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How do rural abet centres address the challenges of HIV /AIDS prevention and support? A view from the Limpopo province of South Africa

Kiggundu, Edith Mwebaza

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CHAPTER ONE
INTRODUCTION TO THE STUDY

1.1 Introduction

Limpopo Province was identified, through research conducted by the Department of Adult Education at the University of the North, (South Africa's Stevens, 1994; Hulst and Kerkhof, 1996), as one of the regions in the country badly affected by poverty (GDP, 3.6%) and high unemployment levels (49%). A report on Limpopo Province in South Africa's *Reconstruction and Development* magazine (1998:6) indicates that the province contributes to more than half of the nation's 61.4% illiteracy rate, with more than 40% of adults illiterate. The statistics suggest that many people in South Africa, particularly in the Limpopo Province, need to participate in education programmes in order to acquire specific skills or knowledge and understanding, to enable them to find employment in a world of rapid technological change, and to become active citizens in a democratic political system.

Such educational background and poor socio-economic circumstances make it difficult to gain a clear understanding and appreciation of the seriousness of being infected with HIV/AIDS. This also applies to the inability of many people to comprehend the complexities of AIDS, its transmission and relevance to their own lives. In addition, people face difficulties in knowing how to deal with it once diagnosed, either in themselves or in their immediate environment (Flisher et al., 1993). Several researchers, such as Janz (1984), Roger (1983), and Boyer (1999), have established that education levels may determine the ability to comprehend such factors as vulnerability, risk behaviour, efficacy of intervention and benefit of behaviour change. Thus the motivation to change behaviour, and in this case also the education level, might determine the level of knowledge and skills available for looking after the sick, as well as the way knowledge and skills about prevention and treatment are transmitted.

1.2 Problem statement

In 2002, when this study began, Limpopo Province (formerly Northern Province) still had one of the lowest rates of HIV/AIDS infection in South Africa, but some researchers (Barnett and Whiteside, 2002; Marks, 2002) believe it is on the brink of an explosive increase. A range of factors is implicated for this increase: Multiple, casual and unprotected sexual relationships, poverty, unemployment, illiteracy, migrant labour; traditions such as polygamy; and the high incidences of violence and rape in the province**.**

Since the beginning of the democratic order in the country, in 1994, people have been able to take part in Adult Basic Education and Training (ABET) programmes, particularly in the workplace and in urban areas. Despite many closures, there are still a number of centres offering ABET, although, as will be shown in a later section on ABET centres, the actual number of people making use of existing provision in South Africa has been very small compared to the scale of estimated need (only 355,900 out of 7.5 million) (Aitchison, 2000). However, it is important to mention that however weak ABET provision may be nationally and provincially, it is still an important resource for HIV/AIDS education and support, especially since many state ABET centres are based in impoverished rural communities, where other resources such as hospitals, clinics, community centres and television broadcast services are inadequate. Poor access to such services (social and otherwise) makes it difficult for people in rural communities to understand the many complexities surrounding HIV/AIDS, yet they are faced with the responsibility of taking care of their children, partners, close relatives and friends who are infected with HIV. Therefore, it is of utmost importance that poor and under-educated people have opportunities to develop a thorough understanding of HIV /AIDS so that they are able to live with and take appropriate care of people with HIV/AIDS in their communities, with the limited resources at their disposal.

The study attempts to explore ways in which rural ABET centres address challenges of HIV/AIDS prevention and support.

Before proceeding it is important to describe several key concepts.

Prevention

In this study prevention refers to efforts made in ABET centres to ensure that learners are not exposed to HIV/AIDS or if they are, they do not expose others to HIV/AIDS infection. Education would be directed towards awareness raising, information giving and prevention strategies that are directed towards the reduction of sexual transmission since unprotected sex with an infected person is the main mode of transmission.

According to Barnett and Whiteside (2002) the most available biomedical interventions in the prevention of the spread of HIV/AIDS, is the use of condoms and altering sexual behaviour, for example being faithful to one partner, delaying first sexual intercourse[1] as well as effective and early treatment of other sexually transmitted infections (STIs). It should be noted, however, that changing people's attitudes and behaviour is not easy. Therfore ABET programmes need to address key issues such as providing information about HIV/AIDS and how to prevent it, bringing the learners to an awareness that they themselves are at risk, and contributing, even if to a limited extent, to changing the personal, social and economic circumstances which make it difficult for people to protect themselves.

Support

In this study, 'support' means providing for the physical, emotional, and social needs of the people infected with and/or affected by HIV/AIDS and love, compassion and understanding towards people infected and affected by HIV/AIDS. It involves social, spiritual, psychological and peer support. This can help people to live positively with HIV/AIDS and thus contribute positively to community growth. It contributes significantly to breaking down silence about the pandemic, and reduction in stigma and discrimination against the people living with HIV/AIDS. The role/challenge of the ABET centres lies with educating educators andlearners about the disease so as to

[1] This is the classic ABC message: A- abstain; B – be faithful; C – condom if necessary. The problem is that even if people have the knowledge, they may not have the incentive or the power to change their behaviour.

reduce the stigma surrounding it so that they are able to show compassion and understanding towards those who are both infected and affected by HIV/AIDS.

Attitude

The oxford dictionary defines the term attitude as "a way of thinking or behaving". According to Rajecki (1982:4-6), attitude is an internal and private experience that can only be inferred indirectly from observed consistency in behaviour. He points out that individuals and groups are not born with attitudes but acquire them through a lifetime of experience, and that attitude tends to direct our behaviour.

In this study attitude will be used to describe the learners' behaviour towards people infected with and affected by HIV/AIDS. People's attitudes vary depending on the level of knowledge and understanding about the subject. As such, investigating prevailing educators and learners' attitudes with respect to HIV/AIDS prevention practices and support will shed light on people's responses towards people affected and infected with HIV/AIDS.

1.3 Aims and objectives of the study

This study aims to examine ways in which rural ABET centres address the challenges of HIV/AIDS prevention and support in region 3 (Vhembe District) of the Limpopo Province of South Africa. It sets out to determine what the personnel in these centres have done, what they are doing at present, what they could do and what they can improve upon. It also investigates the needs and interests of adult learners in these centres, with respect to HIV/AIDS prevention and care. It is envisaged that the results of this study will contribute to the formulation of guidelines for ABET centres throughout the country, to address the challenges of HIV/AIDS prevention and support for people living with HIV/AIDS in rural communities.

The study is designed to investigate:

- What ABET centres are doing to teach learners about HIV/AIDS prevention and support of people living with HIV/AIDS.
- What ABET centres are doing to support people living with HIV/AIDS.
- The prevailing attitudes, beliefs and practices of ABET practitioners and learners with respect to HIV/AIDS prevention practices and support.

- How attitudes, beliefs and practices impact on an ABET centres'ability to address the challenges of HIV/AIDS prevention and support.

It is expected that the information thus generated will contribute to:

- A better understanding of the strengths, weaknesses, opportunities and threats in current rural ABET programmes with respect to the challenges of HIV/AIDS prevention and support.
- The formation of an informed practical framework that policy makers and practitioners in rural ABET centres can draw on to address the challenges of HIV/AIDS prevention.

1.4 Background to the problem

Every year, throughout the world, an increasing number of people are affected and infected by the HIV/AIDS pandemic, either directly or through someone they know and/or care for. HIV/AIDS has affected millions of people worldwide. According to UNAIDS (2003:4) the global HIV/AIDS epidemic killed more than 3 million people, with an estimated 5 million acquiring the HIV virus to bring to 40 million the number of people living with the virus around the world.

Sub-Saharan Africa remains by far the region worst affected by the HIV/AIDS epidemic. In 2003, an estimated 26.6 million people in this region were living with HIV, including 3.2 million who became infected in 2002. AIDS killed approximately 2.3 million people in 2003 (UNAIDS 2003).

