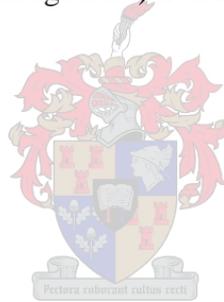


**Perceptions of educators on HIV/AIDS in schools with the
view of Wellness Promotion in the Midlands Area in
Kwa-Zulu Natal**

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



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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 other stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signature:

22 January 2012

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I would like to take this opportunity of thanking the Lord Jesus Christ for the good health and strength that He afforded me during this many years of studying.

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Abstract

The aim of the study was to explore the perceptions of educators regarding HIVAIDS with the view of implementing a wellness programme. The researcher explored the misconceptions that educators, both affected and infected have about the disease. The study objectives were to alleviate the misconceptions that were created by individuals about HIVAIDS and to provide education to individuals on HIVAIDS. It also helped to create an awareness of a healthy wellness promotion programme that will incorporate the physical, emotional, spiritual and social aspects of HIVAIDS.

The study was conducted with educators in the Midlands Area in Kwa-Zulu Natal. The sample was 42 educators and 3 principals from schools in the area. In addition to this a focus group discussion was held with 4 educators. The aim was to get a different perspective from these educators by using probing questions that gave an in-depth explanation to perceptions they had on HIVAIDS and how a wellness programme will help those infected and affected by the disease. Data collection was done through triangulation of three tools: a structured and semi structured questionnaire, focus group discussions and interviews.

The researcher identified gaps in knowledge and to help learners to benefit from the HIV/AIDS prevention programme through education; more can still be done if educators are adequately resourced. It was evident that stigma and discrimination is still very rife in schools and this has not been eradicated completely. This was manifested in the focus group discussion. The study revealed educators were personally affected by HIV/AIDS. Some educators knew of others and learners that are infected and affected with HIV/AIDS. Difficulty was experienced to establish if educators knew of colleagues that have HIV/AIDS. During the study the procedures abided by the ethical principle of privacy. A wellness programme was recommended that will include sporting activity as well as educational programmes assisting to create an awareness of a healthy environment. Peer education can contribute to the delay in onset of sexual activity in secondary school learners. Peer education and support can be regarded as an appropriate strategy to deal with the prevention of HIV/AIDS for young people since they discuss personal issues. The concept of using role models from the sporting community to address students will be valuable.

Opsomming

Die doel van die studie was om die persepsies van opvoeders, met betrekking tot MIV/VIGS, te ondersoek met die doel om 'n welwees-program in te stel. Die navorser het die wanpersepsies ondersoek wat opvoeders, beide geïnfecteerde en geaffekteerde, het rakende MIV/VIGS. 'n Verdere doelwit was om die wanpersepsies by individue rakende MIV/VIGS te verminder en om onderrig aan individue rakende MIV/VIGS te verskaf. Dit het ook gehelp om 'n bewustheid van 'n gesonde welwees-program te skep, wat die fisiese, emosionele, geestelike en maatskaplike aspekte van MIV/VIGS sal dek.

Die studie is onderneem onder opvoeders in die Binnelandse gebied van Kwa-Zulu Natal. Die steekproef het bestaan uit 42 opvoeders en 3 skoolhoofde van skole in die area. Fokusgroep besprekings is ook gehou met 4 opvoeders. Die doel hiervan was om 'n ander perspektief van hierdie opvoeders te kry deur in-diepte gesprekke te voer rakende hul persepsies oor MIV/VIGS en hoe 'n welwees-program kan help. Data is versamel deur drie instrumente: 'n gestruktureerde en semi-gestruktureerde vraelys, fokusgroep-besprekings en onderhoude.

Die navorser het tekortkominge gemerk in die kennisvlakke van die opvoeders rakende MIV/VIGS en ook gevind dat stigma en diskriminasie steeds voorkom in skole. Dit is deur die fokusgroep-besprekings bevestig. Die studie het ook getoon dat opvoeders persoonlik geraak word deur MIV/VIGs. Sommige opvoeders is bewus van kollegas sowel as leerder wat deur MIV/VIGS geraak word, maar daar kon nie vasgestel word of die opvoeders bewus is van kollegas wie MIV-positief is nie.

'n Welwees program is voorgestel wat sport aktiwiteite sowel as opvoedingsprogramme insluit om die bewusmaking van 'n gesonde omgewing aan te moedig. Portuurgroep-opvoeding kan bydra tot die vertraging van seksuele aktiwiteit by laerskool leerders. Portuurgroep-opvoeding en ondersteuning kan beskou word as 'n geskikte strategie om met die voorkoming van MIV/VIGS vir jong mense te handel aangesien dit persoonlike sake aanspreek. Die konsep om rolmodelle uit die sportgemeenskap te gebruik om studente aan te spreek, sal waardevol wees.

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CHAPTER 1 INTRODUCTION

1.1. INTRODUCTION

According to the World Bank, (2002:12) at least 12% of South African education administrative staff and educators are thought to be infected with HIV AIDS. Educators are frequently absent for at least 6 months before developing full borne AIDS. Many educators choose to relocate once they are visibly ill due to the perceived stigma attached to the disease. The perception of most educators is that people infected with HIV AIDS will die within [6-12] months (World Bank 2002:13, United Nations 2003).

Preliminary research in the United States concerning educators' perceptions of HIV positive individuals suggest despite widespread education concerning HIV/AIDS there are still some educators that hold many negative perceptions. Such perceptions include a projected desire to quit teaching before working with someone who has AIDS; fear at having to work with HIV positive individuals and a belief that AIDS is just punishment for immorality (Theron, 2005).

Healthy educators prefer to avoid densely populated aids-infected areas, increasing educator mobility and decreasing educator-learner ratios (Theron, 2005). Temporary educators without adequate experience or scanty training may be hired. Both of the mentioned are inimical to the quality of education and to wellness (Theron, 2005). The implications of the present situation for remaining educators are bleak. Healthy educators will have to contend with augmented workloads and heightened responsibility. Their psychological wellness will be taxed as work demands escalate and as they witness HIV positive colleagues and relative die. The stigma of AIDS causes social isolation which heightens trauma and decreases effective teaching (Theron, 2005).

Stigma and discrimination fuel the HIVAIDS pandemic by creating a culture of secrecy, silence, ignorance, blame, shame and victimization (International Centre for research on Woman, 2003:18). It is further stated that stigma and discrimination felt by individuals are major barriers to utilising health services for prevention, diagnosis and treatment. The shame associated with

felt stigma discourages individuals from seeking Voluntary Counselling and Testing (VCT) and treatment. It further impairs 'educators' abilities to access care or participate in research related to HIV/AIDS. As a result some educators prefer not knowing their status for fear of exposure and their associated risks of stigma, loss of job, break-up of relationships, social ostracism or even violence (International Centre for research on Woman, 2003:18).

1.2. PROBLEM STATEMENT

Education is driven by people and they are the integral part of the education system, but unfortunately the pandemic of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is hindering the education system in Midlands District in Kwa-Zulu Natal.

Ebersohn & Eloff (2003) contend that South Africa is currently trying to achieve a peaceful integration of all people from diverse cultures and races into mainstream society and education. Increased learner diversity can thus be expected to challenge school principals and educators. Beyers & Hay (2007:391) argue that the inclusion of learners with HIV/AIDS in local schools and classrooms presents "probably the ultimate challenge for creating an inclusive environment in the classroom and school". Their argument is based on the fact that the learners who are infected could experience attitudinal barriers from their peer group, educators and the school as a whole and society in general. These learners also experience negative emotions due to trauma, stigmatization and depression that can lead to their need in the classroom. "The danger is ever present that the emotional and social consequences of HIV/AIDS may usurp more and more time and energy of educators and learners" (Beyers & Hay, 2007:392); it is evident additional strain can be placed on educators. The stigma of Aids causes social isolation which in turn decreases the morale, self esteem and teaching ability of educators. Educators who are affected and infected automatically isolate themselves because of fear of the unknown when meeting colleagues and learners.

According to Coombe (2000) stigmatization of infected people is an entrenched response in individuals and is caused by inadequate knowledge, fear of death and disease and sexual morals.

Related experience in schools is that educators perceive HIV/AIDS to be a disease associated with immoral sexual behaviours and it is a disease that has no hope of survival.

According to Nyblade (2002) the stigma surrounding AIDS include amongst others the following prejudices and perceptions HIV:

- Is associated with sexual taboos and immoral behaviour
- Is considered a punishment from God for a sexual sin
- Is caused by sorcery, witchcraft and ill will
- Can be casually transmitted which engenders fear of HIV positive individuals
- Results in painful death and therefore HIV positive individuals must be avoided
- Causes death within a few months due to the loss of weight
- HIV/AIDS infected people need to take bed rest and stay indoors

These perceptions can lead to decline in school and personal wellness (Kelly, 2002). The emotional well-being of educators are affected as they watch their colleagues' health decline due to the disease (Coombe, 2000; World Bank, 2002:13).

Educators like many others are not spared by HIV/AIDS so that, even if facilities continue to be available there may be a lack of educators and other personnel to provide teaching services. It is clear the number of trained educators is decreasing due to the emerging disease. Educators who are infected may try to transfer to another area, or once visibly ill, 'abscond' and disappear. Work load of other educators also increase because they have to take care of the learners in the absence of the 'ill' colleagues.

Educators are faced with the dilemma of dealing with HIV/AIDS learners that are hidden amongst the vast number of children in the school. According to HIV/AIDS Policy the status of learners should not be disclosed without permission and this poses extreme problems to the educator who wants to reach out and provide emotional support to these learners. Supporting this statement Kelly (2002) states that learners with HIV/AIDS often experience lassitude, anxiety, pressure and fear of social isolation due to the fear and stigmatization associated with the

disease. This often makes them unwilling to declare their HIV status and in this way they deprive themselves of the necessary support from schools and their community. It was fitting to explore the perceptions of educators affected and infected so that a wellness programme implemented and perceptions alleviated in the school and community.

1.3 PURPOSE OF THE STUDY

The purpose of the study was to explore the perceptions of educators in relation to HIV AIDS and also to create an awareness of wellness.

1.4 RESEARCH OBJECTIVES

- To alleviate the misconceptions that was created by individuals about HIVAIDS
- To educate individuals on HIVAIDS.
- To create an awareness of a healthy wellness promotion programme.
- To make recommendations to the Department of education who work with people that perceive HIV AIDS as a deadly disease.

1.5 RESEARCH QUESTIONS

- What are the misconceptions of HIVAIDS?
- How is HIV AIDs transmitted?
- What implication has HIVAIDS have on social life, family life and future plans?
- How can behaviours be changed to decrease the pandemic?
- What strategies can be used to educate individuals on HIVAIDS?
- How can awareness be created of a healthy wellness promotion?
- What recommendations can be made to the Department of Education who work with
 - people who perceive HIV AIDS as a deadly disease?
- What education wellness promotion programmes will be appropriate to lessens stigma
 - and prejudices?
- What can be included in a wellness promotion programme?

1.6 SIGNIFICANCE OF STUDY

This study impacted on the wider education system and will provide a healthy environment for educators and learners.

1.7 OPERATIONAL DEFINITIONS

- Soanes (2002:660) defines perception as the ability to understand the true nature of something or as insight.
- Encarta, (2007:1) considers perception to imply a view or a picture. For the purpose of this study, perception is defined as the manner in which educators view HIV AIDS in the learning environment.
- Educators are persons who give systematic, intellectual, moral and social instruction to learners in a classroom setting.
- Learners are recipients of knowledge that is being taught in a learning environment.
- Programme is series or list of events that can be carried out in a learning environment.
- Wellness promotion means emotional, physical mental stability in one's health.

The Department of Public Service and Administration (2002:4) defines a wellness programme as a programme designed to promote the physical and mental health and the well being of employees, including components such as counselling, support groups, nutritional supplements and provision of antiretroviral therapy. It is an intervention aimed at addressing specific issues within the learning environment. Herlihy and Attridge (2005:71) elaborates further a wellness programme is a work based programme that focuses on physical fitness and health-related activities.

1.8 STRUCTURE OF THE STUDY

This chapter identified the problem that would be addressed in this study and provided a rationale for the research. The purpose, objectives research questions, significance of the study, operational definitions were outlined and a brief explanation of the procedures is provided.

Chapter 2 provided a review of the relevant literature relating to the topic of the study. The prevailing situation of HIV/AIDS and the perceptions of educators were outlined. There has

been limited specific research in South Africa on the effect of providing HIV/AIDS wellness promotion programmes to lessen the perceptions of educators, but similar studies from other countries are provided to serve as support for the arguments. The chapter attempted to outline the challenges that teachers faced in their endeavour to effectively implement HIV/AIDS wellness promotion programme when they are also personally affected by HIV/AIDS. Attitudes are defined and conceptualised as well as their different dimensions explained in relation to the successful implementation of HIV/AIDS wellness promotion programme. The role of the educator's attitude in the success or failure to promote an HIV/AIDS wellness was examined and placed in context.

Chapter 3 dealt with the research methodology used in this study with specific reference to subjects, instruments and procedures. The three instruments used for data collection in this study were discussed and explained in detail as well as the analysis of data was outlined.

Chapter 4 is devoted to the presentation and discussion of the analysed data. The aim was to answer the objectives posed in Chapter 1; discuss and interpret the results in the light of previous research.

Chapter 5 contained conclusions on the findings and outlined recommendations. It also included a brief on limitations of the study as well as areas for further research.

1.9 CONCLUSION

In this chapter the introduction, the research questions and objectives as well as the problem statement were highlighted. An in-depth review of the literature pertaining to the topic will be placed in context of the study and highlight the trends of various research papers.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) epidemic was identified in 1981 in the United States of America (Van Dyk, 2001:5). The world is now in its 30th year since the first cases of the Human Immune Virus (HIV) and (AIDS) were identified and still no cure has been found. The latest statistics of the global HIV/AIDS epidemic were published by UNAIDS in November 2010, and refer to the end of 2009. People living with HIV/ AIDS globally are about 33 million people. Adults that are living with HIV/AIDS is about 30 million of this 16 million are woman and approximately 3 million are children. An estimated 5.6 million people were living with HIV/AIDS in South Africa in 2009 that is more than in any other country (UNAIDS, 2010). It is believed in 2009 an estimated 310,000 South Africans died of AIDS (UNAIDS, 2010). Prevalence is 17.8 percent among those aged 15-49 with some age groups being particularly affected (UNAIDS, 2010). Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34 are living with HIV (UNAIDS, 2010).

South Africa has an average of 72.9% pregnant women testing positive at antenatal clinics (Department of Health, 2005). About 20% of South African economically active workforce is HIV positive (Epicentre, 2005:127). South Africa's HIV/AIDS epidemic has had a devastating effect on children in a number of ways. There were an estimated 330,000 under-15s living with HIV in 2009 this is a figure that has almost doubled since 2001 (UNAIDS 2010, UNAIDS 2008). HIV in South Africa is transmitted predominantly through heterosexual sex, with mother-to-child transmission being the other main infection route (UNAIDS 2010, UNAIDS 2008).

2.2. HEALTH POLICY

The South African Department of Education via its policy documents has high expectations of its educators in this regard (Department of Education, 2000; 2002a, b). The National Policy on HIV and AIDS for learners and educators in public schools and for students in further education and training institutions target these groups in public schools and the broader school community. The purpose of this policy is to assist in preventing the spread of HIV infection, to demystify HIV/AIDS, to allay fears, reduce stigma, to instil non-discriminatory and to develop skills,

attitudes and values that students and educators can adopt and maintain behaviours that will protect them from HIV/AIDS (Figure 2.1). This policy is in keeping with international standards and in accordance with education law and the constitutional guarantees of the right to basic education, right not to be unfairly discriminated against, the right to life and bodily integrity, right to privacy, the right to safe environment and the best interest of the child (The National educational Policy Act 1996No.27) on HIV AIDS). According to the Policy Act learners must receive education about HIV AIDS and abstinence in the context of life skills education on an on-going basis. Life skills and HIV AIDS education should not be presented in an isolated learning context, but should be integrated in the whole curriculum. It should be presented in a scientific but understandable way. Appropriate course content should be available for pre- and in-service training of educators to cope with HIV/AIDS in schools (The National educational Policy Act 1996 No.27

2.3 CONCEPTUAL FRAMEWORK

According to the conceptual framework (Figure 2.1) educational awareness plays a major role in promoting wellness for any individuals. HIV and sex education exists in schools as part of the wider Life Orientation curriculum which was implemented in 2002 and also covers subjects such as nutrition and careers guidance. According to a comparative risk assessment for South Africa, unsafe sex ranks as the number one risk factor associated with the loss of potential years of life.

The quality of the education, however, is hindered due to a lack of training of teachers and unwillingness on the part of teachers and schools to provide this education. Training for Life Orientation often takes place outside of school hours which acts as a disincentive to training. The shortage of trained teachers may result in just one teacher in a school being able to teach such classes and school management could be resistant to what is being taught. This has led teaching unions to call for a Life Orientation module to be included in all teachers training (IRIN/PlusNews 2008). In some cases gaps in the delivery of the Life Orientation curriculum may be filled by independent organisations (OneVoice 2011).

In one survey some teachers reported feeling uncomfortable about teaching a curriculum that contradicted with their own values and beliefs. Another problem was believed to be the disadvantaged home life of the students, with some teachers believing poor role models at home

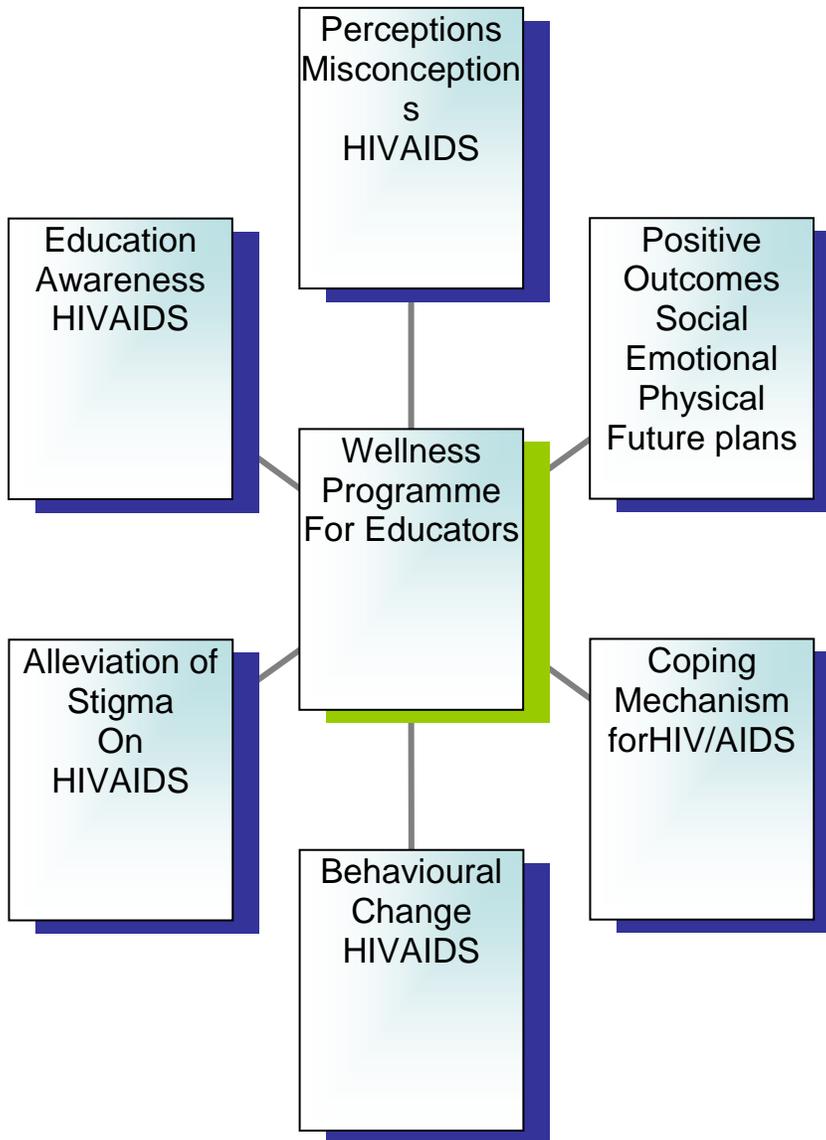
did not help to reinforce HIV prevention messages received in the classroom (OneVoice, 2011). The high dropout rate in South African schools could also compromise effective HIV and sex education. This could mean it is all the more necessary to direct prevention programmes towards younger children while more of them are in education and before most are sexually active (Ahmed et al, 2009).

A study of African universities noted an overwhelming atmosphere of ignorance, secrecy, denial and fear of stigmatization and discrimination in relation to AIDS (World Bank, 2002:14). The conceptual framework (Figure 2.1) addresses the need for behavioural changes that will assist individuals to come to terms with the disease and hereby have a change of lifestyle.

Research in the United States concerning educator perceptions of HIV positive individuals suggests despite widespread education concerning HIV and AIDS, there are still some educators who hold many negative perceptions (Carboni & Dawson, 2001). Such perceptions include a projected desire to quit teaching before working with someone who has AIDS, fear at having to work with HIV positive individuals and a belief that AIDS is just punishment for immorality (Carboni & Dawson, 2001).

Figure 2.1

Conceptual Framework for Exploring the Perceptions of Educators on HIVAIDS with a view of a Wellness Programme.



Source: Adapted from the Yethu I Wellness Employee Wellness Program (EAP).
www.serviceseta.org.za/furtherinfo.html.

According to the frame work (Figure 2.1) HIV/AIDS epidemic has already impacted significantly on the South African society. Kidd and Clay (2003:17) stress research has shown that everyone has some information about HIV/AIDS but a few have enough information to overcome the irrational fears associated with its transmission. The nature of prejudices remains an enigma even after more than two decades of experience with the HIV/AIDS pandemic. These challenges demand that educators and learners understand and are able to address the perceptions of HIV/AIDS in the learning environment (Figure 2.1).

2.4 EDUCATION IN SOUTH AFRICA

Prior to 1998 the response to HIV/AIDS in South Africa was mainly restricted to the health sector. Since then other government departments have come on board in the fight against HIV/AIDS notably the Department of Education. In the Education White paper 6 of 2001 (Department of Education, 2001) inclusive education was promulgated and the development of it in schools should take the incidence and effect of spreading of HIV/AIDS into consideration. South Africa has streamlined a range of policy initiatives at national level into a national programme to combat the spreading of HIV/AIDS. The broad national plan to guide South Africa's response to the pandemic was launched by the South African Minister of Health in June 2000 (Prinsloo, 2005). The plan wants to address and reduce the effect of HIV/AIDS on individuals, families and communities. Researchers such as Vandemoortele & Delamonica (2000) feel education has the potential to influence family and community environments and promote socially acceptable behavioural change as mapped out in the conceptual framework (Figure 2.1).

The broader socio-psychological South African context in which educators function is stressful because they are faced with the rise in the cost of living and high crime rates, in addition added stress of inadequate training and teaching in under resourced at schools (Van Zyl & Pietersen, 1999). Added to this generally challenging context is the potentially stressful impact of the HIV epidemic amongst educators. The rate of educator attrition in South Africa is so alarming that the Education Labour Relations Council (ELRC) commissioned a study to look into the reasons for the situation (Hall, Altman, Nkomo, Peltzer&Zuma, 2005). According to the conceptual framework social and economic realities have a direct impact on HIV/AIDS as well as the quality

of life of educators and learners and their potential success. Since 2007 government funding has been pledged and teacher training had been selected as a special focus for HIV/AIDS curriculum and skills development (Human Sciences Research Council, 2009).

Worldwide the nature of educators is changing (Hall, 2004:5) and the context in which teaching occurs progressively regulates their identity and related activity and ultimately educator health. Increasingly educators in the Western world are expected to respond to situational and relational macro- and micro-trends within the societies (Hall, 2004:4-12); is also applicable to educators in South Africa (Le Grange, 2008). Worldwide educators report feelings of careworn and being dispirited (Hall, 2004:9). South African Educators including those affected by the HIV/AIDS pandemic, report similar stressful and burdening experiences (Theron, 2007). Many South African educators considering quitting the teaching profession expresses the challenges of the profession in an HIV-altered reality as one of the factors motivating their attrition (Hall et al, 2005:27). The changed demands of teaching in a context of HIV/AIDS and the lack of support for affected educators are used as a rationale for the concept of Resilient Educators (REds) support programme (Esterhuizen, 2007).

