

An exploration into the challenges teachers face in implementing HIV/AIDS initiatives and programmes in primary schools: A case study of two primary schools in Nyanga Township.

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ABSTRACT

Twenty years into democracy and South Africa like many of the world's nations still faces manifold challenges in dealing with HIV/AIDS. This disease affects millions of people in various forms; socially, economically and politically. HIV/AIDS is considered to be a global pandemic (UNAIDS, 2011). The largest group at risk appears to be people between the ages of 15 and 24. One crucial way of dealing with this pandemic is through education since the emphasis is on prevention. It is against this background that this study explored the challenges teachers face in implementing HIV and AIDS initiatives and programmes in two primary schools in Crossroads, in the Nyanga region, in the Western Cape. It appears that research on this topic is not normally carried out in primary schools. I therefore start from the premise that literature on the topic, especially in this empirical field (primary schools), is limited.

The conceptual lens used to understand this complex issue is the Bio-ecological Systems Model of Bronfrenbrenner (1977). Teachers operate within various contexts and their teaching is often influenced by their experiences, knowledge and attitudes (Tayob, 2010:3). Furthermore, it appears that the implementation of HIV/AIDS initiatives and programmes at primary school level is dependent on the relationship between many systems. The complexities of understanding these relationships warrant the use of this model within this study. Methodologically, this study employed a qualitative case study research design to investigate this contemporary phenomenon. I employed in-depth qualitative data collection procedures which included: a questionnaire, semi-structured interviews, and document analysis. The findings indicate that educators are seriously constrained by lack of support from school management and parents when engaging in HIV/AIDS initiatives or programmes at respective primary schools. The study also reveals that educators are not well trained to offer counselling to deal with HIV/AIDS related matters and it becomes worse with those infected. In addition, this study reveals that embedded cultural beliefs play a huge impeding factor in attempts to participate in HIV/AIDS initiatives and programmes, which are aimed to empower both educators and learners. The study therefore recommends a need for stronger financial muscle and support from schools management team to ensure that time set aside for life orientation classes be utilised effectively for the benefit of learners with priority on HIV/AIDS studies and initiative programmes. A strategic inclusion of parents, religious and traditional leaders with the Department of Basic Education and all relevant partners is very

critical to achieve the fight against the struggle with HIV/AIDS through means of education at all levels within the sector and beyond.

KEYWORDS/PHRASES

Human Immunodeficiency Virus (HIV)

Acquired Immune Deficiency Syndrome (AIDS)

HIV/AIDS initiatives

Teachers

Bio-ecological systems model

Primary schools

HIV/AIDS and stigma

HIV/AIDS and culture

Qualitative Multiple case studies

Narrative Analysis



DECLARATION

I declare that

An exploration of the challenges teachers face in implementing HIV/AIDS initiatives and programmes in primary schools: A case study of two primary schools in Nyanga Township.

is my own work, that all the sources I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted previously in its entirety, or in any part, at any other higher education institution for degree purposes.

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Nokuthula Nqaba



May 2014

DEDICATION

This thesis is dedicated to my late grandmother, Nokhaya Funeka Mggontshi who passed away in 2002 and to my family who supported me throughout this process.



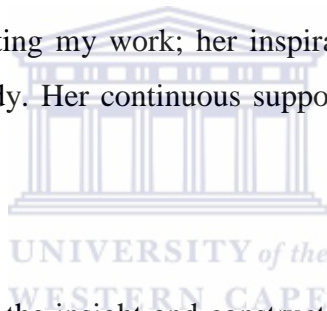
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CHAPTER ONE: INTRODUCTION

1.1 Background and rationale for this study

Twenty years into democracy and South Africa, like many of the world's nations, still faces manifold challenges in dealing with HIV/AIDS. This disease affects millions of people in various forms; socially, economically and politically. HIV/AIDS is considered to be a global pandemic (UNAIDS, 2011). According to the 2013 report on the global AIDS epidemic released by UNAIDS, 35.3 million people were living with HIV in 2012. There are 2.3 million new HIV infections, 70% of which could be found in sub-Saharan Africa (UNAIDS, 2013:12). Although there have been huge inroads in combating the spread of HIV/AIDS in recent years, which lead to a decline in AIDS deaths (in 2012 there were 1.6 million deaths compared to 2.3 million in 2005), HIV/AIDS still remains a global problem. My interest is in the spread of HIV and AIDS amongst young children and adolescence, especially in the South African context. According to South Africa's National Strategic Plan (NSP) 2012-2016, 5.63 million adults and children were living with HIV in 2009. Of these 5.63 million people 5.3 million are adults aged 15 and older, 33 million were females and 334 000 were children. According to the NSP (NSP, 2012-2016:22) the following key population groups will be targeted for preventative intervention:

- Young women between the ages of 15 and 24
- People living in informal settlements
- People with low socio-economic status
- Vulnerable children and orphans

These groups amongst others are especially at risk of contracting HIV and AIDS. Little is known on the actual numbers of children affected and infected by HIV and AIDS in primary schools in South Africa. Schools have been identified as the ideal venues to manage and control the spread of HIV and AIDS (Rutaguminwa & Kamuzora, 2006; Maleka, 2009). Furthermore, it has been noted that educational initiatives, especially preventative programmes, are one way of dealing with this epidemic and bringing about sustained behavioural change (UNAIDS, 2011; Maleka, 2009). Bearing this in mind, this study offers an exploration of the challenges teachers face in dealing with HIV and AIDS initiatives in primary schools.

This study used a qualitative multiple case study design based on two cases; two primary schools in Crossroads, in the Nyanga region in Cape Town to explore this phenomenon. The criteria used in the purposive selection of the cases are based on the fact that HIV/AIDS is more prevalent in areas where there is a high poverty rate, a high rate of crime against women and children, and a high rate of people with low socio-economic status. Case study design is especially suited to cases that explore 'sensitive issues' like HIV/AIDS (Yin, 2009).

My rationale for doing this particular study stems from my exposure to the topic in my B. Ed (Honours) year and my employment in the Department of Cultural Affairs. One of the components dealt with by this department was a School Sport Component which dealt directly with building awareness on HIV/AIDS through sporting activities. These sport programmes were launched at primary school level. I also gained exposure to the Nyanga region, its inhabitants and the many social problems that ails this community. Babbie & Mouton (2001) argue that one cannot understand the case in isolation from the context or environment in which the case(s) is embedded. It is for this reason that I offer a description of the context in which the multiple cases are embedded.

1.2 The statement of the problem

HIV/AIDS is a reality no one can deny. Even those who started by doubting its existence have now been forced to revisit their stance, as fatalities have become the daily occurrence. Existing HIV/AIDS statistics show that South Africa is one of the countries with the highest infection rates, not only in Africa but also globally (Ala, 2001:1). The most intriguing question is why is that the case? To be sure, there is no simple answer to this question because there is a confluence of factors at play, which range from sexual irresponsibility, poor health conditions, poverty, unemployment, culture or cultural beliefs and practices, as well as what we might call religious dogmatism to negligence by national governments to act promptly. Thus, to address HIV/AIDS problems requires broad thinking and a consideration of all these factors. Education is generally seen to be the key to finding a solution to or preventing the high or increased rate of the spread of the HIV virus and to overcome all the challenging issues related to it (Vergnani, 1993). However, it appears that the targeted group is 15-24 years old (UNAIDS, 2011), which include learners at secondary school level. I think that because this group has been identified as a high risk group that younger children, those at primary school level should also be targeted. According to Visser (2004 in Tayob, 2010:5)

children in primary schools in South Africa are between the ages of 5 and 14 where the HIV prevalence rate is at its lowest. At this age group children are forming and changing their “attitudes, skills and behaviour”. It therefore is crucial to target this section of the population. This is reiterated by Vergnani (1993) and Mahomed (1998) who noted that primary schools should be the most appropriate level for teaching preventative measures and knowledge of HIV/AIDS related issues. The purpose of this study is therefore to explore or investigate challenges teachers face in the implementation of HIV/AIDS initiatives or programmes at primary school level.

1.3 Research questions

The main research question this study will attempt to answer is “What are the challenges teachers face in implementing HIV and AIDS initiatives and programmes in primary schools?”

The sub research questions are:

1. What is the nature of HIV/AIDS initiatives and programmes currently being implemented in primary schools?
2. How do teachers react to the HIV/AIDS initiatives and programmes currently being implemented in primary schools?
3. What role does culture play in the implementation of HIV/AIDS initiatives or programmes in primary schools?
4. What is the constraining factors teachers’ face in the implementation of HIV/AIDS initiatives and programmes in primary schools?

1.4 Aims and objectives of the study

This study has one broad aim, namely “to explore the challenges teachers face in the implementation of HIV/AIDS initiatives in primary schools”. This broad aim leads to the following objectives:

- To offer international and national literature on the phenomenon under study.
- To offer an overview of the HIV/AIDS programmes currently being implemented in primary schooling in South Africa.
- To explore the constraining factors that inhibits teachers’ abilities to deal with this sensitive issue.

1.5 Significance of the study

There is very limited research in South Africa on the teachers' views regarding HIV/AIDS and sexuality education in primary schools. Furthermore, most research on HIV/AIDS and sexuality education in South Africa focuses on HIV/AIDS education and its impact on educators and adolescents in secondary schools (Peltzer & Promtussananon, 2003; van Schalkwyk, 2003). So, this study aims to overcome these shortcomings by exploring the challenges teachers face in implementing HIV/AIDS initiatives or programmes in primary schools. As previously mentioned, research in this area is lacking.

1.6 Delimitation of this study

This study investigates the challenges teachers face in implementing HIV/AIDS initiatives or programmes in primary schools. Empirically, the findings cannot be generalised because the study was limited to two primary schools only. These two primary schools have their own context and the findings must be understood in relation to the location of the school and the school context. Merriam (2009), however, posits that conducting multiple case studies, as in this study, is “a common strategy for enhancing the external validity or generalisation of your findings” (2009:50).

1.7 Definitions of terms used in this study

HIV (Human Immunodeficiency Virus)

A virus that causes AIDS.

AIDS (Acquired Immunodeficiency Syndrome)

A disease caused by HIV causing the immune system to break down making people more vulnerable to infections and diseases.

SEXUAL BEHAVIOUR

The manner in which humans experience and express their sexuality.

PRIMARY SCHOOL

Schools consisting of the Foundation Phase (Grade R- 3), Intermediate Phase (Grade 4-6) and Senior Phase (Grade 7-8).

TEACHER

In this thesis the word teacher is used interchangeably with the term educator to mean any person trained in teaching either in a primary or secondary school.

HIV/AIDS INITIATIVES and PROGRAMMES

In this thesis it refers to formal and informal school related programmes dealing with HIV/AIDS issues.

TOWNSHIP

Undeveloped urban living areas or informal settlements built on the periphery of towns and cities.

STIGMA

The word stigma is used in this thesis to mean social stigma meaning to be discriminated against because of one's status.

GENDER

Refers to being male or female

CULTURE

Embedded traditions or beliefs of a group of people and is passed down from one generation to the next.



1.8 The structure of the thesis

In Chapter 1, I introduce the study by illuminating the background and rationale for doing the study, the research questions and the aims and objectives of the study. I also highlight the research problem and the significance of this study. This is followed by Chapter 2 where I explore literature on this topic internationally, cross-nationally and nationally. The main purpose of this chapter is to establish what has been written on the subject in different contexts. To highlight the South African context and to introduce the theoretical lenses that will be used in the study. This is followed by Chapter 3, which presents the methodology used in this study and justifies why a specific research method (in this case a qualitative

method) was used and not others. It also prepares the reader's mind-set by painting a picture on how the research material was gathered and which constraints were faced in the process, which might have had an impact on the findings of this study. In Chapter 4 I present the findings of the two cases and enter into a cross case analysis, which provides discussions on the findings emanating from the data collected. Finally, Chapter 5 will provide a summary of the key research findings and their implications for future interventions as well as make recommendations for further research on this subject.



CHAPTER 2: Literature Review

2.1 Introduction

In Chapter 1 I provided an overview of this study. In this chapter I review literature that could help in understanding the complexities surrounding the implementation of HIV/AIDS initiatives and programmes on primary school level. I used a thematic approach in this review, moving from global issues to focusing on the South African context, especially highlighting the crucial role of education as a mechanism to combat the spread of this dreaded disease, as well as issues related to culture, stigma and discrimination as possible challenges in the implementation process.

2.2 The HIV/AIDS Pandemic: An Overview

As previously stated, the HIV/AIDS pandemic is a global crisis which demands urgent attention and full participation, commitment, sustained action and the alliances of individuals, organizations and other sectors. As a result, in 2000, a collective decision was made when the global community took a historic step in the United Nations Millennium Declaration by acknowledging the importance of an effective response to HIV/AIDS and by placing it in the context of the broader development agenda so as to get necessary attention (United Nation's Report, 2013). This emanated from the fact that HIV/AIDS have been around for a while despite all the attempts and initiatives taken globally and in South Africa in particular but still seem not to be effective. HIV/AIDS remains a serious challenge to the world, despite it being prioritised as a global health issue (West et al., 2007; Atwell et al., 2004). According to Michel Sidibé, UNAIDS Executive Director, "AIDS remains an unfinished MDG [Millennium Development Goal], underscoring the need for continued and strengthened international solidarity and determination to address this most serious of contemporary health challenges" (Global Report-UNAIDS, 2013:02).

However, there has been an increase from previous years in relation to receiving the life-saving antiretroviral therapy. Hence, globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in 2012. Moreover, there were 2.3 (1.9–2.7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1–

3.7) million in 2001. At the same time the number of AIDS deaths is also declining with 1.6 (1.4–1.9) million AIDS deaths in 2012, down from 2.3 (2.1–2.6) million in 2005 (Global Report – UNAIDS, 2013:04).

AIDS accounts for an increasing number of deaths each year. Of the 3.1 million killed in 2005, over half a million were children aged below 15 years. As a result, the high rate of HIV infection among youth in Africa has prompted both national and international attention. In 2011, an estimated 2.5 million people were newly infected with HIV, 330,000 were under the age of 15 whilst nearly 7,000 people contract HIV daily and nearly 300 every hour. But I took note of the decline on people dying with AIDS in 2011 reports as compared to 2005. In 2011, it was reported that 1.7 million people died from AIDS, 230,000 of them were under the age of 15. Currently, an estimated 34 million are living with HIV/AIDS and more than 25 million people have died of AIDS worldwide since the first cases were reported in 1981 (UNAIDS, 2013)

Many reports across Sub-Saharan Africa revealed that more than two-thirds (69 percent) of all people living with HIV, 23.5 million live in sub-Saharan Africa, including 91 percent of the world's HIV-positive children. In 2011, an estimated 1.8 million people in the region became newly infected and an estimated 1.2 million adults and children died of AIDS, accounting for 71 percent of the world's AIDS deaths in 2011 (UNAIDS Sheet, 2012). Young people are at the centre of the global HIV/AIDS epidemic, both regarding new infections and opportunities for halting the transmission of HIV (Monasch & Mahy, 2006: 16). Moreover, high-risk behaviour of children and adolescents such as alcohol and substance abuse, unplanned pregnancies and unprotected sexual activities, are a major concerns in South Africa (Gallant and Maticka-Tyndale, 2004). The lack of HIV monitoring facilities in many developing countries means that it is difficult to produce precise estimates, and the actual figures could be higher (World Bank, 2001; UNAIDS, 2008). It is clear that large numbers of children around the world are living with HIV and are being killed by AIDS on a daily basis – something that is very hard for an adult to accept; harder still for children who may be too young to understand why they are dying (Vergnani, 1993; World Bank, 2001).

Moreover, in all the estimates given above, South Africa within Sub-Saharan Africa remains on top. The latest estimation shows that South Africa has 5.6 million of people living with HIV/AIDS with an estimated 1.3 million under 25 years (Dorrington et al., 2006:1). It has been further suggested that South Africa has one of the highest rates of sexual assaults in the

world, with adolescent girls between the ages of 12 and 17 being particularly at risk. Child rape is becoming more common in South Africa (Bhana. et al., 2006). In 2000, over 52,550 cases of rape or attempted rape of women were reported to South African Police Service. Of these 21, 438 victims were minors under the age of 18 years, and 7,898 of these were under 12 years. Whilst other countries within the same group have very low estimates, including countries like Uganda with 1.4 and Ethiopia with the lowest rate of 790 000 (UNAIDS: World AIDS Day Report, 2012).

