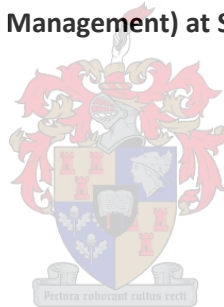


An investigation into the effectiveness of HIV/AIDS campaigns in dealing with stigma in schools

Tsoho Ramose

Assignment submitted in partial fulfilment of the requirement for the degree of master of Philosophy (HIV/AIDS Management) at Stellenbosch University



**Africa Centre for HIV/AIDS Management
Faculty of Economic and Management Sciences
Study leader: Dr. Thozamile Qubuda
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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

T. Ramose
January 2012

ABSTRACT**BACKGROUND:**

The focus of the study was to assess the effectiveness of HIV/AIDS awareness campaigns in reducing stigma and discrimination in schools. The findings of the study from all three high schools that took part in the study indicated that stigma still exists in schools. The existence of stigma and discrimination in school can have far much reaching effect. For effective teaching and learning to take every one should feel belonging and welcomed at school, however if people will be discriminated and stigmatised because of the HIV status chances are learners will dropout of school or not attend regular because of the bad treatment that they receive. Bad treatment directed to people because of their positive HIV status will further compound the stress of having to accept and deal with their status and ultimately this might affect their health.

OBJECTIVES:

Objectives were as follows:

- Assess the effectiveness of HIV/AIDS campaigns in reducing stigma in three high schools around J.T Gaetsewe region.
- Identify factors contributing to stigma in three High schools around J.T Gaetsewe region.
- Provide guidelines for policy and programme development to help in reduction of stigma in the school environment.

METHODS:

The quantitative research approach was used for the study. The questionnaires were used to collect data. According to O'Neill (2006), quantitative data analysis enables you to make sense of data by: analysing, summarising or doing exploratory analysis and to communicate meaning to others by presenting data as data tables, graphical displays and summary statistics.

RESULTS:

It was evident from the results of the study that despites efforts made to educate people about various aspects of HIV/AIDS stigma and discrimination still exists in schools. Such state of affairs is likely to pose a threat in tremendous efforts put in place to control the spread and mitigating the social effects of HIV/AIDS. People are still afraid of being closely associated with people affected or infected by HIV/AIDS.

CONCLUSION:

HIV/AIDS related stigma and discrimination exists in different settings and various programmes have been put in place as an attempt to deal with it. In schools programmes such life skills training and inclusion of HIV/AIDS education as part of the school curriculum are some of the efforts made in an attempt to increase learner's knowledge concerning HIV/AIDS. Despite these efforts, the research findings indicated that stigma and discrimination still exists and this state of affairs calls for more effort.

OPSOMMING

AGTERGROND:

Die fokus van hierdie studie was om vas te stel hoe doeltreffend MIV/Vigs-bewusmakingsveldtogte is, met betrekking tot die vermindering van stigma en diskriminasie in skole. Die bevindinge van die studie by al drie hoërskole wat deelgeneem het aan die studie, het aangedui dat die stigma steeds bestaan in skole. Die bestaan van stigma en diskriminasie in skole het 'n baie verrykende effek. Vir doeltreffende onderrig en leer om plaas te vind, moet leerders voel dat hulle op skool behoort en moet hulle ook welkom daar voel. Indien daar teen leerders gediskrimineer en gestigmatiseer word as gevolg van hul MIV-status, is die kans groot dat hulle nie skool gereed sal bywoon nie en selfs glad nie meer skool gaan bywoon nie, as gevolg van die swak behandeling wat hulle by die skool ontvang. Slegte behandeling van mense as gevolg van hul positiewe MIV/VIGS-status, sal verder bydra tot die spanning om hul status te aanvaar en daarmee saam te leef en mag ook hulle gesondheid verder benadeel.

DOELWITTE

Doelwitte is soos volg:

- Bepaal die doeltreffendheid van MIV/VIGS-bewusmakingsveldtogte met betrekking tot die vermindering van stigma in drie hoërskole in die JT Gaetsewe-streek.
- Identifiseer faktore wat bydra tot die stigma in die drie hoërskole in die JT Gaetsewe-streek.
- Verskaf riglyne vir beleid en programontwikkeling om te help met die vermindering van stigma in die skoolomgewing.

METODES

'n Kwantitatiewe navorsingsbenadering is gebruik vir die studie. Vraelyste is gebruik om data in te samel. Volgens O'Neill (2006), sal kwantitatiewe data-ontleding jou in staat stel om sin te maak van die data deur : ontleding, opsomming en verkennende ontleding en deur te kommunikeer deur die aanbieding van data met behulp van data tabelle, grafiese uitstallings en opsommingstatistieke.

UITSLAE

Dit was duidelik uit die resultate van die studie dat ten spyte van pogings om mense op te voed oor verkeie aspekte van MIV/VIGS, dat stigma en diskriminasie nog steeds bestaan in skole. Hierdie toestand van sake plaas 'n bedreiging op die geweldige pogings wat aangewend word om die verspeiding van MIV/VIGS te beheer en die verligting van sosiale gevolge van MIV/VIGS. Mense is steed bang om te na betrokke te wees met mense wat wat leef met MIV/VIGS.

GEVOLGTREKKING

MIV/VIGS-gerwante stigma en diskriminasie bestaan in verskillende instellings en verskeie programme is in plek gestel as 'n poging om dit te hanteer. Programme soos lewensvaardighede, opleiding in skole en die insluiting van MIV/VIGS-opvoeding as deel van die skoolkurrikulum is 'n paar van die pogings wat aangewend word om leerders se kennis rakende MIV/VIGS te verhoog.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Virus
HSRC	Human Sciences Research Council
ILO	International Labour Organisation
NHS	National Health Service
PLHA	People Living with HIV and AIDS
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION

1.1. Background

There are various HIV/AIDS awareness campaigns that are conducted in the school and outside the school environment in an attempt to provide valuable information and knowledge regarding HIV/AIDS. Campaigns of this nature helps in clarifying various misconceptions associated with this pandemic. Having limited knowledge regarding HIV/AIDS is detrimental as this is likely to lead to undesirable circumstances such as stress, low self esteem, denial, discrimination and stigmatisation of people living with HIV/AIDS or affected by it.

“From an early age in the AIDS epidemic a series of powerful images were used, that reinforced and legitimised stigmatisation” (Cogan, 1998). These are some of the images -AIDS was considered to be a punishment for immoral behaviour and as a horror whereby infected people were demonised and feared.