The forceful call for the support of South African educators affected by HIV/AIDS is related to the belief that the infections have radically altered teaching for many South African in the profession (Theron, 2007). This altered educator experience is related to them being affected by colleagues, learners and or family members being HIV positive or dying from AIDS related illness, or to teaching infected orphans and learners made vulnerable by this pandemic (Hall et al, 2005:23-24). A photo voice study conducted with 40 educators in Kwa-Zulu Natal suggested they experienced the impacts of HIV/AIDS as a 'traumatic journey' and that it had become a 'heavy load' (De Lange, et al 2006:59).

In a survey on educator perceptions of HIV/AIDS and positive infected colleagues and the impact thereof on wellness was conducted by Vaal Triangle Campus in North West University and it was found educators generally perceived HIV to be a sexually transmitted terminal disease. Responses suggestive of stigmatization were in the minority; 3.4% of participants suggested AIDS is a moral scourge, reflective of sexual taboos or unwise sexual practice. The study also revealed educators

generally perceived HIV positive individuals to be terminally ill and those who may not be discriminated against. Responses suggestive of stigmatization were in the minority; 2.5% (7) of participants suggested HIV positive individuals are immoral and irresponsible, 5.9% of the responses reflecting negative perceptions came from White educators. Educators generally perceived HIV positive colleagues who are terminally ill should be allowed to continue their profession without being discriminated against. There is a call for infected educators to be treated with dignity and receive moral support to continue for their daily lives. Only 8.1% of participants suggested HIV positive educators are immoral and irresponsible and should be barred from teaching, 6.5% of the responses reflecting negative perception came from white educators, 7.2% noted ill educators are prone to absenteeism, 6, 8% of the latter responses were made by black educators, 20% of all responses suggested a need to be careful to avoid contact with HIV positive educators.

The same study revealed the impact of HIV positive educators on general school wellness was considered negative, 65% of all participants suggested this group is physically and emotionally ill with poor teaching outcomes and that the impact of them on learner wellbeing was also perceived as being negative; 52% of all responses suggested learner's wellbeing suffers as a result of disrupted education because of frequently absenteeism. The impact of HIV positive educators on colleagues' wellness was generally considered to be negative, 29% of educators responded HIV positive educators create tension because there is avoidance of colleagues and discomfort that causes stress in management of the disease. The knowledge that HIV is a pandemic impacted negatively on educators personal wellness, 33% of educators were psychological burdened because of the death of loved ones and friends and depressed by the stigma of AIDS.

Makuka and Kalikiti (1995) stress AIDS cases and deaths among teachers have had various perceived negative impacts such as they become over-concerned about their health and therefore become nervous and depressed. The teachers are frequently absent and their attitudes to work deteriorate thereby making them unable to perform effectively.

According to Theron (2005) many educators choose to relocate once they are visibly ill or simply disappear, leaving classes without any leadership. Rural areas are especially affected as infected

educators require urban medical services. Ill educators who remain in their post cannot provide the same quality of teaching. Learners observe HIV positive educators' health decline, absenteeism and their eventual death. The value of educators as positive role models will be severely diminished; absenteeism is not restricted to infected educators only. Educators who have infected family members have a higher rate of absenteeism too as they are engaged in caring for ill relatives or burying their love ones (Fredrikson&Kanabus, 2002). Illness disrupts learning and teaching and well educators will have to take on an extra load when their sick colleagues are absent (Theron, 2005). Learners who are ill fall behind with their studies; have to cope with family members that are ill and eventually die. There is a ripple effect that occurs in the schools when educators die of HIV/AIDS as this disrupts the order of day (Theron, 2005).

According to Coombe (2000) the HIV/AIDS pandemic affects and disempowers the education system. In the light of this, the South African education system accepted the challenge to become a central player in addressing the challenges presented by the HIV/AIDS pandemic. One of the nine priorities formulated for educational development addresses the response of the education system to the HIV/AIDS challenge (Prinsloo, 2005). According to Prinsloo (2005) the Tirisano Plan highlights three projects as an intervention strategy for the education system to address the HIV/AIDS pandemic; three projects incorporate the conceptual framework. The first project wants to create awareness about the pandemic, disseminate relevant information to eradicate all the myths about HIV/AIDS and combat discriminatory practices against the individuals infected by the HI virus. The second project wants to ensure that life skills and HIV/AIDS education are integrated into the curriculum at all levels. Learners of all ages should be empowered with knowledge, values and attitudes to make them less vulnerable to the onslaught of the illness. The third project involves planning for HIV/AIDS and the education system where the strategic objective is to develop models to identify the potential effect of HIV/AIDS on the education system.

According to Scriven & Sitddard (2002) it is time to call a spade a spade until a cure is found to alleviate the problems of HIV/AIDS. This reality includes a flexible approach to the curriculum, additional teaching and the administrative workload and possibly less contact session in the classrooms if learners without educators have to be accommodated. There is growing trend under

HIV/AIDS condition to have less demand for current formal education service, a decreased supply of schooling services, reduced quality of education and more inequality of opportunity with female students often affected sooner and more adversely.

Education systems are seeking to respond to the pandemic by introducing various curriculum changes, almost all relating to the introduction of life skills, sexual reproduction and reproductive education (HIV/AIDS and education programme, 2001- 2003). Building capacity to cope with the pandemic can involve educators, educational, administrative, religious leaders and the community at large (HIV/AIDS and education programme, 2001- 2003).

Because of possible differences in the perceptions of the pandemic, it is necessary that training for common focused action be offered to those who will be involved. Training can focus on support of affected educators and learners, enhancing awareness about the pandemic, encouraging people to live positively with HIV/AIDS and making provisions of related education (HIV/AIDS and education programme, 2001- 2003). In the light of the prevailing situation it will be necessary to engage people to become open about AIDS problems. Denials are still prevalent in many of the communities regardless of the knowledge about the pandemic. This makes it difficult to make use of the indicators such as the number of deaths due to AIDS (HIV/AIDS and education programme, 2001- 2003).

HIV/AIDS affects the process of education because of the new social interactions that arise from the presence of AIDS affected individuals in schools; community views of educators as those who have brought the pandemic into their midst; the erratic school attendance of pupils from AIDS affected families; and the erratic teaching activities of teachers who are personally infected or whose immediate families are infected by the disease. In available evaluations performed in developing country it was found that education and behaviour change programmes contributed to awareness and knowledge of HIV but had weak to moderate effects on sexual risks behaviour (Logan et al, 2002).

2.5 SUPPORT FOR PLWHA

A meta-analysis of 22 school-based HIV education interventions in developing countries, Kirby et al, (2006) concluded the majority of programmes had some effect on reported risky sexual behaviour. They also identified characteristics of effective preventative intervention, such as participation of all stakeholders, focus on specific behaviour, creation of a safe environment and fitting into community values and resources. Programmes should be specifically developed to match the culture, age and sexual experiences of participants and should address the underlying reasons for high risk behaviour. On a broader level lack of recreational facilities and social norms such as intergenerational silence about sexual behaviour and status of woman and socio-economic environment also play a role (Eaton et al, 2003).

Effective support from the perspective of health promotions can be offered and attrition diminished if the health of affected educators is promoted (Allegrante, 1998). Health is not understood as merely the absence of disease, but rather as a holistic composite, which relates to wellbeing on physical, mental, and social levels (Ross&Deverell, 2004). More recently spirituality has been included as an important facet of wellbeing (Temane and Wissing, 2006).

According to the conceptual framework if educators affected by the HIV epidemic are to be empowered towards coping while remaining within the profession, then it is necessary to understand how the epidemic affects their health (i.e. total educator functioning). Furthermore, if educators are to be empowered towards coping it is necessary to understand what relevant skills they have used so far in order to function adequately. More recently psychology has moved away from the pathogenic approach to one which acknowledges that adverse experiences can result in personal growth, resilience and sustained or elevated health (Almerdom, 2005). Thus if educators need to be empowered the focus on their response to the epidemic should include positive outcomes. The definition of health as a composite well being was introduced at the 1946 International Health Conference in New York by the World Health Organization (WHO 1948). Despite this definition being almost 60 years old it is still accepted as an authoritative explanation of health.

Health promotion is a process that relies on inter- and intra personal processes that prioritise, facilitates or maintain health. It is not sufficient to establish at what level of health the individual is functioning or which inter-and intra personal processes buffer risk; identification of the level of functioning and protective processes must lead to active, purposeful health promotion. Ideally the process leads to policy formulation that prioritises health, the creation of environments that support health, fortified community actions that attain and sustain health and the development of personal skills that promote and preserve health (Figure 2.1) (WHO, 1986).

There is speculation on what educators' support needs will be (Coombe, 2003) but this does not fully speak to how their health is being affected. The general understanding that a HIV epidemic is deleterious to educators on a personal level and this results in depression, grief and fear (Coombe, 2003; Hall et al, 2005; Theron, 2005); are affected on a professional level which results in lowered morale and higher stress (Hall et al, 2005, Theron, 2005); and does not provide detailed nuances of the impacts with regard to the educator as a human being in his or her totality. Furthermore, there is some literature documenting what, if anything has helped affected educators cope with the impact of the epidemic so far.

2.6. HIV WELLNESS PROGRAMME

According to Van der Merwe (2011) most workplace wellness intervention remains in the awareness phase with newsletters, posters, even talks and workshops. Workplace wellness programs seldom lead to lasting and sustainable health and wellness and behaviour change. According to the conceptual framework Van der Merwe (2011) suggests it is important to use the behaviour change model to adapt workplace wellness interventions accordingly. Interventions have to be planned to accommodate educators and learners at all levels of readiness. The behaviour change model starts with the pre-contemplation or the not-so-ready stage where an individual is not at all interested in health and wellness. The contemplation or thinking-about stage is where they are starting to consider implementing some wellness principles into their lifestyle. The getting-ready stage is when they are prepared to change behaviour. The action or doing-it stage is where they are actually living the changed behaviour. The maintenance or staying-with it stage is when they are feeling much better, or have been in action for long enough to make the new behaviour change their new lifestyle. According to Van der Merwe (2011)

stages of change shows where awareness, behaviour change, supportive workplace wellness environment which includes workplace culture, management buy-in and active participation and sustained behaviour change intervention will have most impact within the behaviour change model within workplace wellness.

According to the UK Discussion Paper (August 2006) on Tackling Aids Through Sport, the 16th International AIDS Conference in Toronto in August, for the first time included a plenary session on the role of sport in combating the HIV/AIDS disease and its social consequences. The UK Government's contribution to that debate was endorsed and the government hopes to stimulate interest and contribute to the growing global pool of shared knowledge and understanding and to inspire and enable further action worldwide to prevent the spread of HIV/AIDS.

The UK Discussion Paper (2006) analyzed the role of sport in tackling AIDS primarily in Africa. The UK Government, the United Nations and the G8 have pledged their commitment to halting the spread of AIDS. There is an urgent need to prevent new infections and to achieve this is to provide young people with the knowledge, life skills and commodities with which to protect them and to provide ongoing support and care to people affected by AIDS, especially children and young people.

Sport is extremely popular amongst young people in sub-Saharan Africa, more so than any other voluntary activity. Sport is therefore a credible and attractive way of engaging the attention of young people and providing a platform from which to promote prevention, de-stigmatization and to encourage the development of important life skills.

The UK, and many other developed countries, recognized the wider role that sport can play in achieving domestic policies – such as reducing harmful drug use, preventing crime, enhancing formal and non formal education and improving health especially among young people. The UK Government identified Africa and tackling AIDS as key priorities for its Presidencies of the G8 and the European Union in 2005. The discussion paper explored the ways in which sports-based interventions contributed to tackling AIDS in Africa.

The role of sport in development has risen up the international agenda over the last five years, gaining recognition at UN level and amongst development agencies and NGOs around the world. In 2003 the UN Secretary General Kofi Annan, established an Inter Agency Task Force to report on the role of sport in development and peace. The Task Force's report found a role for sport as a 'vehicle to help mitigate the spread and impact of HIV/AIDS'. The UK's Commission for Africa report published in March 2005 also recognized the importance of youth culture, including sport, in engaging young people in the response to AIDS. Increasingly academics have realized the potential of sport and have begun conducting research into the value and the impact of sport for social development.

Sport has a vast power to attract and engage young people. In sub-Saharan Africa – where 62% of all young people infected with HIV live – sport is the most popular activity amongst teenagers of both sexes. In a survey for the British Council to gauge the interests of young people aged 11 to 20, sport was the clear top response in the two sub-Saharan African countries surveyed: Uganda (where 88% were interested in sport and exercise) and Zambia (83%) (Main Report River Path Associates, 2005). Despite the often limited opportunities to play sport – especially for girls whose commitments to the household leave them with little free time – and poor sports facilities, engagement and involvement in sport remain strong throughout adolescence for both boys and girls. There is also a strong sense amongst both Ugandan and Zambian boys and girls (94% of the Sub-Saharan Africa sample) that they are interested in sport as a way for them to develop leadership skills (Main Report River Path Associates, 2005).

The findings of the British Council survey supported by the views of children that emerges from an analysis of sporting activities in GOAL Kenya's projects. A survey of 45 participants (19 girls and 26 boys) between the ages of 7 and 22 revealed: 98% like playing sport; 89% participate in the sporting activities arranged by GOAL on a regular basis; 91% think more time should be spent on sporting activities; and 93% like going to school on days when sports are played.

Football had great visibility, support and enthusiasm in sub-Saharan Africa. In terms of overall interest in sport either as a participant or as a spectator, for boys football is by far the most popular activity (Zambia 83% and Uganda 80%) (Main Report River Path Associates, 2005).

The girls in both countries, football ranked second in the list of interests (Zambia: 47% and Uganda: 36%) after basketball and netball respectively. Football is the sport played by most boys in both Zambia and Uganda, although girls' participation is spread across a wider range of sports including football, netball, basketball and volleyball.

Watching football on television is also popular: 73% of Zambians (83% of boys and 63% of girls) and 77% of Ugandans (89% of boys and 68% of girls) reported that they regularly watch it. This makes sportspeople popular, recognizable and credible role models for the young group and provides them with a platform to spread positive messages and behaviour.

In Dakar, Senegal in April 2000, the international community reaffirmed its commitment to achieving education for every citizen in every society. The Dakar Framework for Action, Education for All 2000, outlines goals and strategies for attaining that target by 2015. One important condition for fulfilling children's' right to a basic education, is 'the creation of safe, healthy, inclusive and equitably resourced educational environments conducive to excellence in learning'. Improving students' health and nutritional status can redress common sources of absenteeism, poor classroom performance and early school dropout, and thus boost the possibility of Education for All.

Recognising the importance and potential of a healthy school setting, four international agencies - each with decades of specialised experience working through schools to enhance learning and health - recently agreed upon a shared framework to strengthen school health, hygiene and nutrition programmes. Working together to Focus Resources on Effective School Health ("FRESH"), UNESCO, UNICEF, WHO and the World Bank recommend a core group of cost-effective components, as a common starting point for all schools. The components include: (1) health-related school policies; (2) provision of safe water and sanitation; (3) skills-based health education; and (4) school-based health and nutrition services.

When implemented and coordinated well an effective school health programme can provide a strong foundation from which to build a 'health-promoting school' (UNICEF). For example, with the four common components firmly in place, a school can strive to foster health with all

the measures at its disposal - the defining characteristic of a health-promoting school. This might include health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and many other health-related efforts.

Similarly, FRESH lays groundwork from which to attain the five quality standards of a 'child friendly school'. They include quality of the learners and their experiences and needs, the relevance of the curriculum content and processes, the quality of the classroom and broader school environment, and the appropriateness of assessment and achievement of learning outcomes in areas such as literacy, numeric, knowledge, attitudes and skills for life.

A comprehensive and effective school health, hygiene and nutrition programme can be more valuable in addressing HIV/AIDS than specific HIV/AIDS programmes delivered in isolation. As health outcomes and risk behaviours often share the same root causes and tend to cluster, comprehensive school health programmes can help to address a range of health and social issues, and the factors and conditions that affect them. For example, poor nutrition and limited access to clean water and sanitation compromise the immune system and can lead to a range of illnesses and a general failure to thrive, which affects absentees and also makes learning difficult when at school. Enhancing overall health and nutritional status is an important way to reduce vulnerability to HIV/AIDS and sustain the health of those already infected. The FRESH framework provides a model for linking HIV/AIDS-specific approaches with a broader school health programme. There are some ideas for creating a comprehensive cadre of coordinated strategies.

2.6.1 Core framework for action:

Four components that should be made available together in all schools are:

- Health-related policies – School policies can ensure a safe and supportive environment, both physical and psycho-social, for children and young people in a world with HIV/AIDS. At the national level, appropriate legislation and administrative actions can mitigate the impact of HIV/AIDS by ensuring the rights of the affected people to education, combating discrimination within the education sector and directing resources to

strengthen recruitment, training, management and other elements of a nation's educational infrastructure.

- School and national-level policies can also address factors affecting vulnerability to HIV/AIDS, including all types of school violence (e.g. the abuses of students and teachers, sexual harassment and bullying, corporal punishment); security to and from schools; prevention of discrimination on the basis of gender, pregnancy, religion or culture; gender sensitivity; and provision of recreational activities and safe places to play.

Government commitment can contribute to HIV/AIDS preventing through support and guidance to school-based AIDA prevention efforts, particularly if they are part of united national AIDS plans. National policies should call for coordination of the complementary elements of FRESH and increased multi-sectoral collaboration to support their implementation (WHO, 2000).

- Provision of safe water – Safe drinking water and sanitation facilities are essential first steps toward a healthy learning environment. Diarrheal diseases, helminth infections and other water and sanitation related diseases are heavily affecting children's health, well-being and learning abilities. Ensuring private sanitation facilities and easy access to drinking water both at schools and at home, can enable girls to remain in school, particularly during menstruation. This alone is a powerful defence against HIV/AIDS; young people who drop out to become more vulnerable to HIV infection and a range of other health risks including unwanted pregnancy and alcohol and drug use. For young people living with HIV, sanitation and hygiene is crucial, as each infection may provide the virus an opportunity to multiply. Protection against infections may provide the virus an opportunity to multiply. Protection against infections from dirty water or poor hygiene will help HIV infected children, as well as teachers and other school staff, to remain healthy and productive at school.
- Skills-based health education - Education is the key to reducing stigma and promoting greater understanding of HIV/AIDS. It can also provide life saving skills necessary to protect oneself and care for others. Studies indicate that basic knowledge of HIV/AIDS

among young people is alarmingly low, in many countries. The Progress of Nations 2000 report warns "... overcoming the information deficit among boys and girls about their own vulnerability is a matter of extreme urgency, especially at a time when prevalence levels among 15- to 24-year-olds in some countries are soaring as high as 20-25%."

Well-implemented school-based HIV/AIDS prevention programmes have shown to reduce key HIV/AIDS risks, particularly when they go beyond the provision of information and help young people develop knowledge, attitudes, values and life skills needed to make and act on decisions and opportunities concerning health. For example, psycho-social and interpersonal skills can help young people make informed decisions, be assertive, set goals, negotiate, and other competencies that may help them lead a healthy and productive life. Skills-based curricula should target behaviours directly related to HIV prevention; generic life skills programmes that are not attached to specific outcomes have failed to show positive results.

Skills-based health education to prevent HIV/AIDS can be linked with other issues relevant to young people, including pregnancy and reproductive health, population education, family life education, etc. Teachers must be adequately trained both in-service and pre-service in providing skills-based health education for HIV prevention (e.g., interactive teaching and learning methods) and in ways to protect themselves from HIV.

School-based health and nutrition services - Schools can be efficient settings through which to deliver simple and safe health services, such as school feeding and nutrition programmes, de-worming programmes, life saving immunisations, and monitoring of children's basic health and development. Specific to HIV/AIDS prevention and care, schools can also facilitate access to youth-friendly reproductive and sexual health services, especially early and effective care of STI (which can reduce risk of HIV transmission), reproductive health services, counselling, access to male and female condoms, HIV care and treatment, treatment of opportunistic infections such as tuberculosis, and voluntary and confidential counselling and testing - a service which has triggered many young people to adopt safer sexual practices.

Enhancing overall health and nutritional status is an important way to reduce vulnerability to HIV/AIDS, and sustain the health of those already infected. The benefits are not limited to health, but have been shown to improve enrolment, retention, and performance. While schools and education systems cannot be solely responsible for providing such services, they can network more effectively to facilitate their access, through strong links with local health centres and other community resources.

2.7. CONCLUSION

The perception of educators of the disease HIV/AIDS received attention with a view of the wellness programme that is envisaged. Insight was gained of the problems that are faced by those embarking on the quest to make this a better world in which mankind can live. Research can only be of value if it is supported by material reflecting the views of individuals. Research methodology provides a framework to initiate the collection of relevant information with the view of solving the stated problem of the study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The aim of the study was to explore the perceptions of educators of HIV/AIDS in view with a wellness promotion programme. The study was conducted with educators in the Midlands District of Kwa-Zulu Natal. Answers to the following questions were sought:

- What are the misconceptions and perceptions of educators of HIV/AIDS?
- What will be included in an education wellness promotion programmes that will be appropriate to lessens stigma and prejudices?

3.2. RESEARCH APPROACH

The concurrent triangulation approach is the most familiar approach of the six major mixed methods models. It is selected as a model when a researcher uses two different methods in an attempt to confirm, cross validate, or corroborate findings within a single study (Green et al.1989). According to Creswell (2007) this model generally uses a separate qualitative and quantitative approach as a means to offset the weakness inherent within one method and the strengths of the other method. In this case the quantitative and qualitative data collection was concurrent, happening in one phase of the research study. This strategy usually integrates the results of the two methods during the interpretation phase (Creswell, 2007). This interpretation can either note the convergence of the findings as a way to strengthen the knowledge claims of the study or explain any lack of convergence that may result (Creswell, 2007). This decision to use both the methods was advantageous because it is familiar to most researchers and can result in well validated and substantial findings. In addition the concurrent data collection results in a shorter data collection time period has compared to one of the sequential approaches (Creswell, 2007).

The disadvantage of triangulation is that the researcher needs an increased amount of time in comparison to single strategies, difficulty in dealing with a vast amount of data, conflict because of theoretical framework and lack of understanding about triangulation (Sohier, 1988).

According to Merriam (2002) in a qualitative study the researcher is interested in understanding the meaning a phenomenon has for those involved. Understanding the meaning a phenomenon has, the researcher goes to the setting to in order to interview and observe participants in their context. The qualitative study focuses on meaning-making processes the product is richly descriptive in words and sometimes pictures; data are very often in the form of participants' own words.

According to Harvey (2002:5) "quantitative data are data which can be sorted, classified, measured in a strictly objective way, they are capable of being accurately described by a set of rules and formulae or strict procedures which then make their definition unambiguous and independent of individual judgements".

3.3. DATA COLLECTION METHOD

LoBiondo-Wood and Haber (2002:301) state "questionnaires are paper and pencil instruments designed to gather data from individuals about knowledge, attitudes, beliefs and feelings". The questionnaires was distributed and collected at a central and secure point. The researcher allowed the participants to fill in the questionnaire in their own time to avoid any influences.

There was awareness of some possible limitations related to the quantitative research method which did not provide an in-depth picture of issues and feelings and therefore the researcher opted to do interviews and focus groups to gain an in-depth knowledge of the perceptions of educators. Fouche and Delpont (2005:74) define the qualitative research paradigm "as research that elicits participants' accounts of meaning, experience or perceptions. It produces descriptive data in the participants' own response." Burns (2000:11) maintains the role of a qualitative researcher is to capture what people say and do as a product of how they interpret the complexity of their world, to understand events from the viewpoints of the participants.

The qualitative research methodology was utilised because it is the approach that seeks to understand the meaning people attach to their daily life, including perceptions and experiences. Thus, the qualitative study is carried out in a real life situation in an attempt to understand the

phenomenon in context (Maree, 2007). The interview questionnaire will be analyzed using content analysis; content analysis is a method for summarizing any form of content by counting various aspects of the content (Polit & Becks, 2008).

Babbie (2005:484) defines an interview as “a data collection encounter in which one person asks questions of another”. Differences exist between interviews conducted for a qualitative study and those conducted for a quantitative study. In qualitative studies the interview format was open ended questions. Although the researcher defined the focus of the interview there was no fixed sequence of questions. The questions that were addressed in the interviews tended to change as the researcher gained insight from previous interview and observations.