The estimated numbers show that the development of HIV/AIDS epidemic differ from country to country and is influenced by changes in individual behaviour and attitude, which should be reflected in the prevention and treatment programmes offered in the respective country (West et al., 2007). Hence, the South African community has taken full responsibility in reducing and eliminating some of the challenges as a means to fight against HIV/AIDS related factors (UNAIDS, 2007; UNAIDS, 2008; UNAIDS, 2011 and UNAIDS, 2012). This was not always the case. We need only go back to the controversial initiatives and comments surrounding HIV and AIDS made by the former president, Thabo Mbeki and his then minister of health, Dr. Monto Tshabalala-Msiman, a period referred to as the Denialism phase. Their failed initiatives included the controversial Sarafina II and their promotion of Virodene (an antiretroviral drug based on antifreeze and which was found to have no antiviral effects), as well as commenting that HIV did not cause AIDS and instead resulted from socio-economic factors or life-style (Nattrass, 2007). According to Nattrass (2007:20) their controversial comments and failed initiatives “does not only pose serious problems for effective and safe governance within the health sector, but threatens the health and lives of the many AIDS patients who are ill-equipped to judge the relative efficacy of the antiretroviral and alternative therapies”. South Africa therefore only truly started to address the HIV and AIDS epidemic in 2009 with the presidency of Jacob Zuma. Although Zuma made great strides in the fight against HIV and AIDS; the ART programme is now one of the biggest in the world (Maurice, 2014).

South Africa also organized HIV/AIDS preventive initiatives in a form of engagement and included those from neighbouring countries to identify possible and relevant programmes to fight HIV/AIDS towards zero infection (Global Report-UNAIDS, 2013). In addition, the report reveals that young people and/or adolescents are a targeted group that requires urgent attention due to various reasons which at times can be informed by their socio-economic background which leads them to high risk-behaviour (UNAIDS, 2013, De Swardt, 2004).

South Africa reported a decrease in people dying with AIDS but rather an increase with those living with HIV/AIDS assisted by access and availability of ARVs which then improves life span (Global Report-UNIADS, 2013). A high number of HIV new infections and death amongst the youth seem to suggest this group (ages 15 to 24) are the high risk group (World Bank, 2001). Hence, young people should be a relevant targeted group to get help and special attention in building up on an HIV free generation without undermining difficulties facing other groups on HIV/AIDS related diseases (UNAIDS Report, 2012).

It has to be noted that some of the learners at primary school level participate in unprotected sexually activities informed by different reasons, which could be circumstances and at times influenced from their peers (Visser, 1996; Maleka, 2009). Exposure to activities that family members, friends and parents participate in, in front of children could also be a contributing factor to a high-risk behaviour of some of the learners at primary school level, assuming that all is correct as practised by older people whom they trust (Mannah, 2000). According to Visser (1996) and Maleka (2009) the other high-risk behaviours that should be addressed urgently is unprotected sexual behaviour. This can also be seen in the learner pregnancy rates which are higher in schools located in poor areas and in schools that were poorly resourced (Human Sciences Research Council's teenage pregnancy report, 2009). According to Ches these issues need to be addressed by schools through education to prevent high-risk behaviour patterns that can become more serious as these learners develop (Ches et al, 2004). Campbell (2001) confirms that although sexual activity and drug use are high-risk activities associated with adults, they also represent risks for children. It is known that many young people have consensual sex before they reach the age at which national laws deem them legally able to. The age at which sex and HIV education are provided to children differs around the world (Commonwealth Secretariat, 2002; World Bank, 2001).

In both developed and developing countries, there are similar challenges posed by HIV/AIDS such that children and young people often receive inadequate sex education due to a number of factors (Baxen, 2006). These include religious, moral, or cultural reasons or simply lack of resources (UNAIDS, 2012; Campbell, et al., 2006). It is quite possible for children to begin having sex or injecting drugs before they have even been taught that these activities expose them to risks such as HIV/AIDS (Boon, et al., 2006; UNAIDS, 2012). Consequently, they may not only be unaware of how to protect themselves against infection, they may not even know why they should do so. Sex and HIV education may have a lower age-limit but HIV infection does not (Kaiser, 2001). At times children's rights are undermined and exposed to

HIV infection through non-consensual sexual activity, sexual abuse, or rape (Johns, 2004). Not only are such illegal activities terribly emotionally traumatic for a child, they can also result in HIV infection if the abuser is himself HIV+ (Andrew et al., 2002). In South Africa 10.6% of all people over the age of 2 years are living with HIV/AIDS (Setswe & Malope, 2009). Furthermore, 13.6% of the Black population are infected (Tayob, 2010). This shows that there is a need for HIV/AIDS initiatives or education in South African primary schools (van Schalkwyk, 2003).

In addition, some findings confirm that education on HIV/AIDS would play a vital role in empowering young people about bad behaviour, change and attitude towards positive life (UNAIDS, 2012; Global Report, 2013; Maleka 2009; Gallant & Maticka-Tyndale, 2004).

2.3 Education and HIV/AIDS

In the absence of a cure for AIDS, education is generally seen to be the key to finding a solution to preventing the increased rate of the spread of the HIV virus and to overcome challenging issues related to it (Vergnani, 1993; Tayob, 2010). Generally, schools are the one institution in our society regularly attended by most young people, with nearly 95% of all youth aged 5-17 years enrolled in elementary or secondary schools (National Centre for Education Statistics, 1993). Therefore schooling and education can be employed as a very strategic tool to create greater awareness (Tayob, 2010). According to Tayob (2010:2), “a balanced approach of prevention and antiretroviral treatments are the main mechanisms” in dealing with HIV/AIDS. Moreover, education can reduce all socio-cultural beliefs which seem to be more influential and a barrier to educate young people on sensitive issues of sexuality, sexual abuse, high-risk behaviour and HIV/AIDS (Visser, 2007). Education can also be an effective means to challenge prejudice, cultural and religious beliefs for a positive and well managed behaviour and attitude (UNAIDS, 2013). Through education self-esteem and confidence can be boosted such that both learners and educators can be of assistance beyond classrooms, in places like the communities through awareness campaigns (Vergnani, 1993).

‘Compulsory learning’, in formal education sites like schools, about causes of HIV and AIDS and how it can be prevented to safeguard those infected and affected, is crucial (South African National AIDS Council, 2011; Hamilton, 2002). Furthermore, the most common

prevention approach utilised in schools relies on teaching students factual information about high-risk behaviour and the dangers thereof. Preventive programmes should therefore rather focus on personal development (self-esteem development, life skills) and on ecological factors in the lives of the learners such as the provision of a social network and social support (Visser, 1995; Visser, 2007). Failure to embark on awareness campaigns through education would result in a number of challenges that would persist and leave some learners and educators vulnerable (Coombe, 2002). It has to be appreciated that some researchers believe that educational interventions for learners of various ages, as well as for educators, should provide the necessary knowledge and encourage the development of attitudes and skills that can limit the spread and impact of the pandemic (Coombe, 2003:7). This is reiterated by Tayob, who draws on the work of Visser (2004) to explain the importance of conducting HIV Intervention programmes at primary school level. They point to the developmental level of the child being in their foundational years where their attitudes and behaviours are still being shaped. They further note that primary schools offer a “ready audience” for such programmes for example, learners, teachers, parents and the broader school community (Tayob, 2010: 7).

2.4. Children and HIV/AIDS

There is a view that death caused by HIV/AIDS has been reduced as compared to other years as studies revealed more numbers of people living with HIV/AIDS through government support on counselling and ARVs (UNAIDS, 2013). However, recently, the HIV/AIDS National Strategic Plan (2012), emphasized the need to strengthen HIV/AIDS interventions for young people towards 50% reductions on new infections and elimination of high risk behaviour and attitude (UNAIDS, 2012). It has been reported that the most vulnerable of them all are young school-going children of both genders (Maleka, 2009). James et al., (2004) also suggest that during the school-going period children require more attention and appropriate guidance as various patterns of behaviour are developed at this stage and can either protect or place young people at risk later in their adult life. Nevertheless, attempts made to reduce risks behaviour with school-going children will never be undermined.

Moreover, learners', who are ill fall behind in their academic work or studies, drop out of school because they have to take care of others at home and play a parental role irrespective of their age. In some cases, they become breadwinners and it is during this stage that they are even more exposed to sexual abuse. In the process of struggling for support, some of these

children would be forced into prostitution and use sex as a source of income to support their families (Department of Education, 2000; Commonwealth Secretariat, 2002). The abuse of children can proceed to a point that it affects them socially, economically, psychologically and happens worldwide. In Zambia for instance, relatives, guardians and educators would also partake in sexual assaults of girls especially orphans (Human Rights Watch, 2003). Many of the girls interviewed by Human Rights Watch were unable to continue in school either because their income or labour or capacity for caring for a sick person was needed in an AIDS-affected family.

When educators are infected and become very sick, they do not come to work and their workload has to be given to other educators. Sex education is certainly very important at all age levels because the abuse of children is not selective. Statistics show that a child at any stage or age can be raped or abused sexually. "You cannot do AIDS education without addressing sexuality and sexual behaviour" (Online News Hour: AIDS in South Africa, 2000). 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). According to van Schalkwyk (2004) and Berger (1995), parents are regarded as the first people who can play a vital role by being primary sexuality educators to their children at home. As a result, in 1998, the Department of Education realized a need for schools and parents to build relations and form a partnership to close the gap that currently exists between the two stakeholders (Department of Education, 1998; White, 1999). It is suggested that parental involvement should include programmes relating to HIV/AIDS, sexuality education program, learning content and methodology, as well as values (Berger, 1995; Heystek & Louw 1999; Friedman 2002; Kiragu, 2001).

In South Africa, for example, there is a myth that sex with a virgin can 'cure' a man who is HIV positive and this has led to a large number of rapes, sometimes of very young children (Commonwealth Secretariat, 2002; Ashforth, 2001:130). The reality is that having sex with a virgin will never be a cure to HIV but will cause pain and misery and may infect the virgin with the HIV virus, eventually reducing her life span (Department of Education, 2000). A child who engages in sexual activity either voluntarily or involuntarily is at greater risk of coming into contact with HIV if they live in a high-prevalence area, as in the area in which my research was conducted. The Department of Education (2001) states that one third of 12-17 years old children have had sexual intercourse and a large proportion of these children experienced sexual activity by force or violence but not by choice. De Villiers (1985)

reported that South Africa has one of the highest teenage pregnancy rates in the world and that most of these births occur among the poorest sector of the population. As a result, sexual exploitation is more of a problem in developing countries, where having sex for money, food or protection can be a means of survival for some children due to poverty and unemployment rates (World Bank, 2001). In July 2002, a report by the African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN), and the United Nations Children's Fund - East and Southern Africa Regional Office (UNICEF-ESARO) details the horrific sexual abuse that children in Kenya and all over Africa are forced to endure at the hands of parents, teachers, employers, and sex trade customers. In Kenya, the report cites poverty, tribal clashes, lack of education, disintegration of family and social values, large-scale migration, and lack of protection to children at risk as being the major causes of commercial sexual exploitation of children. At times parents play a very minimal role in helping their children avoid being sexually abused. However, due to some African cultural and religious beliefs, which I will allude to later, parents find it difficult to speak about sexual issues to children.

A study from the University of Manitoba reveals that children and youth who have been sexually exploited are victims of child sexual abuse. The sexual exploitation of children and youth is a serious concern in Manitoba, Canada and around the globe. Most adults involved in the sex trade report that their victimization began at a very young age, sometimes as young as nine, and at an average age of 14 (Baxen, 2006). Poverty, class, racism, social isolation, marginalization, peer pressure, past abuse and trauma, sex-based discrimination, mental health, neurological and developmental disorders, system gaps, inaccessible services and other social and financial inequalities contribute to children and youth's vulnerability to sexual exploitation (Vergnani and Frank, 1998). Sex education is thus very important at all age levels because the abuse of children is not selective. Statistics show that a child at any stage or age can be raped or abused sexually. "You cannot do AIDS education without addressing sexuality and sexual behaviour" (Online News Hour: AIDS in South Africa, 2000).

In South African schools, some educators, have a challenge in assisting children that are exposed to sexual abuse and rape and vulnerable to HIV/AIDS to be aware of these challenges and be safe (Smith & Harrison, 2013). This is informed by the fact that the needs of the learners are changing as young people must learn at an earlier age how to protect themselves from HIV/AIDS and take care of affected family members and friends (Africa

Consultative International, 2003). However, the National Education Policy on HIV/AIDS (1999) mentions that the context in which they acquire knowledge and skills must be appropriate for them to adopt and maintain behaviour that will protect them from HIV infection (Department of Education, 1999).

Teachers' values and beliefs have to be taken into cognisance when dealing with sex education especially since their values and beliefs can influence teaching (Vergnani and Palmer, 1998; Johns, 2004). Tayob (2010) notes that:

while teachers are strategically positioned to mediate information that might lead to increased knowledge about HIV/AIDS and preventative measures, their prior experiences, knowledge and attitudes impact on delivery in the classroom and the broader school context. (Tayob, 2010:7)

Furthermore, The Department of Education (2002 and 1999) states that it is important for educators to recognize that any programme concerning sexual education or sexuality must be employed within the rights and responsibilities of young people. On the one hand, all children have a right to be educated on issues such as sexuality, health and HIV/AIDS, amongst other things (Mahomed, 1998; Oshi & Nakalema, 2005). On the other hand, children also have the right to practice their own religion, culture or beliefs without fear. These rights appear to work in contrast to each other which could be a challenge to educators (Johns, 1998).

2.5 Schools and HIV/AIDS

As previously mentioned, South Africa developed key strategic goals, in line with the 2011 Political Declaration, to combat the spread of HIV/AIDS (SANAC, 2011). Of these strategies, school-based HIV prevention programmes, starting as early as primary school, has been viewed as a necessary step to protect the general population from further infection (UNAIDS, 2011; UNAIDS, 2013; Gallant and Maticka-Tyndale, 2004). According to Rutagumirwa and Kamuzora (2006), schools are being recognized as sites or meeting points where young people congregate, and are ideal venues for HIV/AIDS interventions to effectively implement school-based HIV prevention education programmes. Moreover, more than 80% of children enter primary schools and is hence viewed as the single location where the largest proportion of young people can be reached (UNICEF, 2001).

It has been further suggested that studies in different locations support the conclusion that most youth in sub-Saharan Africa initiate sexual activity while they are still of school age,

whether or not they are in school (Kaaya et al., 2002; WHO, 1992). In addition, the struggle against HIV/AIDS require all stakeholders to be involved and schools are better placed as they are well organised and linked to communities through families, and other community organizations, extending their reach and enhancing local ownership of interventions (Bekker, 1996; Burkey, 1993). Hence, school-based programmes are viewed as a strategic point and necessary basis for other programmes related to HIV/AIDS (Stover et al., 2002; UNAIDS, 2011).

South Africa has been viewed as a strategic point within the region by employing all opportunities to minimize and control the spread of HIV/AIDS with a particular view of making schools centres for change through HIV/AIDS and sex education, which will strengthen prevention efforts on young people in order to achieve sustained behavioural change towards a zero infection nation (UNAIDS. Regional Report, 2013). People can have general views and knowledge about HIV/AIDS related diseases but the manner in which those programmes are systematically designed to accumulate efficient knowledge is important for behavioural change towards a healthy life (Maleka, 2009; Burkey, 1993). As Coombe (2003:7) notes, “Educational interventions for learners of various ages, as well as for educators, should provide the necessary knowledge and encourage the development of attitudes and skills that can limit the spread and impact of the pandemic.”

Visser, (2007) and Campbell et al., (2006) further suggest that knowledge and attitudes are easiest to change, but behaviours are much more challenging. For instance, current programmes seem not to be working to respond to the cause as there are clearly not adequate to produce an AIDS-free generation. Levels of basic HIV/AIDS knowledge among young people are generally high, but there is no clear sign that teenage infection rates are falling (West et al., 2007; Coombe, 2003). Hence the idea to develop a well-structured approach on school-based HIV prevention education is necessary (UNAIDS, 2012). The level of knowledge on HIV and AIDS amongst teachers is difficult to access.

Also, inadequate counselling capacity in schools is a major concern for teachers and needs to be increased. This is a difficult challenge and programmes should employ prioritised and feasible approaches to developing core psychosocial support capacities (Coombe, 2003). In addition, the Department of Education of South Africa similarly argued that parents and educators should be more involved and take responsibility to monitor the knowledge and skills of their children at home (DoE, 2000:7). One of the most common views is that primary

schools should be the most appropriate level where learners are taught how to protect themselves against infections and sexually transmitted diseases (Mahomed, 2002; World Health Organization, 1992; Vergnani, 1993; Educator's view in loveLife Workshop: 25/06/2005).