HIV/AIDS –related stigma cover affects self-esteem, mental health, access to care, providers willingness to treat people with HIV, violence and HIV incidence. Interventions to reduce stigma are therefore crucial for improving care, quality of life, and emotional health for people living with HIV and AIDS. HIV/AIDS-related stigma has been specifically identified as a domestic policy challenge that must be addressed to reduce the number of new HIV infections, and eliminating stigma is a crucial element of global efforts (Institute of Medicine,2001,Joint United Nations programme on HIV/AIDS (UNAIDS, 2001; Henry J. Kaiser Family Foundation, 2002; Klein et al., 2002).

One of the biggest hurdles for the global response to AIDS is psychological. That is the stigma factor. To a greater or lesser degree stigma remains a fact of life for people living with HIV. In most schools there are no proper policies in place to deal with stigma and this situation permits some form of discrimination against people living or affected by HIV/AIDS. Stigma remains barrier to public action, for example some people may fail to take treatment just because of fear of being stigmatised. Children will be left on their own after the death of their parents just because no one will be willing to be associated with AIDS just because of stigma accompanying it.

Comprehensive HIV/AIDS education campaigns cover quite a range of areas including the following÷ how to protect and promote ones health, social and emotional aspects which deals with issues such

as maintenance of self confidence and esteem as well as coping with risky situation and loss, sexuality whereby factors such as sexual orientation and development will be dealt with, promotion of equity whereby rights related issues will be covered and lastly overcoming stigma and discrimination.

Providing HIV/AIDS education does not necessarily mean that this information will be effective, this information needs to be absorbed and remembered. People need to be actively involved so that they can engage with information and apply it.

1.2. Research problem

Stigma is still a problem at schools despite the fact both learners and employees at school have been exposed to a number of HIV/AIDS awareness programmes at school or outside the school environment. HIV/AIDS education is conducted in school as part of the syllabus for learners. Mass media such as news papers, TV and radio also plays a major role in providing information. The environment whereby stigma and discrimination prevails is not conducive for learning and teaching. Young people are at the danger of becoming infected with HIV, the focus of the programmes that they are exposed to mainly deals with providing and equipping them with knowledge regarding HIV transmission and how to protect themselves against infection. Other areas of HIV/AIDS education like equity and over coming stigma and discrimination are neglected. The results of this stigmatisation and discrimination of those who are people living with HIV/AIDS and those who are affected is still common in the school environment.

Stigmatisation and discrimination of people can take different forms in the school environment these include denying learners to be part of the groups or team, name calling, denying educators opportunities for career development and refusal of learners to eat food prepared by some suspected to be HIV positive as well as avoiding to be taught by certain educators. Such situations are likely to force out learners out of the system. When stigma is internalised it might influence the ways affected individuals look at themselves and how they interact with others, including health care providers (Lee, Kochman & Sikkema, 2002).

1.3. Significance of the study

Conducting such a study will be beneficial to all stakeholders at the school. These include learners, educators, non academic staff as well as the Department of Education. Learners will benefit if the shortcomings of the current programmes in addressing stigma are identified and developed. Putting

in place effective programme will empower people to deal with stigma by exercising their rights as well as changing people attitudes and perception about people living with HIV/AIDS. If all stake holders are knowledgeable about HIV/AIDS they may be welcoming and have the correct attitude towards people living with HIV/AIDS and those affected by it. If the school environment is welcoming to the learners they are likely not to dropout of school. The Department of Education will also benefit by identifying the ineffectiveness of the current programmes in dealing with stigma and discrimination in schools.” Given the magnitude of this pandemic one could hardly claim that the area of stigma is well studied” (Brown. et al., 2001, p.15).

1.4. Aims and objectives of the study

The aim of the study was to find about the effectiveness of HIV/AIDS awareness campaigns in reducing stigma in three high schools.

The objectives were to:

- Assess the effectiveness of HIV/AIDS campaigns in reducing stigma in three high schools around J.T Gaetsewe region.
- Identify factors contributing to stigma in three High schools around J.T Gaetsewe region.
- Provide guidelines for policy and programme development to help in reduction of stigma in the school environment.

1.5. The Developmental relevance of the study in South Africa

The Impact of HIV/AIDS on the education sector can have far much reaching in effect on the economy of any country because education is important for sustainable development. Increased level of HIV infections, AIDS mortality and morbidity in society in general will impact on learner’s enrolment, through reduced number of learners and increased dropout rate by infected and affected learners (Badcock-Walters & Gorgens 2001). HIV/AIDS further perpetuate some of social and gender stereotypes and inequality. From childhood girls and boys are expected to exhibit traditional practices which might be harmful and protective (Shisana & Davids 2004). Desmond, Michael and Gow (2000) as well as Marcus 1999 state that female are more likely to be taken out of school to help with household chores and take care of the sick, especially when adult female are not available.

The impact of HIV/AIDS cannot only be felt by educators who are affected alone, the impact extend to their colleagues as well as the learners. The impact of HIV/AIDS on morale can extend to both

affected and infected in schools. HIV positive educators are likely to lose interest in furthering their professional development (Coobe, 2000). Issues of declining health and increased rate of absenteeism may impact on the ability to teach (Badcock-Walters et al., 2003).

According to Simbay (2002), knowledge does not necessarily translate it behaviour change. Most studies have shown that with regard to knowledge on the nature of transmission people aged 15 years and older in the general population in South Africa are highly aware of HIV/AIDS but there is little improvement in sexual behaviour changes involving safer sex practices such as reducing the number of sexual partners and using condoms consistently.

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

1.6. Structure of the research report

Chapter 1: This chapter will cover the following background to the study, statement of the problem, aim and objective of the study.

Chapter 2: It is in this chapter where in depth review of literature related to the topic will be done. The relevance of the topic will be shown by taking a closer look at previous studies.

Chapter 3: this chapter will highlight the research method used in the study. The quantitative method was used whereby questionnaires were given to participants. The procedure adopted for sampling will be covered as well as data collection and ethical issues.

Chapter 4: The description of the sample such as the size, age and sex will be done. Apart from sample description this chapter will also indicate the research findings.

Chapter 5: The focus of this chapter will be on the discussions of the findings of the study presented on chapter 4 above.

Chapter 7: The chapter will cover the recommendations and conclusion of the study.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

HIV stigma refers to all unfavourable attitudes, beliefs, and policies directed towards people perceived to have HIV/AIDS as well as towards their significant others and loved ones, close associates, social groups, and communities. Patterns of prejudice, which includes devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities especially those of gender, sexuality and race that are the root of HIV related stigma. Various authors give their own definition of stigma but there are factors that are common across all definitions.

