

**AN INVESTIGATION INTO THE LEVEL OF HIV AND AIDS
AWARENESS AMONG LEARNERS IN THE RURAL SCHOOLS
OF MAKHUDUTHAMAGA MUNICIPALITY IN LIMPOPO**

MASHOMANYE KENNETH MASEMOLA

Assignment presented in partial fulfilment of the requirements for the degree Master
of Philosophy (HIV and AIDS Management) at Stellenbosch University



Study leader: Mr Gary Eva

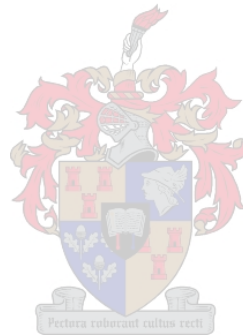
December 2005

DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature:

Date:



ACKNOWLEDGEMENTS

I would like to express my gratitude and appreciation to the following people for their assistance and support:

My supervisor, Mr. Gary Eva for his guidance and support towards the completion of this study;

My colleague, Dr J Raputsoe for his support and guidance in drafting this report;

My mentor on HIV and AIDS training, Dr Mike Wannenburg for his assistance and guidance in arranging the design of this report;

The Limpopo Department of Education for granting me permission to conduct research on HIV and AIDS at schools in the Nebo Circuit;

Mr PR Matlala, area manager of the Nebo Circuit, for coordinating the distribution of the questionnaires to senior secondary schools;

All the principals and learners who voluntarily participated in the completion of the questionnaires;

My beloved wife, Cynthia, my son Tebogo and my daughter Lebogang for their perseverance and support during the course of this study;

My late parents for their love and support.

SUMMARY

The purpose of this research was –

to investigate whether HIV/AIDS awareness campaigns have brought any change to the behaviour of learners in the rural schools of Makhuduthamaga Municipality in Limpopo, who could become a health risk to the prevalence thereof, and make them aware of the implications of the epidemic;

to establish how far these schools have implemented lifeskills education and HIV/AIDS programmes to learners; and

to investigate whether or not the programme has achieved any sustained behavioural change among learners, and increased their level of awareness of HIV/AIDS to tackle barriers to healthier behaviour.

This study comprises a literature study on HIV/AIDS regarding the definition of terms, what AIDS and HIV are, the origin and manner of transmission of the virus, education programmes on HIV/AIDS, and the challenges facing the implementation of HIV/AIDS education programmes. The main data was collected through the distribution of questionnaires to Grade 12 learners of schools from the Nebo circuit in the southern region of Limpopo; and also from officials in the field. The results of the study indicate that most learners are aware of the HIV/AIDS epidemic. Their knowledge, on the whole, with regard to condom use, prevention, the manner of infection, discrimination, and their rights to education was outstanding. Nevertheless there were a few learners who performed unsatisfactorily to some of the questions, namely the question on infection through breastfeeding, the spread of the virus through sneezing and coughing, the cure of the virus by traditional healers and the importance of counselling and testing. Significantly, the study findings indicate that the majority of learners have knowledge of the HIV/AIDS pandemic, therefore the initial hypothesis that the level of knowledge and awareness of HIV/AIDS among learners in the rural schools of the Makhuduthamaga Municipality in Limpopo was not supported.

OPSOMMING

Die doel van die navorsing was –

om vas te stel of MIV/VIGS-bewusmakingsveldtogte enige verandering teweegbring het in die gedrag van leerders van landelike skole in die gebied van die Makhuduthamaga Munisipaliteit in Limpopo, sodat leerders bewus is van die gesondheidsrisiko's en voorkomssyfer van die epidemie asook die implikasies van die epidemie; en

om vas te stel of die program enige volgehoue gedragsverandering by die leerders veroorsaak het en hoe dit hulle bewustheidsvlakke van MIV/VIGS verhoog het, om hulle te help om die hindernisse tot gesonde gedrag te oorkom.

Hierdie studie bevat 'n literatuur studie met betrekking tot die definisie van terme, wat MIV en VIGS is, die oorsprong van die virus en hoe die virus versprei word en ook opvoedingsprogramme oor MIV/VIGS en die uitdagings van die implimentering van die MIV/VIGS-programme. Die navorsingsprojek het sy hoof inligting verkry deur vraelyste te versprei onder Graad 12-leerders van skole van die Nebo-kring in die suidelike deel van Limpopo, en ook onderhoude met beamptes in die veld. Die uitslag van die studie wys dat die meeste leerders bewus is van die MIV/VIGS-epidemie. Hul kennis, meestal, met betrekking tot kondoomgebruik, maniere waarop besmetting plaasvind, diskriminasie en hulle reg tot opvoeding was uitstekend. Daar was egter enkele leerders wat sommige vrae onbevredigend beantwoord het, naamlik besmetting deur borsvoeding, die verspreiding van die virus deur hoes en nies, die genesing van die virus deur tradisionele genesers, en die belangrikheid van voorligting en toetsing. Dit was opmerklik dat die resultate van die studie bewys het dat die meerderheid leerders kennis dra van MIV/VIGS. Die navorsing het dus bewys dat die veronderstelling dat leerders in die landelike skole van Makhuduthamaga Munisipaliteit in Limpopo nie kennis dra van MIV/VIGS of bewus is daarvan nie, nie ondersteun kan word nie.

TABLE OF CONTENTS

	Page
1. Introduction	1
2. Literature study	6
3. HIV/AIDS Policy	12
4. Research Methodology	20
5. Research Findings	23
6. Data Analysis	29
7. Conclusion	31
8. References	33
9. Appendices	
Appendix 1: Definition of Terms	
Appendix 2: Questionnaire	
Appendix 3: Permission to visit schools in the Nebo area for research	



1. INTRODUCTION

Since the development of a global response to the HIV/AIDS pandemic had begun more than a decade ago, remarkable strides have been made towards understanding the nature, scope and impact of HIV/AIDS on individuals, communities and societies around the world.

HIV infection and AIDS is everyone's problem. No one is immune. Although the risks may vary, it is probably true to say that everyone is exposed to some degree of risk, some more than others (World Health Organization, 2002:82).

HIV/AIDS is a serious social development concern, pushing people in many countries deeper into poverty as households lose their breadwinners, livelihoods are compromised and savings are consumed by the costs of healthcare. HIV/AIDS is adding to the strain on national institutions and resources. Social systems that enable people to cope with adversity are being damaged. In the most severely affected settings there is mounting evidence that HIV/AIDS is eroding human security and capacity, undermining economic development and threatening social cohesion.

It is evident that AIDS is the major health threat of this century, an unprecedented public health problem facing the entire world and a disease that will have an impact on all sectors of society and all aspects of human activity. The spread of the disease in each world region depends on a combination of regionally unique, cultural, socio-economic and environmental factors. Factors that contribute or influence the spread of HIV/AIDS are sexual behaviour, intravenous drug abuse, alcohol abuse, urbanization, the immigration labour system, mobility, unemployment, poverty, living standards, poor health conditions, sexually transmitted diseases, blood transfusions and political unrest (Haldenwang, 1993:vi).