South Africa has become the AIDS epicentre of the continent. Current estimates are that one in five adults, or a total of about 5.3 million South Africans, are living with HIV or AIDS, with 1700 more being infected every day (Campbell 2003; UNAIDS 2003). It should be noted that the epidemic reached South Africa a decade after central and East Africa, providing a window of opportunity to develop and implement HIV/AIDS prevention and management programmes. However,as pointed out by Campbell (2003), the apartheid government largely ignored HIV/AIDS and the post-apartheid government has not risen to the challenges of the epidemic.

The HIV/AIDS epidemic in South Africa represents one of the greatest threats and challenges to the socio-economic transformation of the country. Elsewhere AIDS has been shown to have a devastating impact on individual households and communities. Those infected are only a proportion of those finally affected by the loss of breadwinners, parents and children (UNAIDS 2000; Barnett and Whiteside, 2002).

Besides the toll on human lives, the already fragile economies, as noted by UNAIDS, (2002) will be devastated by the disease, largely because of its destructive effects on the labour force through skills loss, unemployment, loss of productivity and shrinking of markets. For instance, UNAIDS has previously warned that the epidemic may cut South Africa's gross domestic product (GDP news- websites) by 17 percent by 2010 and reduce the national economy by $22 billion. Education, health, transport and welfare all suffer greatly as the epidemic takes its toll. In addition, the number of AIDS orphans is expected to increase sharply. Life expectancy has already fallen rapidly (UNAIDS, 2002; Barnett and Whiteside, 2002).

According to the latest *Love Life* AIDS campaign literature (at the time that this study was conducted), from the year 2000 AIDS deaths are expected to rise sharply to an estimated 635,000 deaths per year in 2010. When compared to India, the world's second most populous country with one billion people, which has about 3.8 million people with HIV, the 4.2 million people with HIV /AIDS in South Africa, with a population of just 43 million, is a significant proportion of the population.

It should be pointed out, however, that high infection and mortality rates are not unusual in other countries on the African continent. The sub-Saharan nations in Africa have the largest number of AIDS cases. For example, in Botswana, according to U.N estimates, nearly 36 percent of the population is infected with HIV/AIDS. In Zimbabwe, 25 percent of adults are infected with HIV/AIDS (http: daily news. Yahoo.com/h/nm/20010322/sc/safrica-aids-dc-2.html). The average life expectancy in Sub-Saharan Africa – which would have been 62 years without AIDS -is now 47 years. In Botswana, life expectancy has dropped to 36, a level last seen in 1950. In Lesotho, a person who turned 15 in 2000 has a 74 percent chance of becoming infected before his or her fiftieth birthday (Campbell 2003).

On the other hand, Uganda, once plagued by an HIV rate of nearly 14 percent, now presents a picture of hope for Africa. Under the guidance of President Yoweri Museveni, Uganda launched intensive public-awareness campaigns in partnership with civic, developmental organisations and religious groups. The HIV infection rate subsequently plunged to 6% http://www.cnn.com/2000/HEALTH/AIDS/07/08/AIDS.ADVANCER.02/).
Uganda's experience underlines that through intensive HIV/AIDS awareness campaigns and political leadership the spread of HIV/AIDS among the population can be significantly reduced, as will be discussed in detail in chapter 3 under the sub-heading "HIV/AIDS: Uganda's open secret". The axis of any effective response is a prevention strategy that draws on the explicit and strong commitment of leaders at all levels, that is built on community mobilization, and that extends into every area of the country.

The magnitude of the problem in South Africa, and the need for a collective response, was observed by former President Nelson Mandela in his address to the World Economic Forum at Davos , Switzerland in February 1997:

> The vision which fuelled our struggle for freedom, the deployment of energies and resources, the unity and commitment to common goals- all these are needed if we are to bring AIDS under control.
>
> *(*AIDS action plan for South Africa, 2000*)*

This implies that government alone cannot succeed in fighting HIV/AIDS. The current President of South Africa, Thabo Mbeki, on launching the Partnership against AIDS in October 1998, made an historic declaration on HIV/AIDS. He called on all South Africans to "join hands…in partnership against AIDS… to save our nation", mentioning that government had taken the lead in a new focused initiative to address the multi-faceted nature of the epidemic. However, the government is realising that it cannot succeed alone, and is therefore calling on all sectors of South African society to mobilise in order to meet this new threat and commit themselves to a unified response to address the multi faceted nature of the epidemic (AIDS Action Plan for South Africa 2000:1998).

In an effort to combat the HIV/AIDS virus, the South African government has undertaken a national HIV/AIDS campaign, which has been running for several years, and will be discussed later in this chapter. The government has also allocated more money to all provinces for HIV/AIDS prevention programmes. However, generally the South African government has been slow to react to the AIDS crisis, and it has become embroiled in a series of controversies resulting in disunity and conflict (Campbell 2003). These controversies have been described by Coombe (2000: 11) as: "detours, which have continued to divert the energies of activists, officials and politicians in needless controversy and futile confrontation." The first controversy arose in 1995, when a decision was made at ministerial level to commission *Sarafina II,* a musical about AIDS which would build on the imagery of the musical hit, *Sarafina I.* A contract of R14 million was signed with South African playwright Bongani Ngema in August 1995. When knowledge of the size of the contract became public six months later, there was an outcry from several quarters (Schneider and Stein, 2001). Tender procedures were allegedly not followed. Nor were activists convinced about the potential effectiveness of the production. The result, as analysed by Coombe (2000), was a vitriolic standoff between critics, political parties and officials. President Mandela, in a review of 1996, cited it as one of the ANC's key mistakes of the year (*Cape Argus*, 1997).

This fiasco was followed by another scandal in February 1997, when the Minister of Health tried to fast track the development of *Virodene*, an industrial solvent, under the guise of an anti-AIDS drug, despite warnings from the Medicines Control Council that it was dangerous. The result was a disregard for ethical and procedural guidelines for medicines development (Coombe, 2000). There was a clamour for Virodene from people with AIDS, and the medical profession was accused by both the Minister of Health and the Deputy President of retarding access to life saving therapies (Schneider and Stein, 2001).

Critics have argued that the rapid spread of the HIV epidemic in South Africa has been compounded by poor government action to recognise and respond effectively to the source of the problem. President Mbeki's questioning of the cause of HIV/AIDS and embracing the views of people regarded by the scientific community as HIV/AIDS dissidents, engendered public confusion and undermined the government's anti-Aids campaign. Assembling a panel of dissident scientists in South Africa to

ponder the relationship between HIV and AIDS further created more questions about the government's commitment to existing prevention strategies that are based on the understanding that HIV causes AIDS. This diverted attention and resources from preventive and ameliorative action planned by the Department of Health and Welfare's AIDS Directorate (Schneider and Stein, 2001) and it undermined the very policies set up by the Departments of Health and Education. (to be discussed later in the chapter).

Furthermore, in 1998 the government decided to withhold funding for AZT treatment of pregnant, HIV positive women, on the grounds that the cost-benefit ratio did not favour such funding. The decision was strongly criticised on a number of grounds, especially at the 13th International AIDS conference in Durban, July 2000. The government announced that it would not provide *Nevirapine* for preventing mother-to child transmission of the virus. Some Local HIV/AIDS researchers feared that the government's reluctance to fund AIDS drugs was a result of what they perceived as the President's view of the disease (Schneider, 2002).