UNAIDS defines HIV related stigma and discrimination as “a process of devaluation of people either living with or associated with HIV/AIDS”. Discrimination follows stigma and it is “the unfair and unjust treatment of an individual based on her/his real or perceived HIV status” (UNAIDS, 2008).

“The discrimination and devaluation of identity associated with HIV-related stigma do not come naturally. Rather, they are created by individuals and communities who, for the most part, generate stigma as a response to their own fears. HIV-related stigma manifests itself in various ways. HIV-positive individuals, their loved ones, and even their caregivers are often subjected to rejection by their social circles and communities when they need support the most. They may be forced out of their homes, lose their jobs, or be subjected to violent assault. For these reasons, HIV-related stigma must be recognised and addressed as a life-altering phenomenon” (Herek, 1999). Goffman (1963) described stigma as “an attribute that is deeply discrediting within a particular social interactions.

Goffman explanation focuses on the public’s attitude towards a person who possesses an attribute that falls short of societal expectations. “The person with the attribute is reduced in our minds from a whole and unusual person to a tainted, discounted one”.

The above explanation clearly indicates that people’s perception about others is likely to change as soon one HIV status changes. In school environment people attitudes is likely to change as soon as they learn about ones HIV status or ones association with infected person. In some cases learners are exposed to harsh treatment at school as a result of their HIV status. Children orphaned or rendered vulnerable by AIDS are likely to experience increasing stigmatisation. They faced verbal and physical discrimination at schools and in the community (Streak, 2001b).

“At first relations with the local school were wonderful and Michael thrived there. Only the head teacher and Michael’s personal class assistant knew of his illness...Then someone broke the confidentiality and told parent that Michael had AIDS. That parent, of course, told all others. This caused such panic and hostility that we were forced to move out the area. Michael was no longer welcomed at school. Other children were not allowed to play with him- instead they jeered and taunted him cruelly. One day a local mother started he should have been put down at birth.....Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could be driven out of our home yet again”, British woman describing the experience of the foster son in a British school, National AIDS Trust, UK, 2002.

People who are infected with HI virus are usually accused of being responsible for their infection as a result of acting in an immoral way or being punished for their immoral actions. HIV infection fits the profile of a condition that carries a high level of stigmatisation (Goffman, 1963; Herek, 1999; Jones et al., 1988). Firstly people infected with HIV are often blamed for their condition and many people believe HIV could have been avoided if individuals could have made better moral decisions. Secondly, although HIV is treatable, it is nevertheless a progressive, incurable disease (Herek, 1999; Stoddard, 1994). Thirdly; HIV transmission is poorly understood by some people in the general population, causing them to feel threatened by the mere presence of the disease. Finally, although asymptomatic HIV infection can be concealed, the symptoms of HIV-related illness cannot. HIV related symptoms may be considered repulsive, ugly and disruptive social interaction (Herek, 1999). Schools should not just rely on providing information and knowledge about how people can protect them selves against HIV infection and how the virus is transmitted as a means of dealing with stigma in schools. School HIV/AIDS awareness campaigns should also cover areas such as the rights of infected people and develop policies to deal with stigma in a school environment. Lack of policies or clear guidance related to care of patients reinforces discriminatory behaviour (UNAIDS, 1998).

“We can fight stigma. Enlightened laws and policies are key, but it begins with openness, the courage to speak out. Schools should teach respect and understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change from securing legal protection to ensuring access to health care” (Ban ki-moon, 2007).

There is a need to develop policies that will provide protection to infected and affected learners at schools. Policies must be made available to every stakeholder. Policies will provide some form of legal protect to learners infected and affected by AIDS.

Law and legal protection are essential components of the societal response to stigma and discrimination (Klein et al., 2002). Policies dealing with stigma in schools should not just be development for record sake, they should be communicated to all those who are concerned. There should also be advocacy and adherence to policy. To ensure that all aforementioned conditions are met there should be proper evaluation and monitoring after the implementation.

Despite health officials approach to the AIDS epidemic, their efforts did not prevent HIV/AIDS – related discrimination. People living with HIV, as well as people who are merely believed to be HIV-positive, have been fired from their jobs, evicted from their homes, and denied services. Discrimination has occurred despite legal precedents and protective legislation. It has been reported in the areas of employment, health care, insurance, and education. Ironically, some institutional policies and laws designed to protect people with HIV from stigma can help perpetuate it. For example, privacy laws assist HIV-positive people with managing stigma, but may also contribute to the characterization of AIDS as a dirty little secret (Herek et al., 1998)

2.2. HIV/AIDS globally

A country laws, rules and policies regarding HIV have a significant effect on the lives of the people living with the virus Discriminatory practices can alienate and exclude people living with HI, reinforcing stigma surrounding HIV/AIDS.

In 2010, UNAIDS reported 71 percent of countries have some form of legislation to protect people living with HIV from discrimination. However most of these are still promoting stigma. This view is supported by Ban ki-moon as noted by Washington Times, “Almost all permit some form of discrimination. Forms of discrimination by government policies differ from one country to other. According to Tumushe (2006) Uganda has a policy that supports dismissal or not promotes members of armed forces that test positive while China advocates for testing of Chinese citizen who has been living outside the country for more than a year.

“In healthcare setting people living with HIV can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent, and lack of confidentiality. Such responses are often fuelled by ignorance of transmission routes by doctors, midwives, nurses and hospital staff” (Stutterheim et al., 2008).

Stigma and discrimination in healthcare settings are not only confined to developing countries. Below an HIV positive woman in London, UK tells of her experience with NHS dentist: "I have a dental problem and I go to this clinic, and I go two maybe three times, so eventually I told them about my condition. They explained that I would have to be the last appointment of the day. I have been to that room and sat on that chair, and the same doctor examined me before, but after I told them I was HIV positive so I went for the last appointment of the day last week, they cover the chair, the light, the doctors were wearing three pairs of gloves" (Noleen, 2006).

According to the joint report by ILO and China Centre for Disease Control noted that the national policy for recruiting civil servants specifies that: "those who suffer gonorrhoea, syphilis, chancroid, venereal lymph-granuloma, genital herpes or HIV will be disqualified" (ILO, 2010).

The report issued by UNAIDS 2011 states that people living with HIV were subject to some sort of restrictions in 47 countries. UNAIDS (2011) Human rights and law team state that restrictions can include the need to disclose HIV status, or be subjected to mandatory HIV test, the need for discretionary approval to stay and deportation of individuals once their positive status is discovered. "Until the 4th of January of 2009 the United States restricted all HIV positive people from entering the country, whether they were on holiday or visiting on a longer term (Goosby, 2009). According to UNAIDS (2010) around 2.2. Million people are living with HIV in Europe at the end of 2010.

