of the study was the fact that relatively few respondents practised safer sex. Coombe (2000) asserts that the failure to practise safer sex was related to pressure to engage in early and unprotected sexual intercourse, coercion, pressure to have a child, negative perceptions about condoms and low perceptions about personal risk. Arguably schools are strategically placed to empower learners who find themselves in these situations.

Latham (1993:3) a medical doctor, director of the International Nutrition Programme and professor of the Department of Nutrition maintains that HIV/AIDS is spread by human behaviour and if individuals avoid risk, they invariably reduce the likelihood of contracting the infection. Unless people can be made to understand this- HIV/AIDS will continue to flourish and spread.

Against this backdrop, Campbell & Williams (2000:176) argue that given that biomedical science has not yet produced a curative drug or vaccine to eliminate the virus completely from the human body, or to make the body totally immune to the virus, our only mainstay against infection is behaviour change. However the complexities and difficulties that behaviour change present should ideally be addressed at school via the curriculum. Learners at school may be informed that abstinence from sexual intercourse is the only 100% effective way to prevent the sexual transmission of HIV. The youth in particular should be encouraged to abstain from sex or at least to delay their commencement of sexual relationships for as long as possible. If this is one solution, thus schools are the places where this form of prevention of transmission could be explored.

Studies (UNAIDS in Van Dyk 2001) indicate that programmes encouraging abstinence from sex and freely accepted postponements of the onset of sexual activity by young people have also been successful.

According to Campbell & Williams (2000:176) our best hope for success in circumventing the spread of HIV/AIDS infection lies in deploying two major

strategies, one of which involves the promotion of HIV/AIDS awareness through educational campaigns which would serve as a springboard to encourage 'safer sexual' behaviour, given that the primary mode of transmission in South Africa is via heterosexual sex. The other strategy entails the aggressive detection of the treatment of associated diseases such as STI's that increase the risk of HIV/AIDS infection.

Studies (UNAIDS in Van Dyk 2001) from around the world have revealed that behaviour modification interventions which include information, education and communication programmes, condom promotion programmes and behaviour change initiatives, can in fact initiate changes in high-risk sexual behaviours. Latham (1992:3) argues that included in education should be messages that inform people not only how the virus is spread but also how it is not spread as studies reveal that certain individuals erroneously believe that HIV/AIDS can be spread by mosquitoes or by eating food cooked by individuals infected with HIV.

The thrust of South Africa's HIV/AIDS education is to eradicate myths and fallacies thereby reducing the stigma and prejudice and allaying excessive fears of the epidemic to instil non-discriminatory attitudes towards HIV/AIDS infected and afflicted individuals.

Oulai & Carr-Hill (1993) argue that since the school forms a critical component of the essential infrastructure of societies and communities in respect of dissemination of basic knowledge, skills for survival, delivery of vocational and professional training-schools will thus also form a crucial determinant in how societies will react and recover from the impact of HIV/AIDS on their economic, social and political development. As such schools must be cognisant that in the face of the magnitude of the actual and potential impact of this long wave disaster, education must be transformed. There are new messages to be taught, new clients to serve and new expanded roles to play.

2.4 The nature of HIV/AIDS education

Oulai & Carr-Hill (1993) suggest that one of the core ways of mitigating the spread of the disease and breaking down the walls of ignorance, fear, stigma and prejudice, is for the school to efficiently and openly deliver effective messages on critical issues

such as reproductive biology, sex and sexuality education, use of condoms, sexually infected diseases (STI's), contraception, issues of discrimination and human rights and the status of girls and women in society.

Oulai & Carr-Hill further contend that dialogue and debate encompassing the above critical issues will counteract the menacing forces of intolerance, irrational fears, misconceptions, ostracism, alienation, human rights abuses and suspicion which may compromise the 'open' context for teaching and learning.

In response to the above critical issues raised, Morrell et al (2002) argue that one must take cognisance that schools and teachers are often formally and informally governed and influenced by communities that surround them. As such they are very often unwilling, unable and perhaps afraid to address and advocate discussion on sensitive, delicate and perhaps contentious issues like reproductive biology, sex and sexuality education, contraception, STI's, and the status of girls and women in society. Quackenbush & Villarreal in Van Dyk (2001) maintain that it is crucial that learners need to be assisted to understand that although sexual feelings and impulses are normal, the active expression of sexuality is not appropriate behaviour in young children.

2.5 Gender and HIV/AIDS

Morrell et al (2002) state that it has been widely acknowledged that the pandemic is highly gendered. Grentholtz & Richter (2002) agree that gender stereotypes and the unequal distribution of power between women and men in South Africa contribute to the increased prevalence of HIV amongst women. They further add that the way in which sexual intercourse occurs generally reflects patriarchal power which ultimately continues to impede women's access to gender equity.

In this regard Morrell et al (2002) maintain that while both men and women have a say in the way in which sexual intercourse is conducted one must take cognizance that it is seldom an equal say reason being the different ways in which men and women construct, understand and perform their gender identities, influence how they engage in sexual intercourse. Thus school based interventions need to acknowledge female agency against this backdrop of male gender power.

They further assert that schools play a pivotal role in assisting learners in negotiating their gender identities through fostering and developing more equitable, democratic norms of behaviour that are not vested in domination and subordination. This can effect changes to reduce vulnerability to HIV and create in learners a commitment to gender equity, gender self-awareness and gender harmony.

Similarly Bhana (2003) maintains that there is a prevalence of dominant teaching discourses that powerfully collude to shape and influence teaching decisions and actions. The conservative discourses set up parameters for what is possible in schools; is responsible for the construction and regulation of gender relations between children and teachers in the context of schooling and ultimately cloaks the construction of gender power relations thus facilitating the continuance of unequal power relations.

MacNaughton (2000) and Bhana (2003) contend that gender considerations unfortunately become subsumed in the 'main game' of educating children. In addition Bhana asserts that teachers make assumptions about children and these assumptions in turn form a powerful web or discourse through which children are identified.

MacNaughton (2000) and Bhana (2003) assert that school systems must assume a role of advocacy rather than appear as mere disseminators of knowledge, 'selling' appropriate messages about HIV/AIDS more explicitly, flexibly and effectively to the learners who in the context of power relations and in the configuration of gender relations between the teacher and taught, need to be considered as 'gender knowing' and 'agentic'.

2.6 The influence of the media and its significance on HIV/AIDS

Van Dyk (2001) contends that exposure to television and pictures in magazines serve to increase children's fears of HIV/AIDS. Their knowledge about human sexuality is thus incomplete and riddled with myths and superstition. Van Dyk further maintains that information gathered from a peer group often contains considerable misinformation and distortion, a factor that can create anxiety in children and interfere with the child's healthy sexual development because the child may become accustomed to equating sex with disease and death. In addition, children may then try to distance themselves from all manifestations of HIV/AIDS and their denial

unfortunately makes them all the more vulnerable to the effects of the disease (Van Dyk 2001).

Vergnani & Frank (1998:9) assert that the information that young people may have in relation to sexuality is often inaccurate and misleading. Children are exposed to sexual messages in their daily lives from what they see and hear from their parents, siblings, other adults, their peers, the media soap operas and pornographic magazines, their religion and culture. In addition, many parents are unsure about certain aspects of parenting relating to discipline, protecting their children against alcohol and drug abuse, infection with STI'S and HIV/AIDS and countering the effects of peer pressure and the media etc.

Against this backdrop, Hamachek in Louw et al (2001:73) maintains, "Moral development works hand in hand with intellectual development." As such it is vital that educators assist in the provision of a judicious combination of academic education and morality education to learners. According to Vergnani & Frank (1998:16) it is crucial for learners to explore their own beliefs and attitudes, clarify their values, to become critical of their own judgement and thinking and ultimately develop their own moral framework so that children can make sense of their sexuality and its risk implications.

2.7 HIV/AIDS and Life skills education

According to Ncgobo (2002) in view of the grave implications of HIV/AIDS, the Department Of Education advocates that learners be empowered with life-enhancing skills to facilitate behavioural change and improve the overall quality of their lives. Life skills form a significant component of the learning area Life Orientation. Morrell (2002) suggests that Life skills assist learners to develop skills in decision-making, goal-setting, critical thinking, assertiveness, conflict resolution, clarifying values, norms and attitudes, assertiveness, handling peer pressure, problem-solving skills and self-efficacy. Hence, the acquisition of life-skills is a crucial vehicle in assisting learners manage the risks associated with HIV/AIDS.

The Department Of Education (1996) maintains that learners need to receive education about HIV/AIDS and abstinence in the context of life-skills on an on-going

basis from teachers who are specifically trained for life skills and HIV/AIDS education. A single video or HIV/AIDS awareness' week is insufficient because it is crucial to instil and reinforce the life skills needed to prevent HIV/AIDS infection (Van Dyk 2001).

The Department Of Education (1996) and Van Dyk (2001) are in agreement that it is crucial that life-skills and HIV/AIDS education be integrated throughout the curriculum and not presented as isolated learning material. Areas of learning need to be inter-connected and integrated to enable learners to build and consolidate on what they learn as they progress from one learning situation to the next (Vergnani & Frank 1998:28; Department Of Education 1999:10; Curriculum 2005-National Department Of Education; Louw et al 2001:9).

2.8 Who should provide the education?

The Centres for Disease Control (Van Dyk, 2001) advocates that in primary schools it is advisable for the regular teacher (i.e. class teacher) to provide education pertaining to HIV/AIDS because the teacher is familiar with the learners and also because of the sensitive nature of the learning material namely, bodily changes during puberty, masturbation, procreation, sexually transmitted infections (STI's), pregnancy, contraception etc. As such it is imperative that the teacher take the utmost care to establish a relationship of trust with the learners (Department Of Education 1999:10; Van Dyk 2001; Burns 2002:).

