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TO GOD BE THE GLORY

To accomplish great things, we must not only act, but also dream;
not only plan, but also believe.

Anatole France

CHAPTER 1

INTRODUCING THE STUDY

1.1 Introduction

On September 11 2001, more than 3 000 people died in the New York bombings. But even more tragically, every day around the world HIV infects at least five times that number. The social fabric of whole communities, societies and cultures is threatened. The disease is certain to be a scourge throughout our lifetime (Hernes, 2002). In less than two decades, HIV/AIDS has been transformed from a medical curiosity to an international emergency (UNESCO, 2001). The following statistics elucidate this growing emergency.

There are 16.3 million children in South Africa, 61% of whom live in poverty. Increasing numbers of these children are in distress as a result of the escalating HIV/AIDS epidemic (Smart, 1999). Since the epidemic began, more than 60 million people have been infected: of these, nearly 25 million have died, leaving behind more than 13 million orphaned children (UNESCO, 2002).

In South Africa, the statistics of HIV prevalence and its death rate speak for themselves. According to Barolsky (2003), approximately five million people in South Africa are infected with HIV. Of those infected, nearly 250 000 are under the age of 15 years. Furthermore, Badcock-Walters (2002) notes that one-third of all HIV infected persons were infected during their school years, while a further third were infected within two years of leaving school. The latest statistics (McKay, 2004) reveal that 25% of all new HIV infections are among the youth. Schools are thus confirmed as a high-risk environment.

In recognition of the above, the South African Government has called for a national strategy on children and HIV/AIDS (Smart, 1999). This strategy involves the Department of Education and the implementation plan for Tirisano (Department of Education, 2000). I want to investigate how schools have taken on this challenge in

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the form of HIV/AIDS education, and how learners experience the strategies (programmes) employed at schools.

1.1.1 What were my motivations in this study?

My interest in conducting a study on the experiences of learners involved in HIV/AIDS programmes at schools developed as a result of my role as a Life Orientation Facilitator at a District Office of the Gauteng Department of Education. I was involved in the Life Skills Master Trainer training programme launched by the National Department of Education in 1997. We were taught to be trainers in Life Skills and HIV/AIDS education. Back at our District offices, we prepared facilitators to go out to the schools and train the educators in Life Skills and HIV/AIDS education.

I questioned whether this kind of 'cascade' model of information sharing would be effective. In budget meetings I saw the vast amounts of money intended for HIV/AIDS education and training, and the books and pamphlets on the subject that arrived at the office to be disseminated to schools. I could not determine whether this material was implemented in schools and I could only speculate as to how learners would experience the new information they received on HIV/AIDS.

The importance of HIV/AIDS education is widely recognised, and yet only 44 of the 107 countries studied in Issues in World Health (2001) included AIDS education in their school curricula. Even more distressing, in interviews with 277 secondary school principals in South Africa, 60% acknowledged that their learners were at moderate or high risk of HIV/AIDS, but only 18% of these schools offered a full sex education programme (Issues in World Health, 2001). This discovery motivated me even more to investigate what the state of affairs might be in schools and how learners experience what is offered in terms of HIV/AIDS education.

I was trained as an educational psychologist. This training and my background furthered my interest in learners at schools. I find adolescents a most interesting group to work with as they are in a challenging developmental stage. They experience many pressures and are influenced by the media, their friends, films, the Internet and their

parents, to name but a few. I became interested in determining whether all the money and hours spent on training and sharing information did in fact culminate in something these learners would find beneficial in the context of HIV/AIDS.

As a result, I decided to conduct a case study, exploring adolescent learners' experiences of HIV/AIDS programmes at their schools, and how these experiences impacted on their daily dealing with HIV/AIDS-related issues.

1.1.2 Background of the study

Many educational programmes are developed and presented with the aim of reducing the incidence of HIV/AIDS. In this study, my aim as a researcher and educational psychologist is to focus on the educational and psychological impact of these programmes in terms of experiences. I want to understand the adolescent as a person, because adolescents are the group most vulnerable to HIV/AIDS (Issues in World Health, 2001). I want to know how experience gained from HIV/AIDS programmes that are presented to adolescent learners informs and shapes their attitudes, behaviour and choices.

The focus and rationale of this study is thus not on programme evaluation, but rather on an educational-psychological perspective of the dynamics between learner and content of an HIV/AIDS programme. I want to investigate how different learners experience the HIV/AIDS programmes at their schools.

I thus have a dual purpose in exploring and describing these experiences. Firstly, I wish to gain an understanding of what these experiences of HIV/AIDS programmes are, and how these experiences have impacted on their lives, relationships with parents and friends, and on their daily dealing with HIV/AIDS issues (positively as well as negatively).

Secondly, a sense of what the experiences are could result in the knowledge of what learners found beneficial in the programme and what they would have liked changed. This knowledge might inform future curriculum development in terms of making the programme more relevant to the age and needs of the learners. The focus is on

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adolescent learners because of my own interest in their development and because they are at a vulnerable and susceptible age in terms of HIV/AIDS.

The Human Sciences Research Council (HSRC) Household Survey (Shisana, 2002) estimates that 11.4% of people aged two years and older are HIV positive, with an estimated 2000 more South Africans contracting the disease daily. Young people are particularly susceptible to HIV infection and they also carry the burden of caring for family members living with HIV/AIDS (Issues in World Health, 2001).

Around the world, AIDS is shattering young people's hopes for healthy adult lives. Ebersöhn and Eloff (2002) sketch a portrait of the children of our South African rainbow nation, which depicts the dilemma young people find themselves in, in the face of the HIV/AIDS pandemic. Instead of just being children, these young people enter the job market at a younger age. They grieve for lost family members and are unable to attend school because of their new responsibilities at home.

Adolescents are the heartbeat of all growing nations, especially in the light of the new role they are taking on as noted in the previous paragraph. This makes them vulnerable to marketing campaigns and new trends that hit the market. It is of great importance to know what shape the minds of these young adults are in, in order to understand them better in terms of the choices they make, their attitudes and behaviour as well as their experiences. Before one can do that, however, a closer investigation into the role Government plays in shaping adolescents through formal education is necessary.

The year 2004 marks the last year of a five-year National Education implementation plan, called TIRISANO[1], introduced in 1999 for 2000 by former Minister of Education, Prof. Kader Asmal. The Tirisano programme was introduced as a means to develop an education and training system that was suited to the 21st century (Department of Education, 2000).

[1] Tirisano: This term means "working together" (Gauteng Department of Education, 2001)

The Tirisano implementation plan consists of six programmes, each with a number of projects. The first programme in the Tirisano document is focused on HIV/AIDS. The following table contains the projects attached to this HIV/AIDS programme:

Programme 1: HIV/AIDS	
Project	***Title***
1	A threat to the education system
2	HIV/AIDS and the curriculum
3	HIV/AIDS and children in distress
4	HIV/AIDS in the workplace
5	HIV/AIDS awareness, information and advocacy
6	HIV/AIDS in early childhood development
7	HIV/AIDS in higher education
8	Implementation of the strategic plan and refinement of strategy

Table 1 ***Projects of Tirisano Programme 1***

Through this programme on HIV/AIDS the Department of Education aimed to develop tools and planning models to facilitate the analysis and understanding of the impact of HIV/AIDS on the education system. The programme also aimed to ensure that life skills and HIV/AIDS education are integrated across the curriculum at all levels and that educators are appropriately trained and resourced.

Through this programme the Department of Education intended to establish a system to identify orphans or children in distress, and to co-ordinate support and care programmes for these learners. An HIV/AIDS in the workplace programme would also be developed for all employees at national and provincial level, including educators.

A further aim was to raise the awareness of HIV/AIDS among educators, learners and students at all levels. The development of the necessary structures, capacity and resources to drive the development, implementation and the refinement of policy and strategy was also stated as a major aim (Department of Education, 2000).

This study will focus on projects 2 and 5 as outlined in Table 1, as these focus specifically on HIV/AIDS and the curriculum and on how educators and learners were made aware of and informed about HIV/AIDS-related issues. As a former employee of the Gauteng Department of Education and an educational psychologist, I have an extensive interest in the way schools implement the HIV/AIDS programme as well as the experiences learners have of such programmes at school level.

A working assumption of this inquiry is that not all programmes designed for learners provide them with what they most need, and that only the learners themselves can tell us what it means for them to live in a world with AIDS. This investigation could support or reject this assumption.

I want to establish how these learners experience the programme presented to them in terms of content and expectations. I also make the assumption that this could positively influence their sense of ownership and participation in the programme, impacting positively on behavioural change in terms of HIV/AIDS issues. I believe it is important to know what learners want in education and to make an effort to deliver programmes at a level that will keep their attention and influence their lives.

In this section the background and rationale for the study has been sketched. I will subsequently focus on the problem and aims of my intended research.

1.2 Statement of Intent and Aims

In terms of the HIV/AIDS Policy of the National Department of Education, every school should have an HIV/AIDS programme in place in order to educate learners about HIV/AIDS-related issues (Government Gazette, 1999). I want to form a better understanding of the experience adolescents have gained from such HIV/AIDS programmes presented at their schools.

I should make it clear that, to me, the research problem is not the programme per se, or evaluating the content of the programme. Rather, it is that I want to understand the learners involved in the programme in terms of the experiences they have gained.

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Now that I have articulated the research problem and the justification for this inquiry, I wish to pose the research questions that will guide this investigation.

1.2.1 Research questions

1.2.1.1 Primary research question

How can an understanding of learners' experiences of HIV/AIDS programmes grant insight into their daily dealing with HIV/AIDS issues?

1.2.1.2 Secondary research questions

The following research questions will support the exploration of the primary research question:

- What is the current policy in South Africa for the implementation of HIV/AIDS programmes at school level?
- What does the literature reveal regarding the primary research question?
- How do learners experience HIV/AIDS programmes?
- How do learners benefit from HIV/AIDS programmes and what are their requirements from future programmes?
- How could future HIV/AIDS curriculum development benefit from the description of these experiences in addressing curriculum-related issues that might arise from this study?

1.2.2 Research aims

I propose to do an in-depth study of the experiences of learners at specific schools which are implementing the Gauteng Provincial HIV/AIDS Programme. The aim is to explore and describe these experiences, with the purpose of establishing how the programme has influenced them as individuals needing to cope in a world fighting the AIDS epidemic.

An understanding of these experiences may reveal the impact of such a programme on learners, be it positive or negative. The impact could further be described as the influence on the learners, their attitudes and behaviour, their relationships with their parents and friends and other influences in their daily dealing with HIV/AIDS-related issues.

Knowledge of the experiences of learners may reveal what they have found beneficial in the HIV/AIDS programme, and what they might want changed the next time they are exposed to such a programme. This knowledge may be used to inform future HIV/AIDS curriculum and programme development.

The aim of this study is therefore characterised by exploratory and descriptive research. The aim of explorative research is to investigate a relatively unknown research area (Kruger, 2002). The experiences of learners involved in an HIV/AIDS programme school are unknown to me and perhaps others. If we gain an understanding of these experiences, we might understand how and why adolescents make the choices they do with regard to HIV/AIDS. An understanding of these explored experiences could meaningfully be related to the experiences of peers and even parents of the same HIV/AIDS programme.

Merriam (1998) states that the aim of a descriptive study is to examine phenomena without interference and to "take events as they are". I realise that it will be important to present learners' experiences as they emerge and not according to my own perceptions. Lincoln and Guba (2000) stress the importance of letting the voices of the participants speak, for example through the texts that they create. My aim is to describe, clarify and interpret what I have explored in such a way that the reader will be able to understand these experiences.

The aims of this study are thus briefly the following:

- To form a clear understanding of the current policy for the implementation of HIV/AIDS programmes at school level in South Africa

- To investigate what literature reveals about HIV/AIDS programmes and learners' experiences
- To explore and describe learners' experiences of HIV/AIDS programmes
- To understand how these experiences impact on learners' daily dealing with HIV/AIDS issues
- To establish what learners find beneficial in the HIV/AIDS programme and what they require from future programmes
- To make recommendations, based on learners' experiences of HIV/AIDS programmes, that might inform future programme development

1.3 Paradigmatic perspective

In an address, Dr Michael Samuel (Samuel, 2002) quoted Lincoln and Guba, saying, "it is very difficult for a fish to understand water because it has spent all its life in it. So, it is difficult for scientists (or researchers) to understand what effect the basic axioms and assumptions have upon their everyday thinking and lifestyles" (Lincoln and Guba, 2000:182). It is, according to Samuel, possible for researchers to "feel" the waters of different paradigms, and therefore to use some aspects of different paradigms in their research. Researchers do, however, ultimately feel more comfortable in the "specific waters" of one paradigm.

For the purpose of this study I have chosen to locate my inquiry within the "waters" of the interpretive paradigm. Interpretive research is essentially concerned with meaning and it seeks to understand social members' definitions and understandings of situations (Henning, Van Rensburg & Smit, 2004). This paradigm will assist me in answering my research questions and achieving my aims as it calls for exploring, describing, understanding and interaction. As stated in my research aim, I plan to explore and describe the experiences learners have of an HIV/AIDS programme and how these experiences impact on their daily dealing with HIV/AIDS-related issues.

Within this paradigm there is interaction between me and the participants. The reality is subjective and constructed, as would be the experiences learners construct from the HIV/AIDS programmes. There are many truths within this paradigm, as one would

expect a range of experiences amongst learners, educators and the researcher, all of which would be valid and truthful in their own way. This paradigm aims to better understand the world, as I would like to gain an understanding of the experiences of learners (Samuel 2002).

As an interpretivist, I assume that people's subjective experiences are real and to be taken seriously (ontology), that I can understand others' experiences by interacting with them and listening to what they tell me (epistemology), and that qualitative research techniques are best suited for this task (methodology) (Terre Blanche and Kelly, 1999). As a result, the interpretive paradigm corresponds with my aim to explore and describe learners' experiences of HIV/AIDS programmes at school level. In the following paragraphs I will further emphasise the three dimensions of this study.

I believe that the reality to be studied consists of "people's subjective experiences of the external world" (Terre Blanche and Durrheim 1999:6). Educators have to present HIV/AIDS programmes at their schools. In the same way, learners have to endure these programmes. These programmes affect educators and learners in different ways, according to their "internal reality", which in turn defines their experiences of such programmes. Furthermore, their experiences are shaped and coloured by their daily dealing with HIV/AIDS-related issues.

The **ontology** of this study could thus be summarised as follows: I believe that due to the impact of HIV/AIDS on learners, educators, families and communities and the effects of the transformation process in education in particular and in post-apartheid South Africa as a whole, learners will have **varied experiences** of HIV/AIDS programmes. I aim to investigate (as far as possible) the internal reality of learners' subjective experiences within an interpretive paradigm.

In the interpretive paradigm I adopt an intersubjective or interactional **epistemological** stance towards the reality stated above. Epistemology specifies the nature of the relationship between the researcher and what can be known (Terre Blanche and Kelly, 1999). This means that I will have an interactive relationship with the participants in order to better understand their experiences (subjective realities) of

an HIV/AIDS programme. From an interpretive paradigm I do not view the experiences of learners as constant, but as dependent on the situation and context in which they gain these experiences.

The term "interpretive" refers to the fact that the aim of the research is not to explain human behaviour in terms of universally valid laws or generalisations. Rather, it refers to understanding and interpreting the meaning and intentions that underlie everyday human action (Schurink, 1998), which in this case would explain why different stakeholders in the school have certain reactions to and experiences of the HIV/AIDS programme. To understand a particular social action, I must grasp the meanings that constitute that action (Schwandt, 2000).

In this study I will thus be in an empathetic relationship with the learners involved in the research, and play the role of the subjective observer. The purpose of this relationship is to better understand the experiences of learners involved in an HIV/AIDS programme, in order to give a broad description of these experiences.

The third dimension in the description of the paradigmatic assumptions of this study, is that of **methodology**. Within the interpretive paradigm, I will deploy a qualitative methodology and research design. How learners experience an HIV/AIDS programme in South Africa is currently unknown and may differ from the outcomes envisaged by the writers of such a programme. Schurink (1998) defines qualitative research as a multi-perspective approach (utilising different qualitative techniques and data collection methods) to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the participants attach to it. I aim to understand and describe what learners of specific secondary schools experience regarding an HIV/AIDS programme and this calls for a qualitative approach.

The way we know something is linked to both what we know and our relationship with our research participants (Lincoln and Guba, 2000). Giving voice to the experiences of learners does not depend on me as researcher alone: I must let the learners give voice to their own experiences, which I will capture in written format. In

this way, their own voices will speak in the interpretation of the data (Lincoln and Guba, 2000).

With regard to letting learners give voice to their own experiences, I would like to acknowledge the crisis of representation in Denzin & Lincoln (2000). I will attempt to get as close to the learners' perspectives as I possibly can, but I acknowledge that I remain pivotal in terms of what is eventually written, highlighted, omitted and linked. Thus, the power of what is represented ultimately lies with me, and thus constitutes the crisis of representation, as the end result is a limited product of a multitude of perspectives.

The methodology of qualitative research demands that I use an inductive form of reasoning to develop concepts, insights and understanding from the patterns in the data (Schurink, 1998). By using this form of methodology I aim to identify themes, motifs and categories in the experiences emerging from the data. The qualitative approach will enable me to elicit learners' accounts of meaning and experience. It will also allow me to produce data that is descriptive and representative of the learners' own spoken or written words (Schurink, 1998).

I hope to collect and capture data on the experiences of learners without losing the rich descriptions of their attitudes, feelings and the essence of their expressions (Morse, 1994). This approach will allow participants to express their experiences freely. One of the shortcomings of this approach is that although the data will be richer than when using quantitative methods, the findings will not be able to be generalised to the broader schooling system. As an interpretivist I do not, however, regard this as a problem, as my aim is not to present data that is generalisable. Other limitations are discussed later in this Chapter.

In conclusion, the following table illustrates my own summary of the paradigmatic perspective of this study:

Table 2 *Paradigmatic perspective*

Paradigm	Ontology	Epistemology	Methodology
Interpretive	*Reality can be understood Experiences are real*	*Interactive relationship Knowledge arises from observation*	*Qualitative methods*

1.4 Conceptualisation

For the purpose of this study, the following clarifications will provide an understanding of the concepts used. These clarifications are preliminary and tentative due to the interpretive nature of the study. As such, the concepts will evolve, change and be adapted as the study progresses, in order to reflect multiple perspectives of the concepts. The conceptual framework for this study will be developed in Chapter 2.

1.4.1 Case Study

Henning, Van Rensburg & Smit (2004) define a case study as a format for design characterised by the focus on a phenomenon that has identifiable boundaries. I will be conducting an **instrumental case study**, which is used to provide insight into an issue (Stake, 2000). The issue at hand is learners' experiences of HIV/AIDS programmes at three secondary schools. In an instrumental case study, the case plays a supportive role and facilitates our understanding of something else (Stake, 2000). The cases in question are the three schools.

1.4.2 Exploring

Exploring is defined as "examining thoroughly in order to learn about" (WordiQ, 2004). In this study the phenomenon I intend to examine thoroughly is learners' experiences of HIV/AIDS programmes, in order to understand these experiences in terms of the impact they have on adolescents' daily dealing with HIV/AIDS issues.

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1.4.3 Experiences

Experience is defined as the accumulation of **knowledge or skill** that results from direct participation in events or activities (WordNet, 2004). Experience is also regarded as the prime factor in **developing one's point of view**. Naturally, this results in differences between each person with respect to their experiences (WordiQ Encyclopedia, 2004).

According to the *Dictionary of Qualitative Inquiry* (Schwandt, 2001), qualitative inquiry deals with human lived experience. It is the **life-world** as it is lived, felt, undergone, made sense of, and accomplished by human beings that are the object of study. "Experience has a processual, historical character; it is anticipatory and open. There is a knowing *within* experience" (Schwandt, 2001:86).

The notion that there are different senses of experiences is explained by using two German words (Schwandt, 2001):

- ***'Erlebnis'*** denotes experience as something **one has**, an event or adventure connected with a subject
- ***'Erfahrung'*** refers to experience as something one **undergoes** so that subjectivity is drawn into an "event" of meaning

Within the context of this study, the experiences that learners have of an HIV/AIDS programme could be defined as a series of events participated in or lived through (erfahrung) that made a powerful impression on their minds or senses, and through which knowledge and skill (erlebnis) were accumulated and their points of view developed.

HIV/AIDS has a direct impact on our daily lives and leaves a lasting impression in our minds. I aim to define what the impressions are that an HIV/AIDS programme has left on the minds and senses of learners at specific schools. Further, impressions of their attitudes, behaviour, relationships with peers and parents and daily dealing with HIV/AIDS-related issues will be formed.

1.4.4 Learners

This study will focus on three secondary schools. The learners at these schools who participate in this study will thus be in the **late adolescent and young adult phase** of their development. One of the purposes of these learners being at school is for them to **gain skills and experience** from the information and the activities they engage in at this level. It is therefore imperative to this study to investigate what these young adults have gained in terms of knowledge, skills, values and attitudes from their engagement in an HIV/AIDS programme.[2]

1.4.5 HIV/AIDS Programmes

HIV is an abbreviation of Human Immuno Deficiency Virus. The final stage of HIV infection is called AIDS, which stands for Acquired Immuno Deficiency Syndrome.

A programme, in terms of this study, can be defined as a **listing** of the order of events and other **pertinent information** for some public presentation (WordiQ, 2004). **Circular 33/2001** (Department of Education, 2001(a)) lists the information regarding HIV/AIDS that should be presented to learners. This information forms the core curriculum for the HIV/AIDS programme and is captured in Chapter 2. For the purpose of this study, I refer to the contents of this circular when I refer to an HIV/AIDS programme.

I need to clarify that there is a difference in HIV/AIDS programmes presented by the Government and by non-Governmental Organisations (NGOs). NGOs, relief, faith-based and other organisations of the same nature present informal programmes, and are sometimes contracted to present programmes in the formal sector, such as at schools and other Government organisations. My study focuses specifically on the formal, in-school implementation of the prescribed HIV/AIDS programme of the Department of Education.

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[2] The terms learner, adolescent, young person, child and participant are used alternately throughout the text

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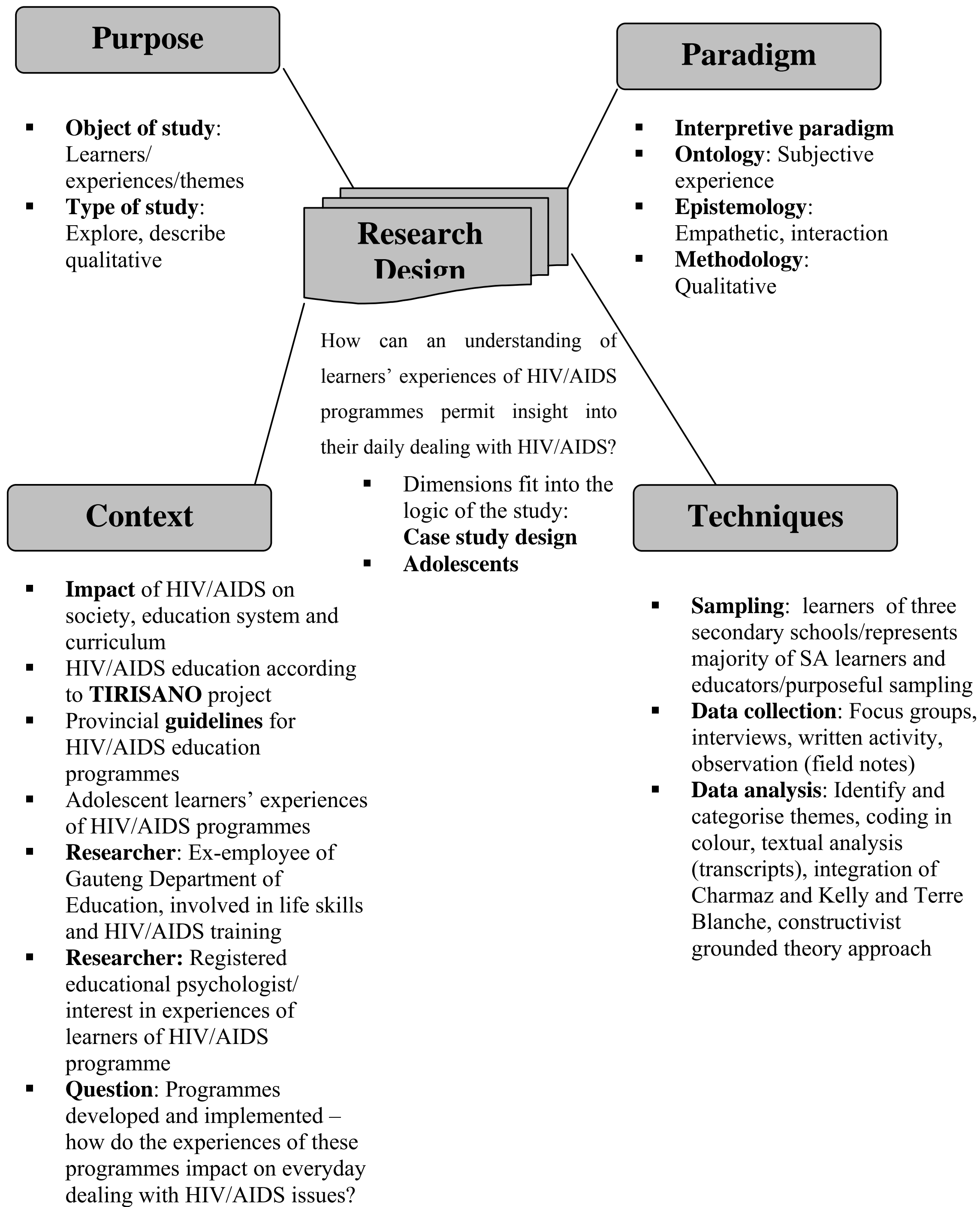
1.5 Research Design and Methodology

Design decisions have four dimensions to consider. The following diagram is adapted from Durrheim (1999) to give an overview of the design decisions for this study. An in-depth discussion of these decisions will follow in **Chapter 3** of this study. I will give a brief discussion of this diagram.

Diagram 1 *Research Design*



1.5.1 Research Design

Merriam (1998) is of the opinion that qualitative case studies have illuminated educational practice for nearly thirty years. In my study I will follow the definitions and descriptions of the case study according to the opinions of Stake (2000) as well as Merriam (1998), who uses Stake extensively in her writings on case studies. Both these authors define the case as a single entity, a unit around which there are boundaries.

Henning, Van Rensburg & Smit (2004:41) state that "a case study as a format for design characterised by the focus on a phenomenon that has identifiable boundaries". In other words, "I can fence in what I am going to study" (Merriam, 1998:27). A school is one example of such a bounded system and, following Merriam (1998), I will investigate a certain phenomenon (learners' experiences of an HIV/AIDS programme) within the boundaries of the case (the school).

The design type identified for this study is thus a case study design, following a qualitative approach. I will be conducting an **instrumental case study**, which is used to provide insight into an issue (Stake, 2000). In an instrumental case study, the case plays a supportive role and it facilitates our understanding of something else (Stake, 2000). This study is qualitative in nature and I aim to give an in-depth description of a small number of bounded system cases (Mouton, 2001:149). The basic strategy of this design is to describe thoroughly a single unit during a specific period of time. I will be working with three specific schools (cases), and a selected number of learners at these schools (participants). I presume that a thorough description of a unit would enable me to develop insights, ideas and questions for further study (Fouche & De Vos, 1998).

I characterise case study in qualitative research as researcher, spending extended time, on site, personally in contact with activities and operations of the case, reflecting, revising meanings of what is going on (Stake, 2000). I want to understand the experiences of learners, in order to explain how these experiences influence their

daily dealing with HIV/AIDS issues, and also because I have an intrinsic interest in this particular aspect of the impact of HIV/AIDS programmes (Stake, 2000).

The case study design aims to answer exploratory, descriptive and explanatory research questions. Case studies are intensive investigations of particular individuals (Lindegger, 1999). This design is thus suited for my study, because I want to explore and describe learners' experiences of HIV/AIDS programmes, providing rich descriptions of how this programme has influenced their daily thinking, acting and dealing with HIV/AIDS issues.

The advantage of this design approach is that it will provide me with an understanding of learners' experiences. According to Morse (1994) the aim of qualitative research is the development of theory, description, clarification and comprehension of a problem rather than the testing of a hypothesis. The case study design does not test a hypothesis, but it does very often generate hypotheses that might be more rigorously tested by other research methods (Lindegger, 1999).

Thus, the value of my study is that I want to give rich descriptions of the experiences of learners in order to clarify how they found the HIV/AIDS programme that was presented to them, and how their experiences of the programme influence their daily lives in dealing with HIV/AIDS. I might also learn from these experiences, in terms of what the learners liked about the programme and what they did not like. This might inform future planning of similar HIV/AIDS programmes. Stake (2000) also stresses the importance of the case study being built around a small number of research questions and of identifying the thematic issues of the case. By using the case study design I aim to identify themes that emerge from the data which might inform us of what learners liked and disliked in the programme.

I will now discuss the methods to be followed in the implementation of this case study.

1.5.2 Data Collection

In this section, I will discuss how I intend to select the source or foundation of my data, how the participants will be selected and how the data will be gathered. This is only a brief discussion. These aspects are discussed in more detail in Chapter 3.

1.5.2.1 Selection of Data Source

I consulted the categories mentioned in Mouton (2001) as a classification of the data sources I could utilise. I have identified the data sources of **observation** and **self-reporting.** For the purpose of this study, observation is defined as direct/non-participant observation by the researcher in a natural setting. Participants will self-report in terms of focus groups and self-reporting media (e.g. written essay/collage).

The data will be in audio **format** for focus group interviews. These audiotapes will be transcribed into written format. Other media produced by the participants will be in written format and will include the notes and journal entries that I will be making.

As I will be interviewing minors I will negotiate **access** to the data in accordance with ethical issues. There should be no legal implications to limit the access to the data. According to the regulations of the Department of Education, I must obtain written permission from the principal and the Department of Education to work with the learners at that specific school.

The **data coverage** will be from a sample of participants. I aim to select the sample from the group that represents the majority of learners and educators in South African secondary schools. I will limit the sample to learners at three specific secondary schools in one of the Districts of the Gauteng Province.

The participants of my study are people rather than physical phenomena in terms of **data definition** (Mouton, 2001). As the researcher I am a source of data in terms of my observation of the participants and the notes I make in that regard. Learners will be of the same grade in all three secondary schools. Data will be collected from them via self-reporting (focus groups and a piece of written work).

1.5.2.2 Selection of cases (sampling)

According to Merriam (1998), there are two levels of sampling in case studies. Firstly, I must select the "case" to be studied and then do sampling within the case to determine the participants. Therefore, due to the aim of this study, I have decided to limit my study to a small number of Grade 11 learners (participants) from three different secondary schools (cases).

In order to determine which schools will be the cases in this case study, I have to establish the criteria that will guide my case selection (Merriam, 1998). In my study, the most important criteria are that the schools I select will have HIV/AIDS programmes, that these programmes have been implemented, that there are Grade 11 learners who have been exposed to these programmes, and that the learners are representative of the diversity in South Africa. These criteria call for the sample design of **purposeful sampling**.

After consultation with life skills facilitators of one of the Districts of the Gauteng Department of Education, three secondary schools that have been part of the provincial HIV/AIDS education process will be identified in that specific district. The learners at these schools will be representative of the majority of learners in South African schools.

These three schools will then be approached and asked to volunteer to be part of the research process. With the assistance of the management of the school, a number of Grade 11 learners who have been involved in the HIV/AIDS programme at the school will be **purposefully** selected as participants in this research project. In order to investigate their experiences of such a programme it is necessary that the selected learners be part of the HIV/AIDS programme presented at that particular school.

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1.5.2.3 Methods of data collection

The purpose of collecting data for this study is to generate enough rich detail, embedded within a specific context, to give a description deep enough to answer the research question – How can an understanding of learners' experiences of a HIV/AIDS programme grant insight into their daily dealing with HIV/AIDS?

To answer this I will discuss the methods of data collection in terms of the mode of observation, data documentation and data capturing.

a) Mode of Observation

To understand the experiences of learners as revealed through the research process, I will utilise the data sources of non-participant observation and self-reporting mentioned in 1.5.2.1. One of the data sources to be utilised is that of **non-participant observation**. I will observe the participants while doing fieldwork. The field notes that I make will help me to develop ideas and questions to verify my own understanding of the information gathered during the research process. Henning et al. (2004) define these kinds of field notes as 'soft' notes consisting of my experience of the field. These notes will therefore include my personal thoughts, feelings and impressions in response to some of the discussions.

Focus group interviews will serve as the major mode of observation in my study. This mode falls under the data source of **self-reporting**. Focus groups are defined as a research technique that collects data through group interaction on a topic determined by the researcher (Morgan, 1997). My interest in learners' experiences therefore provides the focus, and the data will come from the interaction of the groups. "The hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction in a group" (Morgan, 1997:2).

In order to be mindful of my own influence on the data, I will employ the advice of Denzin and Lincoln (2000). They are of the opinion that it is advisable in conducting qualitative research to use the process of crystallisation. They state that in employing

the crystallisation process, the researcher describes the same process from different points of view and this might reduce the likelihood of misinterpretation. "Crystals grow, change, alter… Crystals are prisms that reflect externalities and refract within themselves, creating different colours, patterns and arrays, casting off in different directions" (Denzin & Lincoln, 2000:5).

For the purpose of obtaining different points of view on the same issue, I have decided to include other methods of self-reporting, such as a written activity. While conducting the focus groups I could possibly identify participants who have had experiences that I would like to explore further by means of a face-to-face interview, in order to gain more insight and understanding of those experiences.

b) Data documentation

Data is documented mainly as a historical record for oneself and other possible researchers (Mouton, 2001). In conducting qualitative research within an interpretive paradigm, I will rely mainly on my **field notes** as a researcher and on the **recordings** of focus groups and interviews in documenting the data. Terre Blanche and Kelly (1999) suggest that there are essentially two sorts of field notes. Firstly, there are the notes I will make to describe as fully as possible what participants did and said. Secondly, I will make "soft" notes that are concerned with my unfolding analysis (Henning et al., 2004). I will divide each page of my notebook into two columns: a wide one for descriptions and a narrower one for analytical comments. Basic information, as stipulated in the list above, is also recorded in this notebook for every event described.

Focus group interviews will be recorded. Every tape will be dated clearly and transcribed. The transcriptions will have a blank column where I can document my comments and verify my understanding of the experiences that were revealed during these interviews and discussions. Emergent themes will also be colour-coded in this spare column for the purpose of analysis and interpretation.

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c) Data capturing and editing

In this study the data will be in **textual format** in the form of my field notes, transcribed focus group discussions and interviews, as well as the texts that participants create during the written activity. This type of data is difficult to capture in a short and structured manner (Mouton, 2001).

I will read through the transcriptions repeatedly until I find that I have a clear understanding of what the learners have revealed in terms of their experiences. I will make notes in the space provided on the transcriptions of possible categories as they emerge through my reading process. In this way the data is **edited** in a meaningful manner, and prepared for the process of analysis.

1.5.2.4 Data analysis and Interpretation

In my study I will follow the approach of Charmaz (2000), that of **constructivist grounded theory,** in the analysis and interpretation of my data. According to Charmaz, constructivism recognises the mutual creation of knowledge by the researcher and the participants, and aims at an interpretive understanding of participants' experiences. A constructivist approach to grounded theory reaffirms studying people in their natural settings, and a focus on meaning while using grounded theory furthers interpretive understanding (Charmaz, 2000).

In an interpretive study, there is no clear point when data collection stops and analysis begins. Collecting, analysing and interpreting the data coincides as a process that unfolds as the research progresses. I intend to stay close to the data, and to interpret it from a position of empathetic understanding, which is one of the key principles of interpretive analysis (Terre Blanche and Kelly, 1999). Charmaz (2000) supports this view by stating that one of the strategies of constructivist grounded theory is the simultaneous collection and analysis of data.

Different authors cite a variety of methods and "steps" to utilise in the analysis of qualitative data. For the purpose of my study, I have decided to incorporate the views of Charmaz (2000) on constructivist grounded theory, and especially the strategy of

coding, with the analytic steps of Terre Blanche and Kelly (1999). These analytic steps are not a fixed recipe for application to the data, but serve to "unpack some of the processes involved in immersing oneself in and reflecting on the data" (Terre Blanche & Kelly, 1999:140). Chapter 3 gives a detailed description of the process of analysis and interpretation that will be followed.

1.5.3 Ethical strategies

Qualitative fieldwork could be compared to a journey into a minefield riddled with potential moral and ethical hazards (Schurink, 1998). Ethical concerns should be an integral part of the planning and implementation of research. In the case of HIV/AIDS particularly, there could be complexities in terms of stigma and discrimination to consider (Barolsky, 2003). The ethical strategies applied in this study are described comprehensively in Chapter 3. I will thus only note briefly here the ethical principles and guidelines I intend to follow in this study.

a) Ethical Principles

- I will employ the principle of **autonomy**. By doing so, I will respect the independence of all my participants.
- I aim in my research to do no harm to the learners or any other person or group. This is called the principle of **nonmaleficence**. This requires me to consider potential emotional or social harm that my research could cause participants
- The third principle to consider is that of **beneficence**. To comply with this principle, my research design must be such that it will be of benefit to the participants and to other researchers, even if the benefit is indirect.

b) Ethical Guidelines

The following ethical guidelines will be followed. They are briefly listed here, but discussed in more detail in Chapter 3:

- Consent
- Confidentiality
- Competence
- Reporting results

1.5.4 Trustworthiness

Within the paradigm and approaches followed in this study, I will investigate the **trustworthiness** of this naturalistic study in contrast to the validity and reliability of a rationalist, quantitative study (Samuel 2002). The trustworthiness will also be discussed in more detail in Chapter 3, in terms of credibility, transferability and dependability. These criteria are consequently briefly noted.

I will aim in this study to have **credibility** in terms of the themes that are discovered. Participants will have to verify whether their realities or experiences have been represented with authenticity. The trustworthiness of the study will become more apparent if new ways of thinking are generated by the data. The data need not be generalisable, but transferable in the degree to which participants can claim resonance between their own experiences and the researcher's interpretation.

Transferability is achieved by producing detailed and rich descriptions of contexts. This means that my understanding of the experiences of learners can then be transferred to new contexts of other studies to provide a framework for that research.

