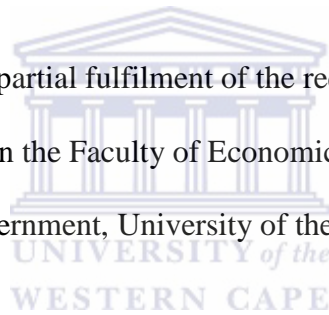


AN ASSESSMENT OF KNOWLEDGE OF HIV/AIDS AMONGST SECONDARY
SCHOOL LEARNERS OF KWAZULU-NATAL: AN EXPLORATORY STUDY OF
BERGVILLE RURAL DISTRICT

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A mini thesis submitted in partial fulfilment of the requirements for the degree of
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School of Government, University of the Western Cape.



Supervisor:

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ABSTRACT

The main purpose of the study was to assess and explore the knowledge of HIV/AIDS among secondary learners in rural Bergville district of KwaZulu-Natal. A stratified random sample of 100 learners was selected from two secondary schools in the area. Data was collected using a questionnaire and interviews were scheduled with the teachers from the selected schools. The questionnaire was administered to a sample of 54 learners from school A and 46 from school B. The mean age was 16, with age range from 13-20. The participants were enrolled for grade 8-12 in both schools. Both qualitative and quantitative data on learners' knowledge and perception about HIV/AIDS, condom use and sexual issues including their attitudes towards people living with HIV/AIDS were collected in the questionnaire. Chi-square test was used for statistics purpose to test if the HIV knowledge of learners were associated with gender, culture and religion. Qualitative interviews with 9 teachers from both schools were conducted. The main purpose of the interviews was to investigate the management of HIV/AIDS in public schools in rural areas. Furthermore, to assess the learner's attitude towards HIV/AIDS education provided in schools.

The results showed that the learners in Bergville district were more knowledgeable of HIV/AIDS through HIV/AIDS education in schools that had limited effect on gender, culture and religion. Quantitative findings presented, indicated no significant differences between those learners attending church and cultural activities that offer HIV/AIDS awareness programmes and those who do not with regard to the knowledge of HIV/AIDS. However, culture stood out to be associated with one item on the knowledge of whether school children can get HIV/AIDS (p-value = 0.04). On average, the level of knowledge of HIV/AIDS between female and male learners was similar. The major findings on both quantitative and qualitative findings confirmed that learners' knowledge levels were very high for modes of transmission and prevention of HIV/AIDS. Despite this knowledge, poor behavioural change among learners is a major setback thus increasing high risk of contracting HIV. Adequate knowledge about issues of cure, HIV testing and treatment was of concern in the findings in this study. Furthermore, data from qualitative interviews with the teachers highlighted the lack of multisectoral response to HIV/AIDS in Bergville rural

communities which thus compromise the effectiveness in management of HIV/AIDS in schools. In summary, the study revealed some of the challenges faced by teachers and learners in regard to HIV/AIDS education.



KEY WORDS

Human Immunodeficiency Virus (HIV)

Acquired Immune Deficiency Syndrome (AIDS)

Sexual behaviour

Secondary schools

Learners

HIV/AIDS knowledge

KwaZulu-Natal (KZN)

Rural

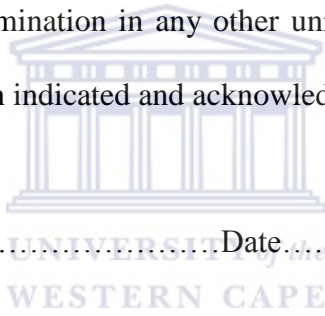
Culture

Gender



DECLARATION

I declare that AN ASSESSMENT OF KNOWLEDGE OF HIV/AIDS AMONGST SECONDARY SCHOOL LEARNERS OF KZN: AN EXPLORATORY STUDY OF BERGVILLE RURAL DISTRICT is my own original work, that it has not been submitted before for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.



Full name.....Date.....

Signed:

DEDICATION

This mini-thesis is dedicated to my late father Mr. B. G. Khumalo and my sister Ntombizodwa Hellen Khumalo.



ACKNOWLEDGEMENT

- I want to thank my supervisor, Mr. O.E. Hohls for his continued leadership, undivided support, advice and suggestions from the beginning to the end of this journey.
- This work would not have been possible without financial support from the Andrew W Mellon Foundation and the Atlantic Philanthropies (PPP, South Africa).
- I want to thank my mother Mrs. S.M. Khumalo for her unconditional love, prayers, support and most for taking care of my son while I was away from home. Without her love, I would not have been this privileged.
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CHAPTER 1 INTRODUCTION

1.1 General orientation

Following the recommendations from the National HIV/AIDS Strategic Plan 2007-2011 to reduce the HIV prevalence by 50% in 2011, adequate knowledge about HIV/AIDS prevention and intervention strategies that will contribute to behavioural change is critical.

The HIV/AIDS pandemic has become the single most serious public health and social problem that is threatening to cripple the future growth and development of the South African economy. Given the lack of vaccine or cure, prevention of the spread of HIV/AIDS remains the most important primary method to combat the disease. It is therefore not only a medical but a social issue which involves socio-economic factors like poverty, gender inequalities, sexual violence and abuse of women.

West *et al.* (2007:276) reported that with a few exceptions the prevention programmes aimed at reducing HIV incidence have not been effective enough. Recent global reports reveal that despite all the efforts of reducing the HIV pandemic, including providing care and treatment to those infected, many more people still become HIV infected (UNAIDS, 2006:3). The recently released National HIV/AIDS Plan 2007-2011 of the Republic of South Africa and the previous one, National HIV/AIDS Strategic Plan 2002-2005 both emphasize the importance of strengthening HIV/AIDS interventions for young people. The most vulnerable of them all are young school-going children of both genders whom according to previous research may receive inadequate and inappropriate guidance on these matters from their peers (Griesel-Roux *et al.*, 2005:251-256; Brook *et al.*, 2006:259-260; Bhana, 2004:129). On the other hand, Rutagumirwa and Kamuzora (2006:2) state that schools are being recognized as sites where young people congregate, and are ideal venues for HIV/AIDS interventions. According to Brookes *et al.* (2004:35), South Africa has a real opportunity to manage and control the spread of HIV/AIDS by focusing more on HIV/AIDS and sex education in schools to strengthen the prevention efforts on young

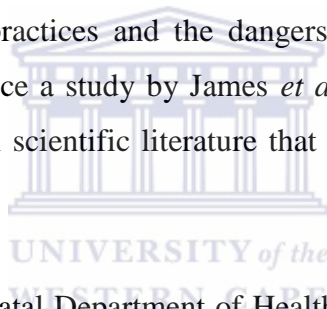
people in order to achieve sustained behavioural change. Furthermore, this can have a positive effect if it is integrated with the role of families looking at specifically mothers as the main source of communication with young children.

According to the KwaZulu-Natal Department of Health (2005/2006), the province of KwaZulu-Natal is one of the most affected areas in the country and is mainly dominated by rural communities with a high level of poverty, unemployment, illiteracy levels and poor infrastructure. Dlamini *et al.* (2003:1) and James *et al.* (2006:282) state that the province has the largest number of school-going children estimated at 2.7 million learners actively attending school. The prevalence of HIV infection among children of less than 20 years of age is limited since the data is normally obtained from antenatal clinics which few young people visit (Department of Health, 2005). With no detailed comparable data existing for South African young children, Bradshaw *et al.* (2004:143) stated that one in ten young people is currently infected with HIV. In addition, Harrison *et al.* (2001:69) report that in South Africa over one third of teenage women attending antenatal clinics are HIV infected. Furthermore, Stadler and Hlongwa (2002: 365) indicate that most new HIV infection occur in people between the ages of 15 and 20. This is a very disturbing observation since these indications show that the reality of HIV infection among children is there and cannot be ignored.

Generally sexual activity starts at an early age and according to Bhana (2004:129-130), young school-going children consist of a large number entering the adolescence stage. This period is characterised by experimentation with new behavioural patterns which, if continued, may lead to the development of life long negative habits placing them at high risk of contracting HIV/AIDS and unwanted pregnancies. Over the years, many efforts have been made to address HIV/AIDS and sex education amongst young school-going children in South Africa. Sathiparsad and Taylor (2006:117) state that even though young school-going children have knowledge about HIV/AIDS, this knowledge does not necessarily translate into safe sexual behaviour. The success of HIV/AIDS prevention depends mainly on the young school-going children's level of sexual experiences and the change in their sexual behaviour (Stadler & Hlongwa, 2002:366).

1.2 Motivation for the study

With the negative implications HIV/AIDS has on South African society, there is an urgent need to expand the knowledge of HIV/AIDS by raising awareness using prevention programmes aimed at reducing the risk of infection amongst young school-going children. These programmes should also include all other young communities of the country with extra efforts to reach out to the rural areas. Life-skills and HIV/AIDS programmes should generally not be similar for all schools. A major transformation in life-skills and HIV/AIDS programmes is needed to bring it in line with the socio-economic status and lifestyle of the rural learners, and this involves moving away from the formal education in classes towards a broader focus on how culture, religion, tradition and gender influence sexual behaviour of young school-going children. The success of the programmes, which are intended to increase the knowledge about safe sex, practices and the dangers of HIV/AIDS carried out in schools is unclear. For instance a study by James *et al.* (2006:281) reveals that few studies have been reported in scientific literature that evaluates the success of these programmes.



According to the KwaZulu-Natal Department of Health annual report for 2005/2006, the province is regarded as the epicentre of the HIV/AIDS crisis as compared to other provinces. The South African National HIV/AIDS Strategic Plan (2007), states that the future course of the HIV/AIDS epidemic depends in many respects on the behaviours that young people adopt or maintain, especially those children under the age of 18 who comprise of about 40% of the total population of South Africa. Children are largely vulnerable to HIV infection through child sexual abuse and their vulnerability means there is a strong encouragement to talk and teach them about child sexual abuse as well as their basic human rights (National HIV/AIDS Strategic Plan, 2007:15-16).

1.3 Statement of the problem

It is well known that young people are critical to the present and future economy of the country. It is very important to invest in them by assuring that they are in good health and well informed about the dangers of HIV/AIDS and also protected from future HIV infection. The study will assess the knowledge level of HIV/AIDS amongst secondary school learners of KwaZulu-Natal in Bergville rural district. The problem of HIV/AIDS which might be due to the lack of HIV knowledge arose as a result of KwaZulu-Natal still continuing to have the highest prevalence of HIV/AIDS relative to other provinces. In recent reports, the problem of teenage pregnancy is evenly spread in all provinces, both rural and urban areas (Department of Education, 2006 & 2007; Cohen, 2007). According to Dommissie (2007:1), the official figures from the provincial department of education reveal that more than 72000 school girls aged between 13 and 19 did not attend school because they were pregnant. Dommissie (2007:1) furthermore states that the province of KwaZulu-Natal is estimated to have a leading number of teenage pregnancies amongst young school-going children as compared to other provinces. The learners in the Bergville district are from different villages with various socio-economic conditions, which are likely to influence their HIV/AIDS risk behaviour.

1.4 Research Questions

The study will seek answers to the following questions:

- Why is there still a high risk of HIV infection amongst young school-going learners?
- What communication takes place between the older generation and young school-going learners in rural communities on the issue of HIV/AIDS?
- What role does culture and religion play in the sexual behaviour of school-going learners?

1.5 Objectives of the study

The objectives of the study are as follows:

- To measure the knowledge of HIV/AIDS amongst secondary school-going learners.
- To examine learners' perceptions about sexual behaviour.
- To determine with whom learners prefer to discuss their personal and intimate issues.
- To investigate the management of HIV/AIDS in public schools.
- To highlight challenges in the implementation of HIV/AIDS awareness programmes in schools.

1.6 Hypothesis

The hypothesis of the study is that young secondary school-going learners of KwaZulu-Natal in the Bergville rural district will become more knowledgeable of HIV/AIDS prevention through the implementation of prevention awareness and Life-skills programmes that focus on how culture, religion, and gender influence sexual behaviour.

1.7 Delimitation of the study

It is difficult for the researcher to generalise about the level of knowledge of HIV/AIDS amongst all secondary school learners in South Africa, because the study is a localised case study. It cannot be disputed that other schools in other KwaZulu-Natal regions (both rural and urban) may have different background and experiences regarding HIV/AIDS. It is very possible that what is significant for Bergville district is not important for other rural areas in KwaZulu-Natal or any other provinces in South Africa.

1.8 Research methods

Qualitative and quantitative research methods will be employed in the study. Babbie and Mouton (2001:74) reveal that qualitative methods are the best research methods that can be used in a study to capture the contextual, psychological and behavioural dimension of people. A stratified random sampling will be conducted to select the participants from two secondary schools situated in the Bergville rural district of KwaZulu-Natal. The data will include both responses from primary and secondary sources. The primary data will be collected using a structured survey questionnaire, which will be distributed to a sample of school-going learners as well as qualitative interviews with the teachers. Furthermore, the primary data will incorporate the responses from the secondary school-going learners as well as qualitative interviews with teachers and principals of the selected schools. For secondary data the researcher will rely on reviewing secondary sources that will include books, journal articles, internet, government publications and other related publications. The main study sample will include both the male and female school-going learners attending public secondary schools in the district.

The structured survey questionnaire will consist of both closed and open-ended questions which will be distributed to a sample of learners randomly selected from the two secondary schools. The open-ended questions will be structured to explore learners' perceptions about HIV/AIDS i.e. knowledge about the disease, transmission, prevention of HIV/AIDS, attitudes towards people living with AIDS, decision making about sex and gender issues. A qualitative interview will also be conducted with teachers and principals of the selected schools. As suggested by Leedy (1997:199-200), the interviewer will not react to responses of the teachers/principals in any way that will likely influence their response. With the permission of the teachers and principals concerned, all interviews will be tape-recorded. The researcher will be present at all times during data collection. All the data collected by the researcher will be analysed, interpreted and the results will be discussed and presented in the final research report.

1.9 Definition of key terms

HIV (Human Immunodeficiency Virus)

The virus that causes AIDS.

AIDS (Acquired Immunodeficiency Syndrome)

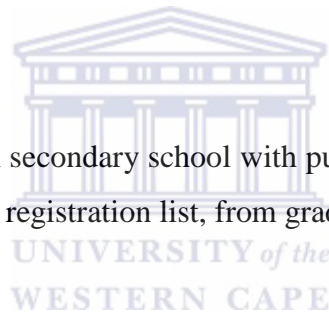
The late and most advanced stage of HIV disease that is characterised by signs and symptoms of severe immune-deficiency, where the body loses the ability to fight against infections because the immune system is weakened.

Sexual behaviour

Any actions that allow the expression of one's sexual feelings and that involve sexual response of the body.

Secondary school learners

A person registered at a given secondary school with purposes of studying and his/her name appearing on the school registration list, from grade 8-12.



HIV/AIDS knowledge

The knowledge of HIV/AIDS in general including HIV/AIDS transmission, prevention, attitudes towards people living with AIDS and decision making about sex.

South Africa (SA)

South Africa, referring to the country, the Republic of South Africa.

KZN

KwaZulu-Natal is one of the nine provinces of the Republic of South Africa.

Rural

Areas situated in farm small holdings and tribal settlement.

Gender

For the purpose of this study, gender indicates whether a learner is a male or female.

Culture

It is the sum of the learned behaviour of a group of people that are generally considered to be the tradition of that people and that are transmitted from generation to generation.

1.10 Significance of the study

The significance of the study entails exploring new education intervention methods focusing mainly on rural school-going learners to improve their knowledge of HIV/AIDS. Furthermore, the study will assess how vulnerable the learners are in contracting HIV. The study will contribute to the existing literature on HIV/AIDS. The level of knowledge of HIV/AIDS of young school-going children would potentially bring to the attention of everyone involved with the life skills programmes the importance of HIV/AIDS and sex education in the school, as well as the opportunity to readdress new interventions in the prevention of the disease and to identify concerns that need to be tackled. This can also lead to the development of evaluation methods that can be used to evaluate and monitor the impact of HIV/AIDS and sex education amongst young school-going children and also how children experience these programmes.

1.11 Chapters outline

This section briefly outlines what will be captured in each chapter. In chapter 2 a literature review on HIV/AIDS and sexual behaviour among young school-going is argued and discussed to give a comprehensive framework on how serious the crisis of HIV/AIDS amongst youth. Chapter 3 defines a research methodology, data collection processes used in this study and a descriptive background and context of the study. Presentation and analysis of results is discussed in chapter 4. In chapter 5 the summary of findings of the study are further discussed. In addition, conclusions and recommendations are provided.

CHAPTER 2 HIV/AIDS AND YOUNG SCHOOL-GOING CHILDREN: A LITERATURE REVIEW

2.1 Introduction

The strategy to address the issue of HIV/AIDS among young school-going children does not only involve knowledge of HIV transmission and prevention programmes but also an understanding of social norms that can have both negative and positive effects on such programmes. The development and behaviour of young children is normally shaped through interaction with all people involved in their upbringing and other societal systems (Rochat & Hough, 2007:20).

This chapter discusses the literature on HIV/AIDS and its implication on young school-going children. The chapter also presents an overview of the HIV/AIDS epidemic followed by an in-depth discussion on HIV/AIDS and young school-going children. Specific issues such as safe sexual practices, risk behaviours, Life-skills and HIV/AIDS education in schools will also be covered. Furthermore the discussion will also include the effect of stigma and culture on HIV/AIDS. In conclusion the chapter will summarize the effect of HIV/AIDS on young school-going children.

2.2 The HIV/AIDS pandemic: an overview

The trends of HIV/AIDS epidemic differ from country to country in accordance with changes in individual behaviour, prevention and treatment programmes offered in each country. Despite all the efforts made across the world in order to fight the HIV/AIDS pandemic, the global epidemic continues to grow (West *et al.*, 2007:275).

The recent global report by UNAIDS (2007a:113) revealed that an estimated 33.2 million people were living with HIV globally in 2007. In South Africa, ever since the first case of HIV/AIDS was reported in 1980, the country continues to experience the threat of HIV/AIDS (Department of Health, 2006:4). The data on the national HIV and syphilis survey shows that the epidemic is declining for the first time in South

Africa (Department of Health, 2007:2-5). On the other hand, UNAIDS (2007a:3) indicate that there is no evidence of major changes in HIV related behaviour amongst South Africans. Recent reports estimate that in 2006 and 2007, about 5.5 million people in South Africa were living with HIV (Department of Health, 2005/06; Henry Kaiser Foundation, 2007; National HIV/AIDS Strategic Plan, 2007; UNAIDS, 2007a; UNAIDS, 2008a).

Within the Republic of South Africa, some provinces are more severely affected by the pandemic than others because of geographic variation and different socio-economic conditions of provinces (Department of Health, 2006). KwaZulu-Natal has been reported to have the highest prevalence of HIV compared to other provinces. Reports by the KwaZulu-Natal Department of Health (in KwaZulu-Natal Office of the Premier, 2006:3) and findings by Shisana *et al.* (2005:35) estimated that the HIV prevalence in KwaZulu-Natal to be between 16% and 22%. In addition, the recent findings by Shisana *et al.* (2009:32) confirm that the HIV prevalence in the province has increased from 11.7% in 2002 to 15.8% in 2008. The HIV prevalence is not only high among the general population of KwaZulu-Natal but also among young people (Shisana *et al.*, 2009: 34; KwaZulu-Natal Office of the Premier, 2006:3-4; Scott, Weiss & Viljoen, 2005:305). Based on these figures HIV/AIDS still finds a home in the province.