Ngcobo (2002:97) asserts that while teachers are expected to teach life skills to learners such a situation is problematic for the following reasons:

- Teachers themselves went through a school system that did not offer life skills education
- Educators responsible for the teaching life skills may hold conservative values
- Teachers must first grapple with their own issues before they can successfully facilitate 'life skill' for learners
- Educators have to work in communities where gender malpractices may exist

- There is a chronic shortage of staff trained specifically for the facilitation of life skills

The implications of the above reasons translate into the fact that the 'open' context for teaching and learning will become compromised.

The Department Of Education (1996:10) advocates "All educators should be trained to provide guidance on HIV/AIDS." Barnett and Blaikie in Oulai & Carr-Hill (1993) report that teachers may find themselves devoting much more time and energy in counselling- a skill few teachers, especially at primary school level possess.

Van Dyk (2001) contends that an effective HIV/AIDS education and Life Skills Programme must focus on and in addition to others, issues like sexual abuse, molestation and violence. In addition learners need to be empowered on how to prevent such abuse and the available routes for help and support in cases of actual or attempted sexual abuse, violence or molestation. In light of this the Department Of Education believed that it is crucial that learners be "educated about their rights concerning their own bodies, to protect themselves against rape, violence, inappropriate sexual behaviour and contracting HIV" (Department Of Education 1996:6).

2.9 Conclusion

The Department Of Education (1999:11) states that the school's implementation plan on HIV/AIDS needs to take cognisance of the behavioural, social and cultural context of the specific community it serves. According to Van Dyk (2001) it should reflect the entire spectrum of religious, cultural and moral values found in a particular community (World Health Organisation 2000:6).

Oulai & Carr-Hill (1993) contend that the school needs to display a willingness and ability to collaborate with a host of partners in order to better confront the challenges presented by the pandemic. In this way schools can ensure that HIV/AIDS policies and interventions designed and developed for implementation within the school are acceptable to all stakeholders. In addition sensitive issues like the accessibility of condoms within the school or the provision of support for learners and educators who are HIV-infected can be addressed Department Of Education.

According to Oulai & Carr-Hill (1993) the school plays a pivotal role in encouraging the participation of the entire community in the design and development of the school's HIV/AIDS implementation plan since such consensus building ensures that the community understands and takes ownership of the HIV/AIDS pandemic instead of having it thrust upon them. Hunter (1992) asserts that close collaboration ensures that all stakeholders function as a co-ordinating mechanism that is effective and constructive and eliminates the possibility of working in a vacuum of control.

The major thrust of the next chapter includes a description of the theoretical framework within which the study is located as well as a discussion of the methodology used in the study.

Chapter 3

3.1 Introduction:

This study explores the experiences of one head of department and three level one educators in the realm of HIV prevention work in a primary school. The purpose of the study is to generate an understanding of how teachers are engaging with HIV/AIDS education in schools. Furthermore, the study hopes to identify any gaps or silences that may exist within the teaching of HIV/AIDS education.

In this chapter I shall describe and expound upon the interpretive paradigm to illustrate the relevant features that facilitated an analysis of data yielded from the research participants. This chapter also explains the research methodology adopted, sample selection, type of instrumentation utilized to collect data as well as the procedures followed for data analysis. The research methodology reported in this chapter consists of a qualitative analysis of a focus group and semi-structured, tape-recorded interviews with three educators (responsible for the delivery of the learning area Life Orientation) and a member of the SMT respectively, in a primary school in the greater Durban area.

3.2 The interpretive paradigm

The interpretive approach will be reviewed with consideration to its applicability to the South African context. The thrust of the interpretive approach is unequivocally captured in the following dictum:

“For scientific purposes treat people as if they were human beings” (Harre’ & Secord in Cohen, Manion & Morrison 2000:20).

The interpretive paradigm views the social world as a process that is created by the individuals concerned. Interpretivists focus on generating understandings, that is, trying to understand human beings, their minds, their feelings and the manner in which these manifest in their outward actions (Collins 2000).

Interpretive researchers believe that one can ‘gain access’ into other human beings by learning the personal reasons or motives that shape a person’s internal feelings and guide decisions to act in particular ways. It can also afford one the opportunity to gain

insight into their cultural meaning systems and processes of communication and negotiation (Neuman, 2000:68,72).

Bleicher in Cohen et al (2000:69) is quick to point out that while one can gain access into other human beings through indirect means for example gestures, sounds and actions, it is only in the process of *understanding* that “we take the step from external signs to the underlying inner life”.

This is especially evident during the research process when the interpretive researcher analyses transcripts of conversations searching for subtle non-verbal communication to understand details of interactions in their context, learning the personal feelings that guides them to act in particular ways. Furthermore in trying to gain a feel for another’s social reality the interpretive researcher has to take cognisance of individual motives even if they seem irrational, carry deep emotions and contain false facts and prejudices (Neuman, 2000:70).

The interpretivist frame of reference assumes a participatory stance. It does not attempt to be value- free as it is believed that it is only through empathy or sympathetic participation that the researcher can adequately grasp the emotional context within which an action took place. In fact the researcher is perceived as the ‘human instrument’ and an individual’s behaviour can only be understood by the researcher sharing their frame of reference: understanding of individual’s *interpretations* of the world around them has to come from the inside and not the outside (Cohen et al 2000:19).

Geertz in Cohen et al (2000:22) argues that “many events are not reducible to simplistic interpretation, hence ‘thick descriptions’ are essential.” In interpretive research the data yielded from the participants may be glossed with the meanings and purposes of those people who are their source. An in depth analysis of these conversations will yield insight and understanding of human behaviour in varied situations and specific contexts.

Finally how we perceive the world is highly dependent on the repertoire of concepts, constructs and principles we can command. It is therefore imperative that the interpretive researcher delve deeply to uncover unique facts and add them to the existing corpus of knowledge, if one seeks to represent a slice of reality that is rooted in direct experience of everyday life (Cohen et al 2000:11).

For the purpose of this study I appropriate the following principles from the interpretive paradigm:

- It is characterized by a concern for the individual
- It strives to understand the 'subjective world' of human experience (*their* interpretations of the world around them)
- Concerted efforts are made to get inside the person and to understand from within- getting a 'feel for another's social reality'
- It works on the assumption that people may not experience social reality in a similar manner- this leaves the door open for the belief that there are shared multiple interpretations of human experience.

3.3 The approach:

A study that aims at understanding and interpreting the experiences of three educators, lends itself to the interpretive perspective. As such, the qualitative approach is perceived as suitable due to its methodological underpinnings which views social reality as 'consisting of people who construct meaning and create interpretations through their daily social interaction.' Such a perspective affords me the opportunity to explore the experiences, learn the personal reasons or motives that shape the participants' feelings and which ultimately influences their decisions to act in particular ways when engaging with HIV/AIDS education (Neuman, 2000:70).

A central endeavour of the interpretive paradigm is that the researcher shares the feelings and interpretations of the people being studied and sees things through their eyes thus affording the researcher 'the feel for another's social reality' (Collins 2000). Collins further argues that the researcher operating within the interpretive perspective analyses transcripts of conversations with the intention of seeking inordinate detail to

gain a more nuanced perspective of interactions in their context. This can be best achieved through the use of qualitative research techniques that translate the individual experiences of the educators into predetermined and pre-defined categories for interrogation.

My decision to choose the largely qualitative research approach hinged on the following premises:

- The study involves the experiences of teachers operating within the interpretive perspective. The qualitative methodology would facilitate greater access to data about their daily experiences of teaching Life Orientation. Thus, data would be best captured in narratives in a qualitative methodological sense.
- Qualitative research would equip me as researcher with the research tool “interviews” to explore as fully as possible, the experiences of the research participants in their capacities as educators of Life Orientation in school.
- Operating within the interpretive paradigm, to gain a rich and detailed description of the educators’ experiences in the teaching of HIV/AIDS education can be best achieved by utilizing the qualitative approach.
- The qualitative approach possesses the elements for this study since it aims at unpacking and interrogating the individual experiences of the educators responsible for the delivery of Life Orientation in primary schools.

Thus, the choice of human interaction through dialogue instead of “scientific” investigation guided me to the realisation that the best possible manner to collect data would be via the qualitative approach (Cohen et al, 2002).

3.4 Research method:

The method utilized in the research process is the case study. Sturman in Cohen et al (2002:181) state that with regards to the case study, human systems have a wholeness or integrity to them rather than being a loose connection of traits, thus necessitating in-depth investigation. In addition they claim that since contexts are unique and dynamic they cannot be clearly understood simply by presenting them with abstract

theories or principles. Geertz in Cohen et al (2002:182) asserts that ‘case studies strive to portray “what it is like” to be in a particular situation, to catch the close-up reality and “thick description” of participants’ lived experiences of, thoughts about and feelings for, a situation.’

The case study was selected because of the following distinguishing hallmarks:

- It is concerned with the portrayal of rich and vivid descriptions of events relevant to the case
- They investigate and report complex dynamic and unfolding interactions of events or human relationships
- It focuses on individual actors or groups of actors, and seeks to understand their perception of events
- It highlights specific events relevant to the case
- They can penetrate situations in ways that are not always susceptible to numerical analysis
- They are strong on reality and can provide insight and assist in interpretation of events

In essence, the case study would be instrumental in providing me with the fine grain details of viewing situations through the eyes of the participants as well as providing the platform to probe deeply to analyse their daily engagement with issues of for example: sexuality, sexual- abuse and HIV/AIDS related matters. In addition, since case studies are regarded as a ‘step to action’ insights gained from the research could be utilized for individual, staff or educational policy development.