The reason for referring to **dependability** rather than reliability in this study is that reliability refers to the degree to which my results will be repeatable. I do not expect to find the same results repeatedly when investigating experiences of learners and therefore aim to have dependable findings. Dependability refers to the degree to which the reader is convinced that the findings did indeed occur as I said (Durrheim and Wassenaar, 1999).

1.6 Limitations of the study

- Although this study intends to concentrate on learners' experiences of HIV/AIDS programmes at their schools, I have to consider that at the time they were exposed to the programme there may have been other influences in other spheres of their lives that may have had an influence on their experiences. I cannot thus say with any certainty that their experiences are a result only of the programme.
- Learners in South Africa come from a diversity of culture, race, religion, language and socio-economic status, which limits the study in terms of the generalisability of results. Although this is a limitation, it is not one of the aims of this study to produce data that are generalisable.
- The learners' responses in this study are based on self-reporting. Their responses might be affected by a "social desirability bias", which means the learners might provide what they think are socially acceptable responses (Shisana, 2002).
- Almost all researchers conducting qualitative studies are confronted with the crisis of representation (Denzin and Lincoln, 2000). This could be a limitation of the study in terms of the representation of the learners' responses and experiences. I acknowledge that I am fundamental in representing what the learners reveal, and take cognisance of this possible limitation.
- This study was conducted during the administration of the former Minister of Education, Kader Asmal. The views on the implementation of HIV/AIDS education in this study should be seen from the perspective of his administration. To address this limitation, the views of the current Minister of Education, Naledi Pandor, will be addressed in Chapter 5.

1.7 Conclusion

In this chapter I introduced my purpose in this study by providing a rationale for my decision to investigate the experiences of learners in terms of HIV/AIDS programmes presented to them at school level. I have an immense interest in the development of adolescents as well as of HIV/AIDS education. In my inquiry these two interests are

combined, by investigating how an understanding of the experiences of learners after exposure to an HIV/AIDS programme might permit insight into their daily dealing with HIV/AIDS.

I thus stated the rationale and aims of this research study and sketched a paradigmatic perspective in terms of the paradigm, ontology, epistemology and methodology to be followed. This study is characterised by an interpretive paradigm, in which the reality can be understood and experiences are real (ontology). There exists an interactive relationship between the participants and the researcher, myself, and knowledge that arises from observation (epistemology).

The research design has been discussed in this chapter and the qualitative methods (methodology) to be followed have been explained. This study will make use of an instrumental case study design. Participants will be Grade 11 learners from three secondary schools (cases) who take part in focus groups for the case study. The process of data collection, capturing, editing, analysis and interpretation was also discussed.

A consideration of ethical strategies, principles and guidelines, the trustworthiness of the study and its possible limitations concluded the chapter. These are aspects that must be thoroughly investigated and adhered to, particularly when one conducts research in the field of HIV/AIDS.

Finally, I will give an outline of what can be expected in the following chapters of this study.

1.8 Organisation of the Thesis

Chapter 2 focuses on an analysis of relevant literature to elaborate on the background of the study and further explore the research problem. The conceptual framework for the study is developed in this chapter. This chapter aims to answer the following research questions:

- What is the current policy for the implementation of HIV/AIDS programmes at school level?

- What does other literature reveal about the primary research question?

Chapter 3 describes the research design in detail, and the methodology followed to collect and analyse the data is justified.

Chapter 4 presents the data, the analysis and the interpretation of the findings. This chapter also serves as a control of the literature, relating the findings to existing studies and interpreting themes, categories and sub-categories by means of literature study. This chapter addresses the following research questions:

- What are learners' experiences of HIV/AIDS programmes?
- What did learners benefit from in the HIV/AIDS programmes and what are their needs from future programmes?

Chapter 5 focuses on the conclusions, shortcomings and recommendations of this study. The following research question is addressed in this chapter:

- How could future HIV/AIDS curriculum development benefit from the description of these experiences and possibly address the curriculum-related issues that might arise from this study?
- Other conclusions and transcendent conclusions will also be discussed in this chapter.

University of Pretoria etd – Griessel-Roux, E (2005)

CHAPTER 2

LITERATURE STUDY AND CONCEPTUAL FRAMEWORK

2.1 Introduction

The HIV/AIDS epidemic has left no part of the world untouched. The problem exists worldwide, although the greatest concentration of HIV infections and AIDS related deaths is in developing countries (Juma, 2001). Education is at the core of one of the great challenges facing humanity: winning the fight against HIV/AIDS (UNESCO 2002). In terms of the realisation of children's rights HIV/AIDS is fast becoming a critical challenge in South Africa (Smart, 2003). As will become evident in this chapter, a reciprocal relationship exists between HIV/AIDS and education, which goes beyond the formal education sector and embraces society and other areas.

The proposed study will focus on the experiences of learners in three schools implementing HIV/AIDS programmes as suggested by the Gauteng Department of Education, and within the framework of the proposed programme of the National Department of Education. The conceptual framework within which these experiences will be studied is sketched in this chapter.

The purpose of this chapter is to investigate the two major fields of knowledge that play a leading role in defining this study. The complexity of HIV/AIDS and the impact it has on the adolescent, society and the education system has an important role to play as one field of knowledge in this study. Theories on adolescent development form part of this field. Policies, plans, curricula and programmes of the National Department of Education and how these are envisaged also need to be investigated as a second field of knowledge. Research into HIV/AIDS programmes at national and international level is included in this field.

I am thus compelled to consider these vast arenas in my attempt to frame this study theoretically. I will structure my discussion in terms of looking at the **"whole"** of the impact of HIV/AIDS. I will approach this framing process **logically**, by first looking

at the **macro** level impact of HIV/AIDS on society. Then I will narrow it down to **meso** level with the impact of HIV/AIDS on the adolescent and the education system and lastly I will focus at **micro** level in terms of HIV/AIDS and the curriculum, with a constant focus on the adolescent and his/her experiences. In this way I will construct the conceptual framework of my study.

The African continent is diverse in terms of its economics, cultural heritage and the level of education of its people (Kaaya and Smith Fawzi, 1999). In a recent report compiled by UNESCO (2002) some of the current known facts regarding HIV/AIDS and education are listed:

- HIV affects all continents and regions
- HIV prevalence among young people is high and rising rapidly
- The full impact of HIV/AIDS on educational institutions is yet to come
- HIV/AIDS is undermining institutional capacity
- The number of children orphaned by AIDS is rising rapidly
- Student enrolment and achievement are likely to fall
- HIV/AIDS-related risks and vulnerability are present in the majority of schools

It has become clear to me that in order to understand and describe the experiences of learners in terms of an HIV/AIDS programme, it is important to investigate the facts listed above. Once an understanding of the impact of these facts on the adolescent is reached, the findings of this literature investigation will provide a framework for the research.

In the face of HIV/AIDS the adolescent is of critical importance. Statistics, as revealed in the literature, indicate the scope of the catastrophe affecting the youth (Issues in World Health, 2001; Shisana, 2002; McKay, 2004; Smart, 2003):

- In 1998 over 2.5 million young people between the ages of 15 and 24 became infected with HIV – half of all new HIV infections that year
- In 2001 an estimated 11.4% of people aged two years and older were HIV positive, with an estimated 2000 more South Africans contracting the disease daily

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- In 2001 an estimated 28.4% of pregnant women in South Africa aged between 20 and 24 years attending antenatal clinics were infected with HIV
- In 2004 nearly 25% of all new infections are among the youth

Other researchers support the above-mentioned statistics (Blanchett, 2000; Coyle, Kirby and Parcel, 1999; Department of Education, 2001(a)). Furthermore, available research examining the risk behaviours of young adults illustrates that even more young people are engaging in behaviours that place them at risk of HIV infection in the future (Blanchett, 2000). We have to come to terms with the reality of sexual activity among the youth, and as such HIV/AIDS education calls for a progressive understanding of both social and sexuality issues which are vital components in the growth and developmental health of youths and adolescents (Nyachuru-Sihlangu, 1992:225).

This chapter will thus firstly focus on the broader impact of HIV/AIDS on society and on the education system. The development of the adolescent will be studied in detail in order to understand and describe his/her experiences. Other studies and educational programmes related to HIV/AIDS at international and national level will be investigated and discussed in order to make comparisons in terms of this study. Lastly, strategies applied in other countries for the prevention of HIV/AIDS will also be compared to our National strategy to set the stage for the curriculum the learners are exposed to and from which they gain experiences.

This introductory discussion has set the stage for the description and development of the conceptual framework of this study. Next I will discuss this framework to locate my enquiry, as illustrated in Diagram 2.

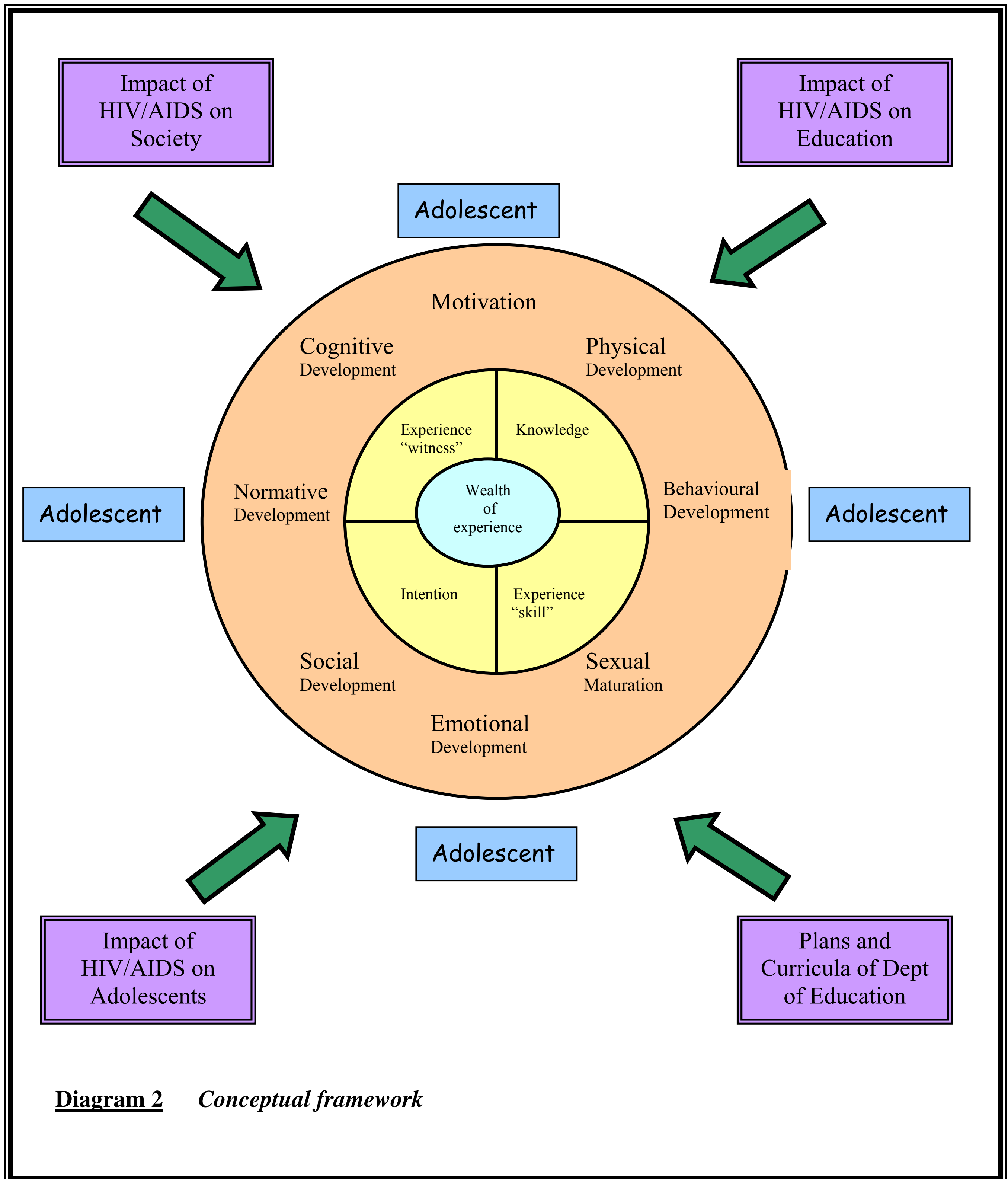

Diagram 2 *Conceptual framework*

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2.2 The impact of HIV/AIDS on society

The impact of HIV/AIDS has already been felt in every aspect of socio-economic life including formal education (Juma, 2001). According to Juma (2001), insufficient research exists to support an objective assessment of the extent of this impact, but various indicators show it to be considerable. HIV/AIDS is affecting learners, educators, parents and communities, organisations and management, the curriculum as well as resources (Smart, 2003).

South Africa is considered to have one of the fastest growing HIV epidemics in the world, with approximately 1600 people being infected every day. Currently in South Africa alone, 3.5 million people are infected with HIV (approximately 10% of the population), and this number is expected to rise to between 6 and 10 million people within 15 years (Call, Riedel and Hein, 2002). The need for urgent steps focussing on the youth to address this enormous problem is evident from the following statistics. The level of HIV infection amongst pregnant adolescents younger than 20 years was 6,7% in 1994 and rose to 12,7% in 1997, and to an alarming 21% in 1998, an increase of 65% within one year (Department of Education, 2001(a)). These statistics are disturbing in terms of adolescent risk behaviour in the face of HIV/AIDS and the challenge it poses to the education system.

In South Africa, more than 60% of new HIV infections occur among 15- to 25-year olds, with adolescent girls being among the most frequently diagnosed (Call et al., 2002). The latest statistics released on teenage pregnancies and abortions clearly indicate that a large number of school-going adolescents are engaged in unprotected sexual activities, which increases their chances of contracting and spreading a sexually transmitted disease or infection and ultimately HIV/AIDS (Department of Education, 2001(a)).

Of the more than fifteen thousand new cases of AIDS reported daily in South Africa, it is estimated that 10% are children (UNAIDS, 1998(b)). In 2004 almost 25% of all new infections in South Africa are among the youth (McKay, 2004). Unfortunately, statistics alone do not fully present the grim reality of HIV/AIDS. Even well written,

carefully considered prevention programmes cannot anticipate the contextual factors in which they will be presented.

HIV spreads fastest and farthest in conditions of poverty, powerlessness and lack of information (Issues in World Health, 2001). There are almost 18 million children under the age of 18 in South Africa of which an estimated 60% live in poverty and are nutritionally vulnerable (Smart, 2003). Worldwide, the AIDS epidemic is most severe in the poorest countries, where the disadvantaged and people with few opportunities, services and support systems, are at greatest risk.

In industrialised countries, living in impoverished family and neighbourhood environments is associated with high-risk behaviours, such as substance abuse and delinquency, early pregnancy, poor nutrition, school failure and feelings of despair (Call et al., 2002). It is thus important to keep in mind that poverty has an effect on adolescents' mental health and risk-taking behaviour when investigating their experiences of an HIV/AIDS programme presented at school.

The health of adolescents is shaped by the daily contexts in which they grow and develop. Transformations in world economics, government, families and technology, among other things, are altering societies around the world, and, in turn, reshaping the contexts of adolescents' lives (Call et al., 2002; Giese, Meintjies, Croke and Chamberlain, 2003). Taking a closer look at how the impact of HIV/AIDS influences families and communities will thus shed light on how adolescents are affected within their daily contexts.

HIV/AIDS is causing devastation all over the world – destroying communities and families and destroying hope for the future (UNESCO, 2002). In a report compiled by Hunter and Williamson (2001) the tremendous impact of HIV/AIDS on the macro systems of a society is captured. Some of the issues raised in this report will be highlighted here to show the impact of HIV/AIDS on the broader systems of society.

Countries may only experience the demographic effects of HIV/AIDS years after the height of the epidemic. According to a UNESCO report published in April 2001 (UNESCO, 2001), the HIV/AIDS epidemic will have a greater impact on the size of

the population of several developing countries than the Second World War had on any society. Robertson and Ensink (1992) seem to support this report by saying that in South Africa the increasing prevalence of HIV seropositivity in woman and children indicates that we are on the brink of an AIDS epidemic of the proportion of that which has swept through other African countries. The increased demand for care stretches already overburdened health and education systems. With infection rates reaching a third of the population, and as many as half of the young in some countries, no institution will remain untouched.

One example of this impact is that the number of orphans peaks seven to ten years after seroprevalence. It is estimated that worldwide there are approximately 13 million AIDS orphans. By 2005 South Africa alone will have more than 800 000 AIDS orphans (Call et al., 2002; Giese et al., 2003). The future estimations are 24.3 million children orphaned by HIV/AIDS by 2010 and 40 million by 2020 (Smart, 2003). Dependency ratios may worsen due to AIDS-related illnesses among adults. The number of widows may increase, and their socio-economic situation may deteriorate. Household composition will change as middle-aged parents die, and grandparents are left to raise young children (Department of Education 2001(a); Hunter and Williamson, 2001; Smart 1999).

The HIV/AIDS epidemic in southern Africa is not expected to peak until 2010-2020, after which it is anticipated that incidence and prevalence will begin to decline. Because orphaning follows deaths by 8 to10 years, orphaning is likely to remain high until 2030 (Richter, Manegold and Pather, 2004). HIV/AIDS thus has demographic effects on aspects such as total population loss, population growth rates, crude death rates, fertility rates, life expectancy, age distribution, infant and child mortality, dependency ratios, gender ratios, widow(er)hood, household composition and/or co-residence (Hunter and Williamson, 2001).

In addition to these demographic issues, HIV/AIDS also threatens to reverse the socio-economic gains made by developing countries. It affects production as well as household income and expenditure, it poses major health problems for health systems and health care practices and it diminishes the capacity of societies to provide essential services and to plan for the future (Barolsky, 2003; UNESCO, 2002).

These socio-economic effects have an impact on social services, the wellbeing of individuals and households, demand for labour, urban poverty, agricultural production, health care and school enrolment. More households will be facing poverty because of lost productivity and loss of access to markets. Child labour will increase inside and outside the home because of the scarcity of adult labour. The death of a parent or another adult in a household quite often affects the nutritional status of surviving children by reducing household income and food expenditure (Call et al., 2002; Juma, 2001). Hence, the AIDS epidemic not only hampers development, it reverses it by destroying productive capacity and widening the gap between rich and poor (UNESCO, 2001).

Health care will become less accessible as conditions related to HIV/AIDS strain the hospital and home care systems. School enrolment will decline owing to increased mortality of children under the age of five and to increasing demands for child labour (Hunter and Williamson, 2001; Smart 1999). Households use a variety of strategies to cope with the economic shock of a prime-age adult death. The most commonly applied strategy is drawing on family savings or selling assets. The ownership of land, livestock, bicycles and radios is quite widespread in rural settings. Many households that suffer an adult's death sell some of the durable goods as part of the coping strategy (Juma, 2001; Richter et al., 2004).

Barnett and Whiteside (1996) report on work carried out by the World Bank. They argue that the effect of HIV/AIDS is quite difficult to pick up even in societies where the epidemic is advanced. They also argue that the impact is reduced by the coping mechanisms of individuals and families. When an adult in the household dies, girls of this family are less likely to be in school, which could, according to this World Bank study, have long-term implications for female literacy and human capital (Barnett and Whiteside, 1996).

It is thus vital to recognise and support the role of the family and community in educating young people about HIV/AIDS. In many countries, the majority of young people who need to learn about prevention are not in school (Giese et al., 2003; UNESCO, 2002). Hunter and Williamson (2001) state that the following aspects of

HIV/AIDS have an impact on families: the loss of family members (death, fostering, adoption), changes in household and family structures, family dissolution, lost income, impoverishment, lost labour, forced migration, grief, stress and the reduced ability to care for and educate children and elderly household members. Many of us are frightened by what is happening. Family members, relatives, friends and colleagues are falling ill and dying, often when they are relatively young (Department of Education, 2001(c)).

At the very least, adolescents of nations devastated by AIDS live in a world of near-constant bereavement, facing the death of family, friends and acquaintances on a daily basis (Barolsky, 2003; Call et al., 2002). Another aspect to consider is that the literature shows that parental death reduces children's self-esteem and increases depression, anxiety, conduct disturbance, academic difficulty, somatic complaints and suicidal acts in the long term (Rotheram-Borus, Lee, Gwadz and Draimin, 2001). Kaaya and Smith Fawzi (1999) support this line of thought, in terms of the psychological impact of HIV/AIDS. They state that the impact of psychological interventions is often difficult to determine, and that the longer-term psychological needs of persons infected and affected by HIV/AIDS are often overshadowed by physical and social needs in a setting with limited resources, and thus often ignored.

These adolescents and their families also face the daily threat of stigmatisation and discrimination (UNESCO, 2002). For families with HIV or families living in high HIV seroprevalence areas, stigma and discrimination is a complex issue. Because the entire family can experience stigma, HIV can be a source of conflict and of shame within families. Discrimination is also the social action whereby abstract stigma becomes visible (UNESCO, 2002; Barolsky, 2003).

Communities are experiencing social strain in coping with large numbers of HIV/AIDS orphans. At the family level, there is already an increased burden and stress on extended family structures. Many grandparents and relatives are looking after young children and some of the problems they experience also lead to school absenteeism and dropout rates (Juma, 2001). Richter, Manegold and Pather (2004) concur that orphans may be additionally disadvantaged by their pre-existing low socio-economic status at the time of their parents' death as well as by their biological

distance from breadwinners and decision makers in the households in which they are placed.

Communities therefore feel the impact of HIV/AIDS. The labour pool is reduced, particularly for agricultural and skilled labour, and this includes health workers and teachers. Poverty is increased and the infrastructure of the community deteriorates. Access of the community to health care and education is reduced and mortality rises. The community has fewer resources to marshal for mutual aid and suffers a general loss of resilience. Traditional models of surrogate childcare are progressively less able to accommodate the orphaned children, especially in poor communities (Hunter and Williamson, 2000; Smart, 1999).

Furthermore, with communities weakened through poverty, hunger and sickness, they will be unable to participate in self-help activities at schools (Juma, 2001). As programme efforts to change people's behaviour continue, other efforts to influence social norms and empower communities to address the epidemic are becoming more important. Researchers and policy-makers now recognise that individual behaviour is more likely to change in the context of a supportive community (Issues in World Health, 2001). Although the literature shows no relationship between sex education and increased sexual activity, many communities are torn between their moral values and the reality of teen sexual behaviour (Alstead, Campsmith & Halley, 1999). This could have a vast influence on how supportive the community is towards the HIV/AIDS programme at the school, which in turn influences the learners' experience of this programme.

Hunter and Williamson (2000) summarise the broader macro impact of HIV/AIDS: the vulnerabilities of children, families and communities are compounded by the geographic concentration of the pandemic. "Vulnerable children are cared for by vulnerable families who reside in vulnerable communities" (Hunter and Williamson, 2000:18).

2.3 The impact of HIV/AIDS on the education system

In South Africa, a context of vulnerability in the face of both HIV-infection and the impact of HIV/AIDS on the education system is created by environmental, social and economic factors. In the rationale of this study, the predicament that some children find themselves in, in terms of family disintegration and adoption of care taking roles, was discussed. The vicious cycle of increasing HIV/AIDS infections leads to decreasing educational services, which therefore leads to greater vulnerability (UNESCO, 2002).

We cannot ignore the fact that HIV/AIDS is placing a vast number of children in distress. Many children are orphaned as a result of HIV/AIDS, leaving them with economic, psychosocial and health hardships (Giese et al., 2003; Hepburn, 2001, Smart, 2003). The impact on education can be seen in the number of learners who drop out of school because they are affected by HIV/AIDS. HIV/AIDS pushes children into poverty and helps keep them there by cutting them off from school, formal training and the transfer of skills from parents (Richter et al., 2004).

All these factors are compounded by the stigma and discrimination associated with HIV/AIDS (Barolsky, 2003; Smart, 1999). UNESCO (2001) supports this belief by stating that stigma and poverty brought about by HIV/AIDS are creating new social castes of children excluded from education, as well as adults with reduced livelihood opportunities.

Particularly severe is the epidemic's impact on schools and education (UNESCO, 2002). HIV/AIDS reduces the supply of education by reducing the numbers of educators who are able to conduct their work in the classroom, and the resources available to them. The high rate of disease and death among teachers, health workers and other professionals will make replacements increasingly hard to find, and there will be fewer to educate and care for them (UNESCO, 2001). Added to this, the epidemic affects the quality of education because of the strains on the material and human resources of the system as well as on the health and mere presence of the

learners. Education in itself offers a measure of protection against HIV/AIDS by providing information and skills, by increasing young people's connectedness and security, by providing access to trusted adults, and by increasing literacy (UNESCO, 2002).

According to a study conducted by UNESCO in 2001 (UNESCO, 2001), millions of learners are already infected, and in some countries more than a third of fifteen-year-olds will die of AIDS-related illnesses in the future. Many of the youth will grow up deprived, de-socialised and disconnected. Children will lose teachers at school and parents who can support them at home. Classes will be dropped and schools will close, and many children will get a poorer education.

Although programmes developed for presentation at school level are aimed at the prevention of HIV/AIDS infection, the reality is that many learners are already **infected** and **affected** by the virus. Orphans especially are a vulnerable group (Giese et al., 2003). In her study, Kruger (2002) highlights some of the ways children are infected and affected. These are noted briefly below:

Infected children

- Children born with HIV/AIDS or infected during breast feeding
- Children infected through early sexual activity
- Children infected with HIV/AIDS through sexual abuse
- Children infected with HIV/AIDS through unsafe health practices

The consequences of these children being infected with the disease are vast. These learners show developmental deterioration and ill health, which are likely to cause barriers to learning. They have an increased frequency of being infected with other childhood illnesses due to their vulnerable immune system. This chronic illness makes it difficult for them to participate in curricular activities. The stigma and social impact of the disease are additional problems. Their levels of cognitive thinking and emotional behaviour are also hampered in this regard.

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Affected children

- Children who live in households where a family member is ill
- Children who lose parents and caregivers
- Children are frequently not told about the diagnosis of other family members
- Children become vulnerable to the implications of poverty

All children have physical and material needs, intellectual and educational requirements and psychosocial wants. Children affected by HIV/AIDS are particularly vulnerable in all these areas, as they take on adult household, parenting and caring responsibilities (Giese et al., 2003; Smart, 1999). The consequences of being affected by the disease are thus manifold. Children are forced to take on roles in their households that they are not ready for. So, for example, a young girl whose parents are infected will have to run the household, cook and see to younger siblings, which in turn has an impact on her performance at school.

These children are forced in many ways to be "grown up" when all they desire is to be able to enjoy their childhood. Hepburn (2001) also states that girls are particularly vulnerable among children affected by HIV/AIDS for the reasons stated above. Two of the reasons given by Hepburn are the prevalence of HIV infection, which is 20 percent higher for these girls than for men, and the increased likelihood that they will drop out of school when a family member falls ill and take over the responsibilities at home. In addition, children from AIDS-infected families have to generate income for family support or must care either for the sick or for younger siblings (Juma, 2001).

The problems associated with children affected by HIV/AIDS begin long before their parents die and extend beyond their individual households to affect relatives, neighbours and whole communities (Barolsky, 2003; Hunter and Williamson, 2000). Typically these children experience a lack of supervision and care, hunger and stunting, educational failure, inadequate health care, psychological problems, disruption of normal childhood and adolescence, exploitation and discrimination (Smart, 1999).

The direct impact of HIV/AIDS on families and households is stressed by Richter, Manegold and Pather (2004). The impact on education is seen as families attempt to adjust to the stresses of economic decline and demoralisation. These include (Richter et al., 2004:12):

- The emergence of child- or adolescent-headed households
- An increase in elderly caregivers, and children caring for old people
- An increase in household dependency ratios
- Separation of siblings
- Child abandonment
- Remarriage

It could thus be said that all children are affected in some way or another by the impact of HIV/AIDS, some more directly than others. Levine (2001) states that particularly children who are orphaned due the HIV crisis will place a multifaceted care burden on institutions (including schools) that will grow over the next 20 years. AIDS orphans generally have problems in coping at various school levels, which in the end excludes them from school participation, although some schools give a special remission to such children (Juma, 2001).

The effects of HIV/AIDS on education have not been fully investigated, but the South African system is already beginning to experience the impact. Of the general population of forty-two million people, four hundred and forty thousand are educators and more than twelve million are learners (NAPTOSA, 2000). This means that a significant number of learners and educators are affected by HIV/AIDS.

HIV/AIDS has an obvious effect on the management of educators, especially their personal interactions with their peers and learners and their job retention. Juma (2001) has found that, especially in the rural areas, many sick educators take little official leave, as they fear rumours of stigmatisation and problems of redeployment or replacement. Fewer educators and a decline in grade one enrolments, absenteeism, increased dropout rates and the large number of orphaned children will lead to the loss of weeks of education that cannot be replaced (Barks-Ruggles, 2001). An analysis of the problem is complicated by a reduction in the number of learners entering the

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system, and the resultant decline in the total number of educators required (Harris and Schubert, 2001).

In a study done in the KwaZulu-Natal area of South Africa (Barks-Ruggles, 2001), the researchers found a huge variation in prevalence, and thus in impact. Some schools are hit dramatically, while others remain relatively untouched. The study states that "while with the current data it is near impossible to model the situation in an individual school, examining the average impact on schools, however theoretically invalid, provides an insight into what they are facing" (Barks-Ruggles, 2001:13).

This situation is further compounded by classroom dynamics and educators' interpersonal skills and shortcomings in respect to communicating the HIV/AIDS message (Badcock-Walters, 2000). Capuzzi and Gross (2000) argue, however, that all or most schools have been directly affected by HIV/AIDS. Some have a student who has been diagnosed HIV positive, others have students whose family members or friends have HIV or AIDS. They state that counsellors and professionals need to take the lead in making sure that appropriate HIV/AIDS education is implemented in these schools (Capuzzi and Gross, 2000).

In this set of circumstances, preventing the further transmission of HIV must be the principal strategy. Moreover, ensuring universal basic education will be one of the most powerful weapons in the fight to contain HIV/AIDS (Giese et al., 2003; UNESCO, 2002, Smart, 2003). Other strategies for prevention are discussed later in this chapter. Prevention, however, depends heavily on education (Kelly, 2002). Kelly states four reasons why education "offers a window of hope unlike any others for escaping the grip of HIV/AIDS". These reasons are (Kelly, 2002:2-3):

- It has been shown that education is related to the reduction of prevalence rates in other countries (Uganda and Zambia)
- Education reaches the majority of young people in a country at an early age. Therefore important messages related to HIV/AIDS can reach these children when they are at a receptive age
- Education is a powerful tool in transforming poverty and gender inequality. Universally, the positive relationship between poverty and education is

acknowledged. The education of boys and girls contributes to the evolution within a society of an environment where there is less acceptance of gender inequality and female disempowerment

- Girls who remain in school longer tend to commence sexual activity at a later age, are more likely to require male partners to use condoms and marry at a later age. These factors contribute to the reduction of HIV transmission

Education systems in many countries must go through significant changes if they are to survive the impact of HIV/AIDS and counter its spread, especially in response to the impact on teacher supply and student demand (UNESCO, 2001). Despite the many challenges HIV/AIDS poses to the educational systems, access to primary education is a basic need and right of every child, as defined in the UN Convention on the Rights of the Child (Hepburn, 2001).

The impact of HIV/AIDS on learners requires the education system to respond in a variety of areas. Studies around the world show that although state departments mandate HIV/AIDS education, the implementation is questionable (Dawson, Chunis and Smith, 2001). At present, national school-based support programmes for children in the context of HIV/AIDS and poverty are limited largely to HIV/AIDS Life Skills programmes and the school-based nutrition programme (Giese et al., 2003).

The voices of children and young people themselves are often not heard. The challenge is to work with them in a way that respects their views and gives them the freedom to participate on their own terms (UNAIDS, 1998). Educators are challenged by this statement to investigate the role they play in dealing with the effects of HIV/AIDS in the classroom (Harris and Schubert, 2001). For me, this highlights the importance of investigating how learners experience the programme presented to them in the light of all the above-mentioned effects HIV/AIDS could already have on them as young adults.

Juma (2001) conducted case studies in Kenya and Tanzania on the impact of HIV/AIDS in the classroom. According to him, it is clear from these case studies that learners are well aware of the causes and dangers of HIV/AIDS. They learn of the problem not only in school, but also from a variety of other sources, including the

media. Schools in Kenya and Tanzania are attempting various ways of imparting AIDS education, including specific programmes tailored towards the disease, as well as poems and drama. The question remains, though, whether these programmes will have the intended impact on learners. To establish whether this is the case or not, one needs to investigate learners' experiences of these programmes.

In an open letter to teachers and parents, Small (1995) makes a statement that I can identify with. He states that education should never be an end in itself, but a means to an end. However, this should not deter us from confronting a very real problem, but should rather encourage us to find creative solutions that work. In terms of HIV/AIDS, considerably more time, resources and commitment are needed to instil in children the need for healthy choices for the future.

2.3.1 The importance of HIV/AIDS education

In almost all of the literature that I consulted for this study, researchers and writers repeatedly highlight the importance of HIV/AIDS education, and that a need for such programmes exists. In the HIV/AIDS strategic approach report (UNESCO, 2002) it is made clear that all adolescents have the right to knowledge and understanding of HIV/AIDS issues. These young people need support in making the right behavioural choices that will ensure their protection against HIV infection. Educators must be prepared for the role they have in HIV/AIDS education, and other organisations that can assist should be recruited.

The literature shows that preventative education works. In countries where successful HIV/AIDS programmes have been implemented, infection rates are declining (UNESCO, April 2001). Preventative education has to keep pace with an ever-changing epidemic and hence has to follow interventions and research closely in order to update practice in the field. By investigating the experiences of learners I hope to contribute to the effectiveness of future programmes.

In an article by the Department of Health (1994:14), educational intervention from an early age is justified by the increasing incidence of HIV among young people and

high teenage pregnancy figures: “It is of urgent importance that every child should receive education that will enable them to adopt and maintain healthy behaviour patterns that eliminate the risk of unwanted pregnancies, abuse and sexually transmitted diseases such as AIDS”.

Against this background, it is clear that Sexuality, Life Skills and HIV/AIDS education must be offered to all learners at all learning institutions. Kelly (2002:2) supports this statement by stating “an education system that does not mainstream HIV/AIDS into every facet of its operations runs the risk of being overwhelmed by the epidemic and the variety of its impacts”.

Education is ruled by certain policies that are put in place by Government and implemented by different educational institutions. The policy that governs HIV/AIDS education is the *National Policy on HIV/AIDS* as published in the Government Gazette (1999). This policy addresses different aspects of HIV/AIDS, namely disclosure and confidentiality, constitutional rights of learners and educators, non-discrimination and equality, a safe school environment and, most importantly, education on HIV/AIDS.

With regard to education on HIV/AIDS, the policy is very clear about the fact that a continuing Life Skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and should be integrated in the life-skills programme. This should include information on HIV/AIDS and development of the life skills necessary for the prevention of HIV transmission, learning content and methodology to be used, as well as values that will be imparted.

The National Policy on HIV/AIDS (Government Gazette, 1999) states further that the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the National Policy. A provincial policy on HIV/AIDS, based on the national policy, can serve as a

guideline for governing bodies of institutions when compiling an implementation plan.

Because this study will be conducted in Gauteng Province, I feel it necessary to include the provincial guidelines as stated in Circular 33/2001 of the Gauteng Department of Education (Department of Education, 2001(a)). This circular once again emphasises the belief that "age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners". This should include the following:

- Provide accurate and scientific **information** on HIV/AIDS and develop the life skills necessary for the prevention of HIV transmission
- The content and instructional methodology should be **age-appropriate** and should be offered from an early age (Gr.R – 12) – see also phase policy documents
- Basic **first-aid principles**, including how to deal with bleeding (universal precautions) should be addressed
- Emphasise the role of drugs, sexual abuse, sexually transmitted diseases and violence in the **transmission of HIV**
- Encourage learners and students to make use of health care, counselling and support services (including services relating to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by **community service organisations** and other disciplines
- Teach learners how to behave towards persons with HIV/AIDS, raising awareness on **prejudice and stereotypes** around HIV/AIDS
- Cultivate an enabling environment and culture for **non-discrimination** towards persons with HIV/AIDS, and
- Provide information on **appropriate prevention and avoidance measures**, including abstinence from sexual intercourse and immorality, being faithful to one partner, the use of condoms, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, and the application of universal precautions when working with body fluids

The above-mentioned points would also serve as the **core curriculum** of an HIV/AIDS programme for schools.

With the introduction of outcomes-based education in South African schools, we now think about education somewhat differently. This new approach impacts on the content of the curriculum, the way in which the curriculum is presented and the way in which learners are involved in the learning process. The learning process within this new approach is described in terms of the construction of new knowledge through the process of transformation and self-regulation (Olivier, 1999). Concepts and meanings are dynamic and are constantly reconstructed during life. Learners also construct new meaning from old meanings.

Learning is therefore not simply the taking in of new information as it exists externally, but is the natural, continuous construction and reconstruction of new, richer and more complex and connected meanings by the learner. Learning proceeds in a way that allows us to select what is to be learned and what is not, depending on the compatibility with our own experiences. Learners are naturally drawn to learning things that are related to their own developmental levels, interests and problems.

The GDE recognises that learners play an important role in their own learning process, and it is in the light of this new approach to education that the department has developed its roll-out plan for the implementation of HIV/AIDS education in schools (Department of Education, 2001(a)). This plan is based on the national policy on HIV/AIDS (Government Gazette, 1999) as well as the former minister of education, Prof. Kader Asmal's TIRISANO plan (Department of Education, 2000). Elements of the TIRISANO plan were discussed in the background of this study in Chapter 1, and the reader is referred to this section to note again the importance of Projects 2 and 5 to this study.

It is recommended in Circular 33/2001 that each school establishes its own Health Advisory Committee (as a sub-committee of the School-Based Support Team) to advise the School Governing Body on all life skills and HIV/AIDS-related matters, to develop a school-based policy and to review it on a regular basis (Department of

Education, 2001(a)). As all educators should integrate life skills in a cross-curricular manner, it is recommended in this circular that educators be trained to understand these skills and to incorporate them in their lessons.

Within the guidelines of the national policies, the GDE has between1998 and 2000 trained over 350 master trainers. These master trainers have involved over 500 secondary schools and have trained more than 4500 educators and over 1000 peer educators. Dedicated budgets have been allocated to school governing bodies for the implementation of HIV/AIDS education. Training manuals, videos and posters have been distributed to schools. Learning programmes have been developed and distributed to schools to assist them in compiling their own HIV/AIDS programmes (Department of Education, 2001(a)).