According to the KwaZulu-Natal Office of the Premier (2006:4), there is 42% HIV prevalence in UThukela district Municipality which encompasses the Bergville area. Although this figure indicates that the district is experiencing the full reality of HIV/AIDS, studies on the impact of HIV/AIDS amongst communities residing in this remote area are limited. According to Gaede (2005:35), the community within the area had knowledge of HIV/AIDS but there was no corresponding improvement in sexual behaviour.

Young people have been recognized as that section of the population at great risk of contracting HIV/AIDS, because they are at a stage of sexual experimentation (Bradshaw *et al.*, 2004:135; Brookes *et al.*, 2004:3; Chernoff & Davison, 2005:91-92; Henry Kaiser Foundation, 2007; Ngcobo & Pillay, 2004:7-8; Simbayi *et al.*, 2005:59; UNAIDS, 2006:3). According to UNAIDS (2006:3), there is an increase in new HIV

infections among young people in most regions of the world. In addition, UNAIDS, (2008a:33) report that young people between the age of 15-24 account for an estimated 45% of new infections worldwide. In South Africa, of the 5.5 million people infected with HIV/AIDS, an estimated 1.3 million are under 25 years (Dorrington *et al.*, 2006:1).

Reich and Rubin (2007:92); Lerclerc-Madlala (2002:2) and Hallman (2005:47) believe that despite the availability of all the information on HIV/AIDS in schools, young people living in environments where there is a high prevalence of HIV/AIDS and socio-economic challenges may still be more vulnerable to the HIV infection. For example, in rural KwaZulu-Natal, Harrison, *et al.* (2001:76) found that young schoolgirls in the age group 14-15 have multiple partners and engage in commercial sex with older men in order to earn money. According to Ott *et al.* (2003:159), the majority of HIV infections are being contracted through sexual activities.

2.3 HIV/AIDS and sexual behaviour among young school-going children



KwaZulu-Natal is the most populous of South Africa's nine provinces (KwaZulu-Natal Department of Health, 2006:16). The province also has the highest number of learners compared to other provinces (Taylor *et al.*, 2003:97; James *et al.*, 2004:264; James *et al.*, 2006:282). It is during the school going period where various patterns of behaviour are developed that can either protect or place young people at risk later in adult life (James *et al.*, 2004:264).

It is therefore important for young children at this stage to make the right choices about their sexual behaviour that will protect them from HIV infection (Detroit Public School Board of Education, 2006:4). Studies revealed that the largest percentage of new HIV infections occur mostly in people under the age of 25 (Griessel-Roux *et al.*, 2005:253; Visser, 2005:204; UNAIDS, 2008a). On the other hand, studies by Pettifor *et al.* (2004:8) and Shisana *et al.* (2005:37) showed that in South Africa the HIV prevalence among the age group 15-24 is about 10%. The prevalence was shown to be higher among females than in males (see figure 2.1 UNAIDS, 2008a:33) and higher

HIV prevalence continues to be reported among youth residing in KwaZulu-Natal compared to other provinces (Pettifor *et al.*, 2004:8; Shisana *et al.*, 2005:37-38). Furthermore, the recent report by Shisana *et al.* (2009:34) reported that most provinces have shown a decline in HIV prevalence among the age group 15-24. However, KwaZulu-Natal has shown an increase from 7.2% in 2002 to 15.3% in 2008. This still makes it the province with the highest HIV prevalence among youth.

In other findings, Jaspan *et al.* (2006:644-646) indicated that young children between the ages of 11 and 13 are already at high risk of HIV infection. This has been confirmed by reports from the provincial hospitals in KwaZulu-Natal where even young girls of 13 years old have tested positive for HIV (Leclerc-Madlala, 2002:4). According to Griessel-Roux *et al.* (2005:253), the impact of HIV/AIDS among young school-going children is being reflected by the number of learners who drop out of school as a result of the pandemic. In South Africa, the reliable figures of HIV infections among young school-going children are however not yet available.

In the context of HIV/AIDS, unprotected sexual activity is one of the possible ways of transmitting HIV if one of the partners is infected. Research findings indicate such high risk sexual behaviour among young people. This behaviour is characterized by early sexual activity, infrequent condom use and multiple sexual partners (Visser, 2005:203; Meekers & Klein 2002:62; Karnell *et al.*, 2006:295-296). For instance, Bhana (2004:132) found that young children of 14 years and younger had already engaged in sexual activities. Such behaviour might lead to HIV infection, sexually transmitted infections (STIs) and unplanned pregnancies. Stadler and Hlongwa (2002:366) also supported this finding in their study in which they reveal that each year, one third of all births and sexually transmitted infections (STIs) occur among adolescents. In addition, Bhana (2004:131) reported a high prevalence of sexually transmitted infections among sexually active young school-going children in KwaZulu-Natal compared to other provinces.

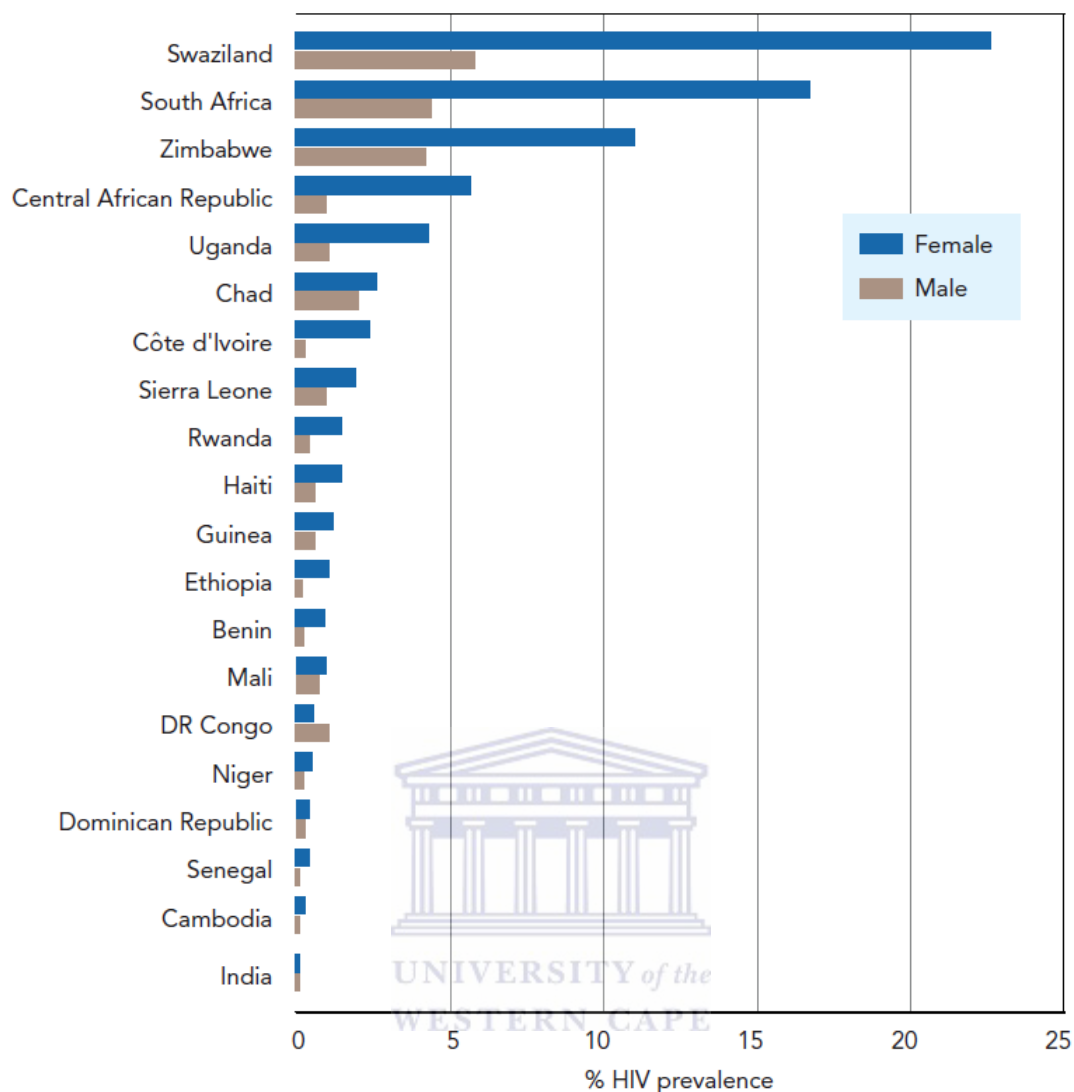


Figure 2.1: HIV prevalence (%) among 15-24 years old, by sex and selected countries, 2005-2007. Source: (UNAIDS, 2008a:33); 2008 Report on the global AIDS epidemic.

Studies concerning condom usage among South African youths have been done and the majority of such studies found a low level of condom usage among young people. For instance, Bradshaw *et al.* (2004:144) reported the lowest condom usage among sexually active youth in rural areas than in urban areas. Furthermore they reported that a third of the youth still believe that using a condom means lack of trust in your sexual partner. Tladi (2006:380) found a low condom usage among females who are financially dependent on their partners compared to those who are financially independent. Furthermore, Hallman (2005:45) also established that in KwaZulu-Natal

females coming from poor households were associated with having multiple sexual partners and lower condom usage. Both female and male learners in KwaZulu-Natal were found to be uncertain about the effect of condom use while confidence of how to use a condom was also very low in both groups (James *et al.*, 2004:268). It is therefore important to emphasize condom usage and delay of onset of sexual activities among young people especially in areas where HIV infections are reported to be high (Mantell *et al.*, 2006:118-120).

The high rates of pregnancy among teenagers are tangible outcomes of unprotected sexual activities. For instance, LoveLife (2003:105) revealed that in South Africa, one in three women become pregnant before the age of 18, while out of 7.9 million beneficiaries of the child grant, 13349 are 17 year old, 3588 are 16 year old and 411 are 15 year old teenage mothers (Department of Social Development, 2005/06). These are the age groups of teenage mothers who presumably are supposed to be in school. KwaZulu-Natal province reported 5868 cases of pregnant pupils in 2006, the highest number compared to other provinces (Department of Education, 2005/06; Cohen, 2007). Rutenbberg *et al.* (2002:7) also established that in the province young girls want to become pregnant in order to prove their fertility and to strengthen their relationships with their male partners.

This places them at a high risk of contracting HIV. It is therefore South Africa's priority to explore more appropriate knowledge and programmes aimed at reducing the risk of future HIV infection among young children.

2.4 The response of the National Department of Education to HIV/AIDS

Schools are an important setting where young children gather during the day. The school classrooms are appropriate venues to teach young children about skills and information that will protect them from the risk of HIV infection (Rosen *et al.*, Murray & Moreland, 2004:1; Rutagumirwa & Kamuzora, 2006:2; Paxton, 2002:282). The campaign programmes on HIV/AIDS and sexual education appear to have a positive effect if they are introduced prior to the onset of sexual activity than later

(Agha, 2002:270; Department of Health, 1999). In addition, Kirby *et al.* (2005:5) suggest that such programmes can be a promising intervention for reducing adolescent's sexual risk behaviour if based on a written curriculum and implemented among groups in schools, clinics or any other community settings.

The Department of Education responded to the HIV/AIDS crisis by developing a curriculum based on a form of Life-skills orientation as an HIV/AIDS prevention strategy in primary and secondary schools (Visser, 2005:203). According to Magnani, *et al.* (2005:289-304), Life-skills is defined as the formalised teaching of requisite skills for surviving, living with others and succeeding in complex society. According to Visser (2005:205), the aim of Life-skills is to develop effective communication and responsible decision making skills that will protect young people and others from HIV infection and also to promote a positive attitude towards those living with HIV/AIDS. In 1995, the Department of Education, Health and Welfare collaborated on a national programme to implement Life-skills training, sexuality and HIV/AIDS education in schools (Visser, 2005:206). The Tirisano plan was also developed and introduced as one of the education policies to ensure the implementation of the programme at all levels (Department of Education, 2000; Griessel-Roux *et al.*, 2005:253). In the year 2000, the South African government allocated the bulk of the National Integrated Plan's (NIP) budget to all nine provincial education departments in order to start the implementation of the Life-skills programmes by introducing Conditional Grants (Department of Education, 2001). All the schools were mandated to implement Life-skills and HIV/AIDS programs by 2005 (Department of Education, 2000 & 2001).

A report by the Department of Education (2006) confirms the continuation of Life-skills and HIV/AIDS education in all schools. In addition, the department has recently established a strong collaboration with the Department of Health. They also identify those learners who are in need of health-related intervention or treatment and run peer education programmes in all provinces (Department of Education, 2006).

As required, the KwaZulu-Natal department of Education responded positively towards the need for HIV/AIDS awareness programmes in their schools. Reports by Singh (2003:unnumbered) indicated that in the year 2000, more than 15 000 primary and secondary educators were trained in Life-skills. In addition, 5000 secondary

school-going children were trained as peer educators, 300 in care and support projects and 80 in counselling. Inter-sectoral collaboration meetings and workshops were held quarterly to monitor and evaluate the implementation of the programme (Singh, 2003:unnumbered).

2.4.1 Purpose of Life-skills and HIV/AIDS education programmes in South Africa

In the context of the HIV/AIDS pandemic, the overall purpose is to ensure access to appropriate prevention, care and support for young school-going children infected and affected by HIV/AIDS (Department of Education, 1999; Hickey *et al.*, 2003:22; Singh, 2003:unnumbered). Furthermore, Life-skills and HIV/AIDS education programmes can also have a positive impact on risk behaviour associated with self esteem, peer group norms, gender and cultural roles (Visser, 2005:205).

According to the Detroit public school Board of Education (2006:3), sexuality and HIV education can increase the understanding of abstinence as well as the legal, physical, emotional, social and economic consequences of early sexual activity among young school-going children. Life-skills programmes can also reduce the rate of teenage pregnancies, which normally leads to school dropouts (James *et al.*, 2006:281).

2.4.2 Implementation of Life-skills and HIV/AIDS education in schools: the challenges

The findings of an evaluation done in schools on the impact of Life-skills and HIV/AIDS indicate that most young school-going children are learning about HIV/AIDS in their schools. It was however highlighted that the programme lacked the ability to completely change sexual behaviour of young-school going children (see also, Kirby *et al.*, 2005:38; LoveLife, 2003:105-122; James *et al.*, 2006:292; Visser, 2005:203).

In KwaZulu-Natal, the programme has shown no corresponding improvement in sexual behaviour of learners in terms of condom usage (James *et al.*, 2006:292). Mantell *et al.* (2006:113-122) reported an increase in the number of sexual partners

among the age group 14-18 years and that abstinence is very low among young school going-children.

The programme also fails to equip learners with skills on how to resist peer pressure and being able to discuss sexual issues with their parents and partners (Reddy *et al.*, 2005:33). The majority of female secondary learners still believe that males have more control in a relationship, including making decisions with regards to sexual issues (Harrison *et al.*, 2001:76; Nyawo *et al.*, 2006:10).

There are still many challenges in the implementation of Life-skills and HIV/AIDS education at the school level. Firstly, the programme has not been implemented in some schools as planned due to organisational problems (Visser, 2005:203). This has been because health programmes are sometimes not regarded as important interventions by some communities (Varga & Shongwe, 1999:3).

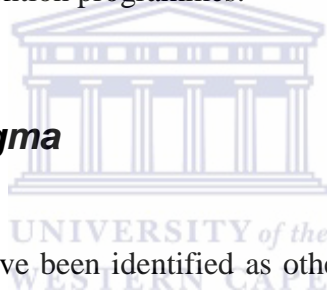
Another problem lies in how Life-skills education is actually delivered by teachers to the learners since the teaching methods of the Life-skills and HIV/AIDS education are totally different from the day-to day teaching (Paxton, 2002:282). Sometime it can be as difficult for a teacher to discuss sexual issues with learners as it might be for parents while a similar problem was observed among teachers in KwaZulu-Natal (see James *et al.*, 2006:292). It is therefore important for the school management, parents and learners themselves to provide moral support to teachers who are teaching such education programmes (Reddy *et al.*, 2005:32). In addition, the schools should also provide the relevant material required to make it easy to deliver such programme to learners.

The HIV/AIDS crisis requires a multisectoral approach from all. Varga and Shongwe (1999:20) report that in other areas there is no continuity of these programmes outside the school. In that matter the health department suggested that the whole programme must involve everybody including community members, non-governmental organisations (NGOs) and Faith Based Organisations (FBOs) working on HIV/AIDS programmes (National HIV/AIDS Strategic Plan, 2000 & 2007). In many African families and communities it is still very difficult to talk openly about sex, and some elderly people still assume that teaching the young generation about sex will actually

promote early practices (Aggleton & Warwick, 2005:265; Sarthiparsad & Taylor, 2006:131). Among young children the greater knowledge of HIV/AIDS has been associated with a more open family communication with their parents (Ramirez *et al.* 2002:37), and it is therefore important to involve parents and other elderly community members in such programmes. Sarthiparsad and Taylor (2006:131) also view parent participation as the best approach that may encourage openness between parents and children in discussions involving sexual matters.

Recent data from the Association of School Attendance and HIV/AIDS in 36 Sub-Saharan countries including rural South Africa showed that young children from rural areas, who attend school, are at a lower risk of HIV infection than those who do not attend (Hargreaves *et al.*, 2008:113-119). They further suggest that it is very important to encourage young children to attend school so that they gain knowledge of different HIV/AIDS intervention programmes.

2.5 HIV/AIDS and stigma



Stigma and discrimination have been identified as other factors that have a negative effect in the control and prevention of HIV/AIDS around the world (Cao *et al.*, 2006:518). Stigma related to medical conditions is greatest when the condition is associated with the individual's behaviour or when the cause of the condition is viewed as the responsibility of the individual (Strydom, 2003:59-58).

In many countries, stigma associated with HIV/AIDS has resulted in the limitation of promoting condom usage, HIV testing, quality of care and treatment provided to HIV-positive patients (Brown *et al.*, 2003:49-51; Skinner & Mfecane, 2004:7; Holzemer & Uys, 2004:165). Stigma and discrimination regarding HIV/AIDS has been reported in workplaces, churches, secondary and primary schools, among university students and, within the community with the worst being experienced in rural areas (Meintjes & Khuzwayo, 2007:3; Skinner & Mfecane, 2004:160; Shisana *et al.*, 2005:93).

Young children who have lost their parents or family member because of HIV/AIDS are likely to experience stigma and discrimination at schools and in their communities

(Skinner & Mfecane, 2004:160). The stigma and discrimination in schools and pre-schools is even worse for those young children who are infected with HIV. An incident has been reported of a young boy who was not allowed to study at one of the schools in South Africa after his foster mother had disclosed his HIV status to the media (Stein, 2003:5). Stigma may also prevent these vulnerable children from receiving prevention programmes offered at schools as well as other resources aimed at reducing the spread of HIV/AIDS among young people (Skinner & Mfecane, 2004:160).

According to Meintjes and Khuzwayo (2007:3), causes of stigma may be related to the lack of knowledge about HIV/AIDS with regards to the ways of transmission mainly for fear of being infected. Furthermore, they also put forward that children who stigmatise those children with HIV/AIDS can adopt attitudes of parents and educators towards the pandemic and people living with HIV/AIDS. Nowadays, when young people die, there is usually gossip, rumours and assumptions in the neighbourhood about the cause of the death. Mchunu and Preston-Whyte (2005: unnumbered) also reported the same situation among the Okhahlamba communities. As a consequence, the negative impact of rumours and gossip about HIV/AIDS has the ability for HIV to be seen as a social danger that cannot be controlled (Stadler, 2003:360).