Government HIV/AIDS strategies have been criticised by various stakeholders as:

> Simply a broad set of guidelines, and not an operational plan with targets for every clinic, school, municipality and province. As a result, the implementation of the HIV/AIDS strategy is very uneven in the country. Gauteng province has for a number of years run an impressive multi-sectoral HIV/AIDS programme; yet Mpumalanga has virtually no HIV/AIDS programme and consistently fails to spend its budget for the disease.
>
> (Focus 2003:26)

Government officials have also been criticised for not taking the lead in the fight against HIV/AIDS:

> There is no one who holds a high position in government who is consistently speaking out about AIDS. Deputy President Zuma has been designated to do so. But he has been devoting most of his energies to brokering a peace plan for the Congo.
>
> *(*Focus 2003:26)

The 13th International AIDS Conference in Durban, however, is believed to have produced changes in the government's responses to the pandemic. For example, in spite of his utterances about the cause of AIDS, President Mbeki admitted at the official opening of the Conference that the epidemic was very serious and the government was committed to fighting it. In closing the same conference, former President Mandela insisted on moving 'from rhetoric to action', and 'rising above our differences… to save our people' (*Weekly Mail and Guardian*, 21-27 July 2000:40). The *Financial Mail* (21 July 2000) also reported that at this Conference, the South African government's failure to provide leadership on AIDS was replaced by an invigorating energy as speakers from many different parts of the world confronted the grim truth about AIDS.

President Mbeki, in his State of the Nation address, 8 February 2002, stated that Government, working in partnership with all sectors, particularly the South Africa National AIDS Council (SANAC), would intensify its comprehensive programme against AIDS, sexually-transmitted diseases, tuberculosis and other communicable diseases. He indicated that the focus of the government remains:

> A massive prevention campaign directed at ensuring that the high rates of awareness translate into a change of lifestyle; care for the affected and infected; treatment of all diseases, including those associated with AIDS; and research and vaccine.

This shift in attitude/approach is evidenced by the boost for the HIV/AIDS programme in the 2002/2003 budgets. The government increased spending on HIV/AIDS prevention programmes in schools and communities, hospital treatment and community-care programmes by R1 billion, in addition to the R4 billion for the treatment of HIV/AIDS related illnesses. By 2003 the government had increased the budget allocation for HIV/AIDS from R342 million in 2001/2, to R3, 6 billion in 2005/6 *(*Focus 2003:26)

The government expects to distribute 400 million free condoms before the end of 2003, using outlets such as shebeens[2], schools and clinics. According to a government press release in mid April 2003, government hospitals now offer HIV-positive

[2] Shebeen, an Irish name for an unlicensed tavern, adopted by South African townships and suburban homes.

pregnant women and their newborn babies the Antiretroviral (ARV) drug, *Nevirapine*, to prevent mother-to-child HIV transmission. By the end of December 2002, almost seven thousand women had been given *Nevirapine*. As the transmission rate from HIV positive mothers is around 30%, the programme may be estimated to have saved about 21,000 babies from infection (Schneider, 2002).

However, while the government proclaims its mother-to-child programme as an achievement, it should not be forgotten that it was forced to extend its offer to all its health facilities only after the pressure group Treatment Action Campaign (TAC) brought a court action against the health minister and her provincial counterparts. Had it failed to roll out *Nevirapine*, the government would have faced a contempt of court charge (AIDS Focus, 2003).

Apart from the government institutions, every person, community and private enterprise, as well as the media, have been called upon to become aware of their responsibilities and exercise them in an active and sustainable manner. So far, many organisations have responded to this call and have started bringing HIV/AIDS debates into the open. For example, several multi-media campaigns mounted by non-government organisations, such as *Soul City* and *Love Life,* aim to change the sexual behaviour of the youth in order to reduce the rate of HIV/AIDS infection. These media campaigns bring AIDS issues into the living rooms of many South African families by using radio, television and print.

The television soap opera *Soul City* is an example of how racial, cultural, gender and violence issues can be tackled through the medium of television. In addition to dealing with cultural issues and having a dramatic story line, *Soul City* effectively introduces understanding of social issues such as AIDS through its dramatic medium. The media drive is linked to state programmes at clinics, emergency help lines and community education (Crewe, 2000).

Although the government in general, and the Department of Health in particular, have been accused of denial and obfuscation with regard to AIDS (Van der Vliet, 2004) the Ministry of Education in South Africa has acknowledged the seriousness of the HIV/AIDS epidemic, and that there is a great deal that can be done to influence the

course of the epidemic. Through its National Policy on HIV/AIDS (Department of Education, 1999) it seeks to promote effective awareness and prevention programmes in the public education system, including the system of Adult Basic Education and Training (ABET). The policy is intended to minimize the social, economic and development consequences of HIV/AIDS for the education system, for all learners, students and educators and to provide leadership in implementation. The policy in part states that:

- The constitutional rights of all learners and educators must be protected equally.
- There should be no compulsory disclosure of HIV/AIDS status.
- The testing of learners as a prerequisite for attendance at an institution, or an educator as a prerequisite of service, is prohibited.
- No HIV positive learner or educator may be discriminated against, but must be treated in a just, humane and life-affirming way.
- No learner may be denied admission to, or continued attendance at, an institution because of his or her actual or perceived HIV status.
- No educator may be denied appointment to a post because of his/her actual or perceived HIV status.
- Learners and educators who are HIV positive should lead as full a life as possible.
- Infection control measures must be universally applied to ensure safe institutional environments.
- Learners must receive education about HIV/AIDS and abstinence in the context of life-skills education as part of the integrated curriculum.
- Educational institutions will ensure that learners acquire age and context-appropriate knowledge and skills so that they can behave in ways that will protect them from infection.
- Educators need more knowledge of, and skills to deal with, HIV/AIDS, and should be trained to give guidance on HIV/AIDS.

It should be pointed out that however well stated and well intentioned a policy is, it will be rendered useless if it is not translated into practice. Although National Policy

on HIV/AIDS is available, it has been undermined by the government's inability to provide resources and support for ABET centres to conduct effective programmes.

Another exception to the norm of denial and obfuscation, as observed by Crewe (2000:37-38), is the *National HIV/AIDS and Life-Skilsl Programme*. The programme addresses difficult racial, moral and ethical issues, and aims to get HIV/AIDS education into all schools through teacher training and curriculum innovation. While this has not been a uniformly successful programme, it has explored ways in which diverse groups of people can overcome suspicions and tensions and work together to develop an appropriate and dynamic response (Crewe, 2000).

In the late 1990s, it was clear that getting HIV/AIDS education into schools should be the work of the education departments in all nine provinces. This has been achieved through collaboration between the national Departments of Education and Health. In a unique move, the Department of Health raised the money, and gave Education the authority to spend it. The government established the National Project Committee for HIV/AIDS and Life-skills, with representatives from all the provincial education and health departments, as well as from the national NGOs, youth organizations and teacher unions (Crewe,2000).

The Life-skills programme was intended to cover all primary schools and ABET centres. In this way all young people and illiterate adults would have comprehensive HIV and AIDS education that would enable them to remain uninfected, and know how best to deal with HIV/AIDS in their communities.

However, despite these efforts by government and NGOs, HIV/AIDS has continued to spread, with serious socio-economic consequences. The failure by some politicians to recognize the HIV/AIDS threat to society is matched by the communities' denial and silence. Communities still refuse to name HIV/AIDS as a scourge that is wiping out the citizenry in its prime. Denial of AIDS as a cause of death is widespread as families hide behind the notion of 'respect for the dead' (AIDS Focus, 2003). (This will be discussed further in chapter two under 'stigma and denial'). Open discussion of HIV/AIDS infection is still largely a taboo subject among the majority of the population, especially in the rural areas (Barnet and Whiteside, 2002; Marks, 2002;

Luyirika, 2000). So acute are the sensitivities around HIV/AIDS that in at least one highly publicized incident in 1998 a young woman, Dlamini Gugu, was killed by members of her own community in whom she had confided her HIV positive status. There have been several reported cases of individuals being ostracised, beaten or otherwise discriminated against by members of their communities after admitting to being HIV positive.