From the policies, circulars and other literature available, it is clear to me that there should be a programme addressing HIV/AIDS education in an outcomes-based fashion in place at every school in Gauteng. These programmes should take cognisance of the important role that educators and learners play in the process of implementation.

I find it interesting that none of these policies or implementation plans refer to the importance of evaluating how the learners experience these programmes, even though the Department of Education recognises that learners play an important role in their own learning. Kelly (2002) stresses that HIV/AIDS education should engage the whole person, going beyond academic, intellectual knowledge and including the spheres of action and behaviour.

It is therefore of vital importance to research the experiences learners have had of HIV/AIDS programmes at their schools. I aim to determine how they have constructed meaning from their learning processes, and how this affects their daily dealing with HIV/AIDS-related issues. Because an HIV/AIDS epidemic is constantly evolving, monitoring its effects provides essential information to guide policy and programme development (Hunter and Williamson, 2000).

2.4 The adolescent and HIV/AIDS

2.4.1 Introduction

As stated, adolescents are the fastest growing group who are at risk of contracting HIV/AIDS (Bhattacharya, Cleland, and Holland, 2000). As the AIDS epidemic spreads, younger and younger individuals are becoming exposed to the risk of HIV infection. Although young people suffer most from HIV/AIDS, the epidemic among the youth remains largely invisible, both to young people themselves and to society as a whole. Young people often carry HIV for years without knowing that they are infected. As a consequence, the epidemic spreads beyond high-risk groups to the broader population of young people, making it even harder to control (Issues in World Health, 2001).

Adolescence is a critical developmental period with long-term implications for the health and wellbeing of the individual and for society as a whole (Call et al., 2002). Adolescence differs in essence from earlier years in the nature of the challenges encountered and in the capacity of the individual to respond effectively to these challenges. Adolescence is the first phase of life requiring, and presumably stimulating, mature patterns of functioning. Conversely, failure to cope effectively with the challenges of adolescence may have negative consequences for subsequent development (Hendry, Shucksmith, Love, and Glendinning, 1993).

A central factor in adolescents' health and wellbeing is their interaction with their environment, with the people and settings in their daily lives. Call, Riedel and Hein (2002) state further that adolescents play an active role in selecting and interacting with the contexts of their immediate environment. They have little or no influence, however, over the macro-societal changes that impact on their health and wellbeing. It is vital to ask how these macro- and micro-contextual changes will influence the opportunities and choices that adolescents have for good health in the future.

Most adolescents enjoy excellent health and wellbeing. Unfortunately, the youth often jeopardise their health by engaging in behaviour with serious short- and long-term consequences such as premature death, significant morbidity, and social problems.

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Such behaviours include tobacco, alcohol and other substance use, sexual risk behaviour that can result in HIV infection, infection by other sexually transmitted diseases, and unintended pregnancy (Collins, Robin and Wooley, 2002). Indeed, many of the threats to adolescents are as much to their emotional wellbeing and mental health as to their physical health (Call et al., 2002).

Health and social scientists view adolescents as an appropriate group for education on the risk of HIV/AIDS and for the introduction of appropriate interventions to prevent the spread of HIV/AIDS among them. Research on HIV-infected populations reveals that those who engage in risky sexual behaviour begin such behaviour in their adolescent years (Selvan, Ross and Kapadia, 2001). It is for this reason that understanding adolescents and their knowledge about their attitudes, beliefs, perceived norms and intended behaviour patterns is important.

The focus of many intervention programmes nationally and globally has been on changing behaviour as a way of reducing "risk" activities which may increase the possibility of HIV infection (Barolsky, 2003). One of the biggest threats to the wellbeing of teenagers is early and unprotected sexual activity (Raffaelli et al., 1996). By the 12th grade, two thirds of girls and three quarters of boys have engaged in sexual activity, often without effective contraception. As a result, more than one million teenage girls become pregnant each year, and sexually active adolescents have the highest sexually transmitted disease rates of all groups.

Coyle, Kirby and Parcel (1999) support these statements by stating that HIV infections, other STDs and unintended pregnancy are serious problems among adolescents in America. Approximately a quarter of all new HIV infections occur among persons between the ages of 13 and 21. The Centre for Disease Control and Prevention (CDC) estimates AIDS-related illnesses as the sixth leading cause of death among 15 to 24-year-olds (Dawson et al., 2001).

In the United States, over half of adolescents report engaging in sexual intercourse by the age of 19, and data suggest that adolescents are not behaving according to the messages they can recite (Alstead et al., 1999). In addition, it is currently estimated

that one in four new HIV infections in the United States occur among people under the age of 20 (Bensley and Bensley, 1997).

Given these disturbing statistics, there is an urgent need to identify factors that promote responsible sexuality among adolescents. One also has to understand this type of behaviour in terms of the experiences of adolescents in order to reach them effectively.

The benefits of HIV and sexuality education are numerous. Preventing HIV infection among youths would help reduce the mounting cost of treatment, providing resources that could help meet other needs of young people. In particular, addressing HIV/AIDS among the youth earlier rather than later could do much to stem the spread of the epidemic. Another reason to focus prevention efforts on the youth is that HIV-positive youth, because they have been recently infected, are highly infectious (Issues in World Health, 2001).

Health education programmes with the goals of influencing sexual risk behaviour among adolescents usually prompt controversy where diverse views on religion, cultural and social values may exist (Buseh, Glass, and McElmurry, 2001). Adolescents are a very important sub-population to target for HIV/AIDS prevention as most children who have not contracted HIV from their mothers are expected to be free of HIV at puberty. Grier and Hodges (2001) agree that although fewer parents are refusing HIV/AIDS education for their learners, controversy stemming from religious beliefs continues, as do confidentiality issues. Another viewpoint held by Bhattacharya, Cleland and Holland (2000) is that although knowledge as gained from educational programmes is a necessary factor, it is not sufficient for preventing adolescents from engaging in risk behaviours.

Successful health education programmes could assist adolescents to remain free of HIV infection and their community could have a cohort of healthy young adults and parents. I want to establish what the experiences of adolescents are regarding these programmes and if, indeed, they could lead them to healthy young adult lives.

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2.4.2 Exploring learners' experiences in terms of adolescent development

Adolescence is typically defined as beginning at puberty, a physiological transformation that gives boys and girls adult bodies and alters how they are perceived and treated by others, as well as how they view themselves (Call et al., 2002). When one takes a closer look at society today and compares it to twenty years ago, it is not difficult to see that children now become "adolescents" at an earlier age. In the twenty-first century, both physical and mental changes take place earlier. Children are sexually "aware" at an earlier age due to their exposure to the media, especially television and the Internet.

"Experience" was conceptualised in the previous chapter as the prime factor in developing one's point of view (WordiQ, 2004). Adolescents face changes at all levels of development, which in turn influence how their point of view is shaped, how knowledge and skill are acquired, and culminating ultimately in what we define as experience. Exploration of learners' experiences thus necessitates a closer look at adolescent development.

Diagram 3 illustrates the different spheres of adolescent development that inform and shape their experiences. This diagram is my own interpretation of literature on adolescent development (Hait, 2003; Huberman, 2002).

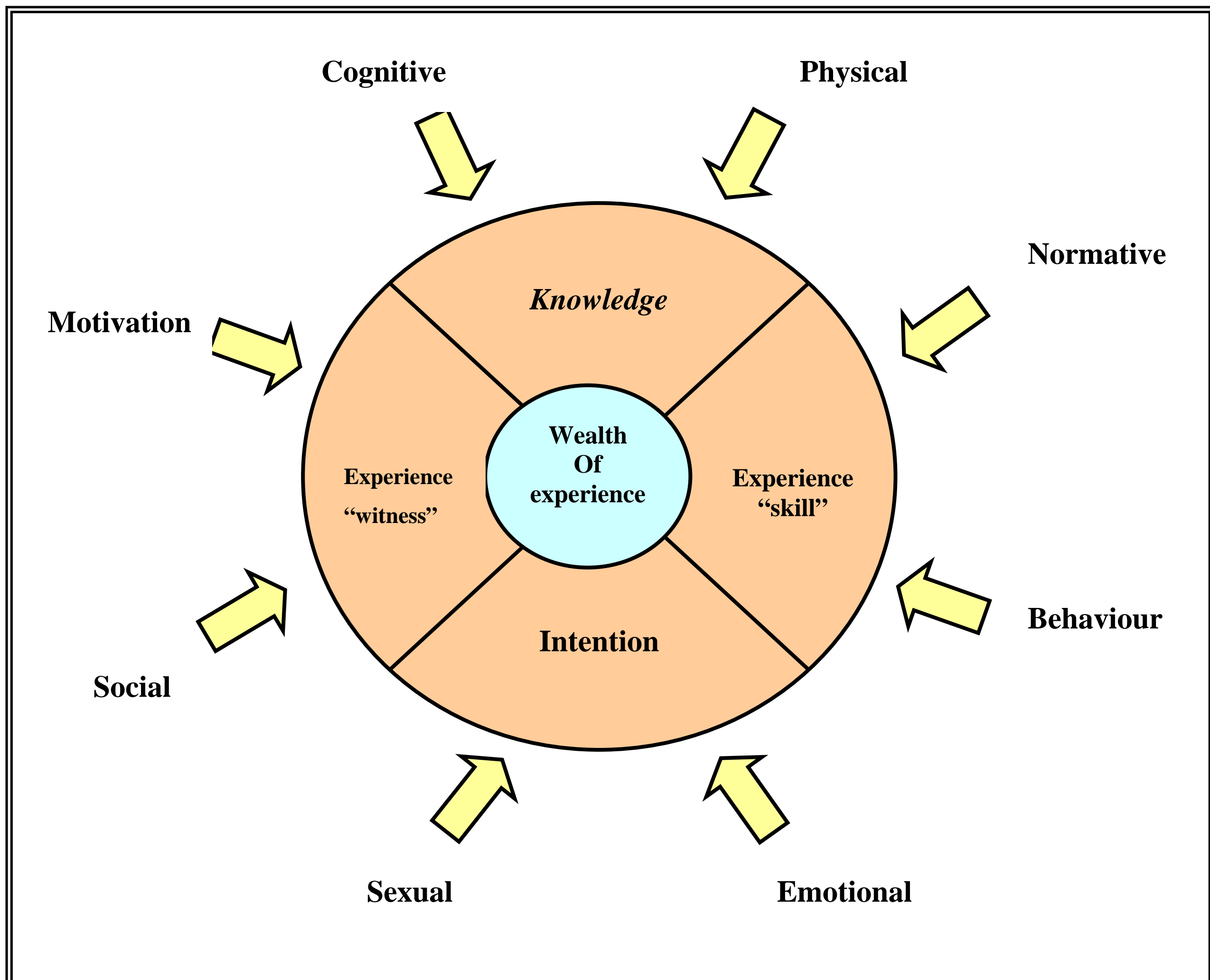

Diagram 3: ***Influence of development on experience***

Physically, adolescents complete puberty and the physical transition from childhood to adulthood. These sudden and rapid physical changes find expression in self-consciousness, sensitivity and consciousness of their own body changes, often compared to the changes in their peers. Biological theories indicate physical changes in boys and girls, and these are supported by psychoanalytical theories, underlining the fact that adolescence is a time of emotional upheaval caused by the sexual conflicts brought on by sexual maturation (Atwater, 1983). Cunningham (1993) holds the same view, and states that the adolescent's body is maturing and taking on an adult appearance. It is a time of self-examination, and the adolescent must decide "who" he or she really is.

As a result, **behavioural** changes may set in, and in some families significant conflict may arise over the adolescent's gestures of rebellion during this phase of development (Hait, 2003; Huberman, 2002). Behaviour links strongly with **motivation**. Edwards (1999) is of the opinion that motivation has to do with what makes people act the way they do. A working definition of motivation, according to Edwards (1999:21), is that "motivation is the collection of accounts of choices, intensities, and feelings of acts". Motivation is thus the label we use for certain aspects of what we do (Edwards, 1999). In terms of learners' experiences in the context of HIV/AIDS programmes, it could be of great value to take cognisance of the role motivation plays in their behaviour.

Motivation also links with what we think. Ideas take form in our heads before we act on them (Edwards, 1999). Adolescents develop advanced reasoning and abstract thinking skills as part of **cognitive development**. Advanced reasoning skills include the ability to think about multiple options and possibilities. Abstract thinking means thinking about things that cannot be seen, heard or touched, for example faith, trust, beliefs and spirituality. Cognitive development thus has a strong influence on, and links with, **social** and **normative** development (Huebner, 2000).

To think about thinking in a process is called metacognition. Ebersöhn (in Ebersöhn and Eloff, 2003) refers to this process as self talk. Adolescents also develop this skill, which allows them to reflect on how they feel and what they are thinking (Huebner, 2000). Cognitively there is a movement towards independence. Adolescents display an increased independent functioning; a firmer and more cohesive sense of identity, examination of inner experiences, ability to think ideas through, increased emotional stability, concern for others and self-reliance (Facts for Families, 2004). If adolescents can think about how they feel and what they are thinking, they should be able to give a detailed account of how they experienced the HIV/AIDS programmes at their schools.

Huebner (2000) holds the view that there are five **psychosocial** issues that adolescents have to deal with. These issues are:

- Establishing an identity
- Establishing autonomy

- Establishing intimacy
- Becoming comfortable with one's sexuality
- Achievement

Briefly, these issues refer to important **social** tasks that adolescents need to master. Over the course of adolescence opinions of influential others (parents and friends) are integrated with their own likes and dislikes. The eventual outcome is adolescents with secure **identities** who have a clear sense of their values and beliefs (Huebner, 2000). Establishing **autonomy** really means becoming an independent and self-governing person within relationships. Autonomous adolescents have gained the ability to make and follow through their own decisions (Huebner, 2000).

Psychosocial theories emphasise the positive role that social influences play during adolescence. This theory is supported by empirical studies that have shown that adolescent development is significantly affected by social influences (Atwater, 1983). As adolescents take key developmental steps, the daily contexts of their lives are vital influences that can hinder or foster the development of health and wellbeing, for example families affected by poverty (Call et al., 2002; Giese et al.,2003). It is thus important to interpret the experiences adolescents have of HIV/AIDS programmes against the social circle of influence in their lives.

Intimacy refers to close relationships in which people are honest, open, caring and trusting. Friendships provide the first setting in which adolescents can practice their **social skills** with those who are their equals. It is with their friends that adolescents learn how to begin, maintain and terminate relationships, practice social skills and become intimate (Huebner, 2000).

Huberman (2002) is of the opinion that adolescents become comfortable with their own **sexuality** in this developmental stage. They understand that they are sexual and should understand the options and consequences of sexual expression. They should also have a clear understanding of pregnancy and HIV as well as the consequences of sexual intercourse. Adolescents also have the capacity to learn about intimate, loving and long-term relationships. This capacity links with their **emotional** development,

being able to understand their own feelings and having the ability to analyse why they feel a certain way (Huberman, 2002).

Sex role and identity forms an integral part of the developmental stage the adolescent is in, and might inform the interpretation of experiences of HIV/AIDS programmes. According to Atwater (1983), sexual identity is an important part of the adolescent's personal identity. Each person's development is influenced by sex roles – the expected behaviour associated with one's biological sex or gender. Maturation and the appearance of secondary sex characteristics lead to greater identification with the appropriate male or female sex role.

Apart from sex roles and identification with the appropriate sex, adolescents' **attitudes** towards sex have been changing with every generation. This part of their development is greatly influenced by the media, and today adolescents talk about sex more openly and freely, and hold more liberal attitudes than in previous generations. They are more inclined to talk about sensitive subjects such as homosexuality, are more accepting of premarital sex and insistent on personal choice in sex. Decisions regarding appropriate sexual behaviour are based more on personal values than on conformity to sexual codes (Atwater, 1983; Cunningham, 1993).

Although adolescents talk about sex more openly and honestly, Cunningham (1993) is of the opinion that their cognitive immaturity limits their ability to make rational decisions about sexuality. Cunningham states that adolescents find it difficult to think through the possible consequences of their actions, while they tend to focus on the immediate situation and not on the implications their actions have for the future. They focus on their immediate needs only, although they are aware of the possible consequences (Huberman, 2002). I hope to establish whether this is in fact the case through researching the experiences learners have of HIV/AIDS programmes.

Normative development refers to morals, values and self-direction (Facts for Families, 2004). Adolescents have a vast capacity for setting goals and show interest in moral reasoning. They have insight and place an increased emphasis on personal dignity and self-esteem. Social and cultural traditions regain some of their previous importance in the eyes of adolescents (Facts for Families, 2004).

Adolescents' developmental stages thus impact on their experience in terms of knowledge, intention (behaviour/attitude) and skill. All these aspects culminate and integrate in the wealth of their experiences, which could serve as a guide in exploring and describing their experiences of the HIV/AIDS programme at their schools.

Hendry, Shucksmith, Love and Glendinning (1993) see adolescence as a **transitional process** rather than a stage. They agree with the theoretical views stated by Atwater and Cunningham in the section above in terms of physiological and emotional development. They are of the opinion that physiological and emotional pressures accompany this development (Hendry et al. 1993). Some of these pressures are internal to the adolescent, while others originate from parents, teachers, peers and the wider society. The interplay between these pressures contributes to the success or failure of the transition from childhood to maturity. I agree with these writers that young people today are under greater pressure emotionally and sexually than they were a generation ago. How they experience this pressure, and where they feel it comes from, are aspects I hope to clarify in my research.

The causes of this transitional period lie primarily in the **social setting** the adolescent finds himself in, and focus on the nature of roles and role conflict, the pressures of social expectations and the relative influence of significant others, such as parents, teachers and peers (Hendry et al. 1993). These causes are also characterised as the personal and social learning tasks of adolescence, and are an aspect of adolescent development that will assist me in understanding and interpreting the experiences learners have of the HIV/AIDS programme presented to them. The following list includes some of these tasks (Hendry et al., 1993:8):

- Achieving new and more mature relations with age mates of both sexes
- Achieving a masculine or feminine social role
- Accepting one's physique and using the body effectively
- Achieving emotional independence from parents
- Preparing for marriage and family life
- Preparing for an economic career

- Acquiring a set of values and an ethical system as a guide to behaviour – developing an ideology
- Desiring and achieving socially responsible behaviour

All of the tasks mentioned above ultimately form and shape the self-concept of the adolescent. His sense of competence and future personal identity depends on how well expectations are accepted and processed into personal lifestyles at this stage of development (Hendry et al., 1993). If these behaviour patterns fit the requirements of roles encountered at school, in heterosexual relationships and in community life generally, then the outcome is satisfactory. Alternatively, if adolescents fail to gain structure in their personal identity, confusion and conflict may result. I believe that their self-concept will thus influence their experience of the HIV/AIDS programme to which they are exposed.

In my study of literature dealing with adolescent development (Atwater, 1983; Cunningham, 1993; Hendry et al., 1993), one aspect that receives ample attention is the role that the **peer group** plays in the lives of adolescents. According to Castrogiovanni (2001), peer groups provide adolescents with the following:

- The opportunity to learn how to interact with others
- Support in defining identity, interests, abilities and personality
- Autonomy without the control of adults and parents
- Opportunities for witnessing the strategies others use to cope with similar problems, and for observing how effective these are
- Instrumental and emotional support
- Building and maintaining friendships

Peer groups appear to have a dynamic role in adolescent development. Being liked, accepted and defining one's role within a social group are important features of life as an adolescent (Hendry et al., 1993). By experiencing the values and norms of the peer group, the adolescent is able to evaluate the perspectives of others, while developing his or her own values and attitudes.

The peer group may act as a sounding board for the adolescent (Cunningham, 1993). Peer groups act as a source of behavioural standards in some contexts, and offer adolescents opportunities both for role-taking and for role-modeling. Within this framework, the adolescent can try out new identities, values and challenges to their self-esteem. It will be of enormous value to my study to determine the influence of the peer group on learners' experiences of HIV/AIDS programmes.

Other aspects that have an influence on how learners experience HIV/AIDS programmes in their particular developmental stage, include the facts that they are a vulnerable group, and that they display risk behaviour in terms of HIV/AIDS. These aspects will now be discussed under the subsequent two headings.

2.4.3 Why adolescents are so vulnerable to HIV/AIDS

The question that is asked in this section is: why does adolescence increase vulnerability to HIV/AIDS? I will investigate various answers that are offered in the literature. One thing that is clear from the discussion of the developmental stages of the adolescent is that this is a period of unpredictable behaviour. Sometimes adolescents lack the judgement that comes with experience and therefore disregard the consequences of their actions (Huberman, 2002).

HIV has a long incubation period and as a result the risks of HIV/AIDS may be particularly hard for adolescents to grasp (Issues in World Health, 2001). Although there are relatively few reported adolescents with full-blown AIDS due to this long incubation period, the mean age of HIV infection has declined steadily over the last decade (Smith, Dane and Archer, 2000). The risky behaviour of adolescents does not have immediate apparent consequences. Children and adolescents have been disproportionately affected by the epidemic. Levels of infection peak in the 15-24 age group, and the impact on families, households and communities is often harder on the young people within them (UNESCO 2002).

Adolescents are particularly vulnerable to HIV/AIDS because of the physical, psychological, social and economic attributes of adolescence (Issues in World Health, 2001). Many adolescents are economically dependent and socially inexperienced,

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have not been taught or have not otherwise learned how to protect themselves from infection, and generally have less access to health care than adults.

Contrary to what some parents may wish to believe, many young people are sexually active from their mid-teenage years. Young people are also prominent among injecting drug users. Ignorance about the disease and lack of means of protection will condemn many of these young people to an early death. Dawson, Chunis and Smith (2001) say the rapid increase in HIV infection among adolescents is not surprising since they typically operate within the framework of a "personal fable" that provides them with a sense of invulnerability. Hait (2003) concurs with this view in stating that another myth of adolescence is that of the "indestructible self", and the feeling that "it will never happen to me, only the other person". This sense of invulnerability may relate to many adolescent risk-taking behaviours such as taking drugs or having unprotected sex.

The rates of teenage pregnancy and sexually transmitted disease (STD) have long indicated that adolescents are a population extremely vulnerable to HIV infection (Murphy, Rotheram-Borus and Reid, 1998). A recent survey among the youth found that one in every three young women in South Africa has had a baby by the time she is 18 years old. But only one in three of these teenagers planned their pregnancies, and half of them were still at school when they conceived (Haffajee, 1996).

Young people have a right to the knowledge and means by which to protect themselves and their partners against infection (UNESCO, 2002). Nevertheless, most young people have only limited knowledge about HIV/AIDS, largely because societies make it difficult for them to obtain information (Issues in World Health, 2001). One can only wonder what the impact of a national strategy on HIV/AIDS education would be. Hopefully the experiences of learners in the HIV/AIDS programmes will shed some light on this issue.

At the same time, social norms and expectations, along with peer opinion, powerfully affect young people's behaviour, often in ways that increase their health risks. Even adolescents knowledgeable about HIV/AIDS may not engage in safer sexual practices because they do not perceive themselves personally at risk of contracting the virus

(Dawson et al., 2001). Many of these adolescents have no audience to discuss the problems they encounter. Neither parents nor friends are available (Morrell, 2003). This makes them more vulnerable to the virus and one cannot emphasise the importance of HIV/AIDS education to this group of teens enough.

One group of adolescents that is especially vulnerable to HIV infection is girls. On a daily basis in schools across the nation, South African girls of every race and economic class encounter sexual violence and harassment that impedes their realisation of the right to education (Human Rights Watch, 2001). Violence against women in South African society generally is widely recognised to have reached levels among the highest in the world. Human Rights Watch (2001:2) found that girls who encountered sexual violence at school "were raped in school toilets, in empty classrooms and hallways, in hostels and dormitories" by both teachers and other learners.

Adolescents will remain vulnerable to HIV infection and AIDS for the foreseeable future, because there is no cure for the virus and no vaccine. A new organisation called SAAVI (South African AIDS Vaccine Initiative) is investigating the possibility of a vaccine against the virus (McKay, 2004). Adolescents are at risk from HIV because they are sexually active, often do not use condoms, may have multiple sex partners, and do not use precautions if they know their partner is safe (Capuzzi and Gross, 2000). As adolescents continue to engage in unprotected sex and to use drugs intravenously, the risk escalates.

2.5 Programmes on HIV/AIDS education

2.5.1 Introduction

One way of reducing the vulnerability of adolescents to HIV/AIDS, and to reduce their at-risk behaviour, is by providing programmes that will educate them. Capuzzi and Gross (2000) believe that we must continue to intervene at the points of crisis and at the same time set in place prevention programmes that will eventually reduce the need for crisis intervention.

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I wish to stress the point that this study is not aimed at investigating the content of prevention programmes, but rather at how learners experience these programmes and the impact these experiences might have on their daily coping with HIV/AIDS issues. As such, the findings of this study might also inform future programme development.

Many leading researchers, organisations and governments stress the importance of HIV/AIDS education programmes. The UNESCO report (2000:25) states that “well implemented HIV/AIDS prevention programmes can reduce risk by delaying the age of first sex, increasing condom use, reducing the number of sexual partners, promoting the early treatment of sexually transmitted infections, promoting access to voluntary and confidential counseling and testing, and reducing other forms of risky behaviour such as drug use, and injecting drug use in particular”. The report states further that the messages of these programmes need to meet local needs, and they need to take cultural differences into account (UNESCO, 2000).

The question remains whether learners experience these programmes in the way that was intended, and if in fact they have the results hoped for by the UNESCO (2000) report. In the light of this I will investigate the research that has been done on programmes at international and national level, and what this research intended to clarify. By doing so, I hope to gain an understanding of the literature and at the same time determine whether the experiences of learners have been researched and the outcome of this research.

2.5.2 Programmes implemented at international level

In my study of the literature on international programmes concerned with HIV/AIDS education and prevention, I came across many studies, some more and some less relevant to the purpose of my study. There are, however, almost no studies on the experiences of learners. I came across only one study, done in Wisconsin, USA (Smith Cox, 2000) that took the experiences of the participants into consideration.

Many studies focus on programme evaluation that target knowledge, attitudes and behaviour in terms of HIV/AIDS. These studies are mainly focused on pre- and post-programme evaluation, to determine how the programme changed or influenced

specific knowledge, attitudes and behaviour regarding HIV/AIDS. They were mainly researched by means of questionnaires. Many studies also focus on sexual behaviour and attitudes towards the use of condoms. I did not include a summary of these studies because I deem them less relevant to my study.

Table 3 provides a summary of the main aspects of nine research studies relevant to my study. In the last column of the table an indication is given whether the experiences of the participants were researched or not.

<u>Table 3</u> ***HIV/AIDS programmes at international level***

Country	Reference	Programme	Aim	Discussion	Experiences
Israel	Slonim-Nevo, 2001	Cognitive behavioural programme (treatment and control group, 12 month period follow up)	To determine the knowledge of, attitudes to, coping skills and behaviour regarding HIV/AIDS among juvenile delinquents, subject a treatment group to the programme and determine the effectiveness of the programme after twelve months.	After 12 months the treatment group had better knowledge, attitudes and coping skills. The findings were optimistic that the programme had a positive effect in that it changed important sexual behaviours.	No
USA: California / Texas	Coyle, Kirby and Parcel, 1999	Safer Choices programme (two-year programme)	A two-year educational programme aimed at improving knowledge re. HIV/AIDS, self-efficacy of condom use, parent-child communication.	Positive increase in knowledge, attitudes, normative beliefs. Increased communication, reduced unprotected sex, increased use of condoms.	No
USA: New Jersey	Lohrmann, Blake and Collins, 2001	School-based HIV prevention education programme	Aimed at determining perceptions and practices of educators, principals and superintendents regarding HIV policy, curriculum and staff development.	I found that this research focused on educators and curriculum development and not on learners. The educators were, however, positive about HIV/AIDS education and developing programmes and policy around it.	No
India	Selvan, Ross and	Study of perceived norms, beliefs and	To study variables influencing intended sexual behaviour and	The outcome of the research only shows significant results in terms	No

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	Kapadia, 2001	intended sexual behaviour	variables responsible for current sexual behavioural patterns.	of female students who show more intention to abstain and keep from having sexual relationships.	
Hungary	Gyarmathy, Thomas and Mikl, 2002	Sexual activity and condom use of adolescents	Determining the knowledge, attitude and behaviour re. HIV/AIDS and assessing risky and preventive behaviour.	Percentages of the sexually active adolescents and condom use among adolescents were determined. They found a correlation between a fear of AIDS and condom use.	No
USA: Rural South	Smith, Dane and Archer, 2000	School-based sexual risk reduction intervention (36-hour peer education training programme)	36-hour peer education training programme with an HIV/AIDS knowledge, attitude and behaviour survey before and after training.	They found increased communication about sexual issues among adolescents after the training. They found it an effective method for improving selected sexual knowledge, attitudes and behaviour among participants.	No
Israel	Ben-Zur, Breznitz, Wardi and Berzon, 2000	Denial of HIV/AIDS and preventive behaviour among Israeli adolescents	To investigate the association between denial and the use of condoms to prevent the spread of HIV.	A strong relation was found between denial and reported frequency of condom use, over and above attitude and anxiety. Denial creates a barrier to information being carried over, and denial is seen as an emotion-focused, avoidant type of coping.	No, but the themes around denial might be of use later in this study. Denial was discussed in terms of: Information Threat Personal relevance Responsibility Urgency.

					Anxiety
Netherlands	Vogels, Brugman and van Zessen, 1999	Aids related knowledge, attitudes and behaviour	Questionnaire to determine the difference in knowledge, attitude and behaviour re. HIV/AIDS between Dutch students and dropouts.	No significant difference was found in the knowledge and attitudes of the two groups. This raised the question of whether school based programmes were effective at all.	No
USA: Wisconsin	Smith Cox, N. 2000	Building the capacity of HIV prevention peer educators (3½ day programme)	Peer education programme to increase the awareness of HIV/AIDS, disseminate information and foster risk reduction behaviour.	Positive influence on knowledge, skills and attitudes. Qualitative responses resulted in the following themes: new understanding and connection among diverse individuals; increased understanding of contextual factors; increased self-awareness and empowerment.	**Yes** From the qualitative responses experiences were validated and participants were supported so they could move beyond feelings of isolation and powerlessness to take action. Positive outcomes were that participants were able to develop trust and give voice to their lived experiences and emotional reactions

From this evaluation of research conducted at international level it is clear that only the study of Smith Cox (2000) has taken the experiences of the participants into consideration. It seems that where a one-on-one intervention was possible, the positive results were greater (Ben-Zur, Breznitz, Wardi & Berzon, 2000; Coyle, Kirby & Parcel, 1999; Smith, Dane & Archer, 2000). This is of significance to my study, as I will have personal contact with the participants, and will not merely work with data as reflected by a questionnaire.

It was interesting, though, to see that most of the programmes had a positive outcome and effect on knowledge, attitudes and behaviour regarding HIV/AIDS issues. This positive outcome was what the programme intended. What I regard as a limitation to these studies was that not one came to a conclusion on whether the knowledge, attitude or behaviour that was positively influenced was actually what the participants wanted to be taught, to be changed or felt necessary to cope in the context of HIV/AIDS.

No opportunity was given for participants to provide input on how the programme matched their specific needs and expectations with regard to HIV/AIDS issues. This is one of the specific issues that I intend to investigate in order to establish how these learners experience the programme presented to them in terms of content and expectation. The assumption I make is that this could positively influence their sense of ownership and participation in the programme, thus probably impacting favourably on behavioural change with regard to HIV/AIDS issues.

One further study I found interesting was the Programs-that-Work study. This study is not a programme evaluation, but rather an explanation of the Programs-that-Work guide. The Centre for Disease Control and Prevention (CDC) started a guide in 1992 covering programmes that reduce health-risk behaviour, called Programs-That-Work (PTW) (Collins, Robin and Wooley, 2002). Initially, eight programmes were identified to reduce sexual risk behaviour and to assist educators in HIV/AIDS education. Every year approximately two programmes are added to the PTW.

These programmes must have produced a significant positive effect to be included in the PTW programme, based on self-report or biological markers, such as: delay of initiation of first sexual intercourse, return to abstinence among those who have already engaged in sexual intercourse, reduced frequency of intercourse, reduced number of sexual partners, increased use of condoms or other contraceptives, and decreased pregnancy or STD rates (Collins et al., 2002).

Collins, Robin and Wooley (2002) state clearly the limitations of this programme. Some programmes are area and context specific, and may not have the same results in other areas with different contexts. Also, more research is needed to understand the processes by which programmes are adopted, implemented and maintained. They conclude the report by saying that much remains to be learned about effective prevention programmes for youth. I hope that an analysis of the experiences learners have of such programmes will assist future development of more effective programmes.

2.5.3 Programmes implemented at national level

In my study of the literature, I came across far more studies done at international level than locally. At national level very few studies have been conducted on the impact of HIV/AIDS education in the formal school sector, and none that I came across focused on the experiences of the participants. I will briefly discuss the studies conducted at national level that have some relevance to my study.

Jameson and Glover (1992) conducted a study on AIDS education in schools in Grahamstown. They investigated AIDS awareness, attitudes and opinions among educators, theology students and health professionals by means of a questionnaire. They evaluated their current awareness, attitudes and opinions, and then submitted these participants to a lecture on AIDS issues. After a period of six weeks participants were asked to complete a similar questionnaire to which a few changes had been made.

In the evaluation of the follow-up questionnaire, there was a marked improvement in factual knowledge about AIDS, which showed the need for awareness programmes. A

positive outcome of this research that has relevance to my study is the question time after the lecture. The participants shared their feelings and experiences, although this did not form part of the formal research project. The researchers felt that these discussions revealed that AIDS education programmes are essential.

Eaton and Flisher (2000) conducted a review of research literature involving HIV/AIDS knowledge of South Africans aged between 14 and 35. They included 34 studies that measured knowledge of the disease. The key finding of this study was that most young people in South Africa have heard of AIDS. The second most important finding was that the youth show highly variable knowledge about the illness itself.

The question that this study does not answer is how the youth experienced the way they obtained this knowledge they have. I want to know whether the knowledge they gained was in fact the knowledge they wanted to gain, and how they felt about the way they came to this knowledge. This is one of the reasons I want to investigate learners' experiences of HIV/AIDS programmes. Do these programmes meet their needs and expectations?

One other study I came across has some relevance to my study. This is a study conducted on adolescents in Swaziland, researching their primary and preferred sources of HIV/AIDS and sexual risk behaviour information (Buseh, Glass and McElmurry, 2002). This study used a questionnaire to determine the sources that adolescents currently get their information from, and also to determine which medium they preferred for future information.

The outcome was that print and broadcast media were the primary sources of information. The adolescents revealed that they preferred health care workers as their main source of information, especially regarding sexual risk information. This is important to my study, because adolescents might reveal through their experiences that they do not want educators to deliver HIV/AIDS programmes. It is to be hoped that my study will shed some light on these issues as well.

From the literature I studied regarding HIV/AIDS studies in South Africa, it became clear to me that most of them highlight the need for HIV/AIDS programmes. There

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are also many existing programmes that are implemented at school level. One aspect that I found these studies did not focus on is the experiences of the learners or participants. I feel that it is important to understand whether the knowledge, attitudes and behaviour that one tries to convey to these adolescents is in fact what they want to hear, and that it is coming from the right person.

The fact remains that adolescents need knowledge about HIV/AIDS. They also need an appropriate attitude towards the disease that will influence their behaviour with regard to HIV/AIDS. It is therefore important to investigate what is done at policy and implementation level to ensure that learners are equipped to deal with HIV/AIDS issues. Therefore, in this chapter I considered the importance of HIV/AIDS education and how policy in South Africa outlines programme delivery to the learners I am investigating in this study.

2.6 Conclusion

In this chapter I consulted a range of articles and books in order to develop a conceptual framework within which I will conduct my research. I investigated the impact HIV/AIDS has on society and the education system. I also attempted to paint a picture of adolescents and to show how vulnerable they are to the epidemic at their age.

One of my main aims in this study is to investigate the experiences adolescent learners have of HIV/AIDS programmes presented to them. I investigated other research done on this subject, nationally and internationally, to determine the value of such a study. I came to the conclusion that “experience” is not an aspect covered in detail by other researchers, and that I might add value to future studies and programmes by investigating this aspect further.

As such, the conceptual framework of my study encompasses the complex field of HIV/AIDS and the impact it has on the adolescent, society and the education system, on the one hand. On the other hand, policies, plans and curricula of the Department of

Education and how these are viewed or envisaged forms the other part of this framework.

I will be investigating adolescents, who are in a transitional period of their sexual development. I have to be sensitive to the fact that they are at a vulnerable stage in their development, and that all spheres of life affected by HIV/AIDS issues influence them. They are subjected to HIV/AIDS education programmes, imposed by the national government on all schools. Within this context I want to investigate how they experience these programmes, and to determine how these experiences might assist in further programme development, in order to make it even more relevant to this special group of young people.

Diagram 2 in this chapter serves as a summary and visual representation of the conceptual framework of this study.

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CHAPTER 3

RESEARCH DESIGN

3.1 Introduction

Combs (1995) uses the analogy of a vehicle in describing the qualitative research process. I will introduce this chapter with a quotation from his article: "Much is said when one travels hopefully; research is no exception to this dictum as we explore roads less travelled and learn how to negotiate one turn at a time. Implicit to this enterprise is understanding what drives our research vehicles" (Combs, 1995:6). This chapter contains the elements that drove my research vehicle.

I selected a qualitative research design and methodology for this study because I did not know what I would find, and because I wanted to capture data on learners' experiences of HIV/AIDS programmes without losing the rich descriptions of their attitudes and feelings and the essence of their experiences (Morse, 1994). This approach allowed learners to express their experiences freely.

In this chapter I will therefore discuss how I went about gathering, analysing and interpreting the data that I needed to fulfil the purpose of my study: the focus of this study is to establish whether an understanding of the experiences of learners would permit insight into their daily dealing with HIV/AIDS and related issues. In the subsequent sections I will discuss the design decisions I made for my study and provide explanations for these decisions.

According to Durrheim (1999), design decisions have four dimensions. Briefly, these dimensions refer to the purpose, context, paradigm and techniques of the research design, as revealed in more detail in Diagram 1 in Chapter 1(p.17). Through reflection on issues relevant to each of these four dimensions, I developed the research design, which links my research question to the execution of my research. This chapter will focus on a discussion of these dimensions.

3.2 Context and setting

The context and setting of this study was discussed in detail in the first and second chapters of this study. This section serves as a summary of the context and setting in order to stay focused on the purpose of this study.

