

CHAPTER 1

ORIENTATION, STATEMENT OF THE PROBLEM AND GOALS OF THE STUDY

1.1 BACKGROUND

AIDS (Acquired Immune Deficiency Syndrome) has been likened to the holocaust and to the plague. Some regard it as a sign of God's wrath against mankind and the leprosy of our time (Saayman and Kriel, 1992:70). Whatever feelings this disease engenders in one, there is no doubt that from the time of its first discovery, the world would never be quite the same again. It is estimated that around 18,8 million people around the world have already died of AIDS, since it was first described and identified in 1981 in the United States of America (Evian, 2000:3).

In order to understand the impact of HIV/AIDS on education in South Africa, one needs to contextualize this disease in global and national terms. At present, indications are that approximately 34,3 million people in the world are living with HIV (Human Immuno-Deficiency Virus), and most of them do not even know that they are HIV-positive (UNAIDS Report, 2000b:8). What is even more staggering is that most of these people, given the present scenario, will die within the next ten years. This report indicates that in 1999 alone, 5,4 million people were infected with HIV, of which 4 million came from sub-Saharan Africa.

Kelly (2001:1) states that about 80% of the total AIDS-related deaths in the world during 2000 came from Africa. He further states that 80% of adults in the subcontinent are infected.

Kelly (2001:4) points out that AIDS will lead to negative population growth, which will be evident in South Africa by 2003. Life expectancy is presently

estimated as being below 55 years and by 2010 it is expected to be around 50 years and even 30 years in some countries in Africa.

According to the UNAIDS Report (2000b:26) the impact of HIV/AIDS will be felt in every sector of the economy, from an individual household to the macro-economy as well as from the health sector to education, agriculture and industry. Kelly (2001:3) also describes this impact in graphic terms. The effects of the disease range from issues related to the psychological trauma and suffering as a result of contracting the disease, the loss of earning capacity, funeral costs and the increasing number of AIDS orphans.

Shell (2000:8) reports that the first two cases of AIDS in South Africa were recorded in 1982 and the first known AIDS-related death occurred in 1985. He also mentions that of the diagnosed cases over the period 1982-1986 all, except two, had died. By 1995 the estimates of HIV-positive people in South Africa had risen dramatically and were in the region of 1,8 million people. In 1996 approximately 700 people were being infected daily. According to the UNAIDS Report (2000b:9) South Africa has 4,2 million people (19,9% of its population), infected with the virus, which makes it the country with the largest number of people living with AIDS than any other country in the world.

When one examines the impact on education as a sector (UNAIDS Report, 2000b:29), one sees that HIV/ AIDS has affected it in various ways. Teacher numbers are dwindling, families are unable to afford schooling as breadwinners are dying of AIDS and children are dropping out of school to care for their dying parents. The UNAIDS Report (2000b:29) indicates that between 1996 and 1998 in the Central African Republic, 85% of teachers who died were HIV-positive and had died on average 10 years before the minimum retirement age of 52 years. It further estimates that 71000 children in this country (Central African Republic) would be unable to receive a primary education by the year 2005 because of the

drastic loss of teachers due to AIDS-related deaths. The death of just one teacher will affect the education of 30-50 children, (loveLife, 2001a:33).

In South Africa the impact on education would be just as catastrophic. The Department of Education (DoE), in a document entitled “Education in South Africa: Achievements since 1994” (South Africa, 2001:29), mentioned other ways in which education will be affected by the HIV/AIDS issue. Besides those teachers that would either be ill, absent or dying, other teachers would also have to provide support to members of their families who succumb to the virus, as well as to the AIDS orphans within the extended family. The report states that the equivalent of 2,6 teachers would have to be trained to replace every teacher that leaves the department. It further envisaged the teacher-pupil ratio would increase to 1:50 by 2006. Older, experienced teachers would be replaced with younger personnel, and this would have an impact on the quality and standard of education.

In the unveiling of the macro plan for Education, called “Tirisano” (Working Together), the Minister of Education, Professor Kader Asmal, identified nine priorities and HIV/AIDS was one of them (South Africa, 2001:7). According to this document, the education sector’s strategy to deal with the HIV/AIDS pandemic had a three-pronged approach: Firstly, to embark on an awareness, information and advocacy campaign; secondly to ensure the introduction of the issue of HIV/AIDS into the curriculum; and thirdly to plan for the inclusion of HIV/AIDS-related issues within the education system.

In the education sector, the policymakers thus realize that there needs to be a decisive response to the issue of HIV/AIDS. This is particularly important in the light of the fact that the affected and infected would encompass educators, learners, members of teacher unions and the policymakers in education. In other words all the role players in education would be affected.

1.2 ANALYSIS OF THE PROBLEM

1.2.1 Awareness of the Problem

South African citizens became aware of the AIDS disease in the early 1980's, with the initial reports that it was a disease that was affecting primarily the gay and lesbian community. It was initially even called GRIDS or "Gay Related Immune Deficiency Syndrome (South Africa, 2000:47).

Gradually, the realization was beginning to dawn upon many that this disease was going to affect a much larger section of the population than was initially thought. By 1987, there was still a lot of debate about "whose disease" this really was. The debate shifted from AIDS being classified as a homosexual disease to a "white man's disease" to a "black man's disease" (The AIDS Law Project and the AIDS Legal Network, 2001:36). During this period, there was a typical knee-jerk reaction across the world – there appeared to be a need to find someone to blame for the scourge. In the meantime the virus was spreading like the proverbial "wildfire"! It is reported that during the period from 1990 to 2000, the infection rate among pregnant women rose from less than 1% to over 20% (The AIDS Law Project and AIDS Legal Network, 2001:36). In fact it was not just media hype, but even governments reacted in an irrational way and passed tough laws that they thought would protect their citizens (The AIDS Law Project and AIDS Legal Network, 2001:32).

What further exacerbated the problem, was the resultant prejudice and discrimination suffered by people affected and infected by the disease, as well as members of the gay and lesbian community (South Africa, 2000:1). AIDS and a person's HIV-status became a closely guarded secret due to the stigmatization that characterized the disease. This tendency to "go underground " was possibly another contributory factor to the rampant spread of the virus.

There was severe and widespread abuse and discrimination against people with HIV/AIDS throughout South Africa, and these people's basic human rights were

infringed. It was agreed that there was a need for legislation to protect them, and for people to be educated about HIV/AIDS. Various sectors started preparing to educate their constituencies.

It was in this context that educators began to see the growing threat of the HIV/AIDS issue, both as citizens of this country and as educators. The HIV/AIDS issue had begun to become an integral part of sexuality education. In 1997, the Department of Education (DoE) initiated a training programme for selected educators to be trained as AIDS education facilitators. The training was conducted by the Planned Parenthood Association of South Africa (PPASA), which is a non-governmental organization (Dwadwa, 1997:9)

Material was also given to educators for use in educating learners about HIV/AIDS and other sexually transmitted diseases. However, at the same time the DoE did not make sexuality and AIDS education compulsory in the school curriculum. Dwadwa (1997:9) reports that literature, audio-visual material and videos on HIV/AIDS and sexuality education were made available to educators, but there was no provision on the timetable to teach it. Priority was being given to so-called academic subjects. Guidance, Right Living and life-skills education was marginalized. An example of this situation is the Eastern Cape schools, where in 1997, 99% of these schools were not offering guidance as a subject (Dwadwa, 1997:9).

It is clear that although training of educators started as early as the mid-1990's, the implementation of HIV/AIDS education did not appear to be very effective in the schools themselves. Educators had at best received a weeklong training programme, which did not really equip them to handle the issue of sexuality education in the classroom effectively.

A recent report on the status of the HIV/AIDS response by the education sector in KwaZulu-Natal was commissioned by the KwaZulu-Natal Department of

Education and Culture (South Africa, 2002a:14). This report cites several issues that impacted negatively on the effectiveness of the HIV/AIDS training programmes. Some examples are: “more often than not, training courses from other sections and directorates target the same schools and teachers simultaneously. This results in principals sending out unsuitable teachers, or not sending a teacher at all, thus causing poor workshop turnout. At times principals attend the four-day workshop with no intention of implementing the programme. Some principals send a different teacher every day for the duration of the course...This results in patchy and scanty training.” (South Africa, 2002a:14).

Another important issue that has impeded efforts to fight HIV/AIDS was sexual violence in schools and the rape and sexual harassment of girls by teachers and other students (Human Rights Watch, 2001:5). In more recent times this has become a much-reported issue in the media.

It is clear then that there is a complex interplay of a host of factors that fuel the relentless march of HIV/AIDS. It is therefore imperative that government's efforts must be effective. One way of ascertaining how effective this intervention is, is to assess its impact on educators and learners at grassroots level.

1.2.2 Investigation of the Problem

There is no doubt that from the 1980's when HIV/AIDS was first discovered to the present, the average person has definitely heard about this disease and is aware that this virus can wreak havoc and that it is doing so with societies across the world. Researchers have realized that whilst they cannot turn back the clock for those who are already infected with the virus, they can try to minimize the further spread of the virus through various means. They have concluded that the only solution is to prevent new infections (South Africa, 1994:19). This is linked to the issue of modes of transmission, and this in turn is linked directly to the question of risk behaviour.

This focus on prevention of new infections, is also advocated in loveLife (2001a:24), which states that although the international goal in respect of HIV/AIDS is to find an AIDS vaccine, the primary focus is to achieve social mobilization towards healthier and safer sexual behaviour. This is regarded as the most effective way to combat the HIV/AIDS scourge. Effective ways to attain this goal have been, and are currently being explored.

Van Dyk (1993:3) corroborates this view in stating that HIV/AIDS is not just a medical problem for which medical science has to find answers. It can also be controlled through education and behavioural changes. She argues that it places control of the disease back into people's hands. This then demands that the authorities empower individuals with knowledge and responsibility.

However, what is still not clear in South Africa is the manner in which the individual is changing his/her behaviour, attitudes and perceptions in response to the disease. It has become very clear that this is the most crucial issue in the fight: that only the individual can truly protect himself or herself from contracting this disease.

Van Dyk (1993:10) compares HIV/AIDS to the Trojan horse that the Greeks used to destroy the city of Troy. The only reason they succeeded was because of the naivete of the people who, if they responded sensibly to the perceived threat, would never have been defeated. In other words, bigger than the threat of the disease itself, are peoples' responses to the disease, which would determine its impact on their lives.

This view is further supported in an UNAIDS Case Study (2000a:47), where it states that the outcome of the battle against HIV/AIDS is decided within communities. People, not institutions, ultimately decide whether to adapt their sexual, economic and social behaviour to the advent of HIV/AIDS. It states that government and non-governmental organizations can only influence, constrain or

facilitate people's responses to HIV/AIDS. It also reiterates that the most important aspect in the fight is people's capacity to assess how HIV/AIDS affects their lives, their subsequent actions and their ability to learn from their actions. The role of government and others would be to ensure that they play their part in educating people.

Weinstein (1989:142) also argues that the individual's role is critical in this epic battle and that the failure to acknowledge personal vulnerability has been regarded as a barrier to people taking the necessary precautions. He further states that people tend to be unrealistic in their optimistic view about their own susceptibility to harm. They hold the view that although HIV/AIDS is dangerous and posing a real threat to society, they themselves are not really at risk.

Bandura (1989:128) provides another dimension to this perspective. He contends that regulating one's behaviour is not just an act of will. To achieve what he calls self-directed change requires the acquisition of certain skills in self-motivation and self-guidance. He asserts that there is a difference between possessing coping-skills and being able to use them effectively under difficult circumstances. One also needs a strong self-belief in one's capability to exercise personal control. He (Bandura, 1989:128) argues that people need to be given not just reasons, but the means and resources to achieve such behavioural change.

The South African government and other interested role players can play a meaningful role in achieving this. One can then argue that although the individual's response to HIV/AIDS is a critical issue in dealing with the pandemic, at the same time, the way a country's leadership responds in turn influences the individual citizen's perception of the danger that this disease poses.

Van Dyk (1993:26) shares a similar viewpoint, and states categorically that the rampant spread of HIV/AIDS can be blamed on governments across the world

that failed to respond decisively and timeously. Van Dyk (1993:28) mentions, as an example of this lack of decisiveness, that although AIDS was diagnosed in 1981, it was only in 1987 that “Ronald Reagan scraped together the political courage to discuss AIDS in public.”

In an article in the Sunday Times (24 November 2001:21) much of the blame for the spread of HIV/AIDS in South Africa is also placed at the South African government’s doorstep, due to its lack of decisiveness. The report states that the three major disasters of the 20th century were the following: the Holocaust under Nazi Germany, the atomic bomb and AIDS. The writer then comments that the major disaster for the 21st century was the attitude of the government towards AIDS!

However, the positive impact of leaders who are decisive in their response can be seen in the example of a country such as Uganda. The President of Uganda, Yoweri Museveni changed his stance on a controversial issue such as the use of condoms, which he previously opposed, to advocating its use as a weapon against HIV/AIDS. The result was a significant fall in HIV prevalence in that country (UNAIDS Report, 2000b:38)

The UNAIDS Report (2000b:107) examined factors that make a difference in the way countries responded to the HIV/AIDS pandemic. It illustrated that some countries through their responses were more effective in stabilizing HIV rates or achieving a turnaround in prevalence rates. It further discusses a number of common features in effective national responses. This ranges from factors such as national leadership’s willingness to be committed at the highest level to fighting the pandemic; the development of a single powerful national AIDS plan which involves all the role-players; social programmes that educate; community-based programmes; adequate resources and the ability to learn from experience. These are some of the factors that set some countries apart from others in the fight against HIV/AIDS.

The UNAIDS Report (2000b:37) details other factors that have also impacted on the spread of the virus. Factors such as racial, religious and sexual intolerance, discrimination against people who are suspected to be HIV-positive, the status of women, abuse of power, poverty and numerous other factors.

Essentially, one can thus argue that whilst the onus is on individuals to adopt safer behaviours to guard against being infected, the state has a responsibility to educate its citizens about the need to actually engage in low risk behaviours.

It is in this context that one needs to examine what the South African government's response to HIV/AIDS is, and how effective it is in changing citizen's attitudes, perceptions and behaviour. In a report entitled, "The Impending Catastrophe Revisited", (loveLife, 2001a:24) a criticism was levelled at the South African government for not responding in time. The report mentions that at one stage this country had the "advantage of witnessing this emerging epidemic north of its borders and could have responded proactively." However, that opportunity was lost, as a large majority of those at high risk at that time have already been infected by this stage.

Presently in South Africa there is a high level of awareness about HIV/AIDS, but there is a lack of knowledge and understanding (The AIDS Law Project and AIDS Legal Network, 2001:66). This is summarized in the following statement cited in Saayman and Kriel (1992:8) as general misconceptions people have about HIV/AIDS:

"AIDS is a problem of the immoral and unregenerate; indeed, AIDS is God's punishment on homosexuals, promiscuous heterosexuals, and drug addicts. 'Moral', 'truly born again' people can keep themselves pure, and therefore have nothing to fear, except perhaps accidentally becoming infected through contaminated blood transfusions."

It is obvious that knowing about HIV/AIDS is clearly not enough. The awareness campaigns have achieved what they set out to do, which is to create an awareness of the disease with the average person. Whiteside and Sunter (2000:125) state quite succinctly that the challenge was then to go beyond knowledge and to take this battle to a more personal level by encouraging people to confront their own vulnerability. The question then arises: To what extent is the DoE's response succeeding in this regard? Is the DoE succeeding in helping educators and learners to perceive their own susceptibility to HIV/AIDS?

1.2.3. Statement of the Problem

In the light of the above analysis of the problem, this investigation revolves around the following:

- What effect has HIV/AIDS had on education as a sector throughout the world and particularly in South Africa?
- What is the nature of the response globally, in South Africa in general, and specifically with regards to the DoE in respect of the HIV/AIDS crisis.
- How effective is the DoE's response?
- What are the areas of lags or neglect in terms of the response and how can they be addressed?
- Are educators and learners aware of the extent of the DoE's response, and what are their perceptions of this response?
- To what extent have educators and learners changed their behaviours in response to the HIV/AIDS epidemic?
- What are educators and learners attitudes to HIV/AIDS-related issues globally and in South Africa?

1.3. AIMS OF THE RESEARCH

With the above-mentioned questions in mind, the aims of this investigation are to determine:

- The effect that HIV/AIDS has had on the world, on South Africa in general, and the education sector in South Africa in particular.
- To examine the responses to this disease across the globe and in South Africa as a country.
- To examine the responses of the various stakeholders in Education.
- To examine the responses of other interested organizations, for example non-governmental and community organizations.
- To examine the theoretical basis of health behaviours by focussing on various models of health behaviours.
- To evaluate educators' and learners' knowledge, attitudes and behaviours with regards to the issue of HIV/AIDS.
- To evaluate educators' and learners' knowledge of DoE's policies and their school's policies in respect of HIV/AIDS.
- To evaluate the effectiveness of the response of the DoE to HIV/AIDS.
- To examine attitudes of educators and learners to HIV/AIDS-related issues.
- To assess to what extent educators and learners have changed their risk-taking behaviours in terms of HIV/AIDS.
- To compare various groups' knowledge and attitudes to HIV/AIDS-related issues.

1.4 RESEARCH METHOD

A literature study will be conducted in order to gain clarity on the issue of HIV/AIDS, as well as the response of the world, the response of the South African government and the DoE to the disease. This will give some insight into what has been done in the education arena, thereby providing a historical perspective on the past and present impact of HIV/AIDS on education. It will also assist in identifying gaps and lags. Finally it will also serve as a framework to contextualize the empirical research.

A quantitative research design will be used in the empirical study. A questionnaire will be designed and administered to a sample of secondary school educators and learners in the Durban South Region in order to assess the impact of the DoE's response in changing knowledge, attitudes and behaviours of educators and learners in terms of HIV/AIDS.

1.5 DEMARCATION OF THE RESEARCH

It was decided to confine the sample group to secondary school educators and Grade 10 learners in the Durban South Region, as this area encompasses schools that are very diverse and reflective of the nation as a whole in terms of cultural, social and ethnic/racial groups. It also provides some degree of homogeneity in terms of experiences within the secondary school environment, as well as in terms of the geographical considerations.

1.6 CLARIFICATION OF CONCEPTS

It is necessary to define concepts that would be referred to in the course of this research:

1.6.1 **AIDS** is the acronym for "Acquired Immune Deficiency Syndrome". AIDS is the clinical definition given to the onset of certain life-threatening infections in persons whose immune systems have ceased to function properly as a result of infection with HIV (South Africa, 2000:15)

1.6.2. **Code of Good Practice on HIV/AIDS** is a set of principles, practical guidelines and rules, example to encourage fair labour practices and to set up HIV/AIDS management policies and programmes (The AIDS Law Project and AIDS Legal Network, 2001: 456)

1.6.3. **HIV** is the acronym for "Human Immuno-Deficiency Virus." This is a virus, which attacks and may ultimately destroy the body's natural immune system (The AIDS law Project and AIDS Legal Network, 2001: 456).