Participants was allowed and even encouraged to raise important issues not addressed by the researcher. Interviews in the qualitative studies range from semi-structured (fixed set of questions) to unstructured (open-ended questions with probes) (Burns & Grove, 2007).

The interview schedule was prepared beforehand to assist with a smooth flow of activities. The interview schedule focused on a few concise questions or themes. Questions were logically and sequentially formulated. Open ended questions were asked and follow up questions developed on interesting issues that was relevant to the study.

According to De Vos et al. (2002) interviewing is the predominant mode of data collection in qualitative research. Silverman, cited by Cohen et al. (2005) points out those interviews are useful for gathering facts, assessing beliefs about facts and identifying feelings and motives. Tuckman (as cited in Cohen et al., 2005:35) states the purpose of an interview is to be “used as a principle means of gathering information directed to research objectives, it provides access to what is inside a person’s head, it makes it possible to measure knowledge and information what the person likes and dislikes and what the person thinks in terms of attitudes and beliefs”. The interview gave the participants an opportunity to express them with regard to the research topic and to give their own points of view. Interviews were used to capture detailed accounts of the views, perceptions and understanding of educators about HIV/AIDS and a wellness promotion programme.

Johnson & Christensen (2000) describe focus groups as a type of group interview in which the researcher leads a discussion with small groups of individuals to examine in detail how the group members think and feel about a topic. One focus groups discussion was held with educators from schools. The focus group discussion was informal and the researcher had probing questions that was addressed. The researcher focussed on the experiences , barriers, training programmes, as well as what did they see fit as a wellness programme for people lining with the pandemic of HIV/AIDS. The researcher also probed into the aspect of VCT as well as top management role in this aspect.

3.3.1. Data collection process

According to Brink (2006) the researcher is guided by the five important questions: What? How? Who? Where? When? A researcher will consider what type of information is required for the study. The researcher will identify how data will be collected and what research instrument will be used. The type of instrument can vary from a checklist to questionnaires (Brink, 2006). If the researcher is going to collect all the data; the ‘who’ question is easy to answer. The setting where data will be collected must be carefully determined. This could take place in an appropriate setting, keeping in mind that the researcher will be mindful of not exposing her clients and maintaining confidentiality. Researcher must decide when data will be collected. The researcher collected data in the month of November 2011. Individual interviews were conducted and questionnaires were handed to the principles of three different schools. The interview had probing questions and also clarified what was expected in the questionnaire. Focus group discussion was held with educators from the different schools.

3.2.2 Data analysis.

Babbie (2001:10) defines data analysis as “a process of making sense of what has been observed”. De Vos (2005:333) adds data analysis is a process of bringing order, structure and meaning to the mass of collected data. Qualitative data analysis transforms data into findings; data was recorded in notebooks and notes were taken during each interview.

Nine step procedures for data analysis were adapted by a guide that was given by Thavhanyedza (2009), the nine steps are depicted as follow:

<p>Step 1: Planning for recording of data.</p> <p>The researcher planned how data was recorded and used interview notes to further probe the situation.</p>
<p>Step 2: Data collection and Preliminary analysis.</p> <p>The researcher analysed the data during the interview process with the participants.</p> <p>After conducting the interview, the data collected from each interview was analysed.</p>
<p>Step 3: Managing or organising the data.</p> <p>The researcher developed a data inventory system. The interviews and semi structured questions was collected and organised by the researcher. This was entered electronically and a back up system was in place.</p>
<p>Step 4: Reading and writing Memos.</p> <p>After writing and reading the interviews the researcher gained much more insight to the problem at hand. The reading was done so that categories and themes can be established.</p>
<p>Step 5: Generating categories, patterns and themes.</p> <p>The researcher identified common themes and placed them under set categories</p>
<p>Step 6: Coding the data.</p> <p>The researcher applied a coding scheme to the identified themes and categories. The researcher used numbers to code the themes and categories.</p>
<p>Step 7: Testing emergent understandings.</p> <p>The researcher evaluated the usefulness and centrality of data that was presented in the themes</p>
<p>Step 8: Searching for alternative explanations.</p> <p>The researcher used the critical analytical competence to identify and document alternative explanation, herby justifying any apparent plausible explanation.</p>
<p>Step 9: Writing a report.</p> <p>The data was analysed and grouped into themes and a pattern.</p>

3.3 RESEARCH POPULATION

According to Burns (2000:83) a population is an entire group of people or objects or events, which all have at least one characteristic in common and must be defined specifically and unambiguously. Rossouw (2003:103) defines a population as a collectively that researchers plan

to study and about which they want to make a statement. The population for the purpose of this study included the educators in schools in the Midlands area of Kwa-Zulu Natal.

3.4 RESEARCH SAMPLING

Soanes (2002:794) defines a sample as a small part or quantity intended to show what the whole represents. A sample will be defined in this study as representatives of the population; will include educators from both rural and urban settings.

Sampling is a process of selecting part of the group under study (Rossouw, 2003:103). Sampling methods are classified as either probability or non probability. In probability samples, each member of the population has a known non-zero probability. Probability methods include random sampling, systematic sampling and stratified sampling. In non- probability sampling, members are selected from the population in some non random manner. These include convenience sampling, judgement sampling, quota sampling and snowball sampling. Convenience sampling was considered for the purpose of this study. Convenience sampling was used where the researcher was interested in getting an inexpensive approximation of the truth. As the name implies, the sample was selected because it was convenient. There were six schools that were identified for the study. The principal of the sixth school felt that this school is not affected by the disease of HIV/AIDS. The researcher adhered to one of the principles of ethical consideration i.e. voluntary participation.

3.5 ETHICAL CONSIDERATIONS

Burns (2000:17) indicates the ethical principles, rule and conventions distinguish socially acceptable behaviour from that which is considered to be socially unacceptable. Babbie (2001:470) elaborates by stating that anyone involved in research needs to be aware of the general agreement about what is proper and improper in scientific research. Various authors (Burns, 2000:18-22; Strydom, 2005b:58-69) contend it is important to consider ethical aspects in order to do the following: avoid physical and emotional harm; obtain informed consent; avoid any deception of participants; maintain confidentiality; enhance the researcher's competences; debrief participants and ensure cooperation with contributors. The researcher abided by the discussed guidelines.

3.5.1 Voluntary participation.

According to Cohen et al (2000) respondents cannot be coerced into completing questionnaires. They may encourage, but the decision to become involved and when to withdraw from the research is entirely at their discretion. The researcher explained that participation was voluntary and that they could withdraw at anytime with no obligation.

3.5.2 Privacy, anonymity and confidentiality

Strydom (2005:61) mentions privacy implies the element of personal seclusion, while confidentiality indicates the handling of information in a classified manner. It is believed confidentiality could only be achieved if no names of participants are revealed. Anonymity and confidentiality was ensured by keeping the questionnaires under lock and key until the study is over. The researcher was personally responsible for all questionnaires.

3.5.3 Avoidance of harm

Participants were not put at risk and vulnerable populations were respected. In additions to this proposal an informed consent form was developed for participants before they engaged in the research. The following form acknowledged those participants' rights was protected throughout the research. According to Sarantakos (2005) the following aspects must be included:

- Identification of researcher
- Indication – how participants – selected
- Identification of purpose research
- Identification of benefits of participating
- Identification level and type of participant involvement
- Notation of risk to participants
- Guarantee of confidentiality
- Assurance that participants can withdraw at any time
- Provision of names of persons to contact if questions arise

An ethical issue may arise when there is a need to anticipate the possibility of harmful, intimate information being disclosed during data collection process e.g. a learner may discuss parental

abuse, sexual abuse. It is difficult to anticipate and try to plan for the impact for this information during and after the interview (Palton, 2002).

3.5.4 Debriefing of participants

Debriefing sessions after the study, during which the participants has the opportunity of working through their experiences and its aftermath, are one way in which researchers can assist the respondents in minimising any possible harm which may have been done, in spite of all their precautions against such harm (Strydom, 2005: 67). In this study of exploring the perception of educators on HIV/AIDS no harm was inflicted and therefore debriefing of the participants after the interviews was not fundamental but was exercised when necessary.

3.5.5 Permission from the Department of Education was obtained.

In planning a study it is important to anticipate repercussions of conducting the research on certain audiences (learners and educators) and not to misuse the results to the advantage of one group (School) or another. Researcher should provide these at the research site with a preliminary copy of any publications from the research (Creswell, 2007).

Permission from the department of education as well as from the individual schools was obtained (Appendix A).

3.6. LIMITATION OF THE STUDY

The greatest limitation was time factor. The researcher is employed as teacher at secondary school and is a single parent with 3 children. The sample size could have been bigger and this would have allowed for a wider opinion of educators and their perceptions. The researcher felt that the sixth school would have helped to change the demographics of the study.

3.7. CONCLUSION

The research paradigm, design, methodology and ethical considerations have been discussed to provide a basis for calculating, analysing and discussion the findings. Presenting the findings and relating it to solve the problem will make a contribution towards the body of knowledge.

CHAPTER 4

RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

The analysis of data and presentation of the results is an extension after all the data was collected from the various sources. The data was gathered, managed and analyzed using Statistical Package for Social Science (SPSS 19). Data was coded, entered, analyzed and verified by the researcher. The data was analyzed by tallying and tabulation. Data was described using descriptive statistics and was also presented in the form of graphs, and tables from the Statistical Package for Social Science 19 (SPSS 19).

4.2 POPULATION AND SAMPLE

The target population of this study was the educators from schools in the Midland District of KwaZulu Natal. There were six schools identified for this research but one school did not give permission for the study. The study sample consisted of 42 educators and 3 principals. The total number of educators who voluntarily participated in the study was 42 in total. The researcher distributed 45 questionnaires to study participants and only 42 questionnaires were returned and completed by participants. Ensuring to maintain confidentiality the researcher had all questionnaires coded. The participants signed a consent form to ensure they were willing to participate in the study.

Figure 4.1
Gender

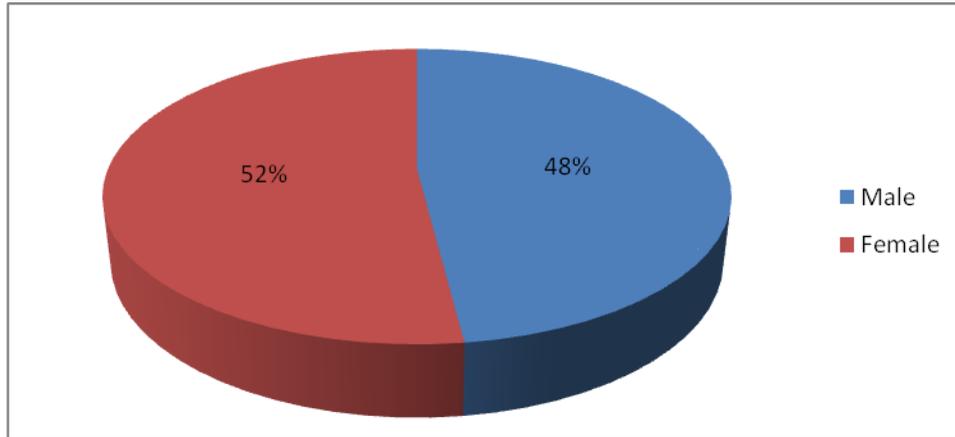


Figure 4.1 shows that 52% (n= 22) of the study participants were female and 48% (n=20) were male participants.

Table 4.1
Educator

	Frequency	Percent
Yes	41	98%
No	1	2%
Total	42	100%

Table 4.1 depicts where 98% (n=41) of the study participants were educators and only 2% (n=1) never responded to this variable. This may have been an error of omission by the participant completing the questionnaire.

Figure 4.2
Experience being an educator

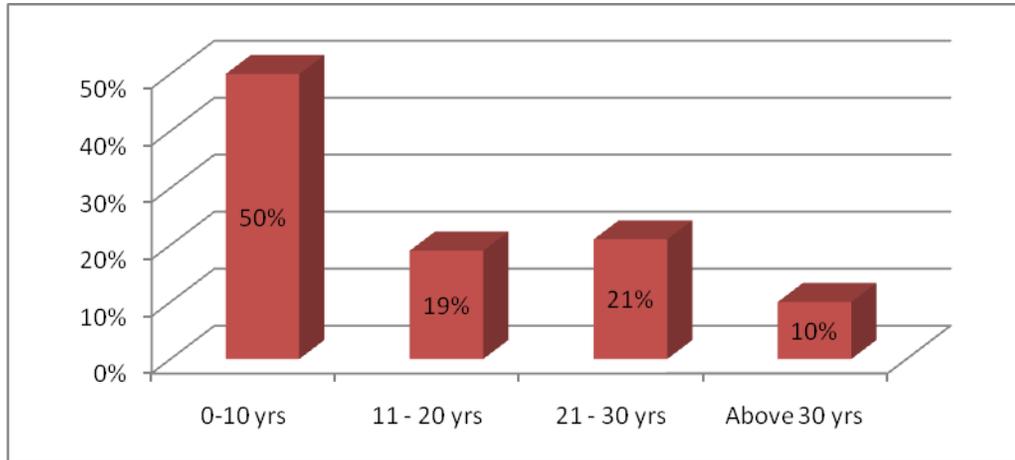


Figure 4.2 shows 50% (n=21) of the participants had an experience between 0-10 years as an educator, followed by 21% (n= 9) had experience between 21-30 years as an educator, followed by 19% (n=8) had an experience between 11-20 years as an educator, and 10% (n= 4) had an experience above 30 years as an educator.

Figure 4.3
Race

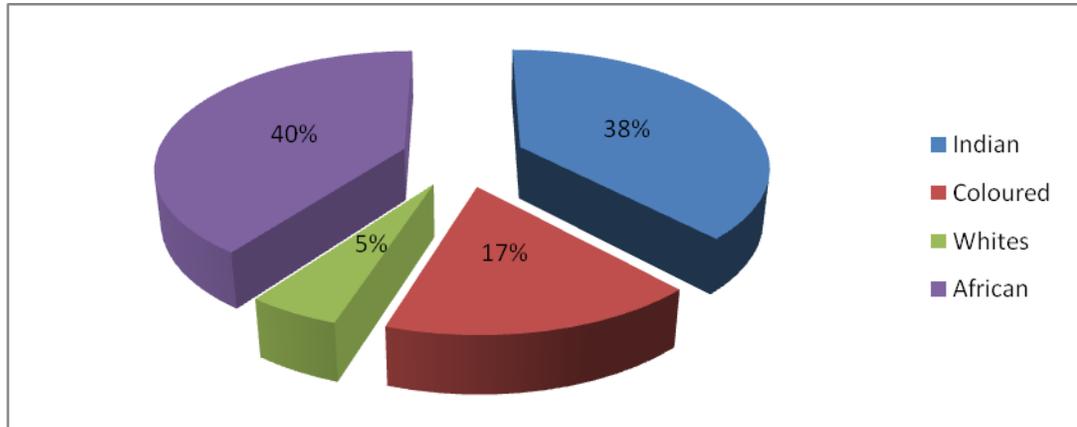


Figure 4.3 depicts that 40% (n= 17) of the study participants were African Coloured and 5% (n= 2) of the study participants were Whites.

Table 4.2
Age Group

	Frequency	Valid Percent
20-25 yrs	11	26%
26 - 30 yrs	3	7%
31-35 yrs	7	17%
36-40 yrs	4	9%
41-45 yrs	5	12%
46-50 yrs	4	9%
51-55 yrs	6	14%
Over 55 yrs	2	5%
Total	42	100.0

Table 4.2 depicts that the majority of the study participants were 26% (n=11) ranging from 20-25 years of age, followed by 17% (n=7) were at the age between 26 – 30 years of age, followed by 14% (n=6) were at the age between 51-55 years old, followed by 12% (n=5) were at the age between 41-45 years old, followed by 9% (n=4) were between the age of between 36-40 years and 48-50 years old respectively, 7% (n=3) were between the age of 31-35 years old and 5% (n=2) were over 55 years old.

Figure 4.4
Type of area live

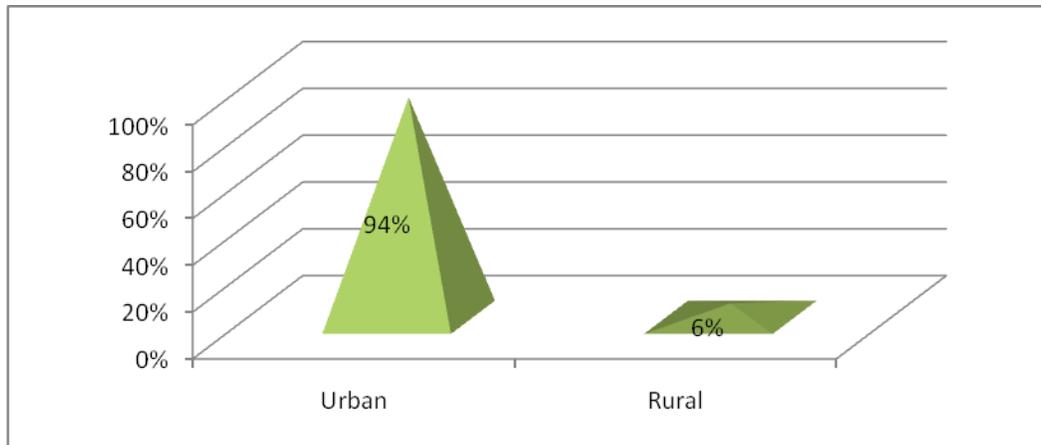


Figure 4.4 shows that 94% (n= 34) of the study participants residing in urban area, and 6% (n=8) residing in rural area.

Figure 4.5
Willing to live with people having HIV/AIDS

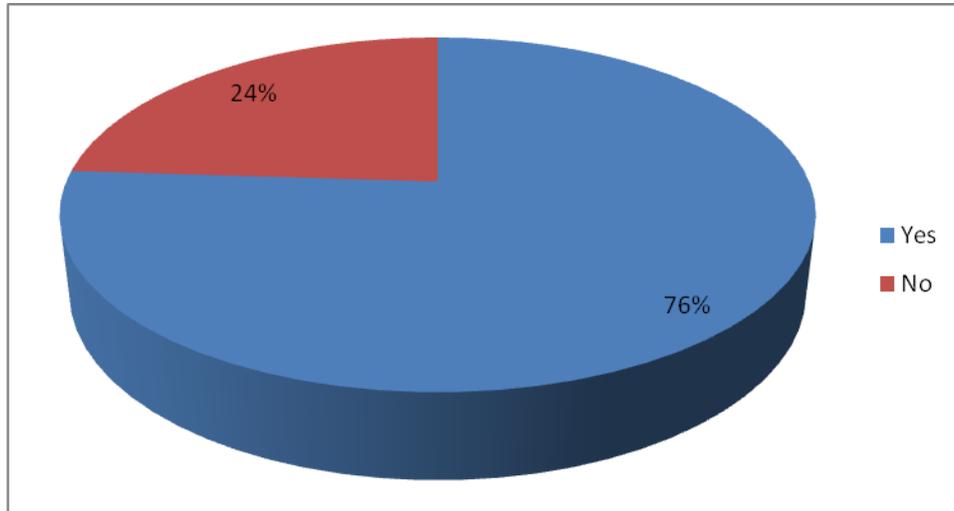


Figure 4.5 shows 76% (n= 31) willing to live with people having HIV/AIDS, and 24% (n= 11) not willing to live with people having HIV/AIDS.

In figure 4.5 there is an increased willingness of people wanting to live with people living with HIV/AIDS because of the awareness campaigns that HIV/AIDS is not transmitted through just touching someone or sharing a utensil with the infected person. According to Adesoji (2005) HIV/AIDS is a social issue and could therefore be brought into education with the aim of bringing about a change in behaviour within the society. This makes a difference in acceptance of the disease. The conceptual framework suggests that behavioural change will contribute to the wellness of those that are affected and infected with HIV/AIDS.

Table 4.3**Reluctant to live with people having HIV/AIDS**

	Frequency	Percent
Yes	12	29%
No	30	71%
Total	42	100%

Table 4.3 shows 71% (n=30) were not reluctant to live with people having HIV/AIDS and 29% (n=12) said yes they were reluctant to live with people having HIV/AIDS. Question in figure 4.6 and in Table 4.3 reinforces that people are willing and not reluctant to live with people that are HIV/AIDS infected because the percentages are almost similar. There are two aspects to figure 4.6 and table 4.3., the first is that people are willing to live with PLWHA because of the infected person maybe a close family member and out of this obligation there is willingness. Figure 4.6 depicts that 86 % of the participants responded positively and this because people are educated at the workplace and even though they come into contact they are aware that they will not be infected just by holding hands or hugging someone.

Figure 4.6
Dislike having contact with HIV/AIDS people

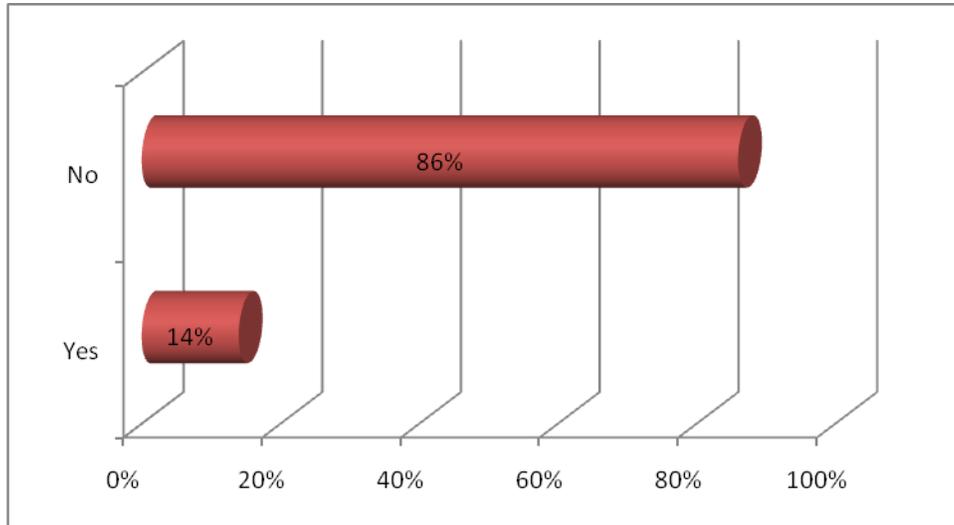


Figure 4.6 depicts 86% (n= 36) like having contact with HIV/AIDS people, and 14% (n= 6) dislike having contact with HIV/AIDS people. According to the response that only 14% disliked having contact with HIV/AIDS people suggest that the community response to the pandemic of HIV/AIDS is being transformed by education of the public about the disease (Coombe, 2001).

Figure 4.7
Feeling empathetic towards people living with HIV and AIDS

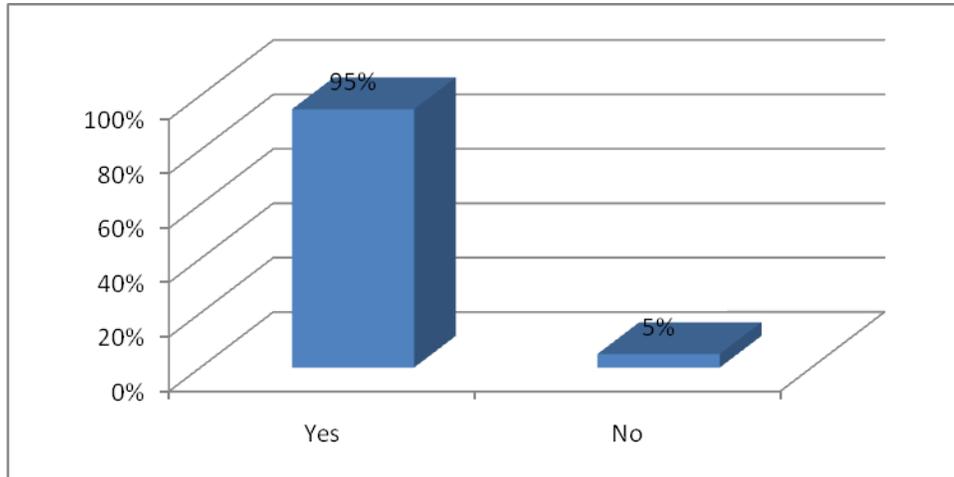


Figure 4.7 shows 95% (n= 37) of the study participants feeling empathetic towards people living with HIV/AIDS, and 5% (n= 5) said no, meaning that participants don't feel empathetic towards people living with HIV/AIDS.