HIV/AIDS is a new epidemic and its origins have not been positively identified. A few of the important historical and scientific landmarks are not only the progress of the epidemic but also the progress in understanding the disease as well as the development of treatments for those who are affected.

AIDS presents a new and unique type of challenge to health and social welfare services. Few diseases have evolved on such a broad geographical front, such as the combination of physical and psychological stress that has associated itself in all societies with HIV infection and AIDS. No disease has been highlighted to the extent that AIDS has been, and the close symbiosis between the individual and the community dictates a need for each member to protect and support the other (World Health Organization, 2002:77).

HIV affects the body by attacking the immune system. The immune system is the body's defence mechanism against infection by micro-organisms that cause the disease. Among the cells that make up the immune system there is one called a CD4 lymphocyte, that enters infected areas and eventually destroys the cell. With time this leads to a progressive and finally a profound impairment of the immune system resulting in the infected person becoming susceptible to infections and diseases such as cancer.

1.1 Problem statement

The lack of HIV/AIDS awareness among learners in the rural schools of Makhuduthamaga Municipality in Limpopo can pose a great problem to communities and schools in that area. It is therefore a great challenge to the municipality and the government to provide enough learning materials on HIV/AIDS to learners and capacity to educate learners about the pandemic by means of workshops, campaigns, competitions and seminars for educators. The following problem statements should be answered:

- Do learners in rural schools lack awareness about the HIV/AIDS pandemic?
- How can the research findings with regard to the HIV/AIDS pandemic assist learners in taking precautionary measures during their early sexual relations?

1.2 Aims of the study

The aim of the study is to investigate the level of awareness of the HIV/AIDS epidemic among learners in the rural schools of Makhuduthamaga Municipality

communities. The investigation will reveal the level of the knowledge, attitude and perceptions of learners and will determine to what extent the levels of HIV/AIDS awareness through the implementation of life skills and HIV/AIDS education programmes have managed to assist learners to have knowledge and an understanding of HIV/AIDS, the way in which a person becomes infected, and the prevention thereof. Additionally, to establish how learners express their attitude towards other learners living with HIV/AIDS, and to assess how the knowledge and attitude of learners about safer sex practices, condom use, behaviour and perception change, prevention and health care skills.

1.3 Research hypothesis

An Hypothesis is a suggested explanation for a group of facts or phenomena either accepted as a basis for further verification or accepted as likely to be true (Sinclair,1994:767), or a tentative intelligent guess posed for purpose of directing one's thinking towards the solution of the problem (Leedy, 1997:60). According to Kumar (1999:64), a hypothesis primarily arises from a "hunch" or an idea that is then tested through a study. The importance of a hypothesis thus lies in the ability to bring focus and direction to the study. In the context of this study, a hypothesis will be understood as a statement that is still to be researched, verified confirmed, or falsified. The hypothesis of this research was that the level of awareness of the HIV/AIDS pandemic among learners in rural schools of Makhuduthamaga Municipality in Limpopo is low.

By means of data gathered from the completion of a questionnaire by learners in rural schools of Makhuduthamaga Municipality in Limpopo, it would be ascertained whether the hypothesis could be supported or not.

1.4 Research Methodology

The methodology of this study comprised a literature review, interviews of officials in the field, and most importantly, the administering of questionnaires.

The aim of the Literature review, "...a systematic circumspect search to trace all published information about a specific subject in whatever terms it exists and to collect useful researches" (see Gabbers 1996:305 in Ogina 2003:9), was to find out what was available on the HIV/AIDS pandemic, particularly regarding awareness issues.

It is crucial to study the results of previous research done by others on the topic (see Wallen & Frankel, 200:48 in.. 2003:9), to learn from other scholars how they theorized and conceptualized HIV/AIDS issues, what they have found empirically, and what instrumentation they used and to what affect.

Scrutinizing existing definitions, different theories, models and hypotheses in the field of research is important. The main purpose is to avoid duplication, and to discover what is the most recent and considered to be the most authoritative theorizing about HIV/AIDS.

Gaps in knowledge as well as weakness in previous studies must be identified. In other words, to determine what has already been done and what is yet to be studied or improved, and to note the advantages and disadvantages of research methods used by others. The researcher must also identify variables that have to be considered in the research as well as those that prove irrelevant. Definitions used in previous works must be utilized. Lastly the available instrumentation that is valid and reliable must be identified (Mouton:2001).

More detail of the methodology of this study is outlined in Section 4.

1.5 The area of study

The area of study is directed at learners attending schools in the Makhuduthamaga Municipality in Limpopo. The Municipality comprises a total population of 263 000 citizens from various tribal areas under 36 traditional leaders. The Municipality has three provincial hospitals, one magistrate's office, one police station, three subpolice stations, eighty high schools and several primary schools. Most of the literate citizens are teachers, nurses, police personnel and administrative personnel who are employed

in various provincial offices. Resources such as television, radios and newspapers, to provide information about issues on the HIV/AIDS epidemic, are found in few homes.

The study focussed on Grade 12 high school learners of both genders whose ages ranged between 15 and 20 years, and who were provided with questionnaires to complete anonymously for the investigation. The completion of the questionnaire was done by twenty learners (i.e. ten females and ten males, from each school) to serve as a sample for each school. The distribution was done in such a manner so as to save time, travelling and financial costs of printed study materials and to facilitate control over the questionnaires. Participation by learners was voluntary.



2. LITERATURE STUDY

The literature study commenced with an examination of the definition of terms (see Appendix 1).

As will become apparent, below, there is, to my knowledge, practically no literature on specific research of the effectiveness of awareness programmes in high schools – and this is clearly so regarding rural South African schools.

However, I decided to include some information from the literature that some readers may consider obvious, but that has a bearing on the research questions.

2.1 What is AIDS?

AIDS is a condition caused by a virus known as the human immune deficiency virus (HIV) which impairs the immune system (Larson, 1990:5). It is called an acquired deficiency syndrome disease because it is not caused by a genetic defect. The virus attacks the body's immune system, leaving it prey to a host of opportunistic diseases. It was originally called a syndrome because its victims suffered but without any known cause for the illness (Kaus & Reed, 1987).

2.2 The Human Immune Deficiency Virus

The HI virus is a retrovirus related to the human T-Cell leukaemia virus and to retroviruses that infect animals (Kaplan & Sadock, 1998). It is a virus belonging to the family of retroviruses (socialized because they reverse the usual biological process and cause infected cells to translate the viral genetic material, RNA into another form, DNA) (Whiteside & FitzSimmons, 1992:3).