2.6 Culture and HIV/AIDS

Culture is a very sensitive and valuable word in various groups within the society. It holds a critical view; norms, values and standards in many families and can be used as a strategic tool to resolve particular challenges within the society at large. The manner in which culture is viewed and valued differs from one cultural group to the other. Both religious and cultural beliefs can be exploited for the benefit of the society (Shishana et al., 2005). The influence of culture and religious beliefs appears to also have an effect on HIV/AIDS. Campaigns on abstinence, or circumcision of both young women and men are evident in certain cultures (Shishana et al., 2005). In South African traditional belief systems on health and disease, ancestors and God are the ultimate causes of illness (Sow, 1980). It is common for people to believe that they become ill because they have done something to anger the spirits of ancestors or God. Ancestors may either send illnesses themselves to the afflicted person or have withdrawn their protection (van Dyk, 2001). Furthermore, in South Africa most people especially in rural areas still believe that HIV/AIDS is caused by witchcraft (Ashforth, 2001; Kalichman & Simbayi, 2004). Mchunu and Preston-White (2005) reported on the same beliefs in some areas of the Okhahlamba district, in Bergville Kwazulu-Natal. 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 the causes and effects of HIV/AIDS for them to pass it on to the younger generation.

With regards to AIDS, there are beliefs that the condition comes from spirits which is reinforced by the fact that some people have AIDS and others do not without any recognizable differences in their lives (Ashfort, 2001; Goffman, 1968). Attributing the cause of AIDS to ancestral spirits or an angry God leads directly to stigmatizing. They believe that people with HIV-AIDS have surely brought their condition upon themselves and their community. Attributing the cause of AIDS to the afflicted, brings about a sense of repulsion,

as well as the justice of social sanctions, two major dimensions of stigmatizing belief (Goffman, 1963; Marks, 2002).

Chances for educators to face similar challenges as parents in engaging in sexual education is highly common since educators are also members of the society and subscribe to the very same values, norms and standard as the rest of society. According to Helleve et al. (2009), quite a number of teachers saw teaching topics such as sex education, HIV transmission as a response to declining moral standards, while others suggested that they were teaching issues that parents failed to address at home with their children. However, a group of educators were more concerned about young people's sexual behaviour than about preventing HIV/ AIDS. Parents and educators believe that children are still too young to talk about sexual problems and also at home parents do not share any information with their children on sexual issues.

In places such as Asia, preventing the disease is particularly difficult for cultural reasons since talking about sex is a taboo (Commonwealth Secretariat, 2001). Similarly, in South Africa children grow up with the understanding that they cannot discuss sexual issues with their parents or with friends in front of old people because of their cultural beliefs. Some cultural groups, such as the Xhosa speaking people, find it very difficult to mention sexual organs in public since it is viewed as being disrespectful and rude. As a result, some of the teachers were struggling in teaching about sexuality as it was perceived to be challenging in terms of language and communication norms (Visser, 2004). Furthermore, some parents are not comfortable with sex education being taught in schools because they believe that educators will give their children the information that will contradict what they tell their children at home, and in turn go against their culture. Others believe that telling children about the use of condoms is to encourage them to have sex (Van Schalkwyk, 2004; Wilbraham, 2002).

The Commonwealth Secretariat maintains that, "educating learners to use condoms is difficult, but we need to educate them because they are the target and become the victims of HIV/AIDS" (Commonwealth Secretariat, 2002). The UNAIDS Report (2002) points out that young people living in households that were disrupted were less likely to use condoms compared to those living in communities with good infrastructure. It is crucial therefore to understand the role of culture in inhibiting educators from implementing HIV/AIDS initiatives and programmes in schools.

2.7 HIV/AIDS initiatives and programmes as means of breaking silence

It has been reported that children in Africa represent 92 percent of the estimated 2.5 million children under the age of 15 living with HIV globally (World Bank, 2012). Hence, it is still important to find ways to combat the spread of HIV/AIDS. During the 16 Days of Activism [2006], women made mention of the fact that children must be advised to stay away from strangers and any men to avoid being victims of rape. The World Health Organization (WHO, 2003) also mentioned that some of the women become silent about all kinds of abuse that they are experiencing at home. According to Leclerc-Madlala some people living with HIV/AIDS (infected and affected) decide not to disclose their status to anyone including family members but rather die in silence because of stigma (Leclerc-Madlala, 2002 and 2004). Most of the women live in secrecy because of multiple forms of stigma associated with the disease, including being branded promiscuous, a bad mother deserving of HIV/AIDS and many such labels (Commonwealth Secretariat, 2003). In the Sport Strategy HIV/AIDS report (2001-2002:2), Annan argued that “the epidemic can be stopped if people are not afraid to talk about it. We need a complete mobilization of society at large”. HIV/AIDS initiatives such as lovelife, sport activities, Life Orientation and HIV/AIDS and Environmental Committees are very common in public schools but the approach in implementing these programmes differs from one school to another. In most cases it appears as if they are employed as part of extra mural programmes, during free periods to keep learners occupied. Following is a brief look at two different initiatives and programmes:

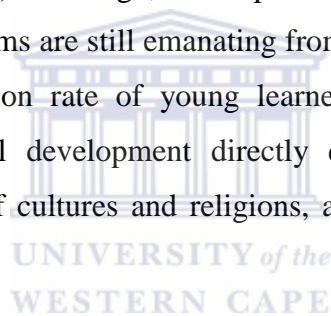
2.7.1 Life Orientation and Health Programmes

The Revised National Curriculum Statement (RNCS) is utilised by schools as a guiding document on how to educate learners in different fields of education. This curriculum entails different sections on how to equip learners with skills that they may need for a healthy life style and better future at an early stage or age. The above-mentioned document has eight learning area statements for Grades R-9. Life Skills is taught in the foundation phase of schooling (Grades R-3) and Life Orientation to the rest of the grades (Grades 4-12) (DoE, 2002).

The Revised National Curriculum Statement - Grade R-9 (2002:26) defines the concept of life orientation “as a guide to prepare learners for life and its possibilities. The life orientation learning area equips learners for meaningful and successful living in a rapidly changing and transforming society”. It is therefore concerned with the social, personal, intellectual, emotional and physical growth of learners. Furthermore, it is aimed at developing skills,

knowledge and values and to empower learners to make or take well-informed decisions in order to have a meaningful and successful life (DoE, 2002; Omar, 2003). In the new Curriculum and Assessment Policy Statement (CAPS) the subject Life Skills is divided into 4 areas: Beginning Knowledge, Personal and social well-being, Creative arts and physical education. HIV/AIDS related issues are covered under Personal and social well-being (Department of Education, 2011).

The Department of Health (2000) identified schools as a better place to develop and empower learners on education and health programs. In addition, many social and personal problems are always associated with lifestyle choices and high-risk behaviour more especially with children as well as learners. The Life Orientation Learning Area Statement has been introduced and implemented in schools to address issues related to nutrition, and diseases including HIV/AIDS and sexually-transmitted diseases (STDs), safety, violence, abuse and environmental health (DoE, 2002). Although, health promotion is part of the learning area in life orientation in schools, problems are still emanating from social relationships, cultural and religious beliefs and the infection rate of young learners is alarming and needs to be addressed (Omar, 2003). Social development directly deals with human rights, social relationships and the diversity of cultures and religions, as contained in the South African Constitution (DoE, 2002).



2.7.2 Lovelife

Lovelife came into South Africa in 1999, as a non-governmental organization to assist in the fight against the backdrop of an epidemic that was continuing to grow along the worse project possible. During that time, many programmes were initiated to fight HIV/AIDS and to help young people protect themselves from the virus by using conventional messages (Love Lifestyle, 2004). Lovelife came on board to play a very critical role in contributing to a campaign that could potentially save millions of young lives from HIV/AIDS infection in South Africa.

The focus of Lovelife is on youth, specifically on those between the ages of 12 and 17. By targeting this age group, Lovelife seeks to encourage critical thinking, promote an optimistic solution-orientated vision of the future, bolster the person's self-esteem, and encourage, fact-based discussions of the issues that affect their lives (Love Lifestyle, 2004; Rapakuana, 2003). The above organization has to build a strong relationship with other organizations in order to reach its target group at all levels of the community and for sustainability. The

organization managed to build sound relations. In addition, the Department of Cultural Affairs and Sport also came on board to work alongside Lovelife by utilizing sport which has been identified as one of the progressive tools to unite people and deal with social development to fight HIV/AIDS (Lovelife Games Manual, 2005; School Sport Policy, 2002).

The Lovelife Debating Programme was initiated and designed to have a broad appeal to young people of all ages, races, abilities and interests. The purpose of the debate is to increase confidence and presentation skills. It forces speakers to focus on problem-solving, changing behaviour and attitude and to expand their minds in making well-informed decisions about their lives (Love Lifestyle 2004; Lovelife Games 2005). However, this programme is failing to serve its purpose because the youth and children are still dying in significant numbers and currently there are some concerns raised with regard to messages that seem not to be clear enough which are presented by Lovelife on billboards and on television.

2.8 Stigma and HIV/AIDS

According to Brandt (1988:148), the way a society responds to problems of disease reveals its deepest cultural, social and moral values and this has certainly been the case with AIDS globally. Kalichman and Simbayi (2004:572) illustrate that AIDS-related stigmas are pervasive in some segments of the South African society and stigmas can impede efforts to promote voluntary counselling and testing and other HIV-AIDS prevention efforts. Research conducted by Jones, (1984), Ainlay et al., (1986), Irwin (1981) and Waxman (1977) reveals that stigmatization and discrimination are some of the major obstacles to effective HIV/AIDS prevention and care. De Bruyn suggests that stigma and discrimination feed on cultural differences and block out common humanity (Save the Children, 2001). Those who are already objectified, marginalized and excluded are pushed even further from recognition of shared humanity and from the support of human society (Sport Strategy HIV/AIDS, 2001-2002:2). Stigma can also contribute to the high level of absenteeism of educators and learners from school. At the same time, parents may even refuse to allow a child infected to go to school with the fear for his/her safety against elements of stigma and discrimination as it can be attached to cultural beliefs (Save the Children, 2001).

Stigmatizing beliefs about HIV-AIDS and associated fears of discrimination often influence decisions to seek HIV testing and motivation to access other prevention services (Chesney & Smith, 1999:573). Stigma is a powerful discrediting and tainting social label that radically

changes the way individuals view themselves and are viewed as persons (Anne, et al., 1998). Different stakeholders agree that the silence and stigma surrounding HIV/AIDS must be broken and replaced by openness and compassion (Leclerc-Madlala, 2004). According to Samuelsen et al., (2012), people who are stigmatized are usually considered deviant or shameful for some reason or the other, and as a result are shunned, avoided, discredited, rejected, restrained or penalized. As such, stigma is an expression of social and cultural norms, shaping relationships among people according to those norms. Stigma marks the boundaries a society creates between "normals" and "outsiders," between "us" and "them" (Goffman, 1968; Dudley, 1983).

HIV/AIDS-related stigma threatens to undermine interventions to prevent and treat HIV/AIDS. To address stigma in a South African community, a thorough understanding of the nature of stigma in the specific cultural context is needed. According to Visser, et al. (2004), more people that become perpetrators of stigma in communities are elderly people, male, less educated and less knowledgeable about HIV. Visser (2007) further states that such people are less likely to know someone with HIV and had more traditional cultural viewpoints. It has been mentioned that "fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover" (Dudley, 1983). HIV/AIDS-related stigma is a real or perceived negative response to an individual, people, communities or societies. Stigma is characterized by a wide range of things including rejection, denial, and discrediting, disregarding, underrating and social distance (Sexual Health, 2004).

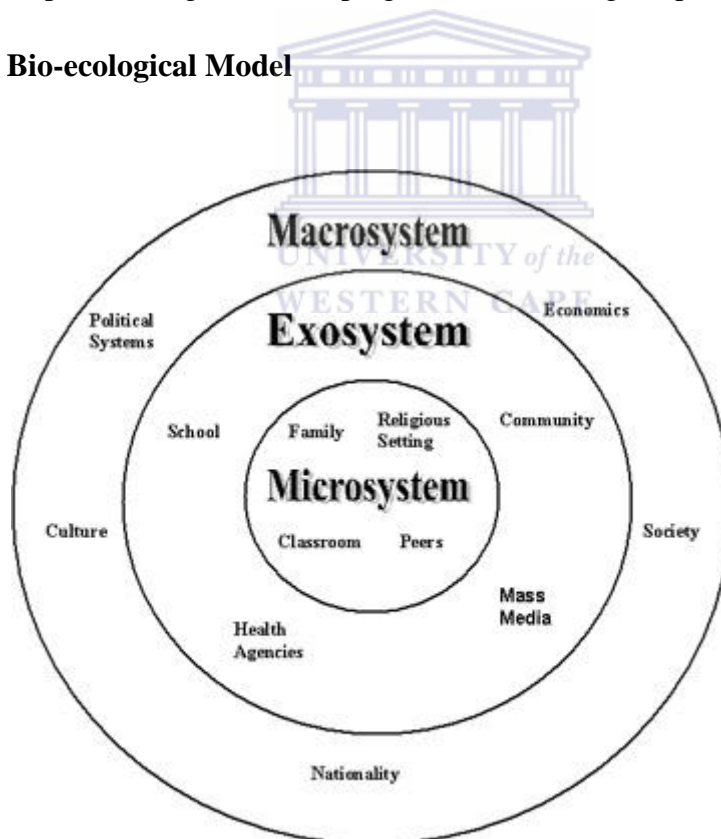
It is difficult to determine the extent to which discriminatory attitudes result in discriminatory actions (although it is apparent how such attitudes will contribute to an environment in which people with HIV/AIDS feel stigmatized). However, it is clear from reports and that people with HIV/AIDS have experienced unfair discrimination in a wide range of areas (Charlton, 2000). Research and inquiries into discrimination against people with HIV/AIDS has shown that it can touch on almost every aspect of a person's life. Surveys of people's attitudes and opinions about such things as working with someone with HIV/AIDS, housing for people with HIV/AIDS or isolation of people with HIV/AIDS have found that a substantial minority hold highly discriminatory views (Charlton, 2000; Centre for the Study of AIDS, 2004). As a

result, it has been stated that women with both primary and secondary education reported that a teacher with HIV/AIDS should not be allowed to teach (Health Population Nutrition, 2003).

2.9 Theoretical Framework

The theoretical framework used in this study is Bronfenbrenner's – Bio-ecological Model. Teachers operate mainly within the Microsystem more specifically on implementing HIV/AIDS initiatives and programmes within the classroom. This is done within a certain internal (the school) and external context (the community, media, health agencies) that make up the Exosystem. They are also subject to a broader context that ultimately informs their practices, when in turn impacts on implementation. This context includes culture, economics, society and political systems. These make up the Macrosystem. The interrelationship between these systems depicted in figure 1 is helping in understanding the phenomenon under study.

FIGURE 1: Bio-ecological Model



Understanding the nature of this study and targeted group (s), the Bio-Ecological Systems Model is very relevant as it is concerned with the interaction between the individual and between different levels of the social context. This is informed by the fact that this model is actual portrayed as a key factor to understand interrelated influential matters within a study

that relate to interaction between individuals, communities and social context (Bronfenbrenner, 1977; Donald et al., 2010). This model align very well with this study as it actually relates to teachers, learners and parents and/ or relatives who are part of the community within which the schools are located (Swart & Pettipher, 2005). In this case, applying Bronfenbrenner's Bio-Ecological model to relate better with teachers, it creates the opportunity to explore how teachers, communities, schools, peers and families influence each other (Swart & Pettipher, 2005). This can be articulated from the view that teachers as individuals belong to families, communities and particular social and economic contexts; and their knowledge and attitude are in most cases informed by particular views within their surroundings. So, in order to understand the knowledge and attitude of teachers on HIV/AIDS related matters in schools within communities, Bio-Ecological Systems theory of Bronfenbrenner has been identified to assisting in serving the purpose of the study (Bronfenbrenner, 1977).

However, it is also important to share the background on the existence and recognition of the model. The Bio-Ecological Systems Model was developed by an Urie Bronfenbrenner (1917-2005) a Russian American Developmental psychologist. He is well known as a developmental psychologist but later became popular for developing ecological systems theory where he demarcated four types of nested systems: the Microsystems, Mesosystem, Exosystem and the Macrosystem. He later added a fifth system called the Chronosystem, the evolution of the external systems over time (Swart & Pettipher, 2005). Nevertheless, due to the nature of the study and targeted group employed within its socio-economic dynamics in a particular community, this finds more expression on three systems as listed in the cycle above.

However, Swart & Pettipher (2005) showed that these systems are aligned to particular principles that speak direct to living conditions of people within a society influenced by a variety of factors to their daily lives. These factors can be informed by the knowledge one has and influenced by information received through political influence, culture and religious beliefs. Mass media can be used as a tool to spread information on a particular view towards a particular direction within a particular context. Hence, a body of information possessed by a person or culture has to be properly analyzed and its validity to people. Some authors argued that there are different forms of knowledge such as knowledge by acquaintance, factual

knowledge and procedural knowledge which have influence in shaping attitude (Reber, Allen and Reber, 2009). This therefore speaks to norms, standards and values that individuals normally apply to their characters influenced by social context (Donald et al., 2010). This also applies to difficulties that one realizes to understand values and actions that lead to a particular behavior of individuals including of parents, learners, teachers and others, if they are divorced from the social context in which they occur (Fazio & Olson, 2003). However, all these factors have a direct bearing to shape and mould the attitude and behaviour of individuals in a community through the kind of knowledge they accumulate from the surroundings on sensitive issues like HIV/AIDS (Bronfenbrenner, 1997).