The International Centre for Research on Women (2003:21) asserts that people often do not recognise when their words, actions or beliefs are stigmatising or discriminating against persons living with HIV/AIDS. In the response above of 5% showing no empathy is an indication that there is still some stigma attached to people living with immoral behaviours and that they deserve what they get (The International Centre for Research on Women (2003:21)).

Table 4.4
Discriminate against people living with HIV/AIDS

	Frequency	Percent
Yes	6	14%
No	36	86%
Total	42	100%

Table 4.4 indicate 86% (n=36) of the study participants do not discriminate against people living with HIV/AIDS AND 14% (N=6) of the study participants discriminate people living with HIV/AIDS.

Despite international efforts to tackle HIV/AIDS, stigma and discrimination remain amongst the poorly understood aspects of the epidemic (Parker & Aggleton, 2002:1) In the response above with 14 % discriminating against HIV/AIDS people is a clear indication that education and awareness is playing a vital role. According to Coombe (2001) addressing the HIV/AIDS crisis creatively and flexibly means adjusting the educational delivery system on HIV/AIDS awareness. The challenge for society is to make people fear getting the disease without them turning against those who are already HIV positive. This means that a support system be put in place to make it easier for people to be open, to go for tests and to seek care. The disease needs to be treated as an illness and not a scandal that has to be kept secret. The respect for and observance of rights and freedoms for people with HIV and AIDS, as well as the avoidance of HIV and AIDS-related discrimination and stigma is to be practiced.

Communities and societies have to create an environment where communities become more caring towards people living with HIV and AIDS and orphans and all individuals should take responsibility for education around prevention. Although HIV and AIDS is a terrible disease that can destroy families and communities, it should never be forgotten that it is also a preventable disease (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.8
Thinking that one should provide condoms free in entertaining places

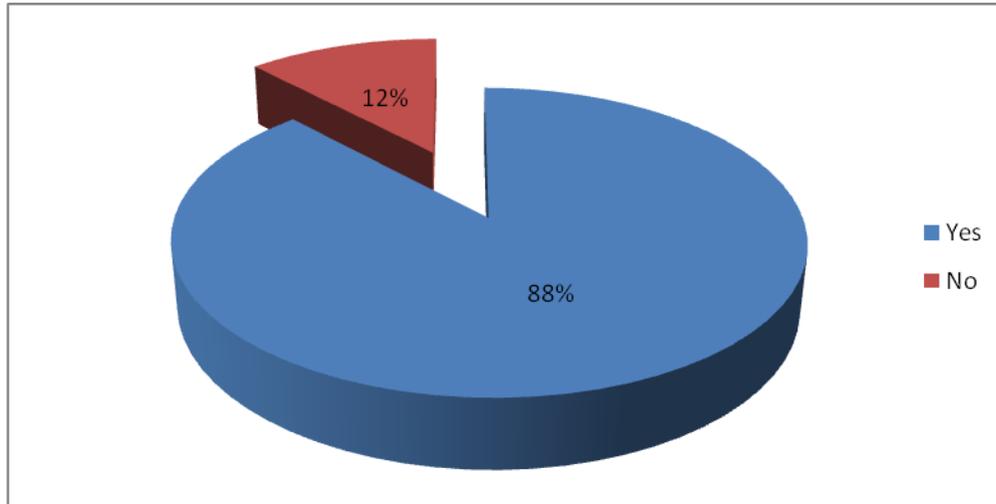


Figure 4.8 depicts that 88% (n= 36) of the study participants think condoms should be provided free in entertaining places and 12% (n= 6) not thinking condoms should be provided free in entertaining places. According to the response there is consensus that condom distribution will form a kind of support to help in decreasing the disease.

Condoms are the best way to prevent the spread of AIDS, but people need easy access to them. Millions of free condoms are distributed every year and many of those end up being wasted. Condom distribution works best when people are also taught why to use them, how to use them properly, how to store them and how to throw them away safely (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.9
Supporting public health promotions

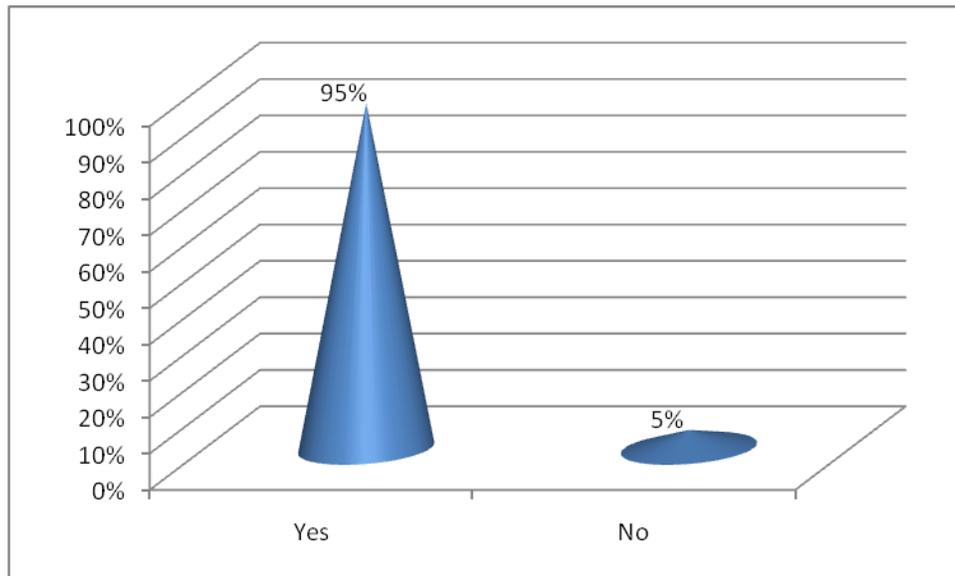


Figure 4.9 shows 95% (n= 39) of the study participants supporting public health promotions, and 5% (n= 3) not supporting public health promotions.

Table 4.5
Knowing that HIV is a contagious disease

	Frequency	Valid Percent
Yes	34	87%
No	8	13%
Total	42	100%

Table 4.5 depicts 87% (n=34) knowing that HIV is a contagious disease and 13% (n=8) do not know that HIV is a contagious disease.

According to the UK Discussion Paper (August 2006) on Tackling Aids through sport, lack of basic knowledge about HIV is still widespread in Africa. In a survey carried out in 21 African countries, more than 60% of young women had either never heard of the virus or had at least one major misconception about how it is spread.

Figure 4.10
Knowing the source of HIV/AIDS infection

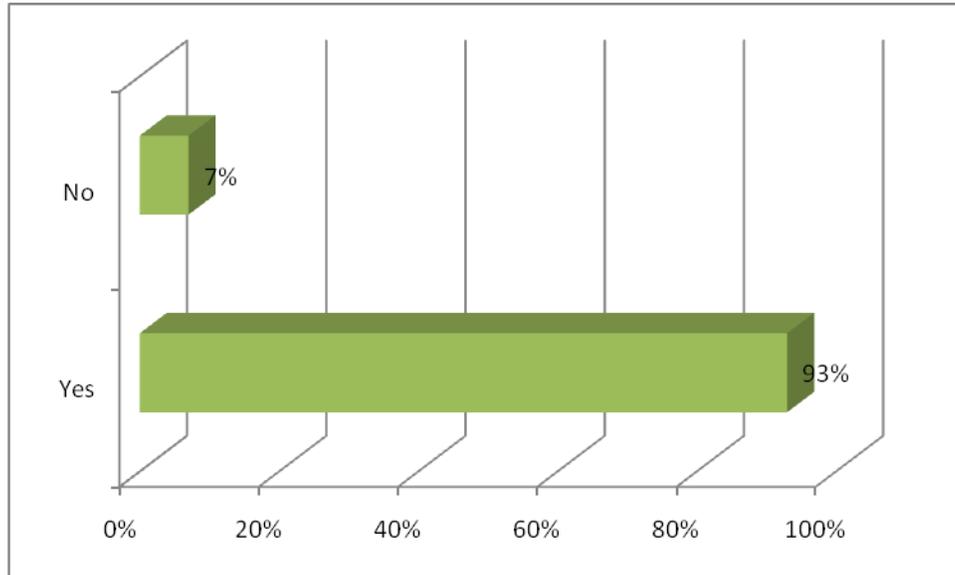


Figure 4.10 shows 93% (n= 38) of the study participants know the source of HIV/AIDS, and 7% (n=4) do not know the source of HIV/AIDS.

Figure 4.11
Knowing of people living with HIV/AIDS

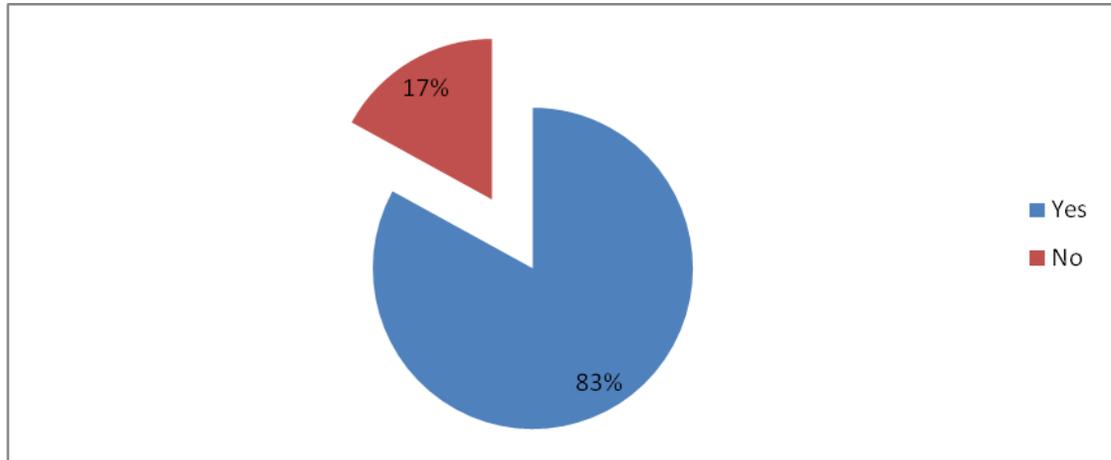


Figure 4.11 indicate 83% (n= 35) of the study participants know of people living with HIV/AIDS, and 17% (n= 7) not knowing of people living with HIV/AIDS.

Table 4.6
Knowing of any relatives of people living with HIV

	Frequency	Valid Percent
Yes	27	64%
No	15	36%
Total	42	100%

Table 4.6 shows 64% (n=27) of the study participants know of relatives of people living with HIV/AIDS and 36% (n=15) said no, not knowing of any relatives of people living with HIV/AIDS.

Figure 4.12
Knowing of people having casual contact with people living with HIV/AIDS

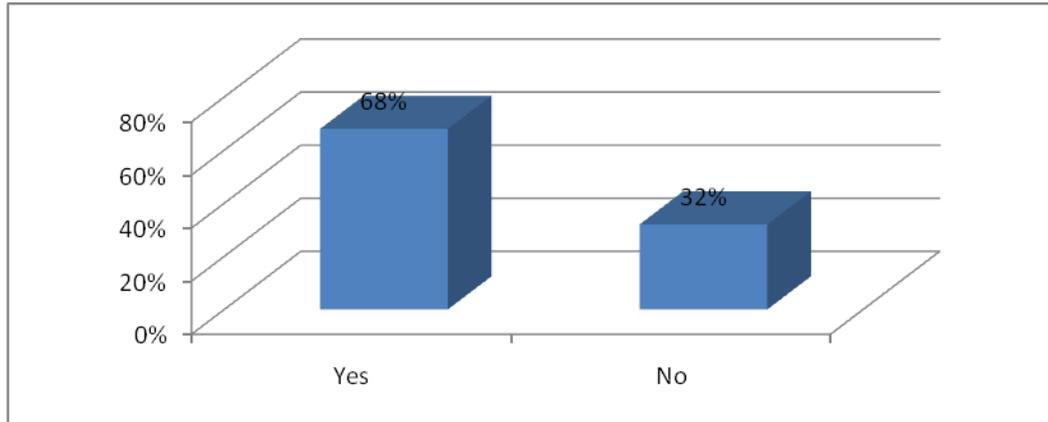


Figure 4.12 shows 68% (n= 28) know of people having casual contact with people living with HIV/AIDS, and 32% (n= 14) do not know of people having casual contact with people living with HIV/AIDS

Figure 4.13
Knowing that people can get HIV/AIDS through sharing needles among drug users

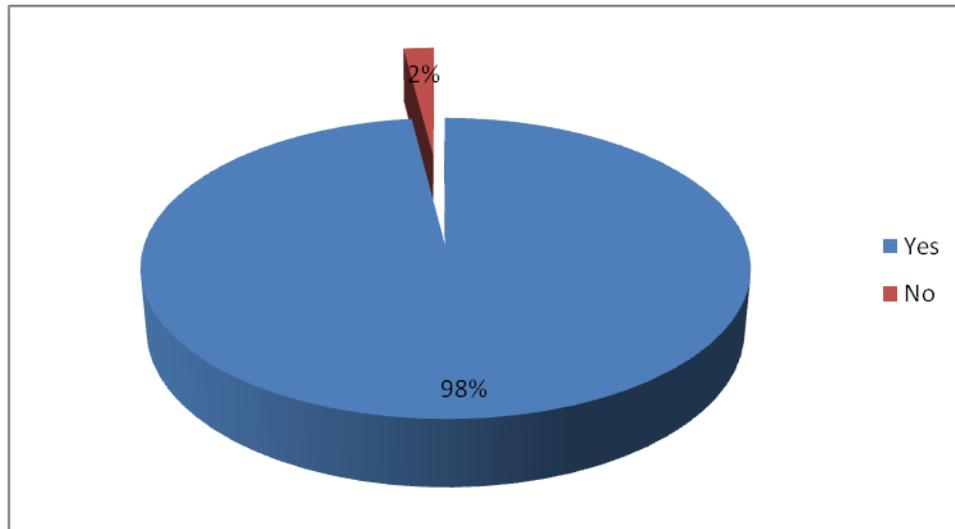


Figure 4.13 depicts 98% (n= 41) of the participants know that people can get HIV/AIDS through sharing needles among drug users, 2% (n=1) do not know people can get HIV/AIDS through sharing needles among drug users.

Medical workers can get it from accidentally pricking themselves with needles they have used to inject HIV positive people (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Table 4.7
Knowing that people can get HIV/AIDS through
having oral sex with an HIV infected person

	Frequency	Percent
Yes	33	79%
No	9	21%
Total	42	100

Table 4.7 shows 79% (n=33) of the participants know that people can get HIV/AIDS through having oral sex with an HIV infected person, and 21% (n=9) not knowing that people can get HIV/AIDS through having oral sex with an HIV infected person.

Individuals cannot get AIDS from kissing someone on the lips, hugging, sharing food and drink or using the same bath or toilet as someone who is HIV positive. (Deep kissing or French kissing can pass on HIV if you have sores in your mouth). The same applies to having oral sex, if there is an open wound in the mouth and there is blood to blood contact, the virus can be past on (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.14

Knowing people can get HIV/AIDS through shaking hands with an infected person

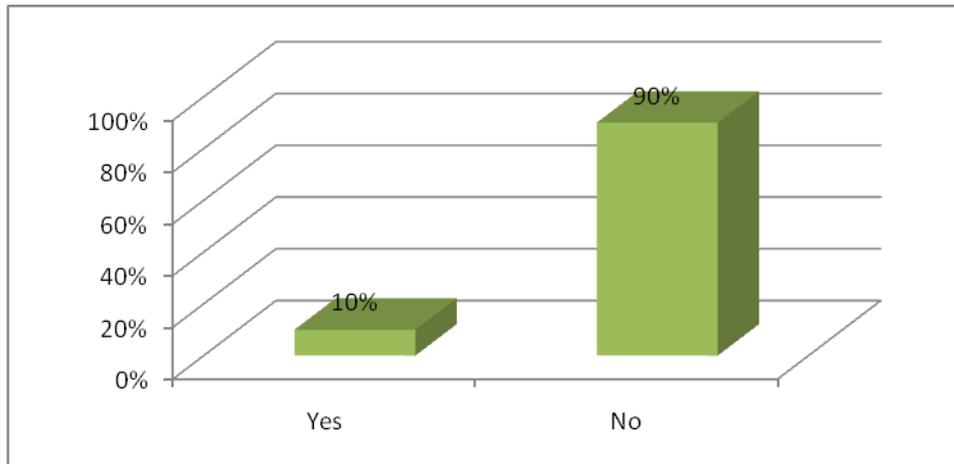


Figure 4.14 shows 90% (n= 32) not knowing people can get HIV/AIDS through sharing hands with an infected person, and 10% (n=10) knowing people can get HIV/AIDS through sharing hands with an infected individual.

Figure 4.15

Knowing people can get HIV/AIDS through mosquito bite with an infected person

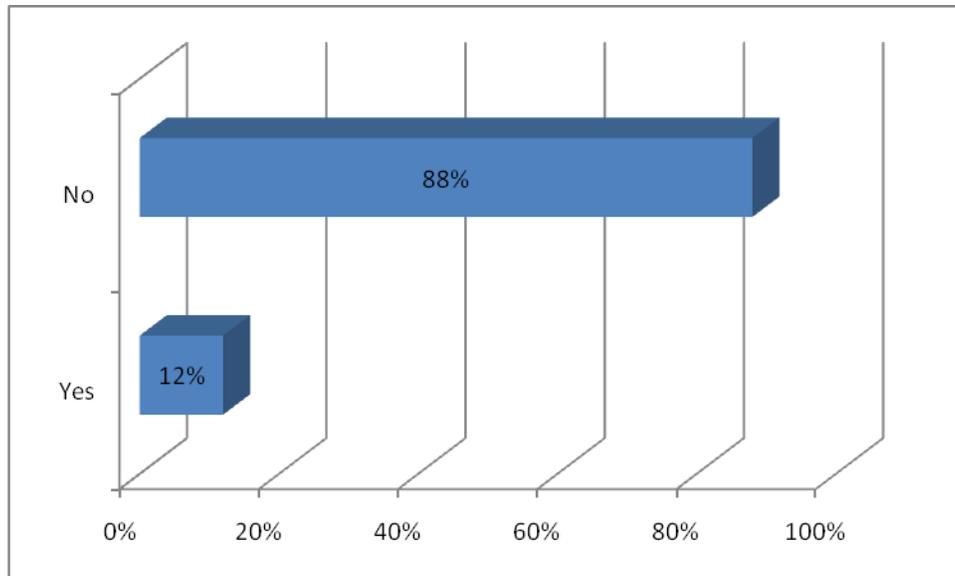


Figure 4.15 shows that 88% (n= 36) of the study participants not knowing people can get HIV/AIDS through mosquito bite with an infected person, and 12% (n=6) do not know people can get HIV/AIDS through mosquito bite with an infected person.

Figure 4.16
Knowing that people can get HIV/AIDS through sharing food together with an infected person

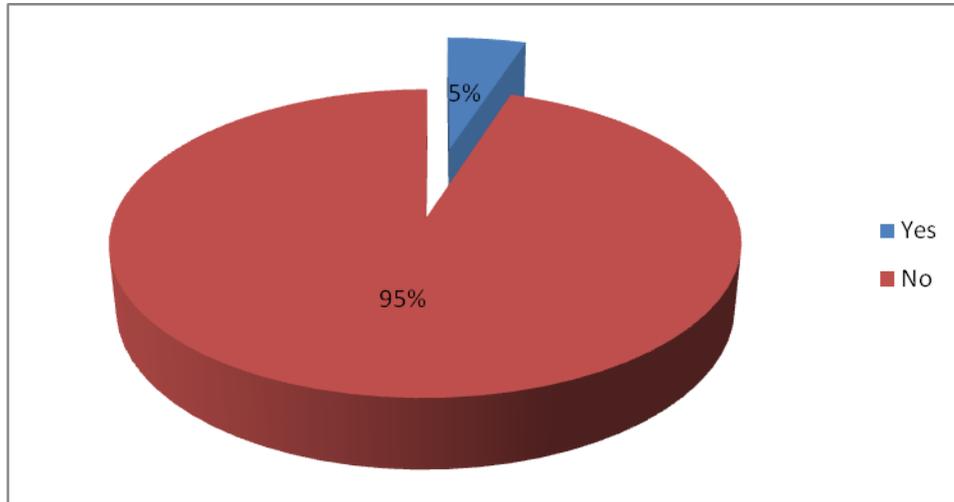


Figure 4.16 shows 95% (n=40) of the study participants not knowing that people can get HIV/AIDS through sharing food together with an infected person, and 5% (n=2) knowing that people can get HIV/AIDS through sharing food together with an infected person.

Table 4.8
Knowing that people can get HIV/AIDS through sharing tools and official utensils with an infected person

	Frequency	Valid Percent
Yes	2	45%
No	40	95%
Total	42	100%

Table 4.8 depicts that 95% (n=40) not knowing that people can get HIV/AIDS through sharing tools and official utensils with an infected person and 45% (n=2) knowing that that people can get HIV/AIDS through sharing tools and official utensils with an infected person.

Figure 4.17
Knowing that people can get HIV/AIDS through sharing public swimming pools with an infected person

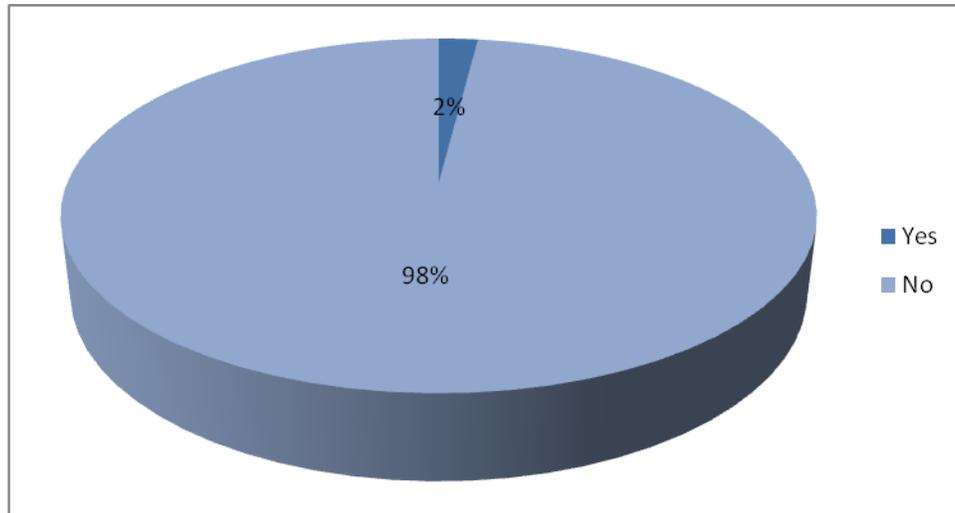


Figure 4.17 shows 98% (n= 41) not knowing that people can get HIV/AIDS through sharing public swimming pools with an infected person, and 2% (n= 1) knowing that people can get HIV/AIDS through sharing public swimming pools with an infected person.

Figure 4.18

Knowing that you can prevent HIV/AIDS by not sharing needle

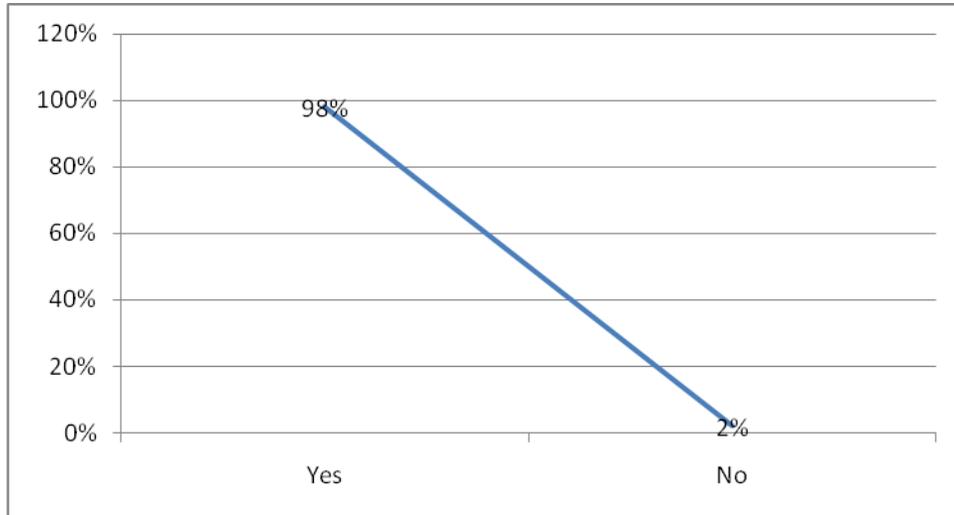


Figure 4.18 shows 98% (n= 41) know that you can prevent HIV/AIDS by not sharing needle, and 2% (n= 1) not knowing that you can prevent HIV/AIDS by not sharing needle.

