CHAPTER 1

INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

The international debate on the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) takes the form of different discourses, for example the bio-medical and socio-political discourses (Burns, 2002:3). From the educational point of view space must be created for a discourse on HIV/AIDS and the school, specifically schools with Grade 12 learners. The specificity of contexts – the differences between Africa and the developed world and between one school and another, for example – have to be taken into account. In turn this involves acknowledging the place and importance of race and culture when exploring the topic. Universal solutions do not exist and it is therefore necessary to develop local responses.

The problems created by HIV/AIDS in schools are the visible (observable) ones, as in the case of learners’ declining enrolment, high drop-out figures, high absenteeism levels and, in the case of educators, early deaths and high absenteeism levels. However, there are also additional hidden problems, such as stress for learners who need to care for their dying parents and manage households without parents, and educators who are afflicted with similar stress-related problems.

The purpose of this study is not to propose intervention strategies or solutions to the HIV/AIDS pandemic but only to explore and understand the influence of HIV/AIDS on the school, as perceived by learners, educators and officials from the Department of Education (DoE). Perceptions are based on experiences but a vast array of spiritual and cultural assumptions taint these perceptions. The research is situated within a naturalistic inquiry, in order to locate the influence of HIV/AIDS on schools within the cultural, political, social and economic context in which they operate. This is about the understanding of the influence of HIV/AIDS on the schools of the informal settlements where the research was conducted. The
empirical data is drawn from focus group interviews with a total of 8 to 10 members per group, in each of five schools. While the data is drawn from the participants in the informal settlements, it is likely that they can be generalised to other similar social contexts.

In this chapter, the researcher will discuss the context in which the study takes place and the background to the research problem on the school and HIV/AIDS, in particular, the perceptions of learners, educators and district officials within the South African Department of Education (DoE). The need to conduct the research will also be discussed, basing the argument on the perception that although there have been public education campaigns on HIV/AIDS in the country, through the medium of posters, broadcasting, print media and Life Skills education, HIV infections have become a major public health, education and socio-economic emergency. The research problem will be analysed and research questions formulated. The rationale for the research problem, research strategies and methodology will be laid out. This chapter concludes by giving a general layout of the other chapters.

1.2 BACKGROUND OF THE STUDY

In South Africa, the euphoria of peaceful transition from apartheid to democracy has been dulled by the devastation of HIV/AIDS. The epidemic has had a disproportionate effect on poor, previously disenfranchised groups, in which the apartheid migrant labour system has destroyed family life and created conjugal instability (Gow & Desmond, 2002:18). South Africa is now in the midst of a maturing epidemic, with AIDS dominating most sectors of society. The education sector is no exception.

Twenty years ago, the first AIDS case was diagnosed in South Africa (Parliament South Africa, 2001:9), since when the HIV/AIDS epidemic has become entrenched. Its magnitude and the deleterious effects have made it the most serious communicable disease, to challenge the country and Sub-Saharan region, which has the world’s highest number of recorded incidents of HIV/AIDS. An estimated total of over four million South Africans are living with HIV/AIDS, placing the
country at the top of the league (UNAIDS(a), 2000:9). It was estimated that by the year 2005, there would be 6 million South Africans infected with HIV, and almost 1 million children under the age of 15 whose mothers would have died of AIDS (Parliament of South Africa, 2001:3).

Before 1994, the apartheid government’s approach to dealing with AIDS was insufficient and lacked credibility. The Mandela government set about redressing this in 1994 by establishing AIDS as one of the 23 presidential lead projects and one of the 12 Reconstruction and Development Programmes (RDP). The initial period of hope was, however, short lived. The biggest setback came when President Mbeki (who took office in 1999) expressed doubt about whether HIV caused AIDS. President Mbeki also questioned the safety and efficiency of antiretroviral medication. Subsequently, a presidential AIDS panel was created with equal numbers of AIDS denialists and orthodox AIDS scientists (Parliament of South Africa, 2001:5).

The general lack of access to antiretroviral (ARV) therapy is another compounding factor for the majority of people living with HIV/AIDS. ARV therapy, that can reduce mortality and enhance the quality of life, is not affordable to most of the population. HIV/AIDS has extremely high rates of morbidity and mortality rates and has drastically cut life expectancy statistics. Consequently, on a national level, mortality levels, life expectancies, fertility levels, rates of natural increase and population growth rates have been, and will continue to be, reduced by HIV/AIDS. This will have a profound influence on the life expectancy of infants, children and people between the ages of 15 and 44 years (Van Aardt, 2002:67). The average life expectancy of South Africans is estimated to decline to about 40 years by 2010, from an average of about 63 years in 1993. During the same period, its influence on life expectancy will vary from province to province (Van Aardt, 2002:31; Parliament South Africa, 2001:31).

HIV/AIDS is creating a host of problems that threaten to overwhelm the structure of educational organisations, management and provision. It is disrupting social systems, exacerbating poverty, reducing productivity, wiping out hard-worn human capacity, and reversing development gains. Notwithstanding the catastrophic
effects that are already being experienced, the full consequences of the pandemic are still to be felt. Kelly (2001:1) wrote that: “The storm has been gathering for almost two decades”. The then Minister of Education, Professor Kader Asmal alluded to this issue (NDoE, 2002:2), saying that many schools were already experiencing the effects of the pandemic as teachers, learners and members of their families were falling ill. Before the epidemic is brought under control, such effects will become harsher and more widespread. A majority of teachers will eventually be teaching some learners who are either HIV positive or HIV-affected. In most staffrooms, one or more teachers will be infected. Other school employees will not be exempt. Illness disrupts learning and teaching. Teachers have to take on an extra load when sick teachers are absent. Learners who are ill or who have family members who are ill or dying, fall behind in their studies.

Educators and learners carry the burden, and when they die, schools suffer disruption, loss and sorrow. It may not be an exaggeration to conclude that many schools will be crippled by the influence of the disease on staff, learners and their families. When educators are infected, the chronic illness and premature deaths associated with HIV/AIDS are resulting in absenteeism at work and low productivity. The DoE, as an employer, is obliged to recruit and retain educators, even though they may be known to be infected. Claims on related benefits, such as medical and disability schemes are increasingly accelerating (Sunday Times, 21 May 2000).

When parents are ill or die, children are often kept away from school to care for adults. There are increasing numbers of orphans, most of whom will have less access to education and adult role models. Limited family recourses are spent on care and funerals. Food production declines and malnutrition increases, with poverty, inequality and crime increasing. People, educators and learners become stigmatised and face harm and discrimination (Smart et al., 2001:30).

Many youths are sexually active but do not have the concomitant life skills to deal with sexual negotiations, particularly around safer sex. Sexual abuse, rape and transactional sex or sex for favours, often with older men, all contribute to the
vulnerability of youth. Poverty will often drive young girls to give sex in exchange for money, gifts or payment for education.

A variety of AIDS-related “demand and supply” factors have been identified, which are expected to have a highly adverse influence on the education sector and schooling in particular (Kelly, 2002:17). However, even at this late stage of the epidemic, relatively little detailed empirical research has been undertaken in South Africa, that systematically investigates the actual and likely influence of the epidemic on the education sector. More importantly, it would give curriculum designers and policymakers clear sets of recommendations about what should be done. Many of the predictions that are currently being made about the future influence of the epidemic on the education sector amount, therefore, to little more than unsubstantiated assertions.

The AIDS scourge threatens to undermine the substantial gains made in expanding educational participation during the past decade, and thereby prevent attainment of national educational objectives (Smart et al., 2001:30). Anything that threatens or diminishes the role of education directly influences and reduces personal community and national development. HIV/AIDS represents the largest threat to this education process, by increasing the scale of most existing problems of supply, quality and output (Rugalema & Khanye, 2002:25). This threat is increased by a general lack of seriousness regarding the problem, and its influence on the systematic functioning of education at all levels.

Curriculum change, materials development and condom distribution, while intended to contribute to high levels of awareness, have shown little evidence of influencing behaviour to date. There are numerous reports of continuing high rates of new infections, and the spread of HIV/AIDS, particularly amongst teenagers, leading to learners dropping out. An increase in the number of people infected with HIV is a cause for concern. Nowhere will its influence be greater than in the education sector, with more than 12 million learners at school. To place this in perspective, it should be noted that one-third of all HIV-infected persons were infected during school years, while a further one-third were infected within two years of leaving
school (Gow & Desmond, 2002:95). This confirms schools as a high-risk environment, but also suggests that the school is the key strategic ground on which the battle to mitigate the influence will be won or lost.

In addition, the epidemic poses a significant and complex threat to society as a whole, but South Africa has the capacity to rise above this challenge, manage its way through this crisis and redesign its education future. If these hopes can be fulfilled, then the country would be in a position to mitigate as effectively and efficiently as possible the manifold influence of the epidemic HIV/AIDS.

1.3 THE RESEARCH PROBLEM: AN ANALYSIS

The influence of HIV/AIDS in South Africa on the learner, the educator, the curriculum and the education sector cannot be overlooked or wished away, but has to be addressed. Secondary schools and tertiary students are at an age where sexual activities are often beginning, or have already begun. Potentially, they may be putting themselves at the risk of acquiring HIV/AIDS and other sexually transmitted infections (STI's), particularly if they are not properly informed. They therefore need to consider themselves to be at a risk and undertake safer sexual practices or abstain from these activities (Smart et al., 2001:36).

Educators at all levels of the education sector are at a significant risk of HIV/AIDS. There are indications that they may be at an even greater than average risk of HIV, as their income and status in their communities give them ample opportunities for high-risk behaviour (Gow & Desmond, 2002:105). In South Africa, the high mortality rate of teachers will probably lead to an increased demand for educators. This comes at a time when the Government has been rationalising teacher-training colleges. The HIV/AIDS influence on educators is also of great concern.

The existence of HIV/AIDS and its influence demands the curriculum to address the infusion and integration of related issues. Educators, through the curriculum, could be the most important source of accurate health-directed information for students. Public education campaigns, to date, may have made major advances in instilling knowledge, but have largely failed to reduce risk-taking behaviour and to
combat new HIV infections. Depending on the level of knowledge and sophistication, family and/or friends may be a source of myths, prejudice and misinformation. This therefore, compels the curriculum designers to do something. The influence of HIV/AIDS within the education sector might result in the loss of key individuals on leadership level, including planners, district and circuit officials, principals and managers in general. This might further compromise the quality of education and efficiency of service delivery. Age, experience and the quality of education is expected to fall (Gow & Desmond, 2002:105).

Against the above background, the research question for this thesis can be framed as follows:

**How do learners, educators and district officials within the Department of Education in the schools of some of the informal settlements of Gauteng perceive the influence of HIV/AIDS on the activities of the school?**

In order to help answer this research question, the following sub-questions will be asked:

- How does HIV/AIDS influence learners?
- How does HIV/AIDS influence educators?
- How does HIV/AIDS influence the district officials of the DoE?
- What is the reaction of the DoE towards HIV/AIDS and what steps have been taken to address, or mitigate the influence?
- Is there a need for curriculum infusion and integration of HIV/AIDS programmes?
- Has an HIV/AIDS curriculum helped in the classroom?
- What do you think the education sector should do in order to mitigate the influence of HIV/AIDS?