2.3. HIV/AIDS IN South Africa

UNAIDS estimated that HIV prevalence was 17.8% among the 15-49 year olds at the end of 2009. Their high and low estimates were 17.2% and 18.3% respectively. According to their own estimates of the total population, this implies that around 5.6 million South Africans were living with HIV at the end of 2009, including 300,000 children less than 15 years old (UNAIDS, 2011). The ASSSA2008 model produces similar estimates of 5.5 million people living with HIV in 2009, or around 11% of the total population.

The South African National Department of Health estimates that 30 to 32 % Of pregnant women (aged 15-49) were living with HIV in 2010. Although new infections among mature age group in South Africa remain high, new infections among teenagers seem to be on the decline. HIV prevalence figure in the 15-19 age group for 2005, 2006 and 2007 were 16%, 14% and 13% respectively (UNAIDS, 2008).

High percentage of HIV positive of the country might be attributed to early denialism by the government. "Public health researchers have attributed 330,000 to 340,000 AIDS deaths along with 171,000 other HIV infections and 35,000 infant HIV infections to the South African's government former embrace of AIDS denialism (Chigwedere et al., 2003).

According to the National Institutes of Allergy and Infectious Diseases scientists and physicians have raised alarm at the cost of AIDS denialism, which discourages HIV positive people from using proven treatment. "Social stigma associated with HIV/AIDS, tacitly perpetuated by government's reluctance to bring the crisis into the open the open and face it head on prevents many from speaking out about the causes of illnesses and deaths of their loved ones and leads doctors to record uncontroversial diagnosis on deaths certificates ... The South African government needs to stop being defensive and show backbone and courage to acknowledge and seriously tackle the HIV/AIDS crisis of its people" (The Lancet, 2005).

It is not all doom and gloom with regard to the governments actions towards the control of the disease, "Marking a welcome change from the south African history of HIV, the government launched a major counselling and testing campaign (VCT) in 2010 (SANAC 2010, February).

2.4. HIV/AIDS in education

In South Africa HIV/AIDS represents the largest single threat to equal access to education (Moletsane, 2006). The study conducted by HSRC indicated that drop-out is steadily on the rise as families are affected by HIV/AIDS.

According to the study the report released by the HRSC in 2009 it is evident that even though awareness campaigns have reached a lot of people across all ages in South Africa, accurate knowledge about HIV/AIDS is poor. Of particular worry is the lack of knowledge regarding how to prevent sexual transmission of HIV? Young people of school going age are particularly susceptible to disease (UNICEF, 2003).

Within the 15 to 24 year old group, girls-and black young women above all-are disproportionately affected. For example, emerging research data from Kwazulu Natal estimates that among 15-19 years olds, the vast majority of whom are in school, 15,64% of black girls are likely to be HIV-positive compared to only 2.58% black boys (Health 24, May 2006).

There are number of applicable legislations that are put in place as an attempt to minimise the impact of HIV/AIDS in education. Section 9 of National Policy Act No. 27 of 1996 states that:

- A continuing life skills and HIV/AIDS education programme must be implemented at all schools and institutions for learners, student educators and other staff members.
- Age appropriate education on HIV/AIDS must form part of the curriculum for all learners and students and should be integrated in the in the life skills education programme for pre-primary, primary and secondary school learners.
- Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.
- Parents of learners and students must be informed about all life skills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as 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.
- If learners, students and 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.

2.5. Research gaps

There are numerous studies that have been conducted in relation to HIV/AIDS stigma and discrimination, but their main focus was not to address the effectiveness of HIV/AIDS awareness campaigns in addressing stigma and discrimination in schools. As a result of this state of affairs, little is being understood concerning the effects of HIV/AIDS awareness campaigns in reducing HIV/AIDS related stigma in schools.

2.6. Conclusion

The literature review tried to discuss HIV/AIDS related stigma and discrimination broadly. The discussion centred around a number of areas such as conditions favouring the existence of stigma and discrimination, the effects of stigma and discrimination, stigma reduction measures. It is evident from the findings of previous study that stigma and discrimination plays a major role in disrupting efforts put in plays to control the disease. Molofe (2009) indicated that certain behaviours such as condom use have become signifiers of the HIV/AIDS and could possibly lead to rejection of those who initiate their use. Over and above that stigma and discrimination can also affect the person's willing to go for HIV test voluntarily. Special attention needs to be directed to the issue of stigma and discrimination so that visible progress and success can be registered in the fight against the disease.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

The focus of this chapter will be on research methodology. Amongst others, the research methods aspects that will be covered includes the following: research design, population selection and sample size, rationale behind research design, data collection methods measuring instruments, data analysis as well as ethical considerations.

3.2. Research design

The quantitative approach was used for the purpose of this study. The survey was used whereby self administered questionnaires will be given to 20 learners, 5 educators and 2 non academic staff per school. Each group had its own specific questionnaire to complete. Three high schools were selected for this study.

Creswell (1994) identified the following advantages and disadvantages of questionnaires:

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 questionnaires

Disadvantages of questionnaires

Questionnaires occur after the events, so participants may forget the important issues

Questionnaires are standardized, so it is not possible to explain any points in the question the participants may misinterpret

Respondents may answer superficially if the questionnaire takes too long to complete

3.2.1. Rationale for research design

Surveys are relatively inexpensive and are useful in describing the characteristics of a large population. No other method of observation can provide this general capability (Bradburn et al., 1988). Survey are also not time consuming.

3.3. Data collection methods

Self administered questionnaires were used to collect data. The questionnaires were intended to test learners and staff HIV/ AIDS knowledge and attitudes towards people living with HIV/AIDS.

According to Tuckman (1978) questionnaires are used by the researchers to convert the information directly given to given by people into data.

3.3.1. Population

According to Castillo (2009), research population is generally a large collection of individuals or objects that is the main focus of scientific query. It is for the benefit of the population that researches are done. However, due to the large sizes of populations, researchers often cannot test every individual in the population because it is too expensive and time consuming. This is the reason why researchers rely on sampling techniques. The total population for the study involves all learners and the staff from the following three high schools: Remmogo, KP. Toto and Lesedi. The total number of population per school is 720 learners and 31 staff members from Remmogo, 455 learners and 23 staff members from Lesedi, 1020 learners and 45 staff members from KP, Toto.