The retrovirus attacks white blood cells in the body, gradually breaking down the immune system that fights infection. HIV is the hypothesized cause of AIDS (Rogers, 1989). After entering the human host, HIV specifically attacks a particular white blood cell called T4-Lymphocytes that play a crucial role in the coordination of the

immune response (Palloni & Glickshch 1991:21; in Haldenwang, 1993). Once the HIV has established itself within a T-Lymphocyte, the virus is capable of altering the normal functioning of the cell, and induces T-Lymphocyte to reduce more human immune deficiency virus at the expense of antibody production (Whiteside, 1990a; Whiteside & FitzSimmons, 1992).

The body mounts a defence against the invading virus by producing antibodies, but in the long run and for reasons not yet understood, the response is ineffective. The target cells, particularly the T4-hymphocytes, are functionally impaired or destroyed and the body's defences are progressively disabled. The outcome is an increased vulnerability to a variety of opportunistic infections caused by certain viruses, bacteria, fungi or parasites that would not normally cause disease in healthy persons (see Arendse, 1991:219; Palloni & Glicklich, 1991:21; in Haldenwang, 1993:3).

2.3 The origins of AIDS

In 1981, in San Francisco, a number of reports of death from immune system failure among "gay" men and drug addicts in particular, began to cause alarm in medical circles (Harpur, 1994 & Rogers, 1989). Dr Luc Montagnier and Dr Roberto Gallo, the scientists who first established the cause of AIDS (Rogers, 1989) researched the incidence that they were analyzing the same virus, namely human immune deficiency virus (HIV) (Harpur, 1994).

The exact date that AIDS emerged as a killer is hard to establish. However, by June 1981, the medical profession was alerted by numerous reports of incidences where immune system failure was occurring (Harpur 1994, Rogers, 1989). Such recognition occurred more or less at the same time in several areas of the world – the USA, Haiti, Europe and Africa (Rogers, 1989). During 1981 the centres for disease control in America reported a growing number of patients with rare conditions of Pneumocystic Carini Pneumonia (PCP) and the cancer Kaposi's sarcoma. This was the first recognition of the spread of AIDS (Rogers, 1989) (Buhr, 2001:1).

In May 1983, Dr Luc Montagnier and his research team in France disclosed their discovery of the virus LAV/HTLV-111, which was linked to AIDS (Harpur, 1994).

In April Robert Gallo and his researchers at the United States National Cancer Institute indicated that they had isolated the AIDS virus (Harpur, 1994). In the same year reports were received that HIV and AIDS cases had been diagnosed in the Far East, indicating that the AIDS problem was one of global, pandemic proportions (Harpur, 1994). By 1992 Montagnier and Gallo, the two foremost AIDS researchers in the world, were convinced that they were analyzing the same virus, namely HIV) (Buhr, 2001:1).

2.4 AIDS in South Africa

South Africa was one of the last countries in Africa to be affected by the epidemic. By the end of 1989, a number of surveillance studies had been presented, and confirmed the entry of HIV infection into the heterosexual population in South Africa. While visits from homosexual patients to HIV clinics reached a plateau in 1989, visits from heterosexual patients started to increase. Although prevalence of HIV was still low in the general population, probably below 0,5%, an alarming increase in the number of AIDS cases in particular risk categories was predicted. HIV data suggested a spread of infection that was far more extensive than the still low number of reported AIDS cases. Of an estimated total of 122 951 HIV infected individuals in South Africa in 1991, 69% were from urban populations, 20% from rural populations – of which 7% from homosexual men. Data from the National HIV Surveillance Programme showed an increase in the point prevalence of HIV among antenatal clinic attendees from 0,76% in 1990 to 7,6% in 1994, but with wide geographical variants (SA Journal of Science, June.2000-Vol.96.No.6. p274-275).

In 1990 the first antenatal surveys to test for HIV were carried out, and 0,8% of women were found to be HIV positive. It was estimated that there were between 74 000 and 120 000 people in South Africa then living with HIV. Since this time antenatal surveys have been carried out annually. In 1991 the prevalence rate was 1,4% based on antenatal testing and in 2003 data showed that the HIV prevalence rate among pregnant women was 27,9% (Science in Africa, 2003).

In 1992, the first cases of HIV were diagnosed in South Africa and for the first few years of the epidemic, cases were mainly among white homosexual men. Following

the same trends seen in other countries, as the number of cases increased, the virus began spreading to other demographic groups.

By the beginning of 2003, using survey data, researchers estimated that about 5 million people infected with HIV. This figure is expected to rise even further. Experts calculate that on average 1 500 people may be infected each day in South Africa. South Africa is one of the countries where the epidemic is spreading most rapidly. Swaziland, Botswana, Lesotho, Zimbabwe and Zambia also have a very high prevalence (Evian, 2003: 20).

2.5 How is the virus transmitted?

HIV is a fragile virus which cannot pass through intact skin. Infection can only occur if infected body fluids or blood enter the body (Arendse, 1991:219, Larson, 1990:6). The virus is transmitted mainly in three ways. Most commonly it is passed from person to person through sexual contact in either homosexual or heterosexual relationships. It can also be transmitted via blood during transfusion, by sharing contaminated needles or the accidental injuries sustained from needles pricking health care workers. HIV infection is increasingly passed from mother to infant before or during birth (B.B. Haldenwang, 1993:4). When HIV enters the body, it looks for CD4 cells. When it finds a CD4 cell, it attaches itself to the cell and enters it. Once inside, HIV finds the DNA in the cell nucleus. HIV makes a copy of itself from DNA building materials in the cell. This copy then hides itself in the DNA of the CD cell. Under a microscope, the cell's DNA appears normal, even though it is now mixed with HIV DNA. Once safely hidden in the cell's DNA, HIV can do one of two things – it can stay quietly in the cells, or it can turn on the cell's DNA and use the cells' machinery to make copies of itself. To make copies it uses a protein called reverse transcriptase. If it begins to reproduce, it can make thousands of new HIV. These new viruses leave the cell and enter other C4 cells and the same thing happens again. When the HIV DNA lies inside the cell's DNA, there is no way for the body to get rid of it. HIV hides so well that the body does not even know it is there (Granich & Mermin, 1999:9).

HIV infection is sexually transmitted primarily through unprotected vaginal or anal intercourse (i.e. sexual intercourse without a condom) and (possibly) through oral sexual contact under certain conditions. HIV is transmitted when the virus enters a person's bloodstream via the body fluids of an infected individual. In order to gain entry into the body, the HIV virus needs to connect to CD4 receptors, which are found on various types of cells such as macrophages and CD4 cells. Because many of the cells in the linings of the genital and anal tract have just such receptors, HIV can easily gain entrance into these cells (Evian, 2000).