It should be mentioned at this stage that as long as stigmatisation and discrimination exist, people will find it difficult to be open about their HIV/AIDS status, and yet so long as people maintain secrecy, campaigns against HIV/AIDS may be in vain. This means that South Africa still has a long way to go, and there is no room for complacency.

Nevertheless, there may also be room for optimism, as noted by Crewe (2000:37):

> Much as it might be too late to stop the effects of a major epidemic, but it may not be too late to avoid a catastrophe, To do that South Africa has to focus on the real issues, and unite and put aside government and NGO differences in order to forge a new and common understanding of how we can respond in a way that is mutually respectful, critical challenging and ultimately effective.
>
> Crewe (2000:37)

Furthermore, communities should be prepared to name the threat posed by HIV/AIDS and put pressure on their counsellors and Members of Parliament to take up the issue, so that politicians do not get away with their apparently disinterested approach to HIV/AIDS (AIDS Focus, 2003).

1.5 Contribution of the study to the advancement of knowledge

Many programmes in South Africa providing care and support for people living with HIV/AIDS (PWA or PLWA) have been organised at community level in line with local needs, but these community-based programmes are being overwhelmed by the growing number of people living with HIV/AIDS, especially in rural impoverished areas (Barnett and Whiteside 2002; Marks, 2002). Meeting this growing demand will require active participation and involvement of all sectors of South African society.

ABET programmes, targeted at the rural underserved population, can play a vital role in formulation of appropriate strategies of addressing the problem of HIV/AIDS prevention and support, and are a site for programme implementation and development.

A review of literature reveals that no studies from an adult education perspective have been conducted regarding the ways in which rural ABET centres address the challenge of HIV/AIDS prevention and support in South Africa. Thus, this study contributes to an understanding of existing strategies and provides an informed framework for the development and implementation of appropriate strategies for HIV/AIDS prevention and support.

1.6 Description of the research method and scope of the study

This study used qualitative research methods. Five ABET centres in Vhembe District of Limpopo Province, Makhahlule, Matangari, Mbaleni, Mutangwa Manugu and Rivoni were selected as representing the rural ABET centres in Limpopo Province. These particular ABET centres were chosen because they were sites of a community development initiative, the 'Ikhwelo Project', run by Project Literacy, an educational NGO, in partnership with the Department of Education in the Eastern Cape and Limpopo Province. In 2002, when this research commenced, Ikhwelo Centres were almost the only public ABET centres still operating in Limpopo Province following a period of hash cutbacks. Limpopo Province was chosen over the Eastern Cape for this study because I had lived and worked there for several years and I was familiar with the people, language and geography of the former Venda (Vhembe District). The research method is set out in detail in Chapter 4.

Selected District coordinators, Centre Managers, and adult educators were interviewed to provide relevant information regarding the activities carried out in the centres, the problems experienced, existing strategies and infrastructure in their centres to address the challenges of HIV/AIDS. In addition, focus group discussions were held with groups of learners in each ABET centre on two occasions in 2002 and 2003 to gain insight into the knowledge, attitudes, beliefs and practices of ABET practitioners and learners with respect to HIV/AIDS prevention practices and care issues.

1.7 Organisation of the remainder of the study

This thesis is divided into eleven chapters which correspond to the steps suggested in the research aims and objectives listed above.

Chapter two provides the theoretical framework on which the study is based.

Chapter three reviews the findings of other researchers regarding HIV/AIDS. It provides a focus for the study on key aspects related to strategies for HIV/AIDS prevention and support. These aspects include the social context of HIV/AIDS, theories of coping with stressful events, a range of responses to HIV/AIDS, for example denial, stigma, condom use and voluntary testing and counselling and finally, gender and HIV/AIDS.

Chapter four contains a further review of the literature on providing HIV/AIDS education in a culturally sensitive manner. It presents the challenges faced by educators who provide HIV/AIDS education in rural areas worldwide, and finally experiences and practices regarding HIV/AIDS education in Uganda and Botswana.

Chapter five provides an account of the research methods. It describes the manner in which the sample was selected, and the way in which interviews, critical incidents and case studies were used to gather and interpret data.

Chapter six seven, eight, nine, and ten report on the results of the study in the five case studies.

Chapter eleven concludes the thesis. It provides an analysis and discussion of the findings, including suggestions made by the participants of the study, as well as recommendations and conclusions. This chapter presents suggestions for future research.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.1 Introduction

While the previous chapter introduced the aims and objectives of the research, this chapter provides the theoretical background to the study. It begins by examining the social context of HIV/AIDS, then describes the theory and practice of adult education and the gap that exists between theories and principles of adult education and the real life context in which they are applied in South Africa. Next it develops an understanding of human and social capital theories, the link between human and social capital and HIV/AIDS prevention and support, and finally how they add to individual health.

2.2 HIV/AIDS in social context

Researchers such as Ankrah (1991), Schneider (2002), Crowthers (2001),Barnett and Whiteside (2002), Maticka-Tyndale (2001), and Gilbert and Walker (2002) argue that there is a long-standing relationship between social inequalities and health in general. Yet for many years, as pointed out by Schneider (2002:6), despite the highly publicised nature of both the AIDS epidemic and the profile of inequalities in South Africa, there has been relatively little attempt at linking the two in a coherent *social* epidemiology of HIV. Research, as observed by Ankrah (1991:967), has tended to be clinical or biomedical in orientation. An emerging body of social science research is attempting to uncover the social, cultural and historical dimensions of HIV. Nonetheless, the continued inclination of policy makers is to fight AIDS chiefly through the health and medical system almost exclusively, despite the limited resources available for that sector.

Social science has some difficulties in getting to grips with HIV/AIDS. HIV/AIDS does not form an autonomous arena of activity; it is not a set of social activities separate from the usual ebb and flow of social life. Nor is it part of a concern with

'health' and 'reproductive health'. Rather, HIV/AIDS encompasses wide stretches of social life, especially, but not only, sexual and family activities. As such, understanding HIV/AIDS requires penetrating to the very core of cultural, economic and social structures and the lives people live within these structures (Crowthers, 2001:5).

Traditionally, AIDS has been viewed as a medical problem. This study of how rural ABET centres deal with HIV/AIDS proposes that prevailing social conditions are an integral causative/perpetuating factor of AIDS; a condition that has not received due attention thus far. The pervasive effect of poverty in its manifold manifestations in most Sub-Saharan African countries is but one of the critical social dimensions that must be addressed fundamentally, if AIDS is to be combated.

The context of AIDS in Africa

Ankrah (1991), citing Struchiner (1990), described AIDS as a 'disease of poverty', explaining that in conditions of poverty the AIDS virus flourishes. Studies have shown that of the 35 poorest nations in the world, 26 are located in Africa. By all accounts the continent has the highest number of HIV infected persons; with an estimated 23 million people infected (close to 70 percent of the global estimate of 33.3 million of HIV-positive people) in 2001. Despite the fact that the world's most impoverished region has potentially the largest number of infected people, Ankrah (1991) noted that little attention had been given by social scientists to the study of a possible linkage between social conditions and AIDS. The few researchers who have so far been identified as upholding this school of thought, such as Ankrah (1991), Schneider (2002), Crowthers (2001), Barnett and Whiteside (2002), Maticka-Tyndale (2001) and Gilbert and Walker (2002), argue that social inequality is the greatest transmitter of HIV/AIDS. They argue that strategies for change need to address social inequality, and the empowerment of women in particular, if rates of transmission are to decline. They focus specifically on the social dimension/side, and they emphasize that policy and programme measures to stop HIV/AIDS should be a collective balanced *social* and *biomedical* effort.

The social side of HIV/AIDS involves a high level of social inequalities in a variety of dimensions, namely: poverty, gender, race and ethnicity, class and occupation. In

the section that follows I will examine the dimensions of social inequalities and their complex relation to health.