3.3.2. Sampling method

Three High Schools around John Taolo Gaetswe District were used for the purpose of the study. The names of the high schools are Remmogo in Maruping village, K.P. Toto and Lesedi in Batlharos village. 20 grade 12 learners who are between the age of 16 and 18 years were randomly selected from each school. Random sampling is a sampling in which every member of the population has an equal chance of being selected for the study, Christensen (2004). The total number of learners used in the study amount to 60. 5 educators were selected from each school and the total number of educators who took part in the study was 15. 2 non academic staff members were selected per school and their total number is 6. There are different staff levels at the school (Post level 1, 2, 3 and 4 educators and non academic staff). In order to ensure representivity of the staff stratified sampling was used.

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

3.4. Measuring instrument

3.4.1. Questionnaires

Self administered questionnaires with close ended questions were used as a measuring instrument. Two separate sheets of questionnaires were used. Each sheet contained ten questions. One sheet will be used to assess participants HIV/AIDS Knowledge while the other sheet will test participant's attitudes towards people living and affected by HIV/AIDS.

3.5. Data analysis

Data was analysed by using a descriptive method whereby a description of results was made based on each research subject responses to questionnaires.

3.6. Informed consent

Before the commencement of the study a research proposal was forwarded to the Stellenbosch University's Ethics Committee in order to give a go ahead to the intended study. An informed consent was one of the conditions that had to be met before by the applicant before he can engage any participants as the subject in the study. The intention of the informed consent process was to inform participants about the nature of research and participants protected rights to confidentiality, and their ability to withdraw from the study at anytime. Participants were also informed about the duration they are expected to be involved in the study as well as the risks and the benefits of taking part in the study. Relevant information such as researcher's name, telephone numbers, and address as well as those of the researcher's supervisor and the Stellenbosch University Ethics committee were provided in order to enable the participants to seek clarity if needs be. The approval to the above protocol was granted by the Stellenbosch University.

3.7. Ethical consideration

When most people think of ethics (or morals) they think of the rules for distinguishing between right and wrong, such as the Golden Rule (" Do unto other as you would have them do unto you") a code of professional conduct like Hippocratic Oath (First of all, do no harm) Resnik (2007). Taking in cognisance the fact that human beings were to be used for the study it was quite imperative to ensure that the study was conducted within the ethical boundaries and the rule of law as well as ensuring that participants rights were not tempered with. According to (Resnik, 2007) many of ethical norms help to ensure that researchers can be held accountable to the public, for instance federal policies on research misconduct, conflict of interests, and the human subject protection.

In compliance to ethical issues the following were ensured:

- Participation was voluntary
- Potential participant were at liberty to decline;
- Confidentiality was adhered to;
- Participants were at liberty to terminate their participation at any time with any implication;
- Support in the form of counselling was availed to any one who might experience emotional disturbance as a result of taking part in the study; and
- Participants' anonymity and privacy was ensured.

All relevant authorities have granted permission before the commencement of the study. These include Ethics committee of the Stellenbosch University; Principals of the high school where the study was conducted and the Circuit manager from Northern Cape Department of education. Staff also completed their consent form before taking part in the study and parents completed on behalf of their children who took part in the study. Ethical lapses in research can significantly harm human and animal subjects, students and public (Resnik, 2007).

CHAPTER 4

RESEARCH FINDINGS AND ANALYSIS

4.1. Introduction

The focus of this chapter will be on the findings of the research and the analysis of data collected through questionnaires. Once you have collected data you need to make sense of responses you got back. Quantitative data analyses enable you to make sense of data by: organising them, summarising them, exploratory analysis, and to communicate meaning to others by presenting data as tables, graphical displays and summary statistics (O'Neil, 2006)

4.2. Biographical information

4.2.1. Number of participants

A total number of 81 participants took part in the study. 27 participants from each school amongst the three High schools took part by completing questionnaires. This 27 is made up of 20 grade 12 learners, 5 academic staff and 2 non academic staff. 20 learners were randomly selected from each of the three high schools. The staff members were stratified and a specific number of participants were randomly selected under each of the four strata. Selection was done as follows: Post level 1 (4 educators), Post level 2 HOD (1 educator), principalship (1 educator) and 2 non academic staff members.

TABLE 1: Number of grade 12 participants

MALES	FEMALES	TOTAL NUMBER OF PARTICIPANTS
30	30	60

TABLE 2: Number of academic and non academic staff participants

TOTAL NUMBER OF PARTICIPANTS	POST LEVEL 1 EDUCATORS	POST LEVEL 2 EDUCATORS (HOD)	PRINCIPALSHIP (PL 1-3)	NON ACADEMIC STAFF
7	3	1	1	2

4.2.2. Race distribution

AFRICANS	INDIANS
79	3

TABLE 3

All three High schools where the study was conducted are situated in the rural areas and all learners are of Africans. Both academic and non academic staff members are Africans except for the 3

4.2.3. Educational level

	GRADE 10 AND BELOW	GRADE 11 TO 12	MATRIC PLUS THREE YEARS QUALIFICATIONS	MATRIC PLUS 4 YRS AND ABOVE
LEARNERS		60		
NON ACADEMIC STAFF	8			
ACADEMIC STAFF			5	10

TABLE 4

All 60 learners who took in the study are grade 12 learners. 8 non academic staff members (Cleaners and canteen ladies) indicated that they did not study beyond grade ten levels. Out of 15 academic staff members 5 indicated to have achieved matric plus three years qualification while 10 got matric plus 4 years qualification and beyond.

4.3. Responses to questionnaires

A set of two questionnaire tables each containing ten questions were given to both learners and staff at the school. A first set of questions were aimed at assessing participant's level of HIV/AIDS knowledge while the second set seeks to determine their attitude towards people living with HIV/AIDS. Same set of questions were given to both learners and the staff to test knowledge but slightly different questions were given to test for attitude. Participants were expected to respond by stating whether they agree or disagree with statements given.

Questionnaires for learners

Table 5: Responses questionnaires to test HIV/AIDS knowledge

	Agree	Disagree
You can get infected with HIV by sharing toilet with infected person	2%	98%
You get infected by sharing kitchen utensils with infected person	0%	100%
HIV/AIDS is a punishment for immoral behaviour	24%	76%
HIV/AIDS is curable	15%	85%
Having sex with a virgin cures one of AIDS	5%	95%
Taking shower after having sex with infected person cures one of AIDS	9%	91%
Condoms do not prevent HIV infection	24%	76%
You are not supposed have sex when you are HIV positive	25%	75%
HIV can only be transmitted through sexual inter course	15%	85%
HIV/AIDS only affects homosexuals	10%	90%

TABLE 5

4.3.1. Response to question about the sharing of toilets.

98 % of participants indicated that one cannot be infected with HIV as a result of sharing a toilet with infected person while 2% agreed with the statement. This response in a way indicate that learners are much conversant with the ways in with HIV can be transmitted from one person to the other. Moreover this can also signal the role played by various HIV awareness campaign learners have been exposed to. Noting the fact that age specific HIV/AIDS education is part of the school curriculum from an early age, it understandable to have such a high percentage of learner indicating knowledge about modes of transmission.