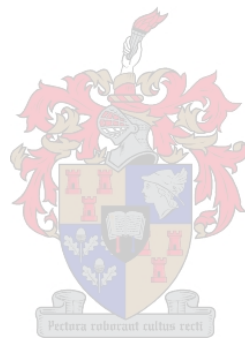
2.6 The Symptoms of HIV infections

The symptoms are much like the symptoms of the flu: sore throat, fever, headache, stomach pain, diarrhoea and listlessness. After a week a rash may appear on the chest, face and neck. People may also suffer from night sweats, muscle and joint pains, swelling in their lymph nodes, nausea and vomiting (Granich & Mermin, 1999: 14-15).

Major symptoms and opportunistic diseases begin to appear as the immune system continues to become very low while the viral load becomes very high. The following symptoms are usually an indication of advanced immune deficiency:

- Persistent and recurrent oral and vaginal Candida infections (or thrush): Candida or thrush in the mouth is a common sign of immune deficiency and it does not usually occur unless the CD4 cell count is decreased-usually to <350 cells/mm³)
- Recurrent herpes infections such as herpes simplex (cold sores)
- Recurrent herpes zoster (or shingles)
- Bacterial skin infections and skin rashes
- Intermittent or constant unexplained fever that lasts for more than a month
- Night sweats
- Persistent and intractable chronic diarrhoea that lasts for more than a month
- Significant and unexplained weight loss (more than 10% of the usual body weight)

- Generalized lymphadenoma (or in some cases, the shrinking of previously enlarged lymph nodes).
- Abdominal discomfort, headaches
- Oral hairy leucoplakia (thickened white patches on the side of the tongue)
- Persistent cough and reactivation of tuberculosis
- Opportunistic diseases of various kinds
- The person in the major symptomatic phase of HIV infection is usually bedridden for up to 50% of the day during the last month (Van Dyk, 1999:39).



3. HIV/AIDS POLICY

3.1 HIV/AIDS education

Education and information are fundamental human rights, and children and young people may not be denied the basic information, education and skills that they need to protect themselves against HIV/AIDS. We may not allow religious values, social morals or cultural preferences to prevent children and young people from being empowered with the education and skills that they need to reduce high-risk behaviour.

According to Van Dyk (2001), HIV/AIDS education should comply with the following requirements and standards if it is to be successful in schools:

- HIV/AIDS education should never be presented in isolation – that is to say, in a special “AIDS period”. If HIV/AIDS education is presented in isolation, children may acquire an irrational fear of the disease. Such a distorted emphasis may interfere with the child’s healthy sexual development because the child may become accustomed to equating sex with disease and death.
- HIV/AIDS education should preferably form part of a lifeskills education programme which includes sexuality education as well as information on HIV/AIDS.
- HIV/AIDS information can also be integrated into the existing school curriculum, either as part of other health-related subjects, or within one or more subject areas such as biology, science, social science, mathematics and religious studies.
- HIV/AIDS education should begin as early as the junior primary school phase (or grade 1). At this early age, the child’s behaviour patterns have not yet been established and they are very receptive to the principles that govern healthy behaviour.

- HIV/AIDS education should be an ongoing process. A single lecture or video or an HIV/AIDS information week in the senior phase is not sufficient because it is necessary to begin instilling the lifeskills one needs to prevent HIV infection at a young age (these lessons should be continuously reinforced as the child gets older).
- It is important to include parents, community leaders and spiritual leaders so that they make an active contribution (input) to all stages of programme development. If HIV/AIDS programmes are to be successful, they have to have the active support of all stakeholders in the community, and they also need to reflect the whole spectrum of religious, cultural and moral values found in any particular community.
- The educator should feel at ease with the content of the HIV/AIDS curriculum and should be a role model with whom learners can easily identify.
- Information about HIV/AIDS should never be presented in a way that frightens children. Research has shown that anxiety-oriented approaches in HIV/AIDS education are counterproductive because the individual's anxiety levels escalate to a point where they are inclined to evade or deny the truth of the information.
- HIV/AIDS education that focuses on problems while ignoring sexuality as a normal aspect of all human life may very well retard the normal sexual development of the child. The positive and delightful aspects of sexual activity should never be ignored. Children must be made aware that sexual feelings and impulses which are present from birth are both pleasant and normal. They must also nevertheless be helped to understand that, although sexual feelings are normal, the active expression of sexuality is not appropriate behaviour for young children.
- Sexuality and HIV/AIDS education should always be tailored so that it is appropriate to a child or young person's particular developmental stage. It is therefore important for us to have a clear idea of the degree of cognitive, emotional, social, moral and sexual development in children in specific age

groups so that the sexual education we offer to children will be exactly appropriate and suited to the developmental stage through which they are passing. Teachers should (in addition) always remain sensitive to individual and cultural developmental needs and differences and adjust their education programmes accordingly.

- HIV/AIDS education should never concentrate on the dissemination of information on HIV and AIDS alone. A child can only make responsible decisions if he or she has the necessary skills and knowledge to implement these decisions. For an HIV/AIDS education programme to be successful there should be a balance between knowledge, lifeskills, values and attitudes.
- Basic knowledge, attitudes, values and skills (which are not exclusively HIV/AIDS related) should be established, promoted and reinforced in all the phases of a child's primary and secondary school career. The content and the way in which this knowledge and these attitudes and skills are taught, should be adapted to the child's age and developmental phase (Van Dyk, 2001: 154-156).

3.2 Education on HIV/AIDS Programmes



The National Education Policy Act, 1996 (No. 27 of 1996) (Republic of South Africa, 1996) paragraph 3 states that:

Because the ministry of Education acknowledges that the seriousness of the HIV/AIDS epidemic and international and local evidence suggested that there is a great deal that can be done to influence the course of the epidemic, the ministry is committed to minimize the social, economic and developmental consequences of HIV/AIDS to the education system of all learners, students and educators, and educators and provide leadership to implement and HIV/AIDS policy.

The Act also states in section 9 that:

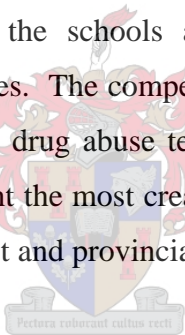
- I. A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members.
- II. Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students and should be integrated in the lifeskills education programme for pre-primary, primary and secondary school learners.
- III. Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.
- IV. Parents of learners and students must be informed about all lifeskills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality educators and imparters of values at home.
- V. If learners, students or educators are infected with HIV, they should be informed that they can still lead normal, healthy lives for many years by taking care of their health.

3.3 Implementation of the national policy on HIV/AIDS

According to the National Education Policy Act.1996 (Act No.27 of 1996 section 14(1)), (Republic of South Africa, 1996) every education department must designate an HIV/AIDS programme manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the department's HIV/AIDS programme, to advise management regarding programme implementation and progress and to create a supportive and non-discriminatory environment.