Figure 4.19

Knowing that you can prevent HIV/AIDS by not sharing needle

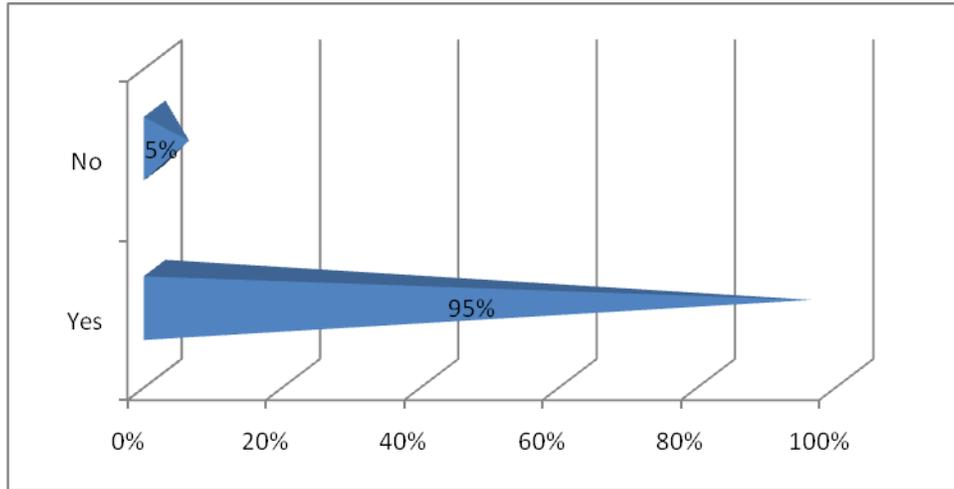


Figure 4.19 shows 95% (n= 40) of the study participants knowing that an individual can prevent HIV/AIDS through reducing unnecessary blood transfusions and injections, and 5% (n=2) not knowing that a person can prevent HIV/AIDS through reducing unnecessary blood transfusions and injections.

While individuals could easily contract HIV from a blood transfusion if it is contaminated; all blood in SA is tested for safety (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Table 4.9

Knowing that you can prevent HIV/AIDS by using condoms during sexual intercourse

	Frequency	Percent	Valid Percent
Yes	42	100.0	100.0

Table 4.9 shows all study participants know that they can prevent HIV/AIDS by using condoms during sexual intercourse.

Table.4.10**Knowing that you can prevent HIV/AIDS prevention of mother to child**

	Frequency	Percent
Yes	39	93%
No	3	7%
Total	42	100%

Table 4.10 shows 93% (n=39) of the study participants know they can prevent HIV/AIDS prevention of mother to child and 7% (n=3) said no, meaning that they do not know they can prevent HIV/AIDS prevention of mother to child.

HIV positive mothers can pass the infection to their babies. An estimated 15-30 % of mothers with HIV will transmit the infection during either pregnancy or during childbirth. This happens because of the contact with blood. Another 10-20 % will pass the HIV to the baby through breast milk. The Prevention of Mother to Child Transmission (PMCT) treatment is available at all state hospitals and greatly reduces

the risk to babies. If the mother has been taking the full cocktail of anti-retroviral the risk is reduced even more (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.20
Knowing that you can prevent HIV/AIDS by treating STIs promptly

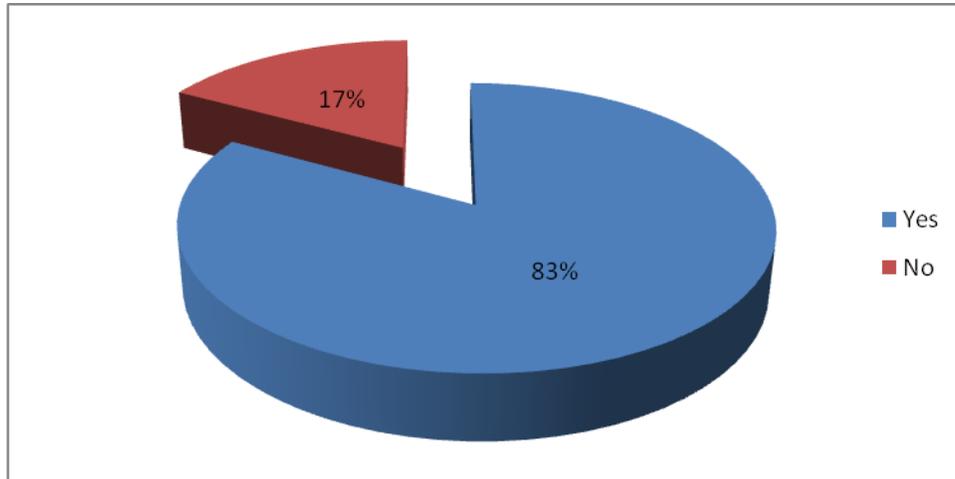


Figure 4.20 depicts 83% of the participants saying yes and 17% saying no.

Men and women who have other sexually transmitted diseases (such as syphilis or gonorrhoea) are also more vulnerable because they often have open sores on their private parts (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.21
Knowing that you can prevent HIV/AIDS by not donating blood illegally

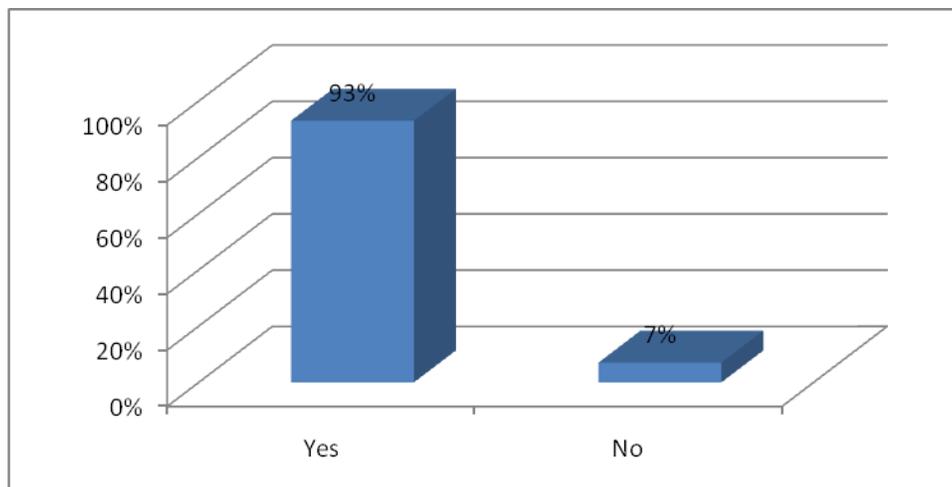


Figure 4.21 depicts 93% (n= 39) of the study participants know the individual can prevent HIV/AIDS by not donating blood illegally, and 7% (n=3) not knowing HIV/AIDS can be prevented by not donating blood illegally.

While individuals could easily contract HIV from a blood transfusion if the blood is contaminated; all blood in SA is tested for safety (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.22

Knowing that you can prevent HIV/AIDS by avoiding mosquito bites

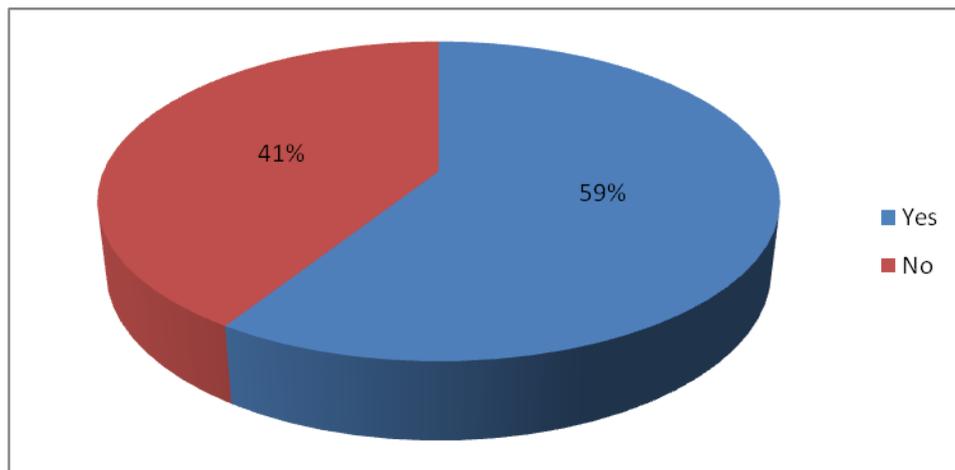


Figure 4.22 shows 59% (n= 24) of the study participants know they can prevent HIV/AIDS by avoiding mosquito bites and 41% (n= 17) not knowing that HIV/AIDS can be prevented by avoiding mosquito bites.

Table 4.11

Knowing that you can prevent HIV/AIDS by not sharing public swimming pools with an infected person

	Frequency	Valid Percent
Yes	4	10%
No	38	90%
Total	42	100%

Table 4.11 depicts 10% (n=4) of the study participants said yes, meaning that they know HIV/AIDS can be prevented by not sharing public swimming pools with an infected person and 90% (n=38) said no, meaning they do not know they can prevent HIV/AIDS by not sharing public swimming pools with an infected person.

Figure 4.23

Knowing that you can prevent HIV/AIDS by not sharing food with people living with HIV or AIDS

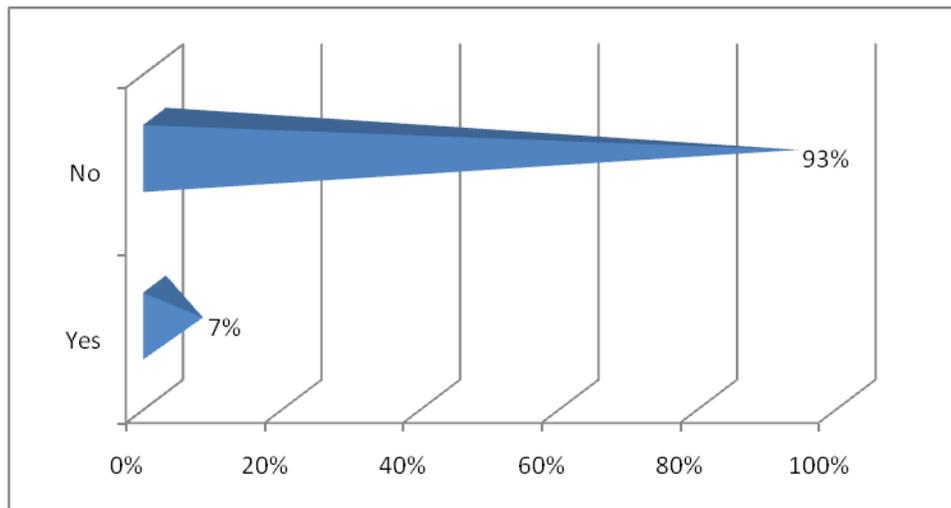


Figure 4.23 shows 93% (n= 39) knowing HIV/AIDS can be prevented by not sharing food with people living with HIV or AIDS and 7% (n= 3) did not know HIV/AIDS can be prevented by not sharing food with people living with HIV or AIDS.

Individuals cannot get HIV and AIDS from someone by sharing cups, plates, facilities or toilets with them. They can touch, hug or kiss someone with HIV and AIDS without fear (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006).

Figure 4.24

Knowing that you can prevent HIV/AIDS by isolating people living with HIV or AIDS

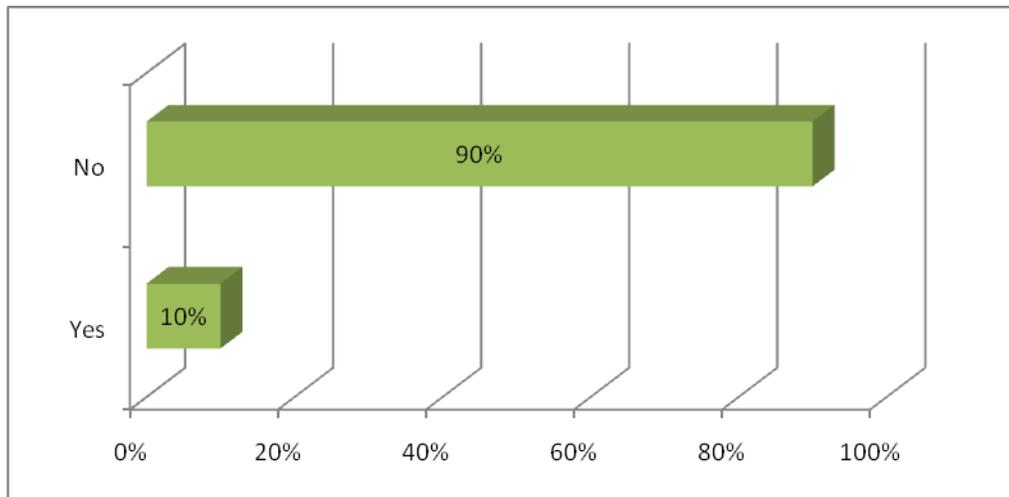


Figure 4.24 shows 90% (n= 38) know HIV/AIDS can be prevented by isolating people living with HIV or AIDS, and 10% (n= 4) not knowing HIV/AIDS can be prevented by isolating people living with HIV or AIDS.

Figure 4.25

Aware of learners that are HIV positive

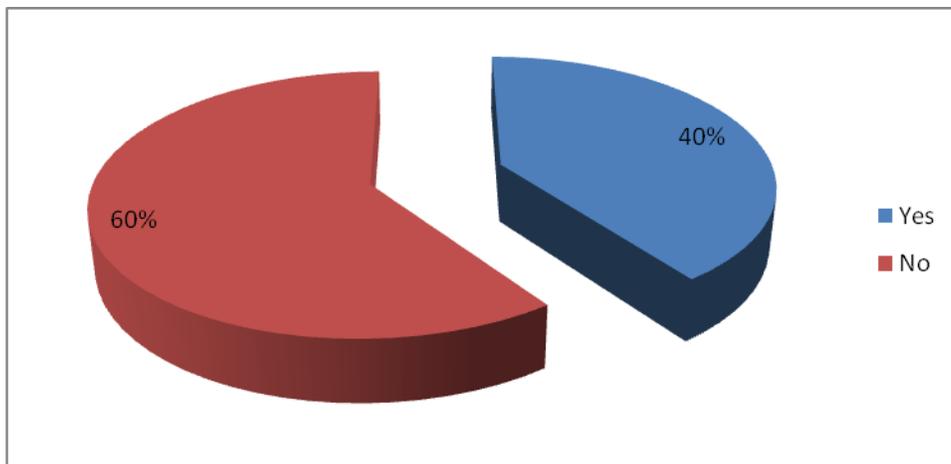


Figure 4.25 depicts 60% (n= 25) not aware of learners that are HIV positive and 40% (n=17) aware of learners that are HIV positive.

Table 4.12

Aware of educators that are HIV positive

	Frequency	Valid Percent
Yes	15	36%
No	27	64%
Total	42	100%

Table 4.12 depicts 64% (n=27) of the study participants are not aware of educators that are HIV positive, and 36% (n=15) of the study participants are aware of educators that are HIV positive.

Despite being tasked with educating learners, educators have to deal with personal effects of HIV/AIDS, which to a certain extent may affect the way they carry out their duties. It was observed educators who are ill from HIV/AIDS do not adequately perform their duties as a result there is poor performance and decrease in time with students (ZIMTA, 2002). In this response it may be that people are willing to disclose their status or through observation other educators may assume their colleague has HIV/AIDS.

Figure 4.26

Any recreational facilities in the school

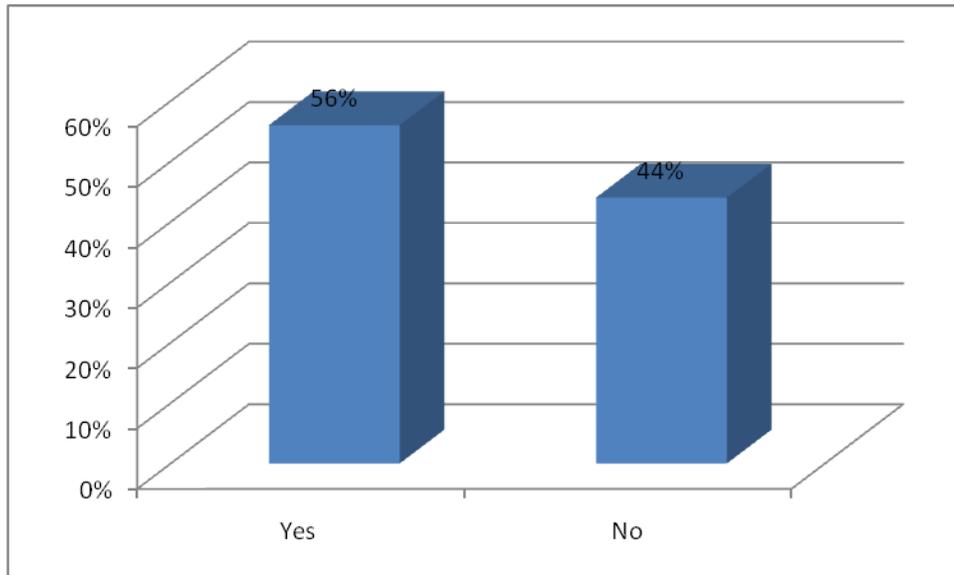


Figure 4.26 depicts 56% of the participants are aware of recreational facilities in the school while 44% were unaware of recreational facilities at school.

According to the UK Discussion Paper (August 2006) on Tackling Aids through sport, it has been Noted that sport is hugely popular amongst young people in sub-Saharan Africa, more so than any other voluntary activity. Sport is therefore a credible and attractive way of engaging the attention of people and proving a platform from which to promote prevention, de-stigmatisation and to encourage the development of important life skills.

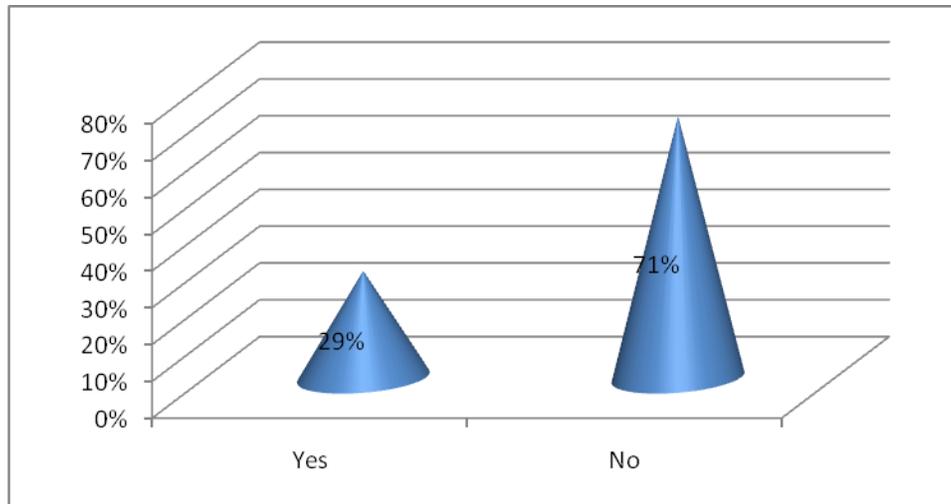
Figure 4.27 Gym Facilities near the school

Figure 4.17 depicts 71% (n= 30) of the study participants said no, there is no, there is no gym facilities near the school, and 29% (n= 12) there are gym facilities near the school.

According to the UK Discussion Paper (August 2006) on Tackling Aids through sport states that the although the development of life skills through participation in sports activities has until now received limited attention in mainstream development work, studies and policy-making, the experience in the developed world demonstrate that participation in sport brings great benefits to young people's health, social development, confidence, self-esteem and academic performance. In brief, sport provides the opportunity for young people: to take on challenges and stretch themselves; to develop self-esteem, self-confidence and social skills and make new friends. The response above indicates that there is very little opportunities for learners to be involved in gym activities.

Figure 4.28
Schools have a HIV/AIDS VCT programme

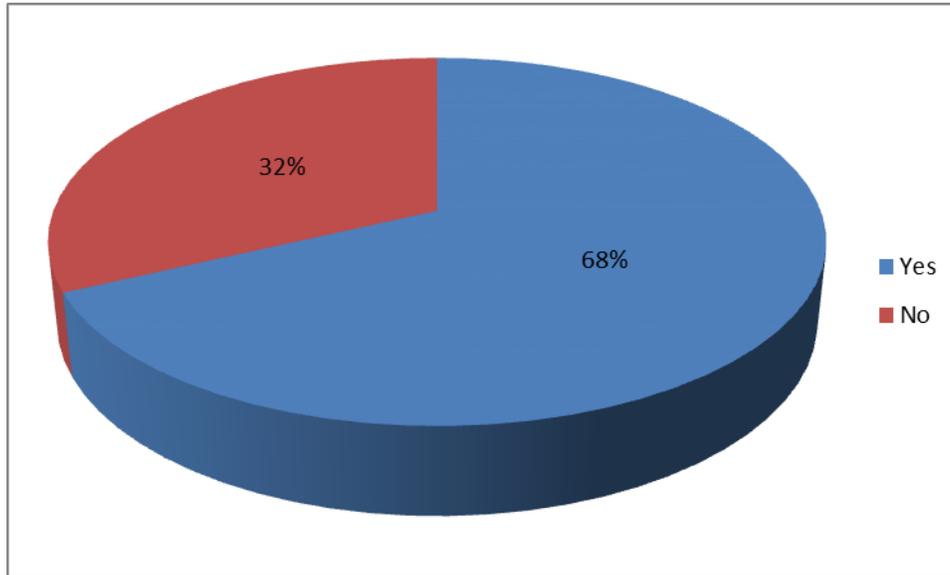


Figure 4.28 depicts 68% (n= 28) a school has HIV/AIDS VCT programme and 32% (n=14) they have no HIV/AIDS VCT programme.

During the focus group discussion the researcher established the participants did not understand the question and this increased percentage of 68% maybe an indication there is some sort of counselling but not an actual programme. With the introduction of new guidelines in February 2010 the government's policy on VCT has been expanded to include provider-initiated HCT. Previously healthcare workers recommended testing only if HIV disease was suspected. Now regular HIV testing while still voluntary is to be routinely recommended to everyone as an important part of normal health-seeking behaviour. This is the main difference between VCT and HCT. (Counselling and testing VCT & HCT .Education and Training Unit www.etu.org.za). Educators at schools are advised to refer educators as well as learners to proper designated centres.

Table 4.13
Schools have a nutritional programme

	Frequency	Percent
Yes	18	43%
No	24	57%
Total	42	100%

Table 4.14 depicts 57% (n=24) of the study participants responded in the negative where their school have no nutritional programme and 43% (n=18) said yes their school have a nutritional programme.

Recognising the importance and potential of a healthy school setting, four international agencies - each with decades of specialised experience working through schools to enhance learning and health - recently agreed upon a shared framework to strengthen school health, hygiene and nutrition programmes. Working together to Focus Resources on Effective School Health ("FRESH"), UNESCO, UNICEF, WHO and the World Bank recommend a core group of cost-effective components, as a common starting point for all schools. The components include: health-related school policies; provision of safe water and sanitation; skills-based health education; and school-based health and nutrition services.