A policy on HIV/AIDS for schools has been produced by the National Department of Education (Government Gazette, 1999). This policy calls on teachers to take action in the struggle against HIV/AIDS, and is supported by documents such as the Education White Paper 6 and the implementation plan for Tirisano. As discussed in the previous chapter, each school is expected to formulate its own HIV/AIDS policy according to the guidelines provided by the Provincial Education Department (Department of Education, 2001(a)).

As a former employee of the Department of Education in the Gauteng Province, I was part of the team that trained teachers in Life Skills and HIV/AIDS education. I am, however, also a registered educational psychologist, which heightens my interest in just how learners experience the HIV/AIDS programmes presented at their schools. From my own experience of visiting schools to determine how the HIV/AIDS programmes were being implemented, I knew before I started with this study that I might find it difficult to find schools that are running accountable programmes.

My suspicions were affirmed when I started searching for schools to take part in my study. The importance of HIV/AIDS education is widely recognised, and yet only 44 of the 107 countries studied included AIDS education in their school curricula (Issues in World Health, 2001). Even more distressing is that in interviews with 277 secondary school principals in South Africa, 60% acknowledged that their learners were at moderate or high risk of HIV/AIDS, but only 18% of these schools offered a full sex education programme (Issues in World Health, 2001).

Fortunately, as the Gauteng Province has many schools, and through the help of some of my former Life Skills facilitators I was able to select three secondary schools that

present HIV/AIDS programmes at different levels, which adds an interesting dimension to this study. The process of selection is discussed later in this chapter.

The context of this study is influenced, however, not only by policy and plans of the Department of Education and my own experience. Parents, the community and the media also influence learners' experiences. HIV/AIDS has a vast impact on society and the education system as discussed in Chapter 2, and I had to take these influences into account while investigating learners' experiences.

This research study is thus set within the ever-changing HIV/AIDS epidemic. I hereby conclude the purpose and context dimensions of the research design. Next I will discuss the dimensions of paradigm and techniques.

3.3 Research Design

Myers (1997) is of the opinion that the motivation for doing qualitative research comes from the observation that if there is one thing that distinguishes humans from the natural world, it is our ability to talk! Qualitative research methods are designed to help researchers like me to understand people and the social and cultural contexts within which they live. I focused in this study on what I could learn from what the learners told me about their experiences of the HIV/AIDS programmes at their schools, and I wondered if an understanding of these experiences would permit any insight into how these learners coped on a daily basis with HIV/AIDS and related issues.

My paradigmatic approach in this study was to work from an **interpretive paradigm**. The interpretive paradigm that I chose to work within was discussed extensively in Chapter 1. In terms of research design, interpretive research designs act as flexible guides to the implementation of the research (Terre Blanche and Kelly, 1999). One of the design types suited for interpretive studies is the case study.

Merriam (1998) believes that case studies in qualitative research have illuminated educational practice for nearly thirty years. As mentioned earlier I followed the definitions and descriptions of the case study provided by Stake (2000) and Merriam

(1998), who uses Stake extensively in her writings on case studies. Both these authors define the case as a single entity, a unit around which there are boundaries. Henning (2004:41) states "a case study as a format for design is thus characterised by the focus on a phenomenon that has identifiable boundaries". In other words, "I can fence in what I am going to study" (Merriam, 1998:27). A school is one example of such a bounded system, and following Merriam (1998), I planned to investigate a certain phenomenon (the experiences of learners of a HIV/AIDS programme) within the boundaries of the case (the school).

More specifically, I conducted an **instrumental case study**, which was used to provide insight into an issue (Stake, 2000). In an instrumental case study, the case plays a supportive role and it facilitates our understanding of something else (Stake, 2000). The cases in question are the three schools that I worked with. Exploring and describing the learners' experiences of HIV/AIDS programmes presented at these schools, and how an understanding of these experiences permitted insight into their daily dealing with HIV/AIDS issues, was the focus in this instrumental case study.

The instrumental case study was thus selected here for what it could reveal regarding the phenomenon in question, knowledge we would not otherwise have access to (Merriam, 1998). Stake (2000) also states that the case (three schools) is selected to advance an understanding of that other interest (the experiences of learners). Tellis (1997) supports this by stating that the case study is an ideal methodology when a holistic, in-depth investigation is needed.

The basic strategy of this design is to describe thoroughly a single unit during a specific period in time. The case study design aims to answer exploratory, descriptive and explanatory research questions. They are intensive investigations of particular individuals (Lindegger, 1999:255) and well suited to my study. I worked with three specific schools, and a selected number of Grade 11 learners at these schools. I presumed that a thorough description of their experiences would enable me to develop insights, ideas and questions for further study (Fouche and De Vos, 1998).

I characterised the instrumental case study as researcher spending extended time on site, personally in contact with activities and operations of the case, reflecting on the

meanings of what was occurring (Stake, 2000). I wanted to explore and describe the experiences of learners, in order to determine how these experiences influenced them, and also because I had an intrinsic interest in that particular aspect of the impact of HIV/AIDS programmes.

The strength of this design lay in its in-depth insights and establishment of a rapport with the participants (Mouton, 2001). As described in the epistemology of this study, I was in an interactional, empathetic relationship with the participants in an attempt to understand and describe their experiences. I therefore had a personal rapport with them that could strengthen this study in terms of trustworthiness.

Although the participants were representative of the majority of learners in South Africa, their experiences were personal, sometimes private and context bound. The educators at the school presented an HIV/AIDS programme according to their understanding of the provincial guidelines and within their own understanding and experience of issues relating to HIV/AIDS. The learners were also influenced by their specific contextual factors that in turn influenced the way in which they experienced the programme.

These contextual factors arouse criticism of case study research. A frequent criticism is that the results of case study research are not widely applicable in real life (Tellis, 1997). It was, however, not one of the goals of this study to produce data that were generalisable, but rather an in-depth investigation of learners' experiences, in order to understand the impact of these experiences.

Case study knowledge resonates with our own experience because it is more vivid, concrete, and sensory than abstract. Case study knowledge is also more contextual, because our experiences are rooted in context (Merriam, 1998). This design approach thus enabled me to enquire and understand the learners' experiences of an HIV/AIDS programme presented at the school within the specific context of the case at hand.

I will consequently discuss the methods I utilised in the execution of this case study.

3.3.1 Data Collection

The case study does not claim any particular methods for data collection or data analysis (Merriam, 1998). Yin in Merriam (1998:29) is of the opinion that "the case study is a design particularly suited to situations in which it is impossible to separate the phenomenon's variables from their context". My aim in collecting data regarding the experiences of learners was to investigate these experiences, and then to try and place them in their relevant context (Lindegger, 1999).

This aim is a large part of what interpretive research is all about. I needed to be able to define and describe the experiences of learners, but also to place these experiences in the context of how they impact on their daily dealing with HIV/AIDS issues.

In this section I will discuss how I collected data in terms of the selection of data sources, selection of cases and the methods of data collection.

3.3.1.1 Selection of Data Sources

According to Schurink (1998), I needed to ask the following questions in order to know which data to collect: which data sources were information rich? How would I get my information? Whom should I talk to? Where must I go? What must I do next? I will use these questions as a guideline in my discussion of the data collection.

To determine which data sources to use, I consulted the categories stated in Mouton (2001). I identified the data sources of **non-participant observation** and **self-reporting.** For the purpose of this study, observation is defined as direct/ non-participant observation by the researcher in a natural setting. Participants self-reported in focus group interviews and self-reporting media (written essays).

The format followed in the data collection process answered the question of how I would obtain my information. I conducted focus group interviews. For the purpose of this study the focus group is defined as a purposive discussion among eight to ten Grade 11 learners from the same school regarding their experiences (Schurink,

Schurink and Poggenpoel, 1998). These discussions were taped with the consent of the participants. The data were thus in audio **format** for focus group interviews. These audiotapes were transcribed into written format. Other media produced by the participants were in written format as well as the notes that I made.

Whom I should talk to was the next question to be answered. The **data coverage** was from a sample of participants. I aimed to select the sample from the group that represents the majority of learners in South African secondary schools. In other words, I selected Grade 11 learners from three secondary schools that have learners who are representative of our country's unique combination of race, language and colour. I limited the sample to learners at three specific secondary schools in one of the districts of the Gauteng Province. This also answered the question of where I should go.

The answer to the question of what I should do next was to negotiate access to the data that I wanted to collect. The learners gave me first hand information regarding their experiences of the HIV/AIDS programme at their schools. Due to the fact that I interviewed minors I negotiated access to the data in accordance with ethical issues. There were no legal implications limiting access to the data. According to the regulations of the Department of Education I obtained oral permission from the Gauteng Department of Education and the principal of the school to work with the learners at that specific school.

The aspects of data collection that I will discuss next in more detail are those of the selection of the participants and the methods that were followed when collecting data.

3.3.1.2 Selection of Cases (sampling)

The aim of this study is to provide rich descriptions of the experiences of learners of HIV/AIDS programmes in order to determine whether an understanding of these experiences would permit insight into the daily dealing of learners with HIV/AIDS-related issues. According to Merriam (1998), there are two levels of sampling in case studies. Firstly, I had to select the "case" to be studied, and then I did sampling within the case to determine the participants. Therefore, due to the aim of this study, I

decided to limit my study to a small number of Grade 11 learners (participants) from three different secondary schools (cases).

In order to determine which schools would form the cases in this study, I had to establish the criteria that would guide my case selection (Merriam, 1998). In my study, the most important criteria were that the schools I selected had HIV/AIDS programmes, that the programmes had been implemented, that there were Grade 11 learners who had been exposed to these programmes, and that the learners would be representative of the diversity of South Africa. These criteria called for a design of **purposeful sampling**.

There are different types of purposeful sampling. According to the types mentioned in Merriam (1998), I utilised **network sampling.** As Patton (1990:182) argues, "this strategy involves identifying cases of interest from people who know people who know what cases are information-rich, that is, good examples for study, good interview subjects". As a former employee of the Gauteng Department of Education I utilised my network of co-facilitators to conduct network sampling.

After consultation with other Life Skills facilitators of one of the districts of the Gauteng Department of Education three secondary schools were identified in that specific district to serve as the cases for this study. These schools had been part of the provincial HIV/AIDS education process, and adhered to my criteria for selection. The learners of these schools were the participants in this study and representative of the majority of learners in South African schools.

These three schools were then approached to volunteer as part of the research process. With the assistance of the school's management, a number of Grade 11 learners who are/were involved in the HIV/AIDS programme at the school were **purposefully** selected as participants in this research project. Naturally, in order to investigate their experiences of such a programme, these selected learners had to be part of the HIV/AIDS programme presented at the school.

I thus followed the technique of purposeful sampling; more specifically, network sampling, because specific schools and learners were selected to take part in the

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research. I selected at least two groups of learners at each of the identified schools, in order to collect enough data to give rich descriptions of their experiences (Durrheim, 1999).

3.3.1.3 Methods of data collection

The purpose in collecting data for this study was to generate enough rich detail embedded within a specific context, to give a description deep enough to answer the research question – How will an understanding of the experiences of learners in an HIV/AIDS programme permit insight into their daily dealing with HIV/AIDS issues?

To answer to this purpose I will discuss the methods of data collection in terms of the mode of observation, data documentation and data capturing.

a) Mode of Observation

I utilised the data sources of non-participant observation and self-reporting mentioned in 3.3.1.1 to understand the experiences of learners as revealed through the research process. One of the data sources was that of **non-participant observation**. I observed the participants while doing fieldwork. The field notes that I made helped me to develop ideas and questions to verify my own understanding of the information gathered during the research process. Henning, Van Rensburg and Smit (2004) define these kinds of field notes as "soft" notes consisting of my experience of the field. These notes therefore included my personal thoughts, feelings and impressions in response to some of the discussions. An example of my field notes is included in **Appendix B**.

Focus group interviews served as the major mode of observation in my study. This mode falls under the data source of **self-reporting**. Focus groups are defined as a research technique that collects data through group interaction on a topic determined by the researcher (Morgan, 1997). My interest in learners' experiences therefore provided the focus, and the data came from the interaction of the groups. "The hallmark of focus groups is their explicit use of group interaction to produce data and

insights that would be less accessible without the interaction in a group" (Morgan, 1997:2).

Focus group interviews assisted me in gaining access to the subjective experience of learners (Kelly, 1999). Unlike other methods of data collection, focus groups created conversational groups that, in turn, facilitated observation-like understandings (Suter, 2000). The main advantage of focus groups was the opportunity to observe a high level of interaction on a topic in a limited period of time based on my ability as researcher to assemble and direct the focus group sessions (Morgan, 1997). Therefore, in this study, my direct observation of how the groups interacted, and the observation of the focus groups combined to create an understanding of learners' experiences.

Focus groups are unique because they provide an environment in which disclosures are encouraged and nurtured. I chose this method of data collection in the hope that it would provide me with insight into the experiences of learners. Morgan (1997) supports this view when he says that focus groups provide direct evidence of similarities and differences in the participants' opinions and experiences. One weakness of focus groups that I kept in mind was the ability of the group to influence the nature of the data it produced (Morgan, 1997).

I started with one school and conducted two focus groups with selected Grade 11 learners. I introduced the topic of discussion to the learners and gave them the opportunity to interact as a group. My role as moderator was to listen for commonalities and differences of opinion, and to get the group to reflect on the extent to which their experiences were homogenous or diverse (Kelly, 1999). Where I felt it necessary to ask further questions to direct the discussion I did so.

Some of the ideas and issues raised in these two sessions were used to further explore the experiences of learners in subsequent sessions with other participants from the other schools. Because I read through the transcriptions of the sessions as I progressed with the research, it was an indication that data analysis and interpretation began at a very early stage in the research. Morgan (1997), however, warns against the researcher's influence on the data. He believes that this is an issue in almost all

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qualitative research, and researchers should attend to this as it could influence the quality of the data.

In order to be mindful of my own influence on the data, I employed the advice of Denzin and Lincoln (2000). They are of the opinion that it is advisable in conducting qualitative research to use the process of crystallisation. They state that in employing this process, the researcher describes the same procedure from different points of view and this might reduce the likelihood of misinterpretation. “Crystals grow, change, alter… Crystals are prisms that reflect externalities and refract within themselves, creating different colours, patterns and arrays, casting off in different directions” (Denzin and Lincoln, 2000: 5).

Richardson introduced the idea of crystallisation in 1994, and Janesick (2000) is in agreement with Richardson, who offers the idea of crystallisation as a better lens through which to view qualitative research designs and their components. “The image of the crystal replaces that of the land surveyor and the triangle” (Janesick, 2000:391). When we view a crystal, what we see depends on how we hold it to the light. As an interpretivist, this meant that I had to view learners’ experiences from various angles to gain a better understanding.

In order to obtain different points of view on the same issue, I decided to include other methods of self-reporting, such as a written activity. While conducting the focus groups I asked the learners of one school to also write an essay on their experiences. As an educational psychologist, I am of the opinion that some people find it more difficult to talk about things than to present them visually. Therefore, I believe it might have benefited the study to include a written activity with some of the participants to verify the themes that emerged from the focus groups. I entered into discussion with the participants who wrote the essays to verify my understanding of what they had created in written format.

b) Data documentation

Data is documented mainly as a historical record for oneself and other possible researchers (Mouton, 2001). Keeping track of my fieldwork as the process unfolded

created this historical record. I used the checklist suggested in Mouton (2001:107) to make sure that key decisions and actions were documented. This list included the following and can be viewed in **Appendix C**:

- Dates of when I gained access to the field
- Dates when the focus groups and interviews were held as well as when a written activity was completed
- Keeping track of the length of focus group discussions and interviews by clearly marking the recordings in terms of date and time
- Keeping a record of all those who participated in the fieldwork
- Keeping track of factors that influenced the fieldwork adversely
- Keeping track of themes as they started emerging by colour coding in transcriptions

In conducting qualitative research within an interpretive paradigm, I relied mainly on my **field notes** as a researcher and on the **recordings** of focus groups and interviews. Terre Blanche and Kelly (1999) suggest that there are essentially two sorts of field notes. Firstly, there are the notes I made to describe as fully as possible what participants did and said. Secondly, I made "soft" notes that were concerned with my unfolding analysis (Henning et al., 2004). I divided each page of my notebook into two columns: a wide one for descriptions and a narrower one for analytic comments. Basic information as stipulated in the list above was also recorded in this notebook for every event described.

Focus groups were recorded. Every tape was dated clearly and transcribed into written format. As noted above, the transcriptions had a spare column where I could document my comments and verify my understanding of the experiences that were revealed during these interviews and discussions. Emergent themes were also colour coded in this spare column for the purpose of analysis and interpretation.

c) Data capturing and editing

In this study the data was in **textual format** in the form of my field notes, transcribed focus group interviews as well as the text that participants created during a written activity. Examples of these can be viewed in **Appendix A**.

I read through the transcriptions repeatedly until I found that I had a clear understanding of what the learners had revealed in terms of their experiences. I made notes in the space provided on the transcriptions of possible categories as they emerged through my reading process. Similar categories were highlighted and clustered to form themes. In this way the data were edited in a meaningful manner, and prepared for the process of analysis.

3.3.2 Data analysis and interpretation

In my study I followed Charmaz's (2000) approach of constructivist grounded theory in the analysis and interpretation of my data. An example of the data analysis is included in **Appendix A**. According to Charmaz, constructivism recognises the mutual creation of knowledge by the researcher and the participants, and aims for an interpretive understanding of participants' experiences. A constructivist approach to grounded theory reaffirms studying people in their natural settings, and a focus on meaning while using grounded theory furthers interpretive understanding (Charmaz, 2000).

In an interpretive study, there is no clear point when data collection stops and analysis begins. Collecting, analysing and interpreting the data coincides as a process that unfolds as the research progresses. I intended to stay close to the data, and interpreted it from a position of empathetic understanding, which is one of the key principles of interpretive analysis (Terre Blanche and Kelly, 1999). Charmaz (2000) supports this view by stating that one of the strategies of constructivist grounded theory is the simultaneous collection and analysis of data.

Analysis and interpretation of the data would provide possible answers to the research question. A central goal of analysis and interpretation, according to Kelly (1999), is the discovery of regular patterns in the data, which in terms of this study are termed as **themes**. Charmaz also believes that grounded theory methods move each step of the analytic process toward the development, refinement and interrelation of concepts (Charmaz, 2000). I acknowledged the sensitivity and subjectivity of my own engagement with the data and guarded against looking for the "correct themes".

3.3.2.1 Method of analysis and interpretation

Different authors cite a variety of methods and "steps" to use in the analysis of collected qualitative data. For the purpose of my study I decided to integrate the views of Charmaz (2000) on constructivist grounded theory, and especially the strategy of coding, with the analytic steps of Terre Blanche and Kelly (1999). These analytic steps are not a fixed recipe to apply to the data, but serve to "unpack some of the processes involved in immersing oneself in and reflecting on the data" (Terre Blanche and Kelly, 1999:140).

I used the steps stipulated by Terre Blanche and Kelly (1999) as the headings for my discussion. Personally, I prefer working within a structured framework and although these steps provide the framework the discussion is integrated. The following diagram illustrates this integration:

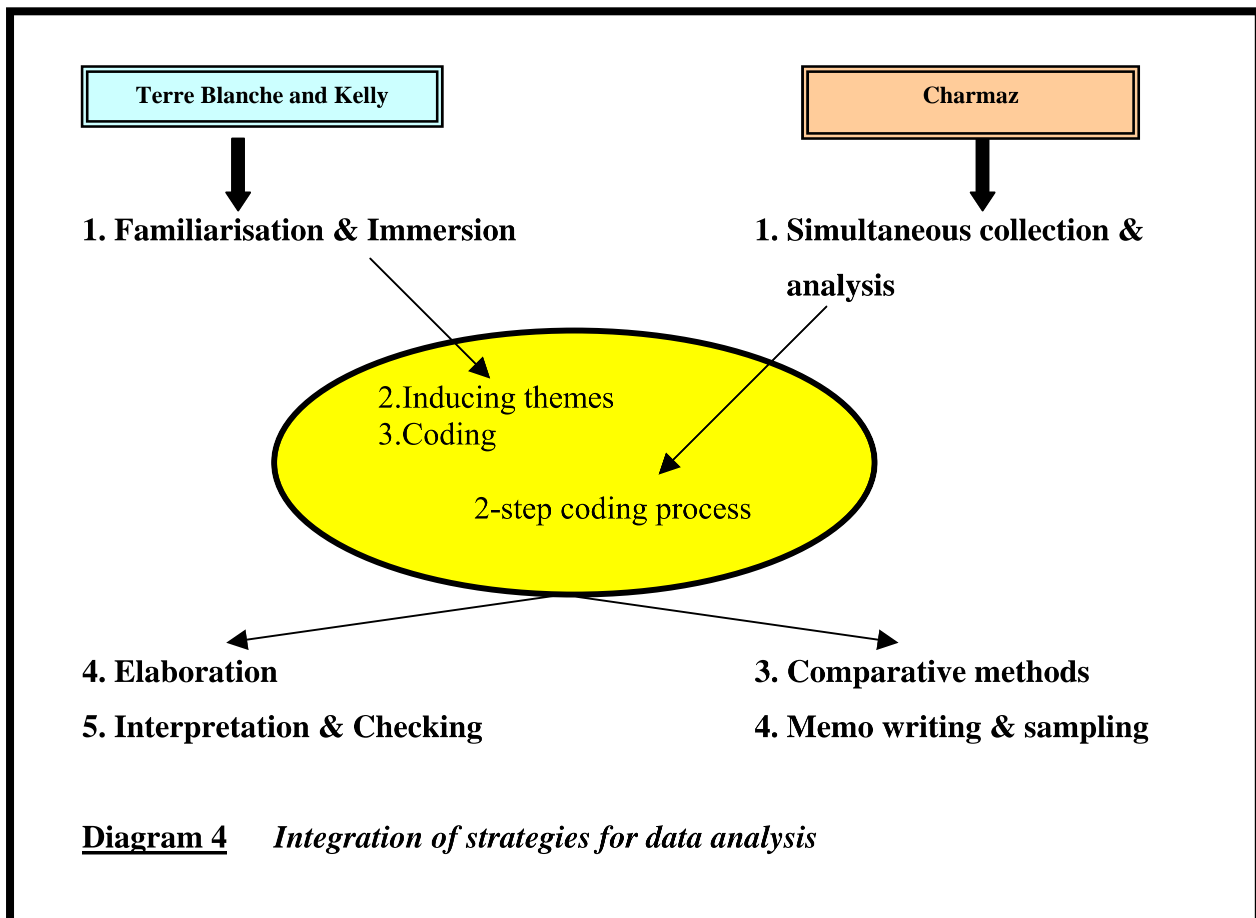

Diagram 4 *Integration of strategies for data analysis*

What I aspired to see as a result of the analysis and interpretation of this study was a compelling account of the experiences of learners; an account close enough to the context so that others who are familiar with the context will recognise it as true, but far enough away to allow them to see these experiences from a new perspective. Hopefully, these experiences will contribute to future curriculum development in terms of relevance to age, experience and needs of learners.

3.3.2.1.1 Data Analysis Steps

Step 1: Familiarisation and immersion

From an interpretive paradigm, data is not collected as a mindless technical exercise. By the time I had collected the data, the process of analysis was well under way and I already had a preliminary understanding of the meaning of my data. Charmaz (2000) also refers to this step as the strategy in constructivist grounded theory of simultaneous collection and analysis of data.

I took all the data that I had collected and immersed myself in it again. I worked with the texts (field notes, transcripts, written work) and read through them numerous times. While reading, I made notes and drew mind maps to ensure that I knew the data well enough to know where I could find certain data and what sort of interpretation was likely to be supported by the data.

Step 2: Inducing themes

As induction denotes inferring general rules or classes from specific instances (Terre Blanche and Kelly, 1999:141), I followed a bottom-up approach to see which categories and themes arose naturally from the data, rather than having prescribed categories and trying to fit the data into these categories. Charmaz (2000) agrees that qualitative researchers should ask questions and follow hunches, but not force data into preconceived categories.

I used the language of the participants in labelling the themes, rather than using abstract theoretical terms. I tried to move beyond merely summarising the content to thinking in terms of processes and tensions that emerged from studying the experiences of learners (Terre Blanche and Kelly, 1999).

Step 3: Coding

For the purpose of my study I define “coding” as “attaching labels to pieces of text”. Charmaz (2000) holds the view that data are narrative constructions, and reconstructions of experience: they do not constitute the original experience itself. Grounded theory analyses of such reconstructions begin with coding the emerging data as it is collected. Henning, Van Rensburg and Smit (2004) state in support that codes are literally made up as the researcher works through the data.

According to Charmaz (2000), I had to interact with my data and pose questions to the data while coding. Coding helped me to gain a new perspective on my material. At this stage of the analysis, I had read through the data and noted those themes that

seemed to transpire naturally. Now I was ready to attach certain labels to the text, or through a process of coding, start to define and categorise the data.

In order to code the data from a constructivist grounded theory perspective, I needed to seek meaning in my data. I had to look for views and values as well as facts, beliefs and ideologies, situations and structures. A constructivist approach further necessitated looking at the data with openness to feeling and experience (Charmaz, 2000).

Some aspects of coding and how I went about coding the data were discussed under data documentation, capturing and editing. As stated earlier, my field notes and the transcripts had a separate column for analysis. In this column I also coded the emergent themes in different coloured pens. By doing this, I broke down the body of the text into smaller meaningful pieces.

These smaller pieces of text, put together, formed clusters that could be analysed. Clustering themes and coding blended into each other, because the themes tended to change in the process of coding as a better understanding of them developed (Terre Blanche and Kelly, 1999). I did not regard codes as final and unchanging, because I realised that a theme might contain other sub-themes and began to analyse those as well.

Step 4: Elaboration

Inducing themes and coding seemed to break the sequence of experiencing the data in a chronological order, because events and remarks that were initially far away from each other were now brought closer together. This gave me the opportunity to compare the pieces that seemed to go together and I could develop further views on the data. This step of exploring the themes more closely is called elaboration (Terre Blanche and Kelly, 1999).

This step also provided the opportunity of revisiting and possibly revising the coding. I kept on coding, elaborating and re-coding until no further significant new insights emerged.

3.3.2.1.2. Data Discussion and Interpretation

Once the outline of the analysis had been constructed, the data were ready to be discussed. This discussion also served as the interpretation of the data. I concentrated on the following aspects in my discussion and interpretation of the data:

- The outline of the analysis served as a mind map or summary of the themes and categories that emerged from the data.
- I made use of examples from the transcripts to illustrate the themes and categories that I identified.
- In my discussion of the themes and categories I utilised excerpts from literature that might support or contradict my findings.

Chapter Four contains this discussion and interpretation in detail. Briefly, a prediction of what could be found in Chapter Four is now discussed in the following and last step of interpretation and checking, as stipulated in Terre Blanche and Kelly (1999).

Step 5: Interpretation and checking

The final step is to put together my interpretation as a written account of the learners' experiences of HIV/AIDS programmes. This involves the synthesis of my data into larger coherent wholes (Mouton, 2001). I used the themes and categories as they emerged to write this interpretation. I discussed my interpretation with other people who know about the topic and some who have no knowledge of it, to consider my interpretation from their fresh perspective as well.

I sought to find examples of other interpretations that confirmed or contradicted some of the points in my interpretation. Mouton (2001:109) calls this relating my results and findings to existing conceptual frameworks or models, and showing whether these are supported or falsified by the new interpretation. I again consulted the literature that I studied to find similarities and contradictions to the results of my study.

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The discussion and interpretation of the data are captured in full detail in Chapter Four, as highlighted previously. Consequently, the findings will then be discussed in the last and fifth chapter. There are, however, aspects of ethics and trustworthiness that needed to be taken into account in the design of the research that I will discuss below.

3.3.3 Ethical Strategies

Qualitative fieldwork could be compared to a journey into a minefield riddled with potential moral and ethical hazards (Schurink, 1998). Ethical concerns should be an integral part of the planning and implementation of research. This is particularly relevant to HIV/AIDS where there could be complexities in terms of stigma and discrimination to consider (Barolsky, 2003). Durrheim and Wassenaar (1999) provide ethical guidelines for research that I will discuss briefly in terms of my study.

c) Ethical Principles

I employed the principle of **autonomy**. By doing so, I respected the independence of all my participants (learners and educators). I addressed issues such as voluntary and informed consent and the freedom of the participants to withdraw from my research at any time. The selected learners were informed of the proceedings before focus groups commenced and they were free to withdraw if they so wished.

I aimed in my research to do no harm to the learners and educators nor to any other person or group. This principle is called the principle of **nonmaleficence**. This required of me to consider potential risks of emotional or social harm that my research could cause participants. If some risk was identified, I made sure that the benefit of my research outweighed this risk; if not, I changed my research strategy to reduce the risk. I was alert during the focus groups to sensitive issues that might have been harmful and diverted the discussion, with the intention that no harm was done.

The third principle to consider was that of **beneficence**. To comply with this principle, my research design had to be such that it would be of benefit to the participants and to other researchers, even if the benefit were indirect. Participants

might have benefited from the focus groups in terms of giving voice to their experiences and sharing with other group members.

d) Ethical Guidelines

i) Consent

I ensured that I gave participants a very clear explanation of what my research entailed in order for them to make a voluntary and informed choice whether to take part in my study. I applied the principle of autonomy here, and even if participants had given voluntary consent, they were still free to withdraw from the research at any time.

Analysis and interpretation of the data were done with the participation, consent and input of the participants. Participants also received feedback with regard to the findings, limitations and recommendations of the study. They would be able to take ownership of the research process and findings.

ii) Confidentiality

I assured the learners of the confidentiality of their participation. They were informed of the nature of the study and the format that the research report would take in terms of the findings. They were also informed of how the data were to be collected, recorded, stored and processed for later release.

The identity of the participants will be concealed and only anonymous quotations will be published. I had taken the decision that where I found a participant in a focus group discussion who wanted to disclose confidential information, I would have a face-to-face interview with that person to adhere to the guideline of confidentiality. It was not necessary to conduct such interviews.

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iii) Competence

To adhere to ethical principles, I had to be competent to conduct the research that I wanted to undertake. HIV/AIDS is a sensitive issue and it might be the case that some of the participants disclosed information of a sensitive nature. As a trained educational psychologist with experience in life skills and HIV/AIDS training I believe that I was competent to deal with sensitive information that might have been disclosed during my research.

iv) Reporting results

I have to take the rights of the learners and educators involved in this study into account when I publish the results of my study. I will protect their identities because their anonymity was guaranteed.

I did not fabricate any data for the purpose of my study and I will point out the limitations in my final chapter. If there are any errors in my publication it will be recognised and publicly acknowledged.

3.3.4 Trustworthiness strategies

I aimed in this study to achieve **credibility** in terms of the themes that were discovered. Participants have verified whether their realities or experiences have been represented with authenticity. The trustworthiness of the study will become more apparent if new ways of thinking are generated by the data. The data need not be generalisable, but should be transferable in the degree to which participants can claim resonance between their own experiences and the researcher's interpretation. **Transferability** was achieved by producing detailed and rich descriptions of contexts. This means that my understanding of the experiences of learners can then be transferred to new contexts of other studies to provide a framework for that research.

Because of the contextual nature of interpretive research, there are usually strong limits on the generalisability of findings (Kelly, 1999). In this study, however, my aim was not to present data that is generalisable. The ability of this study to provide

answers in other contexts lies in the transferability of the findings to other situations. Kelly (1999) stresses that this will only be possible if my study gives an accurate account of the research process and is very clear in terms of the methods I employed. The in-depth description of my research situation and context will assist in determining whether the findings are transferable.

The data are also trustworthy within a naturalistic setting due to its dependability and confirmability. In other words, if the participants were able to confirm that I have given a true account of their experiences. In qualitative research, **trustworthiness** is defined by the degree to which the researcher can produce findings or observations that are believable to herself, to the participants in the study and eventually to the readers of the study (Durrheim, 1999).

The reason for referring to **dependability** rather than reliability in this study is that reliability refers to the degree to which results are repeatable. I did not expect to find the same results repeatedly when investigating experiences of learners and therefore aimed to have dependable findings. Dependability refers to the degree to which the reader is convinced that the findings did indeed occur as I said they did (Durrheim and Wassenaar, 1999).

3.4 The role of the researcher

Throughout the whole research process, the researcher has an important role to play, especially when it comes to data collection (Terre Blanche and Kelly, 1999). Interacting with the learners in their everyday setting was an extension of what we do all the time i.e. interacting with people in their natural settings. Interpretive research might thus seem to come easily and naturally. However, being an interpretive researcher requires special skills such as listening and interpreting: “In interpretive research it is the researcher who is the primary instrument for both collecting and analysing the data” (Terre Blanche and Kelly, 1999:126). My most important role as a researcher was thus to develop very good listening and interpreting skills.

Schurink (1998) further stresses the important role the researcher has in the research process. In order to gain access to the schools to conduct the research, I needed to be

well prepared and able to explain the purpose and methods of the research I intended to undertake. Schurink (1998) also agrees that the researcher is a primary instrument in the research.

The potential bias of the researcher is one of the main sources of error in using the case study design (Mouton, 2001). It is true that I had certain biases and perceptions on two accounts. As a former employee of the Department of Education involved in Life Skills training, I had certain expectations of what I would find in an HIV/AIDS programme at the school in terms of content and application. As an educational psychologist, on the other hand, I might have had certain biases when exploring and describing emergent themes in the experiences of learners. I guarded against these biases by being constantly reflective of what I found, but I realised that I would never be able to remove myself completely. I also reflected on my own role in collecting the data and creating an interpretation, because I could never claim to be completely objective. I was involved in the field at different levels and that made me subjective in many ways. I was, however, mindful of my subjectivity in my interpretation of the data.

I endeavoured to blend in with the setting and to structure my role in such a way as to collect the information required, while at the same time restricting disruption of the flow of events as far as possible. In other words, my role as researcher was that of an outsider, gaining insight into a process that I was not a part of. In this way, the learners might have really opened up to me and shared various experiences they had while taking part in the HIV/AIDS programmes at their school.

3.5 Conclusion

In this chapter I discussed and illustrated the design I followed while conducting my research. The following diagram serves as a summary of the research process:

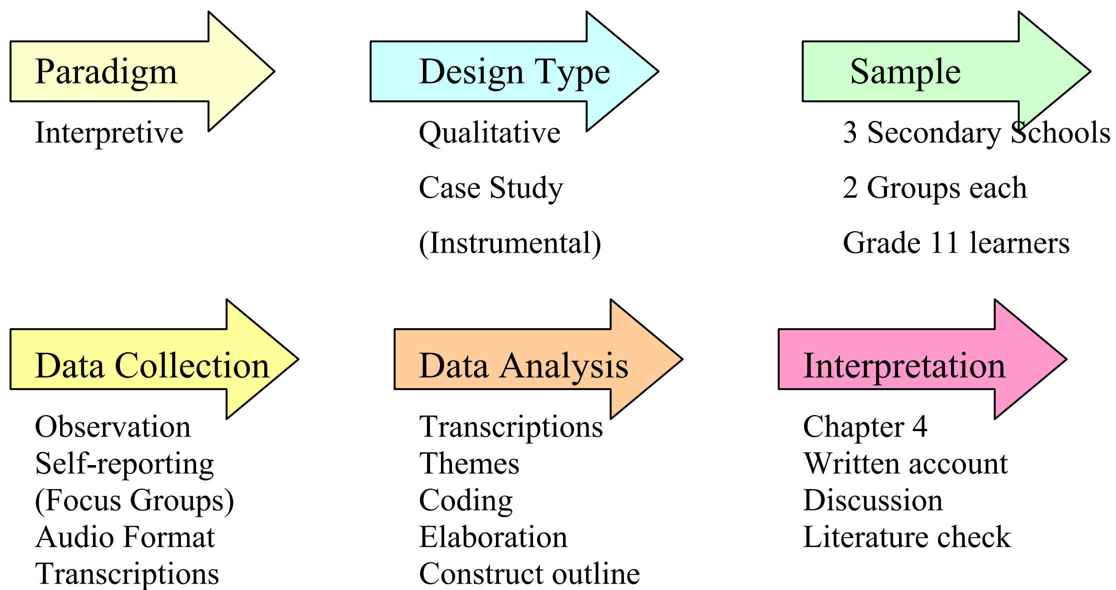

Diagram 5 ***The research process***

I thus conclude this chapter on the research design. I conducted my fieldwork according to this design. The results of my fieldwork are discussed in the following chapter, as well as the analysis and interpretation of the data collected during the research.

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CHAPTER 4

INTERPRETATION OF LEARNERS' EXPERIENCES OF HIV/AIDS PROGRAMMES

4.1 Introduction

In this chapter I discuss the analysis of the data and present the accompanying interpretation. The purpose of this study is to explore and describe how learners experience HIV/AIDS education programmes. These experiences might provide insight into learners' day-to-day dealing with HIV/AIDS-related issues, and could assist in determining the needs these learners have in terms of future HIV/AIDS education programmes. These needs could possibly impact future HIV/AIDS curriculum development.

The context within which the learners' experiences were researched will be discussed and an overview will be given of how the data was collected. Emergent themes and categories will be discussed as they transpired from the focus group data and were interpreted with the aid of excerpts from literature.

4.2 The context within which understandings emerged

In order to investigate learners' experiences of HIV/AIDS programmes, I obtained oral consent from the Department of Education and the principals of the schools involved in the study. The context within which the understandings of these experiences emerged is influenced in more than one way and therefore creates limitations for my study. I will note some of these limitations briefly, as they were discussed in Chapter 1 in broader terms:

- Other than the HIV/AIDS programme the learners were part of, they could have been exposed to other HIV/AIDS information in the media or elsewhere. This might influence the experiences they had in terms of HIV/AIDS, in the

sense that the experience might not have been due to the programme alone, but to an outside source.

- Results obtained from the learners of the three schools involved could not be generalised to all learners in South Africa due to the diversity of learners in terms of their culture, religion, living conditions and social status.
- A possible limitation could be the lack of gender balance in the groups of learners. There were more girls than boys, which may have had an influence on the quality of the responses.
- My description and understanding of the experiences of learners will always be my own interpretation of what they revealed in the focus groups and the possibility of misinterpretation in some cases cannot be ruled out.

The current National Policy on AIDS education (Government Gazette, 1999) and the TIRISANO plan of former Minister of Education Kader Asmal (Department of Education, 2000) serve as the educational framework within which learner's experiences were researched. With regards to education on HIV/AIDS, the policy makes it clear that a continuing life skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and should be integrated in the life-skills programme. This should include information on HIV/AIDS and development of the life skills necessary for the prevention of HIV transmission, learning content and methodology to be used, as well as values that will be imparted (Government Gazette, 1999).