3.5 The context

Phoenix is primarily an urban community characterised by sub-economic brick and tile houses. The 22 year-old, co-education primary school on which this research centers, stands proud on a pseudo hill. The traffic is relatively high with passing taxis and local pedestrians. Most of the people living in this area work in either factories or businesses in Durban. Most of those working outside the Sub-District are men but some women do too. Many families have physically disintegrated owing to the social

challenges that they experience. Alcohol, drug and child sexual abuse are rife and has contributed greatly to the social decay of the community. The use of alcohol and drugs is thought to be a primary reason for family fragmentation. Educators reported that about half of the parents have only primary education. English and isiZulu are the languages of the community. Their religious affiliations are primarily Christian and Hindu. The school is an ex House of Delegates (HOD) school.

3.6 The sample:

The sample selection comprised three educators who taught Life Orientation either across the Intermediate Phase or Senior Phase who participated in the focus group interview and completed questionnaires, one member of the School Management Team (SMT) who participated in a face to face interview and the remainder of the teaching staff complement (nine) in a co-educational primary school in the larger Durban area in KwaZulu-Natal, South Africa who also completed questionnaires.

My sample was selected on the following basis:

- Teachers who were solely responsible for the teaching of the learning area Life Orientation in their school.
- An SMT member who was responsible for teaching HIV/AIDS education.
- The teaching staff as a consequence of their collaborative assistance in the formulation of the school's HIV/AIDS policy.

With regard to the sampling technique for the semi-structured and focus group interviews, purposive sampling was used. This type of sampling method was favoured as it translated into the fact that firstly, all SMT's were handed National guidelines for the compilation of HIV/AIDS policies at their schools and secondly, all educators who were responsible for the delivery of Life Orientation within the Intermediate and Senior Phase could be roped into the study, leading to a more holistic interpretation of their engagement with HIV/AIDS education.

3.7 Instrumentation:

In response to the critical questions, semi-structured interview schedules, and a survey questionnaire were administered. Of the two semi-structured interviews one was administered as a face-to-face interview and the other as a focus group interview. These interviews were selected to generate information around the perceptions of intermediate phase teachers of HIV/AIDS education and the SMT'S experience of the HIV/AIDS curriculum. Questionnaires were aimed at evaluating the level of HIV/AIDS related information of the remaining staff complement.

3.7.1 Interviews:

The choice of the interview as a means of producing data was based on the following merits:

- It can generate unique or divergent feelings about a particular matter for example, educator response to age appropriate information relating to HIV/AIDS
- It allows participants to express how they regard situations from their own point of view- educator attitudes to the provision of sexuality education in the school curriculum
- It allows for greater depth during discussion for example, issues relating to sexual abuse amongst learners

Cohen et al (2002:267) perceive the interview as a research tool that enables participants 'to discuss their interpretations of the world in which they live, and to express how they regard situations from their own point of view.'

Kvale in Cohen et al (2002:267) remarks that interviews are 'an interchange of views between two or more people on a topic of mutual interest, sees the centrality of human interaction for knowledge production, and emphasizes the social situatedness of research data.'

Cannell and Khan in Cohen et al (2002:269) define interviews as 'a two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information.'

Kitwood in Cohen et al (2002:267) concurs that interviews are a potent source of 'pure information and collection.'

Since the central purpose of my study was to elicit personalised data from educators about their experiences with HIV/AIDS education, I chose interviews as the research instrument to gain access to what is "inside a person's head, measure what a person knows (knowledge or information) what a person likes or dislikes (values and preferences), and what a person thinks (attitudes and beliefs) Tuckman in Cohen et al (2002:268).

Two types of research interviews were utilized namely: semi-structured interviews and focus group interviews.

Semi-structured interviews:

This type of research tool seemed particularly useful to me as a researcher as it espoused the following principles:

- Flexibility: both the researcher and participants were provided with the platform to explore and gain a deeper, more nuanced perspective of emotionally loaded issues like sexuality, rape and abuse
- Rapport: the participants were encouraged to talk freely, spontaneously and emotionally so that their responses would be characterized by candour, depth, authenticity and honesty about their experiences within the context of HIV/AIDS
- Degree of structure: the participants were encouraged to raise issues that were not covered in the interview schedule to generate unique and personalised information

The following issues were explored with a member of the SMT:

- Educator attendance at HIV/AIDS workshops
- Service providers of HIV/AIDS training initiatives
- Dissemination of HIV/AIDS related information to the community at large
- Response to the inclusion of sexuality education within the primary school curriculum
- Relevance of curriculum to HIV/AIDS pandemic
- HIV/AIDS policy development within the school arena

Focus group interviews:

Cohen et al (2002:288) define focus group interviews as 'contrived settings, bringing together a specifically chosen sector of the population to discuss a particular given theme or topic, where the interaction with the group leads to data and outcomes.'

This type of interview was favoured because:

- It possesses the potential for discussion to develop thus yielding a wide and varied range of responses about a given topic
- It is less intimidating when discussing sensitive and contentious issues like for example, teenage pregnancies
- Participant interaction during discussion can yield insight, awareness and elicit highly personal data
- It presents the opportunity for participants to have a homogenous background (all teachers who teach Life Orientation) so that discussions are focused and the sample is representative of the population under study.

The following issues were explored with the three educators who taught Life Orientation:

- Participants knowledge and understanding of the concept of HIV/AIDS education
- Response to the inclusion of sexuality education within the primary school curriculum
- Personal choice of HIV/AIDS content in school curriculum
- Inclusion and exclusion of any aspect of HIV/AIDS related issues within the given school curriculum
- Sexual abuse

The semi-structured interview schedule as well as the focus group interviews had predominantly, open-ended questions. This facilitated the use of “prompts” to clarify questions and the use of “probes” to allow participants to elaborate or qualify their responses thereby addressing issues of richness and comprehensiveness. The questions were couched in everyday, non-professional language to generate rich descriptions and authentic data (Cohen et al 2002:278,280).

The research participants were interviewed in their school staff-room as prearranged by them. Due to the fact that the interview was conducted in a “space” selected by the research participants, they seemed more comfortable and relaxed, thus facilitating engagement in dialogue during the interview process.

Since the interview is a social, interpersonal encounter and not merely a data collection exercise, participants were briefed as to the nature of the interviews, in an attempt to make them feel at ease and offer some sort of security to talk freely about sensitive issues (Cohen et al, 2002:279).

With regard to the ethical dimension of the study, research participants were given assurances of confidentiality prior to the interview process. Participants were also informed that they could opt out of the study if ever there was some discomfort. They were also at liberty to ask questions and seek responses to their concerns. Participants

acquiesced to having their responses, during the interview process, tape- recorded. The duration of both the semi-structured and focus group interviews were approximately 45 minutes each. Transcription of the audiotapes took place immediately after the conclusion of the interviews.

3.7.2 The Survey:

The choice of a survey questionnaire as a data gathering technique hinged on the following:

- It can be used to explore the beliefs and opinions of many respondents at the same time
- Many topics or ideas can be explored in a single survey
- Questionnaires encourage greater honesty because of their anonymity
- It gathers standardized information (using the same instruments and questions) from a wide target population
- There are expected high response rates since all respondents would fill in the questionnaires simultaneously

The following issues were explored within the questionnaires:

- Unpacking of acronyms related to HIV/AIDS education
- Modes of transmission of the virus among children and adults
- Identification of non-infectious body fluids
- Exploring HIV/AIDS related myths
- Identification of anti-retroviral drugs and their function
- Universal precautions

In terms of the survey design, self-administered questionnaires were formulated to gauge the level of factual knowledge of HIV/AIDS related information from respondents. The questionnaire was also designed in a manner that allowed respondents to respond in their own way and in their own words. Thus, the research is responsive to the respondents' own frame of reference (Cohen et al, 2002:270).

All the respondents, from the same school site, who participated in the survey, namely the remainder of the staff complement, consented to participating in the study after being briefed about the nature of the research. The respondents' teaching experience ranged from three to twenty three years. These respondents participated in the survey on the basis that they were all responsible for the formulation and development of the school's HIV/AIDS policy. The questionnaires were completed in the school resource centre. The time frame for the completion of the questionnaires was twenty minutes. With regard to the ethical dimension of the study, all respondents were guaranteed anonymity.

3.8 Data analysis:

In keeping with the qualitative methodology utilized to produce data for this study, the researcher engaged in the following procedures to perform data analysis:

Interviews:

- Content analysis of the open-ended data
- The process of transcription involved listening to the taped interviews repeatedly and making comments to provide a context for the emergence of salient themes
- Fragmentation of data into constituent elements- once the broad themes were uncovered, sub-categories were also sought out
- Thereafter the responses of the interview participants were assigned in accordance to the themes or categories generated
- The relationships and patterns amongst the various themes or categories were expounded upon
- Identifying frequency of occurrence of themes
- Using informed intuition to reach conclusions
- Compilation of a composite summary

Questionnaire data:

- Editing of questionnaires to identify or eliminate errors made by respondents to ascertain completeness, accuracy and uniformity
- Data reduction- in preparation for analysis

Being a novice researcher the above procedures guided me and kept me on track with the critical questions and aim of the study.

3.9 Conclusion

Chapter three has comprehensively presented a discussion on how the research was conducted. A case study approach was utilised to understand, through an interpretive framework the individual experiences of educators in the realm of HIV prevention work in a primary school site.

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

Chapter 4

FINDINGS OF THE STUDY

4.1 Introduction:

This chapter provides a synoptic overview of the responses of the research participants to understand their engagement with HIV/AIDS education within the primary school. This chapter will first present the biographical details of the respondents and thereafter discuss the results obtained from the SMT member followed by the interview results of the three Life Orientation educators. The results of the focus group interview will then be presented. Finally the results generated via the survey questionnaire will be presented.

4.2 Biographical details of respondents

The table below suggests the personal profiles of all respondents who participated in the study.