1.6.4. *Risk Behaviour* may be regarded as behaviour that an individual engages in, that makes him/her more susceptible to contracting the HIV virus.

1.6.5. *Self-efficacy* is the degree to which an individual believes that he/she is capable of executing recommended preventative health behaviour. Self-efficacy is concerned with the judgements people make about their capabilities to organize and execute courses of action to desired levels of performance (Carter, 1999:297).

1.6.6. “*Universal precautions*” refers to the concept used worldwide in the context of HIV/AIDS to indicate standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another and includes procedures concerning basic hygiene and the wearing of protective clothing, such as latex gloves or plastic bags when there is risk of exposure to blood, blood pathogens or blood stained body fluids (South Africa, 1999:4)

1.7 RESEARCH PROGRAMME

Chapter 1: This chapter presented the rationale for undertaking this study. It also identified the areas that were going to be investigated, as well as the aims of the research. It has further clarified concepts that were encountered in the course of this research.

Chapter 2: This chapter will provide an overview of the historical development of the HIV/AIDS crisis in South Africa, as well as the South African DoE’s response to the HIV/AIDS pandemic. The DoE’s response will be compared to that of education sectors in other parts of the world. It will also examine the theoretical framework in which this study is contextualized, in order to understand the dynamics of health-related behaviours.

Chapter 3: This chapter will focus on the research methodology adopted in the study.

Chapter 4: The results obtained from the data analysis will be presented in this chapter.

Chapter 5: The summary and educational implications of the research findings will be dealt with in this chapter. An evaluation of the research will be undertaken. Problematic aspects of the study will be discussed, and recommendations in respect of HIV/AIDS and future research will be given.

CHAPTER 2

RESPONSES TO HIV/AIDS IN SOUTH AFRICA AND THE WORLD, AND THEIR IMPACT IN CHANGING ATTITUDES AND RISK BEHAVIOURS

2.1 INTRODUCTION

This chapter explores initial and current official responses by South Africa and the world to the HIV/AIDS crisis. Against this backdrop, the South African DoE's response is evaluated. The theoretical foundations of health behaviours are also examined, in order to provide some understanding of the barriers to the delivery and success of HIV/AIDS education and support programmes to educators and learners. This, in turn indicates the extent to which policies and legislation have succeeded in achieving the desired end regarding the fight against the scourge of HIV/AIDS. The desired end being to reduce the rate of new infections, which in turn requires changing behaviours from high to low risk behaviours. This in turn clarifies how educators and learners perceive the DoE's response to the pandemic, and to what extent they have changed their health behaviours.

2.2 THE GLOBAL RESPONSE TO HIV/AIDS

According to the resource manual, HIV/AIDS and the LAW (The AIDS Law Project and The AIDS Legal Network, 2001:113) there are several binding international agreements in place, in terms of the global response to HIV/AIDS. International law is defined as being made up of standards, rules and principles, which are binding on States when they interact with each other (The AIDS Law Project and The AIDS Legal Network, 2001:96). The resource manual further lists three important international bodies that regulate amongst others, laws relating to HIV/AIDS, namely, The United Nations, The World Trade Organization and The World Health Organization.

2.3 SOUTH AFRICA'S RESPONSE TO HIV/AIDS

Besides these international laws and agreements, there are also laws within countries related to HIV/AIDS. South African law has also recorded a comprehensive response to the crisis since the first official record of an AIDS case in South Africa in 1982 (Shell, 2000:8). There is legislation that is in place, which affords the person affected by or infected with HIV/AIDS protection from discrimination, and also defines certain basic rights. These will be focussed on briefly:

The most important of these is the Constitution of the country (1996), which has several aspects that have relevance indirectly to HIV/AIDS. The resource manual, HIV/AIDS and The Law (The AIDS Law Project and The AIDS Legal Network, 2001:83) cites 15 different sections of the Bill of Rights in the Constitution that are relevant to the issue of HIV/AIDS. It is reassuring to note that according to the South African Constitution, a person with HIV/AIDS has rights, which are enshrined in the constitution. Any transgressions of such rights may be taken to the Constitutional Court.

Rights in terms of HIV/AIDS are further entrenched in various other kinds of legislation in South Africa. The labour laws also clarify and protect and provide mechanisms to ensure that the individual's rights are not infringed. The highest of which is the Labour Relations Act No. 66 of 1995. This Act, inter alia, protects the worker from unfair labour practices such as not being allowed to do certain types of work because of his/her HIV-status or even from unfair dismissal on the same grounds.

An employee is also legally protected in the Employment Equity Act No. 55 of 1998. Educators are also covered by this Act. This Act prevents persons from being unfairly discriminated against on the basis of their HIV-status. It also prevents the individual from being coerced into being tested for HIV by his employer. This cannot be done without authorization from the Labour Court. According to the AIDS Law Project and the AIDS Legal Network (2001:162), this Act was the first Act to directly say that an employer may not unfairly discriminate against employees on the basis of a person's HIV-status. An interesting observation can be made that

this was the first direct reference to HIV/AIDS in government legislation in South Africa, and it came almost 17 years since the advent of HIV/AIDS in the world in 1981!

The “Code of Good Practice on Key Aspects of HIV/AIDS and Employment” was also effected by the Minister of Labour on 1 December 2000. This falls under the Labour Relations Act (No. 66 of 1995, Schedule 8) and the Employment Equity Act (Section 54(1)). This Code serves as a guide to all employers including the DoE, and further enforces workers’ rights.

The other very crucial Labour Act is the Basic Conditions of Employment Act No. 75 of 1997. This Act focusses on basic standards of employment such as leave conditions amongst other matters, and naturally has positive implications in terms of protection for persons infected and affected by HIV/AIDS. There are several other laws and regulations that have been promulgated by the South African government that either directly or indirectly have implications for HIV/AIDS. One can therefore conclude that individuals in this country are clearly protected more than adequately from a legal perspective. What is also significant is that these legal responses range from the highest law of the country, that is, from the Constitution, to regulations that are specific to particular sectors, such as health and education.

2.4 THE EDUCATION SECTOR’S RESPONSE TO HIV/AIDS IN SOUTH AFRICA

The education sector’s response can be examined in terms of schools and the tertiary institutions as two categories of educational institutions.

2.4.1 Schools as educational institutions

In terms of the response of Education as a sector in society to the advent of HIV/AIDS, HIV/AIDS-specific policies have been put in place. These policies represent a management plan, which aims to address the HIV/AIDS crisis in this sector. The national policy on

HIV/AIDS for learners and educators was launched in 1999 by the Minister of Education, Professor Kader Asmal (South Africa, 1999).

As this policy is specifically addressing the issue of HIV/AIDS, it clearly spells out acceptable and unacceptable practices in respect of HIV/AIDS. It also instructs individual schools and educational institutions to adopt their own policy on HIV/AIDS. Critical issues such as discrimination, admission of learners, appointment of educators, disclosure and confidentiality, preventative measures and provision of a safe school environment are addressed. The national policy also details issues relating to HIV/AIDS education and responsibilities of learners and educators with regards to HIV/AIDS. Schools are further directed to establish a Health Advisory Committee at each school. The policy from the national education ministry is thus quite comprehensive and appears to cover all relevant areas in terms of schools.

As a follow-up to the National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions (South Africa, 1999), the DoE released a document, “The HIV/AIDS Emergency: Department of Education’s Guidelines for Educators”(South Africa, 2000). Amongst other issues, the opening message from the Minister of Education, Professor Kader Asmal states that educators “must set an example of responsible sexual behaviour.” He further addresses himself directly to “male educators”, whom he states have a “special responsibility... There must be an end to the practice of male teachers demanding sex with schoolgirls or female teachers...It is also against the law...It is spreading HIV/AIDS and bringing misery and grief to these precious young people and their families.”

In a subsection in this document (South Africa, 2000:12) entitled, “Sexual relations between educators and learners are illegal”, it is stated categorically that sexual relations between educators and learners are illegal, even if the learner consents. Sex that is demanded by an educator constitutes rape, and in the case of learners under 16 years, it is statutory rape, which could result in life imprisonment. It further appeals to educators to report colleagues who are guilty of such behaviour. There is also a clear warning that if an educator is aware of an under-age learner being forced to have sexual relations with an educator, he/she must report such a

matter or he/she can be charged with being an accessory to rape. This no-nonsense, hard-hitting document expresses zero-tolerance for sexual abuse of children by educators. The question is how many educators have had access to this document, and have read it? What follow-up is being done to ensure that the schools are responding decisively and urgently, as time is of the essence? Are these policies, laws and legislation having the desired effect, and what is really the purpose of these policies? If the purpose is to educate, transform behaviours and thereby curb the impact of HIV/AIDS, are they in fact succeeding in this regard?

To this end, one needs to also examine what the educators' and learners' views are of the situation as it affects them personally and what efforts they are making to transform the way they behave and interact with others. This would constitute a fairly accurate measure of the effectiveness of the response by the DoE.

2.4.2 South African tertiary institutions' response to HIV/AIDS as part of the education sector

Du Pre (23 February 2001:2) in an address to the Committee of Technikon Principals (CTP) and the South African Universities Vice Chancellors' Association (SAUVCA), quantified the situation regarding the tertiary education sector in South Africa. He pointed out that there are 21 universities and 15 technikons in South Africa, and an estimated 330 000 students attend universities, and 190 000 students attend technikons. His paper criticized the higher education institutions for the weakness of their response to HIV/AIDS (Du Pre, 23 February 2001:3). Some of the criticisms levelled are the following:

- Responses have been ad hoc and uneven and focussed only on prevention;
- There was little planning to anticipate the impact of HIV/AIDS;
- There was a tendency to treat HIV/AIDS as a health problem;
- Low priority was given to HIV/AIDS;
- There has been a persistent climate of silence and denial;
- There were difficulties in defining institutional response.

In this report (Du Pre, 23 February 2001:5), the CTP and SAUVCA put forward a programme for 2001 with certain key areas, viz.

- Ensuring a planned, rather than an uneven response;
- Developing, promoting institutional responses to the issue of HIV/AIDS;
- Assessing capacity, commitment and deployment of resources;
- Setting of minimum standards for institutional responses to HIV/AIDS in respect of prevention, treatment and support.

SAUVCA also published a report (SAUVCA, 2000), which documents and contextualizes the South African Universities' response to HIV/AIDS. The report indicates that only four universities had approved and adopted a HIV/AIDS policy, while ten other institutions had draft policies and a further seven had no policy at the time of the report (SAUVCA, 2000:15). Once again one notes that as with other sectors, the response is a delayed one – in this case, 19 years after the first notified case of AIDS in the world in 1981!

The SAUVCA Report (SAUVCA, 2000:17) is critical of the fact that few institutions have done more than merely mention HIV/AIDS in their broader plans. It also notes that it has been rare that any institution has actually made HIV/AIDS a core focus across all sectors of operations. These are startling and worrying facts. The report acknowledges that there are a wide range of programmes, but states that the weakness of the programmes lies in the fact that the focus is still on awareness and prevention through health services. More attention needs to be given to issues such as care and support, curriculum development and research. The report recommends using the Beyond Awareness Campaign (see further on) as a way to develop programmes and curricula to prepare students for a “new reality”(SAUVCA, 2000:24).

The Beyond Awareness Campaign (South Africa, 2000) is essentially a strategy adopted by the national government to move beyond advocacy and information programmes to changing behaviours. Kelly (2000a:6) cites several reasons, which could account for the inhibited response from the universities. He states that HIV/AIDS has, what he terms “a deceptive nature”, in that a person who is infected with the virus presents as a well, healthy person for many years before becoming “sick”. Universities like other institutions do not feel the impact of the disease, as it gradually and unobtrusively erodes the institution. Thus, there is no sense of urgency in responding to the virus.

There is also a tendency to see HIV/AIDS as a health issue, which requires a response from the medical and health science areas of the university and to exclude this issue from university politics, management, planning, programming and the “real life” of the university (Kelly, 2000b:7). Kelly further notes that the other issue that has impacted on universities in recent years is the issue of financial constraints, rationalization, closure and amalgamations of institutions. University managers have, according to him, directed their energies to addressing “bread and butter” issues, and have marginalized the HIV/AIDS issue, leaving it to research units within the campuses to forge ahead with research, which is what they have done. One can argue that the universities’ focus in respect of HIV/AIDS has been skewed, and has not been dealt with effectively in mainstream university life.

Kelly (2000b:8) recommends three domains where HIV/AIDS should be incorporated, viz. academic teaching and research, administration and management and university culture. He also points out that a university is an educational institution, which is “person-intensive”. Besides the students, there is the academic staff, as well as administrative and support staff. A university is therefore very vulnerable, and can be seriously affected by the impact of HIV/AIDS. This would hold true for other tertiary institutions as well.

2.5 RESPONSES FROM OTHER ROLE PLAYERS IN EDUCATION IN SOUTH AFRICA

2.5.1 Educator unions’ responses

Other important role-players in Education such as the various educator unions have also adopted policies and strategies on HIV/AIDS. The response from the Association of Professional Educators of KwaZulu-Natal (APEK) will be examined. APEK which is a regional Teachers’ Union in KZN adopted its policy on HIV/AIDS in July 2001 (APEK:2001). In the Foreword of this policy document, it is stated that APEK “...believes that it is the moral responsibility of the Association to educate its membership about the social, economic, employment and human rights implications of this dreadful disease”. The policy was drawn up in accordance with guidelines from the DoE, as well as other relevant legislation, including national labour laws and

regulations. The APEK policy addresses issues such as factual information on HIV/AIDS; modes of transmission; legal implications in terms of discrimination and confidentiality, compensation for occupationally acquired HIV, employee benefits, dismissal and grievance procedures, as well as management in educational institutions.

What conclusions can one draw in the light of this profusion of legislature and policies that ought to guarantee educators and learners protection against discrimination? It would certainly be safe to say that officially, the various state structures and other support structures have responded by putting in place a legal framework as a response to the HIV/AIDS pandemic. However, the following question needs to be answered: Is the legislation achieving the desired effect of educating the citizens and teaching them safer behaviours to prevent or curb HIV/AIDS transmission?

2.5.2. Non-governmental Organizations' (NGO's) responses to HIV/AIDS in South Africa

There has been a tremendous effort on the part of NGO's in South Africa to implement HIV-prevention programmes. One such NGO is Soul City, which is funded by the South African government, overseas donors such as the European Union, Ireland Aid, BP and MTN among others (Soul City & Jacana Education, 2000). Their focus has been multi-pronged, involving the radio, television and print media, such as newspapers and supplements.

Another NGO that has focussed primarily on the schools is the Planned Parenthood Association of South Africa (PPASA). They have been involved in the training of teachers in HIV/AIDS and sexuality education, as well as the provision of manuals and support material for implementation of these programmes (Dwadwa, 1997:9). They have formed partnerships with the Department of Education, and their focus is the learner. Since 1997 they, together with other NGOs have trained more than 10 000 teachers to teach life skills, with the aim being to train approximately two teachers per school.

Educational theatre has become a popular medium of fighting HIV/AIDS. One such example of this is Pieter Dirk Uys's "Foreign AIDS", an educational show which has delivered the AIDS

message to 400 000 children in 200 schools already (Independent on Saturday, 13 July 2002, 8). However, much debate and controversy has arisen over Uys's "in-your-face" play, which is littered with profanities as reported in the Independent on Saturday (13 July, 2002:8). The article quotes Uys as saying to a group of white, middle class, middle-aged theatre-goers: "I am f***king terrified of dying of love." Instead of using the word "intercourse" or talking about "the birds and the bees" to children, Uys says "Can a bird f**k a bee?" Uys's argument for the use of such profanities in AIDS education is that they are "necessary profanities". He believes that this is the tone he needs to use to get through to children (Independent on Saturday, 13 July 2002:8). Uys's show is definitely one of the more controversial and hard-hitting "educational endeavours"!

However, one of the most powerful interventions must surely be from the NGO, loveLife. loveLife has partnerships with several other NGO's, with funding from the Henry J Kaiser Family Foundation, the Bill and Melinda Gates foundation, UNICEF, as well as the South African government. The primary objective of loveLife (loveLife, 2001b: 4) is to positively influence teenage behaviour with the aim of reducing teenage pregnancies, HIV/AIDS and other sexually transmitted infections (STIs). loveLife uses commercial marketing and public health techniques to promote healthy lifestyles among the identified 12-17 year old target group.

loveLife uses an "in-your-face" style that involves radio, television, billboards, print media and the internet. The NGO also has a tollfree parent tele-counselling line as well as a sexual tele-counselling service or call centres called thethajunction, which receive more than 60 000 calls per month (loveLife, 2001b:5). They have clinics nationwide for adolescents, called Y-centres. Some examples of radio programmes are Cross Fire on Yfm, Thand'impilo on Ukhozi fm; examples of print media material are *Tell Me More*, *S'camto PRINT*, *Love Facts*, *Codi* and *Love Them Enough to Talk About Sex*, which are magazines targeting different groups. Some of the television programmes include the following: *Codi*, *JikaJika* and *S'camto* (loveLife, 2001b).

The other critical areas that loveLife tackles are research and community mobilization. The loveLife Games is an initiative designed to instill the concept of healthy lifestyles through sport, and claims to have reached 12 000 children since starting in June 2000 (loveLife, 2001b:46).

loveLife acknowledges that since the launch in September 1999 they have succeeded in creating awareness about adolescent health, but that this is not enough. More important than awareness were behavioural changes from high-risk behaviours to safer behaviours (loveLife, 2001b:50). They envisage that their latest shift in focus to using the community as well as peer educators would assist in this regard.

In evaluating the impact of the NGO's, one must acknowledge that whatever else they may not have succeeded in doing, they certainly succeeded in grabbing the attention of the public at large. There has been an outcry against the sexually explicit sexuality education messages such as those of Pieter Dirk Uys (Independent on Saturday, 13 July 2001:8). In response to one such letter from an outraged parent, Rene Hicks, editor of S'camtoPRINT, responded as follows: "The challenge we face is that one in 16 South Africans has had full penetrative sex by age 13, one in four by age 15 and one in two by age 16. The prevailing message for young people in South Africa is that sex equals HIV equals death - a message that doesn't help much in a society where 55% of sexually-experienced girls have been forced to have sex, mostly by their boyfriends...Unless we equip them to confront their own sexuality and make choices for their own lives, we limit their options and place them at high risk." (Sunday Times and loveLife, 3 February 2002:3)

Besides these organizations mentioned above, there are several other media, community organizations and NGOs that are involved in HIV/AIDS intervention programmes. HIV/AIDS awareness is high throughout South Africa. What is needed is a shift towards programmes that focus on behavioural changes in target groups. The other criticism that can be levelled is that the focus has been primarily the adolescent group. Teachers have merely been trained as facilitators for implementation of sexuality and HIV/AIDS education. There needs to be a greater focus on teachers' high-risk behaviour. Other school personnel such as administrative staff and other staff also need to learn the importance of practising safer health behaviours. This area has been sorely neglected in the schools, with an inordinate amount of focus by NGO's on information campaigns targeting the youth. Research into health behaviour has shown that such

an information-overload does not necessarily result in positive behaviour changes (Bandura, 1989:128; Catania, Kegeles and Coates 1990:54; Chapin, 2000:69).