The focus on HIV/AIDS education as stated in the TIRISANO document differs from the traditional sexuality education familiar to many. Programmes on sexuality education and relevant life skills have been in schools for many years, and are a controversial issue in many circles. The specific focus on HIV/AIDS education as a separate programme was introduced in the TIRISANO document. Important to note, is that sexuality education is a component of the HIV/AIDS programme, although it is not treated that way by all schools (Issues in World Health, 2001).

It was difficult to locate schools with accountable HIV/AIDS programmes that adhered to the criteria for selection as stipulated in Chapter 3. The district that I selected to work in has approximately 200 schools, of which 60 are secondary schools, with an average of 400 learners per school. I eventually chose three schools on the basis that they do present HIV/AIDS programmes at some level in their schools. The three schools I selected have built and prefab classrooms and learners have access to learning resources.

Grade 11 learners from these three schools were selected to take part in focus group interviews. HIV/AIDS education is delivered at these three schools in the following manner: (See **Appendix D** for a synoptic overview of the programme content)

School A: One specific educator touches on HIV/AIDS briefly in the school curriculum in the Life Orientation Learning Area for Grade 8 and 9 learners. This urban school, however, has a group of learners who attend classes in HIV/AIDS as an extra-curricular activity, presented by the same educator. They join the group on a voluntary basis, and are also trained to become peer counselors. These voluntary classes are held once a week for the duration of the year (35 sessions of 90min). The learners in this school are from a high socio-economic background.

School B: This rural school does not include HIV/AIDS education in the school curriculum in classroom time. It contracts an outside person to facilitate HIV/AIDS sessions once a week for the duration of one school term, to an entire grade at a time (8 sessions of 2 hours). The presenter is a social worker, privately contracted. The learners in this school are from a low socio-economic background.

School C: HIV/AIDS education is included in the Life Orientation curriculum for [3]Grade 8 and Grade 9 learners only, presented by the same educator for all grades. No other HIV/AIDS programmes are presented to learners

[3] HIV/AIDS outcomes pertain to ⅛ of 35 sessions per annum

in other grades or in other subjects. Occasionally (perhaps once a year) an outside presenter will be contracted to address specific issues related to HIV/AIDS or other areas of concern. The learners in this urban school are from an average socio-economic background.

The information I gathered in this study came mainly from six focus group interviews, two held at each of the three schools mentioned, and from written essays by the learners of School A. The size of each focus group was between ten and 20 learners. A total of 90 Grade 11 learners, aged between 16 and 18, participated in the focus groups. The learners at School A wrote a total of 31 essays and the same learners participated in the focus groups. The following table illustrates the number of learners who participated in the research as well as their language background:

School/Group	Boys	Girls	Language Groups	Total
A1	4	11	English(4), Indian(2), Afrikaans(2), North Sotho(3), Tswana(3), Chinese(1)	15
A2	7	9	English(3), Indian(2), Afrikaans(3), North Sotho(3), Tswana(3), Chinese(2)	16
B1	3	8	Afrikaans(11)	11
B2	6	9	Afrikaans(15)	15
C1	8	8	English(4), Indian(2), Afrikaans(2), North Sotho(5), Tswana(3)	16
C2	7	10	English(3), Indian(3), Afrikaans(4), North Sotho(3), Tswana(4)	17
Total	**35**	**55**	**Diverse**	**90**

Table 4 **Distribution of participants**

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An audiotape recording was made of all the interviews and transcribed verbatim. The transcriptions were compiled per response and numbered according to the number of responses per focus group. Following, an example of how the transcriptions were compiled:

Focus Group A2: F3. I think we never realised what a reality HIV/AIDS is, and it is like (name) said, it's more like it was always far away, and now we realise it is not, it is very real.

M4. Before, just knowing that someone might have AIDS and I wouldn't know it scared me. I realised that even if you have it, it is not that a big thing. You can't get it just like from a cough or something. You get it through actual contact.

A constructivist grounded theory analysis of the data was conducted in the following sequence. First, I read through all the transcriptions and essays, and made notes in the margin of what I thought could be possible categories. I then read through them again and started clustering categories that I thought had emerged most prominently.

The categories that emerged from the transcripts and written essays were then transferred to another page. I colour coded the categories to cluster them into prominent themes. I assembled data material from the transcripts and essays that belong to each category and searched for possible commonalities and contradictions. I thus integrated the transcripts and essays in the process of analysis. See **Appendix A** for an example of the data analysis.

After clustering the categories, six themes emerged, each with its own sub-categories. The data from the focus groups and essays were rich enough to give an in-depth description of learners' experiences and therefore I did not conduct face-to-face interviews. I inferred that the learners were open enough to share in the groups and that this did not necessitate face-to-face interviews. The following diagram illustrates the themes and categories that emerged:

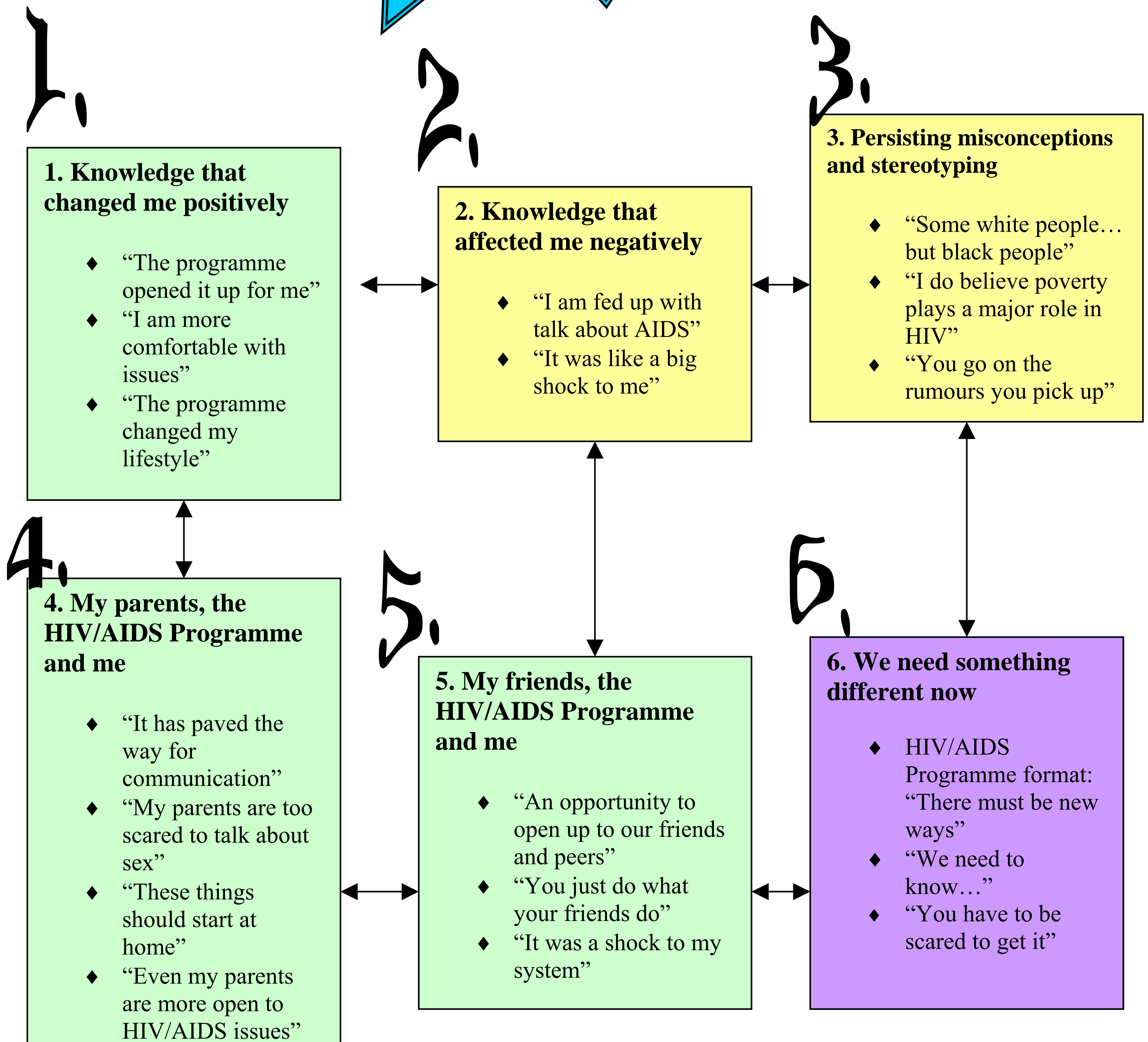

Diagram 6: *Emergent themes from learners' experiences*

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4.3 Discussion of the data

As illustrated in Diagram 6, six prominent themes emerged from the data, each with its own categories. [4]In the following section I will discuss each of these themes and categories and relate these to literature pertaining to these themes.

THEME ONE:

Knowledge that changed me positively

The theme of knowledge and how it has affected the learners is certainly the most prominent and most talked-about experience throughout the focus group interviews. Generally, the learners felt that they had gained knowledge through the programme. The following extracts illustrate the overall experience:

- I know a lot more (response 5, page 1 of transcriptions, M: A)
- I've learnt a lot (response 6, page 2 of transcriptions, F: A)
- I know that I have the knowledge (response 10, page 3 of transcriptions, F: A)
- I have been enlightened with knowledge (response 6, page 15 of transcriptions, F: C)
- I learnt a lot more (response 9, page 15 of transcriptions, F: C)

Many of the programmes studied in the review of literature refer to the importance of the positive increase in knowledge during and after the programme. The studies done in California and Texas (Coyle et al., 1999), Israel (Slonim-Nevo, 2001) and Wisconsin, U.S.A. (Smith Cox, 2000) all reported a positive increase in the knowledge of participants regarding sexuality and HIV/AIDS issues after the HIV/AIDS education programmes.

All the studies mentioned above used closed-question questionnaires in their research. Eaton and Flisher (2000) argue that this kind of method needs re-evaluation because the closed questions might overestimate the knowledge of the participants. They suggest that researchers include some form of open-ended questions in an attempt to

[4] M=Male; F=Female; A,B or C = Which school

establish the participants' understanding of the subject. This suggestion by Eaton and Flisher (2000) underlines one of the positive contributions of my study. I used open-ended statements and questions in open focus group interviews to explore the experiences of the learners and this led to rich detail in terms of their experiences and the impact these experiences had on their daily coping with HIV/ADIS issues.

At this age, adolescents develop advanced reasoning and abstract thinking skills as part of cognitive development. Advanced reasoning skills include the ability to think about multiple options and possibilities (Huebner, 2000). The learners' experiences were thus influenced by the process of "meta-cognition", which allowed them to think about how they felt and what they were thinking about during the HIV/AIDS programme.

Three categories transpired within this theme. I will now discuss these categories, which are:

- "The programme opened it up for me"
- "I am more comfortable with issues"
- "The programme changed my lifestyle"

CATEGORY 1.1

"The programme opened it up for me"

In this category, learners generally experienced that the HIV/AIDS programme opened "things" up for them. These "things" include some of the following aspects: They feel that after the programme they are more confident to talk about HIV/AIDS and related issues. They feel **motivated** to **use the information** and the experiences they have gained to **set an example** for others. In many ways the programme and the knowledge they gained changed and influenced their **attitude** towards HIV/AIDS and people who have the virus.

Thus, the unknown became known through the knowledge and understanding they gained, which in turn gave the learners confidence to share with others. One might suggest that in this respect one of the aims of the HIV/AIDS programme was

achieved, which was to provide accurate and scientific information on HIV/AIDS and to develop the life skills necessary for the prevention of HIV transmission (Department of Education, 2001(a)).

> So it (the programme) really like opened it up for me, to talk about other issues related to AIDS (response 7, page 2, F: A).

> This course has opened my eyes (essays).

> I've learnt so much about it (HIV/AIDS) in this course, which made me very open-minded (essays).

In their responses the learners illustrated how the knowledge they gained **motivated** them to share with others. The following are some of the responses that show how the programme motivated learners to speak openly about HIV/AIDS and what they had learnt in the programme.

> I really think a course like this is a motivation in some way to go out and show people what HIV is actually about. It actually forces you to do it because of what you know (response 19, page 6, F:A).

> People ask you questions and sometimes you have to refer back to the manual, but later you really know the answers to the questions (response 1, page 1,F:A).

> I have started talking about these issues at home and at first it was very difficult, but I just go home every time and tell them what I have learnt, and slowly but surely I think they are getting more of the facts about sex and AIDS (response 8, page 2, M:A).

> I also try to take what I have learnt home to inform my family so that they can also be empowered and be more careful (essays).

To me, these extracts illustrate the power of knowledge. From many of the learners I got the impression that the knowledge they gained empowered them, and they were therefore motivated to use that information. Similar responses are cited in the research of Smith Cox (2000). The participants in his research commented that their experiences were validated and that they were motivated to “move beyond feelings of isolation and powerlessness to take action”.

According to literature on adolescent development, adolescents display an increased independent functioning, a firmer and more cohesive sense of identity, examination of inner experiences and increased emotional stability, to name a few (Facts for Families, 2004). In other words, the more knowledge they gain, the more independent they become. Therefore I inferred that in this study knowledge and information liberated the learners to “act” upon that knowledge.

The learners obtained information, which gave them insight into HIV/AIDS, changed their attitudes and behaviour to such an extent that they felt motivated to share that information and to set an example in order to educate others. Here are a few examples of how the learners intended to **use the knowledge** they had gained.

> I have come to realise that the youth want to know more about AIDS and we want to help, support and advise our communities (essays).

> … I think I started learning more things about it (HIV/AIDS) and I really started wanting to help those with HIV, ja, I want to like spread the word about HIV, so that other people will know what it is (response 9, page 3, F:A).

> I learnt a lot more about the virus, and everything in general. Then from there I am able to transfer the information to other people, and more people can know about the virus and how it works (response 6, page 15, M:A).

These extracts suggest that the knowledge and information these learners gained motivated them to start talking about it to others and to “spread the word” about HIV/AIDS. Thus, their knowledge is translated into motivated action. This fact is also

illustrated by the comment a participant in another research project made, who remarked that "I hope that each day of our lives, there resonates a desire to take an active stand when we detect chaos in someone's life … when our inner voice screams to make a difference" (Smith Cox, 2000:35).

Through the programme the learners thus became more **motivated** to **use the information** they had gained openly. The more knowledge they gained, the less fear and stigma prevailed. They became less frightened of the virus, to the extent that they felt everybody should be tested to determine their HIV status. One group (Group 1, School A) felt that they could **set an example** for others by being open about their HIV status.

> It is good to know your status. I think most of us are getting to a point where we feel it is fine to go for testing … I think we don't mind…
> Personally I think it is one way of setting an example (response 27/28, page 9,F:A).

> Like in my household, my brother just started high school, and I was able to help him understand issues… (response 11, page 4, F:A).

> They (parents) don't have courses to go to, to get the information to give even if they wanted to. So now it is working backwards. We are getting the information and giving it to them (response 16, page 5, M:A).

From these excerpts from the transcriptions it became apparent that learners felt they had enough information and knowledge to **set an example** by what they could share and how their behaviour had changed due to this knowledge. The peer education programme researched by Smith Cox (2000) showed that participants could use their experiences to identify specific action steps to make a difference in their lives, and the lives of others. By changing their own lives, they would set an example for others.

Through the knowledge they gained, an **attitude change** seemed inevitable. Most of the learners responded positively in this regard. They were more positive in their talk

about HIV/AIDS after doing the programme, and more open to supporting those who are HIV positive.

> The programme not only changed my outlook on HIV/AIDS but has also enabled me to change the attitudes of others (essays).

> This programme has really opened my eyes and made it easier for me to talk about AIDS and to talk to people about it (response 12, page 16, F:A).

> Like before this programme I would have said no he is dirty or whatever, but now I'm like, it's OK, he has AIDS. It is not such a big thing anymore. I'm much more open about it (response 16, page 17, F:A).

> This course also made me think differently, that you shouldn't always judge others because of what they do. You should support them (response 49, page 33, translated from Afrikaans, F:B).

Specific changes in attitude are reported by the research of Coyle, Kirby and Parcel (1999). At follow-up the learners in the intervention schools expressed significantly more positive attitudes toward condom use than did learners in comparison schools. No significant difference, however, existed between the learners in the two programmes in their attitude toward sexual intercourse.

Slonim-Nevo (2001) argues that an attitude change and an increase in knowledge is not enough to make a prevention programme effective, that behavioural changes must take place as well. I concur, as my research indicates how the learners' behaviour also changed due to their change in attitude as revealed in the third category of this theme, "The programme changed my lifestyle".

In this category I established that the knowledge that influenced the learners positively made them more open and motivated to talk about what they had learnt, and to set an example by the way their attitude towards HIV/AIDS had changed. Being informed meant they wanted to share their knowledge; they became less

judgemental and more empathetic and wanted to change their behaviour. These changes could probably imply a decrease in stigma and discrimination (Barolsky, 2003). These experiences exemplify that the following outcomes of the Gauteng HIV/AIDS policy were addressed and demonstrated: Providing accurate information on HIV/AIDS, the transmission of HIV/AIDS and raising awareness on prejudice and stereotypes (Department of Education, 2001(a)).

This "openness" to communicate the knowledge the learners gained leads to the next category of being more comfortable with issues, especially where views and perceptions were changed.

CATEGORY 1.2

"I am more comfortable with issues"

The power of knowledge is again illustrated in this category. The fact that the learners gained knowledge through the programme seemed to change their views and perceptions and made them more comfortable with issues surrounding HIV/AIDS. This is demonstrated by a better **understanding and awareness** of the HIV /AIDS virus and also a **decrease in fear, ignorance, misconceptions, stigma and stereotyping**, which will be discussed in this section.

> Well, I think since I started with the HIV programme I am more comfortable with issues. People ask you questions and sometimes you have to refer back to the manual, but later you really know the answers to the questions (response 1, page 1, F:A).

> …it has really changed my views and perceptions about issues. So now I can really tell others about HIV and know that I have the knowledge (response 10, page 3,M:A).

Overall, the level of **awareness and understanding** of HIV/AIDS was raised by the programmes to which learners were exposed. Similarly, Jameson and Glover (1993) reported a marked improvement in the awareness of facts about AIDS in their study. In my study, however, the learners are not only more aware of the danger the disease

holds for themselves, but also more aware of their responsibility to raise awareness amongst others.

> So I think we have to make everyone aware of it (HIV/AIDS), and I think it has really helped in our school, a lot, and personally as well. I have been much enlightened with knowledge, instead of just facts and statistics (response 12, page 4, F:A).

> After we had the classes we became more aware of the issues around it (HIV/AIDS) (response 46, page 26, translated from Afrikaans, F:B).

These extracts link up well with those of setting an example as discussed in Category 1.1. Not only do the learners want to set an example by their changed attitude, but they want to make others aware of HIV/AIDS and the knowledge they have gained as well. Through this understanding they are now also more sensitive to others and the fact that someone close to them might have HIV/AIDS. The study by Smith Cox (2000:35) also reported increased awareness and understanding: "a theme of increased understanding of contextual factors that increase vulnerability to HIV transmission".

> Also other people's situations make you more aware of how close it is to you. Like one girl told me that their domestic worker was actually HIV positive, and you know, questions arise, like what would you do in the same situation (response 24, page 8, F:A).

> The classes that we had definitely made us more aware of the risks and let us think twice about things, like if a person is hurt you wouldn't touch the wound or the blood, but get help for him (response 42, page 38, F:C).

The fact that knowledge can liberate one becomes more evident in the further discussion of this category. The knowledge the learners gained changed their attitude in such a way that they are **no longer scared** of HIV/AIDS or of people who are HIV positive.

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> I am no longer scared of HIV/AIDS and feel that I want to and can go out and help people in my community (essays).

> And it really opened my eyes because I was very scared of it (HIV). I realised that it is not something you catch like a cold, you have to really know about it and tell others about it (response 11, page 4, M:A).

> Before, just knowing that someone might have AIDS and I wouldn't know it, really scared me. I realised that even if you have it, it is not a big thing. You can't get it just like from a cough or something (response 4, page 14, F:A).

> At first we were very scared to hear about it (HIV/AIDS), but now that we know about the risks and dangers and how you get infected, we feel more at ease (response 15, page 23, translated from Afrikaans, M:B).

Jameson and Glover (1993) suggest that fear of AIDS is the result of ignorance and that education would relieve the anxiety caused by having to deal with the unknown. I agree with this suggestion as the participants in my study reported a **decrease in fear** due to the knowledge and information they gained. In contrast, what I do find fascinating is that the learners reported in the last theme that they believe frightening messages might decrease risk behaviour amongst adolescents. I will elaborate further on this finding in the last chapter.

Not only were the learners **less ignorant** with regard to HIV/AIDS after the programme, but they also recognised the ignorance that still exists among their friends, relatives and people in the community. The learners realised that they had many **misconceptions** regarding the spreading of the virus and the knowledge they gained changed their attitudes and encouraged them to think and act differently. Huebner (2000) supports this finding with the opinion that cognitive development has a strong influence on social and normative development. This in turn influences the action adolescents take with regard to issues such as HIV/AIDS.

I knew about all the campaigns for condoms and that, and I thought you would of course use a condom because you don't want to get HIV. But, it opened my eyes to see that not everybody thinks like that (response 10, page 16, M:A).

There are so many people out there that are still so ignorant about the spreading of the virus, and they believe things that are just not true. That is why knowledge is so very important (response 21, page 18, F:A).

Young people live in the illusion that it (contracting HIV) cannot happen to you, because you are so cute and everything… it's not true (response 56, page 27, translated form Afrikaans, F:B).

Some of the misconceptions reported by the learners in my study are also found in the study conducted by Eaton and Flisher (2000). They report similar misconceptions, for example, that blood transfusion is a common HIV transmission route and that hospital blood supplies are contaminated. According to their study, many young people believe that one can be infected with HIV in the process of donating blood.

In one of my focus group interviews (C2), the learners had a debate on this misconception and it became apparent that some learners still believed this, although the others who thought differently convinced them otherwise. This debate is an example that learners not only reported a change in attitude and behaviour, but they actually modeled their changed behaviour in the focus group! Even though this category refers to misconceptions and ignorance, it illustrates the influence peers have on each other, which is discussed in the fifth theme.

With regard to **stigma and stereotyping,** the learners still held different views and perceptions. Generally, they experienced that the programme supported them in removing some of the stigma attached to the virus and assisted them in not simply stereotyping people for they way they looked, dressed or acted. In the focus groups they also expressed different opinions and were not frightened to share their views even if these were different. Here, the social task of establishing autonomy is displayed (Huebner, 2000). Over the course of adolescence, opinions of influential

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others (parents and peers) are integrated with their own opinions. Autonomous adolescents have gained the ability to make and follow through their own decisions (Huebner, 2000).

> I actually disagree with what she is saying, because it is kind of like stigmatising, because we don't really know how she became HIV positive. Let's face it, it might have been her husband who was the one who cheated. So it is actually the stigma that is causing other people to become ignorant. So if you don't learn about these things you end up being a danger to yourself (response 26, page 8, F:A).

> I think it doesn't have anything to do with someone's financial position… People also come from really poor homes, and they are not sleeping around. It's more the people who are stereotyping them (response 34, page 10, F:A).

> Now you see a thin guy in the street and you think he must surely have AIDS. The next thing you know, they are spreading rumors about the guy (response 28, page 45, M:C).

> There is a lot of stigma attached to the virus. We need to learn more about it in education (response 29, page 45, M:C).

> Yes, before we learn the symptoms and that, we need to break down the stigma first. Then we have a clear picture before we start learning about the virus (response 30, page 45, M:C).

> I'd say one of the things that I've experienced is stereotyping. A lot of people don't know about HIV/AIDS so they just have this perception that everyone who has AIDS has slept with 10+ people, that's why he/she has AIDS (essays).

The participants in the study conducted by Smith Cox (2000:34) likewise reported that they could look beyond the stereotyping and stigma after the programme. For example, one participant wrote, "I can be closer as a friend and ally to gay people." Another participant wrote "…we really can come together as human beings regardless

of the labels and stereotypes and make honest connections that we will keep with us for the rest of our lives."

Barolsky (2003) is of the opinion that stigma is one of the key obstacles in communities' ability to care for those infected with HIV. In an interview Barolsky had with members of the Khanya Family Centre one interviewee suggested that there has been a decline in stigmatisation, saying that "it's unfortunate, when we started talking about HIV/AIDS, it was looked at as a sexual sin, who wants to be associated with sin, especially a sexual one, but I think with time, and where we are now regarding HIV in our country … people are now beginning to change their attitudes" (Barolsky, 2003:25).

The learners in my study felt that the knowledge they gained assisted in breaking down the stereotypes and stigma in their minds. Barolsky (2003) correspondingly reports that although stigma is still alive, the depth and extent of that stigma has declined. One outcome of the Gauteng HIV/AIDS policy that was addressed and demonstrated extensively here is teaching learners how to behave towards persons with HIV/AIDS and raising awareness on prejudice and stereotypes around HIV/AIDS (Department of Education, 2001(a)).

Apart from ignorance, stigma and stereotyping, there was not one group that did not raise the issue of **AIDS being a reality** and that learners needed to start dealing with it. There was a general sense of HIV/AIDS coming closer to the learners in their daily lives than it ever had before. To me, the fact that HIV is a reality to the learners made them want to act on it, but also scared them in a sense because it leads to death. Experiences regarding death are further discussed in Theme 2, but relate well to AIDS becoming a **reality** in the contact learners have with people in their families and communities. This experience is in line with adolescent development. As adolescents take key developmental steps, the daily contexts of their lives are vital influences that can hinder or foster their development (Call et al., 2002), Therefore, there is a sense of wanting to act on the knowledge (fostering), but also of being scared of it (hindering).

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> It has made me realise that AIDS is a reality, and that people are dying of it, you know (response 1, page 14, F:A).

> Well, the most interesting to me was when about two weeks ago we watched the videos on like syphilis and the rest of the STDs it really became a reality to me about what it can do to you (response 8, page 2, M:A).

> I think we never realised what a reality HIV/AIDS is, and it is like (name) said, it's more like it was always far away, and now we realise it is not, it is very real (response 3, page 14, F:A).

> People should start realising that it is not nothing, it is real and a reality and people are dying from it (response 58, page 27, translated from Afrikaans, F:B).

> We must all, infected and affected, recognise the realness of this disease, and start doing something because in the end we will lose our loved ones (essays).

Due to the closed-question questionnaire nature of other programmes I found this experience of the reality of HIV/AIDS unique to my study. The learners were able to express themselves verbally and it became clear to me that the reality of HIV/AIDS in our country had really "hit home" in the programmes they attended. I want to propose further that the knowledge they gained and the way this knowledge changed their attitudes might have had an influence on the way they were willing to share their experiences of how HIV/AIDS is becoming a reality in their lives.

CATEGORY 1.3

"The programme changed my lifestyle"

The impact that the programme had on the learners' experiences becomes evident in this category. I have already discussed the impact the HIV/AIDS programme had on the way they feel about HIV/AIDS, how it became visible in their lives and how the programme changed their views, perceptions and attitudes. They also experienced a

change in the way they approach and deal with life as a teenager. These changes are discussed below.

Most of the learners experienced a **change in behaviour**. To some it was a change in how they acted when they went out. To others it was a change in how they behaved towards other people who might have HIV/AIDS. Eaton and Flisher (2000) hold the view that adolescents may be the most open to behavioural change, given that their sexual patterns are not yet ingrained. The following comments by learners illustrate that this view could be supported.

> You know, it (the programme) has changed everything basically. I always just heard about AIDS and it was far from me. Now I know that somebody I know might have AIDS. So in some way it does scare me… I've realised how important it is to stay pure and that (response 7, page 15, F:A).

> It did change my life, because it made me realise that I have to be more careful and I shouldn't do it (sex) unless I know the person very well and trust him, to use a condom or whatever (response 23, page 44, F:C).

> This programme has impacted me in a special way, and I can see that many people's lives have been changed from this course (essays).

> It has changed my behaviour towards myself to protect myself, think twice, take care of myself and love myself (essays).

Earlier I mentioned that Slonim-Nevo (2001) believes that for a prevention programme to be effective, behavioural changes must take place as well. In her study the results also showed that the intervention was effective in changing important sexual behaviours related to HIV/AIDS prevention. In my study, learners reportedly changed more than just their own sexual behaviour. Most of them reported a change in attitude, which resulted in a change in behaviour also towards people who might have HIV/AIDS.

In terms of behaviour, life skills were also developed through the programme, one of these being **decision-making skills**. The learners experienced that the knowledge they gained enlightened them in such a way that they were able to make choices and decisions on that basis.

> I think what is great about this group as well is that we get the information, but we are allowed to make up our own minds. It is not forced on us. We just have the information to make an informed decision (response 47, page 12, F:A).

> We have been educated about AIDS, and I think it is each person's choice how they are going to deal with the information. We have to make that choice in life, nobody can make it for you (response 34, page 46, M:C).

> My behavioural patterns have changed, and I am more cautious about the choices I make (essays).

Small (1995:25) agrees that learners should be able to **make decisions** after being educated in HIV/AIDS. "Sexuality education should be compulsory to ensure that all children are offered the opportunity to make decisions based on accurate information".

Adolescents are faced with many decisions: one of these is whether to engage in sex or not. Most of the groups felt that they were bombarded with knowledge about the virus and how to prevent it from spreading, but one aspect that they would have liked to hear more about was why it was better not to have casual sex. This could indicate that there was an expectation amongst learners that presenters should teach them about **abstinence**.

> We have been emphasising the point that the only way to keep yourself free from this disease is to completely abstain from sex and take safety precautions when handling blood (essays).

> The medical aspects are not all that important. We should learn why it is important not to sleep around (abstain) (response 16, page 29, translated from Afrikaans, F:B).

> Safe sex is mainly abstaining from sex. Safe sex is no sex at all (response 51, page 39, F:C).

> Yes, they should teach us more why it is better not to have sex, not these condom campaigns all the time (response 52, page 39, F:C).

Different views are held by other researchers regarding **abstinence**. In the study conducted by Eaton and Flisher (2000) it was found that 61% and 67% of participants respectively agreed that abstinence protects one from HIV/AIDS infection. These responses were however in closed-question questionnaires. Open questioning more often suggested that few adolescents see abstinence as a way to prevent HIV infection. Another study researched by Eaton and Flisher (2000:117) demonstrated that 82% of the participants were "religious" or "very religious". Of this group of participants, 83% claimed to be sexually abstinent as a result of their religious and moral convictions.

The research conducted by Selvan, Ross and Kapadia (2001) revealed that female learners show more determination to restrain and keep themselves from having sexual relationships. They also conveyed that learners with highly educated parents reported avoiding engaging in sexual activities when they were exposed to such situations.

Abstinence is one aspect that was neglected in the HIV/AIDS programmes to which the learners I interviewed were exposed. The Gauteng HIV/AIDS policy, however, states clearly that it should be included in the core curriculum: "Providing information on appropriate prevention and avoidance measures, **including abstinence** from sexual intercourse and immorality…"(Department of Education, 2001(a)).

One cannot help but wonder why this aspect was not introduced to learners. After studying the developmental stage the adolescent is in, I propose that one reason could

be that presenters might fear being perceived as "preachers" by the adolescent learners. Hait (2003) is of the opinion that it is appropriate during adolescence for learners to have and demonstrate attitudes and behaviour separate from their parents / teachers in establishing their own identity. This often results in gestures of rebellion and significant conflict may arise. Thus, another reason could be that presenters might have excluded abstinence from the HIV/AIDS programmes to possibly prevent the opposite reaction from the adolescent learners.

Another experience that changed some of the learners' lifestyles was what they gained from the programme in terms of **relationships**. It became apparent that they thought differently about relationships and would approach relationships differently in future. This is one of the aspects linked to what the learners would want to be different in HIV/AIDS programmes (Theme 6). They require more knowledge on sexual/intimate relationships with HIV positive people, as discussed under "dating" in the last theme. Relationships and dating are aspects that are usually covered in sexuality education. This experience thus shows that sexuality education has a role to play within HIV/AIDS education.

> Too much time is spent in relationships on the now and the lovemaking, and not enough time is spent on the long term effects of a relationship (response 45, page 12, F:A).

> But after learning a lot I know I can still go on dates, that I won't get HIV from dating and I know more now (response 9, page 15, F:A).

In other literature **abstinence and relationships** are discussed in the same context. Eaton and Flisher (2000) researched 30 programmes conducted on HIV/AIDS in South Africa. One of the most interesting comments made in their research was that only a small proportion of the participants seemed to recognise abstinence as a way to avoid contracting HIV. There seem to be persisting assumptions among these participants about the role of sexual intercourse in "normal" romantic relationships. The researchers state, "It has been widely reported in South Africa that many young

people consider full penetrative intercourse to be an essential and defining feature of dating and relationships" (Eaton & Flisher, 2000:114).

From this I conclude that a reason the learners I interviewed want to know more regarding dating HIV positive people could be that most of them also reported that learners their age are sexually active. This possibly supports the findings of Eaton and Flisher (2000).

However, not all the learners reported the same experience in this regard. A possible reason could relate to their sense of **responsibility**. They felt that they had so much knowledge after the programme that they could not behave irresponsibly anymore, and they had to convince others to be responsible as well. This is contrary to what literature suggests regarding adolescents and responsibility. Cunningham (1993) holds the view that the cognitive immaturity of adolescents limits their ability to make responsible decisions about sexuality and that adolescents find it difficult to think through the possible consequences of their actions.

> And in a way it has really changed my life, because I really want to go out there and help others (response 9, page 3, M:A).

> Sometimes people get so drunk they do things they don't even remember the next day (response 14, page 43, F:C).

> I want to comment on that. Young people are supposed to be responsible, and not drink so much as to not remember what they did (response 15, page 43, M:C).

> We have been taught that in life we should not follow where the path may lead but go instead where there is no path and leave a trail (essays).

Other programmes that have been researched do not show results regarding the experience of responsibility. This topic is, however, cited as a recommendation in the study conducted by Slonim-Nevo (2001). The recommendation is made that a session on life options and future aspirations should be included in the programme to promote

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responsible behaviour: "This topic enables participants to perceive the connection between their own goals and aspirations and to practice safe behaviours. It gives meaning and purpose to the process of changing ones' present lifestyle for the sake of the future and, therefore, increases the likelihood that such changes will actually take place" (Slonim-Nevo, 2001:83).

In summary of this theme I thus conclude that the learners had many positive and life-changing experiences from the knowledge they gained through the HIV/AIDS programmes. They were more open to communication and more motivated to use the information at their disposal. Their attitudes had changed which made them more comfortable with other issues. They realised that HIV/AIDS is a reality in their lives, which made them think twice about their current lifestyles. But, not all the knowledge imparted had a positive outcome. The negative impact some of the knowledge had on the learners is discussed in the subsequent theme.

THEME 2
Knowledge that affected me negatively

Apart from the positive experiences the learners had in terms of knowledge, they also experienced some of the knowledge in a negative way. These experiences were prominent enough to deserve a theme of their own, and there are two categories, namely:

- "I am fed up with talk about AIDS"
- "It was like a big shock to me"

This theme refers mainly to two aspects. On the one hand, the learners felt that they were bombarded with HIV/AIDS prevention information, and on the other hand, some of this information was upsetting and they did not want to hear any more of it. These two aspects constitute the categories of this theme that I will now discuss.

CATEGORY 2.1

“I am fed up with talk about AIDS”

Learners felt that they were repeatedly given the same information and that it was **mostly about HIV/AIDS prevention**. They wanted more than just prevention knowledge and displayed an attitude of “we know about the virus now, but what must we do about it?” Their responses in this regard are discussed in detail under the last theme of “We need something different now”, in terms of the knowledge they want more of.

> We basically learnt the same things like over and over again about HIV/AIDS. They say the same things, don’t use drugs, don’t do this, don’t do that (response 1, page 34, F:C).

> What bothered me still about the classes we had, is that the information was so repeatedly knocked into our heads, that our ears just knocked it right out again. We stopped listening and rather started planning our weekend during or after the class (response 35, page 46, M:C).

> You are used to hearing it, and you just switch off because you are so sick of hearing about it (response 14, page 5, F:A).

This experience of the learners is affirmed by Small (1995:25), who states in his article that learners regard programmes that are focused largely on facts and content as “irrelevant and fundamentally alien to their day-to-day lives”. The question that I want to raise in this regard is that if this comment was made in 1995, why are learners still experiencing sexuality education and HIV/AIDS programmes in the same way? Surely this calls for a review of current practice?

Other research shows that areas of which people have most knowledge are those that are fact driven. These include the fact that HIV is sexually transmitted, and that it is eventually fatal for almost all sufferers (Eaton and Flisher, 2000). It became evident

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from the responses of the learners in my study that they want more than just the facts, as discussed in the last theme.

CATEGORY 2.2

"It was like a big shock to me"

A "shock" is an emotional experience. Theories on emotion state that there are basically four categories of emotions: fear, sadness, anger and joy (Edwards, 1999). For example, shock and worry would be emotions of fear. Grief and pity, on the other hand, would be emotions of sadness. "As we experience a time of anger, deep affection or fear, we know a piece of life that has something different to it" (Edwards, 1999:98). Each emotion has a function. The learners experienced shock as a negative emotion, but the negative impact of the shock could have had a positive outcome in terms of motivation, responsibility, setting and behaviour change in general, which were discussed as part of the positive impact of knowledge.

Some of the learners had negative experiences with regard to the knowledge they received via the programme. It upset them in a way to be stripped of their "safe" views and misconceptions regarding some of the issues concerned with HIV/AIDS. The experiences that they perceived as "upsetting news" are discussed in terms of the emotional shock of realities related to HIV/AIDS such as **death**, **discrimination** and the **impact of poverty**. Only one of these aspects is raised as an outcome of the Gauteng HIV/AIDS policy, namely cultivating an enabling environment and culture of **non-discrimination** towards persons with HIV/AIDS (Department of Education, 2001(a)).

For many learners, **death** was something far removed from their daily lives. Through the programme and the knowledge they gained, the idea of death being an inevitable reality when it comes to HIV/AIDS hit home hard.

> HIV/AIDS training also shocked my system into how serious HIV really is. The videos were disgusting and scary and brilliant at the same time. Those images will live with me forever (essays).

We always just knew that it (HIV) kills you. Now we are more aware of all the other things that accompany it (response 21, page 24, translated from Afrikaans, M:B).