Poverty and social inequality

The existence of health inequalities between populations in more and less developed countries, as well as within different groups in industrial countries, is a well-established phenomenon (Kaplan 1996; Wilkinson, 1996). The size and nature of these inequalities present a major public issue and have been the focus of numerous health studies as well as health policy undertakings (Gilbert and Walker, 2002). It was long believed that these differentials in health would diminish with increasing economic development and improvements in the technology, practice and availability of medical care. However, these predictions, as observed in various studies by eminent researchers such as Whitehead, (1988), Townsend, Davidson and Whitehead, (1988), Nettleton, (1995) and others, have not materialized. This failure is attested to by the vast amount of literature pointing to the continuing existence - and indeed growth – in health inequalities within and between countries.

Gilbert and Walker (2002:3), citing European Union Development (2000), point out that for one quarter of the world's population, absolute poverty remains the principal determinant of their health status and exposure to HIV/AIDS. Clearly Southern African societies remain highly unequal, with small white and black elites contrasting with extensive swathes of black poverty (Crowthers, 2001). Several studies, for instance Campbell, Mzaidume and Williams (1998) have shown that poverty can generate a desperate need to sell sexual services, thereby increasing the chances of weakened and scarred bodies with a higher risk of contracting HIV/AIDS. Crowthers (2001:17) observed that poverty decreases the possibility of using contraceptives and it reduces the possibilities of prolonged resistance to disease. Crowthers (2001) further suggests that raising households and communities out of poverty would enhance their capacity to resist HIV/AIDS once contracted, and probably reduce the chances of obtaining it in the first place.

Class and occupation

Several studies have shown that there is an inverse relationship between HIV/AIDS and class (Nettleton, 1995; Gilbert and Walker, 2002). HIV/AIDS, it has been

claimed, is a disease of poverty (Mbeki, 2000). Although Crowthers (2001: 14) does not fundamentally disagree with the above, he argues that in reality the picture is more complex. He argues that having more resources gives those with some social and economic standing a greater opportunity to indulge in sexual activity. On the other hand, the education normally associated with higher-class positions may parlay into lower risks.

According to Crowthers (2001:16), some occupations seem particularly vulnerable. He cites sex workers as being in the frontline. Occupations where men are separated from their families, for example soldiers, military or police at bases, and mineworkers, also run a very high risk of contracting HIV/AIDS.

Gender factor

Studies have shown that regardless of age group, women are more heavily infected and affected by HIV/AIDS than are men (Nettleton, 1995; Crowther 2001; Gilbert and Walker, 2002). There are several factors that put women at risk, and these will be discussed in subsequent chapters. Briefly however, females are biologically more at risk because the vagina retains infected semen, and sometimes vaginal damage provides openings for transmission of disease. Social factors tend to raise the risk-rate even further. For some women, especially those in extreme poverty, their sexual attractiveness evolves into a major risk. In many situations transactional sex has become a norm. Cultural devaluation of women, as highlighted by Crowthers (2001:14), provides them with few resources to avoid being subject to unprotected sexual intercourse. Moreover, many women lack the economic means to walk away from an abusive relationship, even those that carry a risk of infection (Gilbert and Walker, 2002).

Racial inequalities

Several researchers have identified race and ethnicity in South Africa as another variable influencing people's health. According to Crowthers (2001:13), HIV/AIDS is widely 'coded' as a distinctly racialised disease. Among many black South Africans this has resulted in a 'paranoid' viewpoint in which they see HIV/AIDS as a disease given to blacks by whites, or otherwise manipulated by whites in their interests. The assumption that it is only blacks that have the disease underlies much of the AIDS

literature, and in itself may be seen as a form of racism. It is true that blacks are victims of HIV/AIDS to a degree that outnumbers that of other groups, but this, as observed by Crowthers, could be because of social practices shared by blacks. Nettleton (1995) has argued that just as the working classes are presumed to lead a more unhealthy lifestyle than the middle classes, and are less likely to undertake health-related activities, black people are presumed to have unhealthy lifestyles which are shaped by their religious and cultural practices. One such cultural practice is the customary and legal rights of males to multiple partners according to the man's wishes. Such practices put partners at risk of HIV/AIDS.

In most cases the infection rates for non-black South Africans are very low compared to those of the blacks. However this could be because information on the HIV/AIDS infection rates of non-black groups are seldom publicised (Crowthers, 2001). However, it should be mentioned that although the rates for non-blacks are lower than those of blacks, they are nevertheless very high on a world-comparative scale. The focus on black infection rates has seemingly diverted scholarly and policy attention from the other groups in South African society and generated some complacency. However, all the rates of infection are alarming (Crowthers, 2001).

In South Africa, race, gender and class are inimical to good health through structural, political, cultural and social inequality. As such, racism should be viewed as an integral part of whatever analysis is developed and the question posed should not be whether it operates but when, where and how it operates (Andrew and Jason, in Gilbert and Walker, 2002).

Attempts to arrest the spread of HIV/AIDS in South Africa have not been successful. There is a wide range of reasons for this. One reason is the simplistic focus on changing individual behaviour patterns due to the early framing of HIV/AIDS as an individual health issue (Marais, 2000). Others, as outlined by Marais (2000), in Gilbert and Walker (2002:37), include the inability to merge the "paradigms of the

medical and the political, the scientific and the social" and a lack of political will (described in chapter one) which has characterised the epidemic in South Africa from the outset.

2.3 Adult Education: Theory and Practice

What is adult education?

Before considering how adults learn and should be taught, it is important to briefly understand what is meant by adult education. There is no generally accepted, legalistic definition of what is meant by adult education. Bertelsen (1974:4) saw adult education as any learning experience designed for adults, irrespective of content, level and method used. Adult Education is not just literacy. It is not, in fact, simply the provision of elementary education for those adults who have never been to school or who for many reasons did not learn adequately while in school. This is the view held by Rogers (1992), who describes adult education as the provision of educational opportunities for adults. This covers more or less all forms of planned and systematic learning which adults experience in the process of living their lives. Adult education is not a single undifferentiated whole. It is a complex grouping of educational opportunities to meet the particular needs of different sets of people (Rogers, 1992:19-20).

Adult education, as defined by Knowles, (1980:25/27) is a "process of adults learning" for their own development, alone or with others to advance "the general level of our culture" It is an experiential process of discovering the unknown. According to Tight (1996:59), adult education refers not just to the age and status of its clients, but also encompasses the notion of participatory learning for its own sake and not for credit.

Adult Education for empowerment

Illiteracy, unemployment, poverty and now HIV/AIDS are problems, all of which need to be given special attention by adult educators and trainers. Adult learners and young adults need to acquire skills that will help them to develop strategies, resources and confidence to change from their position on the periphery of society. Hence adult education should be seen as a tool to empower adults to overcome social problems.

Learning in adulthood, according to Merriam and Caffarella (1991), is not just adding to what we already know. Rather new learning transforms existing knowledge into new perspectives and in so doing emancipates the learner. Freire (1974:13) says clearly that education should be cultural action for freedom and that every person should learn in order to transform his or her environment. He observed that adult education could be a vehicle for overcoming structural problems, such as crime, racism, drug abuse, political conflict, unemployment, illiteracy and poverty.

As the HIV/AIDS epidemic grows and its harmful effect on societies becomes increasingly clear, there is a need for a greatly expanded response from, among others, adult education programmes in rural communities. This means that when participating in educational programmes, adults should acquire the role of active participants, instead of spectators; and become functional participants in the fight against HIV/AIDS. This means that ABET centres should not be providers of remedial formal education equivalent to schooling; they should provide an essential toolbox that offers adult learners an opportunity to address their often-deteriorating living conditions.