2.6 HIV/AIDS and culture

Education models aimed at the prevention of HIV/AIDS should also look at culture, beliefs and social explanation for sexual behaviour (Levine & Ross, 2002:4; Varga & Shongwe, 1999:29). According to Airhihenbuwa and Webster (2004:5), culture has been shown to have both positive and negative influences on health behaviours of different individuals. Cultural practices that promote a delay in the early onset of sexual activities and abstinence often have a positive effect on the prevention of HIV infection.

Male circumcision is regarded as cultural practice among other ethnic groups. In this regard, a recent report by UNAIDS (2007a:3) reveals that results from three

randomized controlled trials have provided evidence that male circumcision of high quality can reduce the risk of heterosexual acquired infection in men by 60%. This report was also challenged by some NGOs. In addition, Scott *et al.* (2005:304-113) suggest that it would be useful to reintroduce male circumcision as an additional HIV intervention within KwaZulu-Natal in the future since it had been abandoned before. The negative impact of culture is often shown on the African population in various ways. For instance, Varga (1997:56) state that in some places, having multiple partners is being regarded as one of the natural and traditional parts of African manhood. It is also accepted for older men to have sexual relations with much younger women (Ngcobo & Pillay, 2004:6). Both these practices make young children especially girls more vulnerable and this increases the risk of HIV infection.

Young people's sexual relationships also appear to be shaped by the social rules largely determined by gender (Mantell *et al.*, 2006:10). The focal point of gender lies on the prevention of HIV/AIDS (Seeley *et al.*, 2004:87). For instance, in both National HIV/AIDS Strategic Plans of the Republic of South Africa (National HIV/AIDS Strategic Plan 2000 and 2007) the ABC (Abstain, Be faithful and Condomise) prevention approach is the most effective method in reducing exposure to HIV infection. Gender inequalities might have a negative effect in this approach since many studies indicate the lack of sexual negotiating power among women (see Chernoff *et al.*, 2005:100; Pettifor *et al.*, 2004:2002; Seeley *et al.*, 2004:88; Strebel *et al.*, 2006:517).

Another challenge in the prevention of the pandemic is society's beliefs around HIV/AIDS issues. Some educated people still believe that they are not at risk of being HIV infected. Levine and Ross (2002:13-8) reported similar beliefs among university students. They also established that respondents believed that women, who have no power to negotiate on condom usage with their partners, are mainly those who are poor and mostly living in the rural areas (Levin & Ross, 2002:8). Religion appears to also have an effect on HIV/AIDS. Religious practices like abstinence before marriage and faithfulness between partners can also have a positive effect in the prevention of HIV infection if they are well practiced (Shisana *et al.*, 2005:2).

In South Africa most people especially in rural areas still believe that HIV/AIDS is caused by witchcraft (Ashfort, 2001:1-13; Kalichman & Simbayi, 2004:573; Stadler, 2003:157). Mchunu and Preston-White (2005:unnumbered) reported on the same beliefs in some areas of the Okhahlamba district. This might be due to the confusion about the nature and cause of HIV/AIDS. According to Stadler (2003:157), most elders in South Africa especially in rural areas still believe that traditional healers can cure HIV/AIDS. It is therefore important for the older generation to have sufficient and relevant knowledge of HIV/AIDS for them to pass it on to the younger generation.

2.7 Summary

Research has shown that Life-skills including HIV/AIDS and sex education offered in schools can have a positive effect in the prevention of HIV infection among young people, although most studies showed that there was very little change in the learner's sexual behaviour. In this regard, families, communities, peers and other social systems can have both a positive and negative influence on the sexual behaviour of young school-going children. It is therefore vital to implement intervention programmes aimed at reducing the danger of HIV infection especially among young people and also to increase the emphasis on the integration of culture, gender and beliefs that exist in the society. A better understanding of HIV/AIDS by all will reduce the negative effect of stigmatization and those affected and infected can live a normal and stress-free life. This will contribute positively to the growing generation to make informed choices about their lives.

The next chapter will discuss the methodology that was used to collect data in order to assess the level of HIV/AIDS knowledge amongst secondary school-going learners in the Bergville rural area in KwaZulu-Natal province. A policy framework on HIV/AIDS in schools and the socio-economic profile of the study area will also be provided.

CHAPTER 3 KNOWLEDGE OF HIV/AIDS AMONG YOUNG SCHOOL-GOING CHILDREN IN THE BERGVILLE RURAL DISTRICT: A RESEARCH METHODOLOGY

3.1 Introduction

Bergville is one of the rural areas of the KwaZulu-Natal province. Based on Census 2001, the estimated population is 137 525 and predominantly resident in a rural tribal area of which 85% are African.

3.2 Research Methodology

According to Leedy (1997:9), research methodology controls and dictates the acquisition of data and correlates it after acquisition and extracts meaningfulness from them. This chapter discusses the research design that was employed in this study. Two qualitative approaches, namely a questionnaire and an interview were utilised in the study, including a quantitative method. The chapter also focuses on the data analysis process used in this study as well as an in-depth justification on how and why each research method was conducted.

3.3 Qualitative and Quantitative research methods

Qualitative research is a broad term that encompasses a variety of approaches to interpretive research (Leedy, 1997:155). In addition, Babbie and Mouton (2001:74) state that qualitative methods are the best research methods that can be used in a study to capture the contextual, psychological and behavioural dimension of individuals. Using this method, the study sought to explore and interpret how secondary school-going children and teachers in Bergville perceive the whole issue of HIV/AIDS. Furthermore, the method also allowed the researcher to assess the level of HIV/AIDS

knowledge amongst these children, including their perception about sexual behaviour and attitudes towards the use of condoms and people living with HIV/AIDS. A quantitative method was employed to select a sample and also applied for chi-square test and calculation purposes.

3.4 Data collection instrument

Data collection refers to a wide range of techniques, instruments and approaches used in a study to gather information in order to achieve the study's objectives and questions. In this study, the method of data collection involves the use of questionnaires and qualitative interviews.

3.4.1 Questionnaires and Interviews

The primary data were collected using a structured survey questionnaire consisting of both open and closed ended questions for learners. Face to face interviews were conducted for teachers and principals. The questionnaire allowed the respondents to have enough time to think about the questions in the questionnaire. The first section of the questionnaire entailed questions on the demographic profile, e.g. age, gender, grades, religion, culture etc. The second part consisted of close-ended questions with pre-coded answering categories of “yes” or “no”, and questions with Likert scale application. The questionnaire concluded with open-ended questions.

The advantage of using open-ended questions is to allow the respondents to express their ideas and thoughts freely (Oppenheim, 1992:112). In this study, open-ended questions allowed the learners to reveal their perceptions about HIV/AIDS, i.e. knowledge about the disease, transmission, prevention of HIV/AIDS, attitudes towards people living with HIV/AIDS and decision making about sexual behaviour. The questions were designed and written in a manner that all learners were able to follow and understand.

A set of questions were prepared and used for interviews with teachers and the principals. Brynard and Hanekom (1997:32) state that employing the interviewing

method to collect data allows the researcher to explain in detail matters that are not clear to the respondents. Interviews are also used when one needs to ask more open-ended questions that will allow the respondents to say more on the matter openly (Oppenheim, 1992:81). In this study, interviews were used to give a prepared explanation of the purpose of the study to the principals and teachers. Open-ended questions were used throughout the interviewing session to allow the respondents to elaborate more on the topic of questions by giving their own personal views. The teachers and principals were also interviewed to investigate the management of HIV/AIDS in public schools, and to assess the learners' general sexual behaviour and their response to HIV/AIDS education.

3.5 Data collection process

3.5.1 Time and Setting

The study was conducted at two schools and the data was collected during the first quarter of the school term taking into consideration the mid year examination. For the sake of confidentiality for the researcher and the participating schools, permission to conduct the study was requested beforehand from the District Manager outlining the purpose of the study and its relevance to education. The letter (in Appendix D) also indicated the approximate time the researcher would require for the participants to respond to the questionnaire. A final meeting between the researcher and the District Manager was held to finalise the preparation prior to data collection. A copy of the questionnaire (in Appendix A) was submitted to the District Manager and filed for record purposes together with all other correspondence. The District Manager communicated with the principals of the selected schools requesting their participation and assistance for the researcher to conduct a study at their schools.

At each school, the researcher also had a brief meeting with the principal explaining the purpose of the study, outlining the method to be employed to collect data from the learners. The principals were also given a copy of the questionnaire during the meeting for more clarification as well for the school record. The researcher also gave an assurance of the confidentiality of any data obtained to the District Manager, principal, teachers and learners. For this type of study, the confidentiality will apply to

the responses of the learners, principals and teachers including their names and those of their schools (see Appendix C & D). The principals introduced the researcher to the Life-Orientation teachers who were requested to assist during the study.

The learners were randomly selected in each grade during the Life-Orientation lesson, which took approximately 10 days to complete. On the tenth day, all the randomly selected participants were accommodated in each school hall and the researcher explained the purpose of the study and the questionnaire was handed out to the learners to read through them first. They were also given a chance to bring up any queries regarding the questions. The learners were allowed to answer the questions under the supervision of the researcher and Life Orientation teachers. The interview session for teachers also took place during those two weeks and was conducted by the researcher on the school premises.

3.5.2 Sampling

For data collection purposes and analysis, a well-defined sampling technique had to be identified. Leedy (1997:211) defines sampling as the process of selecting a part from a larger group that will represent the total group. According to Bryman and Cramer (1995:99), sampling can simply be defined as the method that is used during the selection of participants in order to avoid bias. Brynard and Hanekom (1997:44) and Leedy (1997:212) also emphasized that a sample needs to be carefully selected so that it represents accurately the group that is being studied.

The study design applied a stratified random sampling approach to ensure that the selected sample from school-going learners was proportionally representative of the study population. The two schools selected for sampling purposes were schools A and B. The population of each school was stratified into grades 8, 9, 10, 11 and 12. A sample size of 100 participants from both schools was required to participate in the study (see table 3.1). Table 3.1 shows the number of participants and the proportional random sample for each grade in the two schools.

A proportional allocation formula was used to calculate the sample size for each school (Bryman & Cramer, 1995:103-104; Leedy, 1997:216). For school A, 54

learners were required to participate in the study and 46 for school B. A similar approach was followed to determine the number of participants in each grade. Once these numbers were known a simple random selection method was used to select the participants. All learners in a particular grade had to randomly pick a piece of paper with a number on it from a jar. The numbers ranged from 1 to N for that particular grade (see table 3.1). After each learner had picked and identified his/her number, another set of numbers was placed in a second jar with a number 1 to N again. The teacher without looking was then asked to pick out one folded piece of paper with a number on it. The learner with the corresponding number was identified and recorded for participation in the study. This procedure was repeated for each of grades 8-12 in each school until the required numbers of participants (n) for each of the grades were reached.

Table 3.1: *Proportional stratified random sample of secondary school learners.*

Grades	School A		School B	
	Population N	Sample n	Population N	Sample n
Grade 8	46	7	36	6
Grade 9	61	10	37	6
Grade 10	93	15	70	11
Grade 11	61	10	79	13
Grade 12	73	12	68	11
TOTAL	334	54	290	46

The study also applies a purposive sampling framework for interviews with the teachers. Nine teachers and principals of the selected schools who were present during the time of the study were interviewed in a one-on-one session.

3.6 Data Preparation

The preparation stage of data analysis involves devising a good framework in which to produce data so that they provide a fair summary of what has been studied and can be analysed readily to answer the researcher's questions (Sapsford & Jupp, 1996:162). After the completion of data collection, the data was captured and arranged using a Microsoft Access programme. This was done by organising and arranging the data into the following categories: age, gender, grade, language, and family orientation and also identifying if there was any missing data. The captured data was analysed further using a Statistical Programme for Social Scientist (SPSS) application. The data obtained from open-ended questions for learners and interviews with the teachers were analysed through content analysis method.

3.7 Descriptive Background and context

3.7.1 Geographic and Demographic profile of Bergville Rural District



An estimated 60% of the population of KwaZulu-Natal province resides in rural areas (Taylor *et al.*, 2003:1), and Bergville, the focus area of the study, is one of these relatively isolated rural areas in the province. The University of KwaZulu-Natal Centre for HIV/AIDS Networking reports that the skills training available in major urban areas, are inaccessible to most of the people in rural areas and this has a negative impact on initiatives aimed at increasing the HIV/AIDS knowledge and awareness programmes (www.hivan.org.za). This is because HIV/AIDS intervention messages are mostly conveyed to the public in diverse ways, such as television, radio, newspapers or magazines which might be inaccessible to many in rural households (Parker, 2003:10). In addition, Bradshaw *et al.* (2004:144) reported that the youths living in rural areas have the lowest knowledge of HIV/AIDS compared to those that live in urban areas. It is therefore in this regard that the knowledge levels of HIV/AIDS among secondary school-going children in Bergville area have been explored in this study.

Bergville area is located in the Southern Drakensberg within the Okhahlamba Local Municipality of the UThukela district. According to the Integrated Development Plan of the Okhahlamba Local Municipality 2006/7 (in Gumede, 2006:3-6), it has a relatively small population (about 1.5 % of KwaZulu-Natal's total population) and is dominated by youths under the age of 34 years. The most common spoken language is IsiZulu and only 4% of the people speak other languages. Like in most rural areas of South Africa, the unemployment rate is relatively high and most of the employed are unskilled labourers while a third is semi-skilled. The district has one hospital, four clinics and 22 mobile clinics (Gumede, 2006:27).

3.7.2 National policy on HIV/AIDS for learners and educators in public schools (NATIONAL EDUCATION POLICY ACT, 1996 (NO.27 OF 1996))

According to the Department of Education (1996), the main purpose of this policy is to prevent the spread of HIV infection among learners and educators in public schools. Furthermore, to develop knowledge, skills, values and attitudes that may shape the behaviour that will protect them from HIV infection, and to support those who are infected and affected. The policy serves as a framework and guidelines for development of school policies and strategic plan for implementation (see the full annexure of the policy in Appendix E).

3.8 Summary

Qualitative research has the ability to provide information on how people perceive a given research topic. It was an appropriate method to be employed in this study to assess the knowledge of HIV/AIDS amongst secondary school-going learners. It also helps to determine the level of communication between the younger and older generation on HIV/AIDS and sex issues. A quantitative method helps to investigate the effect of social values like culture, religion, gender inequalities in sexual behaviour and knowledge of HIV/AIDS of learners. A stratified random sampling and proportional allocation were the most appropriate statistical methods to estimate and select the learners who were to participate in the study. It also helps to ensure the equalization level for each grade per participating school.

The presentation and discussion of results as well as the detailed summary of the research findings is presented in the next chapter.



CHAPTER 4 PRESENTATION AND ANALYSIS OF RESULTS

4.1 Introduction

In general, data analysis is a process of looking and interpreting the data in such a manner to produce useful information and develop conclusions based on that particular study. According to Sapsford & Jupp (1996:153) data analysis can be defined as the process of transforming 'raw' data into variables that can be analysed to produce information found in the results section of such study. This chapter presents and discusses the findings regarding the responses about the information on the knowledge of HIV/AIDS for the secondary school learners and teachers in Bergville rural district. A set of questions (see Appendix A for the full learner's questionnaire) on the knowledge of HIV/AIDS were posed from the learners in order to measure their level of knowledge of HIV/AIDS.

The questions were constructed to include how informed the learners are about HIV/AIDS in general. Other questions in the questionnaire include modes of transmission, the appropriate ways of prevention, testing and treatment of HIV/AIDS and assessment of learner's attitudes towards people living with HIV/AIDS. Also to determine if learners and parents do communicate on matters related to learner's sexuality and HIV/AIDS. Moreover, also to examine the effect of gender, religion and culture in the education development of young children about HIV/AIDS. A qualitative analysis was used to support the findings from the quantitative analysis and to explore the knowledge of learners in rural areas. Lastly, qualitative interviews were conducted with teachers to investigate the management of HIV/AIDS in schools (see Appendix B for teacher's interview questions). In the presentation of the findings, quantitative (in sections 4.3 to 4.5) analysis on knowledge of the learners will be discussed first followed by the qualitative (in sections 4.6 to 4.11) analysis including the teacher's responses.

4.2 Socio-demographic details of the learners

The participants in this study were secondary school learners who were enrolled in grades 8 – 12, and were between the ages of 13 and 20 years. In total, there were 100 participants of which 48 were males and the other 52 being females. All participants indicated that Zulu was the language of communication at home and few others indicated a combination with other languages. Of all participants, 75% of the total participants live with their parents while the other 25% live either with their guardians, relatives or others. Seventy one percent of the participants indicated that they attend church and 29% indicated they did not. On whether they attend any cultural activities that promote HIV/AIDS awareness, the majority (66%) indicated that they do not while 34% attended.

4.2.1 Sources of HIV/AIDS information

The learners were asked to specify their source of information in relation to where they learned about HIV/AIDS. Of all participants, 99 respondents indicated combinations of school (89%), television (60%), radio (54%), magazines (44%), parents (43%) and friends (17%) as their sources. Only 1 participant did not respond. The participants were allowed to specify more than one source for the latter question.

4.3 Knowledge of HIV/AIDS

The analysis of the results presented was based on a total sample of 100 participants. Where less than 100 participants responded to a given question, the exact numbers were reported. To test the knowledge of the learners, questions 1 to 16 of section II (refer to Appendix A) were used. Questions 1 to 7 of section II and questions 13 and 16(ii) of section II were used to test whether their level of HIV/AIDS knowledge, including their sexual behaviour, were associated with gender, culture and religion. In addition questions 14, 15 and 16 (i) were used also for quantitative analysis. Questions 8, 10, 11 and 12 were used for qualitative purposes. The statistically analysed results (quantitatively) are presented and discussed in Tables 4.1 - 4.10. To test whether the level of knowledge of HIV/AIDS including sexual behaviour of

learners were associated with their gender, culture or religion, the Fisher Exact Test was used whereby if the p-value is found to be less than 0.05, the association will be considered significant (Field, 2005:25). In this study, only the p-value for associations that are significant will be discussed, i.e. p-value < 0.05. The follow-up findings and discussions will be such that the question asked is indicated and discussed using various subheadings, e.g. gender, religion, culture, etc.

4.3.1 Can school children get HIV?

(i) Gender

Of the 100 respondents, 48 were male learners and 52 were females. Of the male respondents, 44 (91.7% of the male total) agreed that school children can get HIV and 4 (8.3% of the male total) disagreed. Of the female respondents, 49 (94.2% of the female total) agreed that school children can get HIV while only 3 (5.8% of the female total) disagreed with the statement. In summary, 93% of the respondents (both females and males) agreed that school-going children can get HIV, and only 7% disagreed.

(ii) Religion

Seventy one percent of the total respondents indicated that they attend church and 29% did not attend church. Of those attending church, 65 (91.5% of the total of those attending church) agreed that school children can get HIV and 6 (8.5% of the total of those attending church) disagreed. For those who do not attend church only 1 learner disagreed with the statement while the other 28 (96.6% of the total of those not attending church) agreed.