Everybody knows that when you have it you are going to die (response 28, page 24, translated from Afrikaans, F:B).

It is a fact that once you have it you will eventually die (response 3, page 28, translated from Afrikaans, F:B).

Although most learners experienced the idea of death in a negative way, the research of Eaton and Flisher (2000) found that between 80% and 98% of youth already knew that AIDS is fatal. I therefore would like to make the assumption that it is not the fact that a sufferer will die of AIDS that they experienced negatively, but the fact that death had become a tangible reality in their lives. As Barolsky (2003:28) avows in her review, “HIV/AIDS incorporates death and illness into the fabric of daily family life”.

Other information that **shocked** some of the learners was the statistics of infection rates and numbers. It came as a shock to some of them that many of their friends displayed risky behaviour and to learn that other significant people in their lives might be HIV positive. This could be linked to the experience of an increased sense of responsibility among learners, hence the shock in discovering this risky behaviour.

It is shocking to find out how many people have it (HIV/AIDS) (response 13, page 23, translated from Afrikaans, F:B).

Yes, you know, it was someone that worked for us for like ten years, and someone you like put on a pedestal and then you find out they are just like anybody else. Someone that is also young and always telling you what not to do, and then she turns around and does it herself. It was like a big shock to me. You find it difficult to trust people after that (response 25, page 8, F:A).

The positive experience learners had in terms of the reality of AIDS had a negative dimension in the sense that some of the realities shocked them. But this may also be a positive outcome by implication. It could be that learners knew what impact these experiences had on them, and this could be the reason for them asking to be made fearful of HIV/AIDS in Theme 6.

I found the communication of their "shock" distinctive to my study. I believe the learners opened up in such a way in the focus groups that they could relate these experiences to me. I suppose it could be due to the fact that I was an outsider and I did not know them or their family situations personally: they could share openly without being suspected or judged for what they said.

The concept of returning to **morals and values** in education is implicated in this category, and links with the discussion on **relationships and abstinence** in the previous theme. The learners had negative experiences in this regard because they felt that if more attention was given to morals and values, the perceived **decline in society's morals** would perhaps be affected positively. Similarly, the participants in Jameson and Glover's (1993) study favoured talk of and instruction of safe sex and moral issues.

> I don't know the statistics or anything, but I think there is also an issue of moral standings declining, and people are sleeping around, it is just a problem we have (response 17, page 6, M:A).

> I also think it comes back to the moral standing of society today, and should we really sacrifice the rest of our lives for a moment of pleasure (response 32, page 9, F:A).

The issue of permissive societies is elucidated by Barolsky (2003). The symptoms of diluted social principles of societies are described as a "lack of respect for the sanctity of human life; breakdown of parental control of children in families; lack of respect for authority, seen through the brazen breaking of the law and total disregard for rules

and regulations; crime and corruption; abuse of alcohol and drugs; abuse of women and children and other vulnerable members of society, lack of respect for other people and property and a general attitude of self-centredness and not caring about other people" (Zuma, 2002 in Barolsky, 2003:21).

A possible reason for learners experiencing the watered down social principles of societies in a negative way could be that they feel overwhelmed and helpless in the fight against AIDS because there are so many other things "out of place". Learners who experienced the programme in such a positive way that they wanted to make a difference in society could have felt particularly powerless in this regard.

The lack of boundaries for adolescents owing to the watered-down social principles could be another reason for their feelings of frustration and helplessness. Hait (2003) emphasises the importance of boundaries in adolescent development, because boundaries make them feel safe. If they have boundaries they can make informed decisions with the positive knowledge they have gained and be empowered to deal with the "out of place" issues. This could also explain their need for sessions focusing on abstinence and relationships, because inherently they want clear guidelines (boundaries) on what and what not to do.

To the learners who had positive experiences it was upsetting that people are too **scared to disclose** their HIV status in fear of discrimination. This could have had a negative impact on these already positive learners, because they felt helpless if they could not establish who needed their help. With the knowledge they gained the learners wanted to be responsible and make a difference. They wanted to feel useful, but non-disclosure due to discrimination aroused feelings of anger and helplessness in these learners.

> What people talk about, is like the people who have to go to the hospital to be tested. They are scared to go because maybe they live in a small community, and the doctors start talking about them. This one has AIDS, and this one is clean. People are scared of what others are going to think of them if word gets out that they have been tested (response 24, page 44, M:C).

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> Take away the confidentiality part and we can maybe make a difference. It is a reality, let's deal with it. Why should people hide it (response 33, page 46,F:C).

> Many young people live in denial. They think it is OK, I am young and healthy, my friends are OK, why would I get it, I won't get it (response 57, page 27, translated from Afrikaans, M:B).

Barolsky (2003) highlights the fear of being discriminated against due to disclosure. She reports that a survey conducted by the Kaiser Foundation in 2002 established that many people preferred **not to disclose** their HIV status to family members even in the final stages of their sickness due to the **stigma** and **discrimination** attached to the disease. In some families the HIV positive person is ignored and isolated. Barolsky later states that "the exclusion of the person living with HIV is an acknowledgement of their condition, but an acknowledgement which rejects rather than cares for their vulnerability, and is instead an affirmation of their status as diseased or contaminated" (Barolsky, 2003:27).

From their comments, the learners made it clear that they are frustrated by the discrimination attached to the disclosure of one's HIV status. They would like to make a difference if only they could get past the barriers society has erected.

The fact that **poverty plays a role** in HIV/AIDS was also upsetting to some learners. The learners experienced the influence of poverty on the HIV infection rate in a negative way. It made them despondent about their efforts to help others and share the knowledge they had gained. This experience could have the potential to take a positive turn in future programmes, as discussed in the last chapter.

> Some people don't grow up in the supportive structure that we have. Sometimes it is difficult for us, as privileged children to understand how people in the poorer communities cope with it (HIV/AIDS) (response 33, page 10, F:A).

Barolsky (2003) gives a better understanding of how the poorer communities have to cope with HIV/AIDS. Her research shows that an extremely difficult environment is created for the poor by a lack of infrastructure which, when combined with symptoms of HIV, makes it difficult for the ill and those who take care of them. I propose that the complexities of HIV/AIDS and poverty could be fruitful opportunities for creating positive experiences. Exactly what I suggest learners could know in terms of HIV/AIDS and poverty in a HIV/AIDS programme is discussed in the last chapter.

In summary of this theme I can say that the positive experiences influenced learners in such a way that other aspects impacted them negatively, and in future programmes this could be utilised to create positive experiences. After they had been involved in these HIV/AIDS programmes learners wanted more than just information and facts. Their experiences were negative because they were eager to learn more than just the facts. With more than just the facts they might feel less helpless, because they would feel empowered to take action.

On the other hand, their attitudes were changed positively, which implies that they wanted to go out and spread the word and make a difference in their communities. The negative experiences in this regard were that certain knowledge they had gained made them feel helpless and powerless in their quest to make a difference.

Despite the knowledge that the learners gained through the HIV/AIDS programmes there were still persisting misconceptions and stereotyping revealed in the focus groups. These misconceptions that live on in the minds of some of the learners are the topic of discussion in the next theme.

THEME 3
Persisting Misconceptions and Stereotyping

Throughout the focus group interviews it became apparent that despite the HIV/AIDS programme certain perceptions and misconceptions still persist in the minds of these learners, and are maintained within their communities. It seems that although some of the learners were influenced to think differently because of the knowledge they gained

in the programme, others still maintain the status quo. The categories in this theme refer to these persisting misconceptions and stereotypes, and are:

- "Some white people…But black people"
- "I do think poverty plays a major role in HIV"
- "You go on the rumours you pick up"

I would like to highlight that these unchanged perceptions were not general and did not involve all the learners. The communication of misconceptions and stereotypes was more prominent amongst the learners in Schools B and C. I assume that due to the more intensive and ongoing nature of the extra-curricular HIV/AIDS programme at School A these learners may have revealed fewer misconceptions and stereotypes than the learners at the other schools.

These persisting misconceptions were, however, prominent enough to deserve to be discussed as categories, because they might also be prominent in other schools and communities. As these experiences are not stated as outcomes of the Gauteng HIV/AIDS policy they could be considered for inclusion as outcomes in future curriculum planning, as discussed in the last chapter.

CATEGORY 3.1

"Some white people…,But black people"

It was interesting to find that the learners communicated their stereotyping as perceptions that did actually change. They acknowledged that everyone can get HIV/AIDS, but in the discussion **racial lines** were drawn. The next excerpt from the transcriptions clearly shows that there is a misconception regarding HIV/AIDS and race. Instead of viewing all people as vulnerable to contracting the virus, the learner differentiates at length between white and black. As such, race is foregrounded in her HIV/AIDS discussion. Although these learners have come a long way in the new rainbow nation, the prevalence of racial stereotyping is disturbing.

> I think that when we go out there, people are made to believe that only black people "carry" the virus. It's just, they don't say anything but their actions and

the way they talk. That thing is always there. Now some white people will come forward and disclose their HIV status, but black people are just more loud and they will say it like it is. Whereas white people will keep it just between them, it is as though they have such a high standard… With black people it is different because you live so closely together with aunts and uncles and cousins and stuff (response 24, page 19, F:A).

Most of our friends think just black people get it (HIV). They (friends) think they cannot get it (HIV) and they have a big attitude because they can't get the virus (response 48, page 33, translated from Afrikaans, F:B).

The research of Smith Cox (2000) touches on the subject of race. It is suggested by Smith Cox that "to prevent HIV transmission among youth it is particularly important to attend to the social realities that put young people at risk. Cultural factors, including racism and homophobia, compound behavioural factors and increase the vulnerability of sexual minority youth and youth of colour to HIV transmission" (Smith Cox, 2000).

I propose that this issue could be broader than simply a racial issue in HIV/AIDS education. It might also suggest that issues of changing societies, citizenship and democracy in South Africa need to be addressed in HIV/AIDS and related programmes in education. I will discuss this aspect in more depth in the final chapter.

CATEGORY 3.2

"I do think poverty plays a major role in HIV"

There were persisting misconceptions and stereotyping coupled with judgemental stigma with regard to poverty and poorer communities. These involved the stereotype and judgemental attitude that poorer communities are more prone to sexual misconduct and that they do not support the members of their households as they should.

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The learners correctly demonstrated that they still believe there is a **higher rate and possibility of infection** in poorer communities due to poverty and the lack of education.

> It's just that when people don't have a good education, they might start sleeping around to earn some money (response 35, page 10, F:A).

> Yes, but there are other ways of earning money as well, like selling things on the street. But I do think poverty plays a major role in HIV as well (response 36, page 10, M:A).

> In many rural areas people don't know about the disease, and mothers even let their daughters do prostitution to get money for food (response 39, page 37, F:C).

However, the stereotype here is that the learners believe education or the lack thereof, as well as socio-economic status, make a difference in the sexual behaviour of adolescents. There are many adolescents with very good educational backgrounds who engage in sexual risk behaviour, and poverty has no part to play in that. Adolescents from affluent families engage in activities such as alcohol and drug abuse, which increases their vulnerability and risk of HIV/AIDS infection.

Booysen and Summerton (in Biakolo, Mathangwane & Odallo, 2003) illustrate this aspect. According to the authors, poverty does play a role in influencing sexual decision-making. Women may, despite their HIV/AIDS knowledge, engage in unsafe sexual practices for economic or financial gain. But, this is due to financial need, and not the lack of knowledge or education as believed by some of the learners.

I propose that learners be given multiple perspectives on poverty. In this way, they might develop compassion and admiration for those who cope with HIV/AIDS despite their economic situation, versus just having "pity" or judging people based on income level. The learners could thus be informed of the complexities of poverty.

It became apparent that learners also still believe that coming from a poverty-stricken area or home implies that you **do not get any support** from parents or family. This is another value judgement linked to a stereotype that remained in the minds of learners after the HIV/AIDS programme.

> Some people don't grow up in the supportive structure that we have. Sometimes, it is difficult for us as privileged children, to understand how people in the poorer communities cope with it (response 33, page 9, F:A).

> I think that what (name) was trying to imply is that when you come from a secure background, you don't tend to sleep around. Where there is no support, like when your parents constantly hit you or don't talk to you, it is different than coming from a supportive family and a secure family structure where you know what love is. Sometimes you don't know what love is, and then love could equal sex (response 37, page 10, F:A).

In the Kaiser Family Foundation survey, 80% of the participants found their families to be supportive once they were open about their HIV status (Barolsky, 2003). These families were mostly from disadvantaged areas suggesting that the idea that poverty equates non-support is a misconception. Poorer communities may possibly find it more difficult to cope with HIV/AIDS physically for logistical reasons in terms of running water, toilet and washing facilities, but not necessarily socially or emotionally in terms of support (Richter et al., 2004). I suggest that it could be beneficial for learners to be educated in these realities in order for them to understand how HIV/AIDS impacts on care and support of those infected and affected by HIV/AIDS, especially in poorer communities. This suggestion is expanded on in Chapter 5.

CATEGORY 3.3

"You go on the rumours you pick up"

Even after participating in the HIV/AIDS programme some learners only talk and listen to what their peers say and think. The influence of the peer group remains prominent at this age (Hendry et al., 1993). I find it appropriate that one of their needs

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was to learn more about peer pressure. This need is also discussed under the theme of "We need something different now" in terms of the knowledge they want from a HIV/AIDS programme.

> We actually just talk to our friends about it. I wouldn't talk to my parents unless I had to (response 41, page 32, translated from Afrikaans, M:B).
> Yes, you go on the rumors you pick up here and there (response 42, page 32, translated from Afrikaans, M:B).
> Yes, and children talk such nonsense (response 43, page 32, translated from Afrikaans, F:B).

Buseh, Glass and McElmurry (2002) conducted a study on the primary and preferred sources for HIV/AIDS information among adolescents in Swaziland. In their study 42% of the learners indicated that they preferred obtaining information from their peers and siblings, rather than from their parents and family members.

Based on the evidence provided in this theme I propose the following: although learners received ample information and knowledge from the programmes they attended, misconceptions and stereotypes still exist among some of them. A possible reason could be that adolescents are easily influenced and the school is not the only exposure they have to HIV/AIDS issues. The peer group sometimes acts like a magnet that constantly pulls them away from family and encourages behaviour that their parents might not agree with (Capuzzi and Gross, 2000). It is also possible that learners are influenced to think a certain way at home and among friends (Cunningham, 1993). The influence of parents and friends and the part they play in the HIV/AIDS programme is discussed in the subsequent two themes.

THEME 4
My parents, the HIV/AIDS Programme and me

Parents were not directly involved in the HIV/AIDS programme at any of the schools where focus group interviews were conducted. But, we do know from our own experience as parents that they are involved in a way in anything their children do and

learn at school (Stanton, 2001). The learners' sharing of so many experiences regarding their parents exemplifies this and how they communicate with their parents regarding HIV/AIDS and sexuality issues. Therefore, a theme is dedicated to these experiences. The categories that were identified for this theme are:

- "It has paved the way for communication"
- "My parents are too scared to talk about sex"
- "These things should start at home"
- "Even my parents are more open to HIV/AIDS issues"

CATEGORY 4.1

"It has paved the way for communication"

Teenagers often complain that they cannot talk to their parents and that their parents do not understand them (Hait, 2003). The learners in the present study did not really experience it to be any different. Communication with parents remained a persistent problem to most of them. Within this category there were positive and negative experiences. Generally learners experienced that the programme urged them to communicate more with their parents, but the results of this communication varied.

> I think the programme has helped, it has paved the way for communication. If we all know about it, it must help the statistics to come down in future (response 19, page 18, M:A).

Although the learners in this study indicated that their parents were not involved in the HIV/AIDS programmes, Buseh, Glass and McElmurry (2002) report that in response to perceived parental needs, parent-training programmes have been designed in Swaziland to identify strategies for making parent-child communication more effective. The Gauteng HIV/AIDS policy does not make provision in the core curriculum for the involvement of parents in the HIV/AIDS programme (Department of Education, 2001(a)). The possibility of including parents in the school's HIV/AIDS programme is discussed in the last chapter.

The learners' attempts to communicate with their parents resulted in several trends. Learners expressed that they were reluctant to communicate with their parents about HIV/AIDS issues in the event that their parents would be suspicious of their actions. They also did not want to break the **trust** that their parents placed in them.

> Maybe your parents won't trust you anymore when you talk to them about AIDS, or maybe they will think you did something (response 44, page 25, translated from Afrikaans, M:B).

Barolsky (2003:9) holds the view that the stigma attached to HIV/AIDS makes disclosure and communication difficult even within families, because some families still respond in "dramatic and retaliatory ways". For me, this statement supports the concern expressed by learners that the trust their parents had in them might be broken if they communicate about HIV/AIDS issues. Evidently this reaction depends on the **structure and support of the family** nucleus, as discussed below.

Through their experiences the learners voiced their need to communicate more, as well as more effectively with their parents. They also expressed that a **secure family structure** and **support** from your parents and family are important prerequisites for communication.

> Hopefully it will be easier for us to talk to our children than it is for us to talk to our parents (response 60, page 27, translated from Afrikaans, M:B).

> Where there is no support, like when your parents constantly hit you or don't talk to you, it is different than coming from a supportive family and a secure family structure where you know what love is. Sometimes you don't know what love is, and then love could equal sex (response 37, page 10, F:A).

The *Safer Choices Programme* (Coyle et al., 1999) was designed to address school and home environments. It was found that one of the reasons many HIV/AIDS prevention programmes were not more effective could have been that they focused on the individual and did not address environments such as the school or home, which

are likely to contribute to individual behaviours. These researchers are of the opinion that school and family contexts are among the most important forces influencing adolescent risk behaviours.

From what I have learnt from learners' experiences in this study I thus agree with these researchers: these learners have a high regard for supportive family structures. This is linked to their empathy with the perceived absence of support in the context of poverty. More evidence of the importance of family support is found in the AIDS Review (Barolsky, 2003), where 80% of the participants found their families to be supportive once they were open about their HIV status.

In terms of communication with parents regarding the HIV/AIDS programme, learners had **diverse experiences**. Some had positive experiences and others experienced communication in a negative way. Of the more **negative experiences**, learners felt that even after the programme it was difficult to really communicate with their parents and to open up to HIV/AIDS issues. Hait (2003) holds the view that adolescents pull away from their parents in a search for their own identity, which often results in conflict and a breakdown in communication.

> I've learnt so much and it has really helped me to start talking about AIDS, because in my family we don't talk about AIDS and sex at all (response 8, page 2, F:A).

> My mother speaks to me, but she just warns me about the people who do have AIDS. She doesn't explain to me or anything (response 59, page 39, F:C).

Other learners had **positive experiences**, and found that the programme helped them in communicating with their parents.

> I found that through this programme it has made it easier for me to talk about issues, especially sex, especially with my parents. You know, my mom and I never used to talk about sex. Now I can get respect, and educate them in some way (response 16, page 17, F:A).

I always tell my mom what we learnt, and my younger sister, then I feel clever (response 40, page 32, translated from Afrikaans, F:B).

My mother and father are both doctors and we usually have discussions about HIV/AIDS. These discussions are not teaching sessions, but rather sharing of one's ideas (essays).

The *Safer Choices Programme* (Coyle et al., 1999) also increased the extent to which learners communicated with parents on ways to prevent HIV, other STD's, and pregnancy, including abstinence and condom use. By follow-up, intervention learners reported slightly higher levels of communication than did comparison learners.

Barolsky (2003) summarises the difficulty of communicating about HIV/AIDS. The review reveals that HIV and AIDS are forcing individuals and families to find new ways of coping with the epidemic. "It has shown that within families and within relationships talking about HIV/AIDS, personal infection and individual fears is often very difficult and sometimes even unachievable. In the same way that it is sometimes unfeasible to talk about HIV/AIDS within the family, so too is it often not viable for families to talk about HIV/AIDS and how they are coping with the disease within the communities in which they are located" (Barolsky, 2003:70).

This statement regarding the communities where families are located sheds some light on the difference in experiences of the learners regarding communication. The participants in the focus groups were representative in terms of South African diversity. This could be a reason why some of them could communicate positively to their parents and others had negative experiences. The effect of culture on parent-child communication is thus an aspect that could be explored further. Another possible reason for positive or negative communication could be that learners have different personalities; some communicate more easily than others. Also, the programme content of the three schools involved might have been different and could have influenced how they communicated the content to their parents.

CATEGORY 4.2

"My parents are too scared to talk about sex"

Apart from the fact that teenagers expressed that they struggled to communicate with their parents, they also experienced that their parents were ignorant, shy, stubborn or scared to communicate about HIV/AIDS and sexuality issues and that they lacked HIV/AIDS knowledge.

Generally the learners experienced that their parents **did not have enough knowledge** about HIV/AIDS to communicate with them. In some cases, however, this was a positive experience, because the learners felt fortunate to have so much knowledge at their age.

> I think it is very good to get an opportunity at our age to get this kind of training, because many of our parents have not been so fortunate to be informed. It is cool that we have the information at our age and that we can advise other people on AIDS (response 13, page 16, M:A).

> We don't think our parents know a lot about HIV/AIDS. We know more than our parents (response 45, page 26, translated from Afrikaans, M:B).

Other learners experienced that their **parents were ignorant** in more than one way. Firstly, ignorant regarding HIV/AIDS issues and secondly, ignorant about the fact that their children were growing up and that they were no longer the small children they thought them to be.

> I think parents sometimes just don't want to face the fact that their kids are growing up. They have this fixed picture of them in their heads as little girls (response 18, page 6, F:A).

In terms of sexuality education, Buseh, Glass and McElmurry (2002) avow that despite the widespread belief that parents should be the primary source of information about sexuality, in practice they usually are not. According to the experiences of the

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learners I assume that this is due to the fact that most parents do not have adequate HIV/AIDS knowledge to be the primary source of information. Also, as mentioned earlier, adolescents at this age would rather gather information from their friends than from their parents (Capuzzi & Gross, 2000).

Furthermore, the learners experienced that **their parents were shy** to talk about sexuality and HIV/AIDS issues, or that they were just too **stubborn** to talk about it. In my opinion, parents might be perceived in this way due to a lack of knowledge or information. A natural reaction when one does not know what to say is to look or act stubborn or shy, or to avoid the issue completely. Some of the learners also experienced that their parents were **scared** to talk about these issues, with the fear that talking about it might raise the learners' level of interest in the subject and lead them to experiment in this field.

> Everyone should receive the training, but there are letters from parents claiming they don't want their children to get HIV/AIDS training (response 37, page 31, translated from Afrikaans, M:B).

> Those parents must have not as yet taught their children about sex and that, and now they are shy that the children will come and ask them things at home (response 38, page 32, translated from Afrikaans, F:B).

> Our parents, and especially the previous generation are so stubborn, that it is up to us to work from the bottom up (response 29, page 9, M:A).

> Yes, I would like to say that I think most parents are shy to talk about it (HIV/AIDS), but some of them just don't have the information to talk to their children (response 16, page 5, F:A).

> I found that my parents are too scared to talk about sex, because it is like a parent tells a child "don't touch the iron", that child will want to touch it (response 19, page 18, M:A).

But most parents are too embarrassed to talk about things like sex (response 62, page 40, M:C).

Evidence of these aspects could not be found in the literature I consulted. Most questionnaires only focus on whether in fact learners communicate with their parents or not. The learners gave extensive evidence in this category, which leads me to believe that parents might well be too shy, stubborn or scared to communicate about HIV/AIDS. This idea links with Category 6.1 where learners expressed the need for their parents to be involved in the HIV/AIDS programme. It might be that learners think parental involvement might address these communication barriers.

This might also be due to South African society and to traditional views that sexuality and HIV/AIDS are not topics for discussion, the related stigma and discrimination, as well as parents not feeling equipped with enough knowledge and skills to engage with their children on these sensitive issues. Parents might also fear that talking about sex could open a Pandora's Box, leading to their children engaging in sexual activities. The learners revealed, however, that they want their parents to be more involved, which is discussed in the next category.

CATEGORY 4.3

"These things should start at home"

When one examines the literature regarding adolescent development, one would think that the teenagers would welcome less involvement from their parents (Capuzzi & Gross, 2000). In their study Capuzzi and Gross experienced quite the contrary. The learners revealed that they would like their parents to be more involved and to educate them at home regarding HIV/AIDS and sexuality issues. They felt that the limited role their parents played in the HIV/AIDS programme was a negative experience. The involvement of parents is also an aspect that learners voiced as a need in Theme 6.

It would actually be good for parents to also educate their children (response 60, page 40).

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> Yes, these things (HIV/AIDS training) should start from home (response 61, page 40, M:C).

> Also, our parents can tell us what they want, but then just after that you watch television, and you see all the things on it your parents told you not to do. To who do you listen now? (response 56, page 49, F:C).

Evidence of the role parents want to play in HIV/AIDS and sexuality education is found in the study of Buseh, Glass and McElmurry (2002). Their study indicates that parents themselves believe they have an important role in providing HIV/AIDS and sexuality education for their children. "Yet, parents and adult elders were the medium reported least by the participants as their primary source for HIV/AIDS and sexual risk information" (Buseh et al., 2002:534).

Jameson and Glover (1993) found in their study that, despite the limited role parents have in these education programmes, learners welcome the involvement of their parents. Of the respondents in their study, 91% felt that parents should be included in the AIDS programme, either by asking for their consent to teach their children or by discussing the subject with them at Parents' Teachers' Association (PTA) meetings.

CATEGORY 4.4

"Even my parents are more open to HIV/AIDS issues"

It was not only the learners' attitudes that changed with the HIV/AIDS programme, but also the attitudes of some of the parents. Learners found that where their parents were negative at the start of the programme, they became more positive and supportive as the programme progressed. Although parents were not interviewed in this study, it might be that they also feel the need to be empowered with knowledge regarding HIV/AIDS.

> Basically, when I started with this training I spoke to my parents and they were not very happy for me to do it. But, after I started the course and explained to them what it is about HIV that we are learning, they started understanding and

> were more supportive. And now, whenever they ask me about HIV stuff, I can understand and answer their questions (response 4, page 1, F:A).

> My mom is a nurse, although she is not one that is very open to talk about issues and AIDS. And my dad also was not very happy for me to take part in this programme. But it has really changed my views and perceptions about issues. So now I can really tell others about HIV and know that I have the knowledge (response 10, page 3, F:A).

> I think I also pretty much realised when I started with the programme that AIDS and HIV was a topic that is not really discussed in our household. And it really opened my eyes, because I was very scared of it… Like in my household, my brother just started high school, and I was able to help him understand issues, and even my parents are more open to talk about it, which is really great (response 11, page 3-4, M:A).

I found this experience to be unique to my study. The learners opened up in the discussion. They could really voice their opinions and feelings openly, and I found it was easy for them to talk about their parents and their relationship with them. Another reason could be that I do not know their parents, and will probably never meet them. Therefore the learners could have had more courage to discuss their relationship with their parents openly. There was a sense of trust because of the anonymity.

In summary, this theme could indicate that learners have a longing to communicate with their parents on HIV/AIDS issues. They would like their parents to be more involved in the HIV/AIDS programmes they are exposed to improve communication about the content and issues of the programme. The learners experienced a desire to be able to talk about anything with their parents, without losing respect or breaking the trust their parents have in them as adolescents.

The question I want to pose with regard to this theme is: what about orphans who are without parents or have non-traditional caregivers? Statistics reveal that by 2005, South Africa alone will have more than 800 000 AIDS orphans (Call et al., 2002). In

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Chapter 5 I will explore how HIV/AIDS programmes could address the need expressed by adolescent learners to include their caregivers in the process.

THEME 5
My friends, the HIV/AIDS Programme and me

The HIV/AIDS programmes learners were exposed to engaged them as groups, which meant that they had to share with fellow learners and experience the programme together. In the focus groups they shared how they related to their friends during the programme and in general to their peers. Here, too, as with their parents, the learners had positive and negative experiences. These experiences are discussed in the following categories:

- "An opportunity to open up to our friends and peers"
- "You just do what your friends do"
- "It was a shock to my system"

CATEGORY 5.1
"An opportunity to open up to our friends and peers"

The learners experienced that they could always count on the support of their friends. This section refers to the positive communication amongst peers and the need to form groups to go out and educate others on HIV/AIDS issues.

Learners experienced that they **related better** to each other because they are the same age. Pramschufer (2001) agrees that adolescents spend an enormous deal of time together because they understand one another and share similar beliefs and interests. Generally, they experienced that the programme assisted them in **communicating better** with their friends.

They experienced that they could open up to their friends and discuss issues that they would not have discussed prior to the programme. During adolescence peers could replace adults / parents by providing emotional support for their friends until they

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achieve more autonomy (Pramschufer, 2001). Adolescents spend most of their time in their peer groups (Castrogiovanni, 2001). Therefore, the group format is one of the strengths of the HIV/AIDS programme and should be built upon.

> I think they (adolescents) find it more comfortable to speak to young people of their own age that can relate to the same problems and face the same temptations as opposed to their parents… I think it is important to educate the youth, because sometimes it is better for them to spread the word (response 17, page 6, F:A).

> It has also given us an opportunity to open up to our friends and peers to talk about AIDS (response 18, page 18, M:A).

> We actually just talk to our friends about it (HIV/AIDS) (response 41, page 32, translated from Afrikaans, M:B).

> Out of what I've learnt, I have been able to talk to my peers and they actually listen because they never wanted to hear all this from family members (essays).

Other studies also refer to positive communication among peers. The participants in the study of Buseh et al., for example, reported the print and broadcast media, followed by friends and siblings, as their primary source for sexual risk behaviour information (Buseh et al., 2002). This relates to the need these learners expressed in Theme 6 for more relevant and visual material. Print and broadcast media, especially advertisements, could serve as a catalyst for HIV/AIDS and sexuality discussions with adolescents.

Many of the learners experienced the support from their peers in such a positive way that they felt inspired to go out to other areas and **educate others** with the knowledge they had gained. A positive link with this desire to educate others is their sense of responsibility and need to set an example as discussed in Theme 1.

> … So I really think it is good for us as young people to do this (HIV/AIDS programme), to educate ourselves, firstly, and then to educate other people, secondly (response 18, page 6, F:A).

> We need to go to the rural areas and do an act or something to teach them about the disease. They maybe know that there is such a disease, but they don't know the facts (response 41, page 38, F:C).

The need to educate others is stressed as a recommendation in the study of Smith Cox (2000). Here, participants spoke about the importance of individuals working as allies and as advocates, and developed action plans to foster alliances among school- and community-based organisations. The positive influence peers have on each other in this regard also has its dark side, as discussed in the next category.

CATEGORY 5.2

"You just do what your friends do"

Although the programme promoted positive communication amongst the learners, they also experienced the **negative influence** peers can have. They demonstrated a need to know more about peer pressure and how to deal with its negative effects. They expressed that although the programme had enlightened them, their friends still had an extensive influence in their lives.

> Just going back to the peer pressure thing now. Everyone is like, everyone is doing it, so you must also try it (response 49, page 13, F:A).

> Yes, before the lady came to give us the training, you just went on the rumours you pick up here and there (response 42, page 32, translated from Afrikaans, M:B).

> I'm telling you a lot of the teenagers our age are sexually active, and they don't really know what they are doing, because their parents also didn't warn them or tell them anything. You just do what your friends do (response 38, page 46-47,M:C).

It is important to note here that peer group relationships become increasingly important during adolescence. Adolescents spend most of their time with the peer group and this has a strong influence, sometimes a very negative one, on their social development and sense of self. Louw, Edwards and Orr (2001:19) maintain that "social conformity is important for the adolescent's social development and provides a sense of belonging and acceptance. Conformity is reflected in, for example, their hairstyles, clothing and speech".

It is possible that owing to their negative influence, learners also experienced the need to **be more assertive** towards these peers. Assertiveness relates to their experiences of abstinence and risk-behaviour. It seems that at this age being "in" with your friends is very important to teenagers. This influences their self-concept and their ability to be assertive. The negative influence peers have as well as the need to be more assertive towards peers could imply that the learners lack the competence necessary to translate knowledge into action.

> A lot of us are not sure of ourselves, and don't feel we can stand up to our friends. That is why there is peer pressure (response 55, page 49, F:C).

> I don't believe in peer pressure. You have to be able to stand up for yourself. If you won't, who will (response 54, page 48, M:C)

> I think what is great about this group as well is that we get the information, but we are allowed to make up our own minds. It is not forced on us (response 47, page 12, M:A).

Comments from the participants in the research by Smith Cox also reflected a theme of increased self-awareness and empowerment. They communicated that they had learnt to value themselves as human beings, and how to be strong in difficult situations (Smith Cox, 2000). Cunningham (1993) supports this outcome with his view that adolescents are in a phase of self-examination, and that they have to decide who they really are and be able to stand up for what they believe in: to be assertive, in other words. "The adolescent must decide which lessons of the past will be integrated

with present realities and be willing to contemplate the possibilities for the future" (Cunningham, 1993:254).

CATEGORY 5.3

"It was a shock to my system"

To some extent, the HIV/AIDS programme forced the learners to communicate with each other. It was their experience that some of the things their friends revealed shocked them, because they did not know how their friends felt or what some of them had done before being exposed to the programme.

> Here are primary school girls who have already had sexual contact with a guy. To me it is a shame, and not fitting, because they are actually still small (response 17, page 29, translated from Afrikaans, F:B).

> I'm telling you a lot of the teenagers our age are sexually active, and they don't really know what they are doing, because their parents also didn't warn them or tell them anything. You just do what your friends do (response 38, page 46-47,F:C).

> I have a few friends (boys and girls) and they share their boyfriends and girlfriends, afterwards they tell each other how they had sex… (essays).

Other studies show that adolescents do engage in **risk behaviour** on a larger scale than one would expect. Coyle, Kirby and Parcel (1999) comment that schools have implemented a multitude of HIV/AIDS prevention programmes over the past several decades which have increased the knowledge of the learners, but few have had a significant impact on sexual risk behaviour.

Behavioural variables and habits studied by Ben-Zur, Breznitz, Wardi and Berzon (2000) suggest that those adolescents who start sexual activity at an early age, and are involved in risky sexual behaviour, tend not to change these habits. This correlates with the findings of Coyle, Kirby and Parcel (1999) that the programme did not have a significant impact on sexual risk behaviour.

To me, there seems to be a discrepancy between the experiences of the learners I interviewed and previous research. In my study, it came as a shock to learners to find out how many of their peers are sexually active, but they also reported that the knowledge they gathered influenced them in such a way that some of them did change their current behaviour in terms of sexual risk. I thus conjecture that with the appropriate format and content, an HIV/AIDS programme could perhaps reduce risk behaviour.

Another shock to some of the learners was to learn that other friends their own age **could be HIV positive**. Somehow these learners could not believe that educated adolescents their own age could demonstrate such risky behaviour that they might be infected with HIV.

> Last week we discussed how AIDS is right here in (town) and that learners in our school are HIV positive. And it troubles me, because these are people who are supposed to be educated and who must be the leaders that must go through to the next generation, so it was a major shock (response 2, page 14, F:A).

Although it came as a shock to some learners, statistics show that South Africa has a national HIV prevalence rate of 11%, that nearly three of the five million infected people are women and 250 000 are below the age of 15 years (Barolsky, 2003:10).

Smith, Dane and Archer (2000) reveal that the situation is much the same in the U.S.A. Although there are relatively few teenagers reported with full-blown AIDS because of the extended incubation period of HIV, the mean age at which HIV infection occurs has declined steadily over the last decade. One in three young adults aged between 18 and 27 infected in 1992, was infected from heterosexual contact.

In summary, the learners did experience that their friends played an important role in their lives and how they experienced the HIV/AIDS programme. Both peer support and negative influence were highlighted and the learners voiced their need to know more about peer pressure. The learners opened up to each other during the HIV/AIDS

programme in such a way that some of them were shocked by what their friends revealed.

These findings seem to underline the strength of pairing the HIV/AIDS curriculum with that of Life Skills in schools. Life Skills related to coping with HIV/AIDS issues that transpired in the discussion are those of communication, decision making, assertiveness, socialising within peer groups, relationships and regulating emotions such as fear, shock and anger. This aspect will be expanded on in Chapter 5.

The focus group discussions led the learners to communicate what they liked about the programme, and what they wanted to be different next time. These ideas form the content of the next and last theme.

THEME 6
"We need something different now"

The learners all agreed that HIV/AIDS education is necessary, and that they want this kind of education. The majority (92%) of the participants in the study of Jameson and Glover (1993) also felt that AIDS education could successfully prevent the spread of AIDS. Most respondents felt that unless some form of intervention programme was started soon, the future would be characterised by "many deaths", "disaster" and "many innocent victims". This indicated a strong positive belief in the value of education as a means of changing the gloomy prognosis. This finding ties in with the comments the learners in my study made.

An insightful finding is learners' experiences of what they did not want in an HIV/AIDS programme. In retrospect, it was fairly easy for them to identify what they liked about the programme, and what they would want different the next time they were exposed to an HIV/AIDS programme. There are three main categories in this theme, which pertain to:

- HIV/AIDS Programme format: "There must be new ways"
- "We need to know…"
- "You have to be scared to get it"

CATEGORY 6.1

HIV/AIDS Programme format: "There must be new ways"

Many of the needs voiced by learners concern the format of the HIV/AIDS programme. These needs are discussed in the following paragraphs.

Most of the learners experienced the **groups** as too big to have a real impact on them. The result of big groups was that learners did not take the programme seriously and tended to make a joke of the process. Another need in terms of groups was that they preferred discussing issues pertaining to HIV/AIDS in separate groups. The girls experienced that they did not ask questions in front of the boys and they would have opened up more if they were educated in a group of girls. Gender issues were raised in this discussion and could possibly support literature regarding ongoing gender / power / vulnerability issues in sexuality as well as HIV/AIDS transmission (Human Rights Watch, 2001).

> Definitely smaller groups, because all of Grade 10-12 was in one group and that was difficult. I think that is the reason why everybody made a joke of it (response 24, page 24, translated from Afrikaans, F:B).

> They (the learners) don't want to do the classes because boys and girls are together. If the groups are separate they might take it more seriously and take part (response 26, page 24, translated from Afrikaans, F:B).

> The groups are too big. I think it should be one grade at a time, and boys and girls separate (response 27, page 30, translated from Afrikaans, F:B).

Small (1995:25) agrees that all learners should be educated on HIV/AIDS. "Sexuality education should be compulsory to ensure that all children are offered the opportunity to make decisions based on accurate information".

One of the needs that received ample attention was that learners wanted a **different format** of methodology in education regarding HIV/AIDS. The learners experienced

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some of the information as **too factual** and would have liked to receive the information in a different format.