Adult Education and the cultural context

Jarvis (1987) provides a model of learning theory based on the adult's life situations. He places learning at the interface of individual and group experience in various socio-cultural milieux. The question 'What is the environment of the adult learner?' should be at the back of the minds of those who plan education programmes. The inner circle of someone's social and cultural environment is the family, a larger unit may be the village or community that a person lives in, still further a city, then a province – country, continent, world.

It should be noted therefore, that adult educators should adopt an approach that takes the current living conditions, environment and cultural background of adult learners as a starting point. Adult education can assist them to analyse the context of their own environment, to become aware of their positions in society and to learn to develop skills to substantially improve those positions (Vella, 1994).

Coombs (1985) supports a flexible educational system, which is directly related to local practices, needs and opportunities. He considers as vital those adult education programmes that address specific needs and opportunities using a variety of methods. The cultural environment of the adult learner should serve as a point of departure for every intervention in the field of adult education, and possibly in other fields as well. Thus in the provision of HIV/AIDS education in rural communities, it is important to deliver culturally sensitive education which will specifically address the needs of the community. This will be discussed later in chapter three under 'delivering HIV/AIDS education in rural communities'.

Interest and needs of adult learners

The cultural environment should also be taken into consideration in relation to the needs of adult learners. As already discussed, all activities related to adult teaching and learning should be based on the needs of those involved. According to Jarvis (1987:11) and Brookfield (1988:319), the learning process itself is essentially the same across stages of life. However, the motivation for and social conditions surrounding childhood learning may be different from those surrounding adult learning (Knowles, 1984). Rakoma (2001) shares this view, suggesting that adult learners have a different orientation to education and learning from that of children. These differences make them approach learning differently. They have an accumulation of experiences, characterised by special developmental trends. It is, therefore, important that whatever educational provision is made for adult learners, there should be a clear understanding of their characteristics and needs.

In a study conducted to assess the learning needs of illiterate adults in the Limpopo Province, Rakoma (1999: 85-90) concluded that needs are job-related, health-related, and education-related. Some are personal enhancement needs, for example, communication with husbands and relatives living away from home. She argues that adults should not participate in adult education programmes for reading and writing purposes only. There should be other benefits to the whole endeavour. Adult learners should be equipped with tools that will help them fight against dependency and deprivation. Adult education programmes in a region such as the Northern Province should develop programmes that are job-oriented, that will also help to cultivate

traditional activities and restore local pride. In other words ABET programmes should be seen as an instrument for socio-cultural advancement.

Minton (1991:102) states that adult learners come to adult education with the intention of satisfying some, if not all, of their deeply felt needs. It is on the basis of this background that Rakoma (2001) suggests that potential adult learners should be encouraged to articulate their own interests and needs so that relevant provisions can be made. Vella (1994: 12) points out that adults desire to be subjects and decision makers with respect to their learning. Participation in diagnosing his or her own need plays a large part in the dedication to learning of an adult learner. An imposed curriculum tends to lead to "apathy, resentment, and probable withdrawal" (Knowles, 980:48). It is therefore imperative that adult education providers consult adult learners about their learning needs within the context in which they exist.

Adult Education in South Africa's Public Adult Learning Centres

The provision and delivery of ABET in South Africa is a relatively new activity and its current status is well documented (Aitchson, 2003; French, 2002; Baatjes et al., 2002,2003). ABET, as currently administered in a variety of different settings, has assumed a particular formalized model since 1996. Previously non-formal ABE or adult literacy, ABET has become more formalized as offered in the different learning sites - NGOs, government public adult learning centres (PALCs) and business. For the purpose of this study, emphasis will be on PALCs and briefly on centres run by NGOs, because four of the case studies presented in this thesis fall under PALCs, while one is run by an NGO.

Although it is policy that curriculum for ABET should be flexible and driven by local contexts, a national curriculum for PALCs has emerged over the last few years. The ABET curriculum for PALCs is strongly influenced by the formal school curriculum (Baatjes, 2003). The eight learning areas adopted for the compulsory schooling system (Mathematical Literacy, Mathematics and Mathematical Science (MLMM), Language, Literacy and Communication (LLC), Natural Science (NS), Human and Social Science (HSS), Economics and Management Science (EMS) Technology, Life Orientation (LO), Arts and Culture (A&C), limit the choices for adults and out-of-school youth learners. They are not designed to meet the variety of interest and needs

of all adult learners. Baatjes (2003:19) notes that the reproduction of the formal school curriculum through ABET programmes is advanced and perpetuated by schoolteachers who are employed as adult educators. The design of assessment tools also reflects the formal school assessment paradigm in format, orientation, content and style. Other curriculum formats exist in NGO ABET centres. Although the curriculum in such centres would be focused largely on literacy in English and numeracy, the curriculum might be more vocationally-oriented or skills-based and directly linked to the needs of the community.

ABET provision has been formalized in such a way that it is contained in levels, which form part of the National Qualification Framework (NQF) structure. For example, participants should obtain a General Education and Training Certificate (GETC) at the end of their basic education. However, some learners may wish to acquire particular skills relevant to their needs, such as managing small businesses for those in the informal sector, or a conflict resolution course for community leaders.

ABET learning areas should be tailored to meet the needs of communities while at the same time teaching core principles with respect to ABET. Indeed the Adult Basic Education and Training and Directorate (1997) recommends that;

- ABET learning areas must be extended and offerings made more flexible;
- In offering ABET, the needs and interests of communities have to be taken into account; and
- ABET learning areas must reflect the interest and needs of learners.

(Adult Basic Education and Training and Directorate, 1997)

However, few government-run ABET centres have taken up these recommendations. An attempt to do so was the Ikhwelo project, which was conceptualised as a 3-year pilot project to address the need that exists in South Africa for a fully productive, literate, and numerate rural and urban population. The project was located in the two poorest of the nine provinces of South Africa, namely Limpopo and Eastern Cape. It was piloted at twenty-eight public adult learning centres in the Eastern Cape and thirty-six in the Limpopo Province. Ikhwelo focused on the development of skills by adult learners in two elective areas, Agriculture and Small, Medium and Micro-

enterprises (SMME). The goal was to provide adults with the skills to become more self-sufficient, while earning recognized academic qualifications.

The formal adult education system is only available to, or used by, a minority of the adult population. In the Limpopo Province there is a high rate of dropout and minimal participation in the system of adult education. In addition to the limited interest in and lack of political will to support ABET, the quality of teaching in PALCs is poor. South Africa has very few well-trained adult educators and PALCs employ mainly schoolteachers who work as part-time adult educators. The need to train adult educators is recognised, but training remains rudimentary and largely delivered through cascade models involving trainers with limited or no experience in the teaching of ABET (Baatjes, 2003).

Much of non-formal adult education in South Africa, as observed by Baatjes (2003:194), was located within the broader social movement, and adult educators developed their knowledge and skills within the NGO sector. Few universities provide professional development programmes for adult educators. As a result South Africa in general, and the Limpopo Province in particular, has very few trained adult educators holding ABET certificates and degrees.

When adult basic education (ABE) was adopted as one of the key focus points of government after 1994, there was an expectation that a significant number of adult educator posts would be established and that government would embark on a development project that would increase and multiply the skills base of adult educators who would then find employment in the PALCS. In the Eastern Cape Province, which has the largest number of under-educated adults after Kwazulu Natal, the restructuring of the provincial Department of Education led to the redundancy of approximately 100 ABE regional officials, who were redeployed into mainstream schooling posts (Baatjes, 2003). Most recently, in the Limpopo province, re-organisation and restructuring in the education system has affected continuity of programmes, especially since experienced and trained ABET practitioners are being transferred to other positions within the Department of Education, only to be replaced by inexperienced personnel.