Figure 4.29
Time allocated for the teaching of life skills

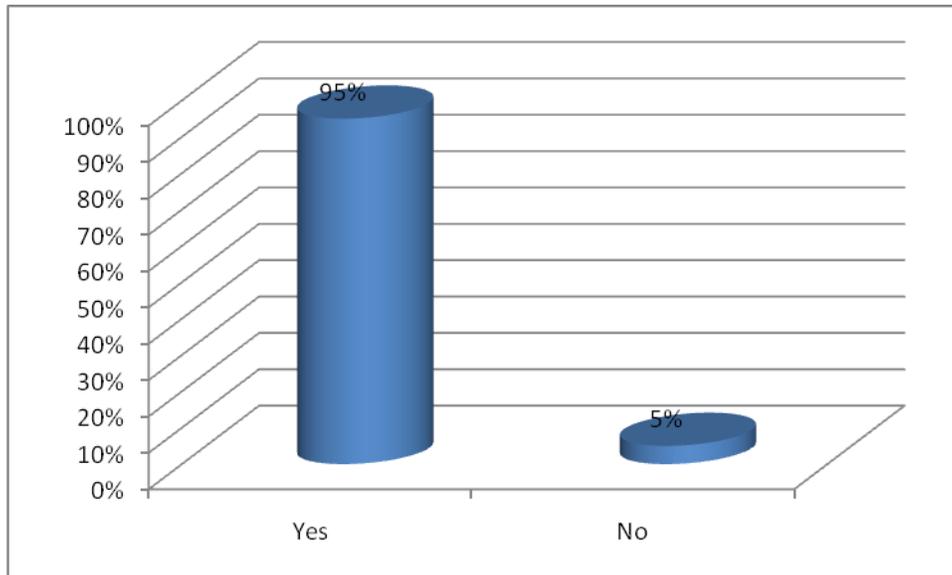


Figure 4.29 shows 95% (n= 40) of the study participants have time allocated for the teaching of life skills, and 5% (n= 2) said no there was no time allocated for the teaching of life (Life Orientation).

According to the NATIONAL POLICY ON HIV AND AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND D STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS (10 AUGUST 1999 VOLUME 410 NUMBER 20372) learners and students must receive education about HIV/AIDS and abstinence in the context of life-skills education on an ongoing basis.

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

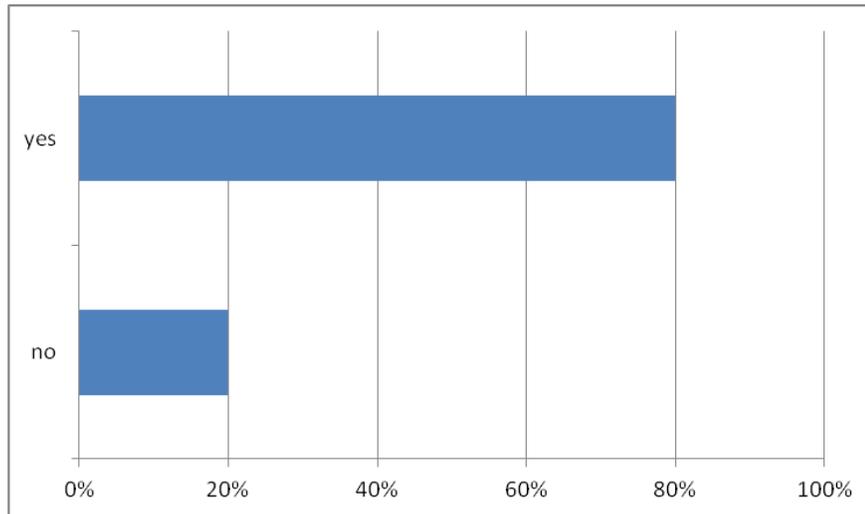
Figure 4.30**Aware of the antiretroviral therapy**

Figure 4.30 shows 80% (n= 33) aware of the antiretroviral therapy (ART) and 20% (n= 9) are not aware of the antiretroviral therapy.

Awareness of antiretroviral therapy is imperative as this will help to make people aware that medication is available to decrease symptoms of the disease.

According to figure 4.30 80% of educators responded they are aware of ART

Risks must be presented as part of informed consent before starting with ART.

Although some educators believe that widespread availability of ART will make people more careless about safe sex, effective ART lowers viral load dramatically and makes people less infective and less likely to transmit an HIV infection. In this sense, highly active antiretroviral therapy (HAART) may be seen as a preventive measure from a public health point of view.

Many of these plan elements require numbers of well-trained people far in excess of the current staff levels (Idemyor, 2004).

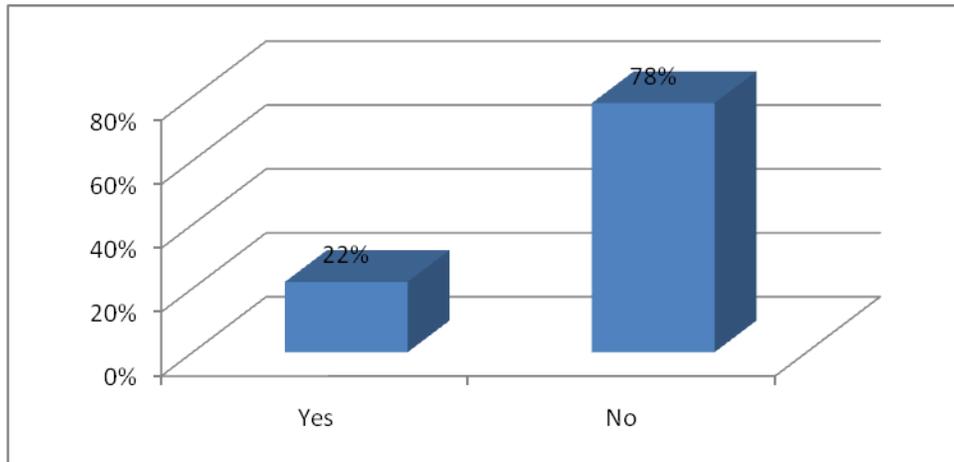
Figure 4.31**Aware of any discrimination against HIV/AIDS in your school**

Figure 32 depicts 78% (n= 32) are not aware of any discrimination against HIV/AIDS in their school and 22% (n= 10) are aware of any discrimination against HIV/AIDS in their school.

According to the National POLICY ON HIV AND AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND D STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS (10 AUGUST 1999 VOLUME 410 NUMBER 20372) learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practiced against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of individuals concerned.

Table 4.14**Aware of any policies regarding to HIV/AIDS**

	Frequency	Valid Percent
Yes	38	90%
No	4	10%
Total	42	100%

Table 4.15 shows that 90% (n =38) of the study participants were aware of any policies regarding HIV/AIDS and 10% (n=4) were not aware of any policies regarding to HIV/AIDS.

According to the NATIONAL POLICY ON HIV AND AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS (10 AUGUST 1999 VOLUME 410 NUMBER 20372) all schools and institutions should train learners, students, educators and staff in first aid and have available and maintain at least two first aid kits.

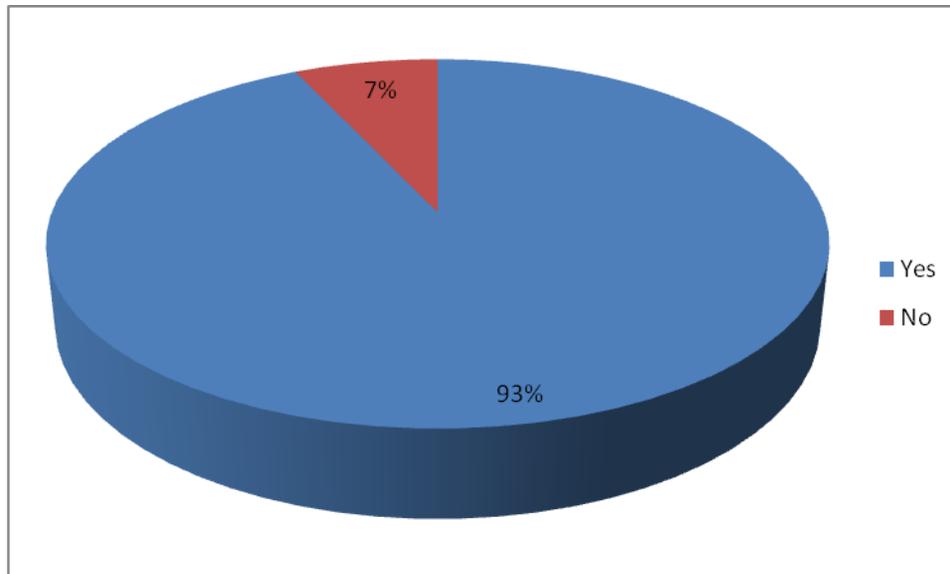
Figure 4.32**Aware of the risk when a learner or educator is injured on the school grounds**

Figure 4.32 shows 93% (n= 39) are aware of the risk when a learner or educator is injured on the school grounds, and 7% (n= 3) are not aware of the risk when a learner or educator is injured on the school grounds.

According to the NATIONAL POLICY ON HIV AND AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND D STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS (10 AUGUST 1999 VOLUME 410 NUMBER 20372) all learners, students, educators and other staff members, including sports coaches, should be given appropriate information and training on HIV transmission, the handling and use of first-aid kits, the application of universal precautions and the importance of adherence universal precautions. Learners, students, educators and other staff members should be trained to manage their own bleeding or injuries and to assist and protect others.

Table 4.15
Abide by universal precautions in your
classroom/school in the event of the learners have to fall
and bleed

	Frequency	Percent
Yes	35	83%
No	7	17%
Total	42	100%

Table 4.15 shows 83% of the study participants abide by universal precautions in their classroom/school in the event of the learners having to fall and bleed and 17% (n=7) do not abide by universal precautions in their classroom/school in the event of the learners having to fall and bleed.

According to the NATIONAL POLICY ON HIV AND AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND D STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS (10 AUGUST 1999 VOLUME 410 NUMBER 20372) the MEC should make provisions for all schools and institutions to implement universal precautions to eliminate the risk of transmission of all blood borne pathogens including HIV/AIDS, effectively in the schools or institution environment.

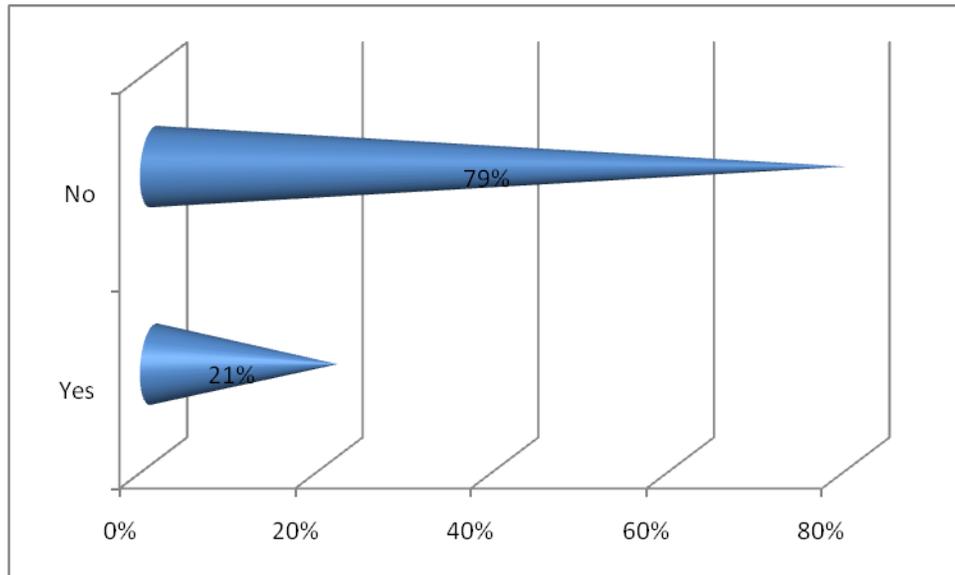
Figure 4.33**Know of educators who are unwell and unable to teach due to HIV/AIDS**

Figure 4.33 depicts 79% (n= 33) do not know of educators who are unwell and unable to teach due to HIV/AIDS and 21% (n= 9) know of educators those are unwell and unable to teach due to HIV/AIDS.

Educators who have infected family members have a higher rate of absenteeism as they are engaged in caring for ill relatives or burying their love ones (Fredrikson&Kanabus, 2002). Illness disrupts learning and teaching and well educators will have to take on an extra load when their sick colleagues are absent (Theron, 2005). Learners who are ill fall behind with their studies; have to cope with family members who are ill and eventually die. There is a ripple effect that occurs in the schools when educators die of HIV/AIDS as this disrupts the order of day (Theron, 2005). This has been observed as the workload increases for the educators that are present at that moment. Educators may not be aware as the percentage suggests but according to Theron (2005) this is evident.

Figure 4.34

Feel that your workload has increase for an educator

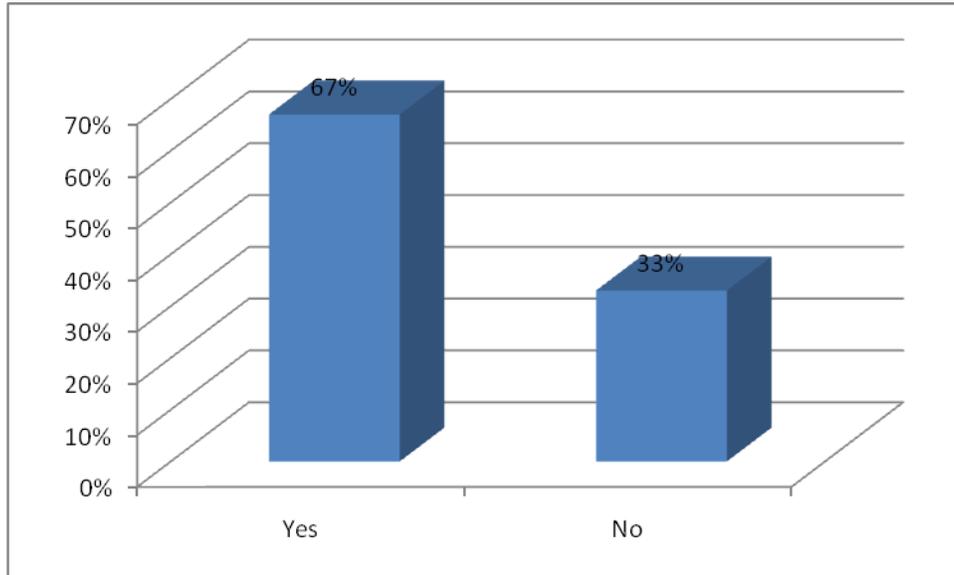


Figure 4.34 shows 67% (n=28) feel their workload has increase for an educator and 33% (n=14) do not feeling their workload has increase as an educator.

Table 4.16 Willing to teach in an area that has high incidence of HIV positive people

	Frequency	Percent
Yes	22	52%
No	20	48%
Total	42	100%

Figure 4.16 shows that 52% (n=22) willing to teach in an area that has high incidence of HIV positive people, and 48% (n=20) not willing to teach in an area that has high incidence of HIV positive people.

Figure 4.35
Aware of any discrimination amongst cultural background and traditional beliefs in respect of HIV/AIDS

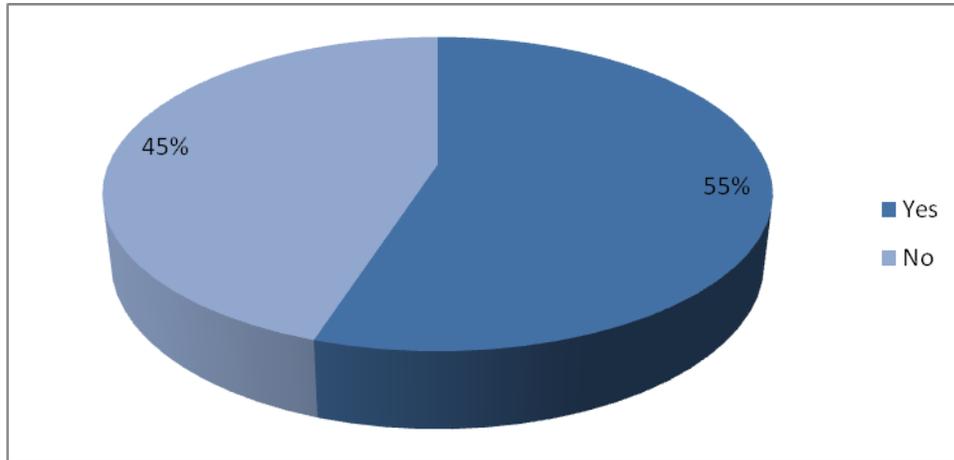


Figure 4.35 shows 55% (n= 23) are aware of any discrimination amongst cultural background and traditional beliefs in respect of HIV/AIDS and 45% (n= 19) are not aware of any discrimination amongst cultural background and traditional beliefs in respect of HIV/AIDS. According to Viljoen (2005) it was mentioned related to the lack of knowledge and ignorance is fear and this enhances cultural perceptions of stigma and traditional beliefs in witchcraft.

4.3 DISCUSSION OF FOCUS GROUP AND PRINCIPAL'S INTERVIEW

There were seven questions for the discussion with the focus group. It was identified there are three themes that emanated from the focus group discussion. The three themes are the experiences and opinions related to HIV/AIDS, the training programmes in school and Voluntary Testing and Counselling and a Wellness Promotion Programme.

After probing with questions clear picture of what the educators are experiencing were established.

Educators in the focus group were reluctant to talk about their experiences and also to disclose whether they knew of educators that are HIV positive. This was understood as being a fear of discrimination if the status was discovered or exposed.

The educators in the focus group raised concerns there were not enough training programmes for them to equip them with skills and knowledge to handle the pandemic.

According to Landsberg (2005) educators need systematic and intensive training either as part of their initial training or as well-planned in-service training by competent and experienced people in order to be able to cope with chronic illnesses such as HIV/AIDS in their classrooms. There was a unanimous agreement by the participants there should be HIV/AIDS awareness programmes throughout the curriculum rather than only in the Life Orientation lessons. Some educators in the focus group discussion indicated there are training programmes conducted by NGO's on a regular basis but educators viewed this as an added burden on an already overloaded workload.

Educators in the focus group indicated there will be more support for their colleagues as well as learners once they are better trained in dealing with the HIV/AIDS issues.

The principals were interviewed that did support educators through staff development programmes. The training was further supported by NGO's like South African Democratic Teachers Union (SADTU) that tried to empower educators through training and workshops on HIV/AIDS and the importance of VCT.

According to the discussion with the educators in the focus group in most schools the educator teaching in the Life Orientation programme was offered the opportunity of workshops and training.

Educators in the focus group discussion indicated that top management should be instrumental in arranging awareness programmes and also to form a positive support system.

The idea of a wellness programme was well debated and educators felt this will benefit educators as well as learners. Educators in the focus group related that wellness can come in the form of physical, emotional or spiritual forms. According to the WHO (1998) wellness or holistic health can be defined as a state of complete physical, mental and social wellbeing. Such wellness is considered to be dynamic and is affected by both by personal and environmental factors (Ross & Deverell.2004). This is clearly indicated in Figure 2.1 in the conceptual framework.

The interview held with the one principal clearly indicates top management is concerned about the HIV/AIDS Pandemic. The following response was recorded:

Interviewer: Tell me about the availability of HIV/AIDS Policy. Does the school have one? Is it easily accessible?

Interviewee: "The schools have an HIV/AIDS policy" which means that a learner can disclose to any teacher whom he/she trust regarding his/her status.

According to the DEPARTMENT OF EDUCATION NATIONAL EDUCATION POLICY ACT, 1996 (NO. 27 OF 1996) NATIONAL POLICY ON HIV/AIDS, FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS, AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS the constitutional rights of all learners,

students and educators must be protected on an equal basis and this means that confidentiality must be adhered to at all times.

Interviewer: How do you monitor the implementation of your schools HIVAIDS policy to ensure that it does not only exist on paper?

Interviewee: I have a committee who monitors policy and report back to me

According to the DEPARTMENT OF EDUCATION NATIONAL EDUCATION POLICY ACT, 1996 (NO. 27 OF 1996) NATIONAL POLICY ON HIV/AIDS, FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS, AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS, the constitutional rights of all learners, students and educators must be protected on an equal basis. If a suitably qualified person ascertains that a learner, student or educator poses a medically recognized significant health risk to others, appropriate measures should be taken. A medically recognized significant health risk in the context of HIV/AIDS could include the presence of untreatable contagious (highly communicable) diseases, uncontrollable bleeding, unmanageable wounds, or sexual or physically aggressive behaviour, which may create the risk of HIV transmission.

Interviewer: Does your school provide leadership training on HIVAIDS?

Interviewee: Yes, LO subject, educators are responsible for training programme of learners to May'khethele project

Interviewer: What strategies are there in place for a wellness programme for people living with HIVAIDS?

Interviewee: RCL, Open groups, community involvement and educators involvement through LO

Interviewer: Are HIVAIDS incorporated in the curriculum e.g. life orientation programmes?

Interviewee: Yes, Educators do talk about it on their lessons and emphasis is on Life Orientation subject from grade 8-12

4.4 CONCLUSION

Discussion, findings, and recommendations will be dealt with in Chapter 5 with reference to the content of the analysis and presentation of results. The key focus of the study was to establish a basis upon which recommendations for a wellness programme finding them self in a particular situation could be made to assist all individuals.

CHAPTER 5
DISCUSSION, FINDINGS AND RECOMMENDATIONS

5.1 INTRODUCTION

The Department of Education has changed their approach to HIV/AIDS Awareness implementation from the ABC to the Abstinence – Based HIV/AIDS education. Table 5.1 reflect a summary of the appreciation of the underlying concerns.

Table 5.1
Summary

5.2 Themes	Sub-Themes
5.2.1.. HIV/AIDS People	<ul style="list-style-type: none"> • Demographics
5.2.2. Discrimination and Stigma	<ul style="list-style-type: none"> • Willingness to live with PLWHA • Empathy towards PLWHA • Reluctant to live with PLWHA • Dislike having contact with PLWHA •
5.2.3. Education and Awareness	<ul style="list-style-type: none"> • HIV/AIDS is contagious • Source of infection • Provisions of Condoms • Public promotion • Prevention of HIV/AIDS • Life Orientation programmes
5.2.4. Recreational Facilities /Fitness areas	<ul style="list-style-type: none"> • Role of fitness grounds and play grounds
5.2.5. Nutritional Programmes	<ul style="list-style-type: none"> • Availability of Programmes
5.2.6. Voluntary Testing and Counselling	<ul style="list-style-type: none"> • Availability of testing • Training –VCT
5.2.7. Antiretroviral Therapy	<ul style="list-style-type: none"> • Availability of drugs • Education on use of drugs

5.2.8. Policies regarding health and HIV/AIDS	<ul style="list-style-type: none"> • School policies on HIV/Aids • Policies on VCT • Policy on stigma and discrimination • Policy on handling injured learners at school
5.2.9.Challenges facing education system	<ul style="list-style-type: none"> • Shortage of teachers • Work overload • Infected and affected educators and learners
5.2.10. Wellness programme	<ul style="list-style-type: none"> • Recommendations for wellness programme

5.2.1. Demographics

It was endeavoured to have a mixed group of people of all race to participate in the questionnaires but this was not achievable as evident in the graph in Figure 4.3. There was almost equal participation from the African and Indian educators and only 5% of white educators and 17% of coloured educators participated. According to Parker and Aggleton (2002) racial and ethnic stigma also interacts with HIV/AIDS related stigma. The epidemic further has been characterised by racial assumptions about African sexuality and by the perceptions in the developing world of the west's immoral behaviour. The assumption is HIV/AIDS belongs to certain race groups only. In Table 4.2 there was equal participation from male and female educators. Educators that participated in the study were 94% that lived in the urban areas and 50% of the educators had 10 years of experience in teaching.

5.2.2 Discrimination and stigma.

The stigma surrounding HIV/AIDS is complex and exacerbates trying to get a solution for the condition. Whilst discrimination is prohibited, stigmatization of infected persons is an entrenched response (Coombe, 2000). It is primarily caused by inadequate knowledge, fear of death and disease, sexual morals and poor acknowledgement of stigma (Kelly 2000). Table 4.4 provide a clear indication that discrimination of HIV/AIDS people no longer exists. In available evaluations performed in developing countries it was found education and behaviour change

programmes contributed to awareness and knowledge of HIV /AIDS but had weak to moderate effects on sexual risk behaviours (Kirby et al, 2006).The conceptual framework in Figure 2.1 makes mention of behavioural change and awareness and knowledge to create wellness for those people affected and infected by HIV/AIDS. According to the conceptual framework wellness depends on the awareness and education of the HIV/AIDS disease and in this way alleviates the sting of stigma. Education is one of our key defences against the spread and impact of AIDS.