Table 4.2 Table displaying profile of respondents

Number	Age	Gender	Level	Marital status
1	23	Female	1	Single
2	27	Female	1	Married
3	29	Female	1	Married
4	29	Male	1	Married
5	32	Female	1	Single
6	33	Female	1	Married
7	35	Female	1	Married
8	39	Male	2	Married
9	41	Female	1	Married
10	43	Male	2	Married

The total sample comprised three males and seven females. Only two of the total sample were single people. The remaining respondents were married. All but two of the samples were level one educators. The age of the respondents ranged from 23-43 years.

The analysis of this chapter will be done as the data is presented and theoretical support for the analysis will be integrated in the process. I shall begin with the first critical question:

Critical Question 1

“What are gaps/silences that exist in the teaching of HIV/AIDS education in schools?”

To answer the above critical question data was collected via a face-to-face interview using a semi structured interview schedule with the head of department of the sample school. The interview was conducted on the school premises at a mutually agreed upon time. Questions in this interview focused on attendance at HIV/AIDS workshops, the involvement of the community in the fight against HIV/AIDS, the inclusion of sexuality education in the curriculum and the design of the school’s HIV/AIDS policy.

4.3 Discussion of responses with (SMT) member (see appendix A)

In response to the question *“Did any of the educators at your school attend HIV/AIDS related- workshops?”* the SMT confirmed that the grade 6 educators at the school had attended workshops. Although he did not personally attend any workshops he taught HIV/AIDS education to grade 5 learners.

His resource has been the Department Of Education (DOE) guide to HIV/AIDS and Sexuality Education. He perceived the content suggested for grade 5 learners as both relevant and age-appropriate and claimed that learners responded positively to the content.

When asked to provide details of the service providers, the SMT claimed that Ikhwezi Community College, a department of education affiliate, as well as a Non-Governmental Organisation called Gift of the Givers facilitated the workshops that educators in the area had attended. The SMT was unsure as to whose initiative the workshops were.

When asked: *“Do you believe that your school has benefited from the attendance of your educators to these HIV/AIDS related- workshops?”*

The SMT was confident that the workshops were beneficial to both the learners as well as the educators in terms of alerting them to the causes and prevention of HIV/AIDS transmission.

In response to the question *“Have you included the local community in workshops related to HIV/AIDS?”* the SMT maintained that the School Governing Body (SGB) had been invited to a workshop organized by the Department Of Education and it was the responsibility of the SGB to disseminate the contents of the workshop to the general parent population.

The SMT provided the following views on the inclusion of sexuality education in the foundation, intermediate and senior phase curricular:

“I strongly support the inclusion of sexuality education in the primary school curriculum as sexuality education has been taboo for far too long. Sexuality education assists learners in understanding and dealing with changes taking place in the body and fosters skills in handling peer pressure.”

With regards to issues of policy the SMT’s response was that the school has an HIV/AIDS policy that was developed by the educators. The only guideline that he could elaborate on in terms of designing the school’s HIV/AIDS policy was the one relating to first aid and the precautions to be taken when dealing with children who have open wounds. He also mentioned that the school’s policy addresses issues of knowledge and understanding of HIV/AIDS, modes of transmission and preventative measures.

Included in school’s policy were guidelines on how to deal with HIV positive learners. The policy ensured that no learner was discriminated against regardless of his or her HIV status. Issues of nutrition for HIV positive people were also emphasised in the policy. What the policy did not address was social welfare support for those learners affected and infected by HIV/AIDS.

On the issue of workshops on HIV/AIDS for educators, the SMT claimed that the only HIV/AIDS related workshops were those conducted for the design of the school's HIV/AIDS policy. He further claimed that the Department Of Education's policy document was adequate and educators followed those guidelines in their lessons. *"We also disseminate hand-outs brought back by educators from workshops they attend to the entire staff."*

4.4 Discussion of responses with the focus group (see appendix B)

The focus group was asked questions pertaining to knowledge and dissemination of HIV/AIDS education, resources available, implementation of the curriculum and personal challenges faced by educators in implementing the HIV/AIDS curriculum.

When data from the focus group discussion was analysed the following themes, with regard to HIV/AIDS, emerged:

- Knowledge and dissemination
- Stakeholders
- Sexuality education
- Challenges faced by educators in teaching HIV/AIDS education
- Intended curriculum
- Resources
- Level of knowledge dissemination

Knowledge and Dissemination:

All respondents were in agreement that HIV/AIDS education formed an integral component of the curriculum to ensure that learners have knowledge on the transmission of the virus, the impact thereof on people's lives and prevention. They further recognized the value of HIV/AIDS education especially since HIV/AIDS affected many of us and yet it was not frequently discussed in the home. The respondents claimed that its inclusion in the curriculum helped to raise awareness and personalize the epidemic.

Parents unfortunately owing to cultural sensitivities didn't talk to children about HIV/AIDS issues so educators had to play a vital role in learners' education and awareness process.

Respondents varied in curriculum content and design as far as dissemination of HIV/AIDS knowledge was concerned. Two of the three respondents claimed that they had well designed content rich programmes for their respective grade learners while the third respondent claimed that she dealt with more general issues in order to create awareness rather than disseminating content-specific information. She believed that at grade four- level this was appropriate and relevant and that more in-depth knowledge was appropriate at perhaps grade seven- level. At grade four level myths and facts about HIV/AIDS were discussed as well as the transmission of other sexually transmitted diseases.

At grade five- level the respondent claimed that learners were taught about their bodies and then given knowledge on HIV/AIDS transmission and prevention. The educator also found it appropriate to deal with issues of sexuality at this level for example, issues of different body parts between genders.

The third respondent claimed that an appropriate curriculum at grade seven-level was one that dealt with how the virus was transmitted and how it could be prevented and extended to include issues of sexual behaviour. Learners at this age should be made aware of age appropriate sexual behaviour and the consequences of experimenting with sex before marriage.

All three respondents expressed the positive impact that the HIV/AIDS curriculum has had on their learners. The learners asked amazing questions and shared personal community experiences of for example, child rape. They also challenged each other's assumptions and created a climate for open, honest communication of HIV/AIDS related issues. All respondents claimed that learners were not inhibited to communicate about their knowledge or ignorance. All three respondents also maintained that their learners possessed a wealth of knowledge on HIV/AIDS and sexuality.

The respondents used as their resource material information supplied either by the D.O.E on Life skills education and HIV/AIDS or material produced by international NGO's viz. "British NGO". All three respondents utilized the prescribed materials as guidelines but designed lessons to suit their classroom contexts.

Respondent one made greater use of pictures and cartoons to generate discussions and disseminate information while respondents two and three used an almost equal number of tests and oral discussions to educate and raise awareness amongst their learners.

Respondent one claimed that she was totally *comfortable* in dealing with the HIV/AIDS and sexuality curriculum with her learners although she thought initially learners were totally amused with the use of terminology such as 'vagina' and 'penis'.

Two of the three respondents believed that mostly parents and the media influenced learners' behaviour. Respondent two maintained that many learners reflected in their attitudes; how their parents behaved for example, those whose parents engaged in extra-marital affairs found it acceptable to have more than one partner. Respondent three believed that the impact of the media (movies and books) played a major influential role in young children's lives. When children were exposed to age appropriate pictures and texts with sexual connotations it appeared romantic and acceptable to them. Children influenced each other through these magazines and by sharing information about movies. She claimed that the media played a stronger role in children's lives than educators and parent's in as far as sexual behaviour is concerned.

On the issue of the relevance of material provided in the prescribed books, respondent one claimed that she designed her own lessons so she took the latitude to decide what should be included and those aspects that need to be excluded. Respondent two believed that very little information concentrates on the virus itself. Most of the information deals with making decisions and the various body parts. The prescribed material should deal more extensively with causes and prevention of the disease. Respondent three perceived that there was a lack of information on sexually transmitted diseases, teenage pregnancies and its consequences. She believed that the

impact of teenage pregnancies should be dealt with in an in-depth manner, as this was a critical area of concern for learners at grade seven-level.

When asked “What aspects of the curriculum should be excluded and why?” all three respondents claimed that nothing dealing with HIV/AIDS and sexuality education should be excluded from the current curriculum.

Respondent one went further and claimed that educators in excluding information may be disadvantaging learners who have either no knowledge or very little knowledge on HIV/AIDS and sexuality. Respondent two believed that exclusion of any aspect could result in peers mis-communicating information at the peril of learners. Respondent three perceived the current curriculum as a means of generating discussion on most issues of sexuality education and providing a forum for learners to confide in her with regards to personal sexual issues as well.

HIV/AIDS and context embedded in education (see appendix B)

A fictional case study was read to the three respondents to understand how context shapes their teaching of the HIV/AIDS curriculum. The case study provided a scenario of a thirteen- year old girl who was sexually abused by her step- brother and had been discreet about the abuse but has now discovered that she is HIV positive.

The respondents were asked to imagine that this was a learner in their class and to provide advice to the learner regarding her situation. All three respondents claimed that they would firstly reassure the child that she was in no way responsible for the abuse or her HIV status- instead it was the adult who had breached her rights and who was the actual guilty party here. All three respondents also alluded to the intense fear that children possess and recognized this as an issue that needed immediate attention. Lastly all three respondents decided that they would enlist the support of a social worker.

They also spoke of being warm and affectionate towards the child and assuming the role of surrogate mother to her. In addition respondent one and three claimed that they would also hug the child, so that the child may feel loved and whole again. They would then proceed to contact the child’s parents once the child had granted them

permission to do so. Respondent two maintained that she would also inform the principal and with his consent seek outside assistance for example, social welfare workers.