4.3.2. Responses to questions about sharing of kitchen utensils.

100% of participants disagreed with the statement that one can get infected by sharing kitchen utensil with infected person. This also indicated sound knowledge concerning transmission of HIV.

4.3.3. Response to statement viewing HIV/AIDS as punishment for immorality

76 % of the respondents disagreed with the statement while 24% indicated to be disagreeing. Even though the percentage of those who are in disagreement is high than those who agree, 24% is unacceptably high. The percentage of those who disagree indicated most learners are still having some misconception concerning HIV/AIDS.

4.3.4. Response to a statement about HIV/AIDS curability

85% of participants indicated that HIV/AIDS is curable while on the other hand 15% agreed with the statement. This might indicate the fact that learners are confusing the fact HIV/AIDS is treatable as a cure.

4.3.5. Response to a statement about the ability of having sex with a virgin in curing HIV/AIDS

98% of participants disagreed with the statement while 2% agreed with it. Even though the percentage of those who agreed is low in comparison to the above statement this signals that HIV/AIDS related myths still exist.

4.3.6. Response to the ability of having shower after sex in curing AIDS

91% of participants disagreed with the statement while 9% are in agreement. The response to the statement clearly supports the fact that there are some people who still believe that there is a cure for HIV/AIDS as observed in 14.1.4, above.

4.3.7. Response to the role of condom in preventing HIV infection

76% of indicated that condom protects one from HIV infection while 24% does not have that believe.

4.3.8. Response to statement about having while HIV positive

25% of participants have a believe HIV positive people are not supposed to have sex. 75% indicated that people can still have sex even if they are infected HIV.

4.3.9. Response to a statement that views sexual intercourse as the only mode of HIV transmission.

85% of participants disagreed with the statement. 15% indicated to be agreeing with the statement.

4.3.10. Response to the statement viewing HIV/AIDS as disease for homosexuals

90% of the participants indicated to be agreeing with the statement while 10% agreement. This indicates a significant number of people who still believe that HIV/AIDS is gender specific deases.

4.4. Responses to questions testing learners attitude towards people living with HIV/AIDS

Questions to test attitude towards people living with HIV/AIDS

	Agree	Disagree
Will you tell any one if you get infected with HIV	80%	20%
Can you share a desk with an infected learner	97%	3%
Can you play in the same team with HIV positive school mate	100%	0%
Will you tell your friends if one of your family members get infected with HIV	80%	20%
Will you feel comfortable to be taught by HIV positive educators	89%	11%
HIV positive learners should not be allowed to attend school	7%	93%
HIV positive educators must be dismissed from work	12%	88%
Can you share laboratory equipments with HIV positive learners	60%	40%
HIV positive learners must be provided with their own separate dishes at school	7%	93%
Will you terminate you friendship with someone if you find out that he/she is HIV positive	7%	93%

TABLE 6

4.4.1. Response to questions about disclosure of one's HIV status and family member's

HIV status

Question 1 and 4 addressed the issue of disclosure. They addressed one's HIV status disclosure and one's family members' disclosure respectively. 80% of participant of indicated they are willing to disclose their status or that of their family members should they get infected HIV while 20% indicated that they will not disclose their status. The fact that there are still people who do not want to disclose their status or that of their family members might be an indication of the fact that people still have fear of being stigmatised and discriminated against because of their HIV status. Indication of their willingness to disclose their HIV status might also signal the fact that they can not voluntarily take an HIV test or freely follow the medical should they be diagnosed to be HIV positive. 20% of participants who have indicated that they cannot disclose their family members status might be conversant with their family members right to confidentiality and the legal implications of disclosing ones status with consent.

4.4.2. Responses to question about playing in the same team with HIV positive school mate

98% indicated their willingness to play in the same team with their teammates who are infected with HIV while 2% percentage said they cannot. This indicates that most of the participants are conversant with the fact that so long as there are no open wounds during contact sports the risk of transmission is minimal.

4.4.3. Responses to questions about sharing with utensils, classrooms, desks and equipments with infected learners.

High percentage of participants indicated their willingness to share utensil at school with infected learners. This shows their desire to be accommodative everyone irrespective of the HIV status. Question number 2, 8 and 9 on the above table addresses the issue of sharing of utensils and equipments with people infected with HIV. 97% of participants indicated their willingness to share a desk with their HIV positive classmates, 93% were against the idea of providing separate dishes to HIV positive learners at schools However there is a notable increase in the percentage of those who say that they are not willing to share laboratory equipments with their infected classmates. This 40% of participants who indicated their unwillingness to share laboratory equipments with their HIV positive classmates might have consider the fact that some of the equipments that they use at the laboratory are sharp and there is a high risk of cuts occurring, if proper care is not taken.

4.4.4. Response to questions about the feelings of being taught by HIV positive educator

89% of participants indicated that they will feel conformable to be taught by HIV positive educators while 11% said they will not. This is a clear indication of the fact that stigma is still a burning issue at schools. Once a learner feels uncomfortable in the presence of HIV positive educator his or her learning will be affected because of the mental state that is not at ease.

4.4.5. Response to question about not allowing HIV positive learners in schools.

93% of the learners indicated that they disagree with the fact that HIV positive learners must not be allowed to attend school. This indicated the fact that high percentage of participants is welcoming and accommodative to classmates who are HIV positive. 7% who indicated their agreement with the statement shows that they might discriminate against HIV positive learners.

4.4.6. Response to question about dismissal of HIV positive educators

88% of the learners are against the dismissal of HIV positive educators while 12% are supportive of the idea. This indicates stigma and discrimination still exist in schools.

4.4.7. Responses to question about termination of friend with HIV positive classmate

93% of learners indicated that they will not terminate their friendship with HIV positive friends while 7% indicated they will terminate their friend , this indicate their level of stigma as well as their discomfort around HIV positive people.