5.2.3. Education and awareness regarding HIV/AIDS

In a study conducted amongst 20 SA rural high school educators, it was established that they are less likely to hold negative perceptions of HIV/AIDS positive individuals, primarily because they are educated individuals (Makena, 1999). A second study that was conducted among 96 educators in South Africa suggested more mixed perceptions, educator responses generally expressed sympathy towards HIV/AIDS victims, but typically stigmatizing responses were included(Rees, 1998). According to the response in Figure 4.7 there are 95% of the participants that feel empathetic towards HIV/AIDS educators. This situation may be due to the health promotion that empowered both individuals and communities about 10 -15 years later. Empowerment is a process through which people gain hegemony over choices and behaviours affecting their health (WHO, 1998).

It is well documented the HIV/AIDS pandemic is impacting adversely on education and educators and disempowering the system (Coombe, 2000). However, just as HIV targets the body's defence system, the AIDS pandemic is disabling the education sector's core functions and protective value. Achieving Education for All will require making HIV/AIDS the highest priority in the most affected countries. As committed to in Dakar, education systems have a responsibility for ensuring the right of every child to a good quality education and HIV/AIDS must be considered part of quality education. Only by managing AIDS' impact on children, young people and the education system itself can realise its potential to decrease vulnerability to HIV/AIDS and reduce the risk of further infections. The evidence for this is growing in countries with severe epidemics, young people with more education are more likely to use condoms and engage in casual sex than their peers with less education.

There is a complete awareness that HIV/AIDS can be protected through the use of condoms; Figure 4.8 illustrates this. Awareness and education can be conducted at almost all events and workshops. The distribution of condoms can be done discreetly to avoid embarrassment to many.

There is resistance to condom use in many cultures. In Britain and France, the government ran very effective TV and billboard advertisements for condoms in the late 80's and early 90's. They made it look "cool" and fashionable to use condoms and very stupid to not use them. The campaigns were very successful with young people and now most of them who are not faithful to one partner, use condoms; infection rates have stayed very low.

On the one hand condom distribution should be well-targeted. Make sure that vulnerable groups can get them easily and conveniently and distribute directly to them. On the other hand, condoms should be accessible for anyone in the community. It should be remembered many people are shy and will not ask for condoms; select places where people have some privacy.

The most effective strategy available at this time to stop the pandemic is prevention of new infections, largely through public education about condom use, increased fidelity, and high-risk behaviors. Many activities are part of an effective prevention strategy, including public advertising, voluntary counseling and testing, community outreach, condom distribution, antiretroviral for pregnant women, and antiretroviral for those for whom medically indicated. A major part of the education effort must be through public advertising (Idemyor, 2004).

HIV/AIDS-related peer education in school contexts often aims at postponing sexual involvement and promoting condom use. This is done through sharing information about HIV, providing role models that promote healthy behaviour, demonstrating negotiation skills and providing individual support (Campbell & Foulis, 2002; Howard & McCabe, 1990; Williams, MacPhail, Campbell, Taljaard, Gouws, Moema, Mzaidume & Rasego, 2000). The effectiveness of peer education and support in an HIV context was illustrated in a variety of studies and proved to contribute to higher levels of knowledge, changed.

Peer education is intended to supplement life skills programmes. It is important that educators understand it does not replace educator delivered curriculum which should by virtue integrate knowledge skills and attitude on HIV/AIDS? Implementing peer education programme has the advantages as it assist learners to develop collective nouns and it affords learners role modeling and informal learning opportunities to influence their peers. It requires support from educators in terms of supervision and planned flexible schedules as peer educators are to perform learner - centered learning activities (Ntombela, 2009).

Community support can make or break a school health programme. In many cases it is community based organizations and individuals, *inter alia*, governmental organizations, community clinics, people living with HIV/AIDS, home-based care programs, volunteer and faith-based support schemes that are leading the way. In other cases misconceptions about sexual education and stigma associated with HIV/AIDS can generate community resistance against any efforts towards the infection. In such instances, communicating the evidence, listening and responding to community concerns and valuing community opinions can help gain commitment Education for All (<http://www.unesco.org/education/efa/index.shtm>).

According to Table 4.3 a percentage of 7.1% of people are willing to live with PLWHA and a small percentage of 29% are not so willing. School health programmes will be greatly enhanced through the in-kind contributions of partners like health professionals and private companies. Further the participation of parents and other community members can amplify the educational benefits beyond the school.

The input and energy of children and young people has substantially enhanced many efforts to prevent and control AIDS and should continue to be harnessed for their own protection and that of their communities. They have served as organisers of programmes, educators and counsellors for their peers, and carers of younger siblings and children orphaned by HIV/AIDS. As more and more children become infected, orphaned or burdened by the impact of AIDS, school programs must be made relevant to the reality they are experiencing, so that even those infected and affected will remain in school. The involvement of children and young people including

those living with HIV/AIDS, can help guarantee that relevance (Education for All (<http://www.unesco.org/education/efa/index.shtml>)).

5.2.4. Recreational facilities

It is widely agreed that new and innovative ways need to be found to reach young people and communicate with them at their level to understand and find it credible. The Commission for Africa report recommends the use of popular elements of youth culture, such as sport, radio and film, to engage young people in the response to AIDS and particularly in strategies to reduce stigma. The UNAIDS *2004 Report on the global AIDS epidemic* also stresses the importance of reaching those who influence young people.

Sport has a huge power to attract and engage young people. In sub-Saharan Africa where 62% of all young people infected with HIV live sport is the most popular activity amongst teenagers of both sexes (2004 Report on the global AIDS epidemic). Although the development of life skills through participation in sports activities has until now received limited attention in mainstream development work, studies and policy-making experience in the developed world demonstrate that participation in sport brings great benefits to young people's health, social development, confidence, self-esteem and academic performance.

In brief sport provides the opportunity for young people to take on challenges and stretch themselves, to develop self-esteem, self-confidence and social skills and make new friends, to co-operate and negotiate as part of a team of their peers, to lead a group of their peers, to play according to a defined set of rules and to face penalties if they break those rules and to develop a positive body image and a sense of control and ownership of their own bodies (particularly important for young women).

Grassroot Soccer Foundation - HIV/AIDS Education Program: An Intervention in Zimbabwe, Evaluation Report August 2004, The Children's Health Council Outcomes Research Consulting Service http://www.grassrootsoccer.org/downloads/CHC_Eval.pdf

5.2.5. Nutritional status

Enhancing overall health and nutritional status is an important way to reduce vulnerability to HIV/AIDS and sustain the health of those already infected. The benefits are not limited to health but have been shown to improve enrolment, retention, and performance. While schools and education systems cannot be solely responsible for providing such services they can network more effectively to facilitate their access, through strong links with local health centres and other community resources. In the conceptual framework (Figure 2.1) a healthy diet leads to a physically well human being.

5.2.6. Voluntary testing and counselling

Most people who are HIV positive do not know about their condition. This means they will unknowingly spread the disease to their partners while they are in the early stages. There are few if any symptoms in the early stages of the disease. The flu-like symptoms that often occur shortly after infection usually pass quickly so most people do not know they have become HIV-positive (seroconvert is the medical term). This underlines the importance of people being tested even if they have no symptoms; it should not be a once-off activity. Educators should be encouraged to be tested every couple of years and they should also encourage learners to be tested regularly.

The Department of Health is promoting voluntary counseling and testing (VCT) at clinics and hospitals. People who want to be tested are counseled before the test and if they are positive; get further counseling and support afterwards. The counseling is very important since people need good advice and emotional support if they are positive. They also need counseling on how to protect their partners.

The major problem with VCT is that it is mostly pregnant women who come for tests. They do this so that they can get medicine like Nevirapine to prevent infection of their babies. A very small percentage of the men who are positive come for tests. Many people say they would rather not know if they have HIV and AIDS since they see it as a death sentence and as an end to their sex lives. They also fear their families and friends will reject them.

Unless people who are HIV positive know it and practice safe sex the spreading of the disease will not be stopped. A way should be found to overcome resistance to testing. People must feel

that it is in their interest to be tested. Linking testing with treatment is the most effective if people know they may stay healthy for longer they will come for tests.

Educators should stress four main aspects as good reasons for testing:

1. If you know you are still negative, you can make sure that you protect yourself and stay negative.
2. If you know that you are positive, you can do the right things to stay healthy.
3. If you are positive, the clinic will help you to get treatment for infections and other support from services that will help you to look after yourself and your family.
4. If you know that you are positive, you can protect your partner by practicing safe sex.

Educators should stress it is the right thing to do and it is an individual's moral responsibility to not spread the disease. The four aspects listed may be more effective since they appeal to people's self-interest. It is also important to set up counseling and testing in places where it is comfortable and where people can go without others finding out. The facilities should be open at times when working people can get there. There should also be a referral system in place so that when someone tests positive they can be offered other forms of support.

Educators should use all our public education and awareness methods to promote testing. VCT is crucial to the success of a comprehensive program. The ultimate goal is to have persons aware of their HIV status and to guide their behavior accordingly (Idemyor, 2004). Figure 4.29) indicated there is a misunderstanding of whether there is VCT programme at schools or just counseling. Given this misunderstanding top management should motivate for VCT at schools and this can be used as a means to drive a wellness programme.

5.2.7. Antiretroviral therapy

There is no cure for individuals who have AIDS. People can live with AIDS for many years if they get proper medical care. Antiretroviral, healthy eating, exercise, a clean environment and a positive mental attitude can also make a big difference. There are medications that can help to fight the illnesses like TB, or related infections pneumonia and gastro (stomach infection) that easily kill people with AIDS; infections are called opportunistic. The medicines used to fight opportunistic infections are available at clinics. Antiretroviral medications (ART) when taken

according to the prescribed regime can greatly reduce the level of HIV in the body, reduce susceptibility to HIV and AIDS illness and extend the person's life; sometimes for many years. ART prevent the virus from reproducing and help prevent further damage to the body. Many people find that after taking ART for a few months, the level of the virus in their blood is so low that it cannot be detected. ART cannot, however, repair damage to organs and systems to the body that the virus has already made. Once a person goes on ART, they must accept that they will have to keep taking the medication for the rest of their lives. Although some professionals believe that widespread availability of ART will make people more careless about safe sex, effective ART lowers viral load dramatically and makes people less infective and less likely to transmit an HIV infection. In this sense, highly active antiretroviral therapy (HAART) may be seen as a preventive measure from a public health point of view (Idemyor, 2004).

TB is often found in people with weakened immune systems and people with HIV are very vulnerable to TB. TB patients have to take a course of treatment for 6 months to 1 year. If they stop before the virus is killed; it will grow stronger and more resistant to medicines. This is called multi-drug resistant TB or MDR TB. This form of TB is becoming more common in SA and we also have a new strain of TB called extreme (Report National HIV and Syphilis Prevalence Survey, South Africa, 2006.). Educators at schools should be observant in picking learners that have signs and symptoms of diseases such as TB.

5.2.8. Policies Regarding Health and HIV/AIDS

School policies can ensure a safe and supportive environment, both physical and psycho-social for children and young people in a world with HIV/AIDS. At the national level, appropriate legislation and administrative actions can mitigate the impact of HIV/AIDS by ensuring the right of HIV/AIDS affected people to education, combating discrimination within the education sector and directing resources to strengthen recruitment, training, management and other elements of a nation's educational infrastructure.

5.9. Challenges facing the education system regarding HIV/AIDS

Related educator morbidity and mortality due to HIV/AIDS together place substantial burdens on education system. Since the disease has an impact on educator trainees and trainers alike, the simple solution of expanding educator; training capacity is insufficient (Coombe& Kelly, 2001).

The problem to alleviate the of loss of educators through HIV/AIDS, related support systems may meet the needs and ensure a supportive workplace environment for educators that are HIV positive and for those are caring for HIV positive family members.

There are interventions that have been put in place in order to support educators to deal with HIV/AIDS challenges as well as equipping them to deliver related prevention education to learners (UNESCO, 2006(c). ZIMTA and the American Federation of Teachers worked in collaboration to implement strategies and activities to help curb the spread of HIV/AIDS among educators in Zimbabwe. The main focus of the intervention was on education, awareness and prevention. In South Africa the educators that participated in the focus group discussed the need for education and awareness that will decrease the burden of the pandemic. In 2003 the South African government approved a Comprehensive National Plan on HIV and AIDS Care, Management and Treatment. This plan was evaluated and revised in 2006 and again in 2011. The 2012-2017 strategy has clear goals and targets to:

- Halve new HIV infections;
- Ensure that at least 80% of people who need treatment for HIV are receiving
- At least 70% of these people should be alive and still on treatment after five years;
- Halve the number of new infections and deaths from TB;
- Ensure that a legal framework exists and is used to protect the rights of people living with HIV; and
- Halve the stigma related to HIV and TB.

The government, however, faces a big challenge in meeting these goals and will need a great deal of cooperation from civil society and local communities. The strategy is based on the

principles of partnership, effective leadership and good communication. It seeks to promote social change and to make sure that funding is available for key programmes.

HIV/AIDS pandemic is grossly affecting schools whilst the education system itself is unstable with the many changes it is undergoing. For example, changes from what was once called traditional curriculum which was content-based to the new curriculum called national curriculum statement which is outcomes-based. Learners and educators are still trying to come to terms with these changes. Challenges in implementing and sustaining effective peer education has been suggested by Deutsch and Swartz (2002, p.130). A number of reasons are cited in the light of the idea expressed:

- Inadequate resources
- Inadequacies in supervisor staffing
- Difficulty in teaching peer educators effective teaching methods.
- Personal (out - of - classroom) behaviour of peer educators.

Inadequate resources have been time and again quoted in the failure in the implementation of the new curriculum which is outcomes-based and learner centered. In adequately trained educators which results in ineffective delivery mode of teaching is also an issue. One could foresee the implementation of peer education being challenged if schools are not ready in the light of what is mentioned above.

Peer education is fairly a new concept and little literature is available which informs the success and the failures of the programme. There are no peer educators training manuals for the program to be considered more structured. Quite seldom educators have been invited to the training where they were to learn the facts about HIV/AIDS and armed with the techniques that could be used in classrooms to educate learners on HIV/AIDS.

5.10. RECOMMENDATIONS FOR A WELLNESS PROGRAMME

The following recommendation will place the research project in context:

- Encouragement of educators to plan extra mural programmes to help HIV/AIDS infected people to focus on their future by setting goals that are achievable and realistic.
- The introduction of vegetable gardens that will encourage people that are living with HIV/AIDS ensuring they have well balanced meals and hereby allow them into a wellness programme like exercises.
- The integration of Life Skills and HIV/AIDS into the Life Orientation learning area through age appropriate and culturally appropriate lessons will help learners to assist those at home that are infected with HIV/AIDS.
- Organize a testing drive led by key local leaders and role models – publicise the drive and mobilize people to go on specific days to be tested.
- Encourage people to take five friends with them to be all tested.
- Get local leaders to talk publicly about being tested and why they did it.
- Organize health workers to come to workplaces to take blood – do a talk or workshop first to motivate people.
- Deutsch and Swartz (2002) suggest the implementation of peer education requires that the educator who is responsible for it has a team of learners who are good at persuading others *and* learners should be credible people with influence.
- Rutanang, a peer education implementation guide for schools written by Deutsch and Swartz (2002) suggests the standards for sustainable peer education programme, its evaluation and programme improvement guidelines.
- Peer education implementation requires a supportive environment which will assist to enhance the programme. Therefore implementation requires intensive planning, coordination, supervision and resources.
- Since this has been the Department of Education initiative, implementation is expected in secondary schools irrespective of whether schools meet the above mentioned criteria or not, but for the schools where the research has been carried out, peer educators enjoyed the support from educators even though there was little time and inadequate resources

available, peer education was implemented. They planned their learning sessions with the support, the supervision and the collaboration of the Life Orientation educators.

- Programmes and activities as a way to engage young people and provide a platform for education and information about HIV and AIDS
- Developing life skills through sports and team activities, especially for young women and girls
- Using team games and sports to promote a sense of social inclusion, breaking down stigma and discrimination, and to provide a safe and supportive environment for people living with HIV or AIDS and children affected by AIDS
- Using sports activities to provide a point of access to voluntary and confidential HIV counseling and testing and other health services
- Harnessing sport's media profile to communicate and promote AIDS messages to a wider audience
- Harnessing the interest of the private sector in using sport to achieve corporate social responsibility objectives
- Encouraging and promoting both celebrity and community sports people and coaches as role models:
- Sports occasions (tournaments, league matches, formal coaching sessions or impromptu kick-around) provide a vehicle onto which AIDS education programmes can “piggy-back”. Sports matches, coaching sessions and sports stars are able to draw a large crowd, often bringing whole communities together in a way other events would not. This presents an ideal medium for public information campaigns (http://www.usaid.gov/gn/health/news/050429_girlssoccer/index.htm http://www.usaid.gov/gn/health/news/050429_girlssoccer/portraits.htm http://www.uncief.org/infobycountry/guinea_25923.html).
- Information or peer discussion groups can be formed at half times, or before or after matches. This technique has proved popular and successful by the Mathare Youth Sports Association in Nairobi, Kenya which now numbers some 15,000 football players, both boys and girls. The Alive and Kicking project, also based in Nairobi, uses the footballs themselves to spread messages by printing slogans about HIV prevention and malaria on balls which are being used in Kenyan schools

- The fact that sport tends – though not exclusively – to be organized in single-sex groups also lends itself to an atmosphere in which groups of peers are more able to discuss sensitive issues around sexual behaviour. Anecdotal evidence from Edusport’s ‘Go Sisters’ football programme in Zambia, supported by UK Sport, tells us that some of the girls who have participated in the programme have opened up to their peer-coaches and told them about sexual abuse that they have suffered and have been able to ask for support and guidance
- http://www.usaid.gov/gn/health/news/050429_girlssoccer/index.htm
http://www.usaid.gov/gn/health/news/050429_girlssoccer/portraits.htm
http://www.uncief.org/infobycountry/guinea_25923.html.
- The Kicking AIDS out (KAO) concept uses sport to raise awareness about HIV and AIDS. It was developed and pioneered in Zambia and is now in use in a number of countries in southern Africa. KAO embeds HIV prevention messages and life skills education into exercises based on traditional games and sports. These exercises range from football dribbling exercises, in which the participants have to race to pick up placards with AIDS messages on them, to passing exercises that make a link between the importance of passing the ball in a football game and the importance of passing on information to friends and relatives about how to prevent HIV infection (http://www.usaid.gov/gn/health/news/050429_girlssoccer/index.htm
http://www.usaid.gov/gn/health/news/050429_girlssoccer/portraits.htm
http://www.uncief.org/infobycountry/guinea_25923.html).
- Organization of Educational programmes to advocate less risky sexual behaviours;
- Organization of educational programmes and awareness to de-stigmatize HIV and AIDS

5.3. CONCLUSION

A review is provided of the definition of health and wellness as stipulated by the World Health Organization (WHO).

The World Health Organization (WHO) constitution defines health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” (1948). Early criticism that this definition was not quantifiable (last 1988) has been proven wrong as investigators in diverse disciplines validated assessments across aspects of physical, mental, and social well being. WHO (1986) clarified the definition of health further, noting that to reach a state of health “an individual or a group must be able to realize aspirations and satisfy needs, and to change or cope with the environment.” Recent conceptualization of health now includes the ability to accommodate potential stresses or internal/external adaptive changes. The Current Physician Desk Reference (PDR) Medical Dictionary (1995) describes health as, “A state characterized by anatomical. Physiological, and psychological integrity, ability to perform personally valued family, work, community roles, ability to deal with physical, biological, psychological and social stress, a feeling of well being and freedom from the risk of disease and untimely death. Given these sources, clearly the biomedical as well as the social science community now acknowledges, theoretically if not empirically, the multifaceted and complex nature of health and well-being (Schuster et al, 2004).

In cooperating the conceptual framework and the recommendations, the perceptions of educators can be transformed to making the disease of HIV/AIDS manageable through a wellness programme of education and awareness, alleviation of stigma, nutrition and recreation, antiretroviral therapy and proper use of policies on HIV/AIDS.

The famous words of Nelson Mandela:

*“Sport has the power to change the world. The power to unite people in a way little else can” –
Nelson Mandela*

REFERENCES

Adesoji.A.O. (2005).Education: An Antidote for the spread of HIV/AIDS .Journal of the Association of Nurses in AIDS CARE. Vol.16. No.2.

Ahmed N et al (2009), 'HIV education in South African schools: The dilemma and conflicts of educators' Scandinavian Journal of Public Health 37 (Supply 2).

Allegrante,J.P.(1998). School-site health promotion for staff. In: Marx,E.,Wooley,S.& Northrop,D.(eds.)Health is Academic, New York, Teachers College Press.

Almerdon,A.M.(2005). Resilience, hardiness, sense of coherence, and post traumatic growth: all paths leading to "light at the end of the tunnel"? Journal of Loss and Trauma10.pp. 253-265.

Babbie, E. (2001).The practice of social research. 9thed. Belmont: Wadsworth/Thomson Learning.

Brink, H. (2006). Fundamental so Research Methodology for Health Care Professional. Juta. & Co. (pty) Ltd

Burns, B.B. (2000). Introduction to Research Methods. 4th ed. London: Sage Publications Ltd.

Burns, N. & K.Grove. (2007) 4th edition. Understanding Nursing Research. Building an evidence based practice.Saunders.Elsevier.

Carboni, A. & L.Dawson. (2001). The Role of the Academic Discipline and Gender in High School Teachers' AIDS related Knowledge.

Cohen, L. (et al). (2000). "Questionnaire" In Research Methods in Education. London: Routledge Falmer.

Coombe, C. (2000). Keeping the education system Healthy: managing the impact of AIDs on Education in South Africa. Current Issues in comparative Education, 3. (Online)url:<http://www.tc.columbia.edu/cice/contnt3.htm>.

Creswell, J.W. (2007) Research Design. Qualitative Quantitative and mixed methods approaches. 2nd ed. Sage Publications, INC.

Deacon, H. (et al). (2005). Understanding HIVAIDS stigma. A theoretical and methodological analysis. Cape Town. HSRC Press.

De Vos, A.S. (2005). Qualitative data analysis and interpretation. Research at Grassroots for the social sciences and human service professions 3rd ed. Pretoria: Van Schalk Publishers.

Department of Education, 2000. Norms and Standards for Teachers. Pretoria: Government Printer

Department of Education. 2001. Education White Paper 6: Special Needs Education, Building an Inclusive education and Training System: Pretoria: Government Printers.

Department of Education, (2002a). Revised National Curriculum Statement Grade R-9 (Schools Natural Sciences). Pretoria: Department of Education.

Department of Education, (2002b). Revised National Curriculum Statement Grade R-9. Schools Life Orientation. Pretoria: Department of Education.

Eaton et al, (2003). Unsafe sexual behaviours in South African youth. Social Sciences and Medicine. 58 (1). 149-165.

Education for All. <http://www.unesco.org/education/efa/index.shtm>

Encarte. (2007). <http://uk.encarta.msn.com/thesaurus/perception.html>.

Epicentre,

Fouche, C.B. (et al) (2005) .Introduction to the research process. Research at Grassroots for the social sciences and human service professions.3rd ed. Pretoria: Van Schalk Publishers.

Fredriksson,J & Kanabus ,A.(2002). The impact of HIV and AIDS on Africa. Online article. Available at: <http://www..avert.org/aidsimpact.htm>.

Grassroot Soccer Foundation - HIV/AIDS Education Program: An Intervention in Zimbabwe, Evaluation Report August 2004, The Children's Health Council Outcomes Research Consulting Service http://www.grassrootsoccer.org/downloads/CHC_Eval.pdf

Greeff, M. (2005). Information collection: Interviewing.

Research at Grassroots for the social sciences and human service professions3rd ed. Pretoria: Van Schalk Publishers.

Hall et al, (2005). Potential Attrition in Education.: The impact of job satisfaction, morale, workload and HIVAIDS.Cape Town: HSRC..

Harvey, DR. (2002). Research methods. Available at: <http://www.lamp.ac.uk/mit/pdf/report/pdf>.

Harrison, D (2009, December). 'An Overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains'

Herlihy, P.A. & M.Attridge. (2005). Research on the integration of employee assistance, work life and wellness services: Past present and future.

Idemyor, V.(2004).International AIDS Conference and How to Globally Counter HIV/AIDS. Advocate Bethany Hospital and Department of Medicine, University

International Institute for Education Planning. HIV/AIDS and educational programme. (2001-2003)

IRIN/PlusNews (2008, 22nd May), 'South Africa: Sex education - the ugly stepchild in teacher training'.

Johnson,B.Christensen,L. (2000).Education Research. Qualitative and Quantitative. Boston

Allyn& Baco.