Furthermore, the development of skilled adult educators is undermined because, as noted by Baatjes (2003:195), the number of adult educators enrolled in university-based programmes has declined. This decline is due to poor conditions of service and limited support from the main employers of adult educators, while a lack of proper conditions of service for adult educators affects the quality of teaching. Adult educators are appointed on part-time bases with annual contracts. They are paid at an hourly rate of between R39 and R93, depending on their qualifications. An educator with only a matriculation certificate is paid R39 per hour (Baatjes, 2003). Furthermore, the appointment of adult educators is linked to the number of learners enrolled at the beginning of the academic year. As a result there is a high turnover of adult educators in the PALCS at the beginning of the year, contributing to the instability of PALCs. The current educator: learner ratio is 1:15, and classes are suspended if this ratio is not maintained. The situation in NGO-run centres is somewhat better and more stable, although conditions of employment remain a challenge (Baatjes, 2003).

The availability of learning support material is also a great concern. Baatjes (2003:19) observed that although there had been an attempt by the state to increase access to materials, most PALCs continued to operate with a lack of materials that had obvious effects on the learning and teaching processes. Another setback is the limited programme duration and contact time. Programmes in PALCs are predominantly offered on a part-time basis. Contact time between learners and educators amounts to approximately 80 hours (two hour session per week) per learning area per year. This is based on the 40-week model of schooling that has been adopted by ABET centres. It should be noted, however, that registration of PALCs is based on the demand for ABET and this is determined by the number of adult learners who register in programmes at the beginning of the academic year. The 40-week year is often reduced by a few weeks because classes start in March and not when school reopens. The duration and contact time in PALCs is small, especially compared to the NGOs, where programmes are often offered on a full-time basis, and 200 hours of contact time per learning area are offered (Baatjes, 2003).

In addition to lack of skilled adult educators and limited contact time, ABET lacks infrastructure. Support for ABET, as noted by Baatjes (2003:18), differs quite

significantly from that of general, further and higher education. Unlike FET institutions, schools and higher education institutions, ABET takes place in sites with limited infrastructure and poorly developed internal quality assurance mechanisms. Baatjes (2003:18) observed that PALCs, although supported by new legislation and policy, remain 'invisible' given the nature of provision and delivery. PALCs remain largely sites of part-time provision and are not supported by proper governance structures and resources. In the case of provision in the workplace, ABET is regarded as a 'sunset activity', supported by short term planning.

Participation in ABET programmes is largely a voluntary activity, the current participation rate, as observed Baatjes (2003:18), being very low (01%) and the drop out rate very high. Adult learners face a range of barriers to participation, which explain non-participation, low retention and high dropout rates (Baatjes, 2003). Non-participation is intricately linked to such issues as poverty, unemployment and access to health care.

The provision and delivery of ABET in PALCs is supported by poor administrative, management, monitoring and evaluation systems. Although, as noted by Baatjes (2003:18), PALCs have been restructured since 1997 with the release of a Regulatory Framework (1996) and later the ABET Act (2000), a very small number of PALCs still run as full-time centres with dedicated Centre Managers.

In this section an attempt has been made to describe the status of adult basic education and training in South Africa and to highlight the significance of ABET as a mechanism for incorporating illiterate and under-educated adults as active participants in the socio-economic, political and cultural life of South Africa. ABET should be viewed as prerequisite for growing a knowledge-rich society and a necessary vehicle in the reconstruction and development of the country. Failure to recognise the significance of ABET, in the socio-economic transformation of South Africa, perpetuates the marginalisation and exclusion of millions of illiterate people in the development of the country. Furthermore, the planners of ABET programmes should endeavour to assess the interest and needs of the adult learners and use them as a guide to developing the programmes.

In provision of adult basic education in South Africa's public learning centres, there is a gap between theories and principles of adult education and the real life context in which they are applied. There are few trained adult educators, limited infrastructure, inadequate management and administrative systems, limited learning support materials, minimal participation in ABET and a high dropout rate (more than 50%), especially in the Limpopo Province. Baatjes (2003) argues that adult learners are more likely to participate in programmes that reflect immediate benefits. However, learners experience multiple deterrents to participation. These deterrents are often associated with poverty, unemployment, health food, shelter and other basic human needs. Incentives to address deterrents need to be considered.

2.4 Theories of Human and Social Capital

Introduction

Given the sketchy successes of health education in reducing transmission of HIV/AIDS, there is a need to develop understandings of community-level factors that enable or constrain the likelihood that people will pay heed to HIV/AIDS prevention messages and attempt to address the challenges of HIV/AIDS in their communities.

This section examines the usefulness of human capital and social capital theory for conceptualising features of community which might explain the ways in which different rural ABET centres address the challenges of HIV/AIDS prevention and support in Limpopo province in particular. It develops an understanding of human capital and social capital. It will also investigate the links between them (measured in terms of trust, reciprocal help and support, positive community identity and participation in formal and informal community associations) and HIV/AIDS prevention and support. Coben (2002) observed that in recent years there has been an increasing interest in the conceptualisation of various types of capital. It has become fashionable to use the term 'capital' in a much wider sense than that of labour power, raw material, buildings and machinery (Winch, 2000). In this section the main types of capital are outlined.

1 Natural Capital: the natural resources stocks from which resource flows useful for livelihoods are derived (e.g. land, water, wildlife, biodiversity, and environmental resources).

2 Social Capital: the social resources (networks, membership of groups, relationships of trust, access to wider institutions of society) upon which people draw in pursuit of livelihoods.

3 Human Capital: the skills, knowledge, ability to labour and good health important to the ability to pursue different livelihood strategies.

4 Cultural Capital: set of social practices and skills that are slowly cultivated as a child grows up, and which demonstrate his or her membership of a particular social group or class. Cultural capital includes, among other things, access to school education and higher academic qualification.

5 Physical Capital: the basic infrastructure (transport, shelter, water, energy and communications) and the production equipment and means, which enable people to pursue their livelihoods.

6 Financial Capital: financial resources which are available to people (whether savings, suppliers of credit or regular remittances or pensions) and which provide them with different livelihood options.

7 Cultural or political capital: Cultural capital can be defined as the cultural resources (heritage, customs, traditions) upon which people draw in pursuit of livelihoods (Campbell, Mzaidume and Williams 2003)

Bebbington (1999:2029) demonstrates that it is interaction between natural capital, human capital, cultural capital, social capital and financial capital, which enhances human well-being and development. These different forms of capital are understood as both input needed (resources) and output (income for example) generated.

For the purpose of this study, human capital and social capital will be discussed. To avoid confusion, it will be helpful to distinguish the senses in which these terms are used.

Human Capital

Human capital, according to Schuller (2000:3), focuses on the economic behaviour of individuals, especially on the way their accumulation of knowledge and skills enables them to increase their productivity and the wealth of the societies they live in. The underlying implication of a human capital perspective is that investment in knowledge and skills brings economic returns individually and therefore collectively. Human Capital theory holds that money and time devoted to education and training should be viewed as an investment in human capital, rather than as a cost to government and/or organization. It is based on the belief that there is a direct link between education and training and economic growth. Education and training are seen to be an investment in which learners and workers are both value-added products and the means by which not only the economy can be improved, but also the health status of the people.

Human Capital Theory, according to Castle (1996:42), has long been attractive to strategic planners in state and business organisations. It promises perpetual economic growth, an end to poverty and a more equal society. Human Capital Theory has to date been a dominant view adopted with regard to forms of capital in society. It has been developed by economists who view human beings as a form of capital that is dependent on different forms of investments in individuals and society so that there are returns through increased income for individuals and economic growth (Schultz, 1961).

According to Human Capital Theory, groups that are disadvantaged, for example rural black women owe their inferior rewards to lower investment in human capital. Therefore adult basic education and training (ABET) is a means for disadvantaged rural women to develop their human capital. An increase in their level of education should lead to an increase in their productivity in the labour market and society. They should become employed in the formal and informal sector and should become financially self-sufficient leading to stable households that in turn should improve the health status of individuals and communities at large.