(iii) Culture

Only 34 of the 100 respondents attend cultural activities and the other 66 do not attend. Of those attending cultural activities, 29 (85.3%) agreed that school children can get HIV and 5 (14.7% of the total of those attending cultural activities) disagreed. For those who do not attend any cultural activities, 64 (97% of the total of those not attending cultural activities) agreed to the statement while only 2 (3.0% of the total of those not attending cultural activities) disagreed. The p-value=0.04, indicates that

there is a significant correlation between attending cultural activities that promotes HIV awareness and knowledge on whether school children can get HIV

Table 4.1: *Can school children get HIV?*

		Yes	No	p-values
Gender	Male	44(91.7%)	4(8.3%)	0.46
	Female	49(94.2%)	3(5.8%)	
Religion	Attending church	65(91.5%)	6(8.5%)	0.34
	Not attending church	28(96.6%)	1(3.4%)	
Culture	Attending cultural activities	29(85.3%)	5(14.7%)	0.04
	Not attending cultural activities	64(97.0%)	2(3.0%)	

(iv) Conclusion

In summary, the majority (93%) of learners are aware that no one is immune to HIV, even school children can become infected. On the contrary, Levin and Ross (2002:13) reported that the majority of university students thought being educated make them invulnerable to HIV infection. No significant differences were found between those learners attending church and those who do not, and also between males and females.

Culture showed a significant difference between the knowledge of learners who attend cultural activities and those who do not. The learners who do not attend cultural activities were 5½ times more likely to think that they are vulnerable to HIV infection than those who attend cultural activities.

4.3.2 Can one get HIV/AIDS by attending school with a child who is infected with HIV?

(i) Gender

Of the male participants, only 2 (4.2% of the total male respondents) think that one can get HIV by attending school with an HIV infected child and 46 (95.8%) disagreed. Of the female participants, 2 (3.8% of the total female respondents) agreed with the statement while a massive 50 (96.2%) disagreed.

(ii) Religion

Only 2 (2.8% of the total of those who attend church) agreed that one can get HIV/AIDS by attending school with a child who is infected with HIV and the remaining 69 (97.2%) disagreed. Of those who do not attend church, only 2 (6.9% of the total) agreed and the other 27 (93.1%) disagreed with the statement.

(iii) Culture

Only 3 (8.8% of the total of those attended cultural activities) agreed that one can get HIV/AIDS by attending a school with a child who is infected with HIV and the other 31 (91.2%) disagreed. From those who do not attend cultural activities, only 1 (1.5%) agreed and the majority of 65 (98.5% of the total of those attending cultural activities) disagreed with the statement.

Table 4.2: *Can one get HIV/AIDS by attending school with a child who is infected with HIV?*

		Yes	No	p-values
Gender	Male	2(4.2%)	46(95.8%)	0.66
	Female	2(3.8%)	50(96.2%)	
Religion	Attending church	2(2.8%)	69(97.2%)	0.33
	Not attending church	2(6.9%)	27(93.1%)	
Culture	Attending cultural activities	3(8.8%)	31(91.2%)	0.11
	Not attending cultural activities	1(1.5%)	65(98.5%)	

(iv) Conclusion

Based on the results, most of the learners (96%) have adequate knowledge about the modes of HIV/AIDS transmission. The learners agreed that by attending school with someone who is HIV infected is by no means an automatic risk of transmission. There were no significant differences between sexes. There were also no significant differences between those learners attending cultural activities and church and those who do not with regard to the knowledge on the modes of HIV transmission.

4.3.3 Can one get HIV/AIDS by sharing the same toilet seat, spoons and plates with someone who is infected with HIV?

All respondents agreed that by sharing toilet seats, spoons and plates with people who are infected with HIV has no effect in HIV/AIDS transmission.

Table 4.3: *Can one get HIV/AIDS by sharing the same toilet seat, spoons and plates with someone who is infected?*

		Yes	No
Gender	Male	48 (100%)	0
	Female	52 (100%)	0
Religion	Attending church	71 (100%)	0
	Not attending church	29 (100%)	0
Culture	Attending cultural activities	34 (100%)	0
	Not attending cultural activities	66 (100%)	0

4.3.4 Does taking an HIV test the only way that one can determine if someone is infected?

(i) Gender

Of the male respondents 25 (52.1% of the male total) agreed that an HIV test is the only way to determine if one is infected and the remaining 23 (47.9%) disagreed. From the female respondents, 31 (59.6% of the total female) agreed and the other 21 (40.4%) disagreed.

(ii) Religion

Of those who indicated attending church, 41 (57.7%) agreed that taking an HIV test is the only way that one can determine if someone has been infected and the other 30 (42.3%) disagreed. From those who do not attend church, 15 (51.7% of the total) agreed to the statement and the remaining 14 (48.3%) disagreed.

(iii) Culture

Among those who attend cultural activities, 20 (58.8%) agreed that taking an HIV test is the only way that one can determine if someone has it or not, but 14 (41.2%) disagreed. From those who do not attend cultural activities, 36 (54.5% of the total) agreed with the statement and the remaining 30 (45.5%) disagreed.

Table 4.4: *Does taking an HIV test the only way that one can determine if someone is infected?*

		Yes	No	p-values
Gender	Male	25(52.1%)	23(47.9%)	0.29
	Female	31(59.6%)	21(40.4%)	
Religion	Attending church	41(57.7%)	30(42.3%)	0.37
	Not attending church	15(51.7%)	14(48.3%)	
Culture	Attending cultural activities	20(58.8%)	14(41.2%)	0.42
	Not attending cultural activities	36(54.5%)	30(45.5%)	

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(iv) Conclusion

In total, only 56% of the respondents agreed that an HIV test is the only way to determine if someone is HIV infected or not. The results pose a serious problem on the issue of testing. Knowing your status is important, and by taking an HIV test is currently the only known method. The statistical test showed no significant differences between the knowledge on HIV testing of those learners attending church and cultural activities that teach about HIV/AIDS and those who do not. No significant differences were found between male and female learners.

4.3.5 Do condoms prevent HIV?

(i) Gender

Of the male learners, 45 (93.8% of the total) agreed that condoms do prevent HIV and only 3 (6.2%) disagreed. Of the female learners, 46 (88.5% of the total) agreed on the statement while 6 (11.5%) disagreed.

(ii) Religion

Of those who attend church, 63(88.7% of the total) agreed that condoms prevent HIV and the remaining 8 (11.3%) disagreed. Of those who do not attend church 28 (96.6% of the total) agreed and only 1 (3.4%) disagreed.

(iii) Culture

Of those who attend cultural activities, 32 (94.1% of the total) agreed that condoms prevent HIV and the other 2 (5.9%) disagreed. Of those who do not attend cultural activities, 59 (89.4% of the total) agreed and the remaining 7 (10.6%) disagreed.

Table 4.5: *Do condoms prevent HIV/AIDS?*

		Yes	No	p-values
Gender	Male	45(93.8%)	3(6.2%)	0.29
	Female	46(88.5%)	6(11.5%)	
Religion	Attending church	63(88.7%)	8(11.3%)	0.20
	Not attending church	28(96.6%)	1(3.4%)	
Culture	Attending cultural activities	32(94.1%)	2(5.9%)	0.35
	Not attending cultural activities	59(89.4%)	7(10.6%)	

(iv) Conclusion

The majority of the learners (91% of the participants) know that condoms prevent HIV. The issue around the condom usage involves gender inequalities. However the findings showed that the level of knowledge about condom use in both genders was more or less similar. There were no significant differences between those learners attending church and cultural activities and those who do not with regard to the knowledge of condoms usage.

4.3.6 If your friend tells you that he/she is HIV infected would he/she be still your friend?

(i) Gender

Of the male learners, 47 (97.9% of the male total) agreed that an infected friend would always be a friend and only 1 (2.1%) disagreed. For the female learners, 51 (98.1% of the female total) agreed while only 1 (1.9%) disagreed.

(ii) Religion

Of those who attend church, 69 (97.2%) agreed that they will still be friends with an HIV infected friend and only 2 (2.8%) disagreed. All respondents who do not attend church agreed with the statement.

(iii) Culture

From those attending cultural activities, 32 (94.1% of the total) agreed that they will keep their friends who are infected with HIV and only 2 (5.9%) disagreed. Again, all the respondents who do not attend cultural activities agreed with the statement.

Table 4.6: *If your friend tells you that he/she is HIV infected would she/he still be your friend?*

		Yes	No	p-values
Gender	Male	47(97.9%)	1(2.1%)	0.73
	Female	51(98.1%)	1 (1.9%)	
Religion	Attending church	69(97.2%)	2(2.8%)	0.50
	Not attending church	29(100%)	0	
Culture	Attending cultural activities	32(94.1%)	2(5.9%)	0.11
	Not attending cultural activities	66(100%)	0	

(iv) Conclusion

The above question was used to assess the learner's attitudes towards people living with HIV/AIDS. These attitudes are used to indicate the stigma that is related to HIV/AIDS amongst the learners. Almost all the learners (98%) indicated a positive

attitude towards people who are living with HIV. Contrary, a report by Preston-Whyte and Mchunu (2005:unnumbered) revealed a high level of negative attitudes among communities in Okhahlamba. It can be recalled that the Bergville rural district forms part of this community. The current research findings can thus be a sign that things are changing in rural areas, as no significant differences were found between the attitude of those learners who attend church and cultural activities and those who do not. There were also no significant differences in gender. In addition, all the respondents who reported not attending church or cultural activities indicated that they will keep their friends despite their HIV status.

4.3.7 There is no cure for HIV/AIDS at the moment.

(i) Gender

Of the male respondents, 35 (72.9% of the male total) agreed to the statement and the remaining 13 (27.1%) disagreed. From the female respondents, 42 (80.8% of the female total) agreed and the other 10 (19.2%) disagreed.

(ii) Religion

Of those attending church, 57 (80.3% of the total) agreed and the remaining 14 (19.7%) disagreed. From those who do not attend church 20 (69.0% of the total) agreed and the other 9 (31.0%) disagreed with the statement.

(iii) Culture

Of those who attend cultural activities, 24 (70.6% of the total) agreed that there is no cure for HIV/AIDS at the moment and the other 10 (29.4%) disagreed. From those who do not attend cultural activities, 53 (80.3% of the total) agreed and the other 13 (19.7%) disagreed with the statement.

(iv) Conclusion

In summary, the results indicate that although most learners (77%) know that there is no cure for HIV/AIDS, at the moment there is a need to expand the knowledge on this issue. The 23% who disagreed with the statement brings concerns to the accessibility of the relevant information and facts regarding access to care and treatment of HIV among the rural communities. No significant differences were found between those

learners attending church and cultural activities and those who do not with respect to the knowledge that HIV is incurable. There were also no significant differences between female and male learners.

Table 4.7: *There is no cure for HIV/AIDS at the moment.*

		Yes	No	p-values
Gender	Male	35(72.9%)	13(27.1%)	0.24
	Female	42(80.8%)	10(19.2%)	
Religion	Attending church	57(80.3%)	14(19.7%)	0.17
	Not attending church	20(69.0%)	9(31.0%)	
Culture	Attending cultural activities	24(70.6%)	10(29.4%)	0.20
	Not attending cultural activities	53(80.3%)	13(19.7%)	

4.3.8 What are the necessary steps to follow after you tested positive for HIV?

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Of the 100 participants, 99 responded to the question “Do you attend clinic for treatment”? Hence the results presented below will be representative of the 99 respondents.

(i) Gender

Of the 99 who responded, 48 were males and 51 females. From the male respondents, 31 (64.6% of the male total) agreed that one could attend a clinic for treatment after testing positive for HIV and the other 17 (35.4%) disagreed. Of the female respondents, 39 (76.5% of the total) agreed and the remaining 12 (23.5%) disagreed.

(ii) Religion

Out of 99 respondents, 71 indicated they do attend church and the remaining 28 did not. Of those attending church, 49 (69.0% of the total) agreed that one should attend a clinic after testing positive for HIV and the other 22 (31.0%) disagreed. From those

who do not attend church, 21 (75.0% of the total) agreed and the remaining 7 (25.0%) disagreed.

(iii) Culture

Out of 99 respondents, 33 indicated they do attend cultural activities that promote HIV awareness and the other 66 did not. Of those who attend cultural activities, 21 (63.6% of the total) agreed that one should attend a clinic after testing positive for HIV and the other 12(36.4%) disagreed. From those who do not attend cultural activities, 49 (74.2% of the total) agreed and the remaining 17 (25.8%) disagreed.

Table 4.8: *What are the necessary steps to follow after you tested positive for HIV?*

Do you attend a clinic for treatment?

		Yes	No	p-values
Gender	Male	31(64.6%)	17(35.4%)	0.14
	Female	39(76.5%)	12(23.5%)	
Religion	Attending church	49(69.0%)	22(31.0%)	0.32
	Not attending church	21(75.0%)	7(25.0%)	
Culture	Attending cultural activities	21(63.6%)	12(36.4%)	0.20
	Not attending cultural activities	49(74.2%)	17(25.8%)	

(iv) Conclusion

Although the majority of learners (70%) know that it is important to attend a clinic after testing positive for HIV, one would expect all the learners to be knowledgeable on the matter. The results require an urgent need about knowledge regarding treatment and management of HIV/AIDS. There were no significant differences between those learners attending church and cultural activities and those who do not with respect to knowledge on the treatment of HIV/AIDS. In addition, no differences were found between males and females.

4.3.9 Do you think you are at risk of contracting HIV?

Of the 100 participants, 95 responded to the above question, hence the results presented below will be representative of the 95 respondents.

(i) Gender

Of the 95 who responded, 44 were male respondents and 51 were females. From the male respondents, 17 (38.6% of the total) thought that they are at risk of contracting HIV and the other 27 (61.4%) thought they are not at risk. Of the female respondents, only 16 (31.4% of the total) thought that they are at risk while the other 35 (68.6%) did not.

(ii) Religion

Of the 95 respondents, 68 indicated they do attend church and the other 27 did not. Of those attending church, 21 (30.9% of the total) thought they are at risk of contracting HIV and the other 47 (69.1%) do not. Of those not attending church 12 (44.4% of the total) thought they are at risk of contracting HIV and the other 15 (55.6%) thought they are not at risk.

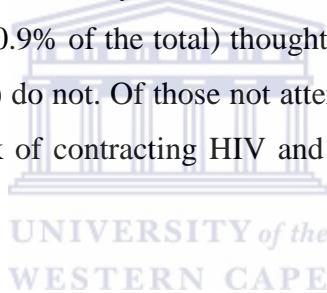


Table 4.9: *Do you think you are at risk of contracting HIV/AIDS?*

		Yes	No	p-values
Gender	Male	17(38.6%)	27(61.4%)	0.30
	Female	16(31.4%)	35(68.6%)	
Religion	Attending church	21(30.9%)	47(69.1%)	0.16
	Not attending church	12(44.4%)	15(55.6%)	
Culture	Attending cultural activities	11(34.4%)	21(65.6%)	0.57
	Not attending cultural activities	22(34.9%)	41(65.1%)	

(iii) Culture

Of the 95 respondents, 32 indicated they do attend cultural activities that promote HIV awareness and the other 63 did not. Of those attending cultural activities, 11

(34.4% of the total) agreed that they think they are at risk of contracting HIV and the other 21 (65.6%) disagreed. Of those not attending cultural activities, 22 (34.9% of the total) agreed that they think they are at risk of contracting HIV and the other 41 (65.1%) disagreed.

(iv) Conclusion

Most learners (65.3%) do not think they are at risk of contracting HIV compared to 34.7% of the total responded who thought they are. The average percentages of both male and female learners who thought they were at risk were more or less equal including those who thought they were not. No significant differences were found between those learners attending church and cultural activities and those who do not with regard to whether they were at risk of contracting HIV.

Furthermore, the participants were requested to substantiate their response on why they thought they are (/not) at risk of contracting HIV/AIDS. Of the 95 participants who responded, the most common reason the majority of learners indicated why they thought they are not at risk of contracting HIV was that they always practice safe sex by using condoms. Moreover, a few other participants below age 16 indicated not to be involved in sexual activities. Additionally, they stated that they were still very young to be involved in such practices. Another small group of learners stated that they were faithful to their partners. Others indicated to be well equipped with knowledge of HIV/AIDS prevention.

Of those who thought they are at risk, the majority clearly showed that they are already involved in sexual activities. Unprotected sexual practices and sometimes forgetting condoms are the most common reasons that the learners indicated as reasons they thought they are at high risk of contracting HIV/AIDS. Other learners thought that the condoms are not 100% safe and anything can happen if is not used properly. The majority of learners were also concerned about not knowing their partner's status, which might put them at high risk. These are some of the statements from the respondents expressing their concern regarding the risk of contracting HIV/AIDS:

A 17-year-old female learner *“I am faithful to my partner but I am not sure if my partner is also faithful to me and I do not even know his status”*.

An 18-year old female learner *“I am currently at a stage of not being able to control my feelings and I fail to protect myself”*.

Sexual abuse and violence by male partners were critical concerns amongst female learners. Furthermore, some thought a male who is infected with HIV might rape them. It is difficult for the learners to sometimes resist pressure from their peers. They thought that inappropriate knowledge about unsafe sexual behaviours from their peers also put them in high risk of infection. The issue of HIV being contracted through blood if one gets involved in an accident was also identified.

Based on the learner’s perceptions for being/not being at risk of contracting HIV, it can be concluded that abstinence is the least important way the learners thought could be a solution to the risk of contracting HIV. Similarly, Mantel *et al.* (2006:113) reported low level of abstinence among secondary school learners in KwaZulu-Natal.

4.3.10 Assessment of the level of the knowledge of HIV/AIDS amongst the learners

The researcher used questions 1 to 7 of section 2 and 16(ii) to assess the scores of each learner. Each question was allocated a 1-point for the correct response and 0 for the incorrect response. Based on the 8 questions, the learner’s scores were evaluated and the results are presented in Table 4.10 below. The scores were grouped into three categories; with those less than 5 out of total of 8 considered low-level, those of scores 5 and 6 moderate-level, and scores 7 and 8 of high-level.

The results clearly showed that the learners (65%) were well equipped with an appropriate knowledge of HIV/AIDS. Of a total of 100 learners, only 2 had results with low-level indication of knowledge of HIV/AIDS.

Table 4.10: Scores of the learners on the level of knowledge of HIV/AIDS.

Scores out of 8	Knowledge level	Number of learners
< 5	Low	2
5 & 6	Moderate	33
7 & 8	High	65
N		100

4.4 Voluntary testing and counselling (VCT)

Voluntary counselling and testing (VCT) has been regarded as a challenge globally. According to Strode *et al.* (2005:47), VCT has been seen as a secondary prevention strategy that helps HIV positive individuals and serodiscordant couples to reduce the risk of infecting others or re-infecting themselves.

In the follow-up discussions, the participants were asked to examine their knowledge about treatment and management of HIV/AIDS. Furthermore, to observe how accessible the voluntary counselling, testing, care and support services are to rural communities, especially the young school-going children. The main purpose was to investigate if the health information available was reaching all, including communities in rural areas.

4.4.1 If you were able to take HIV/AIDS test would you do so?

The majority (81%) of learners were willing to take an HIV test. This positive response shows that despite the notion about individuals being afraid to go for HIV tests, most young school-going children would not hesitate if the opportunity arises. This is a sign of positive developments in the fight against HIV/AIDS among communities residing in rural areas, especially young people.

4.4.2 Do you regularly attend a clinic to test for HIV/AIDS?

At least 68% of the learners indicated that they always undertake an HIV test while 32% never had before. This results in a combination of the preceding findings (section 4.4.1 above); the above difference of more than 10% shows that there is shortage of testing places in rural areas. The researcher could not foresee the outcome beforehand as it would have added more information if participants were requested to elaborate more on this issue.