> They used to tell us in the class every single day the same things over and over. The suffering and all that. It was the same story over and over (response 7, page 34, F:C).

> The lady that presented the programme to us and I don't know about you, but to me it was a lot about what the virus looks like and how it attacks you. It was very content driven, about the virus itself (response 2, page 22, translated from Afrikaans, M:B).

> We want to know more about the other things related to AIDS once you have it. Like who can help you, where you can go and so on (response 13, page 43, F:C).

As if speaking in one voice all the learners expressed a need for **more visual material**. These included videos, photographs and personal contact with HIV positive patients. They fewer facts on paper and more of what they can "see" the virus does to you. The learners also expressed a need for acts and demonstrations that would have a greater impact on them than reading someone's life story on paper.

> Our education must be more practical. There is no use in just handing out pamphlets. We don't read it. We need to see it with our own eyes (response 39, page 47, F:C).

> More visual things will definitely help. We don't read a lot, and reading about something doesn't hit you as hard as seeing it (response 40, page 47, M:C).

> Yes, talking doesn't help. If we see a video, everyone is quiet after that, because it hits you hard to see things (response 41, page 47, F:C).

> Take the teenagers to the hospitals where they can see the people literally suffering. Maybe then they will get the message (response 42, page 47, F:C).

I think people should see what the consequences are of their actions that led them to get the virus. Teenagers should see the suffering, then maybe they will listen (response 31, page 45, F:C).

Don't have unprotected sex. It has become such a cliché, they can at least come with some new ideas for education (response 4, page 34, M:C).

I really like that new advertisement, that "for you I kill the bull" one, about condoms. I didn't know those were condoms. That's nice. I really like the ad. It's something different (response 5, page 34, F:C).

We want to see demonstrations (response 20, page 36, M:C).
They could probably act something out. That would be more interesting than to listen to someone (teacher) speak. If you can see it for yourself it would have a greater impact (response 22, page 36, M:C).

I would like to see what someone looks like when they have AIDS (response 8, page 28, translated from Afrikaans, M:B).

They can also show us photographs of sick (HIV/AIDS) people (response 32, page 31, translated from Afrikaans, M:B).

Yes, we want to have HIV/AIDS education, but not the way we got it. There must be new ways (response 10, page 42, F:C).

We don't want to hear so much about the virus. We know the virus is there, but what must we do with it (response 27, page 24, translated from Afrikaans,F:B).

The learners communicated this need quite extensively, and it is clear that they want the education to be more in line with their life world. I would reason that if you want the learners' attention, you should use their modes of communication i.e. information technology, television, Internet, CD-ROM and DVDs.

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Buseh, Glass and McElmurry (2002), are of the opinion that the clear demarcation and understanding of effective ways to reach adolescents is essential in the education process. The choice of an effective medium determines the success of the HIV/AIDS prevention message, identifying effective channels of communication and developing practical and culturally relevant strategies, are all mentioned by Buseh, Glass and McElmurry (2002). This coincides with the learners' call for new channels for HIV/AIDS education.

Another general need voiced is that **not enough time** was dedicated to the programme. Learners were of the opinion that they needed HIV/AIDS education on an ongoing basis, in time dedicated to the curriculum. The outcomes-based curriculum currently implemented at schools makes provision on the time table for the Learning Area Life Orientation up to Grade 9 for all learners. HIV/AIDS forms a part of the outcomes for this learning area. The National Policy on HIV/AIDS is also very clear regarding the fact that a **continuing** Life Skills and HIV/AIDS education programme must be implemented at all schools (Government Gazette, 1999). It is suggested, however, by the experiences of the learners that this kind of ongoing implementation of HIV/AIDS programmes is not happening in all schools.

> It (the programme) should be presented on an ongoing basis and should touch on other aspects as well, like people who get infected by accident, or by rape and so on (response 52, page 26, translated from Afrikaans, F:B).

> The programme was too short. I would like to have it every week in school time (response 11, page 29, translated from Afrikaans, M:B).

The suggestion that HIV/AIDS education should take place on an ongoing basis is sustained by the research of Jameson and Glover (1993) as well as Slonim-Nevo (2001). Jameson and Glover are of the opinion that there is a need to educate parents, teachers and learners and that AIDS education should be continuous (Jameson and Glover, 1993).

Slonim-Nevo (2001:83) elaborates on this suggestion, stating that their programme was spaced over a period of two or three months. “Such spacing enables participants to digest the material, to experiment with it, and to return to discuss conflicts, experiences, and questions within the group”.

The **limited role of parents** in the HIV/AIDS programme was discussed as a category in the fourth theme. The learners felt that their parents could have been more involved in the programme. Here, too, the learners expressed the need for their parents to be more involved, not only in the programme, but in dealing with HIV/AIDS issues at home. The learners wanted their parents to have enough knowledge to be able to educate them about HIV/AIDS at home.

> The education should also start at home, so that you can learn to protect yourself, because it is the innocent girl that gets into trouble because she doesn't have the knowledge (response 37, page 46, F:C).

Other researchers agree with this experience. I mentioned in the previous section that Jameson and Glover believe parents should be educated in HIV/AIDS (Jameson and Glover, 1993). Other studies indicate that parents themselves believe they have an important role to play in the HIV/AIDS and sexuality education of their children (Buseh et al., 2002). The study of Selvan, Ross and Kapadia (2001) amongst adolescents in India shows that an increase in the education of parents was associated with a decrease in children's intention to be involved in sexual behaviour.

In all of the focus group interviews learners expressed the **need for an outside presenter**, especially when that person was also HIV positive. The learners were of the opinion that someone from outside would have a greater impact on them, because they were tired of listening to their teachers. One should consider here that learners also want HIV/AIDS education on an ongoing basis, which could imply that various outside presenters will have to be utilised to prevent them from becoming “insiders”.

I think it would be good to see somebody who has it (AIDS) himself. If someone who has it comes to speak to us (response 35, page 25, translated from Afrikaans, M:B).

Somebody to present the programme who has the virus himself would definitely have a greater impact on us (response 21, page 30, translated from Afrikaans).

Somebody from outside to come and teach us would be much better (response 12, page 35, F:C).

'Cause we would listen. We don't listen to our teachers (response 13, page 35, M:C).

It would be interesting to speak to someone who has HIV, what their lives are like, how they feel about it (response 25, page 36, F:C).

Maybe somebody young who already knew they could get it, who got it, and somebody older who didn't really know about it and got it anyway (response 49, page 39, M:C).

It is evident from these comments from learners that they have a strong need for a presenter other than their teachers. Small (1995:25) says one cannot discuss an adequate sexuality programme without mentioning who the facilitators of the programme will be, and how they will be trained. "It could be argued that teachers are not the most appropriate vehicles for sexuality education".

In two other studies, healthcare and social workers are identified as the appropriate designates to deliver HIV/AIDS programmes. In the study of Buseh, Glass and McElmurry (2002) the majority of learners preferred the healthcare workers as their main sources for preventive messages. Slonim-Nevo (2001) agrees that social work practitioners have experience working with adolescents and should be the ones to deliver the intervention. This raises a question regarding the role of full-time educators in presenting the HIV/AIDS curriculum. The basic assumption of the HIV/AIDS policy of the Department of Education is that educators should present the

HIV/AIDS programme at the school (Department of Education, 2001(c)). The need of the learners for an outside presenter thus contradicts this instruction from the Department of Education and deems further investigation.

According to Slonim-Nevo (2001:83), the idea the learners have of other outside presenters will probably not work. “In contrast, inexperienced group leaders need time to establish trusting relationships. Such processes are lengthy and are surely beyond the scope of HIV/AIDS prevention programmes”. I disagree with this researcher. I believe that, within ethical parameters, a presentation delivered by someone who is, for example, in the beginning stages of HIV/AIDS might have a great impact on the learners, as they themselves have indicated, due to the “visual reality” brought closer to their life-world.

I would like to conclude this category by capturing again the most important differences in learners’ requirements from an HIV/AIDS programme. They want smaller groups, with boys and girls separated. They feel the need for more visual material and fewer facts. They also want the programme to be presented on an ongoing basis by someone closer to the topic, and would like their parents to be involved too. Now that it has been established how they want the programme to be delivered, I will take a closer look at the knowledge they felt lacked in the programmes they were exposed to.

CATEGORY 6.2

“We need to know…”

Knowledge played a major role in the HIV/AIDS programme experiences of the learners. They gained knowledge that influenced them in a positive way, but also knowledge that impacted them negatively. Although they were bombarded with factual knowledge and experienced that they received too much HIV/AIDS prevention information, they expressed a need for different information and knowledge.

There was general consensus amongst learners that they had enough knowledge about the virus itself and all the medical aspects. What they felt they needed was knowledge regarding **coping with AIDS** once one has it, or once one knows of someone who has it. The related topics interest them and link closely with the discussion on care and support later in this section. The learners want to know where to go for help and how to help others who might be HIV positive. It would seem that information regarding voluntary counseling and testing (VCT) should be included in a HIV/AIDS programme (Barolsky, 2003). This will be discussed in more detail in the last chapter.

> It's not only about AIDS. Maybe when you have the virus you have other emotional problems, like getting depression because you know you are going to die. We need to know about this and how to help people who feel that way (response 12, page 42-43, F:C).

According to Louw, Edwards and Orr (2001), depression is a common occurrence among people infected and affected by HIV/AIDS. Educators are warned to be aware of the signs and to intervene as soon as possible. They are of the opinion that educators need to guide these depressed learners to find meaning in life through love, a job, providing a service to other or religion. The occurrence of depression was already signified by learners' experiences of shock.

> Yes, we want to know more about the other things that are related to AIDS once you have it. Like who can help you, where you can go, and so on (response 13, page 43, F:C).

As stated earlier, learners expressed their need to know how to cope with HIV/AIDS themselves. They want to be responsible and feel useful, replacing feelings of frustration and helplessness. They also communicated their need to know where they could go **for care and support** of others. To these learners the mere knowledge of the virus was not enough; they wanted more in terms of coping and dealing with the virus once one contracts it, or knows of someone who has HIV. Mcneil, Mberesero and Kilonzo (1999) also stress the critical role of care and support in assisting people who are HIV positive.

… You should also know that when you get it (HIV) that there are people who can help you and can teach you to cope with it (response 50, page 26, translated from Afrikaans, F:B).

We learnt about the blood and so on, but not how to support and deal with someone who has the virus (response 23, page 30, translated from Afrikaans).

I feel these people have to be counseled every day and we must also know how to help friends or relatives who might have it (response 21, page 44, F:C).

Care and support for those infected with and affected by HIV/AIDS is a topic that should reach much wider than just an HIV/AIDS programme at school. Louw, Edwards and Orr (2001:5) are of the opinion that care and support within the school environment "would entail a holistic approach to the disaster caused by the HIV/AIDS epidemic and the impact it will have on learners who are infected with and affected by HIV/AIDS". According to these authors all educators should be equipped to assist learners in aspects of care and support for those infected with and affected by HIV/AIDS. According to the Norms and Standards for Educators these aspects form part of the pastoral role of the educator (Government Gazette, 1999).

In the programmes the learners were exposed to relationships were dealt with in general, as well as how to make responsible decisions when going on **dates** and having a relationship with the opposite sex. In this category, the learners demonstrated a need to know more about dating someone who is HIV positive. They wanted the knowledge of how relationships can work with someone who has the virus. This need also illustrates the importance of pairing Life Skills and HIV/AIDS education.

When you get into a situation you must know what to do. For example, you fall in love with a girl and then you find out she has AIDS. You must know how to deal with it (response 14, page 29, translated from Afrikaans, M:B).

Gyarmathy et al. (2002) go even further than dating. They suggest that adolescents should be educated to talk to their partners about sex and using condoms when they have sex, and AIDS education should consider couple-oriented in addition to individually targeted education. This links with assertiveness skills as previously discussed.

Learners were very keen in expressing their need for knowledge regarding **treatment** for HIV positive patients. They would like to see the medicine you have to take and want to know where the treatment clinics are as well as the kind of treatment these patients receive.

> We want to see the pills end medicine people who have AIDS must take, and learn about what the medicine does for them (response 36, page 31, translated from Afrikaans, M:B).

> And we want to learn about those anti-retroviral drugs. Who gets it, and where do they get it from (response 17, page 35, F:C).

> Another thing that should be included in an AIDS programme is if you now got AIDS, where should you go for treatment, and what kind of treatment there is. We should get into groups where people have AIDS, and start supporting them (response 16, page 43, F:C).

Although I could not find other researched HIV/AIDS programmes that address this topic, treatment is stated as one of the aspects that should be included in the core curriculum of an HIV/AIDS programme (Department of Education, 2001(a)): "Providing information on **appropriate prevention and avoidance measures**, including abstinence from sexual intercourse and immorality, being faithful to one partner, the use of condoms, obtaining **prompt medical treatment** for sexually transmitted diseases and tuberculosis, and the application of universal precautions when working with body fluids".

One tends to think that adolescents do not want to hear about the “right thing to do” or the “moral high ground” that they should take. It was interesting to me that learners demonstrated a need for the return to **values** in education. This correlates strongly with the call of Minister Kader Asmal for values in education, in which he states in his opening remarks that schools have “an extremely important role to play in supporting the development of our value system and in establishing the regeneration of the ethical fibre of our society” (James, Auerbach and Desai, 2000:3).

> It would also maybe help to focus on morals. In many schools it would be easy because they are all Christians, but it will not work everywhere (response 38, page 25, translated from Afrikaans, F:B).

> What our problem is today is we don't fear anybody or anything. We don't fear our parents, or our teachers. We don't even fear God. So how can we fear AIDS if we don't even fear God. And this is where religion comes in (response 44, page 48, M:C).

> Yes, like we said, rather go back to morals and values in teaching (response 45, page 48, M:C).

The idea of grounding education in values is further supported in the AIDS review of Barolsky. She does, however, present a different dimension to the value system by stating that “we do not need a reflexive, defensive return to traditional values; but instead an attempt, though admittedly difficult, to maintain continuity with valuable historical legacies while incorporating the new and innovative into a meaningful contemporary set of publicly shared values” (Barolsky, 2003:22).

Eaton and Flisher (2000) go further by including religiosity in the discussion. They hold the opinion that traditional faith-based values are strongly held by a significant number of South Africans, be they Christian, Muslim, Jewish or other. According to their research, religious youth may be less likely to be sexually active, but may also therefore take less interest in AIDS-related information. In their study, an astonishing

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83% of the participants reported to be sexually abstinent as a result of their religious and moral convictions.

Peer pressure is a topic that was discussed under the fifth theme. Still, learners felt that they wanted to know more about peer pressure and especially how to cope with negative peer pressure.

> We listen to our friends. Peer pressure is something we should know more about (response 53, page 48, F:C).

In this study, and many others, learners indicated that peers have an enormous influence on each other, positive and negative. For this reason, many organisations have developed peer education programmes, with the aim of preventing HIV transmission among the youth. Smith Cox refers quite extensively to peer education programmes. According to this study, "these interventions are based on models of social influence and attempt to directly and indirectly influence the behaviour of individuals. Peer education programmes have successfully increased awareness, disseminated information, and fostered risk reduction behaviours among individuals" (Smith Cox, 2000:33).

CATEGORY 6.3

"You have to be scared to get it"

I was intrigued to discover that the idea of instilling fear of the virus was a need expressed by many learners. The learners are of the opinion that the visual effects they want will scare them more than someone just lecturing them. They experienced that they wanted to be frightened of getting HIV and that fear would inspire them to think twice before being irresponsible.

> The leading key is fear. Take them (adolescents) to the hospitals and see people dying of AIDS. You have to be scared of the disease to be able to lead a better life (response 47, page 48, F:C).

> I think what is important of such a programme is to instill fear in learners; you have to be scared to get it (HIV/AIDS)… I really think we will prevent it better if people are scared to get it (response 50, page 26, translated from Afrikaans, M:B).

One would think that this need is unique to these learners, and that the idea of instilling fear is an alien idea in the times we live in. I did, however, come across a study in Hungary that supports this idea of fear messages. Gyarmathy, Thomas and Mikl (2002) report that Hungarian teenagers were more likely to use condoms if they were afraid of AIDS.

Rothman and Salovey (1997) refer to this phenomenon as the role of message framing. Health-relevant communications can be framed in terms of the benefits (gains) or costs (losses) associated with a particular behaviour, and the framing of such persuasive messages influences health decision-making (Rothman and Salovey, 1997). We communicated this finding of adolescents wanting to be scared of HIV/AIDS to Peter Salovey. His response via e-mail was: "This is really interesting. We find the same thing when we ask adolescents to design anti-smoking posters. They always design scary, gory ones" (Salovey, 2004). The effectiveness of framing "fear" messages for adolescents will be influenced by the context in which they take decisions and on the degree to which the behaviour is perceived as risky.

Gyarmathy, Thomas and Mikl (2002) state that a recent meta-analysis of the research on fear appeals suggests that strong fear appeals coupled with high-efficacy messages produce the greatest behaviour change. They further suggest, as is the experience of the learners in my study, that AIDS prevention in Hungary may be improved if education programmes include a focus on the fear of AIDS and perceived severity.

This theme forms a crucial part of my study, as the findings could influence future curriculum development and delivery. In the next chapter I will draw conclusions and make recommendations in terms of this study, which will conclude my research on the learners' experiences of HIV/AIDS programmes. I will also strive to transcend these findings in terms of issues that might enhance adolescent learners' HIV/AIDS experiences in the future.

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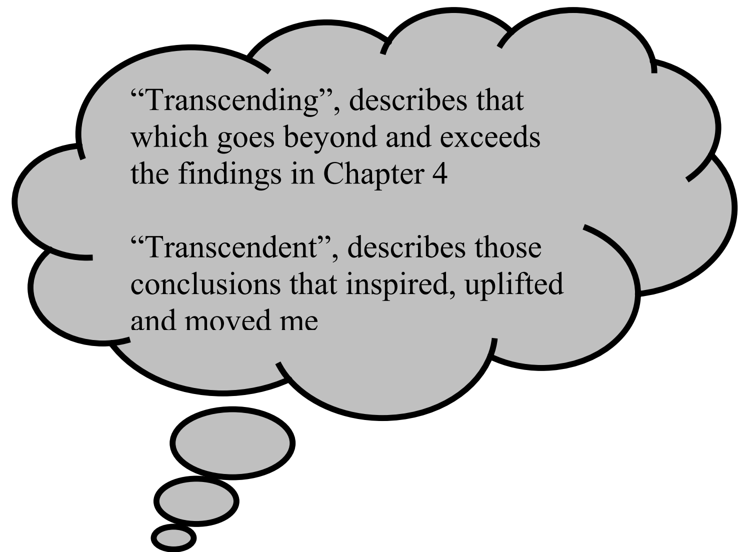
CHAPTER 5

TRANSCENDING FINDINGS



5.1 Introduction

This study set out to explore and describe adolescent learners' experiences of HIV/AIDS programmes presented at their schools. My main research question was aimed at establishing whether an understanding of these experiences would permit insight into the adolescent learners' daily dealing with HIV/AIDS issues. This insight includes their experiences and their needs in terms of HIV/AIDS education to enable them to cope better in future in the context of HIV/AIDS.

With this chapter my study draws to a close. I will start by giving an overview of my research. In a summary of my findings I will indicate how my research aims were addressed. The section headed "transcending findings" will take some of my findings to a different level of discussion, as these findings surpass those previously discussed. Thereafter the limitations, recommendations and contribution of this study will be discussed.

5.2 Overview of study

Chapter 1 gave **background** to the study. Research aims and questions were stated and the rationale for my study discussed. I decided that I would work from an interpretive paradigmatic perspective and highlighted the epistemology, ontology and methodology of my study.

The main focus in **Chapter 2** was to establish the **conceptual framework** for my study: the learner's wealth of experience is at the core of this framework. The adolescent learner's experience is shaped and formed by different aspects of development i.e. physical, cognitive, social, normative, behavioural, emotional, sexual and motivational. The adolescent learner's development and experiences of HIV/AIDS programmes in turn are influenced by the impact of HIV/AIDS on the adolescent, society and education, as well as the policies and curricula of the Department of Education.

In **Chapter 3** the process of my research was outlined. I decided to conduct an instrumental case study on purposefully selected Grade 11 learners from three secondary schools. The data was collected mainly through focus groups and written essays. I applied a constructivist grounded theory approach in the analysis of the data.

In **Chapter 4** the **data** and **findings** of the research were discussed and interpreted. Six prominent **themes** transpired from the analysis of the data. These themes and their categories were discussed at length and interpreted with the assistance of relevant literature and are discussed under research aim 3 of this chapter. The six themes are:

1. Knowledge that changed me positively
2. Knowledge that impacted me negatively
3. Persisting misconceptions and stereotyping
4. My parents, the HIV/AIDS programme and me
5. My friends, the HIV/AIDS programme and me
6. "We need something different now"

5.3 Conclusions and addressed aims

In the subsequent section I will clarify how my research aims were addressed in this study. The discussion is thus guided by my research aims.

***Research aim 1**: To gain a clear understanding of the current policy for the implementation of HIV/AIDS programmes at school level in South Africa*

In an attempt to gain a clear understanding of the policies and curricula of the Department of Education I studied the following documents. The policy that governs HIV/AIDS education is the *National Policy on HIV/AIDS* as published in the Government Gazette (Government Gazette, 1999). This policy addresses different aspects of HIV/AIDS, namely disclosure and confidentiality, constitutional rights of learners and educators, non-discrimination and equality, a safe school environment and particularly education on HIV/AIDS.

With regards to education on HIV/AIDS, the policy is very clear about the fact that a continuing Life Skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and should be integrated in the Life Skills programme. This should include information on HIV/AIDS and developing the life skills necessary for the prevention of HIV transmission, learning content and methodology to be used, as well as values that will be imparted.

The next document of importance with regard to HIV/AIDS education was the implementation plan for TIRISANO of the former Minister of Education, Kader Asmal (Department of Education, 2000). The broad aim of this programme is to develop tools and planning models to facilitate an analysis and understanding of the impact of HIV/AIDS on the education system. The programme also aims to ensure that Life Skills and HIV/AIDS education is integrated across the curriculum at all levels and that educators are appropriately trained and resourced. The aim of this HIV/AIDS programme of the Department of Education is further to raise an

awareness of HIV/AIDS among educators, learners and students at all levels. The specific focus of this study was on project 2 and project 5 as outlined in Table 1 of Chapter 1 p.5. These two projects are specifically focused on HIV/AIDS and the curriculum and how educators and learners are made aware of and informed on HIV/AIDS-related issues.

Of immense importance to this study was the Gauteng provincial document, Circular 33/2001 (Department of Education, 2001(a)), on the implementation of HIV/AIDS programmes at schools. This circular once again emphasises the fact that "age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners". The aspects to be included in the programme were discussed in Chapter 2.

These documents gave me clear guidelines with regards to policies and curricula of the Department of Education on what should be included in an HIV/AIDS programme at school level in South Africa. These documents also formed one of the legs of my conceptual framework and were crucial in interpreting themes and categories.

Research aim 2: To investigate what other literature reveals regarding HIV/AIDS and learners' experiences

This research aim was addressed at length in Chapter 2 while simultaneously developing the conceptual framework for the study. The following aspects were investigated in existing literature:

- The impact of HIV/AIDS on society
- The impact of HIV/AIDS on the education system
- Adolescent development and learners' experiences
- Programmes on HIV/AIDS at international and national level
- The importance of HIV/AIDS education

Some of the aspects of this investigation into existing literature will be highlighted briefly to illustrate the impact of HIV/AIDS on learners' experiences. In South Africa,

more than 60% of new HIV infections occur among 15 to 25 year olds, with adolescent girls being among the most frequently diagnosed (Call et al., 2002). The health of adolescents is integrally shaped by the daily contexts in which they grow and develop. Transformations in world economics, government, families and technology, among other things, are altering societies around the world, and, in turn, reshaping the contexts of adolescents' lives (Call et al., 2002; Giese, Meintjies, Croke and Chamberlain, 2003).

HIV/AIDS has demographic effects on aspects such as total population loss, population growth rates, crude death rates, fertility rates, life expectancy, age distribution, infant and child mortality, dependency ratios, gender ratios, widow(er)hood, household composition and/or co-residence (Hunter and Williamson, 2001). It is thus vital to recognise and support the role of the family and community in educating young people about HIV/AIDS. In many countries, the majority of young people who need to learn about prevention are not in school (Giese et al., 2003; UNESCO, 2002).

The literature showed that parental death reduces children's self-esteem and increases depression, anxiety, conduct disturbance, academic difficulty, somatic complaints and suicidal acts in the long term (Rotheram-Borus, Lee, Gwadz and Draimin, 2001). Adolescents and their families also face the daily threat of stigmatisation and discrimination (UNESCO, 2002). Communities are experiencing a social strain in coping with large numbers of HIV/AIDS orphans. Furthermore, with communities weakened through poverty, hunger and sickness, they will be unable to participate in self-help activities for schools (Juma, 2001). Hunter and Williamson (2000) summarise the broader macro impact of HIV/AIDS: the vulnerabilities of children, families and communities are compounded by the geographic concentration of the pandemic. "Vulnerable children are cared for by vulnerable families who reside in vulnerable communities" (Hunter and Williamson, 2000:18).

The impact on education is seen in the number of learners who drop out of school due to being affected by HIV/AIDS. HIV/AIDS pushes children into poverty and helps keep them there by cutting them off from school, formal training and the transfer of skills from parents (Richter et al., 2004). And, the epidemic affects the quality of

education because of the strains on the material and human resources of the system as well as the health and mere presence of the learners. According to a study conducted by UNESCO in 2001 (UNESCO, 2001), millions of learners are already infected, and in some countries more than a third of fifteen-year-olds will die of AIDS-related illnesses in the future.

Many youth will grow up deprived, de-socialised and disconnected. Children will lose teachers at school and parents who can support them at home. Classes will be dropped and schools will close, and many children will receive poorer education. All children have physical and material needs, intellectual and educational requirements and psychosocial wants. Children affected by HIV/AIDS are particularly vulnerable in all these areas, as they take on adult household, parenting and caring responsibilities (Giese et al., 2003; Smart, 1999).

All these aspects of the impact of HIV/AIDS on society and the education system have a tremendous impact on the development of the adolescent learner. These young people are particularly vulnerable to HIV/AIDS because of the physical, psychological, social and economic attributes of adolescence (Issues in World Health, 2001). Many adolescents are economically dependent and socially inexperienced, have not been taught or have not otherwise learned how to protect themselves from infection, and generally have less access to health care than adults.

Adolescence is a critical developmental period with long-term implications for the health and wellbeing of the individual and for society as a whole (Call et al., 2001). The different spheres of adolescent development that inform and shape their experiences are physical, normative, social, cognitive, emotional and sexual development, as well as aspects of behaviour and motivation. These aspects culminate in the wealth of experience of the adolescent learner.

In my investigation of international and national programmes on HIV/AIDS education and learners' experiences, I found that there were very few programmes concentrating on actual experiences of learners. The focus of many interventions nationally and globally has been on changing behaviour as a way of reducing "risk" activities, which may increase the possibility of HIV infection (Barolsky, 2003).

Many studies focused on the evaluation of programmes that target knowledge, attitudes and behaviour regarding HIV/AIDS. These studies focused mainly on pre- and post-programme evaluation to determine how the programme changed or influenced the specific knowledge, attitudes and behaviour regarding HIV/AIDS, and were researched by means of questionnaires. **At national level very few studies have been conducted on the impact of HIV/AIDS education in the formal school sector, and none that I came across focused on the experiences of the participants.**

In almost all the literature that I studied researchers and writers repeatedly highlighted the importance of HIV/AIDS education, and the need for such programmes to exist. In the HIV/AIDS strategic approach report (UNESCO, 2002) it is made clear that all adolescents have the right to knowledge and understanding regarding HIV/AIDS issues. These young people need support in making the right behavioural choices that will ensure their protection against HIV infection. Educators need to be prepared for the role they have in HIV/AIDS education, and other organisations that can assist should be recruited.

From my literature study I thus established that HIV/AIDS has a vast impact on learners' experiences and that research in this area is required to expand the knowledge base on learners' experiences and HIV/AIDS programmes.

Research aim 3: To explore and describe learners' experiences of HIV/AIDS programmes

This research aim was addressed by implementing my research design and the subsequent interpretation of the data that was collected. I conducted an instrumental case study on selected Grade 11 learners at three secondary schools in one of the educational districts of the Gauteng Province. I collected data mainly through focus groups and essays, which were transcribed and analysed, primarily following a constructivist grounded theory approach. Through the process of analysis the following themes transpired, enabling me to describe the experiences of the learners.

Theme 1: Knowledge that changed me positively:

In this theme I established that the knowledge that influenced the learners positively made them more open and motivated to talk about what they had learnt, and to set an example by the way their attitude towards HIV/AIDS had changed. Being informed meant they wanted to share their knowledge; they became less judgemental and more empathetic and wanted to change their behaviour.

The fact that the learners gained knowledge through the programme seemed to change their views and perceptions and made them more comfortable with issues surrounding HIV/AIDS. This is demonstrated by a better understanding and awareness of the HIV /AIDS virus and probably also a decrease in fear, ignorance, misconceptions, stigma and stereotyping.

Most of the learners experienced a change in behaviour. To some it was a change in how they acted when they went out. To others it was a change in how they behaved towards other people who might have HIV/AIDS. In terms of behaviour, life skills were also developed through the programme, one of these being decision-making skills. The learners expressed that the knowledge they gained enlightened them in such a way that they were able to make choices and decisions on that basis. They felt that they had so much knowledge after the programme that they could not behave irresponsibly anymore, and they had to convince others to be responsible as well.

Theme 2: Knowledge that affected me negatively:

Apart from all the positive experiences the learners had in terms of knowledge, they also experienced some of the knowledge in a negative way. This theme refers mainly to two aspects. On the one hand, the learners felt that they were bombarded with HIV/AIDS prevention information, and on the other hand, some of this information was upsetting for them to hear and they did not want to hear any more of it. The experiences that they perceived as "upsetting news" are discussed in terms of the emotional shock of realities related to HIV/AIDS such as death, discrimination and the impact of poverty. They found this a negative experience because they were eager

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to learn more than just the facts; they wanted to learn about coping, care and support and treatment, for example. With more than just the facts they might feel less helpless, because they would feel empowered to take action.

Theme 3: Persisting misconceptions and stereotyping:

Throughout the focus group interviews it became apparent that despite the HIV/AIDS programme certain stereotypical perceptions and misconceptions still prevail in the minds of these learners, and are probably maintained within their communities. It was interesting to find that the learners communicated their stereotyping as perceptions that did actually change. They acknowledged that anyone can get HIV/AIDS, but in the discussion racial lines were drawn. There were also persisting misconceptions and stereotypes coupled with judgemental stigma with regard to poverty and poorer communities.

The learners demonstrated that they still believe there is definitely a higher rate and possibility of infection in poorer communities due to poverty and a lack of education. The stereotype here is that the learners believe education or the lack thereof, as well as socio-economic status, make a difference in the sexual behaviour of adolescents. It became apparent that learners also still believe that coming from a poverty-stricken area or home implies that you do not get any support from parents or family. This is another value judgement linked to a stereotype that remained in the minds of learners after the HIV/AIDS programme. Even after the HIV/AIDS programme there were still learners who only listened to what their peers said and thought. The influence of the peer group is thus something that remains prominent at this age for the learners.

Theme 4: My parents, the HIV/AIDS programme and me:

Teenagers often complain that they cannot talk to their parents and that their parents do not understand them (Hait, 2003). Learners did not really experience it any different with this HIV/AIDS programme. Communication with parents remained a persistent problem for most of them. Within this theme there were positive and negative experiences. Learners were reluctant to communicate with their parents about HIV/AIDS issues in the event that their parents would be suspicious of their

actions. They also did not want to break the trust that their parents had placed in them. Through their experiences the learners voiced their need to communicate more and better with their parents. They also expressed that a secure family structure and support from parents and family are important prerequisites for communication.

Of the more negative experiences, learners felt that even after the programme they found it difficult to really communicate with their parents and open up to HIV/AIDS issues. Other learners had positive experiences, and found that the programme helped them in communicating with their parents. Apart from the fact that the adolescents struggled to communicate with their parents, they also expressed that their parents were ignorant, shy, stubborn or scared to communicate about HIV/AIDS and sexuality issues and that they lacked HIV/AIDS knowledge.

However, the learners revealed that they would like their parents to be more involved and to educate them at home regarding HIV/AIDS and sexuality issues. They felt that the limited role their parents played in the HIV/AIDS programme was a negative experience. Some learners remarked that where their parents were negative at the start of the programme, they became more positive and supportive as the programme progressed.

Theme 5: My friends, the HIV/AIDS programme and me:

In the focus groups the learners shared their experiences of their friends during the programme and, in general, of their peers. Here too, as with their parents, they had positive and negative experiences. The learners experienced that they could count on the support of their friends and that they related better to each other due to the fact that they were the same age. They felt that they could open up to their friends and discuss issues that they would not have discussed prior to the programme. Many of the learners experienced the support from their peers in such a positive way that they now felt a need to go out to other areas and educate others with the knowledge they had gained.

Although the programme promoted positive communication amongst the learners, they also experienced the negative influence peers can exert. Although the programme

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enlightened them with knowledge, their friends still had an enormous influence in their lives. It is possible that due to the negative influence peers could have, learners also experienced the need to be more assertive towards their peers. Assertiveness relates to their experiences with regard to abstinence and risk-behaviour as discussed in Chapter 4 (p.146).

To some extent the HIV/AIDS programme forced the learners to communicate with each other. It was their experience that some of the things their friends revealed shocked them, because they did not know how their friends felt or what some of them had done before they were exposed to the programme. Another shock to some of the learners was to learn that other friends their own age could be HIV positive. Somehow, these learners could not believe that adolescents their own age who were educated could demonstrate such risky behaviour that they might be infected with HIV.

Theme 6: "We need something different now":

The learners all agreed that HIV/AIDS education is necessary, and that they wanted this kind of education. In retrospect, it was fairly easy for them to identify what they liked about the programme, and what they would want different the next time they were exposed to a similar programme. Many of the needs voiced by learners concerned the format of the HIV/AIDS programme. One of the needs that received ample attention was for a different form of methodology in education regarding HIV/AIDS. The learners experienced some of the information as too factual and would have liked to receive this information in a different format.

The learners wanted smaller groups, with boys and girls kept separate. They expressed a desire for more visual material and fewer facts. They also wanted the programme to be presented on an ongoing basis by someone closer to the topic, and would like their parents to be involved too. Although they were bombarded with factual knowledge and felt that they received too much HIV/AIDS prevention information, they expressed their need for different information and knowledge that they wanted, as captured in Chapter 4 (p.157).

A need expressed by many of the learners was that they wanted to be scared of HIV/AIDS. The learners were of the opinion that the visual effects would scare them more than someone just lecturing them. From the comments the learners made it became apparent that they felt that they wanted to be frightened to contract HIV and that fear would inspire them to think twice before being irresponsible. This theme forms a crucial part of my study, as the findings of this theme could influence future curriculum development and delivery.

Research aim 4: To understand how the experiences of learners in HIV/AIDS programmes impact on their daily dealing with HIV/AIDS issues

The discussion and interpretation of the data in Chapter 4 clearly addressed this research aim. In every theme the impact of the learners' experiences on their daily dealing with HIV/AIDS issues was indicated.

The knowledge the learners gained liberated them with regard to many issues, for example, they felt that after the programme they were more confident to talk about HIV/AIDS and related issues. They felt motivated to use the information and the experiences they gained to set an example to others. In many ways the programme and the knowledge they gained changed and influenced their attitude towards HIV/AIDS and people who have the virus. Thus, the unknown became known through the knowledge and understanding they gained, which in turn gave the learners confidence to share with others.

This knowledge seemed to change their views and perceptions and made them more comfortable with issues surrounding HIV/AIDS in their daily lives. This is demonstrated by a better understanding and awareness of the HIV /AIDS virus and probably also a decrease in fear, ignorance, misconceptions, stigma and stereotyping, as well as the need to be convinced not to engage in casual sex. There was not one group that did not raise the issue of AIDS being a reality and that learners needed to start dealing with it. One aspect that illustrates the impact on their daily lives is how they shared their experiences regarding relationships and dating (Chapter 4: p.116).

Another way in which learners' daily dealing with HIV/AIDS issues is impacted is through their experiences regarding death and the shocking statistics of adolescent risk-behaviour and HIV infection. In a sense, HIV/AIDS is closer to the learners in their daily lives than ever before. Therefore, the learners' behaviour with regard to HIV/AIDS issues has also changed. In their daily dealing with HIV/AIDS issues, they have the desire that others should also change their attitudes and behaviour. However, they feel overwhelmed and helpless in the fight against AIDS because there are so many other issues to address due to the perceived diluted values in society. Learners who experienced the programme in such a positive way that they wanted to make a difference in society felt especially powerless because of all the other issues in society that are out of place.

In their daily dealing with HIV/AIDS issues learners are confronted with persisting misconceptions and stereotypes in the minds of some of their friends, themselves, family and communities. They have to cope with their conceptualisations of race and poverty. The negative influence of peers is an issue that adolescent learners have to cope with on a daily basis. The fact that they might not be coping with it well enough is expressed by their need to know more about peer pressure and how to deal with it. On the other hand, some learners experienced that their peers have a strong positive influence in their lives, and by implication in their daily dealing with HIV/AIDS issues. There were learners who felt peer communication had a positive impact on the way they could communicate with their parents about HIV/AIDS issues. This positive communication with friends and parents is thus utilised as a resource in dealing with HIV/AIDS issues.

I propose thus that the in-depth description of learners' experiences of HIV/AIDS programmes in fact resulted in a better understanding of the impact of these experiences on their daily dealing with HIV/AIDS issues.

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Research aim 5: To establish what learners found beneficial in the HIV/AIDS programme and what their needs are for future programmes

It is evident from the discussion of the learners' experiences that this aim was adequately addressed. In almost every theme there is evidence that learners benefited from the programme in terms of knowledge, attitude and behaviour.

The needs of the learners for future programmes were addressed in Theme 6. These needs pertain mostly to the format of the programme and the knowledge they need in addition to what they were taught in the HIV/AIDS programmes. In this regard, refer also to Table 5 in this chapter.