Human Capital Theory, which was popular in the 1960s, fell into disfavour in South Africa in the 1970 and 1980s after being heavily criticised by Marxist and dependency theorists. Recent critics of Human Capital Theory have found the economists' analysis of economic activity too limiting in its emphasis on people's functions in society that shows little recognition of the role of human relations and networks of relations in economic institution (Coleman, 1990:300, Ashton & Green, 1996). In South Africa, the theory was seen to be flawed, as it promised too much, too fast. It became apparent that there was no simple relationship between 'inputs' and 'outputs' in education. The relationship between schooling and economic returns was affected by many factors, such as changes in the demand for skilled labour and the effectiveness of collective bargaining arrangements (Archer and Moll, 1992 in Castle, 1996). More money and time invested in education and training did not automatically produce more productive workers or stronger economies. Family background and social class were discovered to be more potent institutions for the economic success of individuals and groups than the school. Societies, which managed to reduce rates of innumeracy and illiteracy, did not thereby eliminate poverty, or create equality. One of the strongest criticisms of Human Capital Theory has been that it deflects attention from structural problems and turns them into individual ones (Nasson and Samuel, 1990; Chisholm, 1983 in Castle, 1996).

It should be pointed out, however, that despite these criticisms, Human Capital Theory has experienced a revival internationally in the context of the rise of globalisation. The promises and assumptions of Human Capital Theory are reflected in the thinking of many educational and manpower planners in South Africa today. The transition to a new political dispensation renewed hope that education and training, alongside other interventions, have the power to influence important structural features of economic and social life

Social Capital

Social capital theory emerged from a critique of human capital theory. Studies have shown that society's endowment of educated, trained and healthy workers in itself does not determine how productively they are utilized. As pointed out by Becker (1975), the latest equipment and most innovative ideas in the hands or mind of the brightest, fittest person, will amount to little unless that person has access to others to

inform, correct, assist with and disseminate their work. Life at home, in the boardroom and on the shop floor is both more rewarding and productive when suppliers, colleagues and clients are able to combine their particular skills and resources in a spirit of cooperation and commitment to common objectives (Becker, 1975).

Although the term 'social capital' originated as early as 1920, the initial theoretical development of the concept is attributed to French sociologist Pierre Bourdieu and American sociologist James Coleman (Portes, 2000). Bourdieu (1986) wrote about the interaction of three sources of capital: economic, cultural, and social. Coleman (1988) focused on the role of social capital in the creation of human capital. Although both scholars concentrated on the benefits accruing to individuals or families by virtue of their ties with others, there are significant variations in their theories. For Coleman, social capital is constituted through the social relationships that people have with each other, through the collective knowledge of a group, and the moral, cognitive and social supervision that the group exercises over its members. In other words, social capital is the cementing of social relations, mutual trust and confidence that arise through learning.

The concept of social capital is strongly contested and consequently, variously defined in the sociological and development literature (Gilbert and Walker, 2002). To Bourdieu, social capital exists as a 'network of lasting relations'; in other words, an individual's or individual group's sphere of contacts. Putnam (1996), one of the leading writers in the field, defined social capital as "features of social life, networks, norms and trust that enable participants to act together more effectively to pursue shared objectives" (Putman 1996:114). Putman (2000:19) differentiates social capital from physical capital and human capital as follows:

> Whereas physical capital refers to physical objects and human capital refers to the properties of individuals, social capital refers to connections among individuals-social networks and the norms of reciprocity and trustworthiness that arise from them.
>
> Putman (2000:19)

Portes) (1998) argues that;

> Whereas economic capital is in people's bank accounts and human capital is in their heads, social capital inheres in the structure of their relationships. To possess social capital a person must be related to others, and it is these others, not himself, who are the actual source of his or her advantage.
>
> Portes (1998:6)

In essence, where human capital resides in individuals, social capital resides in relationships (Lin, 2001).

Gilbert and Walker (2002), citing Budlender and Dube (1997:19), argue that different understandings and definitions of social capital have resulted in fuzziness of the concept which renders it theoretically problematic, yet allows for its adaptability to specific issues, circumstances and environments.

Bebbington (1999:2021) developed an analytical framework for rural poverty that highlights the importance of the relationship between different forms of social capital while paying particular attention to the importance of social capital as an asset through which people are able to widen their access to resources and other actors. For example in poor rural areas, people make use of the social networks available to them. In a similar vein, Hawe and Shiell (2002:873) suggest that 'social capital' has relational, material and political aspects and it may have positive or negative effects. It can refer to both dense and loose networks. In the development literature, communities endowed with a rich stock of social networks and civic associations have been shown to be in a stronger position to confront poverty and vulnerability, (Moser, 1996) resolve disputes (Schafft and Brown, 2000) and share beneficial information (Isham et al., 2002).

With regard to health, people are most likely to undergo health-enhancing behaviour change if they live in communities that offer high levels of participation in local networks and organizations which are associated with a high level of trust, reciprocal help and support, and a positive local community identity (Campbell, 2003:51). Campbell further argues that the most important dimension of health enhancing social capital is perceived citizen power. This is a characteristic of communities where

people feel that their needs and views are respected and valued and where they have channels to participate in making decisions in the context of the family, school and neighbourhood.

Campbell (2003: 50) argues that people are more likely to be healthy in communities characterized by high levels of social capital. She adds that communities that are rich in social capital provide a supportive context within which people can collectively negotiate social identities in ways that promote health-enhancing behaviors. Furthermore, residents of communities with high levels of social capital are more likely to have high levels of perceived control over their daily lives. This is important for health, given that people who feel in control of their lives are, in general, more likely to take control of their health, through either health-enhancing behavior or the speedy and appropriate accessing of health services.

The notion of social capital, as observed by Campbell (2003:52), has taken strong hold in the discourse of leading international development agencies, and the task of building or enhancing local social capital is increasingly regarded as a key dimension of a range of health-promoting development initiatives in disadvantaged settings. However, as observed by Campbell (2003:52), the concept has also roused fierce criticism for its failure to take account of the way in which various forms of social exclusion undermine the possibility of creating, sustaining or benefiting from social capital in marginalized communities.

A great deal of writing and research in the social capital tradition, as observed by Campbell (2003), tends to portray social capital as an overwhelmingly positive social resource, and one that is freely available to local communities, irrespective of the extent of their social disadvantage. Yet evidence suggests that not all forms of local participation have equally positive benefits for participants. Furthermore, there is much evidence that social capital is often unequally distributed in particular contexts. Thus, for example, research has shown that effective participation in local networks is most likely to take place among the wealthiest and the most educated members of a community. Furthermore, social capital may serve as a source of social exclusion and disadvantage, in contexts where opportunities for creating, sustaining and accessing beneficial social capital are constrained by poverty or other forms of social inequality, such as caste or gender.

It is important to align with Crowthers (2001:16), who argues that networks may have both vicious and virtuous aspects. In terms of sexual and reproductive health behaviour, networks may be employed to recruit sexual partners for unsafe sex, but on the other hand they may work to limit unsafe behaviour, to spread useful information and to be helpful in providing support and advice.

Furthermore, people's location in terms of networks may well shape the extent of social power they have recourse to in situations where this might be helpful. To that effect, Crowther (200:16) points out that in negotiations over sexual behaviour, those with lower standing in their networks, (for example rural women) and smaller stocks of social capital, may be much more vulnerable.

In this study, social capital is viewed as the norms, social relations and social networks embedded in the social structures of society that enable people to coordinate action to achieve desired goals. It is conceptualised in terms of people's participation in reaching mutually beneficial goals. Particular attention is given to the way in which rural ABET centres build social capital, and are enabled or hindered by the divided and unequal power relations that characterize South African society. Of particular significance to this study is that