4.5. Result for staff questionnaires

Questionnaires to test for knowledge

	Agree	Disagree
1. You can get infected by sharing toilet with infected person	2%	98%
2. You get infected by sharing kitchen utensils with infected person	5%	95%
3. HIV/AIDS is a punishment for immoral behaviour	3%	97%
4. HIV/AIDS is curable	10%	90%
5. Having sex with a virgin cures one of AIDS	2%	98%
6. Taking shower after having sex with infected person cures one of AIDS	0%	100%
7. Condoms do not prevent HIV infection	0%	100%
8. You are not supposed have sex when you are HIV positive	4%	96%
9. HIV can only be transmitted through sexual inter course	2%	98%
10. HIV/AIDS only affects homosexuals	2%	98%

TABLE 7

Questions to test attitude towards people living with HIV/AIDS

	Agree	Disagree
1. Will you tell any one if you get infected with HIV	20%	80%
2. Can you share a desk with an infected colleague	2%	98%
3. Can you play in the same team with your HIV positive colleague	5%	95%
4. Will you tell your friends if one of your family members get infected with HIV	15%	85%
5. Will you feel comfortable to be teach HIV positive learners	0%	100%
6. HIV positive learners should not be allowed to attend school	2%	98%
7. HIV positive educators must be dismissed from work	0%	100%

8. Can you share laboratory equipments with HIV positive colleagues	100%	0%
9. HIV positive learners must be provided with their own separate dishes at school	2%	98%
10. Will you terminate you friendship with someone if you find out that he/she is HIV positive	5%	95%

TABLE 8**4.5.1. Academic and non academic staff response to questionnaire**

The academic and non academic staff response to questionnaires followed the same pattern as learner's responses by showing a great deal of knowledge and low level of negative attitude towards people living with HIV and AIDS.

CHAPTER 5

DISCUSSION OF THE RESEARCH FINDINGS

5.1. Introduction

The focus of the chapter is the discussion of the research finding in relation with the previous research documents based on the HIV/AIDS stigma and discrimination. The interpretation of the research results will also be covered.

5.2. Discussion on the findings of the questionnaires aimed at assessing learner's knowledge

High percentage of learners indicated that they have knowledge regarding HIV transmission by disagreeing with the statement that one can be infected by HIV by sharing a toilet with people who are infected with HIV or sharing kitchen utensils with them. This can be attributed to the fact that age specific HIV/AIDS education is part of the school curriculum from an early age. Apart from the fact that HIV/AIDS education is offered in schools it is also provided through the help of the mass media, both electronic and print media.

NGOs such as Love Life through their peer education programme is also playing a major role in empowering young people with HIV/AIDS education outside the school environment. Young people relate better to their peers than older people. Providing young people with an HIV/AIDS education helps in empowering learners with information that will help them to make correct decisions regarding sex. This is further supported by the evaluation conducted in 2000 schools around Kenya that found out that AIDS education is effectively promoting healthy behaviours and reducing the risk of infection (Kenya National AIDS Control Council, 2009).

76% of participants indicated that HIV/AIDS is not a punishment for immorality. Despite the effort made to impart HIV/AIDS education to young people there is a significant number of learners who still believe that HIV/AIDS is a result of immorality. This indicates that people react differently to HIV/AIDS. The HIV/AIDS pandemic has evoked a wide range of reactions from individuals, communities and even nations, from sympathy and caring to silence, denial, fear, anger and even violence (Malcolm et al., 1998).

85% of participants indicated that HIV/AIDS is not curable while 15% state that it is curable. Having a misconception that HIV/AIDS is curable may have a negative impact on the efforts being put in place to mitigate the spread of the HIV virus, as this is likely to discourage people from using condoms every

time they engage in sex because they believe that they can still be cured of HIV/AIDS should they get infected. There is also a notable percentage (24%) of participants who indicated that condom does not prevent HIV infection. This perception does not encourage condom use.

Nine percent of participants indicated that having shower after sex cures AIDS. Myths of this nature may lead to increase in HIV infection. It is not encouraging to people to make healthy decision when coming to sex. Five percent of participants indicated that having sex with the virgin cures one of AIDS. Myths still exists in relationship to HIV/AIDS this may result from the fact that most HIV/AIDS programme at school only cover scientific aspects of HIV/AIDS and neglect the social aspects. Most of the current programmes do not empower young people on how to handle social challenges of HIV/AIDS such as dealing with myths and misconceptions associated with HIV/AIDS. Literature on AIDS education states that education programmes that deals with the medical and biological facts, and not with the real-life situation that young people find themselves in does not provide young people with adequate awareness Mac Phail (2002).

5.3. Discussion on research findings aimed assessing people's attitude towards PLHA

Twenty percent of participants indicated that they will not disclose their status if they get infected with HIV/AIDS. The fact that they are not willing to disclose their status might indicate they cannot voluntarily go for HIV test because of the fear of being discriminated and stigmatised. Even when an individual suspects they are HIV-positive, they may not seek a test or treatment if it means going to a known AIDS clinic or a community doctor (Muyinda et al., 1997). The fact that HIV/AIDS is associated with many negative perception such promiscuity and having many sexual partners might also contribute to non disclosure. High level of non disclose is also indicated by participant on their response to question 5 whereby they were asked to whether will they make their family members HIV positive status known.

HIV-stigma is often layered on top of many other stigmas associated with such specific group as homosexuals and prostitutes and such behaviours as injecting drug use and casual sex. These layers of stigma have unfortunately helped to extend and deepen the AIDS stigma to many who are infected with affected by the disease (Herek, 1993; Rushing, 1995; Sontag, 1990).

In a situation where discrimination and stigmatisation of infected people is common keeping quiet about one's status might be perceived as the way of protection from being ostracised. Further more once an individual has decided not to disclose his status, this can ultimately affect his willingness to

attend proper counselling and seek proper health care. Consequences of stigma can be viewed along a continuum from mild reactions (e.g. silence and denial), to ostracism and ultimately violence. Research has indicated that AIDS stigma can have a variety of negative effects on HIV test seeking behaviour, willingness to disclose HIV status, health care-seeking behaviour, and quality of health care received, and social support solicited and received (Boyd et al., 1999; King, 1989; Malcolm et al., 1998; Ravies, Seigel & Gorey, 1998; Sowell et al., 1997).

Ninety seven percent of participants indicated their willingness to share a desk with their infected class mates. This clearly indicates a low level of stigma in a classroom environment as well as acceptance of people living with HIV/AIDS stigma. This acceptance can be attributed to learner's level of education. Level of education plays a major role in reducing stigma. AIDS education also helps to reduce stigma and discrimination, by dispelling false information that can lead to fear and blame. This is crucial for prevention, as stigma often makes people reluctant to test for HIV and individuals that are unaware of their HIV infection are more likely to pass the virus to others (UNESCO, 2009). High level of acceptance is also indicated by hundred percent of participants who indicated that they are willing to play in the same team with HIV infected people and eighty nine percent of participants who indicated that they are more comfortable to be taught by HIV positive educators.