In the Nebo circuit area, the HIV/AIDS coordinator is appointed to be responsible for the implementation of the programme. At schools' level, educators are identified to teach lifeskills lessons. These educators are sent for training on HIV/AIDS for a period of three working days, and on completion of the training these educators are provided with learning materials to be used and to support learners at schools level. The coordinators' role is to visit the educators at school for monitoring and providing guidance and support. No workshops or counselling are done by the trained educators.

The provision of information and education of the programme to learners is done through lifeskills lessons. At the moment learners in Grades 1 to 7 have been taught these lessons in lifeskills orientation lessons. For learners in higher grades the programme will be rolled over for the following year. Where an awareness campaign is to be conducted, the schools are engaged in some competition pertaining to lifeskills programmes. The competitions can be in the form of drama, lifeskills awareness, child abuse, drug abuse teenage pregnancy or peer education knowledge. Learners who present the most creative performance are given awards. These competitions start at district and provincial levels.



3.4 The challenges facing the implementation of HIV/AIDS education programmes

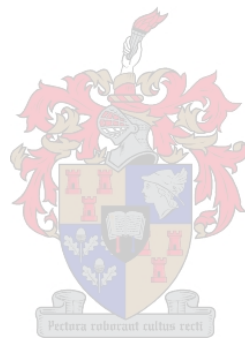
As policy often differs from what actually occurs on the ground, I felt it important to interview full-time officials involved in the field. Also, knowledge of their aims would be important in evaluating what is happening in the schools. I thus interviewed regional program manager (in Lebowakgomo), a coordinator (in Polokwane), and an HIV/AIDS life skills coordinator, about the challenges they face. They responded as follows:

- 3.4.1 Teaching the programme in English at lower grade, especially to Grade 1 learners could pose a problem in the sense that these learners have not yet mastered the medium of instruction for the terms of the programme.

- 3.4.2 The learners cannot hold discussions with the educator about the programme but will revert to listening. At some stage the educator has to provide an easy environment to discuss sensitive issues of the programme in the language of the learner.
- 3.4.3 Most of the teaching materials are not available in the languages of the learners. The educator has to translate the material before making the presentation.
- 3.4.4 More time is needed by the educator to explain some of the meanings of the words to ensure full understanding. This delays the educator in managing his/her daily teaching programme.
- 3.4.5 The educator may be requested to complete the programme content when presenting an HIV/AIDS education programme.
- 3.4.6 Educators find it difficult to demonstrate the use of condoms to learners as this may be an unwelcome intrusion, especially in the African tradition. Some religious bodies associate condom use with promiscuity and immorality. The demonstration of condom use by a female educator to male learners or learners as a whole may be an embarrassment when having to show the real process of how it should be used during sexual practice. Therefore young educators may oppose the teaching of condom use owing to either personal or moral disapproval or embarrassment and the inability to maintain control in the classroom. This may also lead to a situation where learners might give the educators all kinds of nicknames.
- 3.4.7 Not all educators may have the skills to teach or present the programme to all learners in the same way. The learners' ages may need different approaches to enable them to understand the programme content and concept.

- 3.4.8 The teaching of the programme increases the curriculum of the learners and the educator has to carry more workload to complete the teaching syllabus for the learners.
- 3.4.9 The materials provided may have quantitative value or be in a quantitative amount that requires the educators to spend more time to match the curriculum.
- 3.4.10 The educator may be expected to prepare the lesson with the teaching aids of the programme together with other lessons which she/he is teaching different to learners. This will increase the volume of workload and the carrying of more books to impart the lessons.
- 3.4.11 At times the teaching of the programme may not match the environment of the lessons and the educators would be expected to adjust the lesson.
- 3.4.12 The educators teaching the programme do not always receive the participation of supervisors to make the programme more effective and interesting. At some stage the educators are understaffed to carry out other lessons to the learners. Thus an educator who is doing the programme finds it very tedious to finish the lessons.
- 3.4.13 In some schools there is no follow-up from the coordinators to guide or assist the educators, especially where the schools are too far away to be reached by the coordinator either owing to transport problems or other work schedules. The educator becomes too frustrated to dedicate her time to and follow-up on the programme.
- 3.4.14 The lessons provided for this programme are not meant for examination purposes and may discourage educators to dedicate more effort to teaching the subject.
- 3.4.15 In many instances the HIV/AIDS education programme is an addition to the standard curriculum, and the educator's distraction may lead to a disruption

of the presentation of HIV/AIDS education programmes as a result of transfers, resignation, illness and mortality of educators.



4. RESEARCH METHODOLOGY

Section 4 relates to the quantitative phase of the study. The qualitative interviews that preceded this phase are briefly outlined in section 3.4, above.

4.1 Research design

The aim of the study was to investigate the lack of awareness of the HIV/AIDS pandemic among learners in the rural schools of the Makhuduthamaga Municipality communities, what knowledge they had about HIV/AIDS, the methods of prevention to avoid infection, and their attitude and perception regarding the HIV/AIDS epidemic. Another aim was to find out whether they knew their human rights as learners regarding their right to education and whether they knew how to react towards any unfair discrimination regarding their right to study. The study was done using data (e.g. Momentum research, 2000). obtained from a questionnaire that was distributed for completion to learners in Grade 12.

According to Neuman (1997) a questionnaire is an instrument used to measure variables. Welman and Kruger (1999) are of the opinion that quality questionnaire design determines the quality of responses. The questionnaire used for this study focused on the key dimension of this study as stated in the objectives.

The researcher was aware of the advantages and disadvantages of the questionnaire, but because the type of data to be collected involved a personal profile of each respondent which may not be disclosed through interview study to anybody owing to ethical morals, the questionnaire was preferred, e.g. it would have been embarrassing for a male interviewer to ask a nineteen-year-old female interviewee about her sexual practices. This might also pose some moral controversy to other interested parties. The questionnaire was chosen because it enabled respondents to answer some of the personal questions independently and under full anonymity.

Since the purpose of the study was to investigate the lack of HIV/AIDS awareness among learners, the questionnaire was used to achieve the objectives of the study.

Though questionnaires may lack truthfulness, accuracy and reliability, the researcher preferred it as opposed to the interview method.

Questionnaire design determines the quality of responses. The questionnaire used for this study focused on the key dimension of this study as stated in the objectives.

The questionnaire comprised questions that required “Yes” or “No” answers, and respondents were required to select an answer. It covered four areas of the investigation, viz:

- (a) Condom issues
- (b) Prevention and awareness
- (c) The manner of infection and
- (d) Discrimination and learners’ rights

Advantages of questionnaires

- The responses are gathered in a standardized way.
- The questionnaires are more objective than interviews.
- It is relatively quick to collect information using a questionnaire.
- Information can be collected from a large sample.

Disadvantages of questionnaires

- Questionnaires occur after the event, so participants may forget the important issues.
- Questionnaires are standardized, so it is not possible to explain any points in the question that participants may misinterpret.
- Open-ended questions can generate large amounts of data that can take a long time to process and analyse.
- Respondents may answer superficially if the questionnaire takes too long to complete.