According to Jordaan and Jordaan (1989), people are more influenced by experiences within the environment they find themselves in at a particular time. Hence, the experience gained can impact to choices individuals make in their lives. Any living style has a potential to stabilize or shake the stability of health systems in a society which can then destroy the entire nation. Those include influence from schools and communities where many people get influenced in decision making by peer pressure and surroundings. These principles relate exactly to what communities are faced with on daily basis about HIV/AIDS related matters on how people view and how they behave in dealing with it. Bronfenbrenner's theory also highlights the complexity of the multiple systems that interact and impact on teachers. This further helps us to analyze through the conceptualization of nested structure on how broader environment influence our character, attitude, beliefs and actions. So, Bronfenbrenner, (1997) clarifies this better in his Bio-ecological model applying all his systems to bring a clear understanding in studies that include HIV/AIDS and psychological barriers such as stigma, discrimination, culture and religious belief on how HIV/AIDS teachers perceive their role and how influences their knowledge attitude and behaviour.

10. Conclusion

In this chapter I reviewed literature using a thematic approach to help understand the challenges and complexities surrounding this highly sensitive issue of HIV/AIDS. I attempted to show that although South Africa is on track in helping to combat the spread of HIV/AIDS, an increase in the number of young people vulnerable to new HIV infections is concerning. The latter concern therefore increases the need for effective and efficient school-based HIV prevention education programmes to be strengthened at all school levels so as to realize a free

HIV/AIDS generation in the future. The literature speaks to the important role that education can play but it also warns of various challenges facing educators in implementing initiatives and programmes relating to such a sensitive issue. The lack of literature on the implementation of HIV/AIDS initiatives and programmes, more importantly one's dealing with the challenges of implementation, especially in primary schools, shows the significance of this study. In the next chapter, Chapter 3, I turn to the methodological procedures followed in this study.



CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

In the previous chapter I presented literature pertinent to this study. In this chapter I present the methodological procedures employed to understand the research question: “What are the challenges teachers face in implementing HIV and AIDS initiatives or programmes in primary schools? I start by illuminating the research design employed in the study, namely a qualitative multiple case study design. This is followed by an explanation of the multiple qualitative data collection instruments used in the study. Included in this discussion, is a discussion of the sampling decisions taken, issues relating to validity, a discussion of the data analysis methods employed and ethical issues relating to conducting research on such a sensitive issue.

3.2 Research Design

As previously mentioned, this study employed a qualitative multiple case study design to gain a deeper understanding of the phenomenon under study. According to Yin (2009), a case study is an empirical inquiry that:

- Investigates a contemporary phenomenon in depth and within its real life context, especially when
- The boundaries between the phenomenon and context are not clearly evident (Yin, 2009:18).

This empirical study investigated a ‘contemporary phenomenon’ namely HIV/AIDS within a ‘real life context’ two primary schools in the Nyanga region. For Yin (2009), the case should be bounded. The case or cases in this study are teachers who teach Life skills or/and those involved in HIV/AIDS initiatives or programmes at two primary schools. Creswell adds to Yin’s definition by stating that:

case study research is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time through detailed, in-depth data collection involving multiple sources of information (eg. Observations, interviews, audio visual material, and documents and reports)...(Creswell, 2007:73).

In this study I used ‘multiple bounded systems’ (two sites) where I collected data using multiple sources, namely, questionnaires, semi-structured interviews, documents and reports.

Conducting multiple case studies is more expensive and time consuming and often leads to a lot of unmanageable data; however, the “analytical benefits from having two (or more) cases may be substantial” (Yin, 2009:61). Added to this, using qualitative methods (as in this study), is more relevant and appropriate when the researcher is conducting an in-depth exploration of sensitive issues like HIV/AIDS and sexuality (Kruger & Welman, 2001:183; Freebody, 2003). Consequently, it became necessary that direct interaction with educators would be the most suitable way of gathering data and such interaction could only be done effectively by employing a qualitative methodology as opposed to a quantitative methodology.

3.3 Sampling

According to Merriam (2009:81), “two levels of sampling are usually necessary in qualitative case studies”. Here she was referring to first selecting the case (the teachers involved in HIV/AIDS initiatives or programmes at the schools) and then do some sampling within the case (not all the teachers involved in HIV/AIDS initiatives or programmes at the schools could be interviewed). Merriam (2009), points to two different types of sampling; probability sampling (of which simple random sampling is the most familiar example) and nonprobability sampling (of which purposive sampling is the most common example). Patton (2002:230) argues that “the logic of purposeful sampling lies in selecting *information-rich* cases...”. The selection of ‘information-rich cases’ depends on the selection criteria (Merriam, 2009).

Bearing all this in mind, I used three criteria to select the schools, which was the first level of sampling: 1) The schools had to be primary schools, 2) schools had to be located in impoverished area, and 3) schools with an establishment rating (quintile rating) of 1 were considered. The latter are schools experiencing extreme poverty and serving communities where the majority of people come from low socio-economic status. These criteria are based on the key targeted areas identified in the South African National Strategic Plan 2012-2016, to which I alluded to in Chapter 1 (see introduction). Two primary schools in Nyanga Township were selected to participate in the research. The second level of purposive sampling was the selection of the actual cases (a convenient sample of 10 educators; 5 from each school). According to Merriam (2009:78-79) Convenience sampling is a form of

purposeful sampling, where the sample is selected based on “time, money, location, availability of sites or respondents, and so on”.

According to Allison (1996), in qualitative research the sample needs to be properly managed and be large enough to ensure a wide variety of answers. Since qualitative research involves open-ended and face-to-face contact between the researcher and participants, the sample becomes small for proper coordination (Freebody, 2003). For that reason, interviews were conducted with (10) ten educators in total – five educators per school. Gender balance (male and female) was taken into consideration. It was important to explore the challenges from different perspectives. Providing contextual detail is crucial in case study research. Babbie & Mouton (2001:282), note that “the unit of analysis in case study research is rarely isolated from and unaffected by factors in the environment in which it is embedded”. I therefore turn to providing a description of the context in which the cases (two primary schools) are embedded.

3.4 Contextual detail: A narrative of Nyanga a township in Cape Town

Nyanga is one of the oldest townships located in Cape Town in the Western Cape. It has a population of 57.996 of which 98% are black people (Stats SA, 2011). The following Maps 1 and 2 provides an indication of where this township, is located. Figure 1 provides a photograph of informal housing which is unique to townships in South Africa.

MAP 1: Location in South Africa



MAP 2: Nyanga Junction



Figure 1: Photograph of the actual township



Nyanga is the area that was identified as a research site for the study about HIV/AIDS and the problems faced by educators in primary schools when dealing with HIV/AIDS issues. Nyanga is one of the townships found in the Cape Town metropolitan area. Like other South African townships, Nyanga has a very fascinating history. As early as the 1940s, Africans were moving to what was then called the Cape Colony in search of work. Their numbers increased every year. But the state did not welcome them. In fact, they were perceived to be a ‘nuisance’. Consequently, the majority of them were sent back to the rural areas where they had come from. Only those who had jobs were allowed to remain. Accommodation was a problem and the apartheid state used it as a justification for sending them back home. Later, Langa Township was built. There were single hostels meant to accommodate males only. Their wives were not welcome.

During the 1960s, there were two waves of settlement that took place in the Cape Town and African migration to Nyanga was one of them. Although Africans had started coming to Cape Town a few decades earlier, in the 1980s the ‘illegal’ process of large-scale African migration from the impoverished areas of the Eastern Cape began in earnest. People came to this and other areas in search of jobs so that they could support their starving families back home.¹

Nyanga began as an extension of Gugulethu (a neighbouring black township in the Cape Town) and even now many people in Nyanga have family members still living in Gugulethu. Nyanga is sub-divided into five areas: Nyanga, Crossroads, Philippi East, Brown’s Farm and

¹ As expected, there were a number of clashes with the agents of the apartheid government but I will not dwell much on that subject here. Details about how Nyanga came about are provided below. Suffice to say influx control has been a problem in Cape Town for many years and this contributed significantly to the sour relations between whites and blacks.

Samora Machel. This geographical area is characterized by high levels of poverty, overcrowding, crime, unemployment and illiteracy. The area is seriously under-resourced and underdeveloped.

Nyanga is known as a battlefield of wars between big taxi associations: Cape Amalgamated Taxi Association (CATA) and Cape Organisation of Democratic Taxi Association (CODETA) and political wars between African National Congress (ANC) and United Democratic Movement (UDM) members, especially around election time. The crime pattern in Nyanga and Gugulethu is very similar. In 2003, Nyanga had the second highest number of murder cases in the country, an average of more than one murder a day, and a high rate of other serious and violent crimes such as rape and hijacking (Kamaldien, 2012).

Nyanga has one police station, a satellite police station, a small magistrate's court and one Day-Hospital next to Zolani Center (UMAC, Managing Conflict, 2005). From January to December 2004, there were 50 charges for child abuse and from January to March 2005 there were ten charges for child abuse in Nyanga. What is disturbing is that parents are afraid to come forward to report cases like rape because the people that are directly involved in these incidents are fathers and/or family members who are also the breadwinners. So, they are afraid of losing the breadwinners. An article in the City Press shows that sex and drug crimes, hijacking and kidnapping have all increased in Nyanga Township, named the Western Cape Province's murder hotspot (Kamaldien, 2012).

At the same time most women fear a situation whereby they will risk the lives of their children (Siyanoqoba Support Group, SABC 2, 12/06/2005). As a result, the crime rate in this area is increasing and many children are becoming more vulnerable to rape and are getting exposed to HIV/AIDS (see for example *Statistic South Africa*, Census: 2001). Nyanga is one of the poorest areas of Cape Town with unemployment estimated to be around 70%. HIV/AIDS is a huge community issue and one of the many problems besetting this area. This is the township where the current study was conducted.

3.5 Data Collection Instruments

As previously noted this study used multiple sources to collect data. In this section I outline the various sources used in the data collection process.

3.5.1 Questionnaires

Questionnaires, as a research instrument, are normally used when conducting quantitative research. It can reach “many people in an easier and quicker way and is less time consuming and financially expensive” (Carrim, 2006:230). I used it in my study merely as a means of better understanding the qualitative data. It was especially useful in understanding the context and to gain a broader perspective from a larger group of people, both those involved in HIV/AIDS initiatives and programmes but also from those not involved. The questionnaire (refer to Appendix 4) dealt with both open and closed questions. The open questions provided greater depth since participants had time to think and ponder about the issues at hand. People felt free to comment on this sensitive issue since their identity was not revealed. Table 1 outlines the different categories of questions covered in the questionnaire and the purpose for asking these questions.

TABLE 1: Purpose of questions covered in the questionnaire

Question number (s)	Category	Purpose
1-3	Biological details	Provide standard details about the nature of participants
4a and 4b	HIV/AIDS initiatives or programmes	Get a sense of the type of initiatives or programmes the individual schools are involved in.
5a and b; 9	Teacher knowledge and level of confidence	Ascertain the level of knowledge and skills teacher of teachers regarding HIV/AIDS issues and whether they were confident enough to teach or initiate HIV/AIDS programmes
6, 7 and 8	Problems and Support	To identify problems teachers faced when implementing such programmes, how these problems could be addressed and determine the nature of support for teachers to ensure successful implementation.

3.5.2 Semi-structured interviews

In this study semi-structured individual and focus group interviews were employed to explore teachers' views regarding the challenges they face when dealing with issues relating to HIV/AIDS in the primary schools. According to De Marrais (2004), an interview is “a process in which a researcher and participants engage in a conversation focused on questions related to a research study” (2004:55). Merriam (2009) identifies three types of interviews: highly structured interviews (which strictly follow a predetermined interview schedule), semi-structured interviews (where the interview schedule acts merely as a guide) and an unstructured interview (no schedule is used and it is more like a conversation). I selected semi-structured interviews because it was more flexible and it allowed me to “respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic” (Merriam, 2009:90). Guided questions used in the interview schedule can be found in Appendix 4.

I also, as mentioned above, made use of both individual and focus group interviews. Focus interviews were useful in that I could draw on the different perspectives on the matter but it presented me with a few challenges. Firstly, focus group interviews required a certain skill. I had to learn to set boundaries, learn how to record and identify the different voices. Another challenge was getting the group together when it was convenient for all participants. Here I had to follow strict timeframes. Two focus group discussions (5 participants per group) were held, one at each school. Teachers who participated were identified from three categories: Teachers involved in teaching of life skills and life orientation, teachers involved in physical development and movement programmes at the school and teachers who coordinated HIV/AIDS initiatives as part of the extra-curricular activities.

Sensitive issues that teachers felt uncomfortable to discuss as part of the focus group interviews were probed further in the individual interviews. The same 10 teachers were subjected to individual interviews. Individual interviews, according to Babbie & Mouton (2001), are one of the most frequently used methods of data gathering in qualitative research. They further add that “it is an open interview which allows the object of the study to speak for him/her/itself ...” (2001:289). The individual interviews were crucial to this study since it added more depth and was useful in verifying issues that were raised in the focus group discussions. The use of the tape-recorder played a very crucial role during the research, as it was not easy to write everything down while listening. Informal interviews were held with principals as a means to introduce the study, get a feel for the school context and the way

things are done at the individual schools and to identify possible participants for the study. It was during these initial informal interviews that the three categories of teachers involved in HIV/AIDS initiatives or programmes were identified to participate in the focus group interviews.

3.5.3 Documents and reports

Merriam (2009) defines a document “as the umbrella term to refer to wide range of written, visual, digital, and physical material relevant to the study at hand” (2009:139). In this study policies, reports (international and national reports) on HIV/AIDS related issues, school HIV policies and teachers records were scrutinized for its relevance to the research questions and formed part of the data analysis process. Merriam (2009) note that documentary sources are ‘unobtrusive’, “easily accessible, free, and contain information that would take an investigator enormous time and effort to gather otherwise” (2009:155). She does, however, warn that these documents should be checked for ‘authenticity and accuracy’ (2009:154). Now that I covered the data collection instruments used in this study, I now turn to the procedure followed in the data collection process.

3.6 Data Collection Procedure

Before the interviews commenced I made an appointment with the schools’ secretary to meet the principals. The purpose of the meeting was introduce my project and to get permission from the principal to work with educators as participants in the study and to make arrangements on how, when and where the data would be collected at the school. Gaining access to schools for the purpose of research is a difficult process. It was important for the principals, as the ‘gatekeepers’ to buy into my study first. After the principals granted the permission I was requested to meet with educators. One principal asked that I do the presentation for the whole staff so that everyone could have a clear understanding of the study considering the culture so that all participants could be free to express themselves. The principal mentioned that by doing so, I would be creating more opportunities for educators to avail themselves to participate based on their understanding and their interest on the presentation. The other principal allowed me to meet with key teachers involved in HIV/AIDS related issues at the school and I could then arrange times and dates to meet with them. An information sheet (see Appendix 1) and copies of the instruments (see Appendix 4

and 5) were circulated amongst the relevant teachers beforehand. I managed to build rapport with the interviewees, as it was not the first time working with some of them from both schools.

3.7 Data Analysis

According to Merriam (2009), “the process of data collection and analysis is recursive and dynamic” (2009:169). Furthermore, Merriam (2009) defines data analysis as “the process of making sense of the data” (2009:175). She further states that:

Data analysis is a complex process that involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning, between description and interpretation. These meanings or understandings or insights constitute the findings of a study (Merriam, 2009:176).

In this study I used the following basic steps to analyse case study data as suggested by Babbie & Mouton (2001) and Leedy & Ormrod (2005) to make sense of the raw data:

- Organizing data – Interviews were transcribed and documents were analysed for its relevance to the research questions. Questionnaires were analysed using SPSS. The data was broken down into smaller units.
- Generating categories – After perusing the data a number of times, data was coded (open coding) according to certain categories.
- Identifying patterns and themes – Broader categories were identified (search for similarities and differences) to establish patterns and themes (analytical coding).
- Testing the up and coming themes against the data,
- Researching alternatives that would assist in the explanation of the data and
- The writing up of the report.

3.8 Validity and reliability in qualitative research

Yin (2009) identifies various ways of testing the validity and reliability of the study. The following table adapted from Yin (2009:41) provides insights into how this process was followed:

TABLE: 2 TESTING FOR VALIDITY

TEST	Case Study tactics	Phase of the research in which the tactic occurs
Construct validity	Using multiple sources of evidence(method triangulation)	Data collection phase
Internal validity	Do pattern matching	Data analysis phase
External validity	Use replication logic in multiple case studies	Research Design
Reliability	Develop case study database and making the procedure for data collection explicit	Data collection

In this study I adhered to all four ways to test validity. I used multiple sources to collect data (questionnaires, interviews and document analysis) from multiple sources (teacher involved in teaching Life Orientation, Teachers who head HIV/AIDS initiatives and programmes at the schools, and teachers involved in physical movement and sport programmes at the individual schools). This allowed for triangulation, which according to Babbie & Mouton (2001) is the best way to enhance validity and reliability in qualitative research.