Research aim 6: To make recommendations according to the experiences of learners of HIV/AIDS programmes that might inform future programme development

Throughout the research the learners repeatedly revealed their needs for future HIV/AIDS programmes. These needs were captured in detail in the discussion of Theme 6 in Chapter 4 and also serve as recommendations that might inform future programme development. Table 5 in this chapter also contains these recommendations.

The aspects discussed under the following heading, Transcending Findings, might also inform future programme development. Other recommendations that link with these transcending findings are made later in this chapter.

5.4 Transcending findings

In this section I propose ideas that in my opinion exceed the findings discussed in Chapter 4, based on contemplating the different themes as well as reasoning the connections between the themes. These transcending findings are a contribution of my study in terms of the experiences of adolescent learners and HIV/AIDS programmes

and contain possible recommendations for future HIV/AIDS programmes and curriculum development.

Each of these findings is also a conclusion that I have come to that has inspired me in terms of adolescents and HIV/AIDS education. These conclusions also constitute hypotheses that were generated by my study and require further contemplation in further research.

Transcendent conclusion 1: The adolescent's sense of responsibility

Contrary to literature regarding adolescent development (Cunningham, 1993; Hait, 2003; Huberman, 2002) learners in my study experienced a strong sense of responsibility in the fight against HIV/AIDS. They felt that they had so much knowledge after the programme that they did not want to behave irresponsibly anymore, and that they had to convince others to be responsible as well.

Further research is needed to explore this phenomenon of responsible adolescent behaviour. For example, under which other circumstances do adolescents demonstrate responsible behaviour? Other research (Barolsky, 2003) suggests that different contexts possibly determine responsible behaviour, such as sibling households, where young adolescents responsibly care for their younger siblings.

I propose that educators should nurture this sense of responsibility and utilise it optimally in terms of positive peer influence. This sense of responsibility links with the desire learners expressed to set an example and to be role models in their communities. I suggest that educators could put a "buddy system" in place to capitalise on peer group pressure. One learner with a strong sense of responsibility could be the 'buddy' of another who has difficulty socially and in terms of responsible behaviour.

In terms of the experiences learners had, I conjecture that the buddy system would benefit most learners involved. This relationship would create a safe and accepting environment for the social plodder where he/she would be able to voice his/her fears,

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anger or sadness within a confidential relationship, with subsequent positive influence on his/her self-concept, life skills, choices and actions. On the other hand, it could give the socially responsible learner a sense of self-worth and achievement, countering the experiences of helplessness and frustration expressed by other learners.

Transcendent conclusion 2: HIV/AIDS, poverty and values in education

The learners experienced the influence of poverty on the HIV infection rate in a naive and negative way. They felt despondent in their effort to venture out and help others and share the knowledge they had gained. The research of Barolsky (2003) shows that an extremely difficult environment is created for the poor by a lack of infrastructure which, when combined with symptoms of HIV, makes life difficult for the ill and those who take care of them. The learners demonstrated that they still believed in an uncomplicated causality directly and unquestionably linking poverty with HIV/AIDS. Their experiences denoted pity for and judgement of people from a lower socio-economic environment.

Learners thus could benefit by seeing poverty in a different light. This is possible by showing them that there are cases of triumph in adversity and success despite diversity in socio-economic circumstances. Learners could be given multiple perspectives on poverty. This gives them the opportunity to develop values such as compassion and admiration for those who cope with HIV/AIDS despite their socio-economic situation, versus just having “pity” for the poor.

I propose that the complexities of HIV/AIDS and poverty could be fruitful opportunities for creating positive experiences for the learners. Richter (2003) holds the view that the intersection between HIV/AIDS and poverty necessitates a shifting perspective in approaches to meeting the needs of affected children. She is of the opinion that “we respond to what we see, but it is possible to see things differently” (Richter, 2003:10).

Including perspectives on poverty in an HIV/AIDS programme could enhance learners' experiences and adhere to the call for values in education in terms of race, society, citizenship and democracy. The promotion of values of equity, tolerance, multilingualism, openness, accountability and social honour in schools is the central argument of the report of the Working Group on Values in Education (James et al., 2000). These values are important for the personal, intellectual and emotional development of the learner. I thus infer that these values could assist in giving learners a different perspective on poverty and building character when included in HIV/AIDS programmes.

Transcendent conclusion 3: "What must we DO now?"

The learners expressed that they were 'fed-up' with HIV/AIDS prevention information. Although learners communicated their needs with regard to what they still want to know about HIV/AIDS in Theme 6, there are aspects that go beyond or transcend this finding. At its crux, learners communicated that they want to know how to care for and support others who may be affected by HIV/AIDS.

The learners wanted to know where to go for help and how to help others who might be HIV positive. They wanted to be responsible and to feel useful, replacing feelings of frustration and helplessness. They also communicated their need to know where they could go for care and support of others. To these learners, the mere knowledge of the virus was not enough; they wanted more in terms of coping skills related to care and support, and dealing with the virus once one contracts it, or once one knows of someone who is HIV positive and families/people affected by HIV/AIDS.

With all the care, support and treatment knowledge competence skills should be instilled in the learners. This might increase their confidence in dealing with HIV/AIDS issues. Schools could even utilise this aspect as part of the buddy system suggested earlier and form care and support groups at school. By addressing this need, the negative impact of some of the experiences could instead be opportunities for positive experiences in future programmes.

Transcendent conclusion 4: The role of parents: what about the orphans?

The learners expressed the need for their parents to be more involved, not only in the programme, but also in dealing with HIV/AIDS issues at home. The learners wanted their parents to have enough knowledge to educate them about HIV/AIDS at home. Other researchers agree with this experience. I mentioned earlier in Chapter 4 that Jameson and Glover (1993) believe parents should be educated in HIV/AIDS. Other studies indicate that parents themselves believe they have an important role to play in the HIV/AIDS and sexuality education of their children (Buseh et al., 2002). Selvan, Ross and Kapadia (2001) found that an increase in the education of parents was associated with a decrease in children's intentions to be involved in sexual behaviour. The question of how and when parents should be involved in the programme should thus be raised.

The need learners have for their parents to be involved in their HIV/AIDS education implies that all learners might have this need, including those without parents. I posed the following question in Chapter 4: what about orphans who are without parents or who have non-traditional caregivers? Statistics reveal that by 2005, South Africa alone will have more than 800 000 AIDS orphans (Call et al., 2002; Smart, 2003). Children who move in and out of households as a result of death and migration compound the situation further. Caregivers change and siblings may split up. Children become more vulnerable when very aged relatives care for them, often in conditions of mutual dependency. Child-headed households are established when there is an adolescent girl who can perform the role of caregiver, when there are nearby relatives to provide supervision to the household, and when siblings wish to stay together (Richter, 2003).

Richter (2003) states that knowledge gained from working with street children and displaced children demonstrates that even on the street, children attempt to seek out bonding experiences with adults and engage their support. Freeman in Richter (2003) speculates that this behaviour is due to a lack of several formative influences. These influences include early bonding experiences critical for good caring human relationships, the modeling, boundary setting and development of value systems

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necessary for moral development, and the support, caring and discipline needed for emotional stability.

The HIV/AIDS programmes at schools should take these circumstances into consideration and attempt to accommodate these learners in their loss by providing a substitute in its place. The programme could include the “families” of these orphans. I propose that schools could yet again utilise the “buddy system’ in this regard, where orphans and children vulnerable in the context of HIV/AIDS would experience a sense of belonging. In the case of younger learners, adolescent learners could act as the “family member” in the HIV/AIDS programme. Adolescent learners could have teachers as “buddies”, who could act as their sounding board for the HIV/AIDS programme, and who could provide care and support for these learners.

Transcendent conclusion 5: Expand HIV/AIDS education to other life contexts

The focus of this study was on the HIV/AIDS programmes presented at school level and how learners experienced these programmes. The school, however, is not the only opportunity learners have to realise their personal potential in their life worlds. I speculate that HIV/AIDS programmes would have a higher success rate if they were expanded to include learners’ other life contexts.

Other opportunities for the realisation of learners’ potential are the family, peers, faith-based organisations, non-governmental organisations and extra-curricular activities, to name a few. I propose that schools should grasp the opportunity to form working partnerships with other organisations to address HIV/AIDS issues. I was briefly involved in one such partnership in my capacity as educational advisor, between an NGO (St. Mary’s Outreach) and the Department of Education in Pretoria, and they have had increased positive responses to HIV/AIDS education.

Expanding HIV/AIDS education to other spheres and contexts of the learners’ lives could increase exposure to and contact with HIV/AIDS issues, which in turn could assist them in dealing in an integrated way with these issues on a daily basis.

Transcendent conclusion 6: Content does not matter

As an educational advisor the educators I visited constantly complained about the lack of prescribed material since the then new curriculum had been introduced. The educators were of the opinion that learners were not exposed to the same content and would therefore have different levels of outcomes.

I believe that my study proved these sentiments wrong. The learners who participated in my study were from three different schools. These schools were situated in different socio-economic areas and were diverse in the type of HIV/AIDS programmes they presented. The learners, too, were from different backgrounds in terms of socio-economic status, race and language. The outcome of the study was that, despite the diversity and difference in content of the programmes presented to the learners, these learners generally had the same experiences in terms of HIV/AIDS education.

Therefore, I suggest that schools should see this transcendent conclusion as an opportunity to be innovative and to create opportunities for their learners to be exposed to HIV/AIDS education and related issues in any way they can. They should not wait for a prescribed programme from the Department of Education to give learners the "correct" experiences.

Transcendent conclusion 7: The HIV/AIDS Programme

I found that learners want to be educated about HIV/AIDS. I also found that the outlined curriculum is not being implemented broadly. In this study the participants clearly stated what they wanted to be included in HIV/AIDS education. An understanding of their experiences of the HIV/AIDS programmes they were exposed to shows that some of their expectations were not met. I suggest that a comparison of what worked in the programmes they were exposed to, and their expectations of future programmes, could be integrated into recommendations for future programmes and might be utilised by curriculum developers. Table 5 serves as an illustration of

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one such possible comparison. For practitioners, the following overview of HIV/AIDS curriculum content could prove useful.

Table 5 A comparison between what worked and what learners want regarding HIV/AIDS programmes

	GDE curriculum: What worked	Learners: Expectations of HIV/AIDS programmes	Ideal: Integration of what worked and what learners want
Format	❖ Groups, although too big	❖ Small groups ❖ Boys and girls separate ❖ More visual material ❖ In line with life world ❖ More time / ongoing ❖ Parental involvement ❖ Outside presenter	❖ Small groups ❖ Boys and girls separate ❖ More visual material ❖ In line with life world: utilise advertisements and information technology ❖ More time / ongoing: integrate fully with life skills programme ❖ Parental involvement: also "families" of orphans ❖ Outside presenter: combine different presenters with educators also presenting
Knowledge	❖ Scientific information ❖ First-aid principles ❖ Transmission of HIV ❖ Non-discrimination ❖ Life Skills	❖ Coping ❖ Care and support ❖ Treatment ❖ Values ❖ Dating HIV+ ❖ Relationships ❖ Peer pressure ❖ Fear messages	❖ Life skills: communication, assertiveness, relationships, decision making AND ❖ Grounded in values: tolerance, respect, admiration, responsibility FOR ❖ Knowledge on prevention and the virus ❖ Coping ❖ Voluntary counseling and testing ❖ Treatment ❖ Care and support ❖ Social context (e.g. poverty, misconceptions, stereotyping)

Table 5 illustrates the importance of the integration of HIV/AIDS education with life skills education and the teaching of values in education. Learners expressed a need for the integration of values and life skills necessary for dealing with HIV/AIDS issues on a daily basis.

Circular 33/2001 (Department of Education, 2001(a)) states what should be included as the core curriculum of HIV/AIDS programmes in schools. The aspects of the core curriculum that were addressed are captured in Table 5. According to the learners' experiences I infer that the following aspects of the core curriculum were neglected:

- Developing the life skills necessary for the prevention of HIV transmission
- Encouraging learners and students to make use of health care, counseling and support services (including services relating to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organisations and other disciplines
- Providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, being faithful to one partner, the use of condoms, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, and the application of universal precautions when working with body fluids

These aspects that were neglected are some of the areas that learners revealed they wanted to know more about, and could thus be included in future programmes.

Transcendent conclusion 8: Silences in the data

There were aspects in my study that were not voiced by the learners, although these aspects were prominent in other HIV/AIDS literature. These aspects have definite relevance to HIV/AIDS education. I call these aspects the missing links in the learners' experiences and I propound that these could be opportunities for further research. These missing links are:

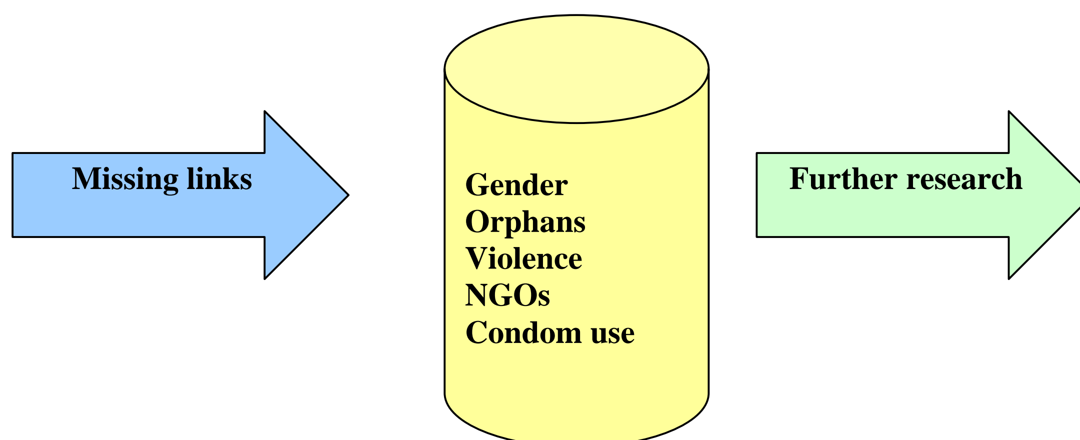

Diagram 7: ***Silences in the learners' experiences***

Gender issues are prominent in other HIV/AIDS literature, particularly in terms of the vulnerability of adolescent girls (Human Rights Watch, 2001). The only mention of gender by the participants in my study was that girls and boys preferred separate HIV/AIDS education sessions. This issue links with another prominent aspect in HIV/AIDS literature, namely violence against women and young girls (Human Rights Watch, 2001). Violence against girls was another missing link in this study. I am not sure whether gender and violence issues were absent because learners did not have experiences in that regard, or because those experiences were too personal to reveal in a focus group discussion or a symptom of societal silences in this regard. There may have been other, more important experiences that learners wanted to share, with the result that gender and violence issues were not mentioned.

Research on condom use was another prominent aspect in HIV/AIDS literature that was not voiced by the learners in my study. The learners mentioned only that they were fed up with hearing the line "use a condom", and they did not relay experiences regarding actual condom use. I speculate that learners did not talk about condoms because they themselves were tired of talking or hearing about them. I also wonder whether the open discussion of the focus groups discouraged them from mentioning condoms in fear of being labeled as "sexually active" by other participants. But, then again, no mention of condom use was made in the essays either, which was a more private opportunity to relate experiences.

The learners in my study communicated freely about their parents, whereas experiences of orphans was another missing link. Did the learners fail to mention orphans because they are not a part of their life world? Could this be possible in view of the fact that there are so many orphans? Did learners not mention orphans out of ignorance or due to the stigma attached? Perhaps learners were so eager to get their parents involved in the HIV/AIDS programme that they forgot about those learners who do not have parents.

The participants in my study did not mention the involvement of NGOs in HIV/AIDS education at all. I speculate that the learners voiced their need for NGOs to be involved when they asked for outside presenters; however, they did not know what to call these "outside" organisations. NGOs may also not have been mentioned because these organisations were not prominent in the HIV/AIDS programmes in which these learners were involved. Yet again, this missing link might be due to the ignorance of the learners with regard to NGOs.

Future research on these missing links could undertake to establish why these aspects were absent in the discourse of learners' experiences.

Transcendent conclusion 9: What was new and different

In my research regarding learners' experiences of HIV/AIDS programmes there were several findings that I did not find as outcomes in other research studies. I surmise that these findings are thus unique contributions of my study. These new and different findings are the following:

- I found learners' experience of the reality of HIV/AIDS to be quite unique to my study. The learners were able to express themselves verbally and it became clear to me that the reality of HIV/AIDS in our country really "hit home" in the programmes they attended. I propose the following generated hypothesis: knowledge gained by the learners and the way this knowledge changed their attitudes might have an influence on the way they were willing to share their

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experiences of how HIV/AIDS is becoming a reality in their lives. This hypothesis could be tested by other researchers.

- The experience of negative and positive communication with parents was new. The learners opened up in the discussion. They could really voice their opinions and feelings openly, and I found it was easy for them to talk about their parents and the relationship they have with them. In the light of these differing experiences, I suggest that the roles of culture, personality and ignorance in the dynamics of communication about sexuality in the parent-child relationship deserve further research.
- The fact that parents' attitudes changed during the programme was also new to my study. This links with the learners' experiences of positive communication with their parents. Subsequently, attitudes were changed due to this parent-child communication. Further research is thus needed regarding influences on parent-child communication and relationships.
- Learners' experiences of responsibility were also unique to this study. The learners expressed that they were empowered with knowledge and that gave them a sense of responsibility in the fight against HIV/AIDS. This sense of responsibility is supported by the communication of the learners' shock regarding the risk behaviour of peers and the high HIV infection rates amongst adolescents, which also constituted another experience unique to my study. This requires further research in psychology, education and development theories per se, and not only in terms of HIV/AIDS education.

5.5 Limitations of the study

Although this study intended to concentrate on the experiences of learners in HIV/AIDS programmes at their schools, one should consider that at the time of the programme there could have been other influences in other spheres of their lives that may also have had an influence on their experiences. I could thus not say with certainty that their experiences were a result of the programme only.

The learners in South Africa come from diverse cultures in terms of race, religion, language and socio-economic status, which limits the study in terms of

generalisability of results. Although it is a limitation, it was not one of the aims of this study to produce data that were generalisable. Rather, the study revealed that despite their diversity learners generally had the same experiences. Therefore, HIV/AIDS programme developers could consult the findings of this study as a guideline on learners' experiences as well as on what their expectations were for future HIV/AIDS programmes.

The learners' responses in this study were based on self-reporting. These responses might have been affected by a "social desirability bias", which means the learners might have provided what they thought were socially acceptable responses (Shisana, 2002). The anonymous essays that some of the learners wrote could have countered this limitation. I infer that due to the anonymity of the essays the learners were probably truthful in writing about their experiences. Generally, the focus groups as well as the written essays revealed the same experiences, thus refuting the suggestion of "social desirability bias".

Almost all qualitative studies are confronted with the crisis of representation (Denzin and Lincoln, 2000). This could be a limitation of the study in terms of the representation of the learners' responses and experiences. I acknowledge that I was fundamental in representing what the learners revealed, and take cognisance of this possible limitation. In the light of this, I consulted some of the participants about the findings of my study. These learners verified that the findings were a satisfactory representation of their experiences and expectations.

There were limited sources available to interpret learners' experiences. Most of the research conducted regarding HIV/AIDS education used closed question questionnaires and did not actually focus on what the participants revealed regarding experiences. As a result some of the findings in this study could not be interrogated, supported or refuted by existing literature. These findings might thus be possible hypotheses for further research.

5.6 Quality Criteria

In this section I will reflect on the quality criteria that have been stated in previous chapters of this study in terms of trustworthiness, crystallisation and the crisis of representation. I aimed in this study to achieve **credibility** in terms of the themes I discovered. Participants verified during member checking that their experiences were represented with authenticity, which addresses credibility and representation issues.

The trustworthiness of the study is clear because new ways of thinking were generated by the data in terms of adolescents' experiences of HIV/AIDS education programmes. The data are not generalisable but rather transferable in the degree to which the learners claimed resonance between their own experiences and my interpretation. **Transferability** is achieved by the detailed and rich descriptions of learners' experiences. This means that my understanding of the experiences of learners could be transferred to new contexts of other studies to provide a framework for that research. Kelly (1999) stresses that this is possible because the study provides an accurate account of the research process and is very clear in terms of the methods that I employed.

Within a naturalistic setting the data are trustworthy due to their dependability and confirmability. In other words, the participants could confirm that I gave a true account of their experiences. The trustworthiness of my study is defined by the degree to which I produced findings that were believable to me, the participants and eventually the readers of this study (Durrheim, 1999).

The reason for referring to **dependability** rather than reliability in this study is that reliability refers to the degree to which my results will be repeatable. I did not expect to find the same results repeatedly whilst investigating experiences of learners and therefore aimed to have dependable findings. I propose that my findings are dependable due to the degree to which the reader was/was not convinced that the findings did indeed occur as I said they did (Durrheim and Wassenaar, 1999). For example, quotes from the transcriptions and the essays are included in the discussion of the data, and an example of the data analysis is included in Appendix A.

I adhered to the process of **crystallisation** as stated by Janesick (2000) and Denzin and Lincoln (2000). I employed different methods of data collection (focus groups, written essays, direct observation) in order to view learners' experiences of HIV/AIDS programmes from various angles. As a result I was able to gather rich data and gained a better understanding of learners' experiences.

I therefore submit that my study adhered to the quality criteria in terms of credibility, transferability, dependability and crystallisation as well as ethical strategies.

5.7 Implications for research, practice and HIV/AIDS programme development

In the section on transcendent conclusions most of the recommendations for further study were made in terms of their relevance in that section. I will, however, note the implications in terms of research, practice and programme development here for the sake of clarity.

I introduced the idea of a buddy system in transcendent conclusion 1. The hypothesis generated is that further **research** could be conducted in this regard in terms of similar systems that might exist, or an appropriate system that could be developed for schools. On the other hand, I recommend that schools could simply **implement** the idea of the buddy system according to the needs of the specific learners in their schools (practice). The buddy system could also be included in the **policy** of the Department of Education as a care and support strategy for schools.

The complexities of HIV/AIDS and poverty have been researched quite extensively, but not the role that poverty could play in HIV/AIDS education programmes. Thus, the hypothesis to be tested by **research** is whether a study of the complexities of poverty might be fruitful in terms of supplementing the values curriculum.

The possibility of HIV/AIDS programmes in other life contexts of learners is another topic for further study. It would be interesting to see how learners experience these programmes. The hypothesis generated for further **research** is thus that an extension

of HIV/AIDS education to other life contexts of learners could influence their experiences and their daily dealing with HIV/AIDS issues. Also, schools could look into the possibility of joining hands with other organisations and forming **partnerships** in the fight against HIV/AIDS (practice).

In terms of the HIV/AIDS programme itself, I recommend that Table 5 in the discussion of transcendent conclusion 7 could serve as a broad guideline for future HIV/AIDS **programme** development. It might also inform **curriculum** developers of what the expectations of learners are in terms of HIV/AIDS education programmes. In terms of **practice**, workshops could be organised where learners could evaluate new HIV/AIDS **programmes** to be included in curriculum and policy, thereby giving their input in terms of the appropriateness of the intended format and content of the programme. Parents could also be included in these workshops and possibly in a few sessions of the actual HIV/AIDS programme.

The silences in the data or missing links discussed in transcendent conclusion 8 are areas for further **research**. I propose that issues of gender, orphans, violence, NGOs and condom use are fruitful areas for research in terms of HIV/AIDS education. Also, a study could be conducted to establish the possible reasons for the absence of these aspects from the experiences of learners of HIV/AIDS programmes.

A last recommendation for further **research** is a possible study to query the accepted view that adolescence equals irresponsibility. The conclusion I came to in this study was that adolescents want to be responsible in terms of HIV/AIDS. Other researchers could possibly explore the circumstances that motivate learners to behave responsibly, which could in turn be included in future HIV/AIDS **programmes** in order to promote responsible behaviour among at-risk adolescents and developmental theories per se.

5.8 Contributions of the study

This study makes a contribution in terms of the knowledge base of HIV/AIDS education. The experiences of learners and the impact HIV/AIDS education has on

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their daily dealing with HIV/AIDS issues can now be added to this knowledge base and utilised as a resource by other researchers.

In terms of research and methodology, the nature of the methods I applied in this study makes a contribution. I used open-ended statements and questions in the focus groups and an open-ended statement for the written activity. This opened the discussion and learners felt free to communicate their experiences of HIV/AIDS programmes. I believe that using open-ended methods in researching learners' experiences of HIV/AIDS programmes resulted in access to rich and descriptive data that would otherwise have stayed unknown had I used closed-question methods.

This study was conducted during the administration of former Minister of Education, Kader Asmal. The views on the implementation of HIV/AIDS education in this study are from the perspective of his administration. It seems that the new Minister of Education, Naledi Pandor, is taking up the challenge of building on this, as one of the priorities of the Department of Education in the new dispensation is "preventing the spread of HIV and AIDS among learners and educators" (Pandor, 2004(a)). A closing remark by Minister Naledi Pandor during the International Winter School Meeting was that "we need to measure the effect of HIV/AIDS on our teachers and our pupils and all those who work in our educational institutions. We have to plan to manage the impact of the pandemic as a long-term systemic problem" (Pandor, 2004(b).

At the budget debate earlier this year, the Deputy Minister of Education pointed out that nurturing a culture of sexual and social responsibility in dealing with HIV/AIDS is linked to the manifesto and values in education, which supports the findings of this study (Pandor, 2004(a)). The Deputy Minister said the challenge for our schools is to influence the learners' ideas about sex and relationships even before the onset of intimate encounters. If this could be achieved it would play a unique role in changing the course of the HIV/AIDS epidemic.

Therefore, even though my study was conducted under a different dispensation, I suggest that the findings are in line with what the new dispensation of Minister Naledi Pandor intends. The findings of my study could contribute to the planning of new

HIV/AIDS programmes in terms of life skills, values in education and learners' expectations.

In an e-mail from Carol Coombe (2003) regarding a sourcebook of HIV/AIDS prevention programmes she writes: "I have always been struck by the fact that there are no identifiable evaluations of school-based prevention programmes in terms of content, implementation and outcomes". The content of the programme was stated in Circular 33/2001 (Department of Education, 2001(a)), and the implementation occurred according to the time frame of the TIRISANO plan (Department of Education, 2000). My study makes a contribution in terms of an evaluation of the outcomes from the perspective of the learners.

The outcomes of HIV/AIDS programmes were investigated in terms of the experiences of learners. The contribution lies in what these experiences are. The results illustrate the success of the programme in terms of positive experiences. A different contribution is made by the needs of learners from future programmes. If curriculum developers take these needs into consideration, future programmes might be more "learner friendly" and learners might have more positive experiences.

Another contribution is that, contrary to literature I studied on adolescent development, the adolescent learners in this study demonstrated a sense of responsibility in terms of HIV/AIDS issues. Schools and curriculum developers could capitalise on this sense of responsibility by utilising it in future HIV/AIDS programmes and in the buddy system as suggested earlier. Also, the important role parents could play in HIV/AIDS education is highlighted by this study. Adolescents want to communicate with their parents and programme developers should take the participation of parents into account when developing new HIV/AIDS programmes.

I conclude this study with a statement used in the HIV/AIDS and Life Skills training for educators, entitled "You taught me". A young person writes:

You taught me the names of cities of the world, but
I don't know how to survive in the streets of my own city
You taught me about the minerals that are in the earth, but
I don't know what to do to prevent my world's destruction
You taught me to speak and write in three languages, but
I do not know how to say what I feel in my heart
You taught me all about reproduction in rats, but
I do not know how to avoid pregnancy
You taught me how to solve math problems, but
I still can't solve my own problems
Yes, you taught me many facts, and thank you,
I am now quite clever, but
Why is it that I feel I know nothing?
Why do I feel I have to leave school to learn about coping with life?

By taking the experiences of learners into account in Life Skills and HIV/AIDS education, children can learn how to cope in the face of HIV/AIDS.

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APPENDIX A

EXAMPLE OF DATA ANALYSIS

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Focus Group 1: 22 May 2003 (M=4;F=11)

F1: Well, I think since I started with the HIV program I am more comfortable with issues. People ask you questions and sometimes you have to refer back to the manual, but later you really know the answers to the questions

R: And have you found that you are in a better position to answer these questions?

F1: Yes. Especially when it comes to knowledge issues such as the window period and high risk behaviour, you know, the things you do not see on T.V. Everybody has the general information, but they do not know anything more.

F2: Basically, when I started with this training I spoke to my parents and they were not very happy for me to do it. But, after I started the course and explained to them what it is about HIV that we are learning, they started understanding and were more supportive. And now, whenever they ask me about HIV stuff, I can understand and answer their questions.

F3: My mother is a nurse, so we basically have a lot of information at home. But since I started the program I know a lot more, especially high risk behaviour

Comfortable
+ knowledge
- gen. information
Parents Attitude
+ knowledge

and things like how it is transmitted and those things you know. But, I've learnt a lot.

F4: About a month ago I lost my cousin. She died of AIDS. Somehow the program has really helped me deal with her death, with all that I have learnt. In my family I hear a lot of strange things about AIDS, you know, one says this, and one says that, and by doing this program I have learnt a lot, about what is the truth and what is not.

F5: I've learnt that even though we know about this AIDS thing, that there is a lot of ignorance. It is not about what you have heard, but what you have set out to do to learn about AIDS, like she said about the window period and that. People just assume that AIDS equals sex, and the other stuff they do not share about. So it (the program) really like opened it up for me, to talk about other issues related to AIDS, because it is not just sex, it's other stuff as well.

M1: Well, the most interesting for me was when about two weeks ago we watched the videos on like syphilis and all the rest of the STD's it really became a reality to me about what it can do to you. I've learnt so much and it has really helped me to start talking about AIDS, because in my family we

Death

Knowledge

Ignorance

Openness

Knowledge

Reality

Communic.

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don't talk about AIDS and sex at all. I have started talking about these issues at home and at first it was very difficult, but I just go home every time and tell them what I have learnt, and slowly but surely I think they are getting more of the facts about sex and AIDS.

F6: I never knew much about HIV and that, and I was always really scared of it and wanted to stay far away from people with it. And I always though that the reason they have it is because their mothers have it, or that they were born with it. But then eventually I think I started learning more things about it and I really started wanting to help those with HIV, ja I want to like spread the word about HIV, so that other people will know what is HIV. Well. It is nice now, because I can share all of it with my mother, because my mother and so never really knew anything much about HIV itself. And in a way it has really changed my life, because I really want to go out there and help others.

F7: My mom is also a nurse, although she is not one that is very open to talk about issues and AIDS. And my dad also was not very happy for me to take part in this program. But it has really changed my views and perceptions about issues. So now I can really

Openness
Parents
Motivation
Knowledge
Use to help
Advocate
Parents
Responsibility
Parents
Attitude

tell others about HIV and know that I have the knowledge.	Knowledge
F8: I think I also pretty much realized when I started with the program that AIDS and HIV was a topic that is not really discussed in our household. And it really opened my eyes because I was very scared of it (HIV). And I realized that it is not something you catch like a cold, you have to really know about it and tell others about it. Like in my household, my brother just started high school, and I was able to help him understand issues, and even my parents are more open to talk about it, which is really great.	Communication Parents Less fear Advocate Attitude
M2: Well, personally I think because there is not a cure for AIDS yet, the only way we can cure it is through knowledge, and it is wonderful that we have that now. Also I think parents do not want to discuss the topic or they are too concerned to actually take on this topic. And you know, AIDS is out there, but what are the chances of it touching my life. So I think we have to make everyone aware of it, and I think it has really helped in our school, a lot, and personally as well. I have been much enlightened with knowledge, in stead of just facts and statistics.	Knowledge Awareness Knowledge Skills

F9: OK, when I first went home and told my family that I have started this AIDS course, my sister asked me: "Do you have AIDS?" because she though the reason I had to study about it was that I probably had it, and I think that are a lot of people's perception, that when you study AIDS you must have it. And, I always though that you can get from blood transfusions and sex and stuff, but I never knew that you can get AIDS from simple things like blow jobs and, or I always though that were the safe things to do, and ja I now realized that it is not.

M3: The interesting thing for me was to see how many people actually do not know about AIDS. You are used to hearing it on the radio, and you just switch it off because you are so sick of hearing about it. So I actually think people enjoy and want to hear from someone directly, making personal contact, face to face, learning about the disease. So, I think it wonderful that we teach the youth about it, and they can go out and teach others personally, face to face.

Stereotype
Misconception

Perceptions

Ignorance
Lack of knowledge

Fed up

Personal (presenter)

educate others

University of Pretoria etd – Griessel-Roux, E (2005)

Knowledge (positive) +	Knowledge (negative) -	Parents	Peers	Needs: future programmes
• Gained • Openness / attitude change • Help / support • Changed views / perceptions • Motivation • Decisionmaking • Utilize / transfer information • Fear decrease • Behaviour change • Understanding • Ignorance • Awareness (danger / death) • Misconceptions • Stigma • Example setting • Stereotyping • Relationships • Perceptions • Reality (death / closeness) • Abstinence • Healthy living / changed lifestyle • Responsibility	• Lack of information • Death • Repetition / Same information • Decline morals / values • Fear (scared / death / dealing with reality / stigma) • Role of poverty / influence • Racial issues • Shock • Communication difficult • Denial • Too many facts	• Attitudes (positive change / openness) • Attitudes (negative towards education) • Lack of knowledge / information • Communication (positive and negative) • Shy to talk / stubborn / scared • Ignorance • Family structure / support • Uninformed / ignorant • Trust • Role (parents vs. media / friends) • Involvement	• Can educate others / parents • Positive support • Peer education • Knowledge • Peer pressure (positive and negative) • Shock (status of friends) • Positive communication • Negative peer influence (self-concept / individuality)	Groups: • Smaller groups • Optional / compulsory • Boys and girls separate Time: • Not once off • Ongoing basis • More training Presenter: • Outside person (not teacher) • HIV + person (life story / reality) • Younger (relate better) Knowledge and information: • Less factual • Prevention and coping • Morals / values / religion • Emotional aspects • New information (developments / statistics) • Instill fear • Relationships (also with HIV+ people) • Giving support • Visual material • Treatment and medication • Parental involvement • New ways of information sharing • Demonstrations / acts / drama • Coping skills / supporting others • Related topics (living with AIDS / support / coping) • Dealing with peer pressure

University of Pretoria etd – Griessel-Roux, E (2005)

APPENDIX B

EXAMPLE OF FIELD NOTES

Group A 1

- Relaxed
- Very open
- good communication
- RESPONSIBILITY !! ✓✓
- gender
- issues — racism — stereotypes
- enjoy classes !
- personal issues ?

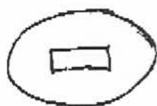
HIV/AIDS → fun to learn

MISCONCEPTIONS !

PARENTS
FRIENDS

GROUP B 2

- Shy to talk ? < Afrikaans background ? / uncomfortable



- WANT MORE !
  - Knowledge
  - Presenter (not a teacher !)

+

- Sexual risk behaviour
  - High level of sexual activity ?

MISCONCEPTIONS
STEREOTYPES
PARENTS !!
FRIENDS
- influence

Group C 1

- Very
  - representative
  - open to talk
- Teacher presenter (-) !!
  - negative experiences — DRILL PREACH ABSTAIN !
- Misconceptions
  - Blood transfusions !

WANT MORE !!
- outside presenter
- visual — SEE HIV +

- Some learners
  - very religious
    MORALS VALUES

PARENTS FRIENDS + & -

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APPENDIX C

CHECKLIST OF DATA DOCUMENTATION

Checklist of Data Documentation

	School A		School B		School C	
Access negotiated telephonically	2003-04-28		2004-03-02		2004-03-02	
Access negotiated meetings with principals	2003-05-05		2004-03-22		2004-03-24	
Focus Groups	A1 2003-05-22	A2 2003-05-22	B1 2004-04-19	B2 2004-04-19	C1 2004-04-22	C2 2004-04-22
Essays	✓	✓				
Length of F.G.	45 min.	40 min.	48 min.	45 min.	40 min.	50 min.
Record of participants	✓	✓	✓	✓	✓	✓
Feedback and member checking	2003-07-22 10 learners		2004-07-27 5 learners		2004-07-28 10 learners	

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APPENDIX D

SYNOPTIC OVERVIEW OF PROGRAMME CONTENT

Synoptic overview of programme content

I already endeavored to delineate differences between the HIV&AIDS programmes in terms of format (see p 100 in this regard). In 2002 I interviewed the three programme presenters in order to explore the content of the HIV&AIDS programmes presented at the three participating schools. I determined that all three HIV&AIDS programmes were developed in terms of guidelines outlined in Circular 33/2001 (Department of Education, 2001 (a)), with specific attention to age appropriateness. The content of the three programmes participating learners were exposed to is presented in the following synopsis.

Each of the programmes provided extensive scientific and prevention information with a decided statistical component. Examples include details of the nature of the virus, facts on ways of infection, essential information regarding the prevention of infection (including abstinence and condom use), information on sexually transmitted diseases (as well as the treatment thereof).

Another theme included in all these HIV&AIDS programmes pertained to basic first aid principles. Universal precautions in dealing with bleeding were prominent in all the programmes.

At risk behaviour related to HIV infection also featured as a main theme in the programme content. Examples of at risk behaviour are drug and needle use, the role of alcohol, as well as unprotected sex.

Awareness of prejudice and stereotypes was included as another programme theme. Examples of this theme include discussions on stigma, discrimination and attitudes towards people in general, as well as in the context of HIV&AIDS.

Linked to the previous theme, a specific theme in all the programmes addressed non-discrimination towards persons infected and affected with HIV&AIDS.

Lastly the programmes included a section on referral services including community service organizations, counseling and support services.

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APPENDIX E

FOCUS GROUP DISCUSSION QUESTIONS

Focus group discussion questions

- **QUESTION 1**
  What were your experiences of the HIV&AIDS programme in which you participated?

- **QUESTION 2**
  How has your experience shaped your attitude towards HIV&AIDS issues? And HIV&AIDS infected persons? And HIV&AIDS affected persons? And your attitude to sexual practices?

- **QUESTION 3**
  How has your experience shaped your behaviour in terms of HIV&AIDS issues? And in terms of HIV&AIDS infected persons? And in terms of HIV&AIDS affected persons? And in terms of your own sexual practices? And in terms of possible at risk behaviour in the context of HIV&AIDS?

- **QUESTION 4**
  How has your participation in the HIV&AIDS programme affected your life? In terms of attitudes? In terms of relationships? In terms of behaviour? In terms of decisions?

- **QUESTION 5**
  What did you find beneficial in the HIV&AIDS programme?

- **QUESTION 6**
  What would you suggest for future HIV&AIDS programmes?