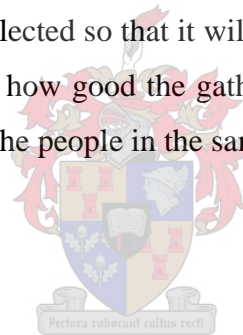
The questionnaire is attached as Appendix 2.

4.2 Sampling

Sampling is a technical accounting device to rationalize the collection of information to choose an appropriate way from which the actual information will be drawn. A sampling theory is in fact the study of the relationship between a population and the samples drawn from it. A sample is the subset of the whole population which is actually investigated by a researcher and whose characteristics will be generated to the entire population (Bless & Higson-Smith: 2000: 83-84).

Leedy (1993:206) points out that “... survey sampling is the process of choosing from a much larger population, a group about which a researcher wishes to make generalized statements so that the selected part will represent the total group. Such a sample must be very carefully selected so that it will faithfully represent the particular group being studied. No matter how good the gathering of data is from such group, the survey cannot be accurate if the people in the sample are improperly selected.”

4.3 Data Collection



Data was collected by means of questionnaires that posed structured questions (Fink, 1995:43). According to Tuckman (1978:196) questionnaires are used by researchers to convert the information directly given by people into data. By providing access to what is inside somebody’s mind, this approach makes it possible to measure what this person knows, likes and dislikes and what she/he thinks. In this study the questionnaires were used as a means of data collection by distributing them for completion among Grade 12 learners.

4.4 Data analysis

According to Creswell (1994:154) data analysis involves reducing and interpreting data. The researcher takes a voluminous amount of information and reduces it to a certain pattern or themes and interprets the information.

5. RESEARCH FINDINGS

In this study the questionnaires were distributed to eighty (80) senior secondary schools of the Nebo circuit area in the Southern Region of Limpopo. Twenty questionnaires were distributed to each school for voluntary completion by Grade 12 learners of both sexes, i.e. ten questionnaires were given to female learners and another ten were given to ten male learners. Forty eight schools returned the questionnaires duly completed by learners. The total sample of the study was that 1 058 learners participated in the study (N = 1 058). The biographical detail consists of their ages and gender as outlined in Table 1 below.

TABLE 1: AGE

Ages	15	16	17	18	19	20	21	22	23	24	TOT
Girls	3	55	140	130	108	72	34	13	7	3	565
Boys	2	24	84	124	103	93	34	13	11	2	493
TOTAL	5	79	224	254	211	165	33	17	18	5	1 058
%	0,5	7,5	21,2	24,0	20,0	15,6	6,3	2,8	1,7	0,5	100%

Age distribution of learners (N=1058)

Table 1 indicates that the average age of the participants was 19,5 years with the youngest being 15 years and the oldest being 24 years of age. The gender distribution of the participants is also displayed in Table 2 below, indicating that there were more female learners than male learners, namely 53,4% female and 46,6% male learners. Table 1 indicates that although there were slightly more female than male learners, the gender distribution of the study was fairly evenly spread.

TABLE 2: Gender distribution

GENDER	Males	Females
TOTAL	493	565
%	46,6%	53,4%

TABLE.3: Questions 1-7

Question	Total	%
1. Do you know a condom?	878	83%
2. Have you used a condom?	720	68%
3. Do you think a condom can prevent infection of virus?	593	56%
4. The use of a condom reduces the risk of getting a STI?	618	58%
5. It is better to abstain from sexual relationship than to use a condom?	858	81%
6. Can you suggest the use of a condom to your lover?	518	49%
7. Can you have sex with your HIV positive partner without condom?	853	80%

Table 3 indicates the total learners who responded differently to the questions by saying yes or no according how they understood the questions in this table. 83% of learners responded yes to question 1 by saying that they know what the condom is. In question 2, 68% responded that they have never used a condom. This implies that in question 1, only 17% do not know what a condom is, while in question 2, 32% had not used a condom before.

58% believe that the use of a condom can reduce the risk of getting infection while 56% think that a condom prevents the infection of the virus and 49% said they can suggest the use of a condom to lover. 80% have indicated that they cannot have sex with a HIV positive partner without a condom. Since most learners indicated that they have used condoms and prefer to abstain indicates that they are aware of the impact of HIV/AIDS pandemic for their lives. Furthermore, the learners who used condoms, and who prefer to abstain from sexual practices are those whose between 19 and 24 years of age. This holds for both sexes.

TABLE 4: Questions 8, 10, 19-23

Question	Total	%
8. You can get the HIV virus if a person sneezes or coughs close to you.	867	82,4%
10. A baby can get HIV/AIDS from its infected mother through breastfeeding.	706	67,2%
18. Can you share a cup with your friend who is HIV positive?	844	80,1%
19. Can you use the same toilet with your friend who is HIV positive?	812	77,4%
20. Can you sit at the same desk with your friend who is HIV positive?	872	82,4%
21. Can you hug or kiss your friend who is HIV positive?	723	68,3%
22. Can you share a razor or needles for intravenous drugs with your friend?	911	86,1%
23. HIV positive learners can donate blood	775	73,3%

(N = 1 058)

Percentages of learners who answered “Yes” to these questions

It is clear that the majority of learners are aware of how the HIV/AIDS disease can infect them. Question numbers 10 and 21 were mostly answered incorrectly by learners.

TABLE 5: Questions 12-17

Question	Total	%
12. Traditional healers can cure HIV/AIDS	728	69%
13. Medical doctors can administer medicines to cure HIV/AIDS	499	47%
14. Currently there is no medical cure for HIV/AIDS	678	64%
15. Fruits and vegetables are good nutrition for HIV/AIDS infected people	814	77%
16. The priest at church can cure HIV/AIDS through prayer	731	69%

(N = 1 058)

In this table 47% of the learners responded very unsatisfactorily to question 13. They maintained that a medical doctor can administer medicine to cure the disease. There were also learners who responded that traditional healers or priests could provide medicine to cure HIV/AIDS. This indicates that the cure for HIV/AIDS is not yet clear to many learners.

TABLE 6: Questions 28-32

Question	Total	%
28. Do you think is safe to know your status?	805	76,1%
29. You must know the danger of testing before you can go for testing	781	74%
30. Do you think is safe to know about HIV/AIDS testing before you go for testing?	776	73,3%
31. Have you ever been tested for HIV/AIDS? (Learners not tested.)	749	71%
32. Can you go for an HIV/AIDS test before pre-counselling?	502	47,4%

(N = 1 058)

Most learners indicated that they had not been tested to know their status.