Kelly, M.J. (2002). Education on its head: aspects of schooling in a world with HIV/AIDS. Current Issues in Comparative Education, 3. (Online)url:[http://:www.tc.columbia...edu/cice/contnt3.htm](http://www.tc.columbia...edu/cice/contnt3.htm).

Kidd, R. &S.Clay. (2003). Understanding and Challenging HIV stigma: Toolkit for action. Washington: PetraRohr-Rouendaal.

Kirby,D.Obasi,A.&Laris,B.A.(2006).The feeectiveness of sex education and HIV education interventions in schools in developing countires.

Landsberg,E.(2005). Learning Support: Addressing Barrier to Learning: A South African Perspective: Pretoria: Van Schalk.

LoBiondo-Wood, G. & J.Haber, (2002).Research in Nursing Methods: critical appraisal and utilization.5th edition. Missouri: Mosby.

Logan et al., T.K. (2002). Woman, Sex and HIV social and contextual factors, meta-analysis of published intervention and implications for practice and research. Psychological Bulletin. 26(6).851-885.

Mangana, M. (2002).Togrther-the education coalition against HIVAIDS.Address by Deputy Minister of Education at the International Conference on HIVAIDS in the Education Sector. May 2002.

Milan, J.D. (2007).HIV AIDS Stigma in the Workplace.<http://www.hivtwork.org>

National Policy on HIV/AIDS for learners and Educators in Public Schools and D students and Educators in Further Education and Training Institutions

10 AUGUST 1999 VOLUME 410 NUMBER 20372)

Ntombela, Z.N.O.(2009). Learners Awareness of HIV/AIDS and their attitudes to peer educators in Secondary School. A dissertation submitted to the Faculty of Education in partial fulfillment of the requirements for the degree of Masters of Education in the Department of Educational Psychology at the University of Zululand. KwaDlangezwa

Nyblade, L. (et al). (2003).Disentangling HIV/AIDS Stigma in Ethiopia, Tanzania and Zambia. Colloborative Research Report. (Online)url:[http://;www.icrw.org/docs/stigma report 093003.pdf](http://www.icrw.org/docs/stigma_report_093003.pdf).

Parker, R. & P.Aggleton (2002).HIV AIDS related to Stigma and discrimination” A conceptual Frameworkand an Agenda for action. New York: The population council Inc. Partnership for Child Development <http://www.child-development.org/>

Prinsloo, E.2005. Socio- economic barriers to learning in contemporary society: In E

Polit, D.F.E. & Beck, C.T. (2008). Nursing research principle and methods. Philadelphia: Lippincott.

Report on the global AIDS epidemic: 4th global report, (2004) UNAIDS. GENEVA

Rees,S. (1998). Teachers attitudes towards the AIDS crisis in South Africa. NUE Connect2,9.

Rossouw, D. (2003). Intellectual tools, skills for human sciences. Pretoria: Van Schalk Publishers.

Ross, E & Deverell, A.2004.Psychosocial approaches to health, illness and disabilities. Pretoria: Van Schalk.

Scriven, A. & Stiddard, L. (2002). Empowering Schools: translating health promotion principles into practice : Health Education. 103. Available url: <http://www.sciencedirect.com>.

Singhal, A. & E.M. Rogers. (2003). Combating Aids. Communication strategies in action. New Delhi: Sage Publishers.

Soanes, C. (2002). South African Pocket Oxford Dictionary. 3rd ed. Cape Town: Oxford University Press.

Sohier, R. (1988). Multiple triangulation and contemporary Nursing Research. Western Journal of Nursing Research, 10(6), 732-742.

Strydom, H. (2005). Ethical aspects of Research in the Social Sciences and Human service profession. Research at Grassroots for the social sciences and human service professions 3rd ed. Pretoria: Van Schalk Publishers.

Temane, Q.M. & Wissing, M.P. (2006). The Role of spirituality as a mediator for psychological well being across different contexts. South African Journal of Psychology 36(3), pp. 582-597.

The National Educational Policy Act 1996 No.27. The National Policy on HIV and AIDS for learners and educators in public schools and for students and learners in further education and training institutions.

Thavhanyedza, T.A. (2009). The Perception of Employee Wellness Programme Practitioners concerning HIV/AIDS workplace Stigma in the Gauteng Provincial Government. Department of Social Work and Criminology. University of Pretoria.

Theron, L.C. (2005). Educator perception of educators' and learners' HIV status with a view of a wellness promotion. South African Journal of Education 25(1), pp. 55-60.

UK Government Discussion Paper. (2006). Tackling Aids through Sport. A cross- departmental paper between the UK Department for Culture, Media and Sport (DCMS) and the Department for International Development (DfID)'

United Nations Department of Economics and Social Affairs (2003). The impact of AIDS. (Online) url:<http://www.unpopulation.org>

UNAIDS, (2004). Progress update on the Global Response to the AIDS Epidemic. Fourth Global report.

UNAIDS (2010) '[UNAIDS report on the global AIDS epidemic](#)'

UNAIDS <http://www.unaids.org>

UNESCO <http://www.unesco.org>

UNICEF <http://www.unicef.org/programme/lifeskills/mainmenu.html>

Vandemoortele, J. & E. Delamonica (2000). The Education Vaccine against HIV. Current Issues in Comparative Education. 3 (1).

Van der Merwe, A. (2011) Workplace wellness solutions through peer educator training. Health Stress Management. (Pty)Ltd.

Van Dyk, A. (2001). HIV/AIDS care and counseling. A multidisciplinary approach. 3rd ed, Cape Town: CPT. Book Printers.

Van Zyl, E. & Pietersen, C. (1999). An investigation into work stress experienced by a group of secondary teachers. South African Journal Education 19(1). pp.74-78.

Viljoen, F. (2005). Righting Stigma: Exploring rights based approach to addressing stigma. Pretoria: University of Pretoria .AIDS and Human Rights Research Unit

World Bank, (2002). Education and HIV/AIDS. A window of hope. World Health Organization
1998. Health promotion Glossary. (Onlineurl: <http://> :

World Bank www.worldbank.org/ WHO

Preventing HIV/AIDS and related discrimination: An important responsibility of Health Promoting
Schools. WHO School Health Information Series, Geneva.

<http://www.who.int/hpr/gshi/publications.htm>

http://www.usaid.gov/gn/health/news/050429_girlssoccer/index.htm

http://www.usaid.gov/gn/health/news/050429_girlssoccer/portraits.htm

http://www.uncief.org/infobycountry/guinea_25923.html

Yethu I Wellness Employee Wellness Program (EAP). www.serviceseta.org.za/furtherinfo html.

ZIMTA(2002): Zimbabwe Teachers Association Membership AIDS Education Project:
Kubantana Network : Harare

Appendix A



MRS ANSUYAH SHUNMUGAM
36 BUSKINGHAM AVENUE
FLAT 14
BUCKINGHAM PLACE
SCOTTSVILLE

Enquiries: Sibusiso Alwar
Date: 22 February 2011
Reference: 0009/2011

PERMISSION TO INTERVIEW LEARNERS, EDUCATORS AND DEPARTMENTAL OFFICIALS

The above matter refers.

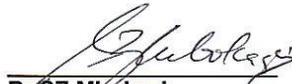
Permission is hereby granted to interview Departmental Officials, learners and educators in selected schools of the Province of KwaZulu-Natal subject to the following conditions:

1. You make all the arrangements concerning your interviews.
2. Educators' programmes are not interrupted.
3. Interviews are not conducted during the time of writing examinations in schools.
4. Learners, educators and schools are not identifiable in any way from the results of the interviews.
5. Your interviews are limited only to targeted schools.
6. A brief summary of the interview content, findings and recommendations is provided to my office.
7. A copy of this letter is submitted to District Managers and principals of schools where the intended interviews are to be conducted.

The KZN Department of education fully supports your commitment to research: **To explore the perceptions of educators on HIV and AIDS in schools with view of wellness promotion in the Midlands area KWAZULU-NATAL.**

It is hoped that you will find the above in order.

Best Wishes


Dr SZ Mbokazi
Acting Superintendent-General

...dedicated to service and performance
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL : Private Bag X9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa

PHYSICAL: Office G25, 188 Pietermaritz Street, Metropolitan Building, PIETERMARITZBURG 3201

TEL: Tel: +27 33 341 8610/8611 | Fax: +27 33 341 8612 | E-mail: sibusiso.alwar@kzndoe.gov.za / smiso.sikhakhane@kzndoe.gov.za



kzn education

Department:
Education
KWAZULU-NATAL

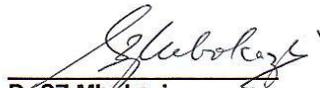
**MRS ANSUYAH SHUNMUGAM
36 BUSKINGHAM AVENUE
FLAT 14
BUCKINGHAM PLACE
SCOTTSVILLE**

Enquiries: Sibusiso Alwar
Date: 22 February 2011
Reference: 0009/2011

LIST OF SCHOOLS

1. Dunveria Secondary School
2. Copesville Secondary School
3. Edendale Secondary School
4. Smero High School
5. St Charles Pietermaritzburg School
6. Girls High School (Pietermaritzburg)

Kind regards


Dr SZ Mbokazi
Acting Superintendent-General

...dedicated to service and performance
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL : Private Bag X9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa

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kzn education

Department:
Education
KWAZULU-NATAL

**MRS ANSUYAH SHUNMUGAM
36 BUSKINGHAM AVENUE
FLAT 14
BUCKINGHAM PLACE
SCOTTSVILLE**

Enquiries: Sibusiso Alwar
Date: 22 February 2011
Reference: 0009/2011

**PROPOSED RESEARCH TITLE: TO EXPLORE THE PERCEPTIONS OF EDUCATORS
ON HIV AND AIDS IN SCHOOLS WITH A VIEW OF WELLNESS PROMOTION IN THE
MIDLANDS AREA KWAZULU NATAL**

Your application to conduct the above-mentioned research in schools in the attached list has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educator programmes are not to be interrupted.
5. The investigation is to be conducted from 01 February 2011 to 28 February 2012.
6. Should you wish to extend the period of your survey at the school(s) please contact Mr Sibusiso Alwar at the contact numbers above.
7. A photocopy of this letter is submitted to the principal of the school where the intended research is to be conducted.
8. Your research will be limited to the schools submitted.
9. A brief summary of the content, findings and recommendations is provided to the Director: Resource Planning.

...dedicated to service and performance
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL : Private Bag X9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa

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kzn education

Department:
Education
KWAZULU-NATAL

10. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director; Resource Planning
Private Bag X9137
Pietermaritzburg
3200

We wish you success in your research.

Kind regards

Dr SZ Mbokazi
Acting Superintendent-General

...dedicated to service and performance
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL : Private Bag X9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa

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Appendix B



UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvenoot • your knowledge partner

12 October 2011

Tel.: 021 - 808-9183
Enquiries: Sidney Engelbrecht
Email: sidney@sun.ac.za

Reference No. 669/2011

Ms A Shunmugam
Africa Centre for HIV/Aids Management
University of Stellenbosch
STELLENBOSCH
7602

Ms A Shunmugam

LETTER OF ETHICS CLEARANCE

With regard to your application, I would like to inform you that the project, *To explore the perceptions of educators on HIV/AIDS in schools with a view of a wellness promotion programme in the midlands are in Kwa-Zulu Natal*, has been approved on condition that:

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.
5. This ethics clearance is valid for one year from 12 October 2011 to 11 October 2012.

We wish you success with your research activities.

Best regards



Sidney Engelbrecht
MR SF ENGELBRECHT

REC Coordinator: Research Ethics Committee: Human Research (Humanlora)

Registered with the National Health Research Ethics Council (NHREC): REC-050411-032



Afdeling Navorsingsontwikkeling • Division for Research Development
Privaatsak/Private Bag X1 • Matieland 7602 • Suid-Afrika/South Africa
Tel: +27 21 808 9184 • Faks/Fax: +27 21 808 4537
www.sun.ac.za/research

Appendix C

University of Stellenbosch
Faculty of Philosophy
HIV AIDS
Stellenbosch

Research topic: Exploring the Perceptions of Educators on HIV AIDS in Schools so that a Programme concerning the Wellness and Productivity of Educators is developed.
Dear Participants

I am a student currently doing my Masters in Philosophy HIV AIDS Management at the University of Stellenbosch

The aim of my study is to explore the perceptions of educators on HIVAIDS and to create an awareness that will alleviate misconceptions about HIVAIDS and then to recommend a wellness programme in schools.

I am asking your permission to participate in this study.

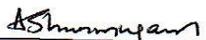
Your participation is voluntary .You may refuse to participate or withdraw from answering these questions at any point in time.

There will be no monetary gain if you participate in this questionnaire/interviews/schedule.

There will be no identification of participants on the questionnaire/Interview schedule. All questionnaires/interview schedules will be kept under lock and key and then destroyed after the data analysis. Confidentiality and anonymity will be maintained at all times

If you have any questions or concerns about completing this questionnaire or participating in this study you may contact me on the following no. 08364221738

Thanking you again


Mrs A Shunugam

University of Stellenbosch
Faculty of Philosophy
HIV AIDS
Stellenbosch

I hereby consent to taking part in the above study
I have read the above and understand that participation is voluntary and of my own
accord

Name of Participant

.....

Signature of Participant

.....

Date

.....



DUNVERIA SECONDARY SCHOOL

Telephone ☎ / Fax ☎ : 033-391 4919

Address - Physical : 50 Rugar Crescent, Raisethorpe.

Postal ☎ : P O Box 520, Luxmi, 3207.

13 September 2011

TO WHOM IT MAY CONCERN

University of Stellenbosch
Faculty of Philosophy
HIV/AIDS
Stellenbosch

This is to confirm that permission has been granted to Mrs Ansuyah Shunmugam to conduct research at the above school with regards to her proposed research –

To explore the perceptions of educators on Hiv and Aids in schools with a view of wellness promotion in the Midlands Area of Kwazulu Natal.


P.M. Govender
(Principal)

KZN DEPARTMENT OF EDUCATION
DUNVERIA SECONDARY SCHOOL
50 RUPAR CRESCENT - RAISETHORPE
PIETERMARITZBURG 3201
P O BOX 520 - LUXMI 3207
TEL/FAX 033 391 4919

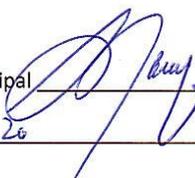
University of Stellenbosch

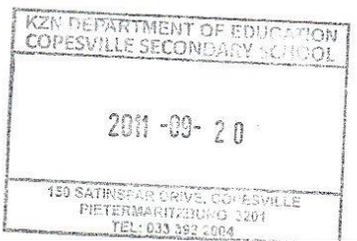
Faculty of Philosophy

HIV/AIDS

Stellenbosch

I, MR, MRS, Ms T.E. ZAKWE the principal of COPEVILLE SEC. SCHOOL school hereby grant Ansuyah Shunmugam permission to conduct research in the school mentioned. I understand that participation of the principal, deputy principal and educators is voluntary.

Signature of Principal 
Date 2011-09-26

School Stamp 

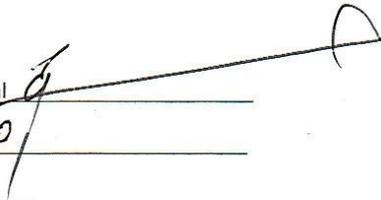
University of Stellenbosch

Faculty of Philosophy

HIV/AIDS

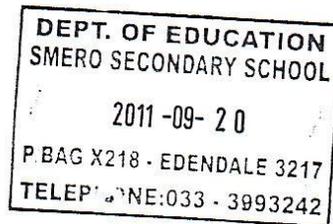
Stellenbosch

I, MR, MRS, Ms THULASIZWE N. NGOBESZ the principal of
SMERO SECONDARY SCHOOL school hereby grant Ansuyah
Shunmugam permission to conduct research in the school mentioned. I understand that
participation of the principal, deputy principal and educators is voluntary.

Signature of Principal 

Date 2011-09-20

School Stamp _____



University of Stellenbosch

Faculty of Philosophy

HIV/AIDS

Stellenbosch

I, MR, MRS, Ms MARY-ANN ALERMAN the principal of PIETERMARITZBURG GIRLS' HIGH school hereby grant Ansuyah Shunmugam permission to conduct research in the school mentioned. I understand that participation of the principal, deputy principal and educators is voluntary.

Signature of Principal M-A. Alerman

Date 15/09/2011

PIETERMARITZBURG GIRLS HIGH
P/BAG X5
SCOTTSVILLE
3209

School Stamp _____

University of Stellenbosch

Faculty of Philosophy

HIV/AIDS

Stellenbosch

I, MR, MRS, Ms T. F. NSUBANE the principal of EDENDALE TECHNICAL HIGH SCHOOL school hereby grant Ansuyah Shunmugam permission to conduct research in the school mentioned. I understand that participation of the principal, deputy principal and educators is voluntary.

Signature of Principal 

Date 16 - 09 - 2011



School Stamp _____

Appendix D

Demographic details

1 Are you :

Male

Female

2 Are you an Educator

 YES NO

3.How long have you been an educator

0-10 years

11-20 years

21-30years

Above 30years

4.Tick the relevant race group

Indian

Coloured

White

Black

Other

5. Tick the relevant age group

20-25 years

26-30years

31-35years

36-40years

41-45 years

46-50years

51-55years	<input type="checkbox"/>
Over 55years	<input type="checkbox"/>
6. Do you live in an area that is?	
Urban	<input type="checkbox"/>
Rural	<input type="checkbox"/>

Kindly tick the correct response

Questionnaire for Study

	YES	NO
1 Are you willing to live with people having HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
2 Are you reluctant to live with people having HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
3 Do you dislike having contact with HIV/AIDS people	<input type="checkbox"/>	<input type="checkbox"/>
4 Do you feel empathetic towards people living with HIV and AIDS	<input type="checkbox"/>	<input type="checkbox"/>
5. Would you discriminate against people living with HIV and AIDS	<input type="checkbox"/>	<input type="checkbox"/>
6 Are you in favour of providing condoms free in entertaining places	<input type="checkbox"/>	<input type="checkbox"/>
7 Would you support public health promotion	<input type="checkbox"/>	<input type="checkbox"/>
8 Are you aware that HIV is a contagious disease	<input type="checkbox"/>	<input type="checkbox"/>
9 Are you aware of sources of HIV/AIDS infection	<input type="checkbox"/>	<input type="checkbox"/>
10 Would you know of people living with HIV and AIDS	<input type="checkbox"/>	<input type="checkbox"/>

11 Would you know of any relatives of people living with HIV	<input type="checkbox"/>	<input type="checkbox"/>
12. Would you know of people having casual contact with people living with HIV AIDS	<input type="checkbox"/>	<input type="checkbox"/>
13 Are you aware that people can get HIV from sexual intercourse without a condom	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO
14. Are you aware that people can get HIV AIDS through sharing needles among drug users	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you aware that people can get HIV/ AIDS through receiving blood from an HIV infected person	<input type="checkbox"/>	<input type="checkbox"/>
16 Are you aware that people can get HIV/ AIDS through mother to child transmission	<input type="checkbox"/>	<input type="checkbox"/>
17 Are you aware that people can get HIV/ AIDS through having oral sex with an HIV infected person	<input type="checkbox"/>	<input type="checkbox"/>
18 Are you aware that people can get HIV/ AIDS through shaking hands with an infected person	<input type="checkbox"/>	<input type="checkbox"/>
19 Are you aware that people can get HIV/ AIDS through mosquito bite with an infected person	<input type="checkbox"/>	<input type="checkbox"/>
20 Are you aware that people can get HIV/ AIDS through sharing food together with an infected person	<input type="checkbox"/>	<input type="checkbox"/>
21 Are you aware that people can get HIV /AIDS through sharing tools and official utensils with an infected person	<input type="checkbox"/>	<input type="checkbox"/>
22 Are you aware that people can get HIV /AIDS through sharing public swimming pools with an infected person	<input type="checkbox"/>	<input type="checkbox"/>
23. Are you aware that you can prevent HIV AIDS by not sharing needle	<input type="checkbox"/>	<input type="checkbox"/>
24 Are you aware that you can prevent HIV AIDS through reducing unnecessary blood transfusions and injections	<input type="checkbox"/>	<input type="checkbox"/>

25 Are you aware that you can prevent HIV AIDS by using condoms during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>
26 Are you aware that you can prevent HIV AIDS prevention of mother to child	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO
27 Are you aware that you can prevent HIV AIDS by treating STIs promptly	<input type="checkbox"/>	<input type="checkbox"/>
28 Are you aware that you can prevent HIV AIDS by not donating blood illegally	<input type="checkbox"/>	<input type="checkbox"/>
29 Are you aware that you can prevent HIV AIDS by avoiding mosquito bite	<input type="checkbox"/>	<input type="checkbox"/>
30 Are you aware that you can prevent HIV AIDS by not sharing public swimming pools with an infected person 24 9.3	<input type="checkbox"/>	<input type="checkbox"/>
31 Are you aware that you can prevent HIV AIDS by not sharing food with people living with HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
32 Do you think that you can prevent HIV/ AIDS by isolating people living with HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
33. Are you aware of learners that are HIV POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>
34. Are you aware of educators that are HIV POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>
35 Are there any recreational facilities in the school	<input type="checkbox"/>	<input type="checkbox"/>
35 Are there any fitness area near the school like play grounds	<input type="checkbox"/>	<input type="checkbox"/>
36 Are there Gym Facilities near the school	<input type="checkbox"/>	<input type="checkbox"/>
37 Does the school have a HIV/AIDS VCT Programme	<input type="checkbox"/>	<input type="checkbox"/>
38. Does the school have a nutritional programme	<input type="checkbox"/>	<input type="checkbox"/>
39. Is there time allocated for the teaching of life skills (Life	<input type="checkbox"/>	<input type="checkbox"/>

Orientation)

- | | | |
|---|--------------------------|--------------------------|
| 40. Are you aware of the ANTIRETROVIRAL THERAPY | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Are you aware of any discrimination against HIV/ AIDS in your school | <input type="checkbox"/> | <input type="checkbox"/> |
| 42 are you aware of policies regarding HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 43 are you aware of the risk when a learner or educator is injured on the school grounds | <input type="checkbox"/> | <input type="checkbox"/> |
| 44 do you abide by universal precautions in your Classroom/school | <input type="checkbox"/> | <input type="checkbox"/> |
| 45 Does educators have training to take care of learners in the event of the learners have to fall and bleed | <input type="checkbox"/> | <input type="checkbox"/> |
| 46 Do you know of educators that are unwell and unable to teach due to HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 47 Do you feel that your workload has increased as an educator | <input type="checkbox"/> | <input type="checkbox"/> |
| 48 Are you willing to teach in an area that has high incidence of HIV positive people | <input type="checkbox"/> | <input type="checkbox"/> |
| 49 Do you know of educators that are caring for families that have family with HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 50 Do you feel that HIV positive people will benefit from a Wellness Promotion Programme. | <input type="checkbox"/> | <input type="checkbox"/> |
| 51 Are you aware of any discrimination amongst cultural background and traditional beliefs in respect of HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |

ANY OTHER COMMENTS ARE WELCOME

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.....
.....
.....
.....
.....
.....
.....

Thank you for your time

Ashunmugam

MRS A SHUNMUGAM

Appendix E

Interview schedule for Principals.

1. Does your school have an HIVAIDS policy.

2. Elaborate on the policy if any.

3. Are your educators aware of the HIVAIDS policy

4. How do you monitor the implementation of your schools HIVAIDS policy to ensure that it does not only exist on paper but put into action?

5. Does all your employees have a health insurance?

6. Does your school provide leadership training on HIVAIDS?

7. Specify what training programmes are available

8. Does HIVAIDS training at School focus on changing perceptions and behaviours.

9. What strategies are there in place for a wellness programme for people living withHIVAIDS.

10. Does your school participate in special events like World Aids Day?

11. Are HIVAIDS in cooperated in the curriculum e.g. life orientation programmes.

Appendix F

Focus Group Questions for Teachers. (Probing Questions)

1. Talk about your experiences about the HIV/AIDS pandemic.
2. In your opinion what are the barriers to HIV/AIDS status disclosure.
3. Have you been for any training programme in HIV/AIDS.
4. Do you see the need for a wellness promotion programme in your school.
5. What aspect of wellness to you see as important.
6. Do you receive any support from top management concerning HIV/AIDS workplace issues.
7. Do You know about Voluntary Counseling and Testing (VCT).