2.6 CURRENT RESEARCH FINDINGS WITH REGARDS TO HIV/AIDS AND EDUCATION

2.6.1 Legislation and training

Research seems to indicate that education sectors in most countries have, although belatedly, like South Africa, put in place legislation and policies in respect of HIV/AIDS. However, it seems that in some cases even the teachers at those very institutions are unaware of such policies (Warman, 1994:1). This then begs the question: What is the point of these policies, if the relevant stakeholders do not even know that they exist?

Warman (1994:1) who conducted a study in the United Kingdom, found that 64% of the schools surveyed did have HIV/AIDS education policies. He (Warman, 1994:1) mentions that teachers from those very schools were themselves sometimes unaware that such policies existed at their school! Another interesting finding of this study was that most teachers perceived the main purpose of HIV/AIDS education programmes to be the imparting of knowledge, rather than to assist in modifying learners' behaviour (Warman, 1994:8). It is evident that there are gaps in the way the issue of HIV/AIDS is being tackled in training.

Grier and Hodges (1998:257) also provide evidence of gaps in other areas of teacher training in respect of HIV/AIDS. They indicate that while factual knowledge of HIV/AIDS was evident among school personnel, actual knowledge and use of the universal precautions was minimal. Grier and Hodges's study also showed that there was much uncertainty among respondents about whether their particular schools had a current infectious disease policy.

These researchers (Grier and Hodges, 1998:257) also found that teachers displayed confusion about when they thought was the correct instance to

implement universal precautions in the classroom, that is, under which circumstances and with which children. Once again it appears that whilst the authorities are putting in place mechanisms such as policies, programmes and structures, these are not always communicated to the educators at grassroots level. This is true even within schools, and also between the educational department headquarters and schools themselves. They (Grier and Hodges, 1998:260) come to the conclusion that little attention has been given to educating school staff with respect to their own safety and comfort level in the day-to-day work in the school setting, specifically regarding the application of universal precautions and self-care.

Ainsa (2000:8), in a study on the situation regarding HIV/AIDS in El Paso, Texas, United States further corroborated Grier and Hodges's findings (1998:260) that teachers tend not to engage in safe behaviours, such as the use of universal precautions when handling blood and body fluids. She (Ainsa, 2000:8) indicated that in schools in this area, teachers, school staff and pupils are aware of the presence of HIV/AIDS "out there", and know about safer behaviours. However, they do not appear to be able to contextualize it on a personal level, that is, they seem to be unaware of the possible presence of HIV/AIDS in their individual classrooms. This, she argues, is due to a lack of information about the possibility of HIV-infected children being present in classrooms, as well as lack of materials, training and support to teachers and learners. What was needed, according to Ainsa (2000:8) was sufficient information, more intensive training and greater support of teachers in order to raise the level of awareness about HIV/AIDS among both staff and pupils on a personal level.

Beverly (1995:101) holds a similar view. She emphasizes the need for every person involved in the educational system to be cognizant of the possibility that they will serve children with non-symptomatic and symptomatic HIV infection. She points out that due to parents' requests for confidentiality, not all teachers will be aware of those children who are HIV-positive. She argues that having

legislation in place supporting the presence of HIV-positive children in schools and respecting their right to an education is merely addressing part of the problem. The other responsibility is to put in place structures to ensure a safe educational environment.

In terms of legislation, Ainsa (2000:12) reports that there are several laws that relate to the various issues regarding HIV/AIDS in American schools. One such law relates to the right of HIV-positive children to attend school. Another important factor, which Ainsa (2000:15) examines, is the question of who then needs to know about the child's HIV-status. She states that the policy on this is that even if the child needs medication at school, only persons immediately involved with the medication need to know.

Ainsa (2000:4) contends that this law has educational and training implications for school personnel in the United States, since more than half the paediatric population that are infected attend school. It also has support implications for the child with AIDS who attends school. These children cannot attend school without systems being put in place to provide the necessary practical and psychological support. This would, in turn require that personnel be trained to do this.

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Books (1998:57) in a similar viewpoint, contends that one of the problems with most professional training programmes has been the neglect of this important issue regarding support for the infected child. These programmes have been inclined to focus on how HIV is transmitted, the use of precautions and the course of the disease. There has been little training, according to her, on the needs of HIV/AIDS-affected children. Professionals may not take into account HIV/AIDS-related stressors from the child's life that may impact on behaviour, and result in delinquency or a slip in grades.

Books (1998:57) cites another interesting perspective on the whole issue of lack of support for the children affected and infected by HIV/AIDS that is related to the stigma associated with this disease. Due to this, she postulates that HIV/AIDS-related illnesses remain family secrets. Added to this are the confidentiality laws in the United States that allow disclosure only with the permission of the infected person. The child could have had access to “traditional sources” of help such as the school and places of worship. However, these are not available to the child, due to the simple fact that the teachers may be unaware of the child’s predicament, and are therefore not in a position to help.

In this regard Ainsa (2000:50) points out the advantages that the training of educators offers to the education sector. She states that informed educators are the most effective agents to help fight the spread of the disease, and to promote safer health habits and behaviours. Ainsa (2000:15) comments that teachers were identified, among others, as personnel who could help students by providing a supportive classroom environment where anxiety about HIV/AIDS could be expressed. Teachers could play an important role in promoting peer acceptance of a sick child. However, she argues that one of the barriers was the inadequate training that teachers underwent in this regard, in particular when dealing with classroom situations involving HIV-infected children. She further states that teachers in reality must share in the responsibility for the management of the HIV-infected child and his family.

Roberts, Pettifor, Cairns and DeMatteo (2000:38) sum up the situation quite succinctly in describing what they call “... a chaotic sequence of events” with the arrival of HIV/AIDS-infected children in Canadian schools. These researchers argue that if schools developed a more inclusive, respectful and informed policy towards the acceptance of HIV/AIDS in the classroom, more parents would feel safe to share the diagnosis of HIV with the school in respect of their children. They further caution that teachers should not be wondering about when to apply universal precautions, as these have ethical implications in terms of discriminating against particular students. They point out that using universal precautions with just a select few would seem neither safe nor ethical. Universal precautions should be used with all students. The danger also exists in selectively applying universal precautions to HIV-positive students only, as

this would lead to breach of confidentiality. They conclude by advocating more research and educative programme development, as this would ensure that schools would be equipped to be able to meet the health and psychological needs of all concerned more effectively.

In conclusion, it is clear that there are gaps in the training of educators, namely:

- Policies are not cascaded to relevant stakeholders, such as educators and other personnel.
- Knowledge is high, but practical guidelines on how and when to use this knowledge are insufficient.
- Educators are not applying the universal precautions, as they ought to be doing.
- Educator training is inadequate and does not prepare educators to adequately support learners (whether HIV-positive or not)
- Insufficient attention is being given to the needs of HIV-positive children in the classroom.

Besides the above-mentioned concerns, there are other factors that influence and exacerbate the impact of HIV/AIDS on the education sector. The issue of educators' and learners' attitudes and how they influence their responses to HIV/AIDS is one such issue.

2.6.2 A global perspective on educators' and learners' attitudes and behaviours with regards to the HIV/AIDS pandemic.

2.6.2.1. International research findings regarding educators' attitudes and behaviours

Research (Warman, 1994:1; Grier and Hodges, 1998:257; Ainsa, 2000:8) seems to point to the fact that educators' attitudes towards HIV/AIDS show a lack of understanding of the disease. There are several factors that impact upon educators and contribute to shaping their attitudes and

behaviours in respect of HIV/AIDS (Books, 1998:61; McFarland and Oliver, 1999:268). This in turn impacts on the way they respond to learners who are infected with the virus.

Books (1998:50) refers to the children who are infected or affected by HIV/AIDS as the “invisible” children and youth. They are also the children who may have escaped infection themselves, but who have family members that are infected. She states that whether living in disadvantaged or economically stable backgrounds, what unites these children is their invisibility to people such as their teachers as HIV/AIDS sweeps through their families and their communities.

The irony of the dilemma faced by these children and youth is that this is a time in their lives when it is imperative that they succeed at school (Books, 1998:60). This is partly because they may have to become supporters to their families. However, they may experience obstacles to such success in the form of misinformation and misunderstanding by educators, their own reactions and consequent behaviour as a response to their HIV/AIDS-related situation, as well as lack of access to proper health care support.

Books (1998:61) details some of the behavioural problems these children present with, as a result of their inability to cope with the impact of HIV/AIDS on their lives. These behaviours range from withdrawal, anxiety, fearfulness in younger children, acting out, verbal disrespect, physical violence and early and unprotected sexual encounters. This can, in some cases, result in misdiagnosis by teachers of a learning disability with some children. To prevent this she suggests close collaboration between teachers and mental health workers.

However, the most critical aspect that is mentioned by Books (1998:61) is that of training of teaching personnel, in particular, to overcome and challenge any prejudices, as well as to address any legitimate concerns they may have. They may then be in a better position to meet the support needs of these children who are affected and infected with HIV/AIDS. However, teacher attitudes are improving according to research findings. White and Ballard in Alali (1995:94) concluded in their survey on teacher attitudes, that generally attitudes in the United

States were less negative than those of teachers in the 1987 study done by Brucker, Martin and Shreeve (1989:63).

However, Alali (1995:36) points out that, whilst attitudes have improved, there is still an emotional reaction to HIV/AIDS. However, this is not just linked to ignorance, misinformation and unrealistic fears about HIV/AIDS, but more especially to fears and prejudice that teachers may have about the issue of sexual orientation. They argue that this is due to the initial portrayal of HIV/AIDS in the early years after the discovery of HIV/AIDS, as a disease associated with homosexuals and promiscuous lifestyles. In the study they conducted among students, many of whom will become elementary and high school teachers, they encountered what they termed “prejudicial attitudes”. They believe that such attitudes will influence these prospective teachers’ future interactions with HIV-positive children. According to the researchers, children who test HIV-positive are likely to experience negative reactions from teachers.

McFarland and Oliver (1999:268) comment that even many school counsellors have not been appropriately concerned about HIV/AIDS because they had wrongfully perceived this as a gay disease, impacting on a small percentage of the students at their schools.

Helge in Alali (1995:51) cites stereotypical belief systems, inadequate HIV/AIDS education, lack of respect for confidentiality and the threat of the social stigma, as factors that impact on HIV-positive individuals and thus school-going children, in the rural areas of the United States.

The issue regarding the influence of teacher attitudes, is addressed even more vociferously by Silin (1992:60). He argues that while teachers would like to be viewed as objective professionals acting in the best interests of the children, when it comes to HIV/AIDS, personal values, prejudices and preconceptions play a role in determining how information is conveyed and whether it is conveyed. He (Silin, 1992:60) describes HIV/AIDS as a disease “...that happens all at once...Teachers quickly recognize that this disease has meanings that extend far beyond the clinic office or hospital room, meanings that will seep into conversations with their own children, affect attitudes towards friends and family, change lifelong behaviours. It even has meanings that challenge their sense of safety in the workplace. This is the all-at-onceness of HIV/AIDS, a disease that not only destroys an individual’s immune system, but also breaks

artificial barriers that we construct between professional and personal lives”. Thus, he advocates a type of training that will address both rational and irrational fears that teachers may have, regarding HIV/AIDS.

Jessee, Poteet-Johnson and Nagy (1993:28) in a study on day care teachers and administrators, focussed on these irrational fears that these individuals experienced. Even though respondents had the knowledge of how HIV was transmitted, they still expressed a general fear of transmission of the virus through casual activities and contact such as sharing of foods and beverages, touching of saliva and tears. The findings point to the fact that no matter what the knowledge level of the respondents, they still experienced fears that they realized were irrational, but that were there anyway!

Brucker and Hall (1996:86) corroborate the findings of White and Ballard in Alali (1995:94) with regards to improved teacher attitudes. They point out that whilst there are still concerns regarding attitudes in the U.S. in general, there was an improvement in attitudes among teachers as compared to the 1987 study (Brucker et. al, 1989:63). Teachers appeared to feel less threatened and less negative towards those with the HIV/AIDS disease than was the case previously. These researchers make the point that teachers must be provided with the most current and accurate information regarding HIV/AIDS. The reason they cite for this is that teachers have a powerful influence on their students in acceptance or rejection of the individual and the situation. They (Brucker et. al, 1996:86) state that negative teacher attitudes towards HIV/AIDS-related issues result in negative student attitudes. In-service training of teachers should therefore also encompass values and attitudes.

The findings of Lebrun and Freeze (1995:34) also concur with that of Brucker and Hall’s findings (1996:86) regarding improved teacher attitudes. These researchers found that in fact 80% of teachers believed that HIV-positive students have the right to participate in all areas of school life and 99% of them believed that HIV-positive students should be mainstreamed into regular classrooms. Moreover, 93% of them were very accepting of colleagues that were HIV-positive. An overwhelming percentage (95%) of them further felt that these “sick” colleagues should continue teaching as long as their health status permitted them to do so. They further

recommended that there is a need for professional development of teachers in respect of policies and practices regarding HIV/AIDS. This would in turn lead to teachers that are better prepared for HIV-positive students in their classrooms and they are clear about policies and procedures and their rights as well as those of their students and colleagues. These researchers are of the opinion that being better informed would lead to acceptance and would make HIV/AIDS less threatening to live with.

Wadsworth and Knight (1996:146) agree that the behaviour modelled by the class teacher will have the most influence on students' acceptance of their peers with HIV/AIDS. These researchers also point out that HIV-positive students will have the greatest chance of success and quality education if their teachers are well prepared by the authorities to educate and create safer classrooms. Preparing teachers would, according to the researchers, involve training teachers not just as sexuality education facilitators, but also in the application of universal precautions, classroom management and accommodation of children who are HIV-positive or have AIDS. The latter involves adjustment of the curriculum and educational programme, provision of catch-up programmes in the case of children who are frequently absent due to illnesses related to HIV/AIDS, provision of emotional and psychological support and the use of a multi-disciplinary team approach.

The findings of a study conducted by Doherty-Poirier, Munro and Salmon (1994:27) also support this standpoint. This study was conducted on teachers and students and the results showed that teachers who had received training in teaching HIV/AIDS-related curricula, produced students who had significantly higher levels of knowledge and displayed more tolerant attitudes regarding HIV/AIDS.

Research findings seem to indicate that if teachers are adequately trained, they would be prepared and thus more empowered to cope more effectively with HIV/AIDS-affected children, than if they are not trained. This in turn would lead to less negative attitudes among teachers and would ultimately influence students' attitudes in the classroom.

Ford and Russo (1997:254) propose that until a cure is found, another effective way of combating this disease was to keep educators informed of the latest advances related to

HIV/AIDS infection. This would help in establishing effective school-based policies and school prevention programmes, as well as serving the educational and psychosocial needs of the HIV-infected child, and the non-infected child. They argue that because schools play a major role in the development of children, they are in an optimal position to participate in the fight against the spread of HIV/AIDS.

In conclusion, when evaluating the impact of the education sector's response globally in influencing and empowering teachers as role players in the fight against HIV/AIDS, it becomes apparent that although teachers' attitudes are changing, they are not practising safer behaviours in managing their classrooms. They also still harbour misconceptions about the transmission of the virus, albeit on an irrational level. They are also not fully in touch with what policies are in place in respect of HIV/AIDS. Research also points to the fact that teachers wield a great deal of influence on learners. Thus researchers concur that harnessing the influence of teachers in this fight would be an effective strategy.

2.6.2.2 International research findings regarding learners' attitudes and behaviours

“When you live with HIV, there are definitely good days...Going to the mall with my good friend who knows my diagnosis is fun because this is the day when I don't have to worry about what I say...There are definitely bad days, too. There are days when the kids talk about AIDS in school...I once asked a boy what he would do if I had it, and he told me he would never go near me but that he knew that I didn't really have it. He was wrong. I do.” –Dawn, age 12. (Sherman, Bonanno, Wiener and Battles: 2000:238).

Sherman et al (2000:245) conducted a study on the effect of disclosure of HIV-status on the psychological wellbeing of children. These researchers concluded that although it has been found in adult studies that disclosure promotes wellness, there is insufficient evidence to prove that it has the same positive effect on children who disclose. They cite that the reasons for this may be related to the resultant social stigma linked to the issue of HIV/AIDS. Disclosure, for example, may cast the family in a negative light, regarding the manner the virus was contracted. They focus on the huge struggle faced by parents of HIV-positive children, as they are not sure

how best to handle the question of whether to allow their child to inform others of their HIV-positive status.

Maieron, Roberts and Prentice-Dunn (1996:321), in examining children's perceptions of sick peers, argue that research has shown that the type of information given to these children will actually influence their attitudes and thereby their response to their sick peers. They argue that merely informing children about the modes of HIV transmission was insufficient in increasing acceptance of sick peers. What was also necessary was to clear up misconceptions by also describing ways that HIV is *not transmitted*. This had a positive effect on how children responded to their peers who were HIV-positive. The researchers regard this as an important finding, as increasing numbers of HIV-positive children are attending school and are coming into contact with classmates and teachers, many of whom fear being near them or have stigmatized views of people with HIV/AIDS.

The reality of the fear of the stigma associated with HIV/AIDS that parents experience, was borne out in a study conducted by Cole, Roberts and McNeal (1996:107) in which they examined children's perceptions of peers with chronic illness, one of which was AIDS. The other diseases were diabetes, asthma, and cystic fibrosis. They found that children rated their peer with AIDS as more responsible for the disease than the others with other illnesses. They conclude that efforts in HIV/AIDS education may be sending out a two-fold message, that is, whilst prevention messages are being conveyed, these messages may also be conveying a sense of personal responsibility allowing "blame the victim" perceptions (Cole et al, 1996:113). They further point out that health education messages must be carefully examined to ensure that whilst they inform children about prevention, they do not at the same time contribute to psychosocial harm for persons living with HIV/AIDS.

Kistner, Eberstein, Quadagno, Sly, Sittig, Foster, Balthazor, Castro and Osborne (1997:294) also supported the view that HIV/AIDS education needs to be carefully designed to ensure that these programmes are tailored to meet the needs of children in respect of their age, race and community. They found that these variables influence children's attitudes to persons with AIDS. They further state that another potential source of influence on children is parental

beliefs about HIV/AIDS and their attitudes to persons with AIDS. Another important finding of this study, which other studies have also pointed out, is that children still have misconceptions about transmission modes of HIV/AIDS. They concur with other researchers that educating about how HIV *is* and *is not transmitted* is likely to have a positive influence on children who are afraid to interact with persons with AIDS.

Moss, Bose, Wolters and Brouwers (1998:24) found in studies with HIV-positive children that in a two-year period, there was a decrease in social self-esteem among these children. They comment that lowered self-esteem seems a likely outcome from the expectancy of peer rejection that might be associated with being HIV-positive. However, they too, caution against categorical acceptance of this finding and also advocate further studies in this area.