### 1.4 MOTIVATION FOR RESEARCH

As indicated above, the AIDS epidemic is beginning to have a serious influence on the education sector, specifically on the demand for, supply of, and the
management and quality of education provided at all levels (Kelly, 2002:17). The quality of learning outcomes and education will be affected by several confounding factors, which will emerge as the pandemic take a deeper hold. Already the education sector has begun to experience increased problems of teacher absenteeism and loss of teachers, education officers, district and circuit managers, planners and management personnel due to HIV/AIDS.

Regrettably, in South Africa, the influence on the education system has yet to be accurately calculated or determined, due to the fact that there are few systematic studies or research being conducted. There is a serious lack of data regarding the perceptions of the learner, educator, and the DoE officials on the school and HIV/AIDS. The researcher felt that there is an urgency and need for the DoE to respond to the challenges of the influence and negative influence of HIV/AIDS, and intends to make a contribution through this naturalistic inquiry to reversing the perceptions of HIV/AIDS on the education sector, and wider society.

Without a reversal in the spread of HIV/AIDS, there will be a less qualified educator’s workforce, as trained and experienced educators are replaced by younger and less well trained teachers. It is apparent that as HIV/AIDS continues to take its toll, there will be schools with no head teachers and no circuit/district management/officials. This has a negative influence on the education system’s ability to plan, manage and implement policies and programmes.

The psychological effect of having an infectious illness and death in its midst, may also affect the school itself. There is likely to be discrimination, ostracism and isolation in the classroom and school of those pupils and teachers who are infected or ill or are members of infected families. Educators may experience high premiums in medical insurance; learners may drop out, to take care of ill parents, fall into prostitution and/or be involved in criminal activities. In addition, the DoE will face serious challenges of large numbers of orphans in the schools.

There is also a profound influence of HIV/AIDS on the content, process and the role of the DoE. The HIV/AIDS epidemic is a serious problem that currently overshadows all other problems in the education sector. The quality of education
is being influenced by circumstances that the researcher in this study saw as urgent, feeling it necessary to gather information about this influence on the education sector. Better data collection and analysis will afford and inform policymakers and planners at the national, provincial and district levels, with current and accurate information about the demographics and all these types of influence of HIV/AIDS within the education system. Because the HIV/AIDS epidemic is constantly evolving, monitoring its effects provides essential information to guide policy and programme development within the education sector.

However, this study acknowledges what the NDoE has done so far. A National Policy for school and Further Education and Training Institutions was developed to ensure that children are not subjected to discrimination and to take precautional measures (Government Gazette, no 20372:410, August 1999). The implementation of Tirisano (a Departmental document on “working together”) – January-December 2004 (DoE, 2000), and the Education White Paper 6 – Inclusive Education (DoE, 2001), both emphasise the role of teachers in addressing the influence of HIV/AIDS on children. The question is how educators would address that influence when they cannot even talk about HIV/AIDS in schools – when they may also even be suffering from HIV/AIDS themselves.

Although a guide for educators on HIV/AIDS has been developed by the Department of Health (Louw, Edwards & Orr, 2001), it was important that educators were encouraged to talk more openly about HIV/AIDS, with encouragement to realise its influence on the learners, themselves, the curriculum and the education sector. This study consequently intended to give urgent attention to the issues outlined above.

1.5 AIMS OF THE STUDY

The study focuses on exploring the perceptions of learners, educators and district officials regarding the influence of HIV/AIDS and the school.

An additional aim of this study is:
To establish ways to integrate HIV/AIDS issues into the curriculum that will provide specific skills and information to help avoid risky and immoral sexual behaviour and reduce the spread of HIV and other STI's and to promote abstinence.

From the above information, this research will outline the process and the findings can help develop guidelines on how the influence of HIV/AIDS could be mitigated within the education sector.

1.6 RESEARCH METHODOLOGICAL ORIENTATION

This research study is situated in the naturalistic inquiry which was developed and devised by Lincoln and Guba (1985). Naturalness or naturalism is a function of what the investigator does and the set of activities an investigator actually engages in while conducting his/her research (Lincoln & Guba, 1985:8). This research is situated in this paradigm to ensure that there is no manipulation on the part of the researcher and that no “a priori units” are imposed on the outcome (Lincoln & Guba, 1985:8) which means that the researcher will not influence the outcomes but will allow the outcome to emerge, or unfold. Naturalistic investigation is what the naturalistic researcher will do in order to acquire insight into the phenomenon. This study will rely heavily on the human instrument when collecting, gathering and analysing data because the human instrument can be developed and continuously refined. Both the researcher and the participants are the human instruments that will be participating in this research. This research study will take place in the natural setting to ensure that data is not divorced from the context. The researcher acquainted herself with the site, a few months before the actual data collection began in order to ensure that a good relationship with trust is built and that the culture and custom of the participants are recognised. The phenomenon under study will be described accurately within its context.

This study will implement qualitative methods of gathering data because these methods come more easily to the ‘human-as-instrument” (Lincoln & Guba, 1985:198). Methods such as the focus group interviews, observations and a thorough literature review will be utilised (Neuman, 1990:20). The researcher will
conduct focus group interviews with four to ten members per group and interviews will continue until redundancy is arrived at (Neuman, 1990:188). The researcher will also observe and then describe what was observed because scientific observation is careful and deliberate and descriptions are more accurate and precise. This will be reported through fieldnotes (Babbie, 2002:82). Tacit knowledge will be used in this study because as with values, it intrudes into every inquiry whether or not the researcher recognises that fact. Tacit knowledge is defined as “all that is remembered somehow minus that which is remembered in the form of words/symbols or other rhetorical forms. It is that which permits us to recognise faces, to comprehend metaphors and to know ourselves. Tacit knowledge includes a multitude of inexpressible associations which give rise to new meanings, new ideas and new applications of the old …” (Babbie, 2002:196).

The research will engage in purposive sampling from the schools in one of the informal settlements of Gauteng. Learners from the Representative Learner Council (RLC) will form its own group and learners from Grades 11 and 12 will form a further group. Educators will also be grouped into the School Management Teams (SMT) and the educators responsible for Life Orientation and Life Skills programmes and volunteers will be grouped. District officials responsible for Life Orientation and Life Skills programmes will also take part in this study. All sampling in this study will be done with this purpose in mind (Babbie, 2002:199).

As data is collected, inductive data analysis will also take place simultaneously. Inductive data analysis may be defined “as a process for making sense of field data” (Lincoln & Guba, 1985:202). This therefore means that from specific raw units of information categories of information will be formed. The researcher in this study will code data which means that raw data will be systematically transformed and aggregated into units which will lead to categorising. Categories will appear in different levels for example level one could be a theme with a sub-category (level 2) and if needed, a further sub-category (level 3).

The design in this study will be emergent and not be influenced (biased), because meaning in this study is determined by context. Some negotiation of outcomes will take place in this study when the researcher takes the transcriptions from the focus
group interviews back to the participants in order for them to check and scrutinise them to ensure that whatever is transcribed was said by them and could be used in arriving at the conclusions and findings of this study. A thick description will be provided in this study using the literature in Chapter 2.

Interpretation will be based on a holistic understanding (ideographic interpretation) and that findings based on the data from the studied context will be provided, however, the possibility of transferability will be vested on the people seeking to make transfer and not the researcher in this study. This study will address the issue of trustworthiness. There will also be prolonged engagement on site, observations, triangulation, and member checking in order to establish credibility of the study. The thick description will be provided to facilitate transferability, dependability and confirmability. A diagram on the flow of a naturalistic inquiry will also be provided in Chapter 3 (Lincoln & Guba, 1985:188).

1.7 CLARIFICATION OF CONCEPTS

For the purpose of this study, the following clarifications will provide a common understanding of the concepts used.

1.7.1 HIV

HIV is the abbreviation of Human Immunodeficiency Virus. This is the name of the virus which undermines the immune system and leads to AIDS. HIV impairs immune functioning by invading critical cells of the immune and central system (Anderson, 1990:3). The virus attacks the body’s immune system and reduces the body’s ability to fight off all kinds of illnesses such as pneumonia, flue, diarrhoea, tuberculosis and certain cancers. The virus eventually weakens the body’s natural resistance against diseases and leaves the body vulnerable to opportunistic diseases.
1.7.2 AIDS

AIDS is an abbreviation of Acquired Immunodeficiency Syndrome. This is a syndrome (collection of diseases) that results from infection with HIV. According to Anderson (1990:17), Acquired Immunodeficiency Syndrome (AIDS) results from a progressive destruction of white blood cells by the Human Immunodeficiency Virus (HIV). T-cells protect the body from infectious diseases and when they reach a critical low level, opportunistic infections or AIDS-related cancers can occur. Ubiquitous organisms that do not cause disease in persons with a healthy immune system cause opportunistic infections. AIDS is a syndrome with many symptoms that mimic other diseases. AIDS is the end-stage consequence of HIV infection.

1.7.3 The influence of HIV/AIDS

The influence of HIV/AIDS is the socio-economic, political and other consequences arising as the result of the spread of the virus. According to Barnett and Whiteside (2002:159), epidemic influence is history-changing events. They terminate some lives, incapacitate others and stunt the capabilities of those who have to divert energy and time into care. In the end, sufficient numbers of deaths and illness makes a society take a path other than that which it would previously have followed. This is the influence.

For the purposes of the study, educator and teacher may be used interchangeably. This will also apply to the learner, as will sometimes be addressed as pupils or students. The DoE may sometimes be addressed as the education sector or system.

1.7.4 Perception

The Oxford English Dictionary (2001) defines perception as an act of perceiving, the intuitive recognition of the truth. It is the action by which the mind refers its sensations to external objects as cause. The aesthetic quality is displayed. The Cambridge English Dictionary (online) explains that perception is a belief or opinion, often held by many people and based on appearances.
1.8 GENERAL OUTLINE OF THE CHAPTERS

The following is a summary of the chapters within this research study:

**Chapter 1**
In this chapter the topic of research is introduced. The background of the study, the research problem, the aim of the study, the research methodology and the clarification of some concepts related to the study is done.

**Chapter 2**
This chapter focuses on a review of relevant literature used to elaborate on the background of the study and further explore the research problem in an attempt to answer the research question.

**Chapter 3**
This chapter describes the naturalistic inquiry research design, qualitative data gathering processes, analysis through coding and categorizing. Research issues such as trustworthiness and ethics are also addressed in this chapter.

**Chapter 4**
Chapter Four presents the analysis of the data, and the interpretation of the findings using responses from the transcripts for support to provide a rich thick description.