4.5 Management and treatment of HIV/AIDS

4.5.1 What are the necessary steps to follow after you tested positive for HIV?

This question was used to assess the possibility if participants would be willing to disclose their status if they tested positive for HIV.

The responses were to the question “Do you discuss it with anyone?”

The majority (68%) of the learners indicated that they would feel free to discuss their HIV status. On the other hand, Gaede (2006:367) reported a very low level of disclosure among HIV positive women in rural KwaZulu-Natal. The fear of disclosing among people who are infected might lead to silence about HIV/AIDS. Recent findings by Simbayi *et al.* (2007: 1829) reveals that people who have disclosed their status are still experiencing discrimination within communities. Furthermore, young learners in KwaZulu-Natal were also discriminated against by other children in school (Meintjies & Khuzwayo, 2007:3). Although the results show that people including rural communities are now starting to understand and accept the importance of living openly with the HIV status, more emphasis on disclosure is needed, as this will teach the communities on how to manage this pandemic.

4.6 Qualitative analysis

4.6.1 Do you understand what HIV/AIDS is?

The question was used to explore the learner's perceptions of HIV/AIDS and also to enable the researcher to have a deeper insight into the knowledge of the learners. Some of the statements reported by the learners that are of concern are:

An 18-year-old female learner *"HIV/AIDS mostly affect women in South Africa, because women fail to say no to sex, they never refuse to do sex"*

An 18-year-old male learner *"Be safe because ARV's are not cheap and we do not know how to get them"*

The majority of learners define HIV/AIDS as Human Immune Deficiency virus and AIDS as Acquired Immune Deficiency Syndrome. Furthermore, the learners are aware of the health and physical effect HIV has on the human body. The above responses indicate the inclusion of HIV/AIDS education in the curriculum and also reveal that schools in deep rural areas provide such lessons to their learners. There were very few learners who indicated that there is no cure for HIV/AIDS. The learners were aware that HIV/AIDS is transmitted through unprotected sexual activities and blood. The learners perceive HIV/AIDS as everybody's problem whether young or old, poor or rich. HIV/AIDS is also seen as a very dangerous disease that kills people. The learners do not have a good understanding on the treatment of HIV/AIDS, including the role of antiretrovirals (ARV's). Furthermore, the department of health's messages on knowledge regarding the availability of the antiretroviral pills in clinics and hospitals appear not to be reaching the rural communities. Most female learners think women are more vulnerable to HIV/AIDS because they lack negotiation skills about sexual issues with their male partners.

In general, the learners perceive HIV/AIDS as both a medical and social problem. Lesser knowledge on the treatment of the disease is of concern among rural communities.

4.7 Strategies and methods of HIV prevention

4.7.1 What HIV/AIDS prevention methods do you know of?

This question was used to determine the learner's level of knowledge on the different methods of preventing HIV/AIDS. The question was also used to find out if the National Department of Health's ABC (Abstinence, Be Faithful and Condoms) campaigns do reach the communities residing in deep rural areas. The themes discussed below were the most significant responses of the learners related to the appropriate ways of prevention. The themes were further classified into groups of those who indicated ABC collectively or AB, AC, BC, A, B and C only. These classifications were used following the recent UNAIDS surveillance where the level of HIV/AIDS knowledge is assessed by looking at the percentage of young people aged 15-24 who correctly identify two ways of preventing the sexual transmission of HIV/AIDS, and of those who identified two misconceptions about HIV/AIDS (UNAIDS, 2008b:15). The participants of this study fall into this age group.

Table 4.11: *Categories of the ways of preventing HIV/AIDS: ABC campaign.*

Category of appropriate ways of Prevention	Number of learners	Percentage
Abstain, be faithful, condoms (ABC)	26	27.3%
Abstain, be faithful (AB)	1	1.1%
Abstain, condoms (AC)	23	24.2%
Be faithful, condoms (BC)	4	4.2%
Abstain (A)	2	2.1%
Be faithful (B)	1	1.1%
Condoms (C)	38	40.0%
N	95	100%

The table (4.11) indicates 95 participants who mentioned abstinence, be faithful and condoms as ways of preventing HIV/AIDS. Twenty-six learners (27.3%) were able to identify the ABC jointly as an appropriate way of preventing HIV/AIDS. Only 1 learner (1.1%) identified the combination of AB, while 23 learners (24.2%) mentioned AC and 4 learners (4.2%) identified BC. Other learners identified only one

method of prevention with 2 learners (2.1%) reported abstinence and 1 learner (1.1%) mentioned being faithful as the method. All the remaining 38 learners (40%) mentioned condoms alone as a method of preventing HIV.

Condoms are the most popular way of preventing HIV/AIDS among the majority of learners. Several other studies have reported an increase in awareness about the role of condoms as effective intervention in the reduction of HIV/AIDS, sexual transmitted infection and unintended pregnancy (Murphy *et al.*, 2006:1446; Setswe, 2007:5; Yotebieng *et al.*, 2009:16; Center for Disease Control and Prevention, 1996; Department of Health, 2003 & 2004). The high knowledge about the use of condoms as prevention strategy among the learners in rural Bergville might have a positive effect in reducing the risk of HIV transmission.

Similar to the findings discussed in subsection 4.3.9. (iv), the participants seems less aware of the combination of abstinence and being faithful (AB) as possible ways of HIV intervention. Setswe (2007:4-5) concluded that several studies demonstrated no evidence that abstinence and faithfulness interventions only had a positive effect in the HIV prevention strategy. In principle, abstinence should be the most effective way to prevent HIV transmission, sexual transmitted infections and unplanned pregnancies. Of all the respondents of this study, about half (52) of them mentioned abstinence in their responses.

Another minor group of learners were worried about being in contact with blood, not sharing razors and toothbrushes. They also mentioned that people need to wear plastic gloves all the time when touching someone else's blood. "*Go to the clinic if you are raped*" (14-year-old female respondent).

There is need to empower the learners about the necessary steps to follow after being sexually abused. Two learners emphasised change of behaviour among young people. Change of behaviour such as not engaging in unprotected sexual activities is a serious challenge that has a negative setback in the fight of HIV/AIDS. Furthermore, two female learners also stated that women with babies should not breastfeed when they are HIV infected.

Only a few learners identified some misconceptions about prevention of HIV/AIDS. There is confusion regarding the role of ARV's, though few learners stated that ARV's prevent HIV/AIDS. This brings concern because it indicates that communities residing in rural areas lack information about HIV/AIDS, including the role of ARV's. One male learner thought eating fresh vegetables and fruit or apples everyday prevents being infected.

The results reveal a high percentage of learners who correctly identified more than two ways of preventing HIV/AIDS and a very low percentage on misconception. It is very important that young learners are exposed to different strategies of preventing HIV infection.

4.8 Communication channels between young and older generation regarding HIV/AIDS and sexual issues.

4.8.1 Learners discussing HIV/AIDS with their parents

The above question was used to establish if the learners do initiate discussions on HIV/AIDS and sexual matters with their parents. The results showed that 68% of learners were very open in discussing in detail HIV/AIDS and sex issues with their parents. The majority of female learners started to discuss HIV with their parents on their first day of menstruation.

In summary, the majority of children asked their parents about the necessary steps to follow after being tested positive for HIV. Another common question was that, does HIV/AIDS really kill or is it just a disease that passes? The learners were curious to know from their parents about the origins of HIV/AIDS and how does it affect people. The learners prefer to hear from their parents about the right time to engage in sexual activities and how they can ensure that the virus does not infect them. The learners also wanted to know from their parents about how to treat and take care of those who are HIV infected. They were uncertain about the role of condom use among married couple. The majority of female learners were concerned about the effect of HIV on pregnancy and what to do. Also out of fear, some participants seemed to be concerned about the after-effects of being HIV positive, such as a 17-year-old male's response:

“I asked them if I am going to be their child again if I am HIV infected. If a member of the family contracts the HIV are we still going to be a family again”?

In addition, the learners indicated that they do share with their parents their knowledge of HIV/AIDS that they have learned from school. The learners also encouraged their parents not to discriminate against those who are HIV infected. Furthermore, the learners encourage their parent to take HIV tests regularly. It has been a usual occurrence amongst the communities in rural areas to use razors for traditional healings (known in the region as “ukugcaba”) and the learners advised their parents to always use a new blade each time they help a family member.

4.8.2 Learners who do not discuss HIV/AIDS issues with their parents

The remaining 32% of the learners indicated they not discuss HIV/AIDS and sexual issues with their parents due to various reasons. Few learners indicated that they do not spend most of their time with their parents while 25% do not live with their parents. Of those learners living with their parents, some indicated that their parents are always busy and others thought the discussions with their parents were not warranted as they are not infected or affected by HIV/AIDS.

The learners raised the negative effect of other cultural beliefs on HIV intervention strategies. According to cultural rules in some families, young generations are not allowed to discuss such issues as HIV/AIDS and sexual activities with their elders/parents. Hence the learners assume that discussing sexual activities and HIV/AIDS as being disrespectful to their parents. Below are some of the statements reported by the participants.

A 16 year old female: *“I am scared because they once asked me that why do I talk about the disease because there are many people who died because of HIV. They warned me not to ever talk to them about HIV”.*

An 18 year old male: *“It is hard for me to talk with my parents about entering manhood, if you try to start those kinds of stories they just ignore you pretending as if*

they did not hear what you were saying. This upsets me a lot and causes a stress on me trying to cope on my own”.

The other fear the participants raised was based on the assumptions that when they start discussing these issues with their parents, they will assume they are already sexual active and that has been causing problems for the learners. In addition, some participants blamed lack of education (school-type) from their parents as a reason not to discuss these issues. So the issue of HIV/AIDS problem is managed by them based on what they learn from school. Advice from a 17-year old female participant: *“Parents should never be afraid or embarrassed to talk to their children about sex and HIV. The children will never disrespect them and they will love you as parents for educating them and wanting to protect them”.*

4.9 Do your parents discuss HIV/AIDS with you?

This question was asked to examine if the parents initiate a dialogue on HIV and sexual issues with their children. It was further used to determine the communication relationship between older and younger generations on HIV/AIDS matters.

4.9.1 Parents discussing HIV/AIDS with their children

The results showed that 79% responded yes to the question of whether their parents discuss HIV/AIDS issues with them, however their explanation did not specifically point out that their parents do initiate such discussions. In general, parents were only telling their children about what to do regarding HIV/AIDS rather than discussing such matters with them.

Most female learners said their parents encouraged them to stay away from boys, and more interesting was specific mention of taxi drivers, security guards and old men to avoid. Furthermore, parents warned them that most males were not honest to their partners. The participants indicated that sexual activities will have negative effects on their studies hence they should avoid the temptation. In addition, the participants indicated that their parents advised them to be faithful in life and choose the right

friends, (this is also shown in section 4.2.1 where 17% of participants indicated that they learned about HIV/AIDS issues from friends). Some parents told their children about HIV prevention strategies. Furthermore, parents encouraged their children to seek treatment and always get tested to protect themselves. Also not to discriminate against those who are infected or affected by HIV/AIDS and for the learner not to be afraid to disclose their status to their parents who are always there for them.

Although most discussion was about appropriate knowledge, some learners mentioned some misconception from their parents. A few parents told their children that HIV only affects adult people. The parents kept on seeing HIV/AIDS as a disease for dirty people. Most learners revealed that their parents told them that HIV only kills. Among some parents, HIV/AIDS is still associated with homosexuality. A few parents advised their children that HIV/AIDS comes from gay persons and male learners should not be friends with a boy who show signs of being homosexual. The above misconceptions further revealed the need to involve the communities in a big way to educate and advance their knowledge on these issues.

4.9.2 Parents not discussing HIV/AIDS with their children

Twenty one percent (21%) of the children had never been asked about HIV/AIDS by their parents. The majority still do not understand the factors that prevent their parents to discuss sexual issues with their children. Children raised a point that most parents assume not discussing HIV/AIDS with their children is the only way to protect their children from being infected. Some participants were convinced that their parents do not have knowledge of HIV/AIDS as a result of not having formal education. Furthermore the parents were shy and embarrassed to discuss such issues in front of children. It is also very challenging for parents to ask their children about whether they are already having a relationship or not. Learners thought that most parents are aware that they have knowledge of HIV/AIDS because children always watch HIV/AIDS programmes. Other parents think their children are responsible for their own life and they do not see a need for them to teach their children about HIV/AIDS. According to a 17 year old female, *“My parents trust me and they know that I am not involved in sexual activities until I am 23 years old and I will not be involved in any relationship until I am 18”*.

4.10 Qualitative interviews with the teachers

A group of teachers of each of the two schools were asked a set of exploratory questions (see Appendix B for interview questions). In total, qualitative interviews were conducted with 4 teachers who were available from school A and 5 teachers from school B. The interviews were conducted in English. There were no specific criteria used for the teachers to participate but the researcher required to have at least one teacher from each school who teaches Life Orientation as a subject. The principals from both schools were not available for interviews due to other commitments. Each interview session lasted for 45 minutes to an hour. The interviews were recorded on audiovisual tapes and the researcher took notes. The researcher identified themes for each question. The themes were raised by at least 3 participants and are discussed below.

4.10.1 Management of HIV/AIDS in public schools in Bergville rural district

The development of HIV/AIDS policy in schools is an initial step in strengthening the HIV interventions for educators and learners. It also serves as a guideline that protects those who are infected from discrimination; therefore it is very important that each school has one.

In both schools, the teachers indicated that a policy does exist in their school, but two stated that they heard of the policy but have never seen a copy and as a result do not know what it entails. Of the teachers who indicated to know about the policy, said it entails the prevention of HIV/AIDS transmission, education on HIV/AIDS, principles of HIV/AIDS, promotion of a safe school environment, accepting and supporting those who were infected and affected by HIV/AIDS and to respect their privacy. Hence the policies in both schools are in line with the national department of education HIV/AIDS policy for schools.

In both schools, the learners learn about HIV/AIDS during the Life Orientation and Life Sciences sessions. The majority of the teachers felt that it is a very serious challenge for them to discuss HIV/AIDS and sexual issues with the learners. They

highlighted that the environment is not suitable for the teachers to discuss such matters. Sometimes the teachers were not even sure where to start mentioning the word 'sex' to young school learners. The teachers seem to be worried how the children will respond and think of them afterwards, given the rural environment in which they teach. The teachers indicated that other learners and teachers still regard HIV/AIDS as a disgrace. Similarly James *et al.* (2006:293) reported lack of skills to discuss sexual issues among teachers in KwaZulu-Natal as a critical challenge in the implementation of Life-skills programmes.

It was therefore not surprising that of all teacher participants, the two Life Skills educators were the only ones who felt comfortable to discuss sexual issues with the learners. Furthermore, they stated that learners were willing to talk about such issues and they sometimes confront them if they have problems. This could indicate why other teachers who are not teaching Life skills have difficulties in discussing such issues with learners.

One educator stated that, *"HIV/AIDS is something that I have never seen and I never have a friend or close family member who have suffered from HIV/AIDS"*. For a learner to think in this manner would be regarded as something that could be fixed in time, but for an educator it was very unfortunate. This statement further agrees with the study reported by Levine and Ross (2002:8) about university students. In rural communities, an educator is regarded as learners' parent/guardian and it is important that they are knowledgeable about the issues that could have a negative effect on the future of the learners.

All the teachers indicated a high rate of pregnancy among young school learners. The teachers were very much concerned about the matter as illustrated by the following statements:

"High rate of pregnancy might be a sign that the learners are not well educated about HIV/AIDS because if they are clear, they will practice safe sex or not having sex to avoid pregnancy and sexually transmitted infection".

At the moment the statistics for HIV amongst young school going children in general is limited. The teachers were not sure about the rate of HIV/AIDS amongst learners

since they did not disclose their status and the statistics are not available. Also the high rate of pregnancy put the learners at a high risk of HIV transmission hence their concern that the HIV/AIDS might be high as well. The problems of pregnancy also have a negative effect on the pregnant learner as most never get a chance to complete their studies. Recent reports and newspapers have confirmed the high rate of pregnancy amongst the learners as being one of the biggest problems facing South Africa in which KwaZulu-Natal is the leading province (Dommissie, 2007:1; Department of Education, 2006 & 2007; Cohen, 2007).

In both schools there is no counselling service or any referral system in place. According to the teachers *“The schools do not have psychosocial service in place for learners thus result in learners not having counselling when needed. Furthermore, there is no partnership with any centres that provides such service. The teachers can only provide advice or assistance in whatever way that they could to any learner that is having problems”*.

The schools have only collaborated with the local hospital where learners were engaged in essay writing competitions. The health workers often visit the schools to conduct HIV/AIDS awareness campaigns. There are no non-governmental and faith based organizations that work with school to promote the prevention of HIV/AIDS by providing peer education to learners. The teachers would like to have community activities that will continue educating learners about HIV/AIDS outside school but especially during school holidays. The teachers' suggestion on the above matter is similar to what was stated by Varga (1999:20) that the problem of HIV/AIDS requires a multisectoral approach from all including the communities.

Most teachers stated that there are some cultural activities that promotes abstinence and also encourages the prevention campaign of the pandemic which are performed within the community but not at school. These cultural activities vary per village and families.

The teachers suggested that learners should be taught about HIV/AIDS at an early stage especially from primary school. It is important to emphasize abstinence among young children. Teachers also pointed out that it is important not to discriminate

against the learners who are HIV infected/affected and they should also feel free within the school environment. In conclusion teachers emphasized the important need to educate the young learners about HIV/AIDS as illustrated by a teacher; *“It will never be enough to teach our children because even today most of the people still get infected”*

4.11 Summary

The summary of the findings and conclusions of the study are further discussed in the next chapter. Additionally the follow-up chapter also provides recommendations and puts forward suggestions for research practitioners and researchers.



CHAPTER 5 CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The overall objective of this study was to investigate the HIV/AIDS knowledge levels amongst the school-going children of rural communities in the Bergville district of KwaZulu-Natal province. The findings were used to establish the level of knowledge of HIV/AIDS of the learners, how they perceive their sexual issues and the involvement of their parents and the general society on the matter. In addition, the findings were also used to examine the management of HIV/AIDS in schools. This chapter gives a summary of the major findings of the study by looking at whether the research was able to attain the objectives of the study. Possible solutions to the research questions were also of interest and developed from the overall findings. The final conclusions and recommendations of the study are presented to explore the knowledge of HIV/AIDS among learners in the Bergville rural district.

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5.2 Summary and conclusion

It was hypothesized that with a knowledge of HIV/AIDS, young secondary school learners of KwaZulu-Natal in the Bergville rural district will become more knowledgeable of HIV/AIDS prevention through the implementation of prevention awareness, Life-skills and HIV/AIDS programmes that focus on how culture, religion, and gender influence sexual behaviour. The statistical test used in this study could not provide adequate conclusions to verify any association between the learner's knowledge of HIV/AIDS and the effect of religion, culture or gender. This could be as a result of various reasons, including some external variations due to a limited level of reliability in some of the data. Given that the samples were randomly selected, these difficulties could not be anticipated in advance. The findings of this study require that for investigation of associations amongst the variables, the sample should be selected based on the given variables, that is participants should be selected equally for gender

associations. Other findings amongst young people in South Africa and other countries also show no significant differences between males and females with regard to knowledge and prevention of HIV/AIDS (Boer & Mashamba: 2005:595; Ntata *et al.*, 2008:204). There are limited studies on the religious effect on the prevention of HIV. Furthermore one international study also reported that the frequency of church-going was not associated with the level of knowledge of HIV/AIDS (Stulhofer *et al.*, 2007:59).