Palmer, Boardman and Bauchner (1996:301), in commenting on the spread of the virus, are of the view that for HIV/AIDS education to be effective in curbing the spread of the disease, the curriculum must include more than knowledge or factual information. They illustrate this in their study, by pointing that whilst children seemed to possess a good amount of knowledge about HIV/AIDS, they were unable to translate this into correct action when presented with hypothetical situations in class. They suggest that HIV/AIDS education programmes should allow children to think about and discuss issues, thereby enabling them to incorporate them into future behaviours.

Alali (1995:2) focusses in this regard on what he calls an equal and counter responsibility facing education authorities, which is the right of the non-infected learner to be protected against infection. However, he cautions that protection of the rights of the non-infected learner should not result in discrimination against the infected learner. He further points out that the courts have consistently upheld the rights of the infected child to education. He describes a two-pronged strategy that education should have, which is education for prevention, and secondly the provision of support services to the HIV-infected.

Alali (1995:12) also highlights the need to protect the rights of the infected child. He cites Section 504 of the Rehabilitation Act of 1973 of the United States of America in this regard,

which protects the HIV-infected person's rights to receive an education. He states categorically that there are no legal grounds for exclusion of learners from receiving an education.

In the light of the above, one can conclude that globally, issues of stigmatization, irrational fears and discrimination still dominate the HIV/AIDS scenario. One needs to look at the current situation regarding HIV/AIDS and the education sector in South Africa.

2.7. EVALUATING THE CURRENT STATUS REGARDING HIV/AIDS IN SOUTH AFRICAN SCHOOLS

Besides the increasing numbers of educator and learner deaths in South Africa, other factors are also exacerbating the impact of HIV/AIDS on education. Reports seem to indicate that misconceptions, abuse and discrimination are still rife in South Africa in spite of the concerted efforts by all the role players, as detailed in previous sections.

Irrational fears still abound, as indicated in a survey among teachers in South Africa, (Rees (1999:9). She (Rees, 1999:9) recorded responses such as:

“I am afraid of people who have AIDS because I think they can transmit it to me even by breathing.”

“We must feel sorry for them, but I don't think I can live with them.”

One of the most well known cases of discrimination was Nkosi Johnson, the late child AIDS activist. Nkosi addressed the XIIIth International AIDS Conference, 9th July 2000 in South Africa (Johnson, 2000:8). He spoke of the plight of the HIV-infected child who can be denied admittance to school on the basis of his HIV-positive status. This happened in his case. He described at the conference that the school admission form asked if the child suffered from any illnesses. His foster mother, Gail Johnson indicated on the form that he suffered from AIDS. This response catapulted them into “fame”. He stated at the conference: “And then...the media found out that there was a problem about me going to school...No one seemed to know what to do with me because I am infected...”

Crewe (1998:24) states that the lack of any official policy by the education department regarding the admission of learners with HIV/AIDS into schools was cause for serious concern. She contends that this has resulted in most schools adopting a “wait and see” attitude if they are faced with having to admit a learner with HIV/AIDS.

An even more recent incident of alleged discrimination was that of a pre-school child Tholakele Pereira (Daily News, 14 June 2002:2). Her application for admission was rejected by three pre-schools, allegedly because she was HIV-positive. The Buccleuch Montessori Nursery School, one of the schools that rejected the application, denied that the child was refused admission for this reason. The school’s advocate argued that they had merely asked the child’s foster mother to wait until she was 3 years old and was past the scratching and biting stage, since the child was HIV-positive.

According to Pereira’s advocate, this decision in itself amounted to discrimination and was based on ignorance. The fact that this case has gone to court is indicative of the ignorance, irrational fears and stigmas that are still associated with the issue of HIV/AIDS. The Principal, as the administrator of the school, appears to be ignorant of modes of transmission of the virus. It is indeed a frightening state of affairs that so many years since the first discovery of the virus, ignorance is so rife even amongst education administrators and educators. The level of ignorance regarding HIV/AIDS amongst the illiterate masses is even more alarming to envisage.

Tholakele’s case again reflects the concern raised by Crewe (1998:24) regarding the question of admission policies at pre-schools. The article indicates that a spokesperson from the department of Social Services and Population Development admitted that there was no policy in place regarding the admission of HIV-positive children to nursery schools or creches. The only hold that the government had over these institutions, was that in the case of government-funded creches and nursery schools, funding could be cut if there was evidence of discriminatory practices towards HIV-positive children. The article states that although the DoE has a strict policy of non-discrimination concerning admittance of children, creches and nursery schools do not fall under the jurisdiction of the DoE, but actually fall under the Department of Social

Services and Population Development. This department apparently does not have a policy in this regard at present.

Another horrific trend in schools in South Africa, is the upsurge in sexual abuse of learners by educators and other learners. In addition to the trauma and emotional ravages of such heinous deeds, there are also serious implications in terms of the spread of HIV/AIDS. Dreyer (2002:32) states that according to statistics presented at the South African Parliament's public hearing on child abuse and baby rape on 17 March 2002, a third of the rapes of school-going girls are perpetrated by teachers.

George (2001:11) effectively sums up the current situation in South African schools. She asked South African schoolgirls the following question: "*What did you learn in school today?*" She recorded many of them as saying that they had learned to be afraid. She quotes several cases of schoolgirls who were the victims of rapes by male learners or male educators. She states that the biggest lesson these girls learnt was that sexual violence at school is inescapable and inevitable. She believes that the lesson is reinforced by the attitude and actions of school officials who often conceal sexual violence, or respond with hostility and indifference to schoolgirls' complaints. Girls reported a failure on the part of school authorities to take their complaints seriously. Schools actively discouraged victims from alerting anyone outside the school. In some instances officials concealed the existence of violence at their schools, and failed to co-operate with authorities outside the school system. George argues that there are wider implications when authorities allow acts of sexual violence to go unchallenged. Schools then become fertile ground for growing behaviour patterns that are harmful to women and children and ultimately society.

The Human Rights Watch Report (Human Rights Watch, 2001) corroborated media and other reports of sexual violence in South African schools. It presented documentary evidence of cases of sexual violence in schools. "In schools across South Africa, thousands of girls of every race and economic group are encountering sexual violence and harrassment that impede their access to education (2001:4).

The report recommended, among other issues, that:

- Laws that require dismissal of educators found guilty of sexual assault against learners should be widely publicised.
- Educators facing allegations of sexual misconduct should not have “classroom contact” with the aggrieved learner.
- Educators who have been convicted of sexual assault or rape should not be permitted to teach anywhere in South Africa.

The KwaZulu-Natal Department of Education (KZNDoE) acknowledges that whilst there are many documented cases of alleged sexual abuse and rape of schoolgirls by their teachers, the DoE’s attempts to prevent these incidents have been ineffectual thus far (South Africa, 2002b:12).

To add to the already bleak picture that emerges, one simply needs to study the types of headlines in the media, such as: “*AIDS wipes out SA’s teachers*” (Sunday Times, 4 November 2001:4). This headline graphically depicts the impact of HIV/AIDS in South Africa. The report states that according to the largest teacher union in South Africa, the SA Democratic Teachers’ Union, teacher deaths have rocketed by more than 40% in the 2000-2001 year. Their statistics are based on claims submitted to their funeral scheme between June 2000 and May 2001. They further state that 1011 teachers had died in the twelve-month period at an average age of 39 years!

Mwase (2000:24) forwards other contributory factors that explain why educators are part of the prime adult age group that is affected by HIV/AIDS. She points out that teachers are often posted away from their families and tend to have more available cash than others in the community. It is therefore easier for them to engage in informal sexual relationships. This puts them at risk of contracting and transmitting HIV/AIDS.

Another alarming trend is the increasing numbers of people who believe that sex with a virgin will cure a person of HIV/AIDS. This urban legend does nothing but increase the number of child rapes in our country. It also serves to help the spread of HIV/AIDS among children and the youth. One finds an increasing number of sexually abused children who have been raped by men who believe in the myth that sex with a virgin cures HIV/AIDS, or by men who seek very young partners to lessen the danger of HIV infection (Desmond, 2002:1).

According to Mwase (2000:25) another area of concern is the impact of the virus on teacher availability and teaching time. To illustrate the point she quotes an example of a teacher, who is one of two teachers at a particular school. This teacher is responsible for the Grades 1, 2 and 3. Since the beginning of 1999, due to his deteriorating health, he is often not well enough to teach. Sometimes, when he does come to school, he is too ill to do much. Much of the burden therefore falls on the other teacher.

Collings (2000:7) also focusses on the issue of sick educators and the impact of this on education. There are large numbers of teachers dying after a few years of service, as well as large numbers of teachers who need long periods of sick leave, as they succumb to HIV/AIDS-related illnesses. This brings to the forefront another issue: Education departments would have to decide how many matriculants they are going to train to replace these teachers. Of course there is also the converse, which is the bleak estimate that 1500-1800 learners could be dying of AIDS every day within seven years, (Collings, 2000:7). This may then result in fewer educators being required than estimated.

In its Recommendations Report regarding HIV/AIDS, the KZNDoE proposes some ways to alleviate this situation (South Africa, 2002b:26):

- Continuing use of substitute teachers as a short-term measure.
- Designing of a substitute system for public service personnel.
- Collaboration with universities on the training they provide versus the projected skills required.

These are merely some of the key issues that the report proposes. What is shocking in the report is that the development of a HIV/AIDS policy for KZNDoE is mentioned as part of a *proposed* plan of action in this report. By implication one concludes that more than two decades after the advent of HIV/AIDS, the KZNDoE is still “planning” in 2002 to draw up a HIV/AIDS policy!

The government’s stance on whether HIV does cause AIDS has also created much confusion. This together with its reluctance to provide drugs to prevent mother to child transmission has been criticized within and outside the country. This has resulted in reactions such as the following: An open letter was written to the Minister of Health, Dr. Manto Tshabalala-Msimang by a body called CINDI, (The Coalition for Children Living in an HIV+ World, 2000:9), which represents more than a hundred organizations in KwaZulu-Natal. In this letter an appeal was made for the provision of anti-retroviral drugs to reduce mother to child transmission, access to treatment for HIV-positive children, nutrition and poverty relief programmes, amongst other things. The letter concluded by stating that the organization notes that the Department of Health has not yet implemented standardized treatment guidelines for persons and children living with HIV/AIDS.

“Time to ignore the government” is another more radical example of some of the suggestions being made as a response to the government (Gazi, 2000:19). The argument presented in this article is that, as the government had for more than two years procrastinated regarding the provision of anti-retro-viral treatment, and had silenced its critics, the time had come to ignore the government! In other words the suggestion was to act in defiance of government’s stance.

Sherriffs (1997:10) succinctly sums up the situation in South Africa, in stating that this country has a lethal recipe of factors that make life easier for HIV – among them poverty, violence, patriarchy, massive social upheaval and cultural change.

In summarizing the crux of the situation, it becomes evident that policies are in place to curb the spread of the HIV/AIDS disease in South Africa, as with other countries. However, not enough appears to be happening at grassroots level to change perceptions and health behaviours of both educators and learners. There are various theories, which forward reasons why the situation exists where both educators and learners have the knowledge of safer health behaviours, yet they do not internalize this as part of their personal lifestyles. Some of these theories will be examined in order to throw some light on factors, which influence individuals' behaviours.

2.8 THEORETICAL FOUNDATIONS OF HEALTH BEHAVIOUR

The aim of the authorities throughout the world, as well as in South Africa, in putting in place policies and legislation, is to educate, prevent transmission and discrimination and to respect the rights of those affected by or infected with HIV/AIDS. In other words, the aim is to effectively fight the scourge of HIV/AIDS. Research as detailed above, however, points to the situation that although knowledge levels among both teachers and learners have increased, this is not translating into safer behaviours and practices on the part of both teachers and learners. It also points to the fact that prejudicial attitudes are still prevalent. In essence then, one might argue, that authorities the world over need to redirect efforts and funding to more effective strategies. Thus the cry is no more “What is the world and our country doing to fight this scourge of HIV/AIDS?” It now becomes, “Why is there so little measurable behavioural change in spite of so much effort, energy and time being spent on educating people?”

One needs to examine some theoretical explanations that throw light on why, in spite of this concerted effort across the world, health behaviours have actually not changed significantly. There are several theories, which more than adequately explain why mere knowledge acquisition regarding HIV/AIDS is insufficient to change health behaviors. Some of these health behaviour models will be examined in this section.

2.8.1 Models of Health Behaviour

The various health behaviour models explain risk-taking behaviours in terms of several factors, that is, they see risk-taking in the context of the interplay of factors such as attitudes, beliefs, self-efficacy, acquisition of behavioral skills and other extrinsic factors such as peer, parental and media influence. Various theories and models expound different reasons why people knowingly engage in high-risk behaviour that may have life-threatening consequences.

2.8.1.1 Social Cognitive Theory

One such theory, which explains risk-taking behaviour, is Bandura's Social Cognitive Theory (1986). This theory is based on the principle that it is easier to alter people's beliefs about causes of their behaviour than to change how they behave. (Bandura, 1986:4). He further contends that people pursue "unhealthful habits" because they do not know how to change their own behaviour. He defines the term "self-efficacy" as not being concerned with the skills one has, but with the judgements of what one can do with whatever skills one possesses. He states that a person's judgement of his/her self-efficacy will determine how much effort he/she will expend, even in the face of obstacles. He lists several sources of developing self-efficacy, which are: family, peers and most importantly, school as an agency for imparting knowledge, behavioural skills and beliefs about capabilities. In HIV/AIDS education, one needs to examine whether schools are targeting all these areas of developing learners' sense of self-efficacy, or are focussing mostly on knowledge acquisition.

2.8.1.2 Health Belief Model

The Health Belief Model (Kirscht and Joseph, 1989) is another behavioural model that focuses on two important elements in health-related behaviour, namely, the threat of illness and the behavioural response to the perceived threat. In perceiving the threat, the individual considers his personal susceptibility to harm to an illness, the perceived severity of the threat of the illness and the value of the behaviour or line of action to overcome the perceived threat, and barriers to the action. In evaluating the cost and benefits of a particular behaviour, the individual must feel convinced that there is definite value in pursuing that particular behaviour.

The proponents of this theory argue that the belief elements produce in an individual, some psychological readiness to act in the face of some perceived threat, in this case, to one's health. Several factors influence this psychological readiness, for example, peers as well as environmental cues. HIV/AIDS education therefore must build a sense of personal susceptibility to harm when educating learners regarding unsafe behaviours. In other words,

these theorists believe that educational efforts must produce in recipients the belief that it is indeed in their best interests to change their way of behaving.

2.8.1.3 Theory of Reasoned Action

The theory of Reasoned Action (Ajzen and Fishbein, 1980) is based on the premise that humans are reasonable creatures who systemically use information available to them to decide what action to take. In other words, to change behaviour there is a need to change the underlying cognitive structure of the behaviour in question. The theory links beliefs, attitudes, intentions and behaviour, and is based on the premise that the individual has the skills and opportunities to engage in the desired action. However, the weakness of this argument lies in the fact that this is not necessarily true in all instances. The theory was therefore further expanded to incorporate the concept of control over the intended behaviour. This refers to the individual's perceived ability to engage in the desired behaviour. If the individual believed that he/she had control over his/her behaviour, this combined with the attitudes and societal norms, together form the right climate for the execution of the desired act. The theory was therefore modified and was referred to as the Theory of Planned Behaviour (Ajzen and Fishbein, 1985: 12).

Fishbein and Middlestadt (1989:97) in applying the theory of Reasoned Action to understanding and changing AIDS-related behaviours, cite several issues that impact on behaviour. One such factor is the identification of the behaviour. A person may define the behaviour according to criteria such as context, time, action and target. If one of these criteria changes the individual may not define the act he engages in as "undesirable". Another important factor is the corresponding intention that fits in with a desired behaviour. These theorists point out that the reason why many educational campaigns and interventions have been unsuccessful is because they have not focussed directly on the appropriate intentions in advocating a desired behaviour. One sees why both teachers and learners have the knowledge of the universal precautions and yet they are unsure of when to apply them, and whether a particular situation is appropriate or not.

2.8.1.4. A Piagetian Cognitive Developmental Perspective combined with the Intuitive Theories' Approach

Sigelman, Derenowski, Woods, Mukai, Alfeld-Liro, Durazo and Maddock (1996:254) argue for the marrying of intuitive theories with a theory that has dominated research and AIDS education responses, which is the Piagetian Cognitive Developmental Perspective. Piaget (Mussen,

Conger, Kagan & Huston, 1984:236) has indeed had a tremendous impact on the manner in which HIV/AIDS education has unfolded the world over. He theorized that cognitive development consisted of four stages, viz. the sensori-motor, pre-operational, concrete operational and formal operational thinking.

An important aspect of Piagetian thinking was the premise that an individual actively constructs his/her world. Cognitive development depends on both maturation and active contact with the outside world (Mussen et. al, 1984:236). In the light of this, the main target age group of HIV/AIDS education has been early adolescence. This is because the basic point of departure with this thinking is that the complexity of children's thinking increased with age. The view was that children needed to be cognitively ready to gain an understanding of disease concepts. This in turn resulted in HIV/AIDS education being targeted to the early adolescent. Any earlier intervention or educational programme was seen as a waste of energy, as children were not maturationally ready to assimilate these behaviours.

These researchers (Sigelman et. al, 1996:255) challenge this view that children cannot benefit from instruction until they are cognitively ready to assimilate new information, and that their levels of conceptual understanding cannot be altered. They (Sigelman et. al, 1996:255) believe that although it may be true that children may lack certain understanding due to age factors, this does not mean that they cannot be exposed to age-appropriate instruction in AIDS education. They believe that the earlier HIV/AIDS education begins the greater the benefits. They contend that early education of elementary school children can prepare them to avoid high-risk behaviours, make better sense of HIV/AIDS-related information, increase their compassion for persons with AIDS, correct misconceptions about transmission through casual contact and reassure children.

A marrying of Piagetian principles with those of the intuitive theories' approach, as espoused by Carey (1985) was therefore advocated by Sigelman et. al. (1996:263). The fundamental principles of this approach are based on the premise that children come to instruction with organized knowledge bases, or intuitive theories of a domain, and if given appropriate

information, they have the capability to formulate new theories regarding that domain (Carey, 1985:69).

They (Sigelman et. al, 1996:263) point out that whilst Piagetian theorists suggest that children's knowledge and understanding increase systemically with age, the intuitive theorists disagree and put it down to increased exposure to more and more information about the AIDS disease each year. The younger the children are when exposed to the HIV/AIDS-related information, the more they will learn. They indicate that even the youngest of children have their knowledge organized into a coherent whole, though not always correct. Their immaturity may result in certain misconceptions regarding the health messages they are exposed to. They cite research findings in this regard, in which elementary school children extend their "germ theory" of colds and flu to HIV/AIDS. In other words children believe that HIV/AIDS can be transmitted from one person to another through saliva exchange, sneezing and other forms of airborne transmission.