**Chapter 5**
In this chapter conclusions and recommendations regarding the perceptions of the learner, the educator, and district officials of the DoE on the schools and HIV/AIDS on will be formulated. The recommended in-service training programme is also included in Chapter 5, suggested as part of the contribution of this thesis towards the curbing of the disease. The limitations and strengths of the study and the contribution are also highlighted which concludes the research project.
1.9 CONCLUSION

This chapter highlights the perceptions of HIV/AIDS that are currently experienced within the DoE. The fact that there is a lack of information about the perceptions of the learner, the educator, and the education sector on the school and HIV/AIDS, prompted the researcher to investigate the extent to which the influence was felt within the school and the education sector. This chapter has also presented an introduction to the study with regards to its context and also to its research questions. The research method and the general outline of the study indicate the direction the study takes.

This is a naturalistic inquiry, which uses qualitative methods of focus group interviews and observations to capture the experiences and perceptions of educators, learners and the DoE officials. A naturalistic inquiry maintains that reality is understood through an individual’s perception of a situation.

In Chapter 2 a thorough literature study will be conducted in an attempt to review relevant literature in order to elaborate on the background of the study and to further explore the research problem.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter seeks to explore the relevant literature on the influence of HIV/AIDS on the learner, the educator, and the education sector. The influence of this epidemic will be explored in each of the four main “institutional arenas” that collectively determine the supply and demand for education, namely the school, household, community and government. This chapter examines the influence of the HIV/AIDS epidemic on the education of children who are either directly or indirectly affected.

HIVAIDS is a worldwide problem that is striking families, especially women and children in developing nations with particular virulence (Boyd-Franklin; Steiner & Boland, 1995:xiii). The secondary effects of HIV/AIDS on the individual include the economic loss that it causes and the societal influence that are only now being recognised. The response to HIV/AIDS to date has ranged from ignorance and fear to stigmatisation and isolation. As the world experiences first hand the devastation of this illness, it is imperative to begin to focus on its influence on the school. HIV/AIDS is no longer a health problem or a medical illness only. It is therefore important that it be perceived within a behavioural, cultural and a social context.

2.2 THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA

The HIV/AIDS epidemic is one of the greatest humanitarian and developmental challenges facing the global community. Across the continent of Africa and in several other affected areas, HIV/AIDS is already taking a devastating toll in human suffering and eventually leads to death. It is causing untold physical, psychological and emotional suffering. It is carrying off the most productive members of society; those in the 15-49 year age range (Parliament South Africa, 2001:2). It is disrupting social systems, exacerbating poverty, reducing productivity, wiping out hard-worn human capacity, and reversing development gains in
improving the quality of people’s lives and reducing poverty (Smart; Denill & Pleaner, 2001:80). Although HIV/AIDS has only begun to scythe its way into many communities and economies, its ravage are increasing rapidly (World Bank, 1999:25).

HIV/AIDS is changing social reality. It is not only affecting how we live and organise society, but how we must analyse that reality. Some people may feel it is too strong to claim that a virus can transform society and culture. However, more than other diseases, HIV/AIDS has exposed the hidden vulnerability in the human condition. It has become a global epidemic and even its metaphors are lethal (Herdt & Lindenbaum, 1992:3). “To know AIDS is to know much about human societies and cultures as well, for AIDS afflicts societies, while HIV undermines the health of individuals” (Herdt & Lindenbaum, 1992:5).

Despite the South African epidemic, having had a late start relative to that in other countries, it still has one of the most predominant levels in the world. The epidemic has already reached catastrophic proportions in many parts of the country, and it is expected that prevalence levels will continue to rise for some years to come. Even so, here is still very little understanding of how best to mitigate the influence or impact, or how best to manage the epidemic, or indeed a comprehensive system of measuring the influence of the epidemic. Broomberg, Steinberg, Masobe and Behr (1991) as cited by Lindegger and Wood (1994:1) estimated that by the year 2000 there will be more AIDS patients who need hospitalisation than there are hospital beds available in South Africa.

Whilst unprotected sex is one of the main causes of HIV/AIDS, it is not sufficient to explain the rapid movement of the virus in South Africa. Sexual activity is not markedly different from other countries with a low incidence of the disease. Some theories show that countries with higher levels of social and economic exclusion and higher income inequalities result in the most rapid growth of the epidemic as borne in South Africa (UNAIDS, 1998b:61).

The rate of infection in South Africa is attributed to migration. This is because people were forced to move away from their families for long periods of time in
order to find work. They often lived in hostels and overcrowded conditions. This became an ideal situation for the spread of the HIV infection and AIDS (Jochelson; Mothibeli & Leger, 1991:157, as cited by Lindegger and Woods, 1994:3). The South African socio-political situation is a catalyst in the spread of this epidemic. HIV in South Africa flourishes most in areas that are burdened by unemployment, homelessness, welfare dependency, prostitution, crime, a high school drop-out and social unrest. In assessing the influence of HIV/AIDS on the South African population and the way people in this country respond to the epidemic, one cannot ignore the legacy of apartheid, which has effectively determined the path of least resistance in racial terms and has caused the unequal access to resources, education and medical care that exacerbate the spread of HIV/AIDS (Lindegger & Woods, 1994:3).

It is confirmed by UNAIDS (1998b:14) that HIV/AIDS has an enormous influence on children. 15 000 new cases of AIDS are reported daily in South Africa and 10% of this estimation are children. This indicates that there has been a mismanagement of the epidemic at virtually every face and failure to monitor the spread of the epidemic properly. This therefore, puts South Africa in a disastrous position, which the country can barely comprehend.

2.2.1 The influence of HIV/AIDS on life expectancy

Research has shown that HIV/AIDS has an influence on life expectancy. It is indicated that an average life expectancy will fall to 40 years by the year 2010. However, this average life expectancy hides variances in certain sub-groups. Those born with the virus can expect to live for an average of 2.5 years. The life expectancy of those born free of the virus but who contract it during their youth or adulthood is about 25 years. The life expectancy of those born free of the virus and with a low risk of contracting HIV will increase into the late 60’s. It is projected that 4,8% of the population will be older that 65 years by the year 2011, a substantial decrease in the elderly sector of the population (Parliament South Africa, 2001:2; Smart et al., 2001:53).
2.3 THE INFLUENCE OF HIV/AIDS ON CHILDREN

Children are defined in a variety of ways. The United Nations and the Constitution of South Africa define a child as someone up to the age of 18 (Gow & Desmond, 2002:3). Children living with HIV/AIDS challenge our belief in childhood innocence; raise questions about the ability to preserve the uninfected from any hint of mortality, and the infected children from death itself. To talk about HIV/AIDS and children in South Africa is to talk of innocence and blame, victim and crime. For children, HIV/AIDS has far reaching effects. The National AIDS and Children Task Team (NACTT) developed the term “children living with HIV/AIDS” for purposes of embracing all children infected and affected by HIV/AIDS. In the context of HIV/AIDS, children fall into two main groups: the infected children/learners and the affected children/learners.

- Infected children are those children who could be infected through maternal transmission, sexual activity or unsafe practices.
- Affected children are those children who could have been abandoned or orphaned by the disease of HIV/AIDS or who may be living with an HIV infected family, who may be vulnerable to the effects of the HIV/AIDS epidemic.

2.3.1 Infected children

2.3.1.1 Mother to child transmission

Children with AIDS fail to thrive and suffer from multiple common childhood infections that do not respond to usual therapy. Their lymph nodes are enlarged, and they have frequent bouts of diarrhoea and fevers. Oral thrush may make eating very difficult. HIV affects the nervous system and the children exhibit cognitive and motor disability. Expectations for growth, development and survival must be adjusted to the stage of the illness. Most develop pneumonia and eventually die of respiratory failure. The child with AIDS need emotional support in a safe and loving home where medical care can be offered in partnership with a social welfare and health care delivery system (Anderson, 1990:23).
In South Africa almost all infections in children under the age of 13 are the results of transmission from an infected mother to her child during pregnancy or from breastfeeding (Smart, 2000:29). The majority of infected children will show signs of HIV or AIDS in the first year of life and some will die before their first birthday. 75% of infected children will survive up to the age of five years, if and only if they receive good care. Those children who progress to AIDS only after infancy, 30 – 40% will remain in good health until their late childhood and early teens (Stein, 2000:23). The influence of HIV/AIDS on children and families is compounded by the fact that most infected families already live in poverty-stricken communities with limited access to basic services and poor infrastructure. This condition will therefore render any mitigating effort detrimental (Gow & Desmond, 2002:49).

2.3.1.2 Children infections due to sexual activity

The highest rates of persons with AIDS, who develop symptomatic illness between the ages of 20 to 29, were actually infected as adolescents. Adolescence is a period that may include biologically heightened sexual awareness and initiation into a variety of sexual practices. Inexperience in the use of condoms, faulty sex education, lack of appreciation of sexual responsibility, and risk-taking behaviours compound the adolescent vulnerability to HIV exposure (Anderson, 1990:24).

The teen years often involve a time of experimentation, characterised by risky behaviour that can leave the South African population vulnerable to contracting a variety of sexually transmitted diseases, including HIV/AIDS. Transmission of HIV in teens and young adults occur primarily through intercourse that results in teen pregnancy. A small percentage acquire the disease through injected drug use (Morris, Ulmer & Chimnani, 2003:138).

Moore and Rosenthal (1991) as quoted by Richter and Swart-Kruger (1994:30) emphasise the reported tendency of adolescents to perceive themselves to be both physically and psychologically invulnerable. This characteristic is thought to be related to the adolescent’s engagement in a wide variety of high-risk behaviours. In addition, external risk is thought to originate in the fact that existing health and counselling services are both generally agreed to be neither convenient,
appropriate nor attractive to young people (Heinz, 1992, as quoted by Richter & Swart-Kruger, 1994:31).

Presently in South Africa almost 400 of every 1 000 births are to young women and girls under the age of 19 (Van Aardt, 2002:30). It is, however, escalating due to the fact that the Department of Social and Welfare offer child grants. This situation is experienced mostly in rural areas.

2.3.1.3 Infections due to sexual abuse

Teenagers between the ages of 15 and 18 fall within the age category most vulnerable to HIV infections through sexual contact. Girls are the most vulnerable to sexual abuse. The physiological, cultural and social factors contribute to the vulnerability of the girl child. Girls between the ages of 5 and 14 years are more likely to be infected through sexual abuse than boys. This is because of the myth that sex with a virgin cures AIDS. Child abuse, including sexual and physical abuse, experienced an enormous increase in South Africa (Gow & Desmond., 2002:84). Sexual abuse occurs across all socio-economic and cultural groups. Children who are abused sexually suffer the trauma of abuse and the high risk of HIV infection, and the least possibility of access to prevention or life-saving medication.

2.3.1.4 Infections from unsafe health practices

There are no accurate figures on the number of children infected through unsafe health practices. These practices may include: Traditional health practices, cultural practices, such as circumcision; unscreened blood products, and the use of contaminated medical instruments, such as used needles. HIV infections and AIDS will affect many children in South Africa (Smart et al., 2001:32).