In response to the question “What issues would you address to learners so as to prevent a similar situation from arising?” all three respondents spoke highly of their lessons and classroom discussions that addressed issues of “stranger danger” where learners were empowered with regards to being touched by people you didn’t know. Learners were also conscientised about their bodies and what constituted “good touching” and “bad touching” even by members in the family or friends. They also accentuated to learners how to deal and manage with this kind of scenario.

Respondent one also alerted her learners on how to defend themselves physically in an attempt to ward off the ‘attacker’. She also discussed with her learners the perils of going to places that are unsupervised by adults. Respondent one was also concerned about their roles and responsibilities in managing abuse. She was uncertain about their level of involvement and the fact that the school had no protocols that they could observe in defining their level of responsibility. She also raised the issue of ‘threat’ by the perpetrator that she believed generated other challenges that consequently impacted on reporting and persecution.

Respondent two also encouraged learners to talk freely about their feelings and experiences and engaged in numerous role playing activities on child abuse, child sexual abuse and ways in which children could prevent abuse.

The issue of a lack of co-operation from the SAPS- Child Protection Unit was also raised as a concern. Often police officers complained of a lack of resources to deal with potential criminal behaviour effectively.

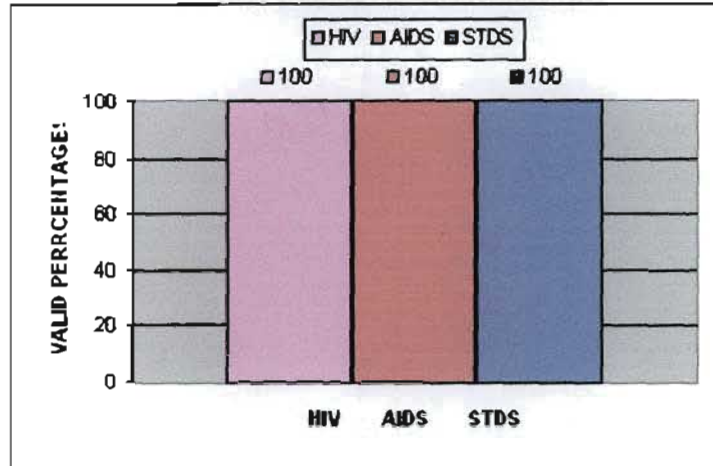
4.5 Responses to questionnaires (see appendix C)

To ascertain the level and knowledge of educators understanding of HIV/AIDS I administered questionnaires to 9 educators that comprised the sum total of the remaining number of educators at the school site. This was also a way of auditing the

knowledge and understanding of the educators of HIV/AIDS as is expected by the curriculum.

In response to the first question viz. “What do the following acronyms namely, HIV, AIDS and STD stand for?” respondents were able to correctly identify them as indicated in Figure 4.1

Figure 4.1 Figure showing respondents’ understanding of acronyms



All respondents claimed that HIV causes AIDS.

Figure 4.2 Figure showing whether HIV causes AIDS

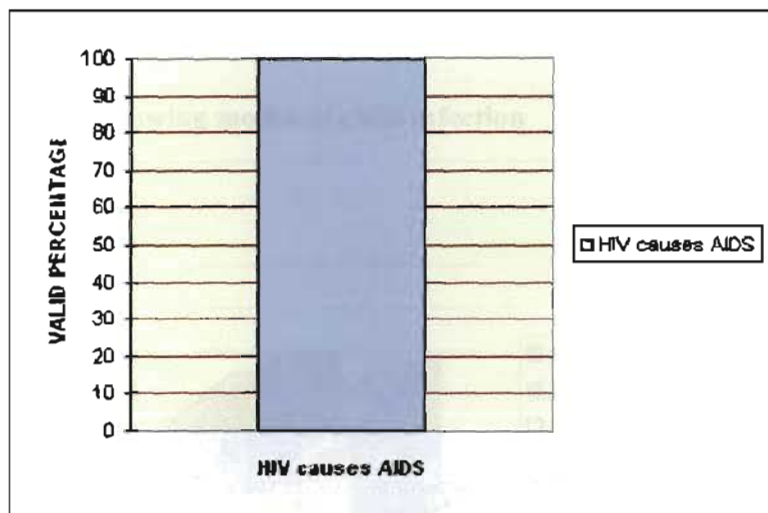
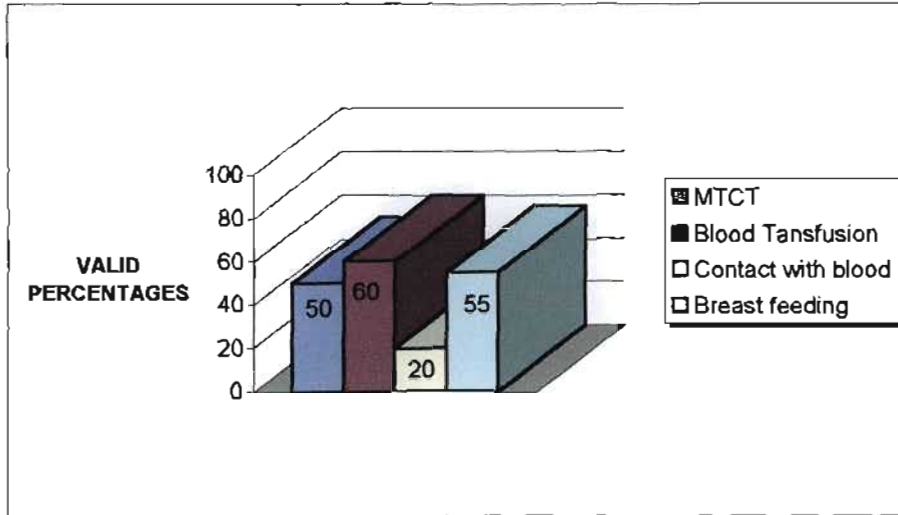
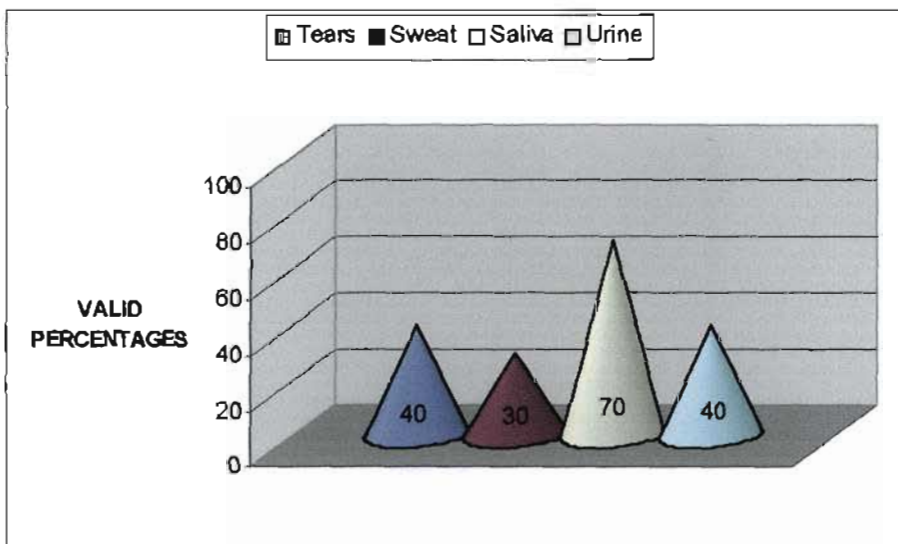


Figure 4.3 Figure showing modes of child infection



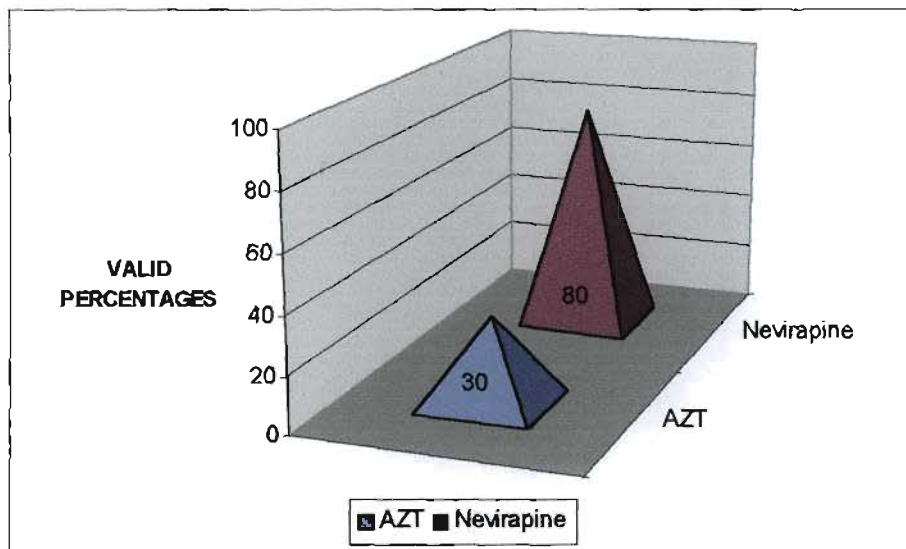
Respondents rated blood transfusion highly as the mode in which children from (0-10 years) may acquire HIV/AIDS. Mother to child transmission and breast-feeding were rated second and contact with blood received the lowest rating.

Figure 4.4 Figure showing educators' understanding of least important body fluids that assist transmission



The majority of respondents rated saliva as a non-infectious body fluid followed by tears and urine. They rated sweat at 30%.