However, there is still greater benefit in exposing children to HIV/AIDS education earlier rather than later. In essence these researchers are stating that health education for children can be effective if it rests on the assumption that even relatively young children have coherent ideas about what causes a disease and they can learn more correct ideas if given appropriate instruction. Kistner et. al. (1996:269) also support the standpoint taken by Sigelman et. al. (1996: 263) that there should be combining of a Piagetian approach with other methods when researching children's conceptions of HIV/AIDS.

2.8.1.5 Third person perception and "optimistic bias"

Other researchers cite other factors that lessen the impact of HIV/AIDS education endeavours. Davison (1983:3) focussed on a concept, which he termed "third-person perception" which he defined as an individual's perception that others are more influenced by media messages than he/she is. The fundamental belief is that individuals expect communication to have a greater impact on others than on themselves.

Carter (1999:296) states that in terms of the notion of personal susceptibility to harm and the third-person perception, Australian research has shown that although people are knowledgeable about HIV/AIDS, they do not perceive themselves to be personally vulnerable or at risk. This would possibly hold true for educators who would in terms of their authoritarian roles in the schools, have in general, a high self-esteem. In terms of Davison's theory, teachers would therefore tend to have the perception that they are not personally at risk of HIV infection.

Another important concept is "optimistic bias." This refers to the belief that an individual has that he/she is less vulnerable to risks than others. The proponent of this concept was Weinstein (1989:142). In terms of HIV/AIDS, the theories of third-person perception and optimistic bias indicate that even if individuals are knowledgeable about transmission modes of the virus, they tend to believe that others are more vulnerable than themselves to being influenced by negative factors outside of themselves.

Chapin (2000: 69) presented another important dimension to these two concepts of third-person perception and optimistic bias. In studies he found that HIV/AIDS-related knowledge reduced third-person perception, in other words, the more students knew about HIV/AIDS, the less likely were they to believe that they would be affected by HIV/AIDS messages. Chapin (2000:71) deviates from the notion that there is a positive relationship between third-person perception and optimistic bias. He argues that there is actually an inverse relationship between these two concepts. He found however, that there was a definite relationship between optimistic bias and self-esteem. Students with high self-esteem tend to be self-assured and confident in their knowledge and choices, resulting in a false sense of security when faced with decisions about sexual risks.

Chapin's findings indicate that students with high self-esteem are more likely to underestimate their personal risk of health hazards than students with low self-esteem. One can extend this line of reasoning to teachers who are symbols of authority in the schools. One would expect that due to their position of relative power in the context of the classroom, they would tend to have higher self-esteem than others including learners. In terms of the research findings, this could

have implications for teacher behaviour. Teachers may also display a sense of complacency regarding their vulnerability to HIV/AIDS.

Chapin (2000:76) advocates that AIDS-related education should begin early, as optimistic bias increases with grade level. The best time for influencing students' sex-risk perceptions is middle school or earlier.

In commenting on the concept of optimistic bias, Reitman, St. Lawrence, Jefferson, Alleyne, Brasfield and Shirley (1996:511) state that to increase adolescents' risk recognition, there must be increased risk-sensitization efforts. One way is to link HIV with other sexually transmitted infections (STIs) in order to achieve maximum impact with youths that do not perceive themselves to be at risk. They further found that HIV/AIDS knowledge is relatively high in the United States (Reitman et. al, 1996:511), and this was not necessarily a good predictor of health behaviours, as was the case in earlier years.

2.8.1.6 AIDS Risk Reduction Theory

Catania et al (1990:54) developed the AIDS Risk Reduction Theory (ARRM). The basic principle of this theory is that social and psychological influences affect behaviour changes. They detail the three stages of behaviour change as

- (a) The labelling of problematic behaviours.
- (b) Making a commitment to change these behaviours.
- (c) Seeking and enacting behavioural change to reduce HIV risk.

Faryna and Morales (2000:52) suggest that an additional stage be introduced into this model, viz. cultural diversity and ethnic identity as the fourth stage. The reason for advocating this stage was based on their research findings, which indicate that ethnicity is an important factor that has a great effect on risk behaviours and risk sensitization. They examined the concept of risk behaviours in the context of ethnicity, and found that the ethnicity and cultural identity had the most powerful relationship in risk prediction. This relationship was stronger than even

gender, knowledge, self-efficacy, attitudes and beliefs. They therefore suggest incorporating the cultural dimension into the latest HIV-prevention theories.

2.8.1.7 Redefining Actions and Decisions Model

The RAD (Redefining Actions and Decisions model) espoused by Schoeberlein, Woolston and Brett (2000:389) present a model for school-based HIV prevention, which appears to pull together the various threads running through health behaviour theories. They base their theory on the premise that effective HIV/AIDS education must produce desirable outcomes in individual's knowledge, attitudes, skills and behaviour (Schoeberlein et al, 2000:389). They further state that such interventions must be culturally, socio-economically and developmentally appropriate to the target group, and the facilitator, that is, the teacher who actually implements the RAD programme with the children. This issue of the comfort or discomfort level of the teacher is an important factor, as they believe that it impacts positively on students' attitudes, knowledge levels and level of comfort when talking about HIV/AIDS (Schoeberlein et al, 2000:403).

The other interesting fact is that the implementation of the RAD model starts in the early years, and progresses from a content-based curriculum in the elementary years to more application and evaluative type of programmes in the later years of the schooling period. They state that risk elimination and risk reduction are optimal outcomes of the model, with the emphasis on risk elimination as the safest way to prevent HIV (Schoeberlein et al, 2000:399).

2.8.2. Concluding remarks regarding the theoretical foundations of HIV/AIDS-related behaviour

All the health behaviour models focus on the individual as well as social influences, such as the influence of peers, family social norms and the media and their effect on health behaviours. Each theoretical school of thought places different emphases on different issues. It is clear that in planning HIV-prevention programmes and HIV/AIDS education strategies, cognizance must

be taken of several critical factors to ensure that programmes have the desired outcome. More recent theories have shown that knowledge of HIV/AIDS is not an accurate indicator of risk-sensitive behaviour, that is, a person may have a high knowledge content of transmission modes and other relevant facts, but may still engage in high-risk behaviour. Researchers have focussed on the following factors, viz. self-efficacy, ethnicity, age, gender, self-esteem, skills and attitude development.

In developing HIV/AIDS education programmes researchers need to consider the fact that in spite of high levels of HIV/AIDS-related knowledge in schools, among both educators and learners, both components do not internalize “safer practices” in and out of school. Researchers have shown that there is no secret, unaccountable reason for this phenomenon, but several factors which can be addressed, as mentioned above. Future school-targeted interventions for both educators and learners need to take cognizance of the above-mentioned factors.

In this regard a report in *The Independent* on Saturday (22 September 2001:3) is worthy of mention. The report states that the Actuarial Society of SA (Assa) has developed an AIDS and demographic model called Assa2000. This model projected that without a change in behaviour or medical interventions, a further 5 million people in South Africa could die within the next 10 years of HIV/AIDS. However, the model shows that even a “modest” change in behaviour would result in 1,2 million fewer people infected with the virus in 10 years. Thus there is a desperate need for effective HIV/AIDS education interventions.

2.9 CONCLUSION

It is clear that the relentless march of AIDS is fuelled by several factors. In South Africa, although the government has responded to this crisis by putting into place legislation and laws, it has also been criticized for its’ lack of decisiveness. Other role-players have also joined forces with the state in developing campaigns for education, research and assistance for those affected and infected with HIV/AIDS. What is of prime importance is how these responses impact on the fight against HIV/AIDS. This becomes the critical factor. One needs to evaluate the impact of the response. An effective way of ascertaining this would be through canvassing the views of

educators and learners regarding HIV/AIDS, as well as assessing to what extent HIV/AIDS-related programmes have helped them adopt safer behaviours.

In describing what is required as a response to the issue of HIV/AIDS, (Educator's Voice, 2000:5) Kayum Ahmed, the convenor of Positive Muslims states that AIDS is a disease that either infects you or affects you. "It is therefore a disease that presents us with a unique opportunity. It allows us to break out of the prisons that we created in our minds. ...It presents us with an opportunity for change...A change in mindset can however only take place through an effective system of education. Statistics, pamphlets and the distribution of condoms, although useful, has a limited effect in terms of sensitizing..."

She further describes what is necessary in the fight against HIV/AIDS. It requires "developing a theology of compassion...It is a process that results in breaking down of barriers between people – between individuals from different cultural and religious backgrounds, between black and white, between those who are HIV-positive and those who are not. It is a process that ultimately leads one to realize that we are of them, and they are of us."(Educator's Voice, 2000:5).

CHAPTER 3

RESEARCH DESIGN

3.1 INTRODUCTION

In the previous chapter a literature study was undertaken. The global responses to HIV/AIDS were examined. In particular, the South African education sector's response was evaluated. The theoretical foundations of health behaviours were also researched. This chapter details the research design used for investigating educators' and learners' knowledge, attitudes and behaviours with regards to HIV/AIDS, and what impact, if any that the DoE's responses to HIV/AIDS has had in changing educators' and learners' risk behaviours.

The existing literature seems to indicate that knowledge of transmission modes of HIV is high (Paniagua, Boyle, Wagner, Ramirez, Holmes, Nieto and Smith, 1994:324; loveLife, 2001b:46). However, research into health behaviours has shown that knowledge acquisition does not necessarily result in positive behaviour change (Bandura, 1989:128; Catania, Kegeles and Coates, 1990:54; Chapin, 2000:69).

In South Africa and elsewhere in the world educators, in the main, received some training as HIV/AIDS education facilitators (Dwadwa, 1997:9). Educators were therefore knowledgeable about the HIV/AIDS scenario, but appeared to have difficulty contextualizing their knowledge on a personal level. Grier and Hodges (1998:257) found that educators had the factual knowledge about HIV/AIDS, however application of this knowledge was poor. Educators were confused about when they thought was the correct instance to apply the universal precautions and under what circumstances and with which children. Grier and Hodges findings (1998:257) were corroborated by other researchers (Ainsa, 2000:8; Beverly, 1995:101).

There appears to be an improvement in educators' attitudes as compared to previous studies (Brucker, et. al, 1989:63; Brucker, et. al: 1996:86; White and Ballard in Alali, 1995:94). However, educators still appear to harbour misconceptions about the transmission of the virus, although on an irrational level (Grier and Hodges, 1998: 260; Ainsa, 2000:8)). In South Africa,

in particular, prejudice, ostracization and discrimination still appear to be rife (Johnson, 2000:8; Human Rights Watch, 2001:4).

Another alarming situation that researchers also found was that whilst at many schools, HIV/AIDS-related policies were in place, educators at those very schools were unaware of whether or not their schools actually had such policies! Warman (1994:10) reported that 64% of the schools they surveyed did have HIV/AIDS policies in their schools. However, educators from those very schools were unaware of the existence of these policies! Grier and Hodges (1998:260) also found in their study that there was much confusion among respondents about whether their schools had a current infectious diseases policy or not.

This chapter details the research design that was used to further investigate the situation in South Africa, in terms of knowledge of transmission modes, attitudes, awareness of official HIV/AIDS policies at school and national level, as well as knowledge and use of universal precautions in schools.

3.2 PROBLEM STATEMENTS AND HYPOTHESES

On the basis of the literature study, the following problem statements and hypotheses were formulated:

Problem statement 1

What are the frequencies and percentages of educators' and learners' responses on various aspects of HIV/AIDS regarding the following factors?

- Knowledge of transmission modes of HIV
- Issues relating to the Department of Education's policy on HIV/AIDS.
- School Responses, and educator/learner relations.
- Attitudes towards HIV/AIDS

Problem statement 2

Is there a significant difference between *educators* and *learners* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues?

H₀₂ There is no significant difference between *educators and learners* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues.

H₂ There is a significant difference between *educators and learners* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues.

To test this hypothesis a t-test will be calculated.

Problem statement 3

Is there a significant difference between *diverse ethnic groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues?

H₀₃ There is no significant difference between *diverse ethnic groups* regarding (a) their knowledge of transmission modes and (b) their attitudes HIV/AIDS.

H₃ There is a significant difference between *diverse ethnic groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

The ethnic groups are Coloured, Black, White and Indian.

To test this hypothesis, analysis of variance will be calculated, followed by Tukey's post hoc test if significant differences are found.

Problem statement 4

Is there a significant difference between *females and males* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues?

H₀₄ There is no significant difference between *females and males* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

H₄ There is a significant difference between *females and males* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

To test this hypothesis, a t-test will be calculated.

Problem statement 5

Is there a significant difference between *diverse age groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues?

H₀₅ There is no significant difference between *diverse age groups* regarding (a) their knowledge of transmission modes and (b) their attitudes HIV/AIDS.

H₅ There is a significant difference between *diverse age groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

The age groups are 20 years and younger; 21-30 years; 31-40 years and older than 40 years.

To test this hypothesis, analysis of variance will be calculated, followed by Tukey's post hoc test if significant differences are found.

Problem statement 6

Is there a significant correlation between attitude to and knowledge of HIV/AIDS for (a) learners and (b) educators?

H₀₆ There is no significant correlation between attitude to and knowledge of HIV/AIDS for (a) learners and (b) educators?

H₆ There is a significant correlation between attitude to and knowledge of HIV/AIDS for (a) learners and (b) educators?

To test this hypothesis, Pearson's correlation will be calculated.

Problem statement 7

Is there a significant relationship between learners' and educators' responses regarding (a) issues relating to the Department of Education's policy on HIV/AIDS and (b) School policies and educator/learner relations?

H₀₇ There is no significant relationship between learners' and educators' responses regarding (a) issues relating to the Department of Education's policy on HIV/AIDS and (b) school policies and educator/learner relations?

H₇ There is a significant relationship between learners' and educators' responses regarding (a) issues relating to the Department of Education's policy on HIV/AIDS and (b) school policies and educator/learner relations?

To test this hypothesis, cross tabs, followed by chi-square will be calculated.

Finally the reliability of the scaled items (Section E) will be calculated by means of Cronbach's alpha correlation coefficient.

In order to answer the research problems and test the above-mentioned hypotheses, the research was conducted as follows:

3.3 RESEARCH DESIGN

A quantitative research design was used.

3.3.1 Research Instrument: Questionnaire

A questionnaire (see Appendix 1) was designed and administered to a sample of secondary school educators and learners. The questionnaire was constructed after studying questions used in similar investigations such as that of Paniagua et. al. (1994:311). Since the advent of HIV/AIDS, many researchers have conducted research and administered HIV/AIDS-related questionnaires, both in South Africa and in other countries. In particular the study conducted by Paniagua et. al (1994:311) was used as a basis for developing the items for the questionnaire used in the current study.

The study of Paniagua et. al, (1994:311) involved the compilation of a pool of AIDS-related items that was suitable for use by researchers. In their study, items from 18 AIDS survey studies were evaluated and a final set of 164 AIDS-related items were identified and integrated into five categories, viz. factual knowledge, misconceptions, attitudes, perceived susceptibility and perceived efficacy. Visser's study (1996:103) was also useful particularly with regards to the South African situation and provided some indicators of appropriate items to be included in the questionnaire.

In the current study, items for the questionnaire had to be adapted, as the setting and background was different from that of other studies. Of particular note was the fact that the AIDS-related "item bank" developed by Paniagua et. al. (1994:311) was developed in the United States. As the current study was being conducted in South Africa, there was a need to adapt some of the questions.

3.3.1.1 Structure of the questionnaire

The questionnaire was designed with the following characteristics in mind:

- It should be easy to answer and be user-friendly.
- It would be divided into sections according to information required.
- It would also have a qualitative component.

3.3.1.2 Composition of the items for the questionnaire

The following sections were identified (See Appendix 1):

Section	Variable	Item Number
A	Biographical data	1 – 5
B	HIV/AIDS knowledge	6 – 15
C & D	Knowledge of DoE's and schools policies and responses	16 – 40
E	Attitudes with regards HIV/AIDS issues	41 – 50
F	Open questions related to attitudes	51 – 53

Section A was designed to elicit data in respect of occupation, gender, race, and age. Section B focussed on factual knowledge about HIV/AIDS. Section C and D attempted to evaluate the impact and awareness of DoE's policies in respect of HIV/AIDS. These sections also assessed school responses, knowledge of universal precautions, as well as knowledge of legal aspects of HIV/AIDS. Section E focussed on attitudes to HIV/AIDS-related issues. Section F consisted of open questions, which attempted to evaluate biases, fears and attitudes to HIV/AIDS.

3.3.1.3 Procedure with regards to the administering of the questionnaire

Learners and educators who were selected (see paragraph 3.3.2.2), each received a questionnaire containing all the items as well as a separate response sheet. Respondents were then asked to follow the instructions given to them on the questionnaire. A supervisor, either the researcher or a colleague was present at all times to address queries. Respondents' attention was drawn to Section F, which consisted of open questions. They were reminded that Section F was to be answered on the questionnaire itself. This section was then to be detached and handed in with the response sheet.

3.3.1.4 Key to the Questionnaire

Each item consisted of a statement. The respondent chose a number that corresponded with his/her selected response. Different sections had multiple-choice items ranging from a choice between 1 and 2 items, to a choice ranging from items 1 to 7. Section E comprised items using a five point Likert scale. This scale was convenient to test attitudes, as it accommodated positive

and negative attitudes. Items nearer to 1 were indicative of a more positive attitude, and those items closer to 5 were indicative of a negative attitude (See Appendix A).

3.3.2 Selection of the sample

3.3.2.1 Sampling method

Convenience and purposive sampling methods were used in the selection of the sample. Purposive sampling involves the selection of a sample based entirely on the judgement of the researcher. In other words, the sample is composed of elements, which contain the most representative or typical attributes of the population (De Vos, 1998:198). Convenience sampling consists of using the most readily available or most convenient group of people for the sample (Brink, 1996:140).

3.3.2.2 Composition of the sample

The sample consisted of 205 respondents, (80 educators and 125 learners), from four secondary schools in the Durban South region. Permission to conduct research was obtained from the Department of Education (See Appendix 2). The sample included respondents from the following subgroups:

- Respondents who were secondary school educators
- Respondents who were Grade 10 learners
- Respondents from a school formerly designated for Coloureds
- Respondents from a school formerly designated for Blacks
- Respondents from a school formerly designated for Whites
- Respondents from a school formerly designated for Indians

3.3.3 The Pilot Study

De Vos (1998:17) defines a pilot study as the process that can be viewed as a “dress rehearsal” of the main investigation. It has the same essential features as the planned investigation, but on a smaller scale. He (De Vos, 1998:182) comments that the purpose of the pilot study was to improve the success and effectiveness of the investigation. He further mentions that the pilot study must be executed in the same manner as the main investigation for it to have value. A pilot study was conducted with six respondents (three educators and three learners).

The results of the pilot study showed that in general there were no problems with the format of the questionnaire. However, although instructions were written at the beginning of the questionnaire, it appeared that respondents tended to go straight to the questions without actually reading the instructions. It was more productive to read aloud the instructions to them prior to commencement. Respondents also appeared to ignore Section F. They were also unsure where to write their responses for this section.