2.3.2 Affected children

The influence of HIV/AIDS epidemic in South Africa will affect all children in one way or another. They will be affected by widespread adult deaths and the broader
financial or economic implications of the epidemic. Many of these children live in poverty and HIV/AIDS worsen the situation. They could be affected in many ways: being orphaned; which could lead them into abuse and exploitation, school drop-out and becoming street children (Smart et al., 2001:33).

In the context of HIV/AIDS, children may be affected directly or indirectly. Children from uninfected households living in affected communities are also affected either directly, for example through day-to-day contact with their peers who have been personally affected or indirectly by the sequels of the epidemic; such as deteriorating levels of education and health care (Smart et al., 2001:33).

2.3.2.1 Children living in households with infected family members

Children who are affected by HIV/AIDS living in infected households experience the long-term care that their parents failing health may require. Children who care for adults may experience a world gone awry. They assume adult responsibilities before they are ready to do so. A young girl of 8 or 9 years may be used to care for younger siblings. Although she is unprepared to take care of the mother, father or both of them, there are difficulties of culture and sensibility. Coping with a parent who is weak and requires food to be cooked or water to be fetched is one thing. Coping with a parent’s severe diarrhoea, declining mental function and mood changes are quite a severe experience (Barnett & Whiteside, 2002:206). These children are traumatised by watching helplessly as their loved-ones die and become uncommonly familiar to death. These children suffer from psychological and emotional stress and eventually leave school prematurely. HIV presents a stress-inducing situation, which might result in an increased rate of psychological and emotional stress, which may in turn have implications for health status (Schlebusch & Cassidy, 1995:27). There is a need for support and care becomes secondary and intervention strategies, which will have the potential for social support and for enhancing the health status of both those children affected and infected with HIV/AIDS (Gow & Desmond, 2002:83).
The combined socio-economic consequences of HIV/AIDS of these children/learners in infected households are far reaching. It reduces the opportunity for growth and development, creating a cycle of dependency, vulnerability and abuse.

2.3.2.2 Children orphaned as a result of HIV/AIDS

The influence of the HIV/AIDS epidemic has left a huge number of children orphaned. UNAIDS defines an orphan as a child under 15 years who has lost either both parents (double orphan), or the mother (maternal orphan). It is from this definition that the UNAIDS global estimation is made. Paternal orphans are disregarded in this definition. The UNAIDS’ estimate of 11 million AIDS orphans world-wide - which is projected to rise to a staggering 40 million by 2020 - is shocking. AIDS orphans constitute between 9 to 12% of South Africa’s total population (Monk, 2000:14; Gow & Desmond, 2002:83).

South Africa is faced with one of the greatest challenges - that of caring for orphans. Research has shown that by 2005 there will be about 800 000 orphans and that by 2010, the number will have increased to 1.95 million (Kaiser, 2000:11). Orphans run great risks of many kinds, like social exclusion, abuse and that of exploitation, than children who have parents. Orphans have less access to food and education than non-orphans. Some studies show that the death rate among AIDS orphans is higher than that of non-orphans (Department of Health, 1998:15).

Orphans are part of all communities. AIDS is generating orphans so fast that family structures can no longer cope. The scale of AIDS orphaning is such that the coping mechanisms are collapsing in the poor world. The stress is evidenced by the growing number of street children. Families and communities can hardly fend for themselves, let alone take care of the orphans (Gow & Desmond., 2002:63). Orphans may have been deprived of proper nutrition during the period that their parents were ill or dying. It is possible that a proportion of them are HIV positive and their poor physical condition reflects illness. Orphans are less likely to have proper schooling (Barnett & Whiteside, 2002:201).
AIDS orphans will influence most spheres of life; they will grow up without parental or elderly supervision and will be inadequately nurtured. Hunter and Williamson (1998:2) summarises the experience of orphans as follows: “Orphans may suffer the loss of their families, depression, increased malnutrition, lack of immunisations or health care, increased demands for labour, lack of schooling, loss of inheritance, forced migration, homelessness, vagrancy, starvation, crime, and exposure to HIV infection. With orphans eventually comprising up to a third of the population under 15 years in some countries, this outgrowth of the HIV/AIDS pandemic may create a lost generation, a large cohort of disadvantaged, undereducated, and less-than-healthy youths.”

Orphans are the most tragic and long-term legacy of the HIV/AIDS epidemic. They are the most vulnerable group and display low self-esteem, aggression, anxiety and depression more than that of other children. They are more likely to be malnourished, ill, abused and sexually exploited (Gow & Desmond, 2002:84). With limited resources and inadequate adult supervision, orphans are more likely to drop-out of school, leaving them with fewer opportunities for growth and development.

2.3.2.3 Children who are vulnerable to the effects of HIV/AIDS

Degrees of vulnerability exist within the broad group of children affected and infected by HIV/AIDS. The adolescent is more vulnerable to high-risk behaviour. These youths are typically at an elevated risk for teen pregnancy, HIV infection; and other STD’s - they often engage in high-risk sexual activities, including unprotected sex with multiple partners. Many youths are sexually active, but do not have the concomitant life skills to deal with sexual negotiations. Inexperience in the use of condoms is particularly a challenge for a male youth. Faulty sex education, lack of appreciation of sexual responsibility, and elevated risk taking behaviours compound the adolescent’s vulnerability to HIV exposure (Kelly, 1995:9).

Although this is not very common in South Africa, children using injected drugs are faced with the need, not only to reduce their risk for contracting HIV infections
during sexual activities but also from their needle use habits, all in the context of powerful drug addiction. When a breadwinner dies of AIDS, the financial burden of HIV/AIDS affects the living standards and quality of life of the house members leading to poverty, malnutrition and poor hygiene (Gow & Desmond, 2002:81). Children such as those have reduced opportunities for education, limited access to health and welfare services and no access to social security (Kelly, 1995:9).

Orphans are the most vulnerable of all children. Even more so are those living on the streets or in child-headed households. Some orphans are forced by circumstances to leave home to supplement the household income through begging in city centres, thereby increasing the numbers of street children. The girl child is particularly vulnerable to sexual abuse by adult males in the household and in turn vulnerable to HIV infection. Some may be exploited and forced into child labour, prostitution or early marriage (World Health Organisation, 2000a:5).

All children will be affected by the influence of HIV/AIDS epidemic. Some will be directly affected as they are in direct contact with an HIV infected family member. Some will be indirectly affected by socio-economic after-effects of the epidemic, such as deteriorating levels of education, healthcare and social services (UNAIDS, 1998:10). Children will continue to be affected by the day to day contact with peers who have been personally affected, going to school with those that are infected, losing friends through the epidemic and by participating in HIV/AIDS community programmes (Anderson, 1990:3; Louw, Edwards & Orr, 2001:5).

Whilst the immediate and most common cases of HIV infection is unprotected sex with an HIV infected person, research has shown that there are a number of co-factors which predispose certain groups to HIV infection and rendering vulnerability. Many of these co-factors are the products of political, economical and social forces, often beyond any individual’s control (Louw et al., 2001:5).

2.3.2.4 The consequences of HIV/AIDS in children

A child with HIV/AIDS may be viewed as an unanticipated source of pollution. At a safer distance, in the hospitals, a child with HIV/AIDS illicit pity, but in school or in
the neighbourhood yard the same child evokes fear. Children with HIV/AIDS are perceived as a danger to our children and the body of ideas through which we seek to protect them are limited (Silin, 1995:30).

Children with HIV/AIDS suffer from, just to name a few; social isolation, stigma, denial and fear. The child is caught in a conspiracy of silence due to fear of community disapproval, discrimination, withdrawal or denial of services. Most families report that they are not willing to share their child’s diagnosis with friends or relatives. The reason being that of parental sense of guilt and shame associated with the behaviours that result in HIV infections (Anderson, 1990:96).

The AIDS epidemic produces a large number of affected children and orphans resulting in increased hardship and poverty. Children from households with infected family members are frequently forced to assume care and other adult responsibilities. As a result of HIV infections in children, all the children will be infected or affected.

Children affected by HIV/AIDS suffer physical, intellectual and psychological consequences of the epidemic and therefore have multiple needs.

- **Physical and material needs**
  Children affected by HIV/AIDS are vulnerable to malnutrition due to both the scarcity of food and food security. Often the family’s supply of bedding is reduced and therefore they sleep on sacks on the floor. Many of these children have no footwear and no clothes. Immunisation and simple medical care may not be reaching these children. In short, there is a need for food and food security, housing, clothing, bedding and health care for these children to lead a normal life (Smart et al., 2001:33; Gow & Desmond, 2002:4).

- **Intellectual needs**
  For children affected by HIV/AIDS to continue attending school as learners like any other learner, their educational needs must be fulfilled. They need books, school fees, uniforms, shoes and funds for school trips; for the younger children there is a need for after school care facilities, especially in urban areas. Older children/
learners need income generating skills such as simple marketable skills in order to survive (Smart et al., 2001:33).

- **Psychological needs**
  Losing a parent or a family member can be very traumatic. Most children have not come to terms with the reality of being orphaned and feel the loss of parental attention and of physical and social security. With the death of their parents, the normal grief process is aggravated by guilt that they were unable to save their parents. This results in behavioural problems. As a result of the independence of the nuclear family being compromised, they are unable to participate effectively in the kinship network where they are perceived as a liability. This then leads to showing socialisation problems (Gow & Desmond., 2002:5). Children who have to take the responsibility of heading the household often feel ill-equipped to provide proper parental guidance and discipline to their siblings. They need love and care. Moral and ethical guidance is absent. Irregular and inadequate supervision are the only forms of adult supervision to which they are exposed (Smart et al., 2001:33).

- **Friends and recreation**
  Children affected by HIV/AIDS need friends and they need to play. Play is universal and is very important for the development of children. Most of these children report having lost friends due to the rigid time budgeting that does not allow them time to play. They experience a decline in social relations, which could lead to feelings of isolation, loneliness and even despair.

- **Non-discrimination and legal protection**
  Children need to be free from any form of discrimination, rejection, stigma and social isolation. They need legal protection with regards to inheriting land and other material goods. They also need protection from relatives, guardians and other people who may abuse their rights. Furthermore, they need a secure, safe, crime and violence free environment.

All children have physical, material, intellectual, educational and psychological needs. Consequently, children affected by HIV/AIDS are particularly vulnerable in all these areas, as they take on adult household, parenting and caring responsi-
capabilities. These children experience a lack of supervision and care; stunting and hunger; educational failure; inadequate health care; psychological problems; disruption of normal childhood and adolescence; and exploitation and discrimination as a consequence of HIV/AIDS (NDoE(b), 2000:5).

2.3.2.5 Poverty

Throughout the world the prevalence of HIV infection has increased most rapidly in poorer and least resourced communities. Barnett and Whiteside (1999:2) refer to the development issues, which result from the AIDS pandemic in Africa as issues of poverty, entitlement and access to food, medical care and income. HIV in South Africa flourishes most in areas that are burdened by unemployment, homelessness, welfare dependency, prostitution, crime, a high school drop-out rate, and special unrest (Lindegger & Woods, 1994:1). It is therefore not surprising that areas like KwaZulu Natal - which have been worst affected by political conflict - violence and poverty have the highest prevalence of HIV in South Africa (Lindegger & Woods, 1994:1; Gow & Desmond, 2002:96).