Figure 4.5 Figure showing respondents knowledge of anti retroviral drugs

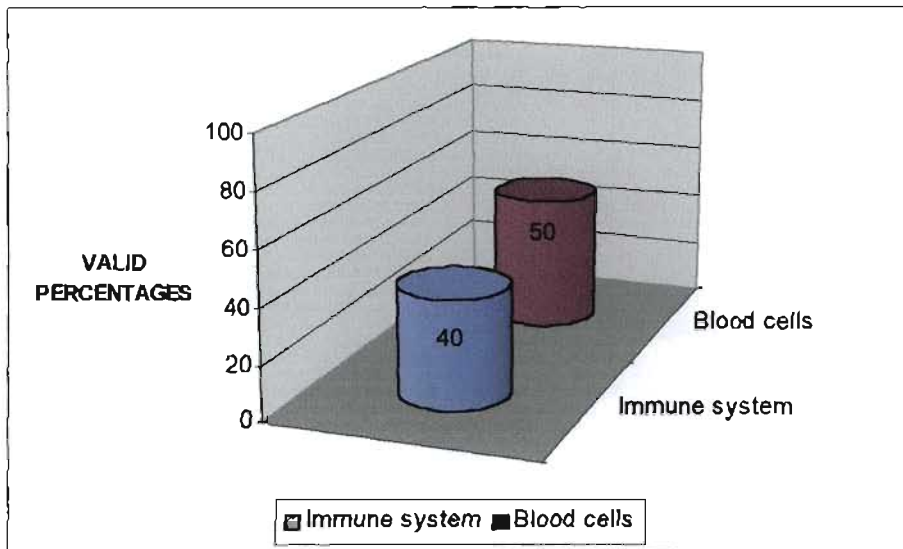


Respondents were able to name AZT and Nevirapine as the anti-retroviral drugs they were aware of.

When asked what the main function of an ART drug was, respondents offered the following:

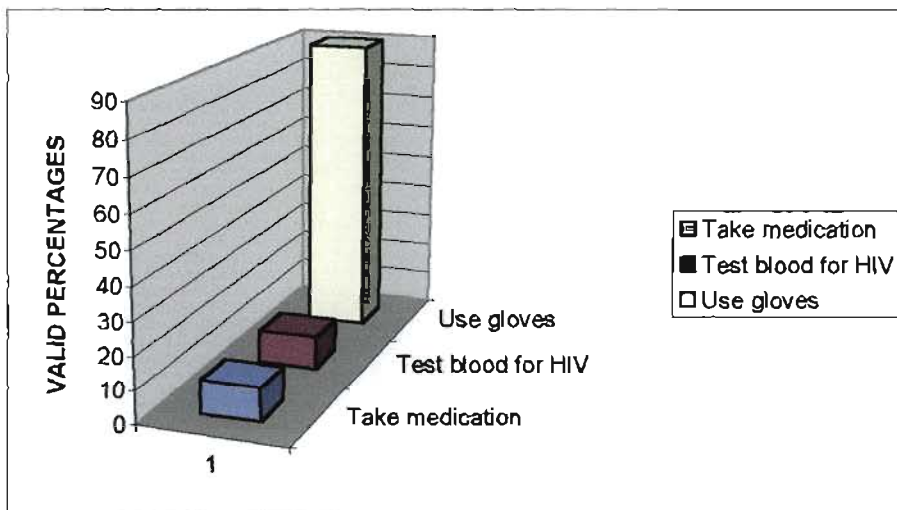
- A drug to boost the immune system
- A drug that slows down the disease
- A drug that prevents mother to child transmission (MTCT)

Figure 4.6 Figure showing respondents understanding of the route of virus



Most respondents claimed that HIV first attacked the blood cells. A significant percentage of respondents also believed that HIV first attacked the immune system.

Figure 4.7 Figure showing respondents understanding of universal precautions in managing HIV/AIDS transmission



When asked to name one universal precaution people may adopt to deal with a blood spill, respondents maintained that people could wear gloves, test the blood for HIV and or take medication.

Most respondents identified kissing and using the same toilet seat as a popular myth of how HIV/AIDS was transmitted. Hugging was rated second as a myth in the transmission of the virus. Other ways of transmission included insect bites, sharing crockery/cutlery and sleeping with a virgin.

The above responses reveal that while some educators had a basic understanding of HIV/AIDS there were still those who did not have adequate understanding of the basics. This does not augur well for the future of the HIV/AIDS curriculum.

4.6 Findings generated from face to face interviews with educators

The following results provide an insight on how the educators in the sample feel about the HIV/AIDS curriculum.

All three respondents maintained that pupils were given a modicum of information in terms of the modes of transmission of HIV/AIDS and prevention strategies, which was not very comprehensive in either scope or coverage.

They believed that dissemination of information on STI's, teenage pregnancies, high-risk sexual behaviour and condom use and availability was limited. They also agreed that despite the fact that pupils seemed to be generally aware of the existence of HIV/AIDS, as well as a basic knowledge of its transmission, pupils did not generally regard themselves as being seriously at risk of HIV-infection. Their attitude of disassociation towards HIV/AIDS was denial, invulnerability and fatalism. Some of the statements that qualify their responses include:

Participant 1: "In spite of knowing of the dangers of certain sexual behaviours, the scare of acquiring HIV/AIDS children still engage in it, living on the edge."

Participant 3: "My lot the bigger ones, they are so much more advanced than when we were teenagers. They are exposed to the media, they get movies, they get books. These are readily available to them and they bring it to school and they show it to each other. By looking at that, although we are giving them the rights and the wrongs- but they see it in the media, magazines and movies and it seems like such a

good thing that they want to try it. So despite you telling them the about the wrongs, whatever, they are still going out there and doing it. "

The respondents also asserted that the issue of overt discrimination and ostracisation was highlighted when the status of HIV-infected individuals became publicly known. The following statements bear reference:

Participant 3: "Because you know some of these kids in my class, they know people in the townships who have AIDS and they have a special name for them and they are not seen in a good light. Those people are really ridiculed and they really go through hell if they know their status and they are HIV positive. Kids always say 'A friend with AIDS is still my friend'. So they know that but I don't know about the parents."

The educators claimed that condoms were not distributed in the school as is evident in the following statement:

Participant 1: "Our school does not provide condoms in the toilets for teachers. They also don't provide condoms to the learners. "

Respondents also claimed that the latest information on the disease was not readily available to them as was mentioned by one educator and confirmed by the other two:

SMT: "We do have a hand-out that she (convenor) has given to us recently in terms of keeping abreast of what is going on and how infection is being spread and how it affects the teacher and all those sort of things. She (convenor) has given us all that she has. "

Participant 1: "It's just us that are doing it but whenever we get anything we inform the staff. "

Respondents also complained about the inability of the police force to offer children protection in the face of sexual abuse.

Participant 1: "There's another child in my class where a guy showed her a hundred rand note and tried to push her and pull her into the bush and he did that twice...we take leave and go to the police station to tell them that on this particular stretch of

road this is what's happening. There are three incidents can't you do something, a means to prevent a rape, only to be told "Sorry we don't have vehicles that will go up and down the road. We cannot park in the corner especially for your children that are walking this way."

Efforts to mobilise parents to respond and take ownership of HIV/AIDS was limited. The following statement was an example of parents' apathy:

SMT: "Yes I think the governing body was invited in these workshops. Then the governing body was to disseminate this information to the parents."

SMT: "In terms of whether parents know what is going on at school, they do because we did send letters to parents telling them that this is what we are doing at school. We told them it was a Departmental requirement to include HIV/AIDS education in the curriculum. It was not a matter of informing them to indicate whether they like it or not."

Participant 1: "Our parents here are quite apathetic and I think our best means would be to have meetings and workshop the parents but I'm not too sure. Here the parents don't really respond well."

Participant 2: "It's important to educate our parents. Many parents are ignorant of the facts of AIDS. They have had no workshops."

In spite of the risks of contracting HIV/AIDS and the prevalence of rape and abuse victims within the school itself, provision of empowerment programmes for the protection of learners did not yet exist. These were some of the statements:

Participant 1: Because I such an experience with one child...who was abused by someone they trusted.

And there's another child in my class where a guy showed her a hundred rand note and tried to push her and pull her into the bushes and he did that twice.

In view of the increasing numbers of abuse and rape victims at the school there was no evidence of developing the skills of teachers in the area of counselling as is evident in the following remarks:

Participant 1: "I have another student who was raped at the age of 5. She does not talk at all. I cannot approach her because she screams at night. I've got to treat her as normal as I can until she herself can open up."

Teachers seemed to latch onto the principal of knowledge as a motivator for initiating sexual behaviour changes.

Participant 3: "Teenagers have knowledge of AIDS. Teenagers are sexually active and it is important to educate them and if they are then the solution is to abstain."

Participant 2: "If they know the right things about AIDS and about sexual contact, they wouldn't want to experiment because they have the knowledge, but it's from not knowing that they want to learn more."

No 'investigations' were carried out to ascertain the level of impact of HIV/AIDS in the surrounding community and its ripple effect on the learners at school.

A striking feature of the school's response to HIV/AIDS was the absence of discussion and dialogue relating to the subordinate status of women and girls and in particular the negotiation of safer sexual practices.

I shall now expound specifically on the following themes that emerged from the data produced during the face-to-face interview with the member of the SMT and the focus group interview with the educators.

Curriculum:

Domestication of the subject: HIV/AIDS was confined exclusively to the learning area Life Orientation. This is in total contradiction to the goals espoused by OBE (Outcomes Based Education). OBE rejects the rigid division of knowledge and skills. Accordingly, the eight learning areas are supposed to be integrated and inter-

connected to enable learners to build and consolidate on what they learn as they progress from one learning situation to another (Van Dyk 2001).