3.9 Limitations

As researcher I was aware of the fact that I was dealing with a sensitive and confidential issue, namely HIV/AIDS related issues. I was also aware that some of the potential informants might not feel comfortable to express their views fully because of their cultural and religious beliefs inhibiting them to talk about sexual issues. Others would be restricted maybe because of their status on HIV and AIDS, whether the person is infected or affected because of parents, family members, close friends, neighbours or colleagues (Bowling, 1997).

Furthermore, I identified only two schools as case studies within the whole community of Nyanga. However, it should be noted that there is very limited information on some of the HIV/AIDS related issues at primary school level. Time was a constraining factor in

conducting this research. Certain teachers could only stay at school till a certain time because of transport and as a result in some interviews not all the questions were answered. However, that said, the present study provides valuable information about the experiences of educators who are tasked to work with learners on HIV/AIDS issues and sexuality in general. One major limitation was the time that lapsed between the interview dates and the time of reporting on this study. As previously mentioned most interviews were conducted in 2006. I did however revisit schools in 2013 to try to update most of what I initially found. Teachers then completed questionnaires covering most of the interview questions. I did this to gauge whether the study was still viable and to test whether or not the responses differed from my initial findings. Therefore, although this report is based on a case study, its findings, as shall be seen below, are far-reaching. Realising that this study involves issues of a highly sensitive nature, ethical concerns was a huge priority.

3.10 Ethical considerations

Babbie & Mouton (2001) note that ethics is typically associated with morality, and both deal with matters of right and wrong. Ethics is defined as conforming to standards of conduct of a given profession or group. I am fully aware of the fact that this research deals with or involves many sensitive issues and has to be treated with a high degree of confidentiality (Silverman, 2001). Nevertheless, some authors have a problem with researchers that use anonymous informants for confidentiality in their studies and they discourage researchers from doing that (Silverman, 2001). But, other authors such as Renzetti & Lee (1993) speak of maintaining anonymity, which is why in this study I used terms like “educators” and “participants” instead of mentioning their names, as it becomes an important factor in sensitive studies in order for the researcher to gain access to participants. To concur with the above statement, I was left with no choice but to use anonymous informants when other people were interested to participate in the study but refused to mention their names. So, to gather more information and gain access on them, I needed to build trust and respect their right not to be mentioned by names in their contribution to this study. However, I did not find it difficult as such a request is allowed and acceptable in academic circles, especially when one deals with sensitive and confidential study (Allison, 1996).

Participants also have a right to privacy, confidentiality, safety, and anonymity (Babbie and Mouton, 2001). These rights are enshrined in the national constitution. As a result, for the

progress of the study the participants were informed prior to their involvement in the project about the confidentiality of their inputs which encouraged them to speak freely (Denzin and Lincoln, 2000). In addition, school names instead would be referring to as schools A and B; and those of the educators are not mentioned in the report, as their principles and values have to be respected (Silverman, 2001; Dale and Davies, 2004). All participants were told in advance that while their involvement in the study was crucial, they were not obliged to participate in the interview. The participation had to be on a voluntary basis not by force or people being threatened (Babbie & Mouton, 2001). Moreover, those who agreed to participate were told that they could withdraw at any time without being asked to provide reasons for their withdrawal. This was based on the understanding that there should be no harm to the participants (Babbie and Mouton, 2001).

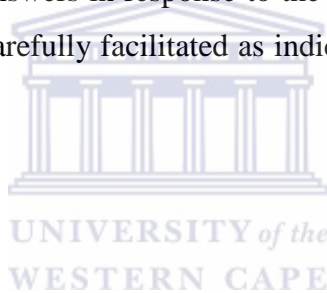


CHAPTER FOUR: FINDINGS AND DISCUSSION

4.1 Introduction:

This chapter presents the study's findings as reflected in the interviews and other sources used in this study. The central objective of the study was to investigate challenges teachers face in the implementation of HIV/AIDS initiatives and programmes in primary schools in Cape Town. The purpose is to present the findings and provide a discussion of the findings which includes an interpretation.

In this chapter data is presented in a narrative form and textual manner. The results of the analysis are based on multiple-case study, in-depth interviews and focus group discussions. Six questions were strategically developed to guide participants and also to provoke coherent discussions that would provide answers in response to the purpose of the study. The process of conducting the research was carefully facilitated as indicated below and the approach was employed in both schools.



4.2 Overview

Interviews with the informants were conducted within a period of one month in April 2006. The participants were educators or teachers working in two primary schools which formed part of this study. The participants were spread between Grade R and Grade 8. As mentioned in the previous chapter, participants are referred to as educators and remain anonymous throughout this thesis. However, for the ease of reference, schools will at least be identified as "Site A and Site B" and educators will be named by numbers as educator 1. For example, if I want to relate to a particular view from a particular teacher, I would rather write as educator 1 from Site B so as to make things much easier for findings and discussion.

As noted previously, ten educators were interviewed from three categories: life orientation, physical development and movement, and co-ordinators of HIV/AIDS programmes. However, it was then brought to my attention by participants themselves that some of them are involved in all the categories mentioned above. Each interview lasted from 30 to 60 minutes. There were 5 educators in total that participated per school and two educators per category. As noted in the methodology chapter, I also conducted focus group discussions.

This chapter is therefore devoted to the findings from both individual and focus group interviews, as well as from questionnaires conducted with the 10 educators and principals. The latter was mainly to quantify what emanated from the qualitative data as explained in Chapter 3 (see 3.1). In this chapter I start by profiling each school and then describing the cases. This is followed by a discussion of the various themes that emanated from the data analysis process.

4.3 Profiling Schools

In this section I profile the schools. I briefly look at the school population, infrastructure and environment. Further I allude to the nature of the school's policy on HIV/AIDS.

4.3.1 Profile of Site 1: School A

This school is directly located in a community called Crossroads in Nyanga Township. The school is 20 years old and had a total number of 38 educators with 28 female educators and 10 male educators and 1365 learners at the time I visited the school. This school is well designed with an indoor sports hall which, at times, is used to host school events, community functions and exams. The level of crime within the area where the school is located is fairly high as presented in previous chapters and the two schools identified are not immune to many criminal activities. However, there are measures in place that ensured the safety of both staff and learners. As a result of these safety measures, learners are strictly kept in the yard and not allowed to go out of school premises during school hours with full time guards at the entrance/exit gate. There are policies in place on health and HIV/AIDS for the school. However, the HIV/AIDS coordinator at the school expressed the problems they experienced in formulating the policy noting that “it was a cut and paste from the Internet and I kept it in my file until we have time to develop our own policy because that does not speak to challenges faced by the school. That is why there are no mechanisms yet because one is quiet on many things that relate to our situation”. It appears that even though the school has a policy the policy has not been shared with all role-players and it does not speak to this particular school since it was taken off the Western Cape Education Department (WCED) website.

4.3.2 Profile of Site2: School B

Like School A, School B is also directly located in a community called Crossroads at Nyanga Township and is 24 years old and had a total number of 21 educators with 17 female educators and 4 male educators with a total number of 1883 learners enrolled at the time of interviews. There is a School Governing Body that partakes in policy making and decision taken at school. Although School B and School A are located in the same area and face many of the same problems (crime, poverty and unemployment) infrastructural School B is worse off than School A. They experience resource problems both in terms of material and human resources, the school building is in a bad condition and there is limited space to accommodate the number of learners currently attending the school. As a result, some classrooms are overcrowded by learners. In some instances, one found three learners squeezed in a study desk meant to be shared by only two learners. The school, like School A is also fenced in and learners are not allowed to leave the school during school hours. The safety of learners and staff is a priority. The school at the time when the research was conducted had a draft HIV/AIDS policy but this policy still needed to be adopted by all stakeholders.

4.4 The Cases

In this section I provide an understanding on the conditions and characters of the participants of this study. Table 3 provides the background of educators who participated in this study, where they come from, where they obtain their HIV and AIDS knowledge and information and what information around HIV and AIDS they received as guided by questionnaires (Appendix 5). Giving a background of educators in this study falls in line with the Bio-Ecological Model (see Chapter 2, section 2.9) which relates better to the attitude and knowledge of individuals and HIV/AIDS as part of a human cycle. In this case, it relates to educators that belongs to a community consist of many influential institutions including schools, religions, politics, health and culture to a character of an individual that has a responsibility to deal with sensitive matters such as HIV/AIDS. As previously mentioned not all educators participated in the study. Only ten educators in total and 5 per school from two primary schools in Nyanga, Cape Town, volunteered to participate in this study. Of the ten educators, three males and 7 females made up the sample. However, some shared fields of work whilst others were responsible at different levels. For instance, of the ten participants some were responsible partly to their work to teach intermediate-phase, life skills and life orientation, Conveners of Social & health Committees and Coordinators for HIV/AIDS

Committee from both schools participated. The average age of the group was 59 and the average level of teaching experience was 30 years. All the teachers in this study attended racially-segregated primary and high schools in the Eastern Cape and Cape Town during their formative years. They all had teacher training and 7 had successfully completed a three-year teachers' diploma and the remaining three participants had obtained an initial degree in education. Some studied at University of the Western Cape (UWC) and at the Cape Peninsula University of Technology (CPUT). Five of them obtained Honours degrees from UWC and CPUT on HIV/AIDS related studies. Following is Table 3 which provides the profile of the educator respondents:



TABLE 1: Profiling the Cases

Code	Site: School A or School B	Age	Gender	Years of Experience	Responsibilities	HIV/AIDS initiatives and programmes currently involved in
A1	School A	47	Female	23	Foundation Phase Teacher	Grassroots soccer, Hoops for Hope. Community health intervention programme
A2	School A	48	Female	19	HIV Coordinator	Work with Bambanani, Hoops for Hope, Grassroots soccer and teach Life Skills
A3	School A	51	Female	23	Convener of Social and Community health Committee	Grassroots soccer, Iltha Yabonga and Bambanani – programmes initiated by Department of Social Development
A4	School A	51	Female	23	Foundation Phase Teacher	Hoops for hope, Grassroots soccer, HIV& AIDS, Chips at Sport Science and Love, life
A5	School A	44	Female	19	Life Skills Teacher	Love life games, Community health intervention programmes, HIV/AIDS, Work with Bambanani, Hoops for Hope, Grassroots soccer and teach Life Skills
B1	School B	40	Male	13	Teacher	International AIDS Days and September as candle light month
B2	School B	49	Female	23	Coordinator of Environment & HIV and a member of Health & Social Committee	International AIDS Day, Candle light Day in September and Ons Plek Project
B3	School B	37	Male	12	Teacher	World AIDS Day and Learner Perform Play drama & Poetry related to HIV/AIDS
B4	School B	59	Female	30	Coordinator of HIV/AIDS	Candle light in May, World AIDS Day and School World AIDS month in September
B5	School B	35	Female	10	Life Skills	World AIDS Day, September month for schools to organise HIV/AIDS initiatives

A number of aspects are worth noting from the table above: As previously noted, this study is situated within a primary school as schools are viewed as better placed and organised institutions to empower the nation through knowledge about HIV/AIDS and other related illnesses targeting young people (HIV/AIDS National Strategic Plan, 2012-2016; Department of Education, 2001 and 2003). In South Africa primary schools cater for learners between the ages of 5 and 13 from Grade R to Grade 7 or 8 across three phases: Foundation Phase (Grade R-1); Intermediate Phase (Grades 4-6) and Senior Phase (Grades 7-8). Most of the teachers participated in this study were teaching in almost all the grades mentioned above.

However, from the table above, it is worth noting that quite a number of these participants were trained under the old curriculum and were therefore not exposed to much training in Life Skills. Furthermore, the table clearly shows the nature of programmes and initiatives organised in these schools which were more ceremonious as set by national Departments. In addition, these were just once off events with nothing much related to informative programmes and initiatives so as to empower and skill educators to assist vulnerable learners by HIV/AIDS and other related diseases. The table also shows that most of these events were organised through external assistance than through the Department of Education (DoE). As a result, the picture drawn from above expressed the nature of the programmes and initiatives organised in schools, which was partly relevant but at a very small scale compared to what one would expect understanding the situation faced by both learners and educators on a fight against HIV/AIDS in schools.

4.5 Discussion of themes emanating from the findings

In the previous two sections of this chapter (section 4.1 and 4.2) I provided a profile of the schools and of the cases. I now turn my attention to the discussion of the themes that emanated from the data analysis process. In order to understand the challenges teachers face in implementing HIV/AIDS initiatives and programmes one cannot divorce them from the inter-locking systems of which they form part (see Bio-Ecological Systems Model – Figure 1 in Chapter 2). Following is a discussion of the findings based on the following themes:

- Teachers training and knowledge on HIV/AIDS
- Culture, tradition and beliefs: Parental choice

- Stigma and discrimination
- Factors inhibiting successful implementation of HIV/AIDS programmes and initiatives

4.5.1 Teacher training and knowledge on HIV/AIDS

The following table (Table: 4) illustrates the type of HIV/AIDS related training teachers received

Table 4: Type of HIV/AIDS related training teachers received

Code	Site: School A or School B	Gender	Teacher Training
A1	School A	Female	HIV/AIDS
A2	School A	Female	HIV/AIDS, Soul Buddyz & Train the Trainer for 6 months
A3	School A	Female	HIV/IDS & Sexuality
A4	School A	Female	Hoops for hope in 2005 & Life Skills
A5	School A	Female	HIV/AIDS & Sport Science
B1	School B	Male	Not trained
B2	School B	Female	Bereavement Support & Life Skills for two days
B3	School B	Male	Not trained
B4	School B	Female	CAPS, One Day training for School Curriculum
B5	School B	Female	Trained in life skills

As previously mentioned, Visser, (2007) and Campbell et al. (2002) suggest that knowledge and attitudes are easiest to change, but behaviours are much more challenging. Moreover, in an information sheet depicting the Western Cape Education Department (WCED) plans for HIV/AIDS and sexual education (WCED, 2003) the department noted that “most children enter school HIV-negative; a growing number leave the school HIV-positive”. In Chapter 1 (Section 1.1) I make reference of the increase of HIV/AIDs amongst young people between the ages of 15 and 24. Furthermore, the WCED through the curriculum and extra-curricular activities encourages teachers to “raise awareness, to disseminate information on HIV and its transmission, and to help change the attitudes, values and behaviour of young people to inhibit the spread of the epidemic”. In the above table I allude to teacher training especially in Life Skills (Foundation Phase) and Life Orientation (Intermediate and Senior Phase). To assist both the educator and learner with HIV/AIDS and sexuality life skills education, curriculum-compliant learning support material (LSM) has been developed and has already been widely distributed.

To assist learners in acquiring the appropriate knowledge, skills and values, the department notes that educators should receive continuous training in HIV/AIDS and sexuality life skills education. The WCED has provided the Provincial Government with an undertaking that 80% of its primary school educators will be trained in HIV/AIDS. Thus far, approximately 85% of schools (and 10 000 educators) have received this training (WCED, 2003). The HIV/AIDS National Strategic Plan, 2012 – 2016 and that of 2007 – 2011; and of 2002-2005 emphasized the need to strengthen HIV/AIDS interventions for young people towards 50% reductions on new infections and elimination of high risk behaviour and attitude (UNAIDS 2012). It has been reported that the most vulnerable of them all are young school-going children of both genders (Maleka. 2009). James et al. (2004) also suggest that during the school going period children require more attention and appropriate guidance as various patterns of behaviour are developed at this stage and can either protect or place young people at risk later in their adult life. Teachers, however, have to receive sufficient training in order to handle such a sensitive issue especially with vulnerable children. It is clear from the table that 8 out of the 10 teachers have responded yes to receiving training. However, the nature of the training was problematic as expressed by Teacher A1:

Yes! we have serious challenges, even though we attended these training but we were trained by NGOs playing games, when DoE trained us, it was some time in 2007 and it was a once off training for two weeks and never again until now.

Teacher B1, however, expressed that he did not receive any such training; as he puts it:

I have 12 years now in teaching and never received any training neither from the NGO nor Department of Education...mmh.....by the way I am not even comfortable talking about it... you know how sensitive is to talk about AIDS elokshini [township].

Besides some not receiving training there are those teachers who do not attend training sessions. As in the case of B1 who noted that:

Yho! I didn't attend any training Mam on HIV/AIDS. That thing becomes a responsibility of educators in HIV committee. They attend training and don't give a proper report back but just say some of the things they have learnt in

passing as comments when we generally speak about something related to.