Crewe (1992:16) states that AIDS reveals and aggravates the social prejudices, economic inequalities, discrimination practices and political injustices that have been the cornerstone of apartheid. He continues to say that poverty remains the primary cause of many diseases and of widespread hunger and malnutrition. Many diseases that have been eradicated from white population, such as TB; pneumonia; measles and polio still occur among black children and adults - a consequence of poor living conditions and inferior health care (Lindegger & Woods, 1994:8).

HIV/AIDS has an impoverishing effect on every aspect of children’s lives. Many children’s parents already live away from home and thus children do not attend school due to poverty. Parents who are ill loose their jobs and sell some of their assets in order to buy food, medication, etc. This is an attempt to mitigate the short-term financial impact of the disease. Eventually families are torn apart, traumatised and fail to cope with the economic impact of the HIV/AIDS illness (Gow & Desmond., 2002:98). Adult illness and death within a household have a number

2.3.2.6 Nutritional status of children

The influence of adult death or the death of a parent in the family may lower the nutritional status of surviving children. The household income and food expenditure may be reduced and less attention may be given to child rearing. Childhood malnutrition can impede intellectual development and thus reduce a person’s long-term productivity; therefore, improving childhood nutrition is of vital importance (Juma, 2001:31).

Malnutrition has been an endemic problem in Africa for decades and is one of the biggest contributors to childhood morbidity and mortality. The influence of HIV/AIDS on childhood malnutrition can be observed at many levels. HIV infection in children compromises their nutritional status and with poor nutritional status disease progression is hastened. HIV infection impacts on the nutritional status of infected children through a variety of direct and indirect means leaving them more susceptible to malnutrition, growth faltering disease and micronutrient deficiency related ailments (Gow & Desmond, 2002:69).

HIV/AIDS attack caregivers and breadwinners within the household, reducing the resources available to purchase food and the caregiver’s ability to provide the child with a nutritionally-balanced diet. This could have an influence on the child’s education, leading to a high drop-out rate causing children to end up on the streets begging or being exposed to early sexual activities. This might render them extremely vulnerable (Gow & Desmond, 2002:69).

Children need to be cared for, supported and protected against all the consequences exposed to them by HIV and AIDS. This will be in a way respecting the rights of these children.
2.4 THE RIGHTS OF CHILDREN INFECTED WITH AND AFFECTED BY HIV/AIDS

The International Convention on the Rights of a Child in principle provides a protective framework for children. It affords them rights which are to be protected by signatory governments. Children have the right to:

- protection from abuse, neglect and all forms of exploitation;
- provision of food, health care, education and social security;
- participation in all matters concerning them (Barnett & Whiteside, 2002:206).

There are many laws and policies in South Africa which are meant to ensure the well-being of all children and learners - the Constitution being one of them. It recognises that everyone has the right to basic education and therefore the state must do all that is reasonable to ensure that everyone receives basic education (Republic of South Africa Constitution, 1996a, Section 27). This idea is taken further in the Republic of South Africa School’s Act (1996b), which requires learners to have equal access to basic and quality education without discrimination of any kind.

The Constitution of the Republic of South Africa (1996a, Section 27) states the following:

- Everyone has the right to have access to:
  - health care services, including reproductive health care;
  - sufficient food and water;
  - social security, that is, if they are unable to support themselves and their dependents, appropriate social assistance.
- The State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights.
- No one may be refused emergency medical treatment.

The rights of the child are also enshrined in Section 28 of the Bill of Rights of the Constitution and thus read: “Every child or learner has the right (a) to a name and a nationality from birth;
(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
(c) to basic nutrition, shelter, basic health care services and social services;
(d) to be protected from maltreatment, neglect, abuse or degradation;
(e) to be protected from exploitative labour practices;
(f) not to be required or permitted to perform work or provide services that:
   (i) are inappropriate for a person of legal age;
   (ii) place the learners’ well-being at risk, education, physical or mental health or spiritual, moral or social development;
(g) a learner’ best interest are of paramount importance in every matter concerning the learner” (Republic of South Africa Constitution, 1996a, Section 27).

All the rights affect both learners infected with and affected by HIV/AIDS. As orphanhood threatens many aspects of children’s lives, it is through the law and policies, especially the Constitution, that orphans can be cared for, supported, respected and provided with quality education. There are three legal key principles that should inform a government’s response to HIV/AIDS. They are:

1. The right to non-discrimination: This means that no person may treat a person unfairly because they are HIV positive or have AIDS. Every person has the right to equality and freedom from discrimination in terms of our Constitution.

2. The right to privacy: This means that every person is entitled to keep certain facts about themselves private and that no one can divulge verbally or in writing any information which ought not to be disclosed.

3. The right to privacy and bodily integrity: This means that a patient must consent to medical treatment and has the right to refuse. In terms of the Child Care Act a child above the age of 14 years may consent to medical treatment, which includes an HIV test. In the case of children below the age of 14 years, the parents or guardian should consent to the HIV test on the child’s behalf (Smart et al., 2001:114).

The rights of children/learners are further respected and protected by the Schools Act of South Africa (1996b) by providing a framework that states:
• Compulsory basic education for all children/learners from the age of 7 to the age of 15 years based on the principle of non-discrimination.
• Banning unfair admission policies and discriminatory educational practices in public schools.
• Admitting learners with disabilities into mainstream schools where reasonably practicable. Schools are therefore encouraged to take steps to make their facilities accessible to learners with disabilities.

The rights of children infected with and/or affected by HIV/AIDS are also contained in the National Education Policy Act (Act no. 27 of 1996) and the National Policy on HIV/AIDS for learners in public schools (NDoE, 1996b).

From the above information, it has become clear that there is sufficient legal and constitutional power to enforce the rights of learners both infected with and affected by HIV/AIDS. It is clear that the needs of learners with HIV and their right to basic education should as far as possible be accommodated and be practicable within the school environment. Learners infected with and affected by HIV/AIDS must never be excluded from school, but must be left to attend classes in accordance with statutory requirements, unless otherwise stated. It takes great energy and courage for children affected by HIV/AIDS to get to school and cope throughout the day. It is therefore insulting when teachers regard the child’s presence at school as meaningless. HIV affected learners need love, support and care. Educators are confronted by the HIV/AIDS affected learners and therefore, being responsible adults implies taking action to ensure the well-being of all learners, especially the learner in need. In times of total disaster the school has been known to take leadership in the community and it is hoped that the HIV/AIDS epidemic will once again impel principals, educators, parents and the broader community to join hands and to do everything possible to care for and provide support to those in their care.

“Iinsuring the health of children and youth, and in particular protecting them from HIV infection and AIDS, means seriously implementing key provisions of the Convention on the Rights of the Child, specifically those pertaining to their rights to access to basic education and life skills; access to health and medical services;
protection against economic and sexual exploitation and their right to participation” (UNICEF, 1990:3).

2.5 HIV TRANSMISSION AT SCHOOL

HIV is not transmitted through an ordinary activity of daily living. Kissing, hugging, sharing the same fork, glass or toilet facilities will not spread HIV. There is no evidence to support transmission in a swimming pool; from a mosquito bite; in the classroom; or in the workplace. Sleeping with a person with AIDS will not spread the infection unless sexual intercourse occurs. HIV is not transmitted by urine, faeces, vomiting, sweat or tears from infected persons. HIV is a weak virus that cannot survive outside the human body (Anderson, 1990:19).

Body fluids that contain large numbers of white blood cells, especially blood, semen or breast milk are the most dangerous and have sufficient concentrations. HIV can only be transmitted from an infected person by the following routes:

- Sexual intercourse (vaginal, anal or oral). This is the most frequent mode of transmission.
- Contact with infected blood, semen, and cervical or vaginal fluids – in situations where the infected body fluid is able to enter a person’s body.
- In children and youths; sexual abuse and child prostitution are known to cause the HIV transmission.
- Anybody who has unprotected sex is at risk, regardless of race, religion or sexual orientation.

Transmission of HIV can only occur where there is an “exit point” from an infected person and an “entry point” into an uninfected person. Body fluids contaminated by blood are potentially infectious. This technique will provide sufficient protection against HIV and other related serious diseases (Anderson, 1990:20; Smart et al., 2001:38).

Although there is no significance in the risk of HIV transmission during teaching, sport and play activities, the main issue is to teach learners never to touch another
learner’s blood in case of injury. An adult should be cautioned about the accident in order to apply and to adhere to universal precautions in the schools (Louw et al., 2001:98).

Despite the fact that there is no evidence of person-to-person transmission of HIV through casual contact at schools, our schools are suffering a severe influence due to the high prevalence of HIV infection. The vast majority of learners are infected by their mothers with HIV during pregnancy, child birth or through breast feeding. A far smaller number of learners may be infected through sexual abuse or early sexual activity.

2.6 THE INFLUENCE OF HIV/AIDS ON LEARNERS

Despite the fact that there are no reliable statistics on the exact number of learners infected by HIV/AIDS in our schools, it is estimated that there are more than 258 000 HIV infected learners in the system. Projections show that post-pubescent young adults are an extremely vulnerable group. The fact that learners have to contend with the usual issues of growing up, or difficult circumstances; such as single parenthood, poverty, violence, being subjected to discrimination, stigmatisation, etc., can have a devastating effect on any person, let alone the learner. This results in emotional issues that need to be dealt with on a professional level (Lipson, 1996:1).

2.6.1 HIV/AIDS orphans and schooling

Illness and death disrupts teaching and learning. The death of parents affects children in many ways (Gow & Desmond, 2002:98). Learners coming from homes where deaths have occurred have sporadic school attendance. Learners attend school at different times. Absenteeism therefore, tends to seriously undermine the quality of instruction and the ability of teachers to cover the planned teaching programme in class. Learners on their part, are not able to follow-up the lesson content that was taught during their absence. AIDS orphans generally have problems coping with numerous school levies, which at the end exclude them from school participation. Poor and irregular attendance is a significant problem. It
challenges the school, the management and the education system to act rapidly in order to mitigate the influence of HIV/AIDS (Juma, 2001:36; Hepburn, 2002:91).

2.6.2 Reduced support for schooling

The death of an adult in his prime reduces school enrolment. The lack of schooling exacerbated by inadequate nutrition makes it difficult for child survivors of this adult’s death to escape poverty. The death of a parent reduces the ability of families to pay for schooling, increasing the demand for children’s labour and reducing the expected returns to adult investments in children schooling. Learners are also withdrawn from school to work outside the home, help with chores, to care for an ailing family member and looking after siblings. Parents do not pay for children’s schooling due to many reasons; one being that they are experiencing financial problems. The other reason could be that they fear that children will not live long enough to realise the higher earnings schooling promises, and lastly, because parents themselves do not expect to live long enough to benefit from their children’s future earnings (Kinghorn & Steinberg, 2000:11).