This 'compartmentalisation' of HIV/AIDS as well as the imposition of time constraints ("1 hour for grade 4,5,6,7 during which time HIV/AIDS has to be taught") has invariably contributed to the 'devaluing' of the status of HIV/AIDS education. In addition, the following statement by the SMT "We haven't really sat and workshopped AIDS" attests to lack of importance HIV/AIDS currently enjoys. HIV/AIDS education deals with sensitive issues viz. puberty, sexual abuse, teenage pregnancy etc. Teachers acknowledged that the issue of trust is crucial, "*I think that the only time they can open up to you is if they can trust you*". "*They will never tell you such details if they don't trust you.*" One of the educators responsible for Life Orientation is a Foundation Phase teacher. The only time the teacher engages with the learners is during Life Orientation. The teacher does not teach any other learning area to these learners. Thus the issue of developing trust between the teacher and learners becomes problematic. In addition the level and depth of interaction between learner and teacher becomes questionable.

Top-down curriculum: teachers tended to engage with the curriculum in a prescriptive manner-"*Basically I follow the curriculum*" despite the fact that OBE encourages them to be proactive, interactive, creative and innovative designers of their own learning programmes. In addition, the teachers relied heavily on the curriculum package provided by the Department.

Age/stage development: in terms of the level of disclosure, teachers believed that the information disseminated to the learners had to be 'age and grade appropriate'. As such teachers provided learners with a 'diluted' or 'watered-down' curriculum. This was clearly evident from statements such as the following:

"Basically, I teach the grade 4's. They're still very little. Whatever I give to them is very broad and very general"

"In grade 5 we could not go and include how AIDS is contracted, beside blood transfusion and drug addicts."

This is a clear example of how teachers failed to take cognisance of the fact that classes are characterised by a wide range of ages and that children develop at differing

paces. It is thus clearly apparent that the teachers themselves were complicit in being the gatekeepers of knowledge!

Community:

HIV/AIDS initiatives and programmes: whilst teachers believed “It’s important to educate our parents, many parents are ignorant of the facts of AIDS” the researcher’s findings revealed the school was guilty of merely paying ‘lip service’ in terms of involving the community in HIV/AIDS initiatives and programmes, This was clearly apparent in the fact that whilst elaborate initiatives involving the community at large were included and described at length within the school’s HIV/AIDS policy, the educators admitted that none of them were actually implemented.

Dissemination of information: teachers acknowledged that the dissemination of HIV/AIDS information to parents and the community at large was crucial “*The child must be able to relate whatever I tell to his/her family*”; “*Helping children to get the message over to their parents and community.... We as educators play a very important role in that sense.*” However, there was no concrete evidence to support this belief/stance. In addition, the SMT revealed that the school’s governing body was invited to a workshop on HIV/AIDS and believed that the dissemination of the information to the community was solely the responsibility of the governing body. The SMT admitted that he/she was unsure as to whether the information had indeed been disseminated to the community. This clearly illustrates a scenario of ‘passing the buck on’. It also brings the complacency and apathy of the educators under the microscope.

It is important to note that the National Policy on HIV/AIDS advocates that parents of learners should be invited to participate in parental guidance workshops and should be made aware of their role as sexuality educators and imparters of values at home. It is crucial for stakeholders to organise themselves in consortia to effectively address issues relating to HIV/AIDS (Department Of Education 1996).

Skills, knowledge and values:

Teachers believed that in terms of the curriculum designed by the Department, there was an over-emphasis on issues pertaining to values, self-esteem, talents, decision making etc. *“Most of it actually concentrates on the person, issues like talents, feelings...not actually a lot is done on HIV/AIDS itself beside causes and prevention. Although it is called an AIDS booklet more time is spent on values, talents, feelings, how special they are and mostly on making decisions.”*

Teachers displayed a very myopic understanding of what HIV/AIDS education really entails. There is thus a danger that all issues pertaining to sexuality and education about sexuality may be coloured by context of HIV/AIDS (Van Dyk 2001). HIV/AIDS education aims to do more than just improve knowledge; it aims to try to transform/influence sexual behaviour. Research has revealed that children acquire information relating to their sexuality in an informal manner namely, via soap operas, peers, pornographic magazines etc.

Life-skills are regarded as a key component of HIV/AIDS education and is based on the premise that if learners engage with issues relating to values, beliefs, attitudes, moral, skills like decision making etc. they would be able to utilise these “core tools” to clarify, understand and (re) negotiate their personal beliefs and develop their own moral framework. This would assist them in making wise and informed decisions about their sexuality especially with regards to delaying the onset of sexual intercourse (Vergnani & Frank 1998).

Gender stereotypes:

Teachers recounted numerous incidents where their learners were involved in incidents relating to rape, abuse and violence. What emerged from their narration was that all the participants seemed to endorse the view that the perpetrators of these crimes were always male and the victims were invariably females. Thus the teachers themselves were complicit in constructing and perpetuating gender stereotypes.

Sexual abuse:**Counselling and support:**

Teachers stated that they engaged with sexual abuse awareness programmes with their learners. For example: *"Well I teach the little ones. We do a lot of stories about stranger danger"; "We talk about body parts and how parts of our body are for us only"; "We learn about good touches and bad touches."*

What emerged from the study was that teachers engaged with sexual abuse at a very superficial level.

This was clearly apparent from the fact that while teachers were aware of learners in their classes who were victims of abuse or rape the teachers' knowledge on how to respond to a victim of abuse and report an abusive situation was limited. For example: *"I have a child who was raped at the age of 5. She does not talk at all. I cannot approach her because she screams and has nightmares. I've got to treat her as normal as I can until she can open up."* In such a scenario the teacher can actually contribute to the secondary abuse and trauma of the victim through lack of support (Ewing 2003).

In addition there was a failure on the part of the school to use the incidents of rape and sexual abuse as a barometer to gauge the type of intervention needed at this school in particular.

Knowledge of teachers:

Data from the study revealed that the teachers' level of knowledge pertaining to HIV/AIDS education was on a very superficial level. For example one of the teachers who was chiefly responsible for drawing up the school's HIV/AIDS policy inquired the following *"Do we have an obligation to let the community know if there is a child in your class who is HIV positive?"*

Compulsory disclosure of a learner's HIV/AIDS status to school authorities is not advocated. In fact any unauthorised disclosure of HIV/AIDS- related information could give rise to legal liability (Department Of Education 1996; Department Of Education 1999; Louw et al 2001; Van Dyk 2001).

A lack of knowledge pertaining to HIV/AIDS can also contribute to shrouding the disease in secrecy. This was clearly evident from the following scenario that the SMT relayed: *“We did have a question from a child who wrote a note to the teacher to ask whether we would be able to get HIV/AIDS by kissing a child deeply. The teacher approached me for advice. I told the teacher he needs to talk to the child privately and individually and tell the child it is risky.”*

4.7 Conclusion

This chapter has presented and discussed the responses of the respondents toward the HIV/AIDS curriculum and its implementation at their school site. While there were varied responses, they were indeed interesting. The following issues emerged to the fore during the discussion on findings: insufficient information (teenage pregnancy, STI's etc.) in the prescribed curriculum of the Department Of Education, unavailability of current information and resources on HIV/AIDS, the lack of police protection and support for learners, parental apathy, lack of correct protocol with regard to victims of sexual abuse and a failure to mainstream HIV/AIDS education across all learning areas.

The following chapter will discuss the recommendations and conclude the thesis.

Chapter 5

Summary of findings, Recommendations and Conclusion

5.1 Introduction

The following study of four teachers was used to explore the experiences and challenges they faced in their engagement with HIV/AIDS education within the classroom.

Their experiences were explored with the following critical questions in mind:

- **What are the gaps/silences that exist in the teaching of HIV/AIDS education in schools?**
- **Why do such gaps exist?**

The rationale for HIV/AIDS education is compelling: it identifies problems of knowledge, understanding and curriculum delivery and offers ways forward that, in principle, can overcome these problems. Data from this research indicated otherwise. Clearly the data showed a disjuncture between theory and practice.

The data revealed the following:

- Respondents exuded a high degree of commitment to HIV/AIDS education. A critical achievement on the part of the respondents was their ability to use creative methods in the classroom to disseminate the message effectively
- Although the respondents in the study were implementing the HIV/AIDS curriculum HIV/AIDS education was not being mainstreamed into all learning areas. The main thrust of HIV/AIDS education was confined to the Life Orientation period. This was clearly inadequate given the comprehensive nature of the HIV/AIDS curriculum.
- The respondents in this study reported that the Department Of Education curriculum dictated the pace and scope of content provided to learners thus leaving little room for creativity and autonomy by educators. Given the urgency of the epidemic and need for intensive HIV/AIDS education, this type of scenario does not augur well for the future of the disease. Furthermore,

South Africa's education policy expects that HIV/AIDS education should be effective and relevant to learners. It sets this out clearly in the Tirisano document with particular emphasis on the three project areas discussed in chapter one.

- Respondents offered ideas of misconceptions that existed among learners', which was consistent with Latham's (1992) views that a large degree of misconceptions around HIV/AIDS exist among many individuals.

5.2 Recommendations:

- More intensive engagement with HIV/AIDS not only as an epidemic but as a discourse
- (Re)-interrogate literature pertaining to HIV/AIDS with specific attention in the spectrum of education
- Addressing the demand for educational services eg. in-service training and pre-service training
- (Re)-negotiating and (re)-interrogating the resources and content of education expressed in terms of the use of the education sector for the mitigation and prevention of HIV/AIDS
- (Re)-addressing the HIV/AIDS pandemic through the lens of an apartheid legacy
- A critical (re)-assessment of training of HIV/AIDS facilitators in terms of efficiency and dissemination of information
- Generate more programmes to address prevention, treatment, care, support, policy, research, media, curriculum and community outreach

5.3 Conclusion

The HIV/AIDS pandemic has had a profound effect on contemporary society that has extended to the classroom. Findings from the study reveal that the disease has engendered a fresh perspective on numerous practices and policies prevalent in society and schools, compelling individuals to adopt a more nuanced stance to accommodate the new challenges initiated by HIV/AIDS.