The participant's response to questions to statement number 7 and 8 that deals with the issues of acceptance of HIV positive learners and educators at school indicate low also indicates low level of discrimination and stigmatisation of people living with HIV/AIDS. Such a positive response towards people living with HIV/AIDS at school it is likely to help infected people in dealing and accepting their status. Literature shows that the ways in which individuals discover and disclose their status to other as well as how they cope with their HIV status, is influenced by cultural and community beliefs and values regarding causes of illness, learned patterns of response to illness, social and economic contexts, and social norms (Mechanic, 1995).

High percentage participants indicated their willingness to share utensils and equipments with their fellow HIV positive learners. This shows welcoming and supportive environment for people living with HIV/AIDS at three High schools where the study was conducted. Such environment will be encouraging to people to people who are infected to continue to be part of the school community without fear of being discriminated or victimised. However three percents of participants who indicated their unwillingness to share utensils may be doing so as a way of coping with their fear of

having to come to contact with PLHA. Stigma is one means of coping with fear that contact with a member of affected of group (e.g. by caring for or sharing utensils with a PLHA) will result in contracting the disease (Meisenhelder & La Charite, 1989).

5.4. Summary of the research findings

The general trend across the response given to all questions indicated that stigma and discrimination of people living with HIV/AIDS still exist in schools but at low level. However the responses to question about disclosure of one's positive HIV status showed a light deviation from a trend whereby a considerable high number of participants indicated their unwillingness to disclose their status. This might suggest fear of being discriminated and stigmatised. With regard to knowledge about HIV/AIDS, most of the participants have shown a great deal of understanding while only a few indicated to be still lacking in knowledge.

5.5. Limitations of the research study

There is a need to take note of the fact that there are some limitations when the interpretation of the study is made. The time available for the study made it impossible to use a large sample. Considering the fact that each of the three high school used in the study have more than 700 learners, 20 learners and 7 staff members that took part in the study per school only represents a small percentage of the total school population. The result of the study may not be the true reflection of the attitudes and perception of the of the whole school community. It is also a challenge to take the results as the view of all schools across the country.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1. Introduction

In conclusion some recommendations are made as an attempt to bring about improvement in the current situation that exists in schools, whereby stigma and discrimination is still experienced and people's knowledge about HIV/AIDS is still unsatisfactory.

6.2. Conclusion

The research was intended to assess the effectiveness of HIV/AIDS campaigns in addressing stigma and discrimination in schools. Through responses given by participants it is clear that the level of knowledge pertaining to HIV/AIDS issues is high and low level of stigmatisation and discrimination against people who affected or living with HIV/AIDS, however some participants responses indicated that there is a need to further engage the people in campaigns with a clear intention of imparting knowledge about HIV/AIDS. Irrespective of high percentage that indicated knowledge the need for further training cannot be overlooked, because one person failure to fully comprehend the dynamics of the protection and transmission of the disease can have far much reaching effect. Lack of proper knowledge can lead to a number of undesirable circumstances. Amongst others these may includes further transmission of the HIV, discrimination and stigmatisation of people affected and infected by the disease, fear, denial, non disclosure one's HIV status and failure to voluntarily go HIV test. For effective learning and teaching to take place every member of the school community should feel welcomed and accepted within the school environment. Proper knowledge regarding all aspects of HIV/AIDS may reduce fear and stigma often associated with the disease. The implementation of the below mentioned recommendations might lead to the improvement of the current situations in schools.

6.3. Recommendations

It is evident from the study it is that HIV/stigma and discrimination still exist at schools. If the situation is not responded to adequately it is likely to get out of proportions. Based on the findings of the study the following recommendations are encouraged:

- The study must be extended to cover schools across the province.
- Further training and campaigns are encouraged to address most problematic areas.
- HIV/AIDS policy must be available and accessible in all schools.

- HIV/AIDS policy must be assessed for their suitability to address stigma and discrimination at schools.
- Grievance procedure and rights of PHLA must be clearly spelt out in HIV/AIDS policies.
- Establishment of relevant structure to handle HIV/AIDS related matters.
- Resource should be availed to the structure to enable it to execute its duties.

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APPENDIX A**Questionnaires for learners****Questionnaires to test for knowledge**

	Agree	Disagree
You can get infected by sharing toilet with infected person		
You get infected by sharing kitchen utensils with infected person		
HIV/AIDS is a punishment for immoral behaviour		
HIV/AIDS is curable		
Having sex with a virgin cures one of AIDS		
Taking shower after having sex with infected person cures one of AIDS		
Condoms do not prevent HIV infection		
You are not supposed have sex when you are HIV positive		
HIV can only be transmitted through sexual inter course		
HIV/AIDS only affects homosexuals		

Questions to test attitude towards people living with HIV/AIDS

	Agree	Disagree
Will you tell any one if you get infected with HIV		
Can you share a desk with an infected learner		
Can you play in the same team with HIV positive school mate		
Will you tell your friends if one of your family members get infected with HIV		
Will you feel comfortable to be taught by HIV positive educators		
HIV positive learners should not be allowed to attend school		
HIV positive educators must be dismissed from work		
Can you share laboratory equipments with HIV positive learners		
HIV positive learners must be provided with their own separate dishes at school		
Will you terminate you friendship with someone if you find out that he/she is HIV positive		

APPENDIX B**Questionnaires for educators and non academic staff****Questionnaires to test for knowledge**

	Agree	Disagree
You can get infected by sharing toilet with infected person		
You get infected by sharing kitchen utensils with infected person		
HIV/AIDS is a punishment for immoral behaviour		
HIV/AIDS is curable		
Having sex with a virgin cures one of AIDS		
Taking shower after having sex with infected person cures one of AIDS		
Condoms do not prevent HIV infection		
You are not supposed have sex when you are HIV positive		
HIV can only be transmitted through sexual inter course		
HIV/AIDS only affects homosexuals		

Questions to test attitude towards people living with HIV/AIDS

	Agree	Disagree
Will you tell any one if you get infected with HIV		
Can you share a desk with an infected colleague		
Can you play in the same team with your HIV positive colleague		
Will you tell your friends if one of your family members get infected with HIV		
Will you feel comfortable to be teach HIV positive learners		
HIV positive learners should not be allowed to attend school		
HIV positive educators must be dismissed from work		
Can you share laboratory equipments with HIV positive colleagues		
HIV positive learners must be provided with their own separate dishes at school		
Will you terminate you friendship with someone if you find out that he/she is HIV positive		

Biographical knowledge questionnaire for staff

POST LEVEL	LEVEL OF EDUCATION	RACE
1	Grade 10 and below	African
2	Grade 11 -12	European
3	Matric plus 3 years qualification	Indian
4	Matric plus 4 years qualification and above	Others