Moreover, the insignificant findings of this study on the effect of culture, religion and gender is mainly related to the fact that the majority (about 90%) of the participants indicated that they acquired most knowledge from school lessons, thus the effect of culture and religion on their knowledge could not be singled out. The teachers also confirmed that they do teach learners about HIV/AIDS during Life Orientation and Life Science lessons, with the likely result that the learners acquired the same knowledge at school. In general, the responses of the learners to questions 1-7 and 16 (ii) were more or less the same for all the participants, irrespective of whether they attended church, cultural activities or not. Furthermore, the levels of knowledge in both genders were similar as well. The follow-up conclusions will examine each objective and summarise the findings of this study.

5.2.1 To measure the knowledge of HIV/AIDS amongst secondary school-going learners

The overall results indicated that the majority of learners have a high level of knowledge of the modes of transmission and prevention strategies of HIV/AIDS. The findings on the questions about this objective evidently proved that learners are well informed, and the percentage of learners who showed high levels of knowledge of HIV/AIDS was over 90%. There were some uncertainties regarding knowledge about testing, treatment and cure for HIV. More than half (56%) of the participants knew that the HIV test is the only way to determine if one has HIV. Although the majority of learners were aware that attending a clinic after testing positive is the right thing to do, 30% of those who did not know bring more questions on the matter. Many interventions on the management and treatment of HIV/AIDS have been introduced globally since there is no cure yet. A few learners in rural Bergville still had the

misconception that HIV can be cured. The findings of this study is similar to the one done by Shisana, *et al* (2005:86) in a national HIV prevalence study amongst the South African population where it was found that there was a lack of knowledge about a cure for HIV.

All the participants of this study indicated a positive attitude towards people infected and affected with HIV/AIDS. On the contrary, however the learners were more concerned about the response of their parents towards them if they chose to disclose their HIV status.

Local government including health workers in the district seem not to provide the necessary support to the communities in the fight against HIV/AIDS. All relevant authorities should revisit their commitment and invest in improving the skills and knowledge of rural communities in all possible ways to manage the effect of HIV/AIDS. Furthermore, access to information and other essential services is still lacking in rural communities and these needs to be addressed urgently.

The overall results indicated the use of condoms as one of the most popular methods of preventing HIV/AIDS. According to Mantell *et al.* (2005:118), learners in rural KwaZulu-Natal had misconceptions regarding knowledge of condom usage as a way of preventing HIV/AIDS. In 2005 and 2006, studies by Magnan *et al.* (2005:289-304) and Maharaj (2006:30) indicated an improvement in knowledge about condom usage, which is also in agreement with the findings of this study. In general, knowledge of condom usage among young people as a preventative mechanism for HIV/AIDS has been improving over the years. However, the learners stated that they sometimes forget to use condoms. The learners seem to underestimate the consequences of engaging in unprotected sexual activities. The high rate of pregnancy among the learners is an indication of carelessness on the importance of using condoms as a method to reduce the risks of HIV transmission. The critical question is whether the learners have easy access to the freely available condoms and if not, who is responsible for making sure that the learners have easy access. The policy on HIV/AIDS for learners and educators stipulates that schools in consultation with the community should decide on whether condoms should be accessible within schools. The schools and communities in the Bergville district are failing to follow such

guidelines. In rural communities like in Bergville where there exist only one hospital and occasional mobile clinics, it is important that the policy allows schools to dispense condoms as well.

5.2.2 To examine learner's perceptions about sexual behaviour

Although there was no direct question posed to the learners to determine whether they are already engaging in sexual activities, some of the questions and responses helped to categorize them on this issue. In general, the learners in rural Bergville are already engaged in sexual activities. This is supported by the qualitative interviews with the teachers and the responses of learners on whether they thought they are at risk of contracting HIV/AIDS or not. The high rate of pregnancy among learners observed by the teachers is the outcomes of unprotected sexual activities. Some male learners stated that they are at risk of contracting HIV because they sometimes forget to use condoms during sexual activities. Moreover, the other group of learners who indicated to be safe specified that they always use condoms when engaging in sexual activities. A few participants indicated that they are not at risk because they are not sexually active. In general, further emphasis on sex education for the young generations is important to reduce the high rate of pregnancy and thus the risk of HIV/AIDS transmission. This study also showed that the learners are very sexually active and hence the issue of abstinence become less effective and other intervention methods should be explored. Sentswe (2007:6) states that in other countries where the AB (abstinence and be faithful) campaigns were implemented, the findings have been inconclusive on the effectiveness of the method. The results showed that only in cases of a combination of the ABC intervention method, was there evidence of success in the reduction of HIV infection (Sentswe, 2007:6).

This is the biggest challenge to researchers, government, parents, teachers, and everyone involved in the various programmes aimed at reducing the high risk of HIV amongst young generations. Young people in the Bergville district are not empowered with all the skills that can help them to say no to sexual activities, more specifically young girls. This could be due to various things like, socio-economic challenges, power relation and gender inequalities in a relationship. In addition, young people are

not taking responsibility of their own lives as a result they end up making wrong choices that make them vulnerable to HIV infection.

The whole issue of HIV/AIDS revolves around the behaviour of the young generation. A change in sexual behaviour of the younger generation can be the most effective way that can reduce the high risk of HIV infection. Furthermore, the influence of culture and religion could assist to avoid some risk behaviours.

5.2.3 To determine with whom learners prefer to discuss their personal and intimate issues.

Although most learners (68%) indicated discussing HIV/AIDS and sex issues with parents, the findings did not reveal clearly whom the learners prefer to discuss their personal and intimacy issues. The dialogue was mainly on HIV/AIDS matters and less on intimate issues. Furthermore, the other 32% who did not discuss the matters with their parents did not have an option to indicate with whom they confide in. This study pointed out that the parents are sometimes shifting the responsibility of teaching their children about sexual issues to the teachers. On the other hand, the teachers are also not following the guidelines on the national HIV/AIDS policy. According to the policy, the parents are supposed to be invited to provide parental guidance sessions in schools.

5.2.4 To investigate the management of HIV/AIDS in public schools

The policy on HIV/AIDS in public schools is well developed and it does support those learners and educators who are infected and affected by HIV. The content of the policy is simple and understandable to all. However, the schools are not using the policy correctly as a guideline to respond to HIV/AIDS effectively. The HIV/AIDS policy developed in both schools surveyed do not reach all the school community and as a result it fails in its implementation plan. The findings of the study indicate that both schools do not have a common vision on how to fight the pandemic. The schools do not provide a room for outside agencies working on HIV/AIDS to come on board and assist in expanding the HIV/AIDS awareness amongst learners. The national and provincial department of education also fails the teachers and learners by not providing HIV/AIDS trainings and skills. The management team in both schools did

not indicate any sign of leadership in HIV/AIDS issues and the schools lack health advisory committee and learners' support systems. To improve the management of HIV/AIDS in schools, involvement and commitment from government, private companies, civil society, international and local funders, teachers, learners and parents could become the most effective solution.

5.2.5 To highlight challenges in the implementation of HIV/AIDS awareness programmes in schools

The teachers in rural areas face many challenges regarding HIV/AIDS issues. There is lack of support from both the national and provincial department of education in terms of empowering teachers and learners with training on HIV/AIDS. The ineffective role of the local government and health workers has a negative effect in the implementation of HIV/AIDS awareness in schools. In addition, constraints in human and financial resources also have a setback in such programmes in rural schools.



5.3 Recommendations

The research ought to contribute to the implementation of Life skills and sex education by highlighting the areas that need to be strengthened, therefore the following recommendations are provided and further discussed in detail.

- Response of the local government to manage HIV/AIDS in schools.
- Ensure the inclusion of community, cultural and religious leaders in HIV/AIDS awareness by the schools.
- Ensure the integration of HIV/AIDS education in all curricula.
- Training of teachers and learners on HIV/AIDS.
- Peer education programmes.
- Flexibility of the National HIV/AIDS policy for public schools (condoms dispense in schools).
- Department of health (role of primary health care workers).

Expanding knowledge of HIV/AIDS at an early age among people, including those residing in deep isolated rural areas, is of great importance in the prevention of HIV/AIDS. Furthermore, access to correct knowledge can also assist the communities to have information about care and treatment at early stages of the disease for those who are infected. The programmes aimed at reducing the HIV infection should also reach the parents so as to prevent misconceptions that are sometimes conveyed by adults to the young generation. The journey in the fight against the pandemic should first start with individuals at home. It is therefore important to strengthen the family institution so that it allows room for discussing HIV and sexual issues between the older and younger generation unreservedly. The community (through religion or cultural norms) at large also has a major role to play in the reduction of high risk of HIV infection amongst the young people. The schools, department of education in collaboration with other government departments, civil society and other stakeholders need to ensure that HIV/AIDS and sex education continue for the young generation, even outside school premises. Life Orientation and life science subjects are not enough to teach the learners about HIV/AIDS, therefore local government should seek funding in order to assist community-based organisations working on HIV/AIDS programmes in the area. Non-governmental and community organisations should also contribute by expanding the knowledge that look at the social impact of the pandemic.

Although culture was not associated with the knowledge and sexual behaviour of learners, it should still be incorporated in Life skills and sex education in schools. The schools and community should attempt to reinforce the cultural values in order to regenerate the morality of young people. Previously, culture was one of the ways that outlines one's personality. It is common knowledge that culture involves various factors like practices, beliefs and norms. The teachers in the Bergville area are aware of the cultural activities that promote HIV awareness within the community, therefore a partnership with cultural leaders will be of great value. Therefore teachers and all people involved in those cultural activities are able to share and compare what works and what does not work for schools as well as for cultural interventions. This might allow room for redevelopment of life skills and HIV/AIDS education that integrate culture. Similarly, religion should also be integrated into the whole process as to add more impact.

The school management should provide leadership and support to ensure that everybody in school takes a responsibility in response to HIV/AIDS. The teachers should try to create an enabling environment that will encourage learners and parents including HIV positive people to participate together in HIV/AIDS awareness programmes. Such programmes can also be in a form of drama about HIV/AIDS and performed on events like World AIDS day. On school premises, the Life skills programmes should also involve all teachers which will provide a big enough pool of knowledgeable educators to assist the younger generation. The HIV/AIDS education should be integrated in all other learning areas. For instance statistics on HIV/AIDS can be used during mathematics lessons and this might bring into attention the reality of HIV/AIDS to the learners. Furthermore, this will also encourage other teachers who are not involved in Life Orientation to feel free to discuss such matters with the learners. It is also important that all the teachers should have knowledge of HIV/AIDS. The department of education as well as the schools need to establish relationships with other stakeholders that deal with the pandemic to provide more workshops on HIV/AIDS to both learners and teachers. They should also be able to understand the social impact of HIV/AIDS in the society and the negative effect of it on the lives of young children. The provincial department of Education and the schools should organise more efficiently and encourage collaboration with local communities that are involved in HIV/AIDS programmes. The main focus should be on stakeholders that promote HIV/AIDS awareness, caring services for orphans and vulnerable children, care and support for those who are infected and affected and prevention of HIV/AIDS amongst the communities at large. In addition, the training should also focus on the protection of a girl child as it is indicated in this study that female learners are more vulnerable to HIV than their male counterparts.

The study also indicated to some extent the role played by learners' peers (or friends), hence, thus peer education programmes in rural areas could add value to reinforce the fight against risk behaviours. Visser (2007:693) and Kiragu (2007:19) concluded that peer education programmes could have a positive contribution in the prevention of HIV/AIDS amongst young people. The schools should take initiatives by establishing a referral system for counselling, which would assist both the learners and teachers who are in need of such service. Researchers and all the stakeholders involved in Life

Skills and HIV/AIDS education need to look more thoroughly at factors that put young school learners at high risk of HIV infection.

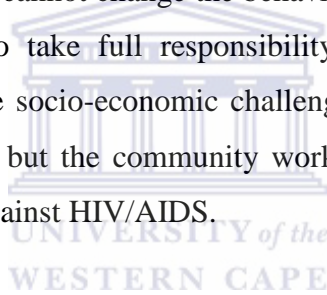
It cannot be ignored that young people are already engaging in risky sexual behaviours. This is also confirmed by the findings of this study and the increase of HIV prevalence among youth in KwaZulu-Natal. It is for this reason that national HIV/AIDS policy for public schools need to be reviewed with regard to access to condoms. It might be difficult for learners to always travel to the district hospital and clinics in order to access condoms therefore the policy should allow dispensing of condoms on school premises.

During the data collection for this study, the researcher noticed a lack of public messages (such as billboards) informing the communities about the dangers of HIV/AIDS or even promoting healthy lifestyles. The health care workers who often provide HIV awareness in schools should avail pamphlets and other information booklets about appropriate knowledge of the disease. It is highly recommended that the focus should also be on access to knowledge about voluntary testing, counselling and treatment, including the role of ARV's. It was mentioned earlier in the study that there is only one hospital and a few clinics for the whole district. The Department of Health at national, provincial and local spheres should consider addressing the matter of accessibility of health services to communities residing in rural areas. Young generations including learners in rural areas should be able to have adequate information on and access to various contraceptive methods, thus preventing unintended pregnancy.

The findings revealed that although the learners are aware of the protection methods, they still put themselves at high risk of HIV transmission through unprotected sexual activities. Because of this, the researcher assumes this might be related to the limited programmes that promote HIV intervention in rural areas, especially the continuation of such programmes outside schools. Another factor might be that youngsters feel that a condom is hindrance. The young generation should be saturated with all the necessary knowledge and interventions that will assist them to make right choices and decisions about their sexual behaviours.

Generally, the results show that the learners have adequate knowledge about modes of HIV transmission and prevention strategies of HIV/AIDS. Now they would really want to understand all the facts about the appropriate methods to follow after being diagnosed with HIV/AIDS. Despite such knowledge, poor behavioural change in sexual activities still put young people at high risk of HIV infection and therefore intervention mechanisms need to be implemented so that risky behaviours can be changed. In addition, young people need to be empowered with skills that will assist them to be responsible for their own lives.

It can be concluded that the successfulness in the implementation of HIV/AIDS awareness programmes amongst learners is not dependent only on schools and teachers but from the financial support and commitment from local government, national and provincial departments of education, health, and other stakeholders. The HIV/AIDS policy for schools cannot change the behaviour of young people, therefore parents and learners need to take full responsibility of their health in order to overcome this pandemic. The socio-economic challenges in the Bergville rural area might have a negative effect but the community working together can still make a huge difference in the fight against HIV/AIDS.



5.4 Future research studies

A more qualitative approach is recommended for this type of study to gain insight into learners' sexual behaviour.

The involvement of all members of a community in such studies could provide more information about the level of knowledge of HIV/AIDS among older generations.

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APPENDIX A: LEARNER'S QUESTIONNAIRE

Questionnaires on the views of secondary school learners in the Bergville Circuit on how informed they are about the dangers of HIV/AIDS

PLEASE DO NOT SUBMIT YOUR NAME AND THE NAME OF YOUR SCHOOL OR ANY OTHER FORM OF IDENTIFICATION ON THE QUESTIONNAIRE. ALL INFORMATION WILL BE HANDLED IN STRICT CONFIDENCE.

Section I: Socio-Demographic Details

1. Age:

2. Gender: Female Male

3. Grade

4. Language used at home:

Afrikaans	English	Sotho	Xhosa	Zulu	Others
-----------	---------	-------	-------	------	--------

5. With whom do you live with at home?

Parents	Relative	Guardian	Others
---------	----------	----------	--------

6. What is your religion?

Do you go attend your church	Yes	No
------------------------------	-----	----

7. Do you attend any cultural activities that teach about the danger of HIV/AIDS?

Yes	No
-----	----

Section II: Knowledge of HIV/AIDS

1. Can school children get HIV?	Yes	No
2. Can one get HIV/AIDS by attending school with a child who is infected with HIV?	Yes	No
3. Can one get HIV/AIDS by sharing the same toilet seat, spoons, and plates with someone who is infected with HIV?	Yes	No
4. Does taking an HIV test the only way that one can determine if someone is infected?	Yes	No
5. Do condoms prevent HIV/AIDS?	Yes	No
6. If your friend tells you that he/she is HIV infected would she/he still be your friend?	Yes	No
7. There is no cure for HIV/AIDS at the moment.	Yes	No

8. Do you understand what HIV/AIDS is?

(Explain) _____

9. Where did you learn about HIV/AIDS? You can choose more than one alternative.

Parents	Friends	School	Church	Radio	Television	Magazine
---------	---------	--------	--------	-------	------------	----------

10. What HIV/AIDS prevention methods do you know of? Explain each one,

11. Do you discuss HIV/AIDS with your parents?

Yes	No
-----	----

If yes, explain what you discuss

If no, explain why not?

12. Do your parents discuss HIV/AIDS with you? If yes explain what they discuss

Yes	No
-----	----

If yes explain what you discuss

If no, explain why not?

13. Do you think you are at risk of contracting HIV?

Yes	No
-----	----

If yes, explain

If no, explain why not?

14. If you were able to take an HIV/AIDS test would you do so?

Yes	No
-----	----

15. Do you regularly attend a clinic to test for HIV/AIDS?

Yes	No
-----	----

16. What are the necessary steps to follow after you tested positive for HIV?

(i) Do you discuss it with anyone?

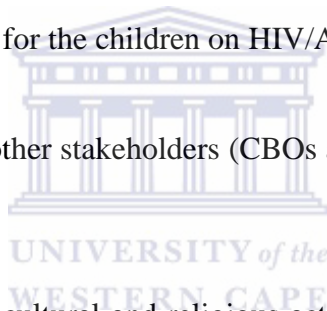
Yes	No
-----	----

(ii) Do you attend a clinic for treatment?

Yes	No
-----	----

APPENDIX B: INTERVIEW QUESTIONS FOR TEACHERS

- (i) Does your school have an HIV/AIDS policy? If yes, what does it entail?
- (ii) What are the strategic measures for the school to manage HIV/AIDS and to educate learners about HIV/AIDS?
- (iii) Is it a challenge to discuss HIV/AIDS and sexual issues with the learners?
- (iv) Does the school experience a high rate of pregnancy amongst learners? If yes, what is the rate of HIV/AIDS amongst them?
- (v) Who provides counselling for the children on HIV/AIDS?
- (vi) Does the school involve other stakeholders (CBOs and NGOs) to educate learners about HIV/AIDS?
- (vii) Does the school include cultural and religious activities to promote and educate learners about HIV/AIDS?
- (viii) As a teacher what can be done to protect learners from future HIV infection?



APPENDIX C: LETTER TO THE SCHOLARS

Dear Scholar

I request your kind assistance in filling out the attached Questionnaire and return it no later than 30 April 2008 preferably (if possible) by post to

Mrs. E. N. Maleka
University of the Western Cape
Private Bag x 17
Bellville
7535

The purpose of this confidential questionnaire is to obtain your views on how informed secondary school learners in the Bergville Circuit are about the dangers of HIV/AIDS. The information is required to explore new education interventions focusing directly on rural school-going learners to improve their knowledge of HIV/AIDS.

Your opinion is of much importance to the undersigned, and therefore my friendly request for you to study the questionnaire and to state as meticulously as possible your experience in respect of each of the factors. Please do not hesitate to give your honest opinion, irrespective of what it may be.

Please be assured that your honest opinion will not in any manner be used to your disadvantage. **You are not required to submit your name or surname or any other form of identification on the questionnaire. All information will be handled in strictest confidence.**

Thank you for your kind cooperation.