The school curriculum for HIV/AIDS, while posing a challenge, has indeed arrived at a relevant and critical time in our country. Given the fact that we have been victims of

systemic discrimination and are products of a racist society, the construct race is held to be 'primordial', fundamental and logically prior to other forms of inequality (Cohen & Kennedy 2000).

As such the curriculum on HIV/AIDS provides an effective and integral platform for dialogue, debate and intervention with regard to abuse, status of women, patriarchal power, reproductive choices of women and the right of females to free choice in sexual relations; thus ensuring that these issues are brought to the fore instead of being sidelined and subsumed within a broader framework of human rights...

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APPENDIX A

INTERVIEW SCHEDULE FOR THE FACE TO FACE INTERVIEW WITH THE SMT

- Q 1. Did any of the educators at your school attend HIV/AIDS related- workshops?**
- Q 2. Who were the service providers of these workshops?**
- Q 3. Were the workshops initiatives of the Department Of Education or an NGO?**
- Q 4. Do you believe that your school has benefited from the attendance of your educators to these HIV/AIDS related- workshops?**
- Q 5. Did you attend any HIV/AIDS related- workshops?**
- Q 6. Have you included the local community in HIV/AIDS related- workshops at your school?**
- Q 7. What are your feelings about the inclusion of sexuality education within the foundation, intermediate and senior phase curricular?**
- Q 8. Did you assist in the teaching of learners about HIV/AIDS related issues?**
- Q 9. Do you think that the curriculum content provided by the Department Of Education was relevant to current issues pertaining to HIV/AIDS?**
- Q 10. Who was responsible for designing your school's HIV/AIDS policy?**
- Q 11. What guidelines were followed in designing the school's HIV/AIDS policy?**
- Q 12. Has your school organised any HIV/AIDS related- workshops for all the educators at your school?**
- Q 13. How does your school policy cater for learners who are HIV positive?**

APPENDIX B

INTERVIEW SCHEDULE FOR THE FOCUS GROUP **INTERVIEW WITH 3 LIFE ORIENTATION EDUCATORS**

- Q 1.1.** What are your personal feelings with regards to the inclusion of HIV/AIDS education within the foundation, intermediate and senior phase curricular?
- Q 1. 2.** Describe those aspects of HIV/AIDS education that you have chosen to include within the school curriculum? How did you come to make these choices?
- Q 1. 3.** Are there any other aspects or issues that you would have *included* in the design of the HIV/AIDS curriculum as developed by the Department Of Education? Please elaborate.
- Q 1. 4.** Are there any specific aspects or issues that you would have *excluded* in the design of the HIV/AIDS curriculum as developed by the Department Of Education? Please elaborate.

Case study scenario:

Abby is a thirteen- year old girl. When she was a little younger, her eldest step-brother always showed her a lot of love and affection. About three years ago he began touching her in a manner that made her feel awkward and in pain. He fondled her private parts and kissed her on her breasts. Abby felt very afraid but did not understand what he was doing. Her step- brother told her that it was their little secret and threatened to hurt her even more if she told her mother. It has since been discovered that Abby is HIV positive...

Imagine that a learner in your class approaches you with a similar scenario:

- Q 2.1.** What advice would you give the learner?
- Q 2.2.** What action would you take to prevent the learner experiencing any further abuse?
- Q 2.3.** What are some of the issues you would address your learners on to prevent a similar incident from occurring?

APPENDIX C

EDUCATOR QUESTIONNAIRE

To understand educator perceptions of HIV/AIDS education

Date: _____

School: _____

Biographical Details

Age

--

Gender

Male	
Female	

Level/Rank

1	2

Marital status

Single	Married	Divorced

Question 1. What do the following acronyms stand for?

H-
I-
V-

A-
I-
D-
S-

S-
T-
D-

Question 2. Do you think that HIV causes AIDS?

YES	
NO	

Question 3. Rate in order of **highest risk** the following modes of transmission of HIV/AIDS in children (0-10 years)
Breast -feeding, Mother to Child Transmission, Contact with blood and Blood transfusion

Question 4. Rate in order of **lowest risk** the least infectious body fluids in the transmission of HIV/AIDS
Saliva, Tears, Sweat and urine

Question 5. Name any two anti-retroviral drugs (ART)?

Question 6. What is the main function of an anti-retroviral drug (ART)?

--

Question 7. Which two areas/systems are most open/vulnerable to an attack by HIV?

Question 8. Identify a universal precaution that one may adopt to deal with a blood spill

--

Question 9. Rate in order of importance two popular myths that are often cited in the transmission of HIV/AIDS

GLOSSARY

Abstinence (sexual) not engaging in sexual activity.

AIDS Acquired Immune Deficiency Syndrome. This acronym emphasises that the disease is *acquired* and *not* inherited. It is caused by a virus that invades the body. The virus then attacks the body's immune system and makes it so weak and ineffectual that it is unable to protect the body from both serious and common infections and pathogens.

Centres for Disease Control and Prevention (CDC) A major agency of the United States Public Health Service charged with protecting the health of the populace by providing leadership and direction in the prevention and control of infectious disease and other preventable conditions

Condom A soft, stretchable sheath placed over the penis during sexual activity to form a barrier between semen and the internal tissues of the sexual partner. A female condom fits over the cervix and also protects the vagina and vulva.

Contraception Methods to prevent conception (a sperm impregnating an ova).

Culture Customs, art, social institutions of a particular group of people.

Curriculum 2005 The new national curriculum for the 21st century that has replaced Christian National Education. This South African education system utilises the Outcomes Based Education method of instruction. Critical thinking, rational thought and deeper understanding are central principles of the new education system, which aims to break down class, race and gender stereotypes thereby creating a democratic country free of discrimination and violence.

Discrimination Treating a person or group of persons differently from others (usually worse).

Epidemic A large number of cases of a disease that affects many people in a wide area.

Gender The state of being male or female, one's personal, social and/or legal status as a male or a female.

Gonorrhoea Common sexually transmitted bacterial infection of the vagina, penis, rectum, throat and/or eyes. Symptoms in males include painful urination, penile discharge, swollen glands and/or sore throat.

Heterosexual A male or female who prefers a sexual partner of the opposite gender.

HIV The human immunodeficiency virus- the virus, which causes AIDS.

Homosexual A male who prefers a sexual partner of the same gender; a female homosexual is referred to as a lesbian.

Immune system A complex series of cells, chemical factors and processes in which blood cells called lymphocytes respond to and eliminate foreign agents or substances in the body's tissues.

Infectious Communicable- a disease or disease agent that can be passed onto other people.

Intravenous Refers to the injection of drugs or other material into a vein.

Kaposi's sarcoma a cancerous condition often associated with AIDS, in which slow-growing tumours in the blood vessel linings cause red to violet patches on the skin surface that eventually become purplish-brown nodules.

Life Orientation guides and prepares learners for life and its possibilities. It specifically equips learners for meaningful and successful living in a rapidly changing and transforming society. The central focus is on the development of *self-in-society*. The vision of Life Orientation is to facilitate individual growth so as to contribute towards the creation of a democratic society, a productive economy and an improved quality of life in the community.

Life skills They refer to certain core skills (for e.g. negotiation, problem solving, critical thinking etc.) that every individual needs to be able to master in order to live their lives in the best way possible. These skills are basic to all parts of our lives and do not only relate to sexuality.

Lymphadenopathy swelling of the lymph nodes, adenoids and other tissues of the immune system.

MTCT Mother-to-child transmission of the HI virus.

Outcomes Based Education (OBE) The international term for the education style used to implement Curriculum 2005. OBE is based on achieving outcomes (what a learner can do at the end of a learning experience or process). It embraces the philosophy that all learners can learn and it defines what learners should learn namely, knowledge, understanding, skills, attitudes and values.

Pandemic an epidemic of worldwide scope

Pathogen Refers to a disease-causing agent.

Peer refers to any individual, other people of about the same age and standing in the community, equals or colleagues.

Puberty Transitional biological stage marking the end of childhood and the start of adolescence, the period of time during which the body matures and achieves reproductive capacity.

Rape Forcible sexual relations with an individual without that person's consent, other sexual intimacies or contact forced on one person by another, using either physical force, the threat of physical force, coercion and/or a weapon.

Safer sex Refers to sex that is as free as possible from disease, pregnancy and the abuse of power.

Semen Fluid that carries sperm from the testicles to the penis.

Sex Usually refers to whether a person is male or female, based on their physical differences. It also refers to the act of intercourse.

Sexual abuse When an individual forces another adult or child to have sexual intercourse or perform other sexual acts against their will.

Sexuality Ability to have sexual feelings. Involves a person's feelings about the self-self-esteem, body image, our beliefs, our fantasies, ability to relate sexually to others and the ability to communicate those feelings.

Sexuality education Aims to assist children develop a positive view of sexuality, provide them with the necessary information, clarify and teach values and skills necessary to make wise, informed decisions about all matters relating to their sexuality.

Sexual intercourse Sexual activity in which the penis is inserted into the vagina.

STD Sexually transmitted disease. This group of diseases includes (for example) syphilis, gonorrhoea, candidiasis, genital herpes and HIV infection

Stereotype A generalisation about a group of people (e.g. men) that distinguishes them from others (e.g. women).

STI Sexually transmitted infections (see STD).

Transmission To spread.

Tuberculosis (TB) A bacterial disease of the lungs accompanied by progressive deterioration, difficult breathing, blood in sputum and eventual suffocation.

Unsafe sex Sexual activity that could spread the AIDS virus (such as vaginal or anal intercourse without a condom).

Vaccine An injection, which prevents people from becoming ill from certain diseases even if, they should come into contact with them.

Virus A tiny organism or germ, which can cause disease in humans, animals or plants. HIV is a type of virus.

World Health Organisation (WHO) A specialised agency of the United Nations that works to promote physical, mental and social health in people around the world.