Here the educator feels that it is not his responsibility to attend these sessions and that such sessions should be left to teachers involved in HIV/AIDS committees at school. This is despite all the policies and guidelines developed by DoE in ensuring that all schools advocate possibilities to fight against the spread of HIV/AIDS by empowering all educators and encouraging them to develop specific HIV/AIDS policies with Health Advisory Committees respectively (DoE, 1999 and DoE on Guidelines for educators, 2000a). Hence, there are norms and standards for educators which specify the role and confidence expected from educators in dealing with HIV/AIDS at school (Department of Education, 2000b). Moreover, the White Paper and Special Needs Education on building an inclusive education and training system is in place in relation to all learning barriers faced by children be it mentally disturbed and socio-economically challenged (DoE, 2001a).

There are also other strategic tools established as means of empowering education system to help educators to carry the task of at hand on HIV/AIDS and related matters. The Department of Health (2001) further supports this responsibility by developing policies that also seek to empower educators on how to support learners surviving under difficult circumstance of HIV/AIDS infected and/ or affected within school context. DoH further encouraged schools to establish school-based support teams to enable them to respond with speed on health and other socio-economic barriers faced by vulnerable children (DoH, 2002). Nonetheless, it has to be noted with serious concerns that with all the policies and legal guiding documents listed above educators still have to carry the extra workload.

Coombe (2000) conveniently argued on the basis that the load of work allocated to teachers is too much. Teachers work already involves the implementation of a curriculum and given South African children's poor academic performance adding extra duties is as important as educating the young on HIV/AIDS related issues could mean more work. So, this suggests that whilst schools are proven to be part of the strategic and key sites to educate children and young people on sensitive issues related to HIV/AIDS and sexual education, extra human resources are required to solely focus on executing that task than to overload teachers and redirect them from their actual responsibility. This is reiterated by Hoadley (2009: 151) who argued that "teachers are struggling to teach, students are failing to learn and school managers are battling to run efficient and effective organisations". She feels that adding the

additional role placed on educators to initiate HIV/AIDS programmes cannot be expected of schools. The lack of training and reporting on training could be seen as a challenge in implementation of HIV/AIDS initiatives and programmes in schools. Hoadley suggested that “ways need to be found to support schools in becoming supportive of vulnerable children” (2009:151).

4. 5. 2 Cultural and traditional beliefs: Parental Choice

The Department of Education (2001) stated that one third of children between the ages of 12-17 have had sexual intercourse and a large proportion of these children experienced sexual activity by force and/or violence. De Villiers (1985) also reported that South Africa has one of the highest teenage pregnancy rates in the world and that most of these births occur among the poorest sector of the population. Jewkes et al., (2001) agrees that teenage pregnancy is common in South Africa. They add that this puts teenagers at risk of HIV noting that 1 out of 5 pregnant teenagers are infected with the virus. Traditional leaders in most rural areas in South Africa have created some confusion by advising their clients to sexually engage with young girls (virgins) to cure HIV/AIDS. This myth that sex with a virgin can 'cure' a man who is HIV+ has led to a large number of rapes, sometimes of very young children (Thom, 2002; Commonwealth Secretariat, 2001; Ashforth, 2001:130). The reality is that having sex with a virgin will never be a cure to HIV but will cause pain and misery and may infect the virgin with the HIV virus eventually reducing her life span (Department of Education, 2000). A child who engages in sexual activity either voluntarily or involuntarily is at greater risk of coming into contact with HIV if they live in a high-prevalence area, as in the area in which my research was conducted.

According to Shisana (2002), both religious and cultural beliefs can be exploited for the benefit of society. She argues that the influence of culture and religious beliefs appears to also have an effect on HIV/AIDS; through HIV/AIDS campaigns on abstinence or circumcision of both young women and men are evident in certain cultures as a tool that can be used to minimize the spread of the virus (Shishana et al., 2005). In contrast Sow (1980) notes that in South Africa, traditional belief systems on health and disease, ancestors and God are the ultimate causes of illness. There is also a belief that AIDS is caused by witchcraft and that can be a factor in delaying people to get tested and know their status so as to find necessary support and medication to minimise the spread (Shisana and Simbayi, 2002).

Kalichman et al. (2004:573) concurs and stated that “with respect to HIV-AIDS, 4% of South Africans believe that AIDS is caused by witchcraft and 14% are unsure whether AIDS is caused by witchcraft and traditional beliefs are likely even more prevalent in rural areas”. According to Brandt (1988: 148), the way a society responds to problems of disease reveals its deepest cultural, social and moral values and this has certainly been the case with AIDS globally. The latter view seems to be more dominant from the engagement with participants in this study. Sow’s (1980) argument resonates with current challenges faced by educators as they remain members of the community whilst educators by profession are not immune to some of the limitations influenced by cultural beliefs on HIV/AIDS related programmes offered at school as expressed by Educator B3:

Where I grew up back home my grandparents told me not to talk about sexual terms and naming private parts in public. In my culture that is viewed as taboo, disrespect and expose high levels of ill-discipline from your family.....at least when we are together as guys.

Educator B1 concurs with Educator B3 by expressing that:

Even today when I watch TV with my mother and see people kissing I shift my eyes away and become so uncomfortable such that if they continue I change the channel. So, sister... you can imagine how difficult is to talk about HIV/AIDS related matters with kids in a classroom situation its worse when you name private parts in isiXhosa it sounds very rude and as amadoda (men) it’s just hard.

Serious limitations on cultural and traditional beliefs were evident from both schools as some of educators stated that people who resides in the community where the study was conducted originates from rural areas or communities of Eastern Cape and at times prioritise cultural beliefs and view traditional healers and pastors as the only solution against scientific matter that would require testing by scientific doctors to get proper medication. Stadler (2003:157) also confirmed by alluding to the fact that most elders in South Africa especially in rural areas still believe that traditional healers can cure HIV/AIDS. Educators further illustrated the reality on the negative attitude and behaviour of parents towards HIV/AIDS and sexual education. For instance, there was a time where a parent visited their school to complain about what a child mentioned at home, as explained by Educator B1:

Another old lady came here very angry with a pamphlet that was used in a classroom and given learners to crayon it with different colours and it had

private parts....hahahaha (laughing)! yho! you can imagine.... lo mama (mother) wanted to know who is teaching children at school.... that thing. You know moss kids.... they were just laughing

Educator A2 noted that:

We have a serious challenge here because parents are not honest. They do not come and disclose the status of health of their children ... that they take medication.

From the findings it appears that both educators and parents are held captive by their culture and religion which makes talking about HIV/AIDS and any sexual related topic problematic. However, there are policies that the Department of Education has put in place that speaks to these challenges in a way of guide on sexual challenges that learners get exposed to at a very early age. Teachers who participated in this study were fully aware of the HIV and AIDS pandemic as they are confronted by it in their schools and homes. They therefore admitted that it should be taught in primary schools but were not trained fully to be able to teach it and at the same time be culturally sensitive. Teachers believed that approximately 10-15% of learners between Grades 4-7 were already sexually active and there were cases of teenage pregnancies in both participating schools. But, as previously mentioned some educators suffer most to execute this task of educating learners about HIV/AIDS and sexual education and really struggling to relate well with parents as educator B2 puts it:

I am not comfortable, it's not easy to openly speak about this sensitive subject due to lack of co-operation from parents on how to educate their children on HIV/AIDS and sexual education at school level, judging from their response and reaction to us when they heard their children at home talking about condoms, penis and virgin they do not want them to be educated about those things.

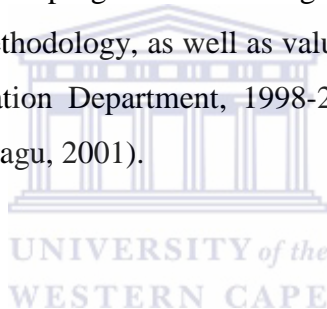
The study also shows that educators, especially those that teach in the foundation-phase, found it much better and easier than those teaching in senior grades to speak about HIV/AIDS. They, however, expressed that learners in the intermediate-phase are more open when it comes to such discussions even going as far as to disclosing the status of family members. The extracts below expresses some views of educators who teach in the foundation phase. For example, Educator B4 states that:

I feel comfortable to deal with some sensitive issues of HIV/AIDS and some terminology that are somehow not suitable for their level of age.

Educator A1: It's more comfortable and confident to address issues of HIV/AIDS, she boldly says that:

I am comfortable because I am a foundation phase teacher dealing with 6-9 year old learners. However that does not take away the issues I encounter on the lack of skill on counselling...because it's of no use to just talk but when they disclose their status or of a family member I cannot help.

According to van Schalkwyk (2004), parents are regarded as the first people who can play a vital role by being primary sexuality educators to their children at home. It is suggested that parental involvement should include programmes relating to HIV/AIDS, sexuality education program, learning content and methodology, as well as values (Asmal, the former Minister of Education; Western Cape Education Department, 1998-2000; Berger, 1995; Heystek and Louw, 1999; Friedman, 2002; Kiragu, 2001).



4.5.3 Stigma and discrimination

According to Skinner & Mfecane (2004:160), young children who have lost their parents or family members because of HIV/AIDS are likely to experience stigma and discrimination at schools and in their communities. Stigma and discrimination have been noticed in all public arenas (schools, workplaces, churches etc). The Department of Education in collaboration with Departments of Social Development and Health have policies in place to support needy children vulnerable by HIV/AIDS. The Tirisano Plan of Action in 2003-2005, for example, aimed to offer support grants and other support functions related to HIV/AIDS within the school context through education and training systems to help people know about the virus and their responsibilities on how to deal with its challenges. These attempts are to break the circle of silence about HIV/AIDS status caused by fears of stigma and discrimination within families and the surroundings.

Some people living with HIV/AIDS (infected and affected) decide not to disclose their status to anyone including family members but rather die in silence because of stigma (Leclerc-Madlala, 2004). In the Sport Strategy HIV/AIDS report (2001-2002:2), Annan argued that “the epidemic can be stopped if people are not afraid to talk about it”. Both stigma and discrimination have the potential to undermine the gains by discouraging people to seek help and other reliable means of support in fighting against the spread of the virus (Chesney & Smith, 1999:573). De Bruyn (1998). suggests that stigma and discrimination feed on cultural differences and block out common humanity. These is also a supporting view that those who are already objectified, marginalized and excluded are pushed even further from recognition of shared humanity and from the support of human society (Sport Strategy HIV/AIDS, 2001-2002:2). Poor lines of communication and bad working relations between a teacher and a parent can also contribute immensely on the lack of trust to disclose the status of the learner as expressed by Educator A5 in the following extract:

Parents do not tell us anything about their children; we do not know the health status of many learners in classrooms. We are also at risk because you don't have knowledge about the history of the learners, sometimes you give a child excuses of which she/he is sick and you don't have info. They abuse the policy of HIV/AIDS on confidentiality as we cannot force them to disclose the health status of a child even though we can help if told on time.

It appears that some parents are reluctant to share any health issues with teachers. At the same time, parents may even refuse to allow a child infected and/or affected to go to school with the fear for his/her safety against elements of stigma and discrimination as it can at times be attached to cultural and traditional beliefs (Boahene, 1996). The latter could be the cause of high absenteeism of learners from school as Educator A3 puts it:

Some learners are withdrawn from school for a period of time due to illness and at times drop out of school because parents kept the illness of a child for a long time not telling us for assistance.

The high absenteeism rate is also noticed by other educators in this school. As expressed by Educator A1:

In other classes absenteeism is very high and result to poor performance of the child academically; and emotionally.

Stigmatizing beliefs about HIV/AIDS, and associated fears of discrimination often influence decisions to seek HIV testing and motivation to access other prevention services (Chesney & Smith, 1999:573). Educators believe that there is very little done by their schools as an attempt to establish good and sound relations with parents to close the gap and in building trust. As a result, they can't advise them even if they diagnosed the illness of a learner on time through visible symptoms of HIV/AIDS. Participants from School A were more concerned about this challenge and cited quite a number of incidents where a learner would disappear for a long time from school and only to find out that parents went to back home to their rural areas in Eastern Cape to organise cultural and traditional ritual as a way of healing the illness. These were related to me in a focus group discussion. For example, Educator A4 mentioned that:

The other year a parent died and later a learner was taken to Eastern Cape and only knew the problem when a report was made that the learner passed away at Eastern Cape and I became angry because I could see that there is something wrong with my learner but I didn't know how to approach the mother to tell the problem.... as they have a right not to disclosebut I was sad when I heard that they both passed away due to their status on HIV/AIDS.

All these perceptions are ill-informed by misinformation about HIV/AIDS and stigma and if that is not corrected by ensuring the spread of reliable information through efficient and effective HIV/AIDS programmes and initiatives in schools and in communities' perceptions will persist and reverse the gains. According to Yama (1997), traditional beliefs about illness are related to misinformation about diseases. However, findings by Kalichman et al.(2004), Yama (1997), and Shisana et al. (2002) confirm that education about stigma and discrimination will help minimise misinformation about HIV/AIDS.

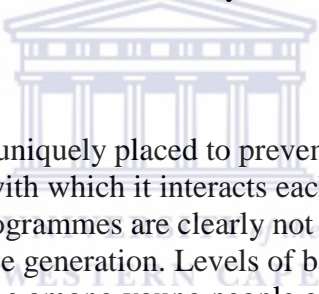
4.5.4 Factors inhibiting successful implementation of HIV/AIDS programmes and initiatives

Schools, as a microsystem consist of many subsystems acting in parallel in an environment which is produced by interactions with other agents, constantly acting and reacting (Moolla, 2011). Family, religious settings, classrooms (teachers and learners interact) and peers form part of the school as a microsystem. Moolla (2011:63) notes that "in order to facilitate positive development, it is imperative for the school, as a microsystem to be developed and

supported too”. This holds true for teachers who interact within this microsystem and who are influenced by both internal and external interactions. In the following sections I allude to problems teachers are faced with as a crucial component of the school, as a microsystem, in initiating HIV and AIDS related programmes.

4.5.4.1 Levels of Knowledge

According to participants, many of them attended some workshops and trainings on HIV/AIDS and sexual education, and also participated in HIV/AIDS initiatives and programmes. However, participants argued that whilst they appreciate all the activities, in practical terms and in real life they were not assisting in shaping educator’s behaviour, values and attitude in dealing with HIV/AIDS and sexual education in a school environment towards AIDS free generation. This finding resonates with inputs made through other researched papers within the very same field of study. For instance, Coombe et al. (, 2002: ii). argued that:



Education system is uniquely placed to prevent infections among the learners with which it interacts each day. However, current programmes are clearly not adequate to produce an AIDS-free generation. Levels of basic HIV/AIDS knowledge among young people are generally high, but there is no clear sign that teenage infection rates are falling. Ongoing problems include a lack of skills to avoid unsafe sex and misconceptions about HIV/AIDS.

As mentioned above, during interviews many educators from both schools reiterated their appreciation on initiatives and programmes organised in their schools through support from Non-Governmental Organisations (NGOs). But, they also expressed their unhappiness and dissatisfaction on the failure of the Department of Education in providing concrete and relevant programmes as means of empowering educators so as to perform the task as expected in fighting against HIV/AIDS. In this instance, educators were on their own with no proper guidance to do the practical work at school on sensitive studies such as HIV/AIDS and sexual education. In this regard, Educator A4 argued that:

Yes, we organised programmes and HIV/AIDS initiatives in our school but they not helping us at all as teacher because most of the time they are organised through the support from

the NGOs and we just participate without benefiting anything content wise. At times they are more about learners and playing games...our responsibility is to just look after those learners and make sure they behave well and participate during games to keep funders happy.

Educator A4 continued to say that:

As HIV/AIDS coordinator I am always told by the Principal that there is no money to organise HIV/AIDS programmes so we depended on the help from NGOs...sometimes NGOs use us just to finish their budget and do not bother whether we get empowered or not as teachers.

Educator B2 similarly note that:

Yes we had trainings by NGOs but we were just playing with kids and also looking after them nothing much we have learnt there, it was a waist of our time but its fine just to get a break from classroom environment.

It appears from the above statements that NGO's are active in schools especially when it comes to HIV/AIDS initiatives and programmes. The problem arising in most cases, as alluded to by the respondents, is the nature of this type of training and how most teachers perceive it. Some participants expressed that it would have been much better if they were properly trained on counselling in dealing with sensitive issues emanating from HIV/AIDS challenges at school. The input made by educators exposed the inadequate assistance they got from the Department of Education, and in dealing with sex education and other sensitive issues like HIV/AIDS related issues with young children. In fact, many participants from both schools clearly stated that ever since they were removed from Education Management & Development Centre (EMDC) North to EMDC South, the Department of Education stopped providing resources to organise their own HIV/AIDS initiatives and programmes, and were no longer getting invites to attend workshops on HIV/AIDS. As a result, almost all educators from School A supported the view expressed by Educator A2:

We cannot be held accountable for the failure of the school not to organising HIV/AIDS initiatives and programmes whilst the Department is also failing to support us. DoE does not prioritise HIV/AIDS in our schools...they just do not care about the spread of the virus. It's been years now without proper training on HIV/AIDS,

no workshops any more.