TABLE 7: Questions 33-37

Question	Total	%
33. Can your friend teach you about HIV/AIDS?	785	74%
34. Can an HIV/AIDS positive teacher teach you at school?	856	81%
35. Parents must teach you about HIV/AIDS at home	678	64%
36. Nurses must teach learners about HIV/AIDS at clinics and at school	740	70%
37. There must be a lesson about HIV/AIDS at school	840	79%

(N = 1 058)

In this table most learners answered the questions positively about accepting any form of teaching from those that are willing to teach them. This indicates that learners are ready to receive more information about the disease from either their peers or any adult who has the correct information

TABLE 8: Questions 25, 26, 39, 40, and 43

Question	Total	%
25. You can lose weight if you have HIV/AIDS	775	73%
Diarrhoea or pneumonia can worsen the condition of your HIV/AIDS status	804	76%
HIV/AIDS can affect everybody, young and old	836	79 %
39. HIV is transmitted through blood, semen and vaginal fluids	844	80%
40. HIV weakens the body's soldiers and causes HIV/AIDS	762	78%
43. If you have one partner you cannot contract HIV/AIDS	677	64%

(N = 1 058)

In this table most learners answered questions 38 and 39 correctly by agreeing that the virus affects everybody and is transmitted through blood and other fluids. The learners answered question 43 unsatisfactorily.

TABLE 9: Questions 44-50

Question	Total	%
Learners who have HIV/AIDS should not be expelled from school	749	71%
Learners who have HIV/AIDS should not mix with other learners	767	72%
Learners who have HIV/AIDS should be free to tell others	767	72%
Learners who have HIV/AIDS must not keep it secret	860	81%
Learners who have HIV must be free to reveal their status	700	66%
Learners who have HIV/AIDS should be supported	918	87%
Teachers must not reveal the names of learners who are HIV positive without their consent	823	78%

(N = 1 058)

In this table most learners answered the questions satisfactorily. This indicates clearly that they know their human rights as far as their rights to education are concerned. They have indicated how they would react to any unfair discrimination, their disclosure of the status without their consent, the importance of confidentiality and their right to study though they are HIV positive. Eighty-seven percent responded that those who are HIV positive should be supported

6. DATA ANALYSIS

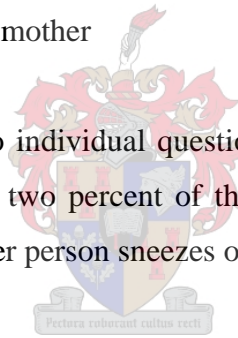
The findings from the questionnaires indicate various responses from most of the learners.

The average age of learners was 19,5 years, with the youngest being 15 years and the oldest being 24 years of age. The gender distribution indicates that more female learners than male learners participated.

The learners displayed knowledge of condoms and the use thereof, especially female learners. In general they preferred to abstain from sex rather than using condoms.

Most learners did not reply satisfactorily to the question of infecting a baby from being breastfed by the infected mother

Regarding correct responses to individual questions some of the learners came up with various answers. Eighty two percent of the learners indicated that a person could get the virus when another person sneezes or coughs close to them.



This reveals that they did not know how the virus is spread to other people. In addition there were learners who responded that traditional healers and priests could cure the virus. Sixty nine percent responded positively to questions 12 and 16 of the questionnaire (Question 12 reads: Traditional healer can cure HIV/AIDS and Question 16 reads: The Priest at Church can cure HIV/AIDS through prayer.)

In Table 6, 76,1% of the learners answered question 28 by saying that it is safe to know one's status, while 47,4% of learners in question 32 agreed that they would rather go for pre-counselling before they go for HIV/AIDS testing. This implies that the programme of voluntary counselling and testing is not yet attended to thoroughly. In some instances it can be argued that it is not possible for learners to opt for having their status tested for fear of stigmatisation if the results are unfavourable or it is not easy for learners to travel some distance to go for testing

because this involves transport costs and they may find nobody at the centre to do testing.

Regarding the learners' human rights or their right to education, most of them answered the questions correctly. Approximately 81% of them agreed that they should not keep their status secret and 87% answered question 49 that they should be supported when they are HIV positive.



7. CONCLUSION

7.1 Specific conclusions

It is clear from the findings in this study, that there is still much distance about what we want the situation to be on the ground, and the actual knowledge and behaviour of school learners. The responses from most of the learners indicate that they have not undergone voluntary counselling and testing. Their answers to the question on infection of the virus through breastfeeding from the HIV positive mothers, suggests most are ignorant of this. This implies that the educators should pay more attention to this topic during their life skills orientation lesson and education, since of the learners would be mothers in future and should know these possibilities before they get be involved. Furthermore the problem of few health centres at the vicinities of the learners could have contributed to their reluctance to travel long distances to go for testing. The problem of transport costs could also have influenced their willingness to visit health institutions. The learners should be informed about the intervention resources to help them when they are HIV positive. They should be assured that they would not be stigmatised by their colleagues if the results may prove positive. Thus it would be possible for any learner to visit any health centre to undergo voluntary testing without fear of stigmatisation by colleagues and members of the community. Because of time factor a comparison study has not done between the interview respondents and the questionnaire respondents.

I therefore recommend, regarding the specific narrower study, that the issue of reluctance to testing be scrutinized with regard to the provisions of resources and facilities for interventions.

7.2 General conclusion

Although South Africa is still at the early stages of the epidemic, there is little doubt that the long-term effects of the disease on society could be devastating and that the AIDS epidemic will in future continue to deeply affect the lives of all South Africans. At worst, individuals will be infected with the virus, develop AIDS and die premature deaths as a result of the epidemic. At best, the lives of South Africans

will be affected by the measures they and the people they interact with adopt to prevent infection. This may include profound challenges in lifestyle, such as changes in sexual behaviour. It will include shouldering the social, medical and economical cost resulting from the infection and death of those who could not prevent infection.

Massive AIDS education and support programmes that reach into all corners of the country have to be built up quickly and effectively.

AIDS should be regarded as a matter of national emergency. Given that a major AIDS epidemic would directly or indirectly affect every South African, formulating strategies for prevention offers a unique opportunity for government, political groupings, community organizations and the business sector (see Christie, 1991:26 in Haldenwang, 1993:51).

The AIDS epidemic is without a doubt one of the major challenges facing Southern Africa in the decade ahead. It is a challenge for all sectors of society, government, business and non-governmental organizations. It seems likely that, although the epidemic will not result in people dying on the street or the population declining, it will increase stress in the Southern African society. It will affect the operations of companies in the region in various ways, it will place enormous pressure on the health care system (both public and private) and it is likely that economic growth will be reduced as a result of the epidemic. All these are consequences that the region can ill afford (Haldenwang, 1993:51). Since the HIV/AIDS pandemic has the great impact to education and economy of the country, it is important that the awareness campaign should be viewed seriously, especially as many of the youth will facing the future alone. Enough resources and information should make available to the learners for intervention and safe behavioural change

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APPENDIX 1: Definition of terms

AIDS: It stands for acquired immune deficiency syndrome. This means the body has great difficulty in fighting infections because the immune system has been weakened.