On the basis of these above-mentioned concerns, it was decided that in the main study, instructions would be read out to respondents. Specific instructions would be given for Section F, in particular with regards to where they were expected to write their responses for this section. They would be reminded that this page needed to be detached from the questionnaire and handed in with the response sheet.

3.4 VALIDITY AND RELIABILITY

3.4.1 Validity

3.4.1.1 Content validity: This is concerned with the representativeness or sampling adequacy of the contents (items) of an instrument (De Vos, Strydom, Fouche, and Delpont, 2002:167).

3.4.1.2 Face validity: Face validity relies on the subjective judgement of the researcher. It essentially asks whether the instrument is measuring what it is supposed to measure (Leedy, 1993:41).

veral criteria were considered in this regard to ensure validity of the instrument. After the construction of the questionnaire, it was submitted to two experts from the University of South Africa (UNISA) for constructive criticism. The questions were constructed as simply as possible to reduce any ambiguities. Instructions to the respondents were as clear as possible. A pilot study was conducted to identify and eliminate problems identified. Respondents were given sufficient time for completion of the questionnaire.

3.4.2 Reliability

Reliability is defined as the degree of consistency or agreement between two independently derived sets of scores; and as the extent to which independent administrations of the same instrument yield the same or similar results under comparable conditions (De Vos, 1998:85). Reliability was arrived at by means of the correlation coefficient. The Cronbach's alpha co-efficient was used for this purpose. The reliability was found to be 0,6, which is relatively good for this kind of questionnaire.

3.5 CONCLUSION

In this chapter the research design was discussed. The problem statements, hypotheses, details of the questionnaire, the sample and the pilot study, as well as validity and reliability were focussed on. In the following chapter the findings of the empirical investigation will be discussed.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

4.1 INTRODUCTION

In the previous chapter the research design used for investigating educators' and learners' knowledge, attitudes and behaviours with regards to HIV/AIDS was described. In this chapter the findings of the empirical investigation are analysed and presented.

4.2 FINDINGS

4.2.1 Demographic data

This section consisted of five questions. Data yielded the following findings:

4.2.1.1 Occupation of respondents

Table 4.1 Occupation of respondents

Respondent	Frequency	Percent (%)
Educator	80	39.0
Learner	125	61.0
Total	205	100.0

Table 4.1 indicates that 80 respondents (39 %) were educators and 125 respondents (61 %) were learners. Thus the majority were learners.

4.2.1.2 Ethnic Groups

Table 4.2 Ethnic groups of respondents

Respondent	Frequency	Percent (%)
Coloured	11	5.4
Black	95	46.3
White	24	11.7
Indian	7	36.1
Missing System	1	.5
Total	205	100.0

Table 4.2 indicates that the largest number of respondents, 95 (46.3%) were Black; while 74 (36.1%) were Indian; 24 (11.7%) were White, and the smallest number, 11 (5.4%) were Coloured. It is interesting that although the four schools were chosen with previous classifications in mind, that is, formerly Coloured, Black, White and Indian schools, the learners attending those schools are no more of that particular race group, as was the case prior to integration of schools. The number of White and Coloured respondents in the sample were much lower than Black and Indian respondents.

4.2.1.3 Gender

Table 4.3 Gender of respondents

Respondent	Frequency	Percent (%)
Female	133	64.9
Male	72	35.1
Total	205	100.0

The majority of the respondents, 133 (64.9%) were females and 72 (35.1 %) were males, as is evident in Table 4.3. Thus the majority were females.

4.2.1.4 Age groups

Table 4.4 Age groups of respondents

Respondent	Frequency	Percent (%)
Under 20 years	120	58.5
20 – 30 years	19	9.3
31 – 40 years	38	18.5
More than 40 years	28	13.7
Total	205	100.0

According to table 4.4, 120 respondents (58.5%) were under 20 years of age. In other words, the majority was in this age group. This is consistent with the percentage of learners (61%), which was equivalent to 125 (see table 4.1). It also indicates that of the 125 learners, 5 were over 20 years old.

4.2.1.5 Source of AIDS-related information

Table 4.5 Source of AIDS-related information

Source	Frequency	Percent (%)
Department of Education	17	8.3
School	32	15.6
Media	131	63.9
Non-governmental organizations	7	3.4
Parents	10	4.9
Friends	4	2.0
None of the above	4	2.0
Total	205	100.0

Most the respondents, 131 of them (63.9%) believed that the media provided most of the AIDS-related information to them, according to table 4.5 above. Only 32 respondents, (15.6%) believed it was their schools that provided them with most of their AIDS-related information.

Seventeen respondents (8.3%) stated that it was the DoE that had given them the most information, and the rest attributed their primary source of AIDS-related knowledge to be their parents, NGO's, friends or other sources. It is interesting to note that even if one interpreted the DoE as being an extension of the school, only 49 (23.9%) believed that both schools and DoE together, provided most of their information.

4.2.2 Problem statement 1

What are the frequencies and percentages of educators' and learners' responses on various aspects of HIV/AIDS regarding the following factors?

- (a) Knowledge of transmission modes of HIV
- (b) Knowledge of policies, procedures with regards to HIV/AIDS
- (c) Sexual relations between educators and learners
- (d) Attitudes of educators and learners towards HIV/AIDS

Findings regarding the above-mentioned problem statement were as follows:

(a) Knowledge of transmission modes

The findings regarding knowledge of transmission modes of the HIV virus are presented in tables 4.6 to 4.9.

Table 4.6 Responses on: A person can contract HIV by donating blood

Response	Frequency	Percent (%)
True	59	28.8
False	122	59.5
Don't know	23	11.2
Total	204	99.5
Missing system	1	.5
Total	205	100.0

From table 4.6, it is clear that the majority of respondents, 122 (59%) knew that one cannot contract HIV by donating blood. Of concern however, is that 40% of them either believed that they could contract HIV in this way or did not know. Knowledge of non-transmission modes is an important area in HIV/AIDS education. It has also been a much-neglected area, as research has shown (Maieron et. al, 1996:321; Kistner et. al, 1997:294). These researchers also showed that knowledge of non-transmission modes also positively influenced attitudes towards the HIV-positive person (Maieron et. al, 1996:321; Kistner et. al, 1997:294).

Table 4.7 Responses on: A person can contract HIV if they touch the vomit or saliva of a HIV-positive person

Response	Frequency	Percent (%)
True	32	15.6
False	140	68.3
Don't know	33	16.1
Total	205	100.0

The majority of respondents, that is 140 (68.3%) believed correctly that one could not contract HIV through this means, as is indicated in table 4.7 above.

Table 4.8a Responses on: Sneezing and coughing can spread the HIV virus

Response	Frequency	Percent (%)
True	12	5.9
False	168	82.0
Don't know	25	12.2
Total	205	100.0

An overwhelming majority, 168 (82.0%) of the whole group were aware that sneezing and coughing is not a mode of transmission, as shown in table 4.8a above. Research has shown that

many children extend their “germ theory” of colds and flu to HIV/AIDS, believing that the virus can be spread through sneezing and other forms of airborne transmission (Sigelman et. al, 1996:263).

However, in the present study 94 (75.2%) learners recognized this as a non-transmission mode of the HIV virus (refer to table 4.8b below, which presents data on learners only).

Table 4.8b Responses of learners on: Sneezing and coughing can spread the HIV virus

Response	Frequency	Percent (%)
True	10	8.0
False	94	75.2
Don't know	21	16.8
Total	125	100.0

Table 4.9 Responses on: The HIV virus can be transmitted in the air

Response	Frequency	Percent (%)
True	1	.5
False	192	93.7
Don't know	12	5.9
Total	205	100.0

A large number of respondents that is, 192 respondents (93.7%) were aware that HIV cannot be transmitted through the air. In other words, respondents understood that they could not “catch the HIV virus”. Once again this knowledge is important in creating positive attitudes, as research has indicated (Cole et. al, 1996:107; Kistner et. al, 1997: 294)

(b) Knowledge of policies, procedures and school responses

This section examined respondents' knowledge of DoE's and individual school responses to HIV/AIDS. Knowledge of safe practices, particularly the universal precautions was also investigated. A further aspect that was focussed on was the issue of educator/learner relations. The findings in respect of these issues are presented in this section in tables 4.10 to 4.13.

Table 4.10a Responses on: I am aware that the DoE has a national policy on HIV/AIDS

Response	Frequency	Percent (%)
True	147	71.7
False	50	24.4
Don't know	7	3.4
Missing system	1	.5
Total	205	100.0

The majority of the respondents, that is 147 respondents (71.7%) were aware that there was a national policy on HIV/AIDS from the DoE, as can be seen in table 4.10a. This policy was implemented in 1999 (South Africa, 1999). It addresses issues ranging from safe practices in the schools to discrimination, confidentiality, admission of learners and the appointment of educators.

Table 4.10b Responses on: I have read the DoE's national policy on HIV/AIDS for educators and learners

Response	Frequency	Percent (%)
True	69	33.7
False	132	64.4
Missing system	4	2.0
Total	205	100.0

As can be seen in table 4.10b, only 69 respondents (33.7%) admitted having read the national policy for learners and educators (South Africa, 1999). In other words 132 respondents (64.4%) had not read this policy. If 132 respondents (64.4%) have not read the national policy for educators and learners (South Africa, 1999), this essentially means that these 64.4% are unaware of the official stance of the national education ministry with regards to HIV/AIDS. This may further mean that 64.4% of these respondents are unable to implement and adopt the strategies recommended by the DoE to fight the HIV/AIDS pandemic, as they possibly do not know that these strategies from the DoE exist at all.

Besides the DoE's response to HIV/AIDS at national level, the other concern is whether individual schools are officially responding to the HIV/AIDS pandemic. Respondents were therefore asked whether their schools had policies in place in this regard.

Table 4.11a Responses on: My school has a policy in HIV/AIDS

Response	Frequency	Percent (%)
True	46	22.4
False	75	36.6
Don't know	84	41.0
Total	205	100.0

Only 46 respondents (22.4%) indicated that their schools did have such policies (see table 4.11a). It is interesting to note that 84 respondents (41.0%) indicated that they did not know whether their school did indeed have a HIV/AIDS policy in place. If the schools of these respondents do have HIV/AIDS policies in place, these policies would most likely be of little benefit, if individuals who attend these schools were unaware of them.

Table 4.11b Responses on: I have read my school policy on HIV/AIDS

Response	Frequency	Percent (%)
True	72	35.1
False	131	63.9

Don't know	1	.5
Missing system	1	.5
Total	205	100.0

In terms of individual school policy on HIV/AIDS, 131 respondents (63.9%) stated that they had not read their school's policy on HIV/AIDS. Any response however effective becomes ineffectual if the target group does not know that it exists or does not read the document.

The national policy on HIV/AIDS for educators and learners states that where community resources make it possible, each school should establish its own Health Advisory Committee (South Africa, 1999:26). This committee (the Health Advisory Committee) would be responsible for implementation of a HIV/AIDS action plan in the school (South Africa, 1999:26).

Table 4.12 Responses on: My school has a Health Advisory Committee

Response	Frequency	Percent (%)
True	32	15.6
False	109	53.2
Don't know	64	31.2
Total	205	

According to table 4.12, one hundred and nine respondents (53.2%) indicated that their school did not have a Health Advisory Committee (HAC), whilst 64 of them (31.2%) indicated that they did not know whether their school did have a HAC or not.

Knowledge and application of universal precautions with regards to HIV/AIDS

The knowledge and application of universal precautions is one of the vital aspects of safer behaviours to prevent HIV-transmission. The findings in this regard were disturbing as detailed in tables 4.13a, 4.13b, 4.13c and 4.13d.

Table 4.13a Responses on: I have heard the term universal precautions

Response	Frequency	Percent (%)
True	54	26.3
False	147	71.7
3 mistakes	4	2.0
Total	205	100.0

Awareness and use of universal precautions is a vital aspect of reducing the rate of transmission of the HIV virus. However, the majority of respondents, 147 (71%) had not heard of the term “universal precautions” at all, as can be seen in table 4.13a.

Table 4.13b Responses on: I have been informed about the application of universal precautions at my school

Response	Frequency	Percent (%)
True	27	13.2
False	175	85.4
3 mistakes	3	1.5
Total	205	100.0

Of further concern was that 175 respondents (85%) denied having been informed about universal precautions at their school (see table 4.13b). Universal precautions are mentioned in the national policy on HIV/AIDS for learners and educators (South Africa, 1999). According to this document (South Africa, 1999) universal precautions are supposed to be implemented in every school (South Africa, 1999:15).

Table 4.13c Responses on: I am aware of how and when to apply universal precautions

Response	Frequency	Percent (%)
True	37	18.0

False	162	79.0
3 mistakes	6	2.9
Total	205	100.0

In terms of the actual application of universal precautions, a large majority of respondents admitted that they did not know how and when to apply universal precautions. In total 162 respondents (79%) indicated that they were not aware of how and when to apply universal precautions (see table 4.13c). This is of particular concern, especially in the light of a comment in the national policy document on HIV/AIDS for educators and learners: "... insignificant risk of transmission during teaching, sport and play activities, however, holds true only if universal precautions are adhered to." By implication, if universal precautions are not applied when necessary there is a significant risk of HIV-transmission during sport and play activities.

Table 4.13d Responses on: Universal precautions may only be used with persons with AIDS

Response	Frequency	Percent (%)
True	26	12.7
False	59	28.8
Don't know	119	58.0
Missing system	1	.5
Total	205	100.0

With regards to whether universal precautions should only be applied when assisting persons with AIDS, as indicated in table 4.13d, the majority of respondents, that is, 119 respondents (58%) did not know if this statement was true or not. Particular mention is made of this issue in the national policy document (South Africa, 1999:8). The document (South Africa, 1999:8) states that in situations of potential exposure such as injuries at school, all persons should be considered as potentially infected and their blood and body fluids should be treated as such.

(c) Sexual relations between educators and learners

The issue of sexual relations between educators and learners and the escalating incidence of rape and sexual abuse of learners has been receiving much attention in recent times (George, 2001:11; Human Rights Watch, 2001:4; South Africa; 2002b:12). The findings with regards to the above-mentioned issues are detailed in tables 4.14a, 4.14b, 4.14c and 4.14d below.

Table 4.14a Responses on: It is illegal for an educator to have sexual intercourse with a learner

Response	Frequency	Percent (%)
True	151	73.7
False	31	15.1
Don't know	23	11.2
Total	205	100.0

From table 4.14a above it can be seen that most respondents were aware that it was illegal for an educator to have sexual relations with a learner: 151 respondents (73.7%) indicated that it was illegal for an educator to have sexual relations with a learner. The question then arises that if the learner consents to sexual relations with an educator, was this lawful or not? A further question was whether the respondent would report such information to the authorities?

The findings in this regard were as follows (see tables 4.14b and 4.14c):

Table 4.14b Responses on: An educator may have sexual intercourse with a learner if the learner consents

Response	Frequency	Percent (%)
True	32	15.6
False	134	65.4
Don't know	37	18.0
Missing system	2	1.0
Total	205	100.0

The above table 4.14b indicates that 134 respondents (65.4%) were aware that educators should not engage in sexual intercourse with learners, even if the learner consents. Sexual relations between educators and learners are illegal in terms of the educators' professional Code of Conduct (South Africa, 1999:23).

Table 4.14c Responses on: I will report an educator if a learner discloses to me that he/she has had sexual intercourse with this educator

Response	Frequency	Percent (%)
True	123	60.0
False	40	19.5
Don't know	41	20.0
Missing system	1	.5
Total	205	100.0

The majority of the respondents, that is 123 respondents (60.0%), as can be seen in table 4.14c above, indicated that they would report an educator who engages in sexual relations with a learner. This is belied somewhat by current research findings in South African schools, which seem to indicate that whilst rape and sexual abuse of schoolgirls in particular is rife, very few of the perpetrators are reported and brought to book (George, 2001:11).

Table 4.14d Responses on: I understand the term statutory rape

Response	Frequency	Percent (%)
True	140	68.3
False	61	29.8
Missing system	4	2.0
Total	205	100.0

According to table 4.14d, most of the respondents, that is 140 (68.3%) indicated that they did understand the term statutory rape. This assertion was not verified. Knowledge and understanding of such legal terminology is particularly important in the light of the escalating incidence of rapes of learners in the schools (George, 2001:11).

(d) Attitudes of educators and learners with regards to HIV/AIDS-related issues

Attitudes of educators and learners to persons with AIDS, has been a much-researched area. Research has indicated that attitudes have improved (Brucker and Hall, 1996:86; White and Ballard in Alali, 1995:94; Lebrun and Freeze, 1995:34).

The findings in the current study were as follows:

Table 4.15 Responses on: Persons with AIDS should be allowed to train as educators

Response	Frequency	Percent (%)
Strongly agree	93	45.4
Agree	71	34.6
Unsure	20	9.8
Disagree	12	5.9
Strongly disagree	9	4.4
Total	205	100.0

According to table 4.15, most respondents displayed positive attitudes towards persons with AIDS: 164 (93 +71) respondents (80.0%) agreed or agreed strongly that persons with AIDS

should be allowed to train as educators. Positive attitudes were also evident in the following areas, as indicated in tables 4.16 and 4.17.

Table 4.16 Responses on: Persons with AIDS should keep their HIV-positive status a secret

Response	Frequency	Percent (%)
Strongly agree	10	4.9
Agree	16	7.8
Unsure	31	15.1
Disagree	69	33.7
Strongly disagree	79	38.5
Total	205	100.0

The majority of respondents disagreed that persons with AIDS should keep their HIV-positive status a secret ($33.7 + 38.5 = 72.2\%$). Only 26 (10+ 16) respondents (12.7%) agreed or strongly agreed that persons with AIDS should not disclose that they were HIV-positive.

Research has indicated that in terms of perceptions of personal susceptibility to HIV/AIDS, although people are knowledgeable about HIV/AIDS, they do not perceive themselves to be personally vulnerable or at risk (Weinstein, 1989:142; Carter, 1999:296). The findings in the current research regarding attitudes about personal susceptibility to HIV/AIDS are presented in table 4.17.

Table 4.17 Responses on: I feel I am safe from contracting AIDS

Response	Frequency	Percent
Strongly agree	34	16.6
Agree	43	21.0
Unsure	43	21.0
Disagree	43	21.0
Strongly disagree	42	20.5
Total	205	100.0

According to table 4.17 only 42 respondents (20.5%) strongly disagreed that they felt safe from contracting HIV/AIDS. Forty-three respondents (21.0%) disagreed that they felt safe from contracting HIV/AIDS. It is interesting to note that 77 (34 + 43) respondents (37.6%) agreed or strongly agreed that they felt safe from contracting HIV/AIDS, whilst 43 respondents (21.0%) felt unsure about how safe they were from contracting the HIV virus.

4.2.3 Problem statement 2

Is there a significant difference between the knowledge and attitudes of educators and learners?

H₀₂ There is no significant difference between *educators and learners* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues.

H₂ There is a significant difference between *educators and learners* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues.