Relatives who take in orphans are also less willing than the parents would have been to invest in children’s schooling. Instead, children or learners are taken out of school and forced into slavery.

From the above information, one could safely say that children who lose their parents have lower enrolment rates.

2.6.3 The influence of HIV/AIDS on school enrolment

HIV prevalence rates are a national crisis. This will attribute to low or declining enrolment of learners in the schools. In South Africa the rates for the nine provinces in the country show variable levels of infections but on the overall that data confirms the dramatic influence of the disease in every province (Gow & Desmond, 2002:101). While there is no sufficient analysis of enrolment data that has been done, KwaZulu Natal is already experiencing a dramatic impact in Grade 1. Badcock-Walters (2001:19) confirm that within the period of three years, a 12%
decline has been experienced in Grade 1. This confirmation means that in the year 2002 there were fewer than 60% of the number of learners in Grade 1 than there were in 1998. Although there could be many reasons for the decline, most of the decline could be said to be directly or indirectly affected or exacerbated by HIV/AIDS and therefore add to the challenges faced by the education system (Gow & Desmond, 2002:102).

Under these circumstances, it is reasonable to conclude that the scale of influence on households and therefore, on learners at school, is likely to be enormous and a challenge to education.

### 2.6.4 Social labelling and discrimination

“AIDS challenges more than medicine. Because it is deadly, continues to spread quickly and is linked to the controversial subjects of sex and drugs, and because in the developed world it arose first among gay men and heroin addicts, it provokes deep and complicated feelings when extended across the society, have political and social consequences” (Carter & Watney, 1989:95). This statement by Stoddard illustrates the political and emotive connotations associated with the condition and the stigma that AIDS carries (Smart et al., 2001:112).

In South Africa the perception of “at risk groups” has also been coloured by racial prejudice. Thus, for many White South Africans, Black people have been blamed for spreading the disease through gross sexual licence, the collapse of family structure and the migration from other countries (Crewe, 1992:16). The need to identify the origin of AIDS and to attribute its spread to particular groups appears to arise particularly out of a psychological need to distance oneself from risk. This distancing mechanism allows for the justification of prejudice, attitudes and behaviour towards AIDS patients and unwillingness to examine one’s own level of risk (Gillian, 1994:21).

Orphans and learners with HIV infection are often discriminated against (Hepburn, 2002:93). Some school rules and regulations unintentionally exclude orphans, for example, it is common practice for schools to send children/learners back home if
their uniform is dirty or they are not wearing a school uniform at all. It is a fact that orphans suffer financial constraints. They therefore feel discriminated against by being sent back home. They consequently stop attending school and that could perhaps result in dropping out. Educators and learners should be made aware of discrimination and how it is expressed. This will help in a situation where HIV positive learners are subjected to negative attitudes and behaviours. Educators need to be watchful for possibilities of discrimination or any other harmful attitudes and behaviours in school in order to diffuse and put such situations under strict control. After all, learners affected and infected by HIV/AIDS have sufficient legal and constitutional protection. The national policy on HIV/AIDS for learners in public schools provides protection in this statement: “Non-discrimination and equality with regard to learners with HIV –

- No learner with or perceived to have HIV or AIDS may be unfairly discriminated against.
- Learners with HIV should be treated in a just, humane and life-affirming way.”

Orphans are also discriminated against by guardians at home. They are made to work like slaves and forced to work even when they are ill. They are forced to stop attending school. Some inheritance that is left by their parents is snatched away by relatives. They don’t even attend to their health needs as they assume they are already infected and therefore will anyway die soon. Orphans often break down, deteriorate and eventually die (Juma, 2001:51).

Learners living with HIV/AIDS face a violation of their rights on a daily basis. They live in fear that if it is discovered that they are HIV positive, they may lose their human dignity, they may be evicted from their homes and even be assaulted by members of their own communities. This fear of discrimination becomes a significant obstacle towards disclosure of ones status, testing, counselling support and treatment. South Africa had a huge task to overcome discrimination and stigmatisation. Although discrimination is still being experienced, some people are coming in the open about their status. This could be attributed to the endeavours by former President Mandela who on World AIDS Day 1995, urged South Africans and the world to act against discrimination and stigma. In July 2000 the family of Albertina and Walter Sisulu took a courageous, inspiring, yet undoubtedly painful
public position to speak out as a family about the loss of a granddaughter to HIV/AIDS (Parliament South Africa, 2001:2). Recently, Mangosuthu Buthelezi announced to the country that his 53 year old son died of HIV/AIDS. As some of our politicians are coming out in the open about HIV/AIDS, stigma and discrimination will eventually shift position from being a central challenge in effectively addressing HIV/AIDS.

This challenge on discrimination and stigma is summed up by Sontag (1988:94) as follows: “The age-old, seemingly inexorable process whereby disease acquires meaning (by coming to stand for the deepest fears) and inflicts stigma, is always worth challenging. With this illness (AIDS), one that elicits so much guilt and shame, the efforts to detach it from these meanings, these metaphors, seems particularly liberating, even consoling. But metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticised, belaboured and used up.”

2.7 THE INFLUENCE OF HIV/AIDS ON EDUCATORS

Educators are members of a special group with a special mission, because parents entrust with them the intellectual and social development of their children. Next to the family they may be the most influential force in forming the children’s characteristics and in preparing them for future professional and social interaction. They are educators and they are members of what is probably the most important and powerful social institution in this country, our education system (Zappulla, 1997:6).

HIV/AIDS does not only affect the number of learners and subsequently the demand for educators, but also the educational needs. The AIDS scourge does threaten to undermine the substantial gains made in expanding educational participation during the past decade and thereby prevent the attainment of national education objectives. Education is the cornerstone of any developing country and therefore anything that threatens the role of education directly influences and calls for a renewed commitment from all South Africans. Educators who are influenced by HIV/AIDS suffer in silence through the discovery of their diagnosis.
2.7.1 Educator morbidity and mortality related to HIV/AIDS

The impact of HIV/AIDS on the education system has not been fully investigated hence the difference in statistics for prevalence. The South African education system, however, is starting to feel and experience the influence of HIV/AIDS. Whilst no reliable statistics exist, estimations show that there are more than 450 000 educators in the system. It has been speculated that at least 10 educators die of HIV/AIDS per week over a period of 10 months. There are a significant number of deaths amongst educators under the age of 50 years (Gow & Desmond, 2002:104).

Research has shown that other African countries have found that large numbers of educators are infected with HIV (Juma, 2001:51). There is also evidence that educators are more HIV prevalent than the general population they serve. Louw et al. (2001:82) indicates that 30% - 40% of educators who are HIV positive will have fully developed AIDS at any time. Education delivery and maintenance will be significantly influenced by the illness and premature death of educators. It is clear that the magnitude of this problem is beyond the experience of everyone involved. To put this into perspective means that all schools will be confronted with a high percentage of both infected and affected learners and educators. It is unfortunate that this is experienced at the time when the national government has recently closed its education training colleges and transferred that responsibility to the universities (Gow & Desmond, 2002:105). Not many students enrol for the education profession at universities. Another detrimental effect is that universities are also faced with a high prevalence of infected students based on the fact that one-third of all HIV infected persons were infected during their school years. A further third HIV infected persons were infected within two years of leaving school (Louw et al., 2001:95).

The increase in teacher mortality may result in a compromise in terms of qualifications and experience. This indicates another crisis within the department that needs an urgent mitigation strategy. According to Professor Kader Asmal, there is a vast shortage of teachers in South Africa presently. About 30 000 new teachers are needed per year, but the current output from higher institutions is in
the region of only 5 000. This is confirmed by UNESCO that the world is facing a shortage of 15 million teachers within the next 10 years.

2.7.2 Educator performance

HIV/AIDS will have a profound effect on the business of teaching and learning. One of the most powerful conflicts that often arise at the workplace is the impact of HIV/AIDS on job performance. Conflicts start when symptomatic illness begins to adversely influence the educator’s health and ability to perform their teaching duties. As their decline progresses, they begin to experience feelings of guilt that they are not doing as much as they normally would or think they should. They are then overwhelmed by fear and they demand even more of themselves. Frustration and distress result as they can no longer meet their own standards of excellence. Some educators may force themselves to come to work for fear of losing their jobs, redeployment and long sick leave (Barnett & Whiteside, 2002:242).

2.7.3 Absenteeism

A study of African enterprise found that HIV related absenteeism accounted for 37% of increased labour costs and AIDS absenteeism accounted for a further 15% (Barnett & Whiteside, 2002:311). Educators will be absent at school due to illness. Absenteeism is not only the result of an educator being ill but sometimes it is a friend or a family member that is sick and needs caring. Sometimes educators attend funerals. This regular absence will impact on the quality of teaching and learning by reducing contact time, performance and consequently compromising the standard of education. This will therefore lead to increased health and replacement educator costs in the system. Both temporal and permanent educator loss from the system due to absenteeism threatens the role played by the education system (Barnett & Whiteside, 2002:311).

2.7.4 Educator discrimination

In this study discrimination has been dealt with under the influence of HIV/AIDS on the learner. However, it is the purpose of this study to expose the fact that
educators who are infected are also being discriminated against. HIV positive educators suffer in silence for fear of isolation, possible rejection, judgement by friends, family members and most importantly by colleagues. By not divulging their HIV positive status, puts them into a psychological prison of hiding and secrecy. These educators fear the reaction of parents and the school community. They know that nothing could bring out the “animal instinct in parents quite like protecting and defending the young” (Kirp, Epstein, Franks, Simon, Conoway & Lewis, 1989:31; Zappulla, 1997:8). HIV positive educators fear that their status might cause some moral and ethical conflicts at school and the community. They fear losing their jobs. Fithian (1984:7), as quoted by Louw et al. (2001:68) also makes the following comment: “It is analogous to taking meaningful work away from an adult with a serious illness but leaving him or her with a desk”.

2.7.5 Educator motivation and morale

HIV positive educators will most probably lose interest in their work and in professional development. Their work as educators will be seriously compromised by prolonged periods of illness. When they are at school they are faced with learners who are HIV infected or have AIDS. They therefore feel helpless, which may lead to avoidance and refusal to help. They are demotivated and their morale is low (Brouwer, Kok, Wolffers & Sebagaus, 2000: 539).

2.8 THE INFLUENCE OF HIV/AIDS ON THE CURRICULUM

Research has shown that many HIV infections occurred during school years. This confirms that schools are a high-risk environment since many young people are sexually active. This suggests that the school is the key strategic ground on which the battle to mitigate the influence of HIV/AIDS will be won or lost.