Yours truly
Mrs. E. N. Maleka
Researcher

APPENDIX D: LETTER TO THE CIRCUIT MANAGER

University of the Western Cape
Private Bag x 17
Bellville
7535

The Bergville Circuit Manager
P/Bag x 1657
Bergville
3350

RE: Request for permission to conduct research in schools in the Bergville circuit

Dear Mr. Hlongwane

I hereby request for the permission to conduct a research study in secondary schools that are within the Bergville circuit. I am currently enrolled at the University of the Western Cape for a Masters degree in Administration. My research topic is: AN ASSESSMENT OF KNOWLEDGE OF HIV/AIDS AMONGST SECONDARY SCHOOL LEARNERS OF KZN: AN EXPLORATORY STUDY OF BERGVILLE RURAL DISTRICT.

The main objective of the research is to assess how informed are the secondary learners in Bergville about the danger of HIV/AIDS as well as to explore new education interventions focusing directly on rural school-going learners to improve their knowledge of HIV/AIDS. The research resulted from the many research studies reported that KwaZulu-Natal is the most affected of all provinces. Furthermore, the literature revealed that in places where the HIV prevalence is high, young people are more vulnerable and it is important to protect and prevent them from future HIV infection. This can be done by emphasizing awareness programmes aimed at reducing the risk of HIV infection among school-going children, since they are the ones on whom the economic future of the country depends.

The empirical study will include a structured survey questionnaire consisting of both closed and open ended questions which will be distributed to a sample of learners randomly selected from two (2) schools in the rural district of Bergville as well as qualitative interviews with teachers and principals from the selected schools.

Please be assured that the honest opinion of all teachers and pupils will not be used to their disadvantages. They will not be required to submit their names or surnames, the names of their schools or any other form of identification on the questionnaire. All information will be handled in the strict confidence.

Thank you for the time and consideration. I am looking forward to your response.

Yours Faithfully
E.N. Maleka (Mrs.)
Researcher

APPENDIX E: NATIONAL HIV/AIDS POLICY FOR SCHOOLS

NATIONAL POLICY ON HIV AND AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND DISTRICT STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS (10 AUGUST 1999 VOLUME 410 NUMBER 20372)

1. BACKGROUND

HIV and AIDS is one of the major challenges to all South Africans. It is estimated that almost 25% of the general population will be HIV positive by the year 2010. In South Africa HIV is spread mainly through:

- Sexual contact
- Breast feeding
- Mother to child

In keeping with International standards and in accordance with education law and the constitutional guarantees of the right to a basic education, right not to be unfairly discriminated against, the right to life and bodily integrity, right to privacy, the right to safe environment and the best interests of the child.

2. PURPOSE / INTENTION OF THIS POLICY

To prevent the spread of HIV infection.
To demystify HIV & AIDS

- Allay fears
- Reduce stigma
- Instill non-discriminatory attitudes

Develop knowledge, skills, values and attitudes in order that they may adopt and maintain behaviour that will protect them from HIV infection and to support infected and affected.

The policy provides a framework for development of provincial and schools policies and strategic plans for implementation thereof. It further recommends establishment of health advisory committees.

3. TARGET GROUP

- Learners and Educators in public schools
- Students and Educators in further education and training institutions
- Broader school community
- Provincial and District officials

4. THE SALIENT FEATURES/KEY MESSAGES OF THE POLICY

4.1 Premises

Because of an increase of infection rates, learners, students and educators with HIV & AIDS will increasingly form part of the population of schools and institutions. Non-discrimination and equality with regard to learners, students and educators.

4.2 HIV & AIDS testing and admission of learners and students and / or the appointment of educators

4.3 Attendance at schools and institutions by learners or students –right to attend any school/institution.

4.4 Disclosure of HIV & AID status

Learners and educators are not compelled to disclose their status. In cases where voluntary disclosure of their status has been done, it should be treated confidentially.

4.5 A safe school / institution environment

Provision must be made for all schools and institutions to implement Universal precautions to eliminate risk of transmission.

4.6 Prevention of HIV transmission during play and sport

4.7 Education on HIV & AIDS – not to be seen as add on, but part of the curriculum

4.8 Duties and responsibilities of learners, students, educators and parents

4.9 Refusal to study with or teach a learner or student with HIV and AIDS or to be taught by an educator with HIV and AIDS.

5. What are its implications in relation to other policies?

5.2 Revised National Curriculum Statement

5.2.1 HIV and AIDS issues cut across all learning areas and therefore in the development of learning programmes these issues must be captured.

5.3 Assessment Policy

5.3.1 It is important that learners who are likely to experience barriers to learning and development are identified early, assessed and provided with learning support. – multiple opportunities, adaptive methods of assessment.

5.4 Education WP 6 – Inclusive ed. (barriers and orphans, learners at risk)

5.4.1 The development of an inclusive education and training system must take into account the incidence and impact of the spread of HIV and AIDS and other infectious diseases.

5.5 Norms and Standards for funding

5.5.1 For the provisioning of all the appropriate equipment to implement universal precautions to eliminate risk of transmission (first aid kits, rubber gloves)

5.6 Work Place Skills plan

5.6.1 Should include development programmes that would address issues on HIV and AIDS.

5.7 IQMS

5.7.1 Whole school evaluation, school development plans (vision, mission) and school improvement plans must also include HIV and AIDS planned strategy to cope with the pandemic.

- SASA

- Learners of compulsory school – going age with HIV/AIDS may be granted exemption from attendance in terms of Section 4(1)

- If and when learners become incapacitated schools and institutions should make work available to them for study at home and should provide support where possible.

5.9 Constitution of the Republic of South Africa 1996.

5.9.1 To prevent discrimination, all learners, students and educators should be educated about fundamental human rights.

6. What are the possible gaps between policy and its implications?

- Insufficient training for educators with regard to HIV and AIDS
- Insufficient resources available at institutions
- Insufficient funding to purchase the necessary resources needed to address the issues of HIV and AIDS at institutions
- Inadequate co-ordination of inter and intra-departmental initiatives concerning HIV and AIDS
- Policy should be updated at regular intervals to accommodate the progress made in the prevention and treatment of HIV and AIDS.

7. What are the possible questions concerning the policy?

Q. In the development of this policy, were all the relevant stakeholders part of the process?

R. Yes. According to the NEPPA agreement, all the relevant stakeholders were consulted in the formulation of the policy. [Department of Justice, Health, Education and Social Services]

Q. Is this policy limited to learners, students and educators of Public schools only?

R. The policy is available to Independent schools. The recommendations and suggestions could be used by these schools.

Q. Are there Provincial and District strategies in place for the monitoring and support of the HIV and AIDS policy?

R. Yes. The National Integrated Plan supported by the Departments of Health, Social Services and Education addresses the issue of HIV and AIDS in a co-ordinated manner. Conditional Grant funding has been 'ring

fenced' to provide resources and teacher training to support the implementation of the policy. In every province HIV and AIDS co-ordinators have been appointed to monitor and support the implementation of the policy. The services of a service provider has also been obtained to assist Schools and School Governing Bodies in developing their HIV and AIDS policy.

Q. NGOs and other departments also run HIV and AIDS programmes for schools. What is the nature of the relationship of the Department of Education towards these programmes?

R. The National Integrated Plan supported by the Departments of Health, Social Services and Education addresses the issue of HIV and AIDS in a co-ordinated manner.

Q. Schools have admitted HIV and AIDS orphans, do these schools have additional support programmes for these learners?

R. Schools can play a huge role in identifying these learners so that they are able to access social grants.

Q. Is there a recourse for parents of learners, who refuse their child to be taught by a teacher, who is infected?

R. Parents can not be punished.

Q. What does the policy say regarding disclosure of HIV status by learners and teachers?

R. Learners and teachers are not compelled to disclose their status, however a holistic programme for life skills and HIV/AIDS education should encourage voluntary disclosure. Unauthorised disclosure of HIV/AIDS related information could give rise to legal liability.

Government Gazette Vol.410, No.20372, 10th August 1999.

GENERAL NOTICES

NOTICE 1926 OF 1999

DEPARTMENT OF EDUCATION

NATIONAL EDUCATION POLICY ACT, 1996 (NO. 27 OF 1996)

NATIONAL POLICY ON HIV/AIDS, FOR LEARNERS AND EDUCATORS IN
PUBLIC SCHOOLS,
AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND
TRAINING INSTITUTIONS

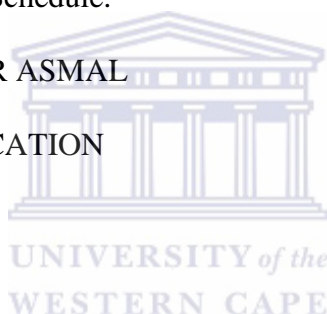
I, Kader Asmal, Minister of Education, after consultation with the Council of Education Ministers, hereby publish the national policy on HIV/AIDS for learners in public schools, and students and educators in further education and training institutions, in terms of section 3(4) of the National Education Policy Act, 1996 (No. 27 of 1996), as set out in the Schedule.

PROFESSOR KADER ASMAL

MINISTER OF EDUCATION

AUGUST 1999

SCHEDULE



NATIONAL POLICY ON HIV/AIDS FOR LEARNERS AND EDUCATORS IN
PUBLIC SCHOOLS AND STUDENTS AND EDUCATORS IN FURTHER
EDUCATION AND TRAINING INSTITUTIONS

PREAMBLE

Acquired Immune Deficiency Syndrome (AIDS) is a communicable disease that is caused by the Human Immunodeficiency Virus (HIV).

In South Africa, HIV is spread mainly through sexual contact between men and women. In addition, around one third of babies born to HIV-infected women will be infected at birth or through breast-feeding. The risk of transmission of the virus from mother to baby is reduced by antiretroviral drugs.

Infection through contact with HIV-infected blood, intravenous drug use and homosexual sex does occur in South Africa, but constitutes a very small proportion of all infections. Blood transfusions are thoroughly screened and the chances of infection from transfusion are extremely low.

People do not develop AIDS as soon as they are infected with HIV. Most experience a long period of around 5 - 8 years during which they feel well and remain productive

members of families and workforces. In this asymptomatic period, they can pass their infection on to other people without realising that they are HIV infected.

During the asymptomatic period, the virus gradually weakens the infected person's immune system, making it increasingly difficult to fight off other infections. Symptoms start to occur and people develop conditions such as skin rashes, chronic diarrhoea, weight loss, fevers, swollen lymph glands and certain cancers. Many of these problems can be prevented or treated effectively. Although these infections can be treated, the underlying HIV infection cannot be cured.

Once HIV-infected people have a severe infection or cancer (a condition known as symptomatic AIDS) they usually die within 1 to 2 years. The estimated average time from HIV infection to death in South Africa is 6 to 10 years. Many HIV infected people progress to AIDS and death in much shorter periods. Some live for 10 years or more with minimal health problems, but virtually all will eventually die of AIDS. HIV-infected babies generally survive for shorter periods than HIV infected adults. Many die within two years of birth, and most will die before they turn five. However, a significant number may survive even into their teenage years before developing AIDS.

No cure for HIV infection is available at present. Any cure which is discovered may well be unaffordable for most South Africans.

HIV/AIDS is one of the major challenges to all South Africans. The findings of the 1998 HIV survey among pregnant women attending public antenatal clinics of the Department of Health, show that the HIV/AIDS epidemic in South Africa is among the most severe in the world and it continues to increase at an alarming pace. The rate of increase is estimated at 33.8%. Using these figures, it is estimated that one in eight of the country's sexually active population those over the age of 14 years - is now infected. In the antenatal survey, the prevalence of HIV/AIDS among pregnant women under the age of 20 years has risen by a frightening 65.4% from 1997 to 1998.

According to the 1998 United Nations Report on HIV/AIDS Human Development in South Africa, it is estimated that almost 25% of the general population will be HIV positive by the year 2010. The achievements of recent decades, particularly in relation to life expectancy and educational attainment, will inevitably be slowed down by the impact of current high rates of HIV prevalence and the rise in AIDS-related illnesses and deaths. This will place increased pressures on learners, students and educators.

Because the Ministry of Education acknowledges the seriousness of the HIV/AIDS epidemic, and international and local evidence suggests that there is a great deal that can be done to influence the course of the epidemic, the Ministry is committed to minimise the social, economic and developmental consequences of HIV/AIDS to the education system, all learners, students and educators, and to provide leadership to implement an HIV/AIDS policy. This policy seeks to contribute towards promoting effective prevention and care within the context of the public education system.

In keeping with international standards and in accordance with education law and the constitutional guarantees of the right to a basic education, the right not to be unfairly

discriminated against, the right to life and bodily integrity, the right to privacy, the right to freedom of access to information, the right to freedom of conscience, religion, thought, belief and opinion, the right to freedom of association, the right to a safe environment, and the best interests of the child, the following shall constitute national policy.

1. DEFINITIONS

In this policy any expression to which a meaning has been assigned in the South African Schools Act, 1996 (Act No. 84 of 1996), the Further Education and Training Act, 1998 (Act No. 98 of 1998) and the Employment of Educators Act, 1998 (Act No. 76 of 1998), shall have that meaning and, unless the context otherwise indicates "AIDS" means the acquired immune deficiency syndrome, that is the final phase of HIV infection;

"HIV" means the human immunodeficiency virus;

"institution" means an institution for further education and training, including an institution contemplated in section 38 of the Further Education and Training Act, 1998 (Act No. 98 of 1998);

"sexual abuse" means abuse of a person targeting their sexual organs, e.g. rape, touching their private parts, or inserting objects into their private parts;

"unfair discrimination" means direct or indirect unfair discrimination against anyone on one or more grounds in terms of the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996);

"universal precautions" refers to the concept used worldwide in the context of HIV/AIDS to indicate standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another and includes procedures concerning basic hygiene and the wearing of protective clothing such as latex or rubber gloves or plastic bags when there is a risk of exposure to blood, blood-borne pathogens or blood-stained body fluids;

"violence" means violent conduct or treatment that harms the person of the victim, for example assault and rape;

"window period" means the period of up to three months before HIV antibodies appear in the blood following HIV infection. During this period HIV tests cannot determine whether a person is infected with HIV or not.

2. PREMISES

2.1 Although there are no known cases of the transmission of HIV in schools or institutions, there are learners with HIV/AIDS in schools. More and more children who acquire HIV prenatally will, with adequate medical care, reach school-going age and attend school. Consequently a large proportion of the learner and student population and educators are at risk of contracting HIV/AIDS.

2.2 HIV cannot be transmitted through day-to-day social contact. The virus is transmitted only through blood, semen, vaginal and cervical fluids and breast milk. Although the virus has been identified in other body fluids such as saliva and urine, no scientific evidence exists to show that these fluids can cause transmission of HIV.

2.3 Because of the increase in infection rates, learners, students and educators with HIV/AIDS will increasingly form part of the population of schools and institutions. Since many young people are sexually active, increasing numbers of learners attending primary and secondary schools, and students attending institutions might be infected. Moreover, there is a risk of HIV transmission as a result of sexual abuse of children in our country. Intravenous drug abuse is also a source of HIV transmission among learners and students. Although the possibility is remote, recipients of infected blood products during blood transfusions (for instance haemophiliacs), may also be present at schools and institutions. Because of the increasing prevalence of HIV/AIDS in schools, it is imperative that each school must have a planned strategy to cope with the epidemic.

2.4 Because of the nature of HIV antibody testing and the "window period" or "apparently well period" between infection and the onset of clearly identifiable symptoms, it is impossible to know with absolute certainty who has HIV/AIDS and who does not. Although the Department of Health conducts tests among women attending ante-natal clinics in public health facilities in South Africa as a mechanism of monitoring the progression of the HIV epidemic in South Africa, testing for HIV/AIDS for employment or attendance at schools is prohibited.

2.5 Compulsory disclosure of a learner's, student's or educator's HIV/AIDS status to school or institution authorities is not advocated as this would serve no meaningful purpose. In case of disclosure, educators should be prepared to handle such disclosures and be given support to handle confidentiality issues.

2.6 Learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practiced against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of individuals concerned.

2.6.1 The risk of transmission of HIV in the day-to-day school or institution environment in the context of physical injuries, can be effectively eliminated by following standard infection-control procedures or precautionary measures (also known as universal precautions) and good hygiene practices under all circumstances. This would imply that in situations of potential exposure, such as in dealing with accidental or other physical injuries, or medical intervention on school or institution premises in case of illness, all persons should be considered as potentially infected and their blood and body fluids treated as such.

2.6.2 Strict adherence to universal precautions under all circumstances in the school or institution is advised.

2.6.3 Current scientific evidence suggests that the risk of HIV transmission during teaching, sport and play activities is insignificant. There is no risk of transmission from saliva, sweat, tears, urine, respiratory droplets, handshaking, swimming-pool water, communal bath water, toilets, food or drinking water. The statement about the insignificant risk of transmission during teaching, sport and play activities, however, holds true only if universal precautions are adhered to. Adequate wound management has to take place in the classroom and laboratory or on the sports field or playground when a learner or student sustains an open bleeding wound. Contact sports such as boxing and rugby could probably be regarded as sports representing a higher risk of HIV transmission than other sports, although the inherent risk of transmission during any such sport is very low.

2.6.4 Public funds should be made available to ensure the application of universal precautions and the supply of adequate information and education on HIV transmission. The State's duty to take all reasonable steps to ensure safe school and institution environments, is regarded as a sound investment in the future of South Africa.

2.6.5 Within the context of sexual relations, the risk of contracting HIV is significant. There are high levels of sexually active persons within the learner population group in schools. This increases the risk of HIV transmission in schools and institutions for further education and training considerably. Besides sexuality education, morality and life skills education being provided by educators, parents should be encouraged to provide their children with healthy morals, sexuality education and guidance regarding sexual abstinence until marriage and faithfulness to their partners. Sexually active persons should be advised to practice safe sex and to use condoms. Learners and students should be educated about their rights concerning their own bodies, to protect themselves against rape, violence, inappropriate sexual behaviour and contracting HIV.

2.7 The constitutional rights of all learners, students and educators must be protected on an equal basis. If a suitably qualified person ascertains that a learner, student or educator poses a medically recognized significant health risk to others, appropriate measures should be taken. A medically recognised significant health risk in the context of HIV/AIDS could include the presence of untreatable contagious (highly communicable) diseases, uncontrollable bleeding, unmanageable wounds, or sexual or physically aggressive behaviour, which may create the risk of HIV transmission.

2.8 Furthermore, learners and students with infectious illnesses such as measles, German measles, chicken pox, whooping cough and mumps should be kept away from the school or institution to protect all other members of the school or institution, especially those whose immune systems may be impaired by HIV/AIDS.

2.9 Schools and institutions should inform parents of vaccination/inoculation programmes and of their possible significance for the wellbeing of learners and students with HIV/AIDS. Local health clinics could be approached to assist with immunisation.

2.10 Learners and students must receive education about HIV/AIDS and abstinence in the context of life-skills education on an ongoing basis.

Life-skills and HIV/AIDS education should not be presented as isolated learning content, but should be integrated in the whole curriculum. It should be presented in a scientific but understandable way. Appropriate course content should be available for the pre-service and in-service training of educators to cope with HIV/AIDS in schools. Enough educators to educate learners about the epidemic should also be provided.

2.10.1 The purpose of education about HIV/AIDS is to prevent the spread of HIV infection, to allay excessive fears of the epidemic, to reduce the stigma attached to it and to instill nondiscriminatory attitudes towards persons with HIV/AIDS. Education should ensure that learners and students acquire age and context-appropriate knowledge and skills in order that they may adopt and maintain behaviour that will protect them from HIV infection.