In order to compare the knowledge and attitudes of educators and learners, a t-test was calculated. The averages and the results of the t-test are presented in tables 4.18 and 4.19.

Table 4.18 Means for knowledge and attitudes of learners and educators

Factor	Occupation	N	Mean
Average HIV knowledge	educator	80	.7372
	learner	125	.5956
Average Attitude	educator	80	2.1275
	learner	125	2.1792

Table 4.19 T-test and significance of difference between average knowledge of HIV/AIDS of learners and educators

t-value	df	Significance
5.114	203	p < 0.01

Table 4.19 indicates that the null-hypothesis can be rejected on the 1%-level of significance. According to tables 4.18 and 4.19, educators have significantly better knowledge than learners of transmission modes of HIV/AIDS (.7372 is greater than .5956, and p is smaller than 0.01). The alternative hypothesis will therefore be accepted.

Another interesting observation can be made regarding the means: Whereas the educator mean for knowledge of HIV/AIDS issues is higher than that of learners indicating more accurate knowledge, the learner mean for attitudes is higher than that of educators. The higher the mean for attitudes, the better the attitudes towards HIV/AIDS issues. This finding further supports the premise that higher knowledge levels do not necessarily indicate more positive attitudes. In other words although learners have less accurate knowledge about HIV/AIDS issues their attitudes tend to be more positive than those of educators.

4.2.4 Problem statement 3

Is there a significant difference in knowledge and attitudes between diverse ethnic groups?

H₀₃ There is no significant difference between *diverse ethnic groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

H₃ There is a significant difference between *diverse ethnic groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

The ethnic groups are Coloured, Black, White and Indian. In order to compare the knowledge and attitudes of diverse ethnic groups, an analysis of variance test was carried out. These results appear in table 4.20 below.

Table 4.20 Analysis of variance for knowledge and attitudes of different ethnic groups

Factor	df	F	Significance
Average HIV knowledge	3	2.167	.093

Average attitude	3	2.254	.083
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Table 4.20 indicates that the null-hypothesis may not be rejected. Thus there is no significant difference between *diverse ethnic groups* regarding (a) their knowledge of transmission and (b) their attitudes towards HIV/AIDS issues ($p = 0.093$ and 0.083 respectively, thus $p > 0.05$).

4.2.5 Problem statement 4

Is there a significant difference in knowledge and attitudes between males and females?

H₀₄ There is no significant difference between *females and males* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

H₄ There is a significant difference between *females and males* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

In order to compare the knowledge and attitudes of females and males, a t-test was calculated. The mean scores and the results of the t-test are presented in table 4.21 and 4.22 below.

Table 4.21 Means for knowledge and attitudes of females and males

Gender	N	Mean
Average HIV knowledge Female	133	.6898
Male	72	.5790
Average Attitude Female	133	2.1496
Male	72	2.1764

The higher the means, the better the knowledge and attitudes. In other words, females have a better knowledge of HIV/AIDS issues than males.

Table 4.22 T-value and significance of difference between knowledge and attitudes of males and females

Factor	t	df	Significance
Average HIV knowledge	3.816	203	.000
Average attitude	-.300	203	.764

Tables 4.21 and 4.22 indicate that the null-hypothesis can be rejected on the 1%-level of significance for knowledge but not for attitude. According to tables 4.21 and 4.22, females have significantly better knowledge than males of transmission modes of HIV/AIDS ($p < 0.01$). The alternative hypothesis will therefore be accepted.

4.2.6 Problem statement 5

Is there a significant difference in knowledge and attitudes between diverse age groups?

H_{05} There is no significant difference between *diverse age groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

H_5 There is a significant difference between *diverse age groups* regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS.

The age groups are 20 years and younger; 21-30 years; 31-40 years and older than 40 years. In order to compare the knowledge and attitudes of diverse age groups, an analysis of variance was calculated. These results appear in tables 4.23 and 4.24 below.

Table 4.23 Analysis of variance for knowledge and attitudes of different age groups

Factor	df	F	Significance
Average HIV knowledge	3	9.400	.000
Average attitude	3	.116	.951

Table 4.24 Means for knowledge of different age groups

Age	Mean	N
Under 20 years	.5942	120
20-30 years	.6713	19
31-40 years	.7681	38
More than 40 years	.7210	28

If the tables 4.23 and 4.24 above are studied, it is clear that groups of 31 years and older know significantly more about ways that HIV/AIDS can be transmitted (.7681 and .7210 are significantly greater than .5942). The null hypothesis may therefore be rejected. There is a significant difference between average knowledge of transmission of HIV/AIDS for various age groups.

4.2.7 Problem statement 6

Is there a significant correlation between attitude to and knowledge of HIV/AIDS for (a) learners and (b) educators?

H_{06} There is no significant correlation between attitude to and knowledge of HIV/AIDS for (a) learners and (b) educators?

H_6 There is a significant correlation between attitude to and knowledge of HIV/AIDS for (a) learners and (b) educators?

In order to test whether there was a significant correlation between attitude to and knowledge of HIV/AIDS, Pearson's correlation was calculated. The results are presented in table 4.25.

Table 4.25. Correlation and significance of correlation of knowledge of transmission modes of HIV/AIDS and attitudes towards AIDS-related issues of learners and educators together

Correlation	Significance
-1.152	p < 0,05

According to table 4.25, this correlation is significant on the 5% level. However, it is very low and negative.

4.2.8 Problem statement 7

Is there a significant relationship between learners' and educators' responses regarding (a) Issues relating to the DoE's policy on HIV/AIDS and (b) School policies and educator/learner relations?

H₀₇ There is no significant relationship between learners' and educators' responses regarding (a) issues relating to the DoE's policy on HIV/AIDS and (b) School policies and educator/learner relations?

H₇ There is a significant relationship between learners' and educators' responses regarding (a) issues relating to the DoE's policy on HIV/AIDS and (b) School policies and educator/learner relations?

In order to test whether there was a relationship between occupation and knowledge of policies, cross tabs, followed by chi-square were calculated. The results are presented in table 4.26. Significant relationships between occupation and issues relating to the DoE's and individual school's policies on HIV/AIDS were found for the following items.

Table 4.26 Chi-square and significance of relationships between policies of the DoE and schools

Policy	chi-square	df	Significance
I am aware of the DoE's stance regarding			

discrimination	3.866	1	p < 0.05
I understand the term “Statutory rape”	11.884	1	p < 0.01
The school’s policy has helped me to adopt safer behaviours in respect of HIV/AIDS	19.503	1	p < 0.01
Class-based lessons are conducted at school	17.508	1	p < 0.01
My school has a Health Advisory Committee	24.368	2	p < 0.01
My school has a policy on HIV/AIDS	21.108	2	p < 0.01
Universal Precautions may only be used with persons with HIV/AIDS	8.905	2	p < 0.05
My school has at least two first aid kits	11.611	2	p < 0.01
Gloves are available at sporting events	16.178	2	p < 0.01
It is illegal for an educator to have sexual intercourse with a learner	16.470	2	p < 0.01
I will report an educator who has sexual intercourse with a learner	8.522	2	p < 0.05
An educator may have sexual intercourse with a learner if the learner consents	34.955	2	p < 0.01

For the above-mentioned items the null-hypothesis may be rejected. Thus there is a significant relationship between occupation (that of learners and educators) and the items listed above.

4.2.9 Open Questions

4.2.9.1 How have the HIV/AIDS-related programmes at school influenced you in adopting safer behaviours and lifestyles?

(i) Educators’ responses

Positive attitudes were evident in the following statements:

“Increased awareness has affected my teaching – I promote responsible lifestyles at every opportunity...”

“I take more precautions when working with injuries that may occur”.

“I will not assist blood injuries without gloves”.

“It has made me more knowledgeable about the disease. I am also less afraid of the consequences of the disease”.

“I have become aware of the rate of infection, attitudes and behaviour towards HIV/AIDS infected people”.

Of note is the fact that the above comments do not focus only on safe sex behaviours, but also safe behaviours when assisting with injuries.

Negative attitudes among educators were evident in the following responses. These comments also corroborate research findings on issues relating to perceptions of personal susceptibility to HIV/AIDS. In other words respondents appear to believe that they are not vulnerable to contracting the HIV virus (Carter, 1999:296; Weinstein, 1989:142):

“It hasn’t, I have always had only one partner since my marriage”.

“Not at all, as my behaviour and lifestyle would not put me at risk anyway”.

“As a divorcee with no relationship with men, it has not affected me”.

“Not at all. I am married with young children and am committed to my family”.

“It has further emphasized my view that a promiscuous lifestyle can lead to AIDS – death, horrible diseases”.

The above statements appear to indicate that the respondents see risk only in the context of sexual encounters and promiscuous lifestyles. No mention is made of safe behaviours in the context of exposure to infected blood, as in the case of injuries, etcetera.

Respondents from certain schools also stated that there were either no or minimal HIV/AIDS-related programmes occurring at their schools:

“Not available at our school”

“I am new to the school. Since I came here I haven’t seen any programmes going on”.

“I’ve never been part of school programmes, however, media programmes do keep me aware”.

“No HIV/AIDS programmes at present”.

“Not much – however, programmes on TV – especially on Sunday on E-TV has certainly influenced my behaviour and lifestyle”.

(ii) Learners' responses (to the question: How have the HIV/AIDS-related programmes at school influenced you in adopting safer behaviours and lifestyles?)

Learners in general appeared less judgemental than educators, particularly towards persons with AIDS. **Positive attitudes** were displayed, as is evident in the following statements:

“They made me more careful about how I speak about AIDS, and more sympathetic to those who are already infected”.

“I think it teach(es) us how to behave and to associate with people who have AIDS because they are human”.

“They have taught a lot, especially how to behave around HIV/AIDS people. That is to treat them like everybody else...and not to forget how important it is to condomise”.

“The school HIV/AIDS programmes have helped me understand that you should treat persons with AIDS the way you treat everyone”.

“I'm not afraid of socializing with those who have HIV anymore. I know the difference of getting HIV and how to help people with HIV”.

“I feel that it is not AIDS which is killing us but ignorance”.

The last comment in particular, in all its simplicity encapsulates the very essence of the fight against HIV/AIDS; that it is not the disease itself but our responses to the disease that pose a real threat to the world (Van Dyk, 1993:10; Weinstein, 1989:142).

(iii) Knowledge of modes of transmission

Learners appeared more aware than educators of the fact that there are other modes of transmission of the HIV virus, besides sexual intercourse, as is evident from the comments below:

“As a qualified peer educator it has also helped me...and on helping others be aware of this virus. It has also changed my life. The way I do things. I am now more careful about touching and cleaning peoples' sores”.

“Personally when I see open blood, I will realise never to touch it, no matter who the person is...and I am actually scared to sleep with anyone”.

“It’s made me much more cautious, and also realise that if I want to be “safe” then I should abstain and be careful of needles, etc”.

“Although it doesn’t really change my behaviour, as I don’t have sexual intercourse, but if I was helping in an accident of some sort, I would know to wear gloves”.

“I also understand that AIDS is not only contracted from sexual intercourse”.

The above statement is a crucial one in the fight that is, for the individual to understand that there are other modes of transmission of the HIV virus besides sexual intercourse.

(iv) Insufficient HIV/AIDS-related programmes

Some learners also indicated that there were insufficient or no HIV/AIDS programmes at their school, for example:

“We do not have many HIV/AIDS-related programmes here (at school)”.

“But we also do not have many HIV/AIDS programmes at school”.

“We haven’t learnt much about AIDS in our school, but I learnt elsewhere”.

From the comments from both educators and learners, it would seem that one of the clearest messages that people have received is that unprotected sexual intercourse is regarded as high risk behaviour in terms of contracting HIV/AIDS. There appears to be less understanding and knowledge of other equally dangerous modes of transmission of the HIV virus such as exposure to infected blood and body fluids, particularly among educators.

4.2.9.2 HIV/AIDS has been the focus of much attention in recent times. How do you feel about the situation regarding HIV/AIDS?

Both learners and educators levelled criticism at the government's response or lack of response to the HIV/AIDS pandemic. Many respondents expressed feelings ranging from disgust at the government's handling of AIDS to disappointment that the government was not doing enough to fight the HIV/AIDS pandemic effectively. Examples include the following:

“Desperate, especially about orphans. I think we are sitting on a time bomb with children growing up without care. I feel government aid is still too little and too late. I worry about the effect of loss of skilled adults on the economy”.(educator)

“I believe our country could do more to assist people with AIDS”. (educator)

“Government is dragging its feet about drugs which can be available for low cost to people who cant afford”. (educator)

“Disgraceful – state must provide financial aid – provide medication – ensure that medical aid covers AIDS and not discriminate (make it national policy)”. (educator)

“Government is too slow to act. Greatly entangled bureaucracy and red tape, example: funds available to treat people of KZN”. (educator)

“...the government must do much more than it is at the moment in order to minimize the effect of AIDS”. (educator)

“Deplorable. Government spends too much time and money on debating that issue while thousands are dying”. (educator)

“People in our country (especially the government) have been avoiding the truth that there is a thing called AIDS and it is alive and it's killing our country”. (learner)

“Another thing that bothers me is that the government refuses to buy pills to help the people with this disease. I think that is selfish”. (learner)

“The government should give the HIV/AIDS drug to pregnant mothers”. (learner)

There were some positive comments from learners: “AIDS awareness in our country is excellent because no one can say ‘I didn't know’ ”.

4.2.9.3 What would you do if you discover that you are HIV-positive? Would you disclose to any person at school that you are HIV-positive? Why/why not?

There were mixed responses to the issue of disclosure among both educators and learners.

It was interesting to note, that of those educators who stated that they would disclose, many said that they would disclose to their principal. The following examples illustrate this:

“My principal and a few close friends as well as the person I was in a close relationship with”.

“I would inform my friends and my principal”.

“Not to my colleagues but only to my employer or management”.

(i) Fear of ostracization

Many educators indicated that they would not disclose for fear of discrimination and ostracization. Statements include:

“I would not disclose because people are not educated, they can discriminate (against) me”.

“I won’t disclose...some people are less informed so they might misinterpret the situation”.

“No. For fear of discrimination and embarrassment”.

“I won’t in terms of how people will perceive me as an HIV/AIDS sufferer. The stigma attached to the disease has not been removed”.

“No – private person, and people are still too judgemental”.

(ii) Respondents’ own irrational fears and prejudices

The following comment summed up many of the reasons for non-disclosure, which were intrinsically tied to the person’s own prejudices and irrational fears.

*Don’t know – Hope to God! I don’t contract this disease. Would I disclose it - Depends on how I react and PROBABLY once I have adjusted then disclose to one or two – but in all likelihood NO – the social stigma will be too much to bear, but I know that I will alienate myself from those close to me, as I know from our discussions that **we don’t look too kindly on those who contract these diseases**. I pray and hope that nobody close to me has AIDS as I really feel that it will take me very long to accept. When the problem is far away and not mine, it is okay, but once it gets closer I react differently.*

(iii) Non-disclosure because the issue of HIV/AIDS was treated as a joke

Although there were mixed responses from learners, of those who indicated that they would not disclose, many of them expressed similar fears of being gossiped about and being treated as a joke. The following quotes serve as examples:

“I won’t tell anyone because people will hate me more than before”.

“I would not tell...some students like to make it as a hobby to bad mouth and gossip...”

“No, because if you tell your friend or anyone at school, they will tell the whole world”.

“They will start despising me, students won’t even come to talk to me as usually”.

“I wouldn’t tell anyone from school because even though kids know about AIDS, once they hear that someone has it they seem to forget everything they’ve learned and treat you differently”.

“No, I wouldn’t as rumours will start about how you contracted AIDS which gives you a really bad name/reputation”.

“If I discovered I became HIV+ through sexual relationship, I wouldn’t tell anyone, but if I became HIV+ through another source I would tell my family and a few close friends”.

“Because once someone knows, he/she may turn it into a joke, rumours will start, and my life at school would be basically an embarrassment and a disaster”.

“I should not tell anyone at school because they will think it is a joke and treat me as a joke”.

“I would not tell anyone because they make fun of the situation”.

“I would not tell anybody because they take everything as a joke”.

(iv) Extreme reactions

Extreme reactions were also evident, with learners in particular mentioning suicide as an option.

“I would kill myself”.

“Firstly I think I would take my own life, because it will bring shame and embarrassment to my family”.

“Commit suicide. I would not disclose to protect my family. I will give another reason for committing suicide”.

(v) Positive attitudes

It was interesting to note that there were some learners who displayed positive attitudes to disclosure.

“Yes, so that I can get the assistance from other pupils/learners because if I shut up my mouth the disease can fill me up fast”.

“Yes, I will, because it is important that you tell other people that you are HIV+ so that you can get help”.

“Yes, I will disclose to any person because they can help me”.

The following comments were particularly indicative of a positive attitude to adversity:

It has been my dream to help the world and people in need, and that would be a great opportunity for me. Somehow I'd be glad that it happened, because I believe that for everything you lose, you gain twice as much...So if I lose my health, I'd gain the ability to help people, which would be good. I believe that I'd get the wisdom from God to help other people.

(vi) Negative attitudes

Negative and judgemental attitudes were particularly evident among educators.

“It is alarming to realize that people are so irresponsible about their own lives and those of their children. I am disgusted at the lack of morals and values that people display”.

“Yes, I would (disclose) because it will certainly be no fault of mine”.

“Not at all, as my behaviour and lifestyle would not put me at risk anyway”.

“Angry, as it can be controlled by people's self-control. The misconceptions or arrogance among the population make me frustrated”.

“If I were foolish to contract it, then I must live with it”.

4.3 CONCLUSION

Results from the empirical investigation were presented in this chapter. Seven research problems and their associated hypotheses were stated. It was also indicated which hypotheses were rejected or not rejected and these results were discussed. The following chapter will focus on conclusions, recommendations and limitations of the current research.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

The purpose of the study was to explore, in the main, the impact of HIV/AIDS globally and in South Africa. A further aim was to investigate world responses and South African responses to the pandemic, and to examine whether these responses were effective in changing educators' and learners' attitudes and risk behaviours in terms of HIV/AIDS.

A literature study was conducted in order to explore the impact of HIV/AIDS on the world, and on South Africa, particularly with regards to the education sector. The world responses, South African responses, education and other state sectors, NGOs and CBOs (Community Based Organizations). The literature study was concluded by exploring the theoretical basis of health behaviours as a basis for understanding factors that influence risk behaviours.

An empirical investigation was conducted with the following goals:

- To examine:
 - (a) Educators' and learners' knowledge of transmission modes of HIV/AIDS
 - (b) Educators' and learners' knowledge of DoE's policies and procedures in terms of HIV/AIDS
 - (c) Educators' and learners' knowledge and attitudes to issues relating to sexual relations between educators and learners.
 - (d) Attitudes of educators and learners to HIV/AIDS-related issues.
- To investigate whether educators and learners differ in knowledge and attitudes with regards to HIV/AIDS issues.
 - To investigate whether ethnic groups differ in knowledge and attitudes to HIV/AIDS issues.
- To investigate whether males and females differ in knowledge and attitudes to HIV/AIDS.