Educator A4 supported this view by noting that:

As HIV/AIDS coordinator I can't even help learners from the support I get here....I survive in many cases where I am required to help through my own experience obtained when I was studying at varsity about HIV/AIDS, other than that I need to be skilled on counselling because I also need help for myself because as educators we also share similar challenges with learners and some die silently without telling anyone but you can see moss when a person is sick of AIDS even if you know but you can't force the person to tell. There is no support from the Principal.

It has been proven beyond the South African context that schools are indeed relevant and reliable institutions to educate children and young people to fight against HIV/AIDS but educators assigned with that particular task require consistent support in organising and implementing effective and efficient initiative and education programmes. Gachuhi stated that “to date, there are too few life skills programmes that are targeting children and young people with information about HIV/AIDS and that meet the criteria for minimally effective education programmes” (Gachuhi, 1999 : iv). At the same time, this study reveals a serious problem with the lack of policy implementation from schools

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4.5.4.2 Mechanisms in place to address HIV/AIDS in schools

As previously mentioned, the Department of Education provided guiding documents to empower schools to develop their own HIV/AIDS policies. It is through this policy that schools can strengthen HIV/AIDS interventions for educators and learners as it serves as a living document that guides the entire school to protect those who are infected against all forms of discrimination. Moreover, the policy protects their right to privacy and confidentiality; therefore, it is very important that each school develop and has one in place at all times.

Nonetheless, in both schools, there were serious challenges about this policy as teachers indicated that such policy does exist in their school. In contrast, some participants mentioned that they heard of the policy but had never seen a copy, and do not know what it entails. According to educator A1, “we have no policy or guidelines to deal with the problem or issues of HIV/AIDS in this school”. This was reiterated by educator B5 who noted that “the school needs to have a policy in place and also to identify how many people who are sick”. The HIV/AIDS coordinators

seem to be the ones that were aware about the policy; Educator A3 indicated that she is the only teacher in the entire school that knows what the policy entails:

I am the only one knows about this policy because it was a cut and paste document from the DoE website, and does not have views of educators and other relevant stakeholders from the school. So, after I was advised by the Principal to quickly develop something during oversight visit by the Department, I kept it in my file until we be given a chance to participate fully and develop our own policy with an attempt to relate to our daily challenges. Hence there are no mechanisms in place except that we only call parents when there is a serious challenge with a child.

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 line with national Department of Education policy on HIV/AIDS for schools. However, failure to develop such policy could contribute badly to how educators treat and approach learners even though they seem to be clearly aware about discrimination and privacy against people vulnerable with HIV/AIDS and other related diseases. Furthermore, partly due to challenges faced by educators, participants from both schools realised the importance of community activities that will continue educating learners about HIV/AIDS outside school which will involve parents as well as community members (Omar, 2003; Warburton, 1998 & White, 1999). According to Maleka (2009), community involvement is similar to views shared by Varga & Shongwe (1999:20) that the problem of HIV/AIDS requires a multisectoral approach from all, including the communities.

In addition, the Department of Education similarly argued that parents and educators should be more involved and take responsibility for monitoring the knowledge and skills of their children at home (Guidelines for Educators, 2000:7). 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 (Shishana, 2002).

Both schools seem not to have measures in place to mitigate the situation on HIV/AIDS, and inadequate counselling capacity in schools is a major concern for teachers and needs to be increased. HIV/AIDS programmes should retain prioritised and feasible approaches to

develop core psychosocial support capacities (Coombe, 2002). One of the most common views is that primary schools should be the most appropriate level where learners are taught how to protect themselves against infections and sexually transmitted diseases (Mahomed, 2002; World Health Organization, 1992; Vergnani, 1993; Educator's view in loveLife Workshop: 25/06/2005). According to the Department of Education (2003), both Tirisano and the national Curriculum (C2005 and RNCS) mandated that information about HIV/AIDS and (age-appropriate) sexuality education must be integrated into the curriculum, at all levels. The teaching of HIV/AIDS and sexuality education must therefore be timetabled and be mainstreamed.

4.6 Conclusion

The purpose of this chapter was not only to provide the findings that emanated from the data but also to offer a discussion around these findings. It is clear from this discussion that teachers face manifold challenges when dealing with HIV/AIDS related issues. These challenges include: lack of sufficient training, lack of parental support and support of school management, the absence of a detailed school-related policy outlining the school's views on HIV/AIDS, lack of knowledge especially on how to teach such a sensitive topic, amongst others.

Although the Department of Education has provided training and ideas on how to formulate a HIV/AIDS policy within schools there still seems to be problems relating to this. Culture and traditional beliefs of parents and teachers remains an important constraining factor. In the next chapter I conclude by providing an overview of the thesis and recommendations to various stakeholders.

5.1 Introduction

This mini thesis attempted to explore the challenges teachers face in implementing HIV/AIDS initiatives and programmes in two primary schools in Nyanga, Cape Town. In Chapter 1, I introduced the background and rationale, as well as the objectives and the research questions for this study. The significance of this study lies in the fact that research on this topic is normally not carried out in primary schools. I proceed in Chapter 2 to review the literature pertinent to this study and also introduced the theoretical model of Bronfenbrenner (1977), namely, the Bio-ecological systems model, which I used to frame my study. It also informed the way I approached all aspects of my research, especially in the analysis phase. A thematic approach was also applied in the literature review highlighting the critical role of education as a mechanism in the fight against the spread of HIV/AIDS. Challenges faced by schools during the implementation process related to culture, religion, stigma and discrimination. Moreover, the lack of community involvement was also noted as a barrier in the fight against the scourge of HIV/AIDS in schools, especially in South Africa.

In Chapter 3 I provide the methodological framework of the study. It dealt with the research design, sampling and data collection procedures as well as the ethical procedures followed in this research. I illuminated the research design applied in the study such as qualitative multiple case study design. I also shed light on the sampling decisions taken, issues related to validity and reliability, a discussion of the data analysis methods employed as well as ethical issues relating to conducting research on such a sensitive issue. Following this, Chapter 4 was devoted to the findings of this research and an analysis and discussion of the themes emanating from the findings. The latter included the following: teachers training and knowledge on HIV/AIDS, culture, tradition and beliefs: parental choice, stigma and discrimination, and factors inhibiting successful implementation of HIV/AIDS programmes and initiatives.

Chapter 5 is therefore the conclusionary chapter where I provide a summary of the main findings by revisiting the research questions, provide some recommendations and look at the possibilities for future research.

5.2 Summary of findings: revisiting the research questions

5.2.1 What is the nature of HIV/AIDS initiatives and programmes currently being implemented in primary schools?

The study indicates that schools have HIV/AIDS initiatives or programmes, however, these programmes appear insufficient to equip educators with the tools for successful implementation. One crucial aspect that this study found is that almost all HIV initiatives and programmes are provided by NGO's and these usually take place on a once-off basis. In this lie implications for successful implementation. Participants have expressed lack or inadequate knowledge around HIV/AIDS at school level. One contributing factor appears to be the 'once-off' workshops provided by NGO's and the WCED. It came out clearly that when learners come to educators to inform them about their family problems or disclose their HIV status teachers are unable to assist. It does appear from my study that teachers felt that they did receive training but the training itself was problematic in that it did not adequately equip them with the necessary tools to handle such a sensitive issues.

5.2.2 How do teachers react to the HIV/AIDS initiatives and programmes currently being implemented in primary schools?

Teachers saw this as 'extra work', which added to their already huge daily workload. Lack of support from school principals was mentioned as one factor that lowers their level of participation. As a result, some of the co-ordinators are no longer participating fully or committed or even interested for that matter to engage in these programmes because of the lack of encouragement from the principals. Participants stated that learners are allowed to attend Lovelife programmes or activities (Lovelife Games Educator's Manual, 2005 and Love lifestyle, 2004), normally arranged by NGO's but that the majority clearly stated that there are no mechanisms in place, in their schools, to address the challenging issues of HIV/AIDS and sexuality education.

5.2.3 What role does culture play in the implementation of HIV/AIDS initiatives or programmes in primary schools?

Culture, more importantly cultural beliefs, played an important role in prohibiting successful implementation. Both parents and teachers cultural beliefs can be viewed as a barrier to the implementation of HIV/AIDS programmes and initiatives. The findings show that parents and teachers are often held captive by their cultural and religious beliefs, which makes talking about HIV/AIDS and any sexual related topics problematic.

5.2.4 Are there any problems faced by teachers who are keen to participate in these initiatives?

The lack of support from the WCED, the school SGB and principals tends to discourage keen teachers from participating in these initiatives. As previously mentioned, most initiatives are brought to the school by NGO's who tend to only work in the school for short periods. Also the nature of these 'workshops' is not enough to sustain the programmes or initiatives.

5.2.5 What are the constraining factors teachers' face in the implementation of HIV/AIDS initiatives and programmes in primary schools?

One of the major constraining factors, which I alluded to earlier are cultural and religious beliefs of both teachers and the community they serve. Furthermore, it becomes difficult for educators to educate learners on HIV/AIDS related issues and sexual education because of the age level of learners and poor cooperation from parents. Although, policy documents from the Department of Education (2002) clearly states that education around these issues are important and should take place at all levels, the findings also show that it's not easy for educators to organise more events on educating themselves and learners due to financial constraints. The existing workload of teachers and the lack of support from principals are also constraining factors.

5.3 Recommendations

As previously mentioned, schools are ideal spaces to be utilised in the fight against the spread of HIV/AIDS, especially if they are keen to adopt well-structured and sustainable HIV/AIDS initiatives and sexual education programme. Following are a few recommendations aimed at policy makers, principals and school management teams, teachers, parents and community leaders:

- Policy makers should be aware of the factors that affect or constrain the implementation of HIV/AIDS policies in schools so as to design support around these constraints. Moreover, the nature of support, through resources including workshops; and other forms of training for educators, must be examined prior to training to ensure quality training. The DoE must take a leading role to ensure that educators are well skilled and empowered to deal with the challenges they face, paying more attention to poorer schools where social problems require more resources.
- Principals and school management teams could offer teachers support by moving away from merely managing the daily activities of schools and by becoming active participants in these programmes.
- Teachers could avail themselves by engaging in accredited certification programmes, like counselling courses in dealing with HIV/AIDS, that would not only improve their personal growth but also help them in dealing with teaching and engaging with sensitive issues that affect their learners.
- Parents should be made aware, through campaigns, about the important role they can play in combating HIV/AIDS amongst young people. As generally reported in this study, educators share no relations with parents due to limited time and their excessive workload. It is evident that educators do not have time to build inclusive and interrelated relations with parents and the communities at large. The building of such relations, between schools and the broader community (churches, health organisation etc.) will help break the chains of silence on HIV/AIDS and remove wrong perceptions created so as to minimise stigma and discrimination. It will also allow space to boost the self-esteem of educators to freely engage with learners on sensitive issues (sexual education). This brings me to aspects that could be considered for further research.

5.4 Future research studies

This study has shown that there is a 'knowledge gap' in this empirical field, namely research into issues relating to HIV/AIDS in primary schools. Furthermore, this study has found that most initiatives, as previously mentioned, are initiated and managed by NGO's. The implications of the nature of work done by NGO's within schools could be researched.



REFERENCES

Ainlay, S., Becker, G. & Coleman, L. (1986). *The dilemma of difference: A multidisciplinary view of Stigma*. London: Sage

Ala, J. (2001). The role of the international community in combating HIV/AIDS in sub-Saharan Africa. *Medical Research of South Africa: AIDS Bulletin*-July 2001, 1(2) University of Witwatersrand, South Africa.

Ashforth, A. (2001). Witchcraft and the problem of public power in post-apartheid South Africa. *School of Social Science Occasional Paper 10*, Institute for Advanced Study, Preston.

Atwell, A., Clarke, L., Conlon, J. & Tabeisa, D. (2004). How to be AIDS AWARE. *Creda Communications*. Epping, South Africa.

Babbie, E. and Mouton, J. (2001). *The Practice of Social research*. Oxford University Press Southern Africa, Cape Town

BBC News (2010, 25th March) ‘ South Africa’s Zuma reveals his HIV-negative’

Baxen, J. (2006). *An analysis of the factors shaping teachers' understanding of HIV and AIDS*. University of Cape Town, Cape Town.

Bekker, K. (1996). *Citizen Participation in Local Government*. Pretoria: J.H. van Schaik.

Berger, E. H. (1995). *Parents are Partners in Education: Families and Schools working together*. Englewood Cliffs: Prentice Hall.

Bhana , D., Morrel, R., Epstein, D. & Moletsane, R. (2006). The hidden work of caring: Teachers and the maturing AIDS epidemic in diverse secondary schools in Durban. *Journal of Education*, 38:5-23.

Boon, H., Mathews, C., Flisher, A. & Schaalma, H. P. (2006). Factors associated with teachers' implementation of HIV/AIDS education in secondary schools in Cape Town, South Africa, *AIDS Care. Psychological and Sociomedical Aspects of AIDS/HIV*, 18(4):388-397.

Bowling, A. (1997). *Research methods in health: Investigating health and health services*. Buckingham and Philadelphia: Open University Press.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist*, 32(7), 513-531.

Burkey, S. (1993). *A guide to self-reliant Participatory Rural Development*. London: Zed Books.

Carrim, N. (2006). Human Rights and the construction of identities in South African Education. Unpublished thesis, University of Wits.

<http://wredspace.wits.ac.za/bistream/handle/10539/2032/carrimN.pdf>.

Campbell, B. & MacPhalia, C. (2006). *'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a Southern African township a CSIR Mining Technology*, Auckland Park, South Africa.

Charlton, J. I. (2000). *Nothing about us without us: disability oppression and empowerment*. Berkeley: University of California Press.

Chesney, M.A. & Smith, A.W. (1994). Critical delays in HIV testing and care: The potential role of stigma. *The American Behaviourist Scientist*, 42(7):1162-1174.

Commonwealth Secretariat, (2001). *A Commonwealth Response to a Global Health Challenge*. London, United Kingdom.

Commonwealth Secretariat, (2002). *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach*. London, United Kingdom.

Commonwealth Secretariat, (2003): *Commonwealth Education Partnerships*. London, United Kingdom.

Coombe C. (2003). *HIV/DS and Teachers education: Consultation on HIV/AIDS and teacher education in East and South Africa*. Kaponong Conference Center: Benoni, South Africa.

Coombe, C. (2000). *Mitigating the impact of HIV and AIDS on education systems in Southern Africa*. Pretoria.

Creswell, J. W. (2007). *Qualitative inquiry & research design: choosing among five approaches*. Thousand Oaks: Sage Publications.

Dale, A. and Davies, R. B. (2004). *Analysing Social and Political Change: Interaction and Practice*. London: Sage Publication.

De Swardt, E. (2004). *Chronic Poverty and Development Policy: Programme for Land and Agrarian Studies*. (School of Government) University of the Western Cape: Cape Town, South Africa.



Denzin N.K. and Lincoln Y.S. (2000). *Handbook of qualitative research 2nd edition. Introduction: The discipline and practice of qualitative research*. London: Sage Publication.

Denzin, N. K., & Lincoln, Y. S. (1998). *The landscape of qualitative research. Theories and issues*. London: SAGE.

Department of Cultural Affairs and Sport (2002). *A child in sport is a child out of court: School Sport Policy*. (Western Cape Sport and Recreation) Cape Town, South Africa.

Department of Cultural Affairs and Sport (2004). *An Evaluation of a brief HIV/AIDS awareness programme presented during the South African Youth Games in*. East London.

Department of Education, (1999). *National Policy on HIV/AIDS, for learners and educators in public schools and training students and educators in further education and training institutions*. Pretoria: Government Gazette, RSA.

Department of Education, (2000). *Guidelines for Educators: HIV/AIDS Emergence*. Pretoria, RSA.

Department of Education, (2001). *White Paper 6: Building an Inclusive Education and Training System*. Pretoria: Government Printers, RSA.

Department of Education, (2002). *Guidelines for Educators: The HIV/AIDS Emergency*. Pretoria: Government Printers, RSA.

Department of Education, (2002). *Revised National Curriculum Statement Grades R-9 (Schools) Policy: Life Orientation*. RSA.

Department of Education, (2002b). *HIV/AIDS Life Skills and Sexuality Education Primary School Programme*. Pretoria: Government Printers, RSA.

Department of Education, (2003). *Information Sheet HIV/AIDS Life Skills Programme: Plans for HIV/AIDS and Sexuality Education*. Western Cape: Government Printers, RSA.

Department of Health. (2006). *Annual report 2005-2006*. Pretoria: Government Printer, RSA.

Department of Health. (2006). *Progress report on declaration of commitment on HIV and AIDS*. Pretoria: Government Printer, March. RSA.