2.10.2 In the primary grades, the regular educator should provide education about HIV/AIDS, while in secondary grades the guidance counselor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life skills and HIV/AIDS education in the school and province. The educators should feel at ease with the content and should be a rolemodel with whom learners and students can easily identify. Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of, and skills to deal with, HIV/AIDS.

2.10.3 All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.

2.11 In order to meet the demands of the wide variety of circumstances posed by the South African community and to acknowledge the importance of governing bodies, councils and parents in the education partnership, this national policy is intended as broad principles only. It is envisaged that the governing body of a school, acting within its functions under the South African Schools Act, 1996, and the Council of a Further Education and Training Institution, acting within its functions under the Further Education and Training Act, 1998, or any provincial law, should preferably give operational effect to the national policy by developing and adopting an HIV/AIDS implementation plan that would reflect the needs, ethos and values of a specific school or institution and its community within the framework of the national policy.

3. NON-DISCRIMINATION AND EQUALITY WITH REGARD TO LEARNERS, STUDENTS AND EDUCATORS WITH HIV/AIDS

3.1 No learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly. Educators should be alert to unfair accusations against any person suspected to have HIV/AIDS.

3.2 Learners, students, educators and other staff with HIV/AIDS should be treated in a just, humane and life-affirming way.

3.3 Any special measures in respect of a learner, student or educator with HIV should be fair and justifiable in the light of medical facts, established legal rules and principles; ethical guidelines; the best interest of the learner, student and educator with HIV/AIDS; school or institution conditions; and the best interest of other learners, students and educators.

3.4 To prevent discrimination, all learners, students and educators should be educated about fundamental human rights as contained in the Constitution of the Republic of South Africa, 1996.

4. HIV/AIDS TESTING AND THE ADMISSION OF LEARNERS TO A SCHOOL AND STUDENTS TO AN INSTITUTION, OR THE APPOINTMENT OF EDUCATORS

4.1 No learner or student may be denied admission to or continued attendance at a school or an institution on account of his or her HIV/AIDS status or perceived HIV/AIDS status.

4.2 No educator may be denied the right to be appointed in a post, to teach or to be promoted on account of his or her HIV/AIDS status or perceived HIV/AIDS status. HIV/AIDS status may not be a reason for dismissal of an educator, nor for refusing to conclude, or continue, or renew an educator's employment contract, nor to treat him or her in any unfair discriminatory manner.

4.3. There is no medical justification for routine testing of learners, students or educators for evidence of HIV infection. The testing of learners or students for HIV/AIDS as a prerequisite for admission to, or continued attendance at school or institution, to determine the incidence of HIV/AIDS at schools or institutions, is prohibited. The testing of educators for HIV/AIDS as a prerequisite for appointment or continued service is prohibited.

5. ATTENDANCE AT SCHOOLS AND INSTITUTIONS BY LEARNERS OR STUDENTS WITH HIV/AIDS

5.1 Learners and students with HIV have the right to attend any school or institution. The needs of learners and students with HIV/AIDS with regard to their right to basic education should as far as is reasonably practicable be accommodated in the school or institution.

5.2 Learners and students with HIV/AIDS are expected to attend classes in accordance with statutory requirements for as long as they are able to do so effectively.

5.3 Learners of compulsory school-going age with HIV/AIDS, who are unable to benefit from attendance at school or home education, may be granted exemption from attendance in terms of section 4(1) of the South African Schools Act, 1996, by the Head of Department, after consultation with the principal, the parent and the medical practitioner where possible.

5.4 If and when learners and students with HIV/AIDS become incapacitated through illness, the school or institution should make work available to them for study at home and should support continued learning where possible. Parents should, where practically possible, be allowed to educate their children at home in accordance with the policy for home education in terms of section 51 of the South African Schools Act, 1996, or provide older learners with distance education.

5.5 Learners and students who cannot be accommodated in this way or who develop HIV/AIDS-related behavioural problems or neurological damage, should be accommodated, as far as is practically possible, within the education system in special schools or specialised residential institutions for learners with special education needs. Educators in these institutions must be empowered to take care of and support HIV-positive learners.

However, placement in special schools should not be used as an excuse to remove HIV-positive learners from mainstream schools.

6. DISCLOSURE OF HIV/AIDS-RELATED INFORMATION AND CONFIDENTIALITY

6.1 No learner or student (or parent on behalf of a learner or student), or educator, is compelled to disclose his or her HIV/AIDS status to the school or institution or employer. (In cases where the medical condition diagnosed is the HIV/AIDS disease, the Regulations relating to communicable diseases and the notification of notifiable medical conditions **Health Act, 1977** only require the person performing the diagnosis to inform the immediate family members and the persons giving care to the person and, in cases of HIV/AIDS-related death, the persons responsible for the preparation of the body of the deceased.)

6.2 Voluntary disclosure of a learner's, student's or educator's HIV/AIDS status to the appropriate authority should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair discrimination is not tolerated. In terms of section 39 of the Child Care Act, 1983 (Act No. 74 of 1983), any learner or student above the age of 14 years with HIV/AIDS, or if the learner is younger than 14 years, his or her parent, is free to disclose such information voluntarily.

6.3 A holistic programme for life-skills and HIV/AIDS education should encourage disclosure. In the event of voluntary disclosure, it may be in the best interests of a learner or student with HIV/AIDS if a member of the staff of the school or institution directly involved with the care of the learner or student, is informed of his or her HIV/AIDS status. An educator may disclose his or her HIV/AIDS status to the principal of the school or institution.

6.4 Any person to whom any information about the medical condition of a learner, student or educator with HIV/AIDS has been divulged, must keep this information confidential.

6.5 Unauthorised disclosure of HIV/AIDS-related information could give rise to legal liability.

6.6 No employer can require an applicant for a job to undergo an HIV test before he/she is considered for employment. An employee cannot be dismissed, retrenched or refused a job simply because he or she is HIV positive.

7. A SAFE SCHOOL AND INSTITUTION ENVIRONMENT

7.1 The MEC should make provision for all schools and institutions to implement universal precautions to eliminate the risk of transmission of all blood-borne pathogens, including HIV, effectively in the school or institution environment. Universal precautions include the following:

7.1.1 The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to HIV, all persons are potentially infected and all blood should be treated as such. All blood, open wounds, sores, breaks in the skin, grazes and open skin lesions, as well as all body fluids and excretions which could be stained or contaminated with blood (for example tears, saliva, mucus, phlegm, urine, vomit, faeces and pus) should therefore be treated as potentially infectious.

(a) Blood, especially in large spills such as from nosebleeds, and old blood or blood stains, should be handled with extreme caution.

(b) Skin exposed accidentally to blood should be washed immediately with soap and running water.

(c) All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water and/or other antiseptics.

(d) If there is a biting or scratching incident where the skin is broken, the wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing.

(e) Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.

(f) Disposable bags and incinerators must be made available to dispose of sanitary wear.

7.1.2 All open wounds, sores, breaks in the skin, grazes and open skin lesions should at all times be covered completely and securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.

7.1.3 Cleansing and washing should always be done with running water and not in containers of water. Where running tap water is not available, containers should be used to pour water over the area to be cleansed. Schools without running water should keep a supply, e.g. in a 25-litre drum, on hand specifically for use in emergencies. This water can be kept fresh for a long period of time by adding a disinfectant, such as Milton, to it.

7.1.4 All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes, open skin lesions, body fluids and excretions should wear protective latex gloves or plastic bags over their hands to eliminate the risk of HIV transmission effectively. Bleeding can be managed by compression with material that will absorb the blood, e.g. a towel.

7.1.5 If a surface has been contaminated with body fluids and excretions which could be stained or contaminated with blood (for instance tears, saliva, mucus, phlegm, urine, vomit, faeces and pus), that surface should be cleaned with running water and fresh, clean household bleach (1:10 solution), and paper or disposable cloths. The person doing the cleaning must wear protective gloves or plastic bags.

7.1.6 Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to an appropriate disposal firm. Tissues and toilet paper can readily be flushed down a toilet.

7.1.7 If instruments (for instance scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong household bleach solution for at least one hour before drying and re-using.

7.1.8 Needles and syringes should not be re-used, but should be safely disposed of.

7.2 All schools and institutions should train learners, students, educators and staff in first aid, and have available and maintain at least two first aid kits, each of which should contain the following:

- (a) two large and two medium pairs of disposable latex gloves;
- (b) two large and two medium pairs of household rubber gloves for handling blood-soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate);
- (c) absorbent material, waterproof plasters, disinfectant (such as hypochlorite), scissors, cotton wool, gauze tape, tissues, containers for water and a resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids.
- (d) protective eye wear; and
- (e) a protective face mask to cover nose and mouth.

7.3 Universal precautions are in essence barriers to prevent contact with blood or body fluids. Adequate barriers can also be established by using less sophisticated devices than those described in 7.2, such as

- (a) unbroken plastic bags on hands where latex or rubber gloves are not available;
- (b) common household bleach for use as disinfectant, diluted one part bleach to ten parts water (1:10 solution) made up as needed.
- (c) spectacles; and
- (d) a scarf.

7.4 Each classroom or other teaching area should preferably have a pair of latex or household rubber gloves.

7.5 Latex or household rubber gloves should be available at every sports event and should also be carried by the playground supervisor.

7.6 First-aid kits and appropriate cleaning equipment should be stored in one or more selected rooms in the school or institution and should be accessible at all times, also by the playground supervisor.

7.7 Used items should be dealt with as indicated in paragraphs 7.1.6 and 7.1.7.

7.8 The contents of the first-aid kits, or the availability of other suitable barriers, should be checked each week against a contents list by a designated staff member of the school or institution. Expired and depleted items should be replaced immediately.

7.9 A fully equipped first-aid kit should be available at all school or institution events, outings and tours, and should be kept on vehicles for the transport of learners to such events.

7.10 All learners, students, educators and other staff members, including sports coaches, should be given appropriate information and training on HIV transmission, the handling and use of first-aid kits, the application of universal precautions and the importance of adherence universal precautions.

7.10.1 Learners, students, educators and other staff members should be trained to manage their own bleeding or injuries and to assist and protect others.

7.10.2 Learners, especially those in pre-primary and primary schools, and students should be instructed never to touch the blood, open wounds, sores, breaks in the skin, grazes and open skin lesions of others, nor to handle emergencies such as nosebleeds, cuts and scrapes of friends on their own. They should be taught to call for the assistance of an educator or other staff member immediately.

7.10.3 Learners and students should be taught that all open wounds, sores, breaks in the skin, grazes and open skin lesions on all persons should be kept covered completely with waterproof dressings or plasters at all times, not only when they occur in the school or institution environment.

7.11 All cleaning staff, learners, students, educators and parents should be informed about the universal precautions that will be adhered to at a school or an institution.

7.12 A copy of this policy must be kept in the media centre of each school or institution.

8. PREVENTION OF HIV TRANSMISSION DURING PLAY AND SPORT

8.1 The risk of HIV transmission as a result of contact play and contact sport is generally insignificant.

8.1.1 The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of learners, students and educators are exposed to infected blood.

8.1.2 Certain contact sports may represent an increased risk of HIV transmission.

8.2 Adequate wound management, in the form of the application of universal precautions, is essential to contain the risk of HIV transmission during contact play and contact sport.

8.2.1 No learner, student or educator may participate in contact play or contact sport with an open wound, sore, break in the skin, graze or open skin lesion.

8.2.2 If bleeding occurs during contact play or contact sport, the injured player should be removed from the playground or sports field immediately and treated appropriately as described in paragraphs 7.1.1 to 7.1.4. Only then may the player resume playing and only for as long as any open wound, sore, break in the skin, graze or open skin lesion remains completely and securely covered.

8.2.3 Blood-stained clothes must be changed.

8.2.4 The same precautions should be applied to injured educators, staff members and injured spectators.

8.3 A fully equipped first-aid kit should be available wherever contact play or contact sport takes place.

8.4 Sports participants, including coaches, with HIV/AIDS should seek medical counselling before participation in sport, in order to assess risks to their own health as well as the risk of HIV transmission to other participants.

8.5 Staff members acting as sports administrators, managers and coaches should ensure the availability of first-aid kits and the adherence to universal precautions in the event of bleeding during participation in sport.

8.6 Staff members acting as sports administrators, managers and coaches have special opportunities for meaningful education of sports participants with respect to HIV/AIDS. They should encourage sports participants to seek medical and other appropriate counselling where appropriate.

9. EDUCATION ON HIV/AIDS

9.1 A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Measures must also be implemented at hostels.

9.2 Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students, and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners. This should include the following:

9.2.1 providing information on HIV/AIDS and developing the life skills necessary for the prevention of HIV transmission;

9.2.2 inculcating from an early age onwards basic first-aid principles, including how to deal with bleeding with the necessary safety precautions;

9.2.3 emphasising the role of drugs, sexual abuse and violence, and sexually transmitted diseases (STDs) in the transmission of HIV, and empowering learners to deal with these situations;

9.2.4 encouraging learners and students to make use of health care, counselling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organisations and other disciplines;

9.2.5 teaching learners and students how to behave towards persons with HIV/AIDS, raising awareness on prejudice and stereotypes around HIV/AIDS;

9.2.6 cultivating an enabling environment and a culture of nondiscrimination towards persons with HIV/AIDS; and

9.2.7 providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions.

9.3 Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.

9.4 Parents of learners and students must be informed about all life-skills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as well as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality educators and imparters of values at home.

9.5 Educators may not have sexual relations with learners or students. Should this happen, the matter has to be handled in terms of the Employment of Educators Act, 1998.

9.6 If learners, students or educators are infected with HIV, they should be informed that they can still lead normal, healthy lives for many years by taking care of their health.

10. DUTIES AND RESPONSIBILITIES OF LEARNERS, STUDENTS, EDUCATORS AND PARENTS

10.1 All learners, students and educators should respect the rights of other learners, students and educators.

10.2 The Code of Conduct adopted for learners at a school or for students at an institution should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission.

10.3 The ultimate responsibility for the behaviour of a learner or a student rests with his or her parents. Parents of all learners and students:

10.3.1 are expected to require learners or students to observe all rules aimed at preventing behaviour which may create a risk of HIV transmission; and

10.3.2 are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school or institution, and to attend meetings convened for them by the governing body or council.

10.4 It is recommended that a learner, student or educator with HIV/AIDS and his or her parent, in the case of learners or students, should consult medical opinion to assess whether the learner, student or educator, owing to his or her condition or conduct, poses a medically recognised significant health risk to others. If such a risk is established, the principal of the school or institution should be informed. The principal of the school or institution must take the necessary steps to ensure the health and safety of other learners, students, educators and staff members.

10.5 Educators have a particular duty to ensure that the rights and dignity of all learners, students and educators are respected and protected.

11. REFUSAL TO STUDY WITH OR TEACH A LEARNER OR STUDENT WITH HIV/AIDS, OR TO WORK WITH OR BE TAUGHT BY AN EDUCATOR WITH HIV/AIDS

11.1 Refusal to study with a learner or student, or to work with or be taught by an educator or other staff member with, or perceived to have HIV/AIDS, should be preempted by providing accurate and understandable information on HIV/AIDS to all educators, staff members, learners, students and their parents.

11.2 Learners and students who refuse to study with a fellow learner or student or be taught by an educator or educators and staff who refuse to work with a fellow educator or staff member or to teach or interact with a learner or student with or perceived to have HIV/AIDS and are concerned that they themselves will be infected, should be counselled.

11.3 The situation should be resolved by the principal and educators in accordance with the principles contained in this policy, the code of conduct for learners, or the code of professional ethics for educators. Should the matter not be resolved through counselling and mediation, disciplinary steps may be taken.

12. SCHOOL AND INSTITUTIONAL IMPLEMENTATION PLANS

12.1 Within the terms of its functions under the South African Schools Act, 1996, the Further Education and Training Act, 1998, or any applicable provincial law, the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the national policy.

12.2 A provincial education policy for HIV/AIDS, based on the national policy, can serve as a guideline for governing bodies when compiling an implementation plan.

12.3 Major roleplayers in the wider school or institution community (for example religious and traditional leaders, representatives of the medical or health care professions or traditional healers) should be involved in developing an implementation plan on HIV/AIDS for the school or institution.

12.4 Within the basic principles laid down in this national policy, the school or institution implementation plan on HIV/AIDS should take into account the needs and values of the specific school or institution and the specific communities it serves.

Consultation on the school or institution implementation plan could address and attempt to resolve complex questions, such as discretion regarding mandatory sexuality education, or whether condoms need to be made accessible within a school or institution as a preventive measure, and if so under what circumstances.

13. HEALTH ADVISORY COMMITTEE

13.1 Where community resources make this possible, it is recommended that each school and institution should establish its own Health Advisory Committee as a committee of the governing body or council. Where the establishment of such a committee is not possible, the school or institution should draw on expertise available to it within the education and health systems. The Health Advisory Committee may as far as possible use the assistance of community health workers led by a nurse, or local clinics.

13.2 Where it is possible to establish a Health Advisory Committee, the Committee should:

13.2.1 be set up by the governing body or council and should consist of educators and other staff, representatives of the parents of learners at the school or students at the institution, representatives of the learners or students, and representatives from the medical or health care professions;

13.2.2 elect its own chairperson who should preferably be a person with knowledge in the field of health care;

13.2.3 advise the governing body or council on all health matters, including HIV/AIDS;

13.2.4 be responsible for developing and promoting a school or institution plan of implementation on HIV/AIDS and review the plan from time to time, especially as new scientific knowledge about HIV/AIDS becomes available; and

13.2.5 be consulted on the provisions relating to the prevention of HIV transmission in the Code of Conduct.

14. IMPLEMENTATION OF THIS NATIONAL POLICY ON HIV/AIDS

14.1 The Director-General of Education and the Heads of provincial departments of education are responsible for the implementation of this policy, in accordance with their responsibilities in terms of the Constitution of the Republic of South Africa, 1996, and any applicable law. Every education department must designate an HIV/AIDS Programme Manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the Department's HIV/AIDS programme, to advise management regarding programme implementation and progress, and to create a supportive and nondiscriminatory environment.

14.2 The principal or the head of a hostel is responsible for the practical implementation of this policy at school, institutional or hostel level, and for maintaining an adequate standard of safety according to this policy.

14.3 It is recommended that a school governing body or the council of an institution should take all reasonable measures within its means to supplement the resources supplied by the State in order to ensure the availability at the school or institution of

adequate barriers (even in the form of less sophisticated material) to prevent contact with blood or body fluids.

14.4 Strict adherence to universal precautions under all circumstances (including play and sports activities) is advised, as the State will be liable for any damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school or institution.

15. REGULAR REVIEW

This policy will be reviewed regularly and adapted to changed circumstances.

16. APPLICATION

16.1 This policy applies to public schools which enroll learners in one or more grades between grade zero and grade twelve, to further education and training institutions, and to educators.

16.2 Copies of this policy must be made available to independent schools registered with the provincial departments of education.

17. INTERPRETATION

In all instances, this policy should be interpreted to ensure respect for the rights of learners, students and educators with HIV/AIDS, as well as other learners, students, educators and members of the school and institution communities.

18. WHERE THIS POLICY MAY BE OBTAINED

This policy may be obtained from The Director: Communication, Department of Education, Private Bag X895, Pretoria, 0001, Tel. No. (012) 312-5271.

This policy is also available on the Internet at the following web site:
<http://education.pwv.gov.za>