Education is an immediate response to the AIDS epidemic. If the HIV threat is ignored, the result for individuals, communities and industry will potentially be devastating (Jochelson et al., 1991:171) as cited by Lindegger et al. (1994:1). Given the multicultural context of South Africa, AIDS education programmes need to be understood and be delivered in the context of different social beliefs about
AIDS and peer sexual norms in different communities. With the current state of knowledge of HIV/AIDS, behavioural intervention remains the only means of primary prevention of HIV. Some research indicates that there has been considerable controversy about the importance of knowledge as a protector against HIV/AIDS. The growing realisation as in other areas of health-related risks is that knowledge is insufficient as a protective factor against HIV infection because this has often not been translated into behavioural change. On the other hand, Kuhn, Steinberg and Matthews (1994:7) believe that the role of education is less than to change entrenched or establishes behaviour, but to shape the development of sexual behaviour and attitudes. Herek and Glunt (1988:89) concur with others that AIDS education programmes must be designed not only to impart information to individuals but also to reduce stigma attached to AIDS.

An effective curriculum will unambiguously demonstrate how adolescents can lower their risks for HIV infection through lifestyle. It will provide youth with the facts of the relationship between their number of sexual partners and their risk for AIDS; the use of protective means for sexually active adolescents, unsafe sexual activity; and drug use to build knowledge, attitudes and skills in areas that put young males at risk for information (Schinke et al., 1992:5). Curriculum change, material development and condom distribution, while apparently contributing to high levels of awareness, have to date shown little evidence of influencing behaviour (Gow & Desmond, 2002:19).

A continuing HIV/AIDS education programme should be implemented at all schools for all learners, educators and other staff members. This education should be age-appropriate and should form part of the compulsory curriculum for all learners. It should be integrated in the Life Skills education programme for pre-primary, primary and secondary school learners.

The Department of Education in the new curriculum came up with the learning area Life Orientation (LO). Life Orientation is a crucial learning area in the new curriculum which is outcomes-based. This learning area looks at the development of the child as a holistic being. It is a fundamental learning area which empowers the learner to live a meaningful life in a society that demands rapid transformation.
It is designed to specifically look at the social, emotional, physical, psychological and effective unfolding of the learner as a whole person as they progress towards adulthood. (NDoE, 1997:18-19).

The Life Orientation learning area aims at equipping learners to live productive lives in an ever-changing society and to accept and embrace other people by acknowledging their uniqueness and intricate human nature. This learning area unfolds all the knowledge, skills and values required for good citizenship (NDoE, 1997:19).

In South Africa the National Department of Education began implementing the Life Skills and HIV/AIDS education project prior to the development of the HIV/AIDS policy. This was because HIV/AIDS became a key issue and priority for the National Department of Education in the short and long term. The project had prepared learning programmes and materials in collaboration with the Department of Health. By the end of 1998 the programme had trained 840 master trainers and more than 10,000 educators in secondary schools. By March 2000 a rapid assessment of the project was to be carried out to evaluate its implementation in schools. Results of the assessment would form the basis for extending the project more broadly. A pilot project on the same theme has been implemented in 10 primary schools in the former Northern Province, now known as the Limpopo Province, and the Free State. There was also a plan to expand it nationwide. However, still today not all educators have been trained on the HIV/AIDS education programme (NDoE, 2000a:24).

The Life Skills and HIV/AIDS education programme in South Africa aims to offer Life Skills education in order to promote a healthy lifestyle, offering HIV/AIDS education in an age-appropriate manner to prevent the transmission of HIV/AIDS and other STD’s. This programme extends from Grade 1 to Grade 7 and the programme for each grade is an alone entity. For each grade there is a teacher guide, as well as an activity book for the learners. When preparing lessons, educators should use both documents simultaneously. The programme of each grade builds on the previous grade. Life Skills and HIV/AIDS education are addressed within the context of sexuality education and follows an outcomes-
based approach. The Life Skills and HIV/AIDS education is integrated throughout the curriculum and it was envisaged that it will be available in all primary and secondary schools by 2003 (Parliament South Africa, 2001:1).

Preparing teachers to integrate HIV/AIDS into the curriculum is a complex process, not just because it raises personal concerns for individuals, but because it may force them to address new subjects such as sex and death. It is complex because it provokes inquiry into basic philosophical issues about the nature of pedagogy, the meaning of childhood and the role of the teacher as change agent. If teachers lack confidence in their own HIV/AIDS information they will fail to respond to many teachable moments. Teachers need good training in HIV/AIDS education so that they become committed (Kelly, 2002:3). A commitment to the curriculum must entail a commitment to the world that it evokes. A curriculum remains lifeless as long as it is cut off from the roots and connections that should feed it. Although teachers like to view themselves as objective professionals acting in the best interest of children, when it comes to HIV/AIDS personal values, prejudice and preconceptions play a critical role in determining what information they do and do not provide. It is therefore important to note that successful pre-service and in-service education depends on the provision of adequate time for teachers to express all their rational and irrational fears (Hein, 1989:10).

To mitigate the influence of HIV/AIDS in South Africa, an effective AIDS education with contextualised AIDS education would be ideal. This curriculum must draw on areas which go beyond medical information. Issues related to race, class, gender, religion and prejudice are deeply interwoven into attitudes about AIDS and cannot be ignored. The focus should not only be on transmission or bio-medical information. This curriculum must adapt a holistic approach (Hein, 1989:10).

2.9 THE INFLUENCE OF HIV/AIDS ON THE COMMUNITY

Communities are experiencing a tremendous social drain because of the influence of HIV/AIDS. The understanding of the epidemic differs considerably from one community to the other. People in urban areas tend to believe that HIV/AIDS is a problem in their community and that although there are high levels of knowledge
on HIV/AIDS, there are still misconceptions about the epidemic (Parliament South Africa, 2001:30). There are some communities who still believe that HIV/AIDS is someone’s creation and that treatment for it is being deliberately withheld in an attempt to reduce the population (Parliament South Africa, 2001:30). Devastated communities already struggling with crime, violence, widespread drug use and inadequate health care resources are now dealing with an epidemic of tragic proportions that will weaken, if not destroy, an entire generation. However, few people recognise AIDS as a real threat to themselves or their communities. Instead, some communities have a strong way of dealing with the HIV/AIDS epidemic. Rather than confronting and dealing with issues posed by HIV/AIDS directly, the focus shifts onto finding out who has AIDS and eliminating them. This could point to feelings of vulnerability, fear and a high level of denial in the community (Kuhn et al., 1994:9).

When a community is affected by HIV/AIDS, parents who are the pillar of strength in a family or breadwinners will get ill, leave work, become financially frustrated and embarrassed. They will leave work in order to care for sick family members or to attend funerals. These parents won’t be able to pay for their children’s school fees or buy uniforms and that consequently lead to children dropping out of school. Children might even be kept out of school in order to care for the sick parents and therefore assume adult roles. The family becomes disrupted; food production declines and consequently malnutrition will be experienced. In short, the family will be poverty stricken.

HIV/AIDS is a stressor in the community. It decreases life expectancy; make people ill; result in deaths of the young, as well as adults. The existing health services - which are under-resourced by nature - become overwhelmed. Steinberg, Masobe and Behr (1991), as cited by Lindegger and Woods (1994:14) estimate that by the year 2000 there will be more AIDS patients who need hospitalisation than there are hospital beds available in South Africa (Zwi & Bachmayer, 1999:9). It therefore suffices to say that at least a large portion of the South African health care system will be and is directed to HIV/AIDS related care. There is a view that AIDS is a great equaliser and that its incidence transcends race, class and gender barriers; hence, communities experiencing health-care
workers, school teachers, managers, politicians becoming ill and eventually die of AIDS. Communities are left with no role models, as adults die, they leave orphans behind.

HIV/AIDS poses a significant and complex threat to society as a whole, exacerbating poverty, promoting despair and destroying community spirit. For this reason it is critically important to understand the social and economic determinants of the disease factor. Detriments such as the migration of workers, the rural urban drift and the role and status of women are increasing the spread of HIV/AIDS. Research has shown that many people recognised that AIDS threatens almost all the major expectations of people’s lives; sexual fulfilment, marriage, having children, being cared for in one’s old age by one’s children, having a proper burial and being remembered by the community after one’s death.

2.9.1 HIV/AIDS orphans in the community

Communities are experiencing a tremendous social strain in trying to cope with large numbers of HIV/AIDS orphans. These communities further experience a tremendous school drop-out rate due to the lack of proper finance. Many children leave school and girls resort to prostitution in urban areas. The number of street children increases. In rural areas orphaned girls assume the role of mothers in the homes to provide essential services to their siblings. In this desperate role as mothers, they are liable to unwanted pregnancies, premature marriages, or engage in commercial sex that exposes them to a high risk of HIV/AIDS infections (Gow & Desmond, 2002:165).

The experiences of the orphans in the communities are quite deplorable, especially the exploitative nature of some of the so-called carers (Smart et al., 2001:94).

2.9.2 Parents and the community

Parents are major role players in any community. They are the primary educators and have to take responsibility for their children. With the challenge that HIV/AIDS presents to them, many parents seem not to be prepared for parenthood and cry
out for help. Trained educators in Life Skills and HIV/AIDS education programmes will have to be the initiators of networking, as well as training parents and the community in order to save the children. The school has to take responsibility for making sure that parents will be effective sexuality educators so that they can play their part in the prevention of abuse, rape, teenage pregnancies and infection with HIV/AIDS. Involving parents will require a holistic approach, ranging from being a good parent and sexuality educator, to contributing to the alleviation of problems like HIV/AIDS in the school community (Louw et al., 2001:88). Although parents are infected with and being affected themselves, community-wide interventions empower the individual considerably to make both health decisions and decisions for their families (Lindegger & Woods, 1994:4). AIDS can disrupt family systems, resulting in trauma and a break-down in the social system. Parents’ participation in HIV/AIDS interventions in the community could help mitigate the influence of HIV/AIDS.

2.9.3 Religious leaders

At the community level, religious leaders are normally expected to play a leading role in HIV/AIDS activities. They are perceived to have a greater influence on causing behaviour change. At the 4th International Conference on Health in Southern Africa a resolution was passed to approach HIV/AIDS by means of community intervention. Involving communities affect and address the broader socio-political and developmental issues at hand (Lindegger & Woods, 1994:4). Such community-wide interventions empower the individual considerably to make health decisions. This compels religious leaders to participate in this community intervention to mitigate the spread of HIV infection.

Religious leaders have finally accepted that HIV/AIDS is not only a medical but also a moral epidemic. This is because of the devastating impact of HIV/AIDS even among the so-called “saved or born again Christians”. Religious leaders are faced with a challenge on the use of condoms in order to prevent the spread of HIV/AIDS infections. Crewe (1992:19) confirms that in South Africa there is still a great deal of opposition from churches in the use of condoms. The overall message was that condom promotions encourage promiscuity. They wanted
education programmes based on cultivating a lifestyle founded on high moral standards, chastity and being aware of the ideal sexual relationship: one man with one woman (Lindegger & Woods, 1994:3).

In order to impinge upon the epidemic, sex and sexuality need to be openly addressed. However, some religious leaders are now trying to bring about an informed responsible discussion on sexuality including the use of condoms; thus enabling individuals to make appropriate and responsible decisions.