- To investigate whether age groups differ in knowledge and attitudes to HIV/AIDS issues.
- To investigate whether there was a correlation between attitude to and knowledge of HIV/AIDS for learners and educators.
- To investigate whether there was a relationship between occupation and responses to HIV/AIDS issues.

5.2 CONCLUSIONS

5.2.1 Conclusions from literature study

a. Educators' and learners' knowledge of HIV/AIDS transmission modes

The existing literature seems to indicate that knowledge of transmission modes of HIV is high (Paniagua, Boyle, Wagner, Ramirez, Holmes, Nieto and Smith, 1994:324; loveLife, 2001b:46). However, research into health behaviours has also shown that knowledge acquisition does not necessarily result in positive behaviour change (Bandura, 1989:128; Catania, Kegeles and Coates, 1990:54; Chapin, 2000:69).

Knowledge of non-transmission modes is an important area in HIV/AIDS education, which has been a much-neglected one, as research has shown (Maieron et. al, 1996:321; Kistner et. al, 1997:294). These researchers have also shown that knowledge of non-transmission modes also positively influenced attitudes to the HIV-positive person (Maieron et. al, 1996:321; Kistner et. al, 1997:294).

b. Knowledge of HIV/AIDS-related policies

Researchers also found that whilst at many schools HIV/AIDS-related policies were in place, educators at those very schools were unaware of whether or not their schools actually had such policies (Warman, 1994:10; Grier and Hodges, 1998:260).

c. Issues relating to sexual relations between educators and learners

Studies in South Africa (George, 2001:11; Human Rights Watch, 2001:4; South Africa, 2002b:12) indicate widespread abuse of learners by educators and other learners. This has further implications for the spread of HIV/AIDS.

d. Attitudes to HIV/AIDS-related issues

There appears to be an improvement in educators' attitudes as compared to previous studies (Brucker, et. al, 1989:63; Brucker, et. al: 1996:86; White and Ballard in Alali, 1995:94). However, educators still appear to harbour misconceptions about the transmission of the virus, although on an irrational level (Grier and Hodges, 1998: 260; Ainsa, 2000:8). In South Africa, in particular, prejudice, ostracization and discrimination still appear to be rife (Johnson, 2000:8; Human Rights Watch, 2001:4).

e. Risk behaviours

Third person perception and optimistic bias: Weinstein (1989:142) and Carter (1999:296) indicated that according to research findings, although individuals were knowledgeable about transmission modes of HIV, they do not perceive themselves as being personally vulnerable or at risk.

Universal precautions: Educators were knowledgeable about the HIV/AIDS scenario, but appeared to have difficulty contextualizing their knowledge on a personal level. Application of this knowledge was poor. For example, although they knew about the universal precautions, they were confused about when was the correct instance to apply the universal precautions and under what circumstances and with which children (Grier and Hodges, 1998:257; Ainsa, 2000:8; Beverly, 1995:101).

5.2.2 Conclusions from empirical investigation

5.2.2.1 Problem statement 1

a. Educators' and learners' knowledge of HIV/AIDS transmission modes

The results of the current investigation confirm that knowledge of transmission modes among both educators and learners is high. It was also found that the educators' knowledge of HIV/AIDS transmission modes is higher than that of learners, indicating that educators have more accurate knowledge than learners.

In terms of knowledge of non-transmission modes, which is an important area in HIV/AIDS education, learners appeared to focus more on non-sexual transmission modes, while educators tended to be more pre-occupied with sexual modes of transmission of the HIV virus.

b. Knowledge of DoE's HIV/AIDS-related policies

The majority of the respondents in this investigation were aware that there was a national policy on HIV/AIDS from the DoE (South Africa, 1999). However, the majority admitted that they have not read this policy (South Africa, 1999). This then indicates that they would be unaware of the official stance of the national education ministry with regards to HIV/AIDS, and would therefore be unable to implement and adopt the strategies recommended by the DoE to fight the HIV/AIDS pandemic.

The current study also found that only a minority indicated that their schools did have a HIV/AIDS policy. A number of respondents did not know whether their school did have a HIV/AIDS policy or not. The majority also stated that they had not read their school's policy on HIV/AIDS. If the schools do have HIV/AIDS policies in place, these policies would most likely be of little benefit, if individuals who attend these schools were unaware of them or have not read them.

c. Issues relating to sexual relations between educators and learners

The majority of respondents were aware that it was illegal for an educator to have sexual relations with a learner. The majority of them were also aware that it was illegal for educators to engage in sexual intercourse with learners, even if the learner consents. The majority indicated that they would report an educator who engages in sexual relations with a learner. Most of the respondents stated that they understand the term statutory rape. However, it still remains a cause for deep concern that many people, although they are in the minority, are still unaware of the issues and legal implications of sexual relations between learners and educators, as well as the rights of learners in this regard. Every learner and educator in every school in South Africa ought to be educated about these issues as a matter of urgency.

d. Attitudes to HIV/AIDS-related issues

The majority of respondents displayed positive attitudes towards persons with AIDS. They further agreed that persons with AIDS should be allowed to train to be educators. Most respondents disagreed that persons with AIDS should keep their HIV-positive status a secret.

In comparing knowledge and attitudes, educators had higher levels of knowledge, but displayed more negative attitudes than learners, regarding how persons contracted the virus. Educators appeared to adopt a judgemental attitude towards persons with AIDS, by implying that

promiscuous, unprotected sexual encounters were the only possible causes of the individual's HIV-positive status.

Attitudes of educators and learners regarding persons with AIDS rights to education, employment and training were positive, with both educators and learners accepting that persons with AIDS have rights that are entrenched in the South African constitution. They also felt strongly about persons with AIDS being protected from discrimination.

e. Risk behaviours

Third person perception and optimistic bias: In terms of third person perception and optimistic bias (Weinstein, 1989:142; Carter, 1999:296) only a small percentage of respondents in the current study felt personally at risk of contracting HIV/AIDS.

Educators particularly, appeared to believe that being in monogamous marriages and safe sex practices protected them from contracting HIV/AIDS. They appeared to ignore non-sexual modes of transmission of HIV/AIDS when looking at personal risk. Learners appeared to take more cognizance of non-sexual modes of transmission of HIV/AIDS.

Universal precautions: The knowledge and application of universal precautions is one of the vital aspects of safer behaviours to prevent HIV-transmission. The findings in this regard were disturbing. The majority of respondents had not heard of the term "universal precautions" at all. In terms of the actual application of universal precautions, a large majority of respondents admitted that they did not know how and when to apply universal precautions. An overwhelming majority also denied having been informed about universal precautions at their school.

5.2.2.2 Problem statement 2

Is there a significant difference between the knowledge and attitudes of educators and learners?

Educators were found to have significantly better knowledge than learners of transmission modes of HIV/AIDS. However, although learners have less accurate knowledge about HIV/AIDS issues, their attitudes tend to be more positive than those of educators.

5.2.2.3 Problem statement 3

Is there a significant difference between the knowledge and attitudes between diverse ethnic groups?

Findings in the current study indicated that there was no significant difference between diverse ethnic groups regarding (a) their knowledge of transmission modes and (b) their attitudes towards HIV/AIDS issues.

5.2.2.4 Problem statement 4

Is there a significant difference between the knowledge and attitudes of males and females?

Findings indicated that females have significantly better knowledge of HIV/AIDS issues than males.

5.2.2.5 Problem statement 5

Is there a significant difference between the knowledge and attitudes between diverse age groups?

Groups of 31 years and older know significantly more about ways that HIV/AIDS can be transmitted than younger groups.

5.2.2.6 Problem statement 6

Is there a significant correlation between attitudes to and knowledge of HIV/AIDS for (a) learners and (b) educators?

There is a significant correlation between attitude to and knowledge of HIV/AIDS for learners and educators. However, the correlation was very low and negative.

5.2.2.7 Problem statement 7

Is there a significant relationship between occupation and knowledge of DoE's and schools' responses to HIV/AIDS?

Significant relationships between occupation of either learners or educators relating to DoE's and school policy on HIV/AIDS were found for the following items:

- I am aware of the DoE's stance regarding discrimination.
- I understand the term "statutory rape".
- The school's policy has helped me to adopt safer behaviours in respect of HIV/AIDS.
 - Class-based lessons are conducted at school.
 - My school has a Health Advisory Committee
 - Universal precautions may only be used with persons with HIV/AIDS.
 - My school has at least two first aid kits.
 - Gloves are available at sporting events.
 - It is illegal for an educator to have sexual intercourse with a learner.
 - I will report an educator who has sexual intercourse with a learner.
 - An educator may have sexual intercourse with a learner if the learner consents.

This means that educators and learners differed significantly in their responses to the above-mentioned items.

5.2.3 Conclusions from literature study and empirical investigation

The following conclusions can be made on the basis of the findings in the literature study and the empirical investigation:

a. Educators' and learners' knowledge of HIV/AIDS transmission modes

Both the existing literature (Paniagua, Boyle, Wagner, Ramirez, Holmes, Nieto and Smith, 1994:324; loveLife, 2001b:46), as well as findings in the current empirical investigation seem to indicate that knowledge of transmission modes of HIV/AIDS is high. This study found that educators' knowledge of HIV/AIDS transmission modes is higher than that of learners, indicating that educators have more accurate knowledge than learners. However, research into health behaviours has also shown that knowledge acquisition does not necessarily result in positive behaviour change

Existing research has also shown that many children extend their "germ theory" of colds and flu to HIV/AIDS, believing that the HIV virus can be spread through coughing and sneezing. Findings in the current study did not find such misconceptions, as an overwhelming majority of respondents knew that HIV/AIDS could not be contracted this way.

In terms of knowledge of non-transmission modes, existing literature indicates that such knowledge positively influenced attitudes towards the HIV-positive person (Maieron et. al, 1996:321; Kistner et. al, 1997:294). In the current study it was further found that learners appeared to focus more on non-sexual transmission modes, while educators tended to be more pre-occupied with sexual modes of transmission of the HIV virus.

b. Knowledge of HIV/AIDS-related policies

The findings in the literature study pointed to the fact that whilst many schools had HIV/AIDS-related policies in place, educators at those very schools were unaware of whether or not their schools actually had such policies (Warman, 1994:10; Grier and Hodges, 1998:260).

This finding was corroborated in the present study, which found that a number of respondents did not know whether their school did have a HIV/AIDS policy or not. The current study also found that only a minority indicated that their schools did have a HIV/AIDS policy. The majority also stated that they had not read their school's policy on HIV/AIDS.

The majority of the respondents in this investigation were aware that there was a national policy on HIV/AIDS from the DoE (South Africa, 1999) but they admitted that they have not read this policy.

One can therefore conclude from both existing research and current findings that official policies are in place, but knowledge and implementation is not effective. Both in South Africa and in other parts of the world there is evidence indicating that educators and learners are unsure of whether their schools have HIV/AIDS policies. They also admit to not having read the policies even when they were aware of such policies!

In terms of national policies on HIV/AIDS, South African educators and learners admitted that they knew of the existence of such policies, but had not made an attempt to read these policies from the DoE. This indicates that there is a need for the DoE to review the manner in which implementation of the national policy on HIV/AIDS is unfolding, as it does not appear to be very effective.

c. Issues relating to sexual relations between educators and learners

Studies in South Africa (George, 2001:11; Human Rights Watch, 2001:4; South Africa, 2002b:12) indicate widespread abuse of learners by educators and other learners.

It was interesting to note that the current study found that the majority of respondents were aware that it was illegal for an educator to have sexual relations with a learner. Most of the respondents stated that they understand the term statutory rape. The majority of them were also aware that even consensual sexual relations between educators and learners were illegal.

In the current study, respondents indicated that they would report an educator who engages in sexual relations with a learner. This is in contradiction with previous research findings where there was little evidence of such reporting. Instead there is greater evidence of collusion between authorities, school communities and perpetrators for various reasons. There was also a general reluctance to report abuse (George, 2001:11)

d. Attitudes to HIV/AIDS-related issues

The current study confirmed previous research findings that there appears to be an improvement in educators' attitudes as compared to previous studies.

However, whilst this was true, the present study also found that educators, in particular, still appear to harbour misconceptions about transmission modes of the virus, although on an irrational level. Educators appeared to adopt a moralistic, blaming attitude towards Persons with AIDS, by implying that promiscuous lifestyles, and unprotected sexual encounters were the only possible causes of the individual's HIV-positive status. This confirmed previous findings in this regard. In South Africa, in particular, prejudice, ostracization and discrimination still appear to be rife.

In contrast to the above moralistic attitudes with regards to how persons with AIDS contracted the HIV/AIDS disease, in terms of human rights issues, both previous and present findings

indicate that the majority of respondents displayed positive attitudes towards persons with AIDS. For example, most respondents in the current study and in other research disagreed that persons with AIDS should keep their HIV-positive status a secret. Attitudes of educators and learners regarding Persons with AIDS rights to education, employment and training were positive, with both educators and learners accepting that persons with AIDS have rights that are entrenched in the South African constitution. They also felt strongly about persons with AIDS being protected from discrimination. Respondents in the present study agreed that persons with AIDS should be allowed to train to be educators.

In comparing knowledge and attitudes, educators had higher levels of knowledge, but displayed more negative attitudes than learners, regarding how persons contracted the virus.

e. Risk behaviours

Third person perception and optimistic bias: Previous studies indicated that, although individuals were knowledgeable about transmission modes of HIV, they do not perceive themselves as being personally vulnerable or at risk.

Similar findings were noted in the present study. In terms of third person perception and optimistic bias only a small percentage of respondents in the current study felt personally at risk of contracting HIV/AIDS, thereby confirming previous findings with regards to this issue.

Educators particularly, appeared to believe that being in monogamous marriages and safe sex practices protected them from contracting HIV/AIDS. They appeared to ignore non-sexual modes of transmission of HIV/AIDS when looking at personal risk. Learners appeared to take more cognizance of non-sexual modes of transmission of HIV/AIDS.

Universal precautions: Previous research findings indicated that educators were knowledgeable about the HIV/AIDS scenario, but appeared to have difficulty contextualizing their knowledge on a personal level. Application of this knowledge was poor. For example, although they knew

about the universal precautions, they were confused about the correct instance to apply the universal precautions and under what circumstances and with which children.

The findings in the current investigation with regards to universal precautions were as disturbing as previous research findings. The majority of respondents had not heard of the term “universal precautions” at all. In terms of the actual application of universal precautions, a large majority of respondents admitted that they did not know how and when to apply universal precautions. Many respondents also denied having been informed about universal precautions at their school.

When comparing various groups in the present study, females, educators and individuals older than 31 years were found to have better knowledge about transmission modes than others.

5.3 RECOMMENDATIONS

The following recommendations are made on the basis of the findings:

5.3.1 Recommendations regarding HIV/AIDS responses

The following recommendations are made on the basis of the findings:

- The DoE in South Africa should conduct a national advocacy campaign focussing on the national policy on HIV/AIDS for educators and learners (South Africa, 1999). Every learner, educator and School Governing Body in South Africa should be made aware of the national policy (South Africa, 1999). This could be done through workshops, which involve all educators and learners, rather than by using the principle of cascading information by training one or two individuals per school. Clearly this may be a costly undertaking, but in the light of research findings it is imperative that educators and learners are educated about safer behaviours to protect them from the scourge of HIV/AIDS.

- Intersectoral collaboration is needed among the DoE, other state departments, CBOs and NGOs to educate learners, educators and communities in every home, school and institution about the universal precautions to be adhered to in respect of HIV/AIDS.
- There needs to be greater focus on non-sexual modes of transmission of HIV/AIDS, particularly because there appears to be a widespread understanding of sexual modes of transmission of the HIV virus.
- The national education ministry's stance on the issue of sexual relations between educators and learners being taboo and illegal (South Africa, 2000:12) needs to be widely publicised in the media and via circulars to schools. This would send out a clear message that such behaviour would not be tolerated under any circumstances. Educators, in particular need to be addressed at school sites, through educator unions, the South African Council for Educators (SACE) and the media on the legal implications of such misconduct.
- The provincial and national education department should make it mandatory that a Health Advisory Committee is put in place at every school. This can be communicated to the School Governing Bodies (SGBs).
- A nationwide "audit" needs to be conducted by the DoE in order to identify which schools do not have a HIV/AIDS policy in place. Schools that do not have such a policy in place must be given a timeframe within which to comply with the guidelines laid down in the national policy on HIV/AIDS (South Africa, 1999)

5.3.2 Recommendations for future research

- A qualitative research approach could be used for a more in-depth understanding of the issues related to the impact and responses to the HIV/AIDS pandemic.
- The present study could be replicated in other provinces and other parts of the country to verify findings.

- A study focussing on different ethnic groups' responses to HIV/AIDS could be undertaken, as the present study did not have sufficient representation from certain ethnic groups in spite of selecting schools that formerly had enrolments from a particular ethnic group.

5.4 LIMITATIONS OF THE STUDY

The following limitations were identified:

- The research design: A quantitative research design was used and a structured questionnaire was administered. There was also a section that comprised open questions. However, in spite of the open questions, the quantitative leaning of the research design restricted the nature of the responses.
- Sample: A relatively small sample in a selected area was used in the investigation, and this has implications in terms of the generalisability of the results.
- Second language learners, in general may have experienced problems understanding the questionnaire, which was in English. It was also difficult to assess whether respondents interpreted the items correctly. This may have affected reliability.
- The degree of honesty from the respondents is also difficult to assess. This is one of the disadvantages of using questionnaires.

Some of the limitations offer scope for further research and have been referred to in the recommendations detailed above.

5.5 SUMMARY

The principal aim of this study was to provide an answer to the problem identified in Chapter One, namely: “The efficacy of the DoE’s response to HIV/AIDS in changing educators’ and learners’ risk behaviours”.

The investigation found that while the DoE had official responses in the form of policies in respect of HIV/AIDS in place since 1999, it had not succeeded in effectively communicating its policies on HIV/AIDS to educators and learners. As a result, educators and learners were unaware of the importance of knowing about the universal precautions related to HIV/AIDS and safer behaviour practices. Such knowledge would have resulted in both educators and learners engaging in safer behaviours. It was also found that the issue of sexual relations between educators and girl learners in particular requires urgent attention, as it is further exacerbating the spread of HIV/AIDS.

The research findings appear to indicate that the DoE was not effective in its response to HIV/AIDS in changing educators’ and learners’ risk behaviours.

The words of Kayum Ahmed are a reminder that HIV/AIDS will touch us all:

It (AIDS) is a ...disease that presents us with a unique opportunity. It allows us to break out of the prisons that we create in our minds...It presents us with an opportunity for change...A change in mindset can only take place through an effective system of education...It requires developing a theology of compassion...It is a process that results in breaking down barriers between people – between individuals from different cultural and religious backgrounds, between black and white, between those who are HIV-positive and those who are not. It is a process that ultimately leads one to realize that we are of them, and they are of us (Educator’s Voice, 2000:5).

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