Antibodies are substances produced by cells in the body's immune system in response to foreign substances that have entered the body.

Discrimination: HIV-related discrimination is action that results from stigma. It occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of his or her actual or presumed HIV status or belonging or being perceived to belong to a particular group (UN AIDS.2001:2) (UN AIDS.2001 Press Release: Stigma and discrimination fuel AIDS epidemic) Ogina.TA:2003.

Unfair Discrimination is defined as treating a person differently in a way that violates his or her fundamental dignity as a human being who is inherently equal in dignity (Bray, 2000:48) but in terms of the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996), under "Equality", unfair discrimination against anyone on one or more grounds. It is stipulated in the national policy on HIV/AIDS for learners and educators in public schools and students, and students and educators in further education and training (section 3(1)) that no learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly.

HIV: It stands for Human Immune Deficiency Virus. This is the virus which undermines the immune system and leads to AIDS. When HIV infects a cell it combines with that cell's genetic material and may lie inactive for years.

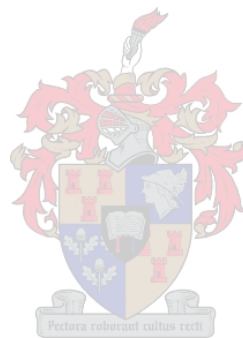
Epidemic: an infectious disease that spreads quickly among a population.

Immune system: a complex system of cells and cell substances that protect the body from infection and disease.

Opportunistic infections: infections that occur because a person's immune system is so weak that it cannot fight off the infections.

Pandemic: an epidemic occurring simultaneously in many countries.

Window period: The period between infection with HIV and Sero conversion (when HIV antibodies can be detected by the HIV antibody test).



APPENDIX 2: HIV/AIDS QUESTIONNAIRE

Name of school			
Gender	Male		Female
Age			Grade
Please answer these questions by marking YES or NO next to each of them.			
1. Do you know a condom?			Yes No
2. Have you ever used a condom?			Yes No
3. Do you think a condom can prevent virus infection?			Yes No
4. The use of a condom reduces the risk of getting an STI.			Yes No
5. It is better to abstain from sexual relationships than to use a condom.			Yes No
6. Can you suggest the use of a condom to your lover?			Yes No
7. Can you have sex with your HIV positive partner without a condom?			Yes No
8. You can get the HIV virus when a person sneezes or coughs close to you.			Yes No
9. You can get HIV/AIDS when bitten by a mosquito.			Yes No
10. A baby can get HIV/AIDS from the infected mother through breastfeeding.			Yes No
11. TB causes HIV/AIDS through lung infection.			Yes No
12. Traditional healers can cure HIV/AIDS.			Yes No
13. A medical doctor can administer medicines to cure HIV/AIDS.			Yes No
14. Currently there is no medical cure for HIV/AIDS			Yes No
15. Fruits and vegetables are good nutrition for an HIV/AIDS infected person.			Yes No
16. The priest at church can cure HIV/AIDS through prayer.			Yes No
17. Use of gloves can protect you against HIV/AIDS infection.			Yes No
18. Can you share a cup your friend who is HIV positive?			Yes No
19. Can you use the same toilet with a friend who is HIV positive?			Yes No
20. Can you sit at the same desk with you friend who is HIV positive?			Yes No
21. Can you hug or kiss your friend who is HIV positive?			Yes No
22. Can you share a razor or needles for intravenous drugs with your friend?			Yes No
23. HIV positive learner scan donate blood.			Yes No
24. A razor or needle can be used several times by different learners.			Yes No

25. You can lose weight if you have HIV/AIDS.	Yes	No
26. Diarrhoea or pneumonia can worsen the condition of your HIV/AIDS status	Yes	No
27. Have you heard about the HIV/AIDS disease?	Yes	No
28. Do you think is safe to know your status?	Yes	No
29. You must know the dangers of testing before you can go for testing.	Yes	No
30. Do you think is safe to know about testing for HIV/AIDS before you go for testing?	Yes	No
31. Have you ever been tested for HIV/AIDS?	Yes	No
32. Can you go for an HIV/AIDS test before pre-counselling?	Yes	No
33. Can friend teach you about HIV/AIDS?	Yes	No
34. Can an HIV positive teacher teach you at school?	Yes	No
35. Parents must teach you about HIV/AIDS at home.	Yes	No
36. Nurses must teach learners about HIV/AIDS at clinic and school.	Yes	No
37. There must be a lesson about HIV/AIDS at school.	Yes	No
38. HIV/AIDS can affect every body, young and old.	Yes	No
39. HIV is transmitted through blood ,semen and vaginal fluids	Yes	No
40. HIV weakens the body's soldiers and causes HIV/AIDS.	Yes	No
41. You cannot contract HIV/AIDS if you have sex with a virgin.	Yes	No
42. Learners who use drugs can have HIV/AIDS.	Yes	No
43. If you have one partner you cannot have HIV/AIDS.	Yes	No
44. Learners who are HIV positive should be expelled from school.	Yes	No
45. Learners who are HIV positive should not mix with others.	Yes	No
46. Learners who are HIV positive should be free to tell others.	Yes	No
47. Learners who are HIV positive must keep it secret.	Yes	No
48. Learners who are HIV positive must be forced to reveal their status.	Yes	No
49. Learners who are HIV positive should be supported.	Yes	No
50. Teachers must reveal the names of learners who are HIV positive without their consent.	Yes	No

APPENDIX 3: PERMISSION TO VISIT SCHOOLS



24 Excelsior Street
Private Bag X9489
Polokwane 0700
Tel: 015-290 7600
Fax: 015-297 6920
015-297 4220
015-297 4494

Enquiries: Mokoka M B
Telephone: 015 290 7684
Fax: 015 297 5521
Reference: 215/G/1

Masemola K M
Private Bag X447
Pretoria
0001

Request for permission to visit schools in Nebo Area for research purposes

Dear Student

1. Receipt of your letter dated 5th October 2004 is acknowledged.
2. The Department wishes to inform you that your request to conduct research on HIV and AIDS during 2005 at schools in Nebo Circuit has been approved.
3. However, the following conditions must be adhered to:
 - 3.1. The research should not have any financial implications for Limpopo Department of Education.
 - 3.2. You make arrangements with the District Office concerning the conduct of the study.
 - 3.3. You should make arrangements with the schools in such a way that there will be minimal disruption of the academic programme.
 - 3.4. You share with the Department, the final product of your study upon completion of the research assignment.
 - 3.5. Respondents should not in any way be identifiable from the results of the investigation.
 - 3.6. The research is conducted in line with ethics in research.
4. It is expected of you to produce the accompanying letter to institutions where you will be conducting your research, as evidence that permission for this activity has been granted.
5. The Department appreciates the contribution that you wish to make and wishes you success in your investigation.


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HEAD OF DEPARTMENT

01-12-04
DATE:.....