Religious organisations in their participation in the HIV/AIDS community intervention could assist in poverty relief, providing homes for the abandoned learners, providing food for the orphans, providing spiritual and pastoral care for learners, parents and educators who experience illness or death of a loved one. Counselling and giving hope is their role (Louw et al., 2001:78).

2.9.4 Traditional healers

In South Africa there are still people who hold to their traditional beliefs. These are some of the people who view the disease as a curse and therefore sought healing from the African herbalist or traditional healers. They attribute HIV/AIDS to cultural beliefs and taboos. Given the current state of knowledge of HIV/AIDS, traditional healers may play an important role in the effort to achieve behaviour change. In South Africa traditional healers command a great deal of support in both urban and rural African communities - thus providing a much respected resource outside the Western medical paradigm. Bodibe (1992) as quoted by Lindegger and Woods (1994:11) identifies traditional healing as an approach to mental health, which should not be neglected in South Africa. He distinguishes the role of traditional healers as sex therapists, and that conjugality and consummation are among the traditional healers’ main concerns. This therefore shows that traditional healers have an essential role to play in the control of STD’s and promoting the use of condoms in combating HIV/AIDS infections. A belief in the active purposeful intervention of supernatural beings (gods) may complement the health belief model which is used as a framework for understanding AIDS-related behaviour (Lindegger & Woods, 1994:11).
2.9.5 Other role-players

Non-governmental organisations have been at the forefront in the early HIV/AIDS service delivery. They were the only delivery structures at that time, with USAID being the most visible donor for many NGO’s. After the October 1989 address by President Thabo Mbeki, the then deputy to President Mandela, many sectors responded with pledges to join the partnership (Gow & Desmond, 2002:165). Continued infections and the high death rates through AIDS related illnesses raised concern among professionals in various groups within the medical industry and they decided to form a consortium. In 1999, the group formed Lovelife, an HIV awareness programme intended to positively influence sexual behaviour among the youth. “The idea was to closely monitor how vulnerable the youth was to HIV infection or unwanted pregnancies. The issue was not sex itself, but what the youth were doing and their attitudes towards sex and sexuality” (Sunday World, 2004:22). Harrison says: “There is a decline in HIV infections and early pregnancies among the youth and that today Lovelife boasts huge success among the youth and parents” (Sunday World, 2004:22). Other programmes involved are S’camto Ground Breakers, The Love Train, Thetla Junction and a Helpline Call Centre. Youth for Life Foundation has also been set-up in Pretoria, which is an AIDS awareness project and it will train other youths to become educators. It operates from the University of the Witwatersrand and Tshwane University of Technology. Soul City was also set up for HIV/AIDS awareness, and The Silver Ring Thing still attracts thousands of youngsters to their presentations promoting total abstinence as the only solution to curb the impact of HIV/AIDS. There are many more projects, but the researcher mentioned just a few. Soul City (2000) and the Helpline are said to have played a major role in increasing accurate knowledge about HIV/AIDS and in shifting people’s attitudes, subjective social norms, intermediate practice, as well as other departments in government like health. Private medical doctors, psychologists and counsellors could also assist on a voluntary basis to examine, treat and counsel learners from poor families without medical schemes. Irrespective of all attempts to mitigate the impact of HIV/AIDS, high and abnormal rates of HIV infections continue in South Africa and people are dying of AIDS in vast numbers.
However, the school can ensure that there is a multi-disciplinary network in the community and that the activities are coordinated in order to pool resources and to avoid duplication of services (Louw et al., 2001:78). Despite obstacles and a world that often does not seem to care, individuals, agents and governments need to recognise and respond to suffering children and their families (Anderson, 1990:158).

2.10 THE INFLUENCE OF HIV/AIDS ON THE EDUCATION SECTOR

The largest cadre of government employees are those concerned with education, including teachers, administrators, managers, etc. Education is crucial. The World Bank places great importance on education and believes education to be “the key to higher incomes, both for individuals and for countries” (Barnett & Whiteside, 2002:301). Education faces both the demand and supply side of influence of HIV/AIDS.

- **Influence on demand**
  Influence result in smaller numbers of children needing education. Fewer children are born and many HIV infected infants do not survive to the school going age. Enrolment may be further influenced by household economic difficulties and the need for children labour. AIDS means that there are learners at all levels with new special needs and that the traditional roles of education will change and be supplemented by supporting a nurturing large numbers of children in crisis, giving them life and survival skills from an early age (Barnett & Whiteside, 2002:302).

- **Influence on supply**
  Institutional audits through management information systems should be in place. The loss of key individuals at leadership level including planners, school inspectors and principals, as well as teachers/educators may further compromise quality and efficiency of the education system. The average age and experience is expected to fall as managers and administrators, who are less vulnerable to HIV/AIDS, are closer to retirement and consequently replacement will be by younger officials drawn from a high risk age group and
environment. HIV/AIDS also impacts on the budget. This implies that HIV/AIDS must be a factor in every aspect of recurrent and capital expenditure, and must anticipate reduced income revenue and slow anticipated rates of economic growth (Barnett & Whiteside, 2002:302).

• **The National and Provincial Departments of Education**
  The National Department of Education develops policies and the Provincial Departments are responsible for implementation. This often results in a disconnection between the expressed intent of the National Department of Education and the capacity and will of the Provincial Departments to implement and operationalise policies. In the case of HIV/AIDS a number of Provincial Departments have begun to react appropriately to the scale of the challenge. They must recognise individually as provinces and as an interdependent group of provinces coordinated nationally, that HIV/AIDS is the greatest management challenge facing their system and they must take appropriate steps to mitigate the impact.

• **The National HIV/AIDS Policy**
  - In response to the high prevalence of HIV/AIDS in South Africa, particularly among the youth, the DoE developed a national policy on HIV/AIDS for learners and educators in public schools and for students and educators in further education and training institutions. This is part of the broader national HIV/AIDS strategy aimed at addressing the HIV/AIDS pandemic policy in August 1999. The ministry of education will provide leadership during its implementation in educational institutions across the country. The policy seeks to contribute towards promoting effective prevention and care within the public educational system context and focuses on providing accurate information on:
    - the nature and risk factors of HIV infection and AIDS;
    - precautionary measures;
    - the obligation resting on school and college communities to avoid discrimination against infected persons;
    - the rights and responsibilities of infected persons, and
    - assistance to infected persons. (NDoE, 2000b:24)
In summary, the National Educational Policy on HIV/AIDS Government Notice no.1926 of 1998 covers the management of HIV/AIDS in schools. It is based on principles of non-discrimination, confidentiality, education, and measures to manage HIV/AIDS within the school environment (NDoe. 2000b:45).

- **Life Skills and HIV/AIDS education project**
  Prior to development of the HIV/AIDS policy the DoE began implementing the Life Skills and HIV/AIDS education project. This project has prepared learning programmes and materials in collaboration with the Department of Health. By the end of 1998, the programme had trained 840 master trainers and more than 10 000 educators in secondary schools. A rapid assessment of the project was to be carried out in the year 2000 to evaluate its implementation in schools. The results of the assessment would form the basis for extending the project more broadly. In 1999, a pilot project on the same theme was implemented in 10 selected primary schools in both the Northern Province and the Free State. The roll-out of this programme could potentially reach 21 304 primary schools and 8 497 388 primary school learners (Ibid. 2000b24). In November 1999 the Cabinet approved funds for an integrated response to the epidemic.

- **The South African School's Act**
  The South African Schools Act no. 84 of 1996 regulates, among other things, admissions and expulsions and provides protection for learners who are infected with HIV. The Schools Act (1996b) further requires that the quality of education received by all learners must be improved (Republic of South Africa School Act, 1996b). Learners must also be better motivated and disciplined to take their education serious and to use the opportunities that are now open to them. The Admission Policy for ordinary public schools, from 1998 is fulfilled in Section 35(1) of the South African Schools Act, which states that: “A public school must admit learners and serve their educational requirements without unfairly discrimination in any way” (Republic of South Africa School Act., 1996b:24)
The National Department of Educations’ strategy and work plan, Tirisano

The National Department of Educations’ strategy and work plan, Tirisano (2000) was the response to the strategic plan developed early 2000 that stated that all government departments, organisations and stakeholders will use that document to the best of their ability, to develop their own strategic and operational plans, so that all initiatives as a country can be harmonised, to maximise efficiency and effectiveness (Parliament South Africa, 2001:19).

Tirisano states clearly that: “We must deal urgently and purposefully with the HIV/AIDS emergency in and through the education and training system. This is the priority that underlies all priorities, for unless we succeed, we face a future full of suffering and loss with untold consequences for our communities and the education institutions that serve them. The Ministry of Education will work alongside the Ministry of Health to ensure that the rights of all persons infected with the HIV/AIDS virus are fully protected” (NDoE, 2000a:2)

HIV/AIDS is a priority area for the DoEd. The HIV/AIDS programme is contained within the Tirisano programme of the Department. However, every school is urged to have an HIV/AIDS policy. All support mechanisms and teaching strategies should be based on the guidelines set out and the Department will create a supportive environment free of prejudice for infected educators and learners (NDoE, 2000a:2).

2.11 CONCLUSION

AIDS is one of the most serious challenges to post-apartheid South Africa. South Africa has experienced a rapid spread of the HIV/AIDS epidemic. According to HIV/AIDS statistics, the epidemic reached a peak 10 years ago when most infected people began dying and the infection rate increased. The apartheid legacy of migrant labour, gross deficiencies in educational opportunities; medical services, including primary and secondary preventative health services; widespread poverty; civil conflict; and political violence, exacerbated the spread of HIV infection (Gow & Desmond, 2002:173). High rates of other sexually-transmitted diseases in both urban and rural areas, a high rate of teenage pregnancies and apparently
widespread mistrust of family planning services, add to the formidable list of problems facing an HIV/AIDS control programme in South Africa.

The impact of the HIV/AIDS epidemic on children is vast and widespread. Children will be infected, become ill and die. Others will live to see their parents or other loved ones become increasingly sick and eventually succumb. More children will be infected by the influence on health, education and the welfare system. All children will be affected in one way or another. The widespread adult deaths will leave a tremendous challenge of orphans who live in poverty. Schools will experience illnesses and the deaths of both learners and educators. Coping mechanisms have to be in place, as the rights of both learners and educators might be violated. Communities and families are already disgruntled and need South Africa to join hands in mitigating the impact of HIV/AIDS.

The education sector is and will experience a high rate of absenteeism by learners, educators and the management, decline in school enrolment, lack of experienced educators and managers due to mortality. The curriculum needs high powered life skills in order to be able to mitigate the influence of HIV/AIDS. The HIV/AIDS epidemic confronts us with a new situation whereby communities remain poor and will be further impoverished by the epidemic itself. The growth of dependent populations and the disappearance of mature adults erode the possibilities of coping at local and national level.

In Chapter 3 the researcher will do a literature study on various research paradigms. The selected research paradigm and data analysis of the empirical investigation for this research will be provided.