Dorrington, R., Johnson, L., Bradshaw, D. & Dawel, T. (2006). *The demographic impact of HIV/AIDS in South Africa. National and Provincial indicators for 2006*. Cape Town. Centre for Acturial Research, South African Medical Research Council and Acturial Society of South Africa.

Dudley, J. R. (1983). *Living with Stigma: The plight of the people who were label mentally retarded*. Springfield: Thomas.

Freebody P. (2003). *Qualitative Research in Education*. London: Sage Publication.

Gallant, M. & Maticka-Tyndale, E. (2004). School-based HIV prevention programmes for African Youth. *Social Science and Medicine*, 58:1337-1351.

Goffman E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Harmondsworth, Middlesex: Penguin.

Hamilton, A. (2002). *Talk to kids About AIDS*. Fair lady, April, 2002.

Helleve, A., Fisher, A.J., Hans, O., Wanjiru, M. & Klemp, K. (2009). South African teachers' reflections on the impact of culture on their teaching of sexuality and HIV/AIDS. *Culture, Health and Security: An International Journal for Research, Intervention and Care*, 11(2):189-204.

Heystek J. and Louw E. M. (1999). *Parental Participation in School Activities* (is it sufficient?). *South African Journal of Education*, 19:21-27.

Irwin, K. (1981). *Stigma: a social psychological analysis*. Hillsdale: N.J. Erlbaum.

Isaac C. D. (1998). *The church and AIDS towards a model for ministry to people with HIV/AIDS for the apostolic faith mission of South Africa*. Bellville: University of the Western Cape.

James, T. A., Finger, W., Ruland, C. D. & Savariaud, S. (2004). *Teacher Training: Essential for school based reproductive health and HIV and AIDS Education*. Focus on Sub-Saharan Africa.

Johns, L. R. (2004). *Rights Versus Risk: Balancing Perspective in a Sexuality Programme for Learners with Moderate Intellectual Disabilities*.

Jones, E. (1984). *Social Stigma: The Psychology of marked relationship*. New York: Freeman.

Kaaya, S.G., Flisher, A., Mbwambo, J., Schaalma, H., Aaro, L. & Klepp, K. (2002). A review of studies of sexual behaviour of school students in SubSahara Africa. *Scandinavian Journal of Public Health*, 30:148-160.

Kalichman, S.C. & Simbayi, L.C. (2004). Traditional belief about the cause of AIDS and AIDS –related stigma in South Africa. *AIDS Care*, 16 (5): 572-580.

Kiragu, K. (2001). *Youth and HIV/AIDS: Can we avoid catastrophe?* Population Reports, Series L: 12. Baltimore: The John Hopkins University: Bloomberg School of Public Health. http://www.jhuccp.org/pr/112/112chapter4_shtm

Kruger, S.J. and Welman, J.C. (2001). *Research Methodology: for the Business and Administrative Science*. Southern Africa: Oxford University Press.

Leclerc-Madlala S. (2004). *Aids Solution is foiled by an evil spell of silence*. Head of Anthropology: University of KwaZulu-Natal, South Africa.

Leclerc-Madlala, S. (2002). *Youth, HIV/AIDS and the importance of sexual culture and context*. Center for Social Science research, CSSR: Working Paper No. 9.

Leedy, P. D. & Ormrod, J. E. (2005). *Practical research: planning and design*. Upper Saddle River, N.J: Pearson Merrill Prentice Hall.

Love Lifestyle and USSASA (2004). *Love lifestyle Debating Programme: Educators Manual*. South Africa.

Loveliflife Team (2005). *Loveliflife Games Manuals: GET ATTITUDE*. South Africa.

Mahomed, I. (1998). *Third Interim Report on aspects of the Law relating to AIDS, HIV/AIDS Discrimination in Schools*. Pretoria: The Commission

Maleka, E.N. (2009). *An assessment of knowledge of HIV/AIDs amongst secondary school learners of Kwazulu-Natal: An exploratory study of Bergville rural district*. Unpublished thesis. School of Governance, University of the Western Cape.

Mannah S. (2000). *Become an AIDS Activist*. The Educator's Voice, South Africa, 4 May 2000.

Mchunu, Z. & Preston-Whyte, A. (2005). "AIDS and the leaders of tomorrow" *Children's voices from South Africa*: University of Michigan, University Library passages. <http://www.hdl.handle.net/2027/spo.4761530.0010.019>

Maurice, J. (2014). South Africa's battle against HIV/AIDS gains momentum. *The Lancet*, 383(9928):1535-1536.

Merriam, S.B. (2009). *Qualitative Research: A guide to design and implementation*. California: Jossey-Bass Printers.

Monasch, R. & Mahy, R. (2006). "Young people: The centre of HIV epidemic: Chapter 2, in D.A. Ross., B. Dick & Ferguson, J (eds), Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries, WHO Technical Report, series 938, World Health Organisation, Geneva, 2006:16.

Nattras, N. (2007). *Mortal Combat: AIDS denialism and the struggle for antiretroviral in South Africa*, Cape Town: University of Kwazulu- Natal Press.

National HIV/AIDS Strategic Plan. (2002). *HIV/AIDS and STI Strategic Plan for South Africa 2000-2005*. Pretoria: Government Printer.

National HIV/AIDS Strategic Plan. (2007). *HIV/AIDS and STI Strategic Plan for South Africa, 2007-2011*. Pretoria: Government Printer.

National HIV/AIDS Strategic Plan. (2012). *HIV/AIDS and STI Strategic Plan for South Africa, 2012-2016*. Pretoria: Government Printer.

Omar, S. (2003). *Strategies to develop health promotion schools in the Western Cape: Case Studies of three schools in Athlone*. Bellville. Unpublished Thesis, University of the Western Cape.

Oshi, D.C. & Nakalema, S. (2005). The role of educators in sex education and the prevention and control of HIV/AIDS in Nigeria. *Sex Education*, 5(1):93-104.

Patton, M. Q. (2002). *Qualitative evaluation and research methods (2nd ed.)*. Newbury Park, CA: Sage Publications Inc.

Peltzer, K., & Promtussananon, S. (2003). HIV and AIDS education in South Africa: teacher knowledge about HIV and AIDS: teacher attitude about and control of HIV and AIDS education. *Social Behaviour and Personality*, 31(4): 349-356.

Rapakwana M. (2003). *Getting the Nation to Play: HIV/AIDS Draft Policy for Sport and Recreation in South Africa*. Pretoria: South Africa.

Renzetti C. M. and Lee R. M. (1993). *Research Sensitive Topics*. California: Sage.

Rutagumirwa, S.K. & Kamuzora, P. (2006). *Secondary school students voice in HIV/AIDS prevention interventions in Tanzania: A case study of Mbeya Region*. Department of Development Studies, University of Dar es Salaam.

Samuelsen. H., Norgaard, O. & Ostergaard, L.R. (2012). Social and cultural aspects of HIV and AIDS in West Africa: A narrative review of qualitative research. *SAHARA-J: Journal of Social Aspects of HIV/AIDS: An Open Access Journal*, 9(2): 64-73.

SANAC, (2011). *National Strategic Plan on HIV, STIs and TB – 2012-2016*.

Save the Children, (RSA) (2001). The role of stigma and discrimination in increasing the vulnerability of children and youth infected with and affected by HIV/AIDS: Report on participatory workshops.

Setwe, G. & Malope, N. (2009). Monitoring the social and other impacts of HIV/AIDS in South Africa. HSRC Conference. [http://:www.hsrc.ac.za](http://www.hsrc.ac.za).

Shishana, O; Rehle, T; Simbayi, L.C; Parker, W; Zuma, K; Bhana, A; Connolly, C; Jooste, S. & Pillay, V. (2005). *South African National HIV prevalence, HIV incidence, behaviour and communication survey 2005*. Cape Town: Human Science Research Council.

Silverman, D. (2001). *Doing qualitative research*. London: Sage.

Smith, K.A. & Harrison, A. (2013). Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa. *Sex Education, Sexuality and Learning*, 13(1):68-81.

Stadler, J. & Hlongwa, L. (2002). Monitoring and evaluation of Love Life's AIDS prevention and advocacy activities in South Africa. *Evaluation and Programme Planning*, 25: 365-376.

Stover, J., Walker, N., Garrett, G.P., Solomon, J.A., Stanecki, A., Ghys, P.D., Grassly, N.C., Anderson, R.M. & Schwartlander, B. (2002). Can we reverse the HIV/AIDS pandemic with an expanded response? *The Lancet*, 360:73-77.

Swart, E. & Pehipher, R. (2005). A framework for understanding inclusion. In E. Landsberg, D. Kruger & N. Nel (Eds), *Addressing barriers to learning: A South African perspective*. Pretoria: Van Schaik.

Tayob, H. (2010). *Understanding primary school teacher's knowledge and attitudes around HIV/AIDS*. Unpublished Thesis, School of Governance, Stellenbosch University.

UNAIDS (2002). *On the Global HIV/AIDS Epidemic*. Geneva.

UNAIDS (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic*. Geneva.

UNAIDS (2011). *HIV in ASIA and the PACIFIC: Getting to Zero*. Geneva.

UNAIDS (2011). *World Aids Day Report: FASTER. SMATTER. BETTER*. Geneva.

UNAIDS (2012). *Global Report: UNAIDS Report on the Global AIDS Epidemic*. Geneva.

UNAIDS (2013). *Global Report: UNAIDS Report on the Global AIDS Epidemic*. Geneva.

UNAIDS/WHO. (2008). *Report on the global AIDS epidemic*. Geneva: WHO, 2008.

UNICEF, (2001). *Annual Report*. Division of Communication, New York, USA.

Van Dyk, A. (2001). *HIVAIDS care & counseling: a multidisciplinary approach*. Pinelands, Cape Town: Pearson Education South Africa 2001

Van Rooyen S. and Ngwenya M. (1997). *Sexuality Education: from babyhood to adolescence*. Pretoria: Kagiso Publisher.

Van Schalkwyk, K. E. (2004). *Parents' views on HIV/AIDS and sexuality education in primary schools in a specific area of the Western Cape*. Unpublished Thesis (M. Ed. (Educational Psychology-Faculty Education))--University of the Western Cape.

Vergnani, T. (1993). *An Investigation into student guidance teachers perceptions of their role as AIDS educators and counsellor*. Bellville: University of the Western Cape.

Vergnani, T. and Frank, E. (1998). *Sexuality Education for Intermediate Phase (Grades 4-6) Teachers*. Sandton: Heinemann.

Vergnani, T. and Palmer, L. (1998). *Sexuality Education for Foundation Phase (Grades 1-3) Teachers*. Sandton: Heinemann.

Visser, M. (1996). Evaluation of the first Aids kit, the AIDS and Lifestyle education programme for teenagers. *South African Journal of Psychology*, 26(2):103-113.

Visser, M. (2004). *The Impact of individual differences on the willingness of teachers in Mozambique to communicate about HIV and AIDS in schools and communities*. Florida State University.

Visser, M., Schoeman, J. & Perold, J. (2004). Evaluation of HIV/AIDS prevention in South African schools. *Journal of Health Psychology*, 9(2):263-280.

Visser, M. J. (2007). HIV/AIDS prevention through peer education and support in secondary school in South Africa. *Journal of Social Aspects of HIV/AIDS*, 4 (3): 678- 694.

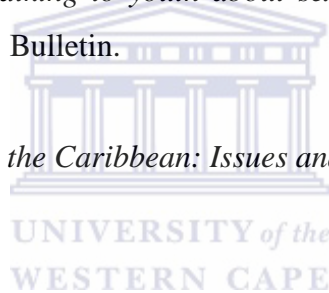
Waxman, C. I. (1977). *The stigma of poverty: a critique of poverty theories and policies*. New York: Pergamon Press.

West, R., Corneli, A.N., Best, K., Kurkjian, K.M. & Cates Jr. W. (2007). Focusing HIV prevention on those most likely to transmit the virus. *AIDS Education and Prevention*, 19(4): 275-288.

White, S. (1999). *The Art of Facilitating Participation: Releasing the power of grassroots communication*. New Delhi: Sage Publishers.

Wilbraham, L. (2002). *Parents talking to youth about sex and AIDS: Some problems with health education materials*. *AIDS Bulletin*.

World Bank (2001). *HIV/AIDS in the Caribbean: Issues and Options*. Washing, D.C.
www.sanac.org.za.



World Health Organisation (WHO). (1992). *Study of the sexual experiences of young people in eleven African countries: The narrative research method*. Geneva:WHO.

Yin, R. K. (2009). *Case study research: design and methods*. Los Angeles: Sage Publication

APPENDIX A

CONSENT FORM FOR PRINCIPALS

LETTER OF CONSENT

RESEARCH TITLE: An investigation on possible factors that contribute to challenges faced by educators on HIV/AIDS initiatives in primary school: A study of selected public primary schools in the Western Cape at Nyanga Township.

PRINCIPAL RESEARCHER: Nokuthula Nqaba

I hereby give my consent to participate in this study and to be interviewed by the interviewer. This is for the purpose of data to be collected by means of an interview to be used in the research study. Permission to record the interviews has been requested, and I am aware that I may refuse to have the interview tape-recorded.

I understand that participation is voluntary, that I may refrain from answering any or all questions which might make me feel uncomfortable and that I have the right to withdraw from the study at any time if I so wish. Information gathered from the study will be handled with confidentiality and pseudonyms will be used to protect my identity.

I am assured that the information will be used for research purposes only and I am reassured that there are no risks involved in participation in the study.

I consent to voluntarily participate in this research study by completing this form.

Signed:.....on.....this day.....at.....

APPENDIX B

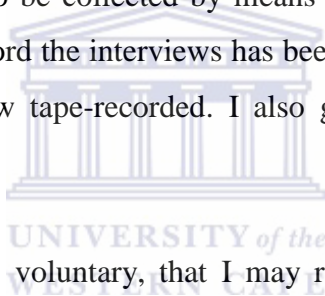
CONSENT FORM FOR TEACHERS

LETTER OF CONSENT

RESEARCH TITLE: An investigation on possible factors that contribute to challenges faced by educators on HIV/AIDS initiatives in primary school: A study of selected public primary schools in the Western Cape at Nyanga Township.

PRINCIPAL RESEARCHER: Nokuthula Nqaba

I hereby give my consent to participate in this study and to be interviewed by the interviewer. This is for the purpose of data to be collected by means of an interview to be used in the research study. Permission to record the interviews has been requested, and I am aware that I may refuse to have the interview tape-recorded. I also give my consent to complete the teacher questionnaire



I understand that participation is voluntary, that I may refrain from answering any or all questions which might make me feel uncomfortable and that I have the right to withdraw from the study at any time if I so wish. Information gathered from the study will be handled with confidentiality and pseudonyms will be used to protect my identity.

I am assured that the information will be used for research purposes only and I am reassured that there are no risks involved in participation in the study.

I consent to voluntarily participate in this research study by completing this form.

Signed:.....on.....this day.....at.....

APPENDIX C
Questionnaire

1. Age of a participant? Please indicate your age below

1(a) Gender? Please tick next to your gender below

Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
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1(b) Years of experience in teaching? Please indicate year(s) below

1(c) Is there any training that you attended in life orientation? Please tick below

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, please name the type of training and its duration:

1. Are there any other categories related to HIV/AIDS & sexual education

that you also responsible for in your school? Please tick below

3. Do teachers have enough knowledge to deal with issues of HIV/AIDS in your school?

Yes		No	
-----	--	----	--

If yes, please name them and also specify if you are trained in that area:

2. Does the school have any initiative programs on HIV/AIDS?

YES		NO	
-----	--	----	--

If yes, please name them:



YES		NO	
-----	--	----	--

Explain

4. Are there any problems faced by teachers who are keen to participate in these initiatives?

YES		NO	
-----	--	----	--

If yes, please list all the problems:

5. What are the mechanisms put in place by the school to address these Problems?

6. Are teachers confident and comfortable to address the issue of HIV/AIDS when teaching learners in class? Elaborate

7. What measures could be taken to fill the gaps in current HIV/AIDS training programmes and guidelines to increase the level of participation by school teachers?



APPENDIX D

INTERVIEW SCHEDULE

1. Are there any other categories related to HIV/AIDS & sexual education that you also responsible for in your school (elaborate the type & nature of these)?
2. As a teacher do you feel that you have enough knowledge to deal with HIV/AIDS in your school?
3. Do teachers face any problems when they participate in HIV/AIDS initiatives?
4. What mechanisms are in place to address these problems (refer to the previous question)?

5. Are you confident and comfortable to address the issues of HIV/AIDS in your school (refer to discrimination, culture and stigma)?
6. What measures do you think could be taken to increase the level of teacher's participation (refer in training, guidelines or policies that have to be delivered)?
7. Is anything else that would like to share with me on HIV/AIDS related topic and the challenge that you face when dealing with these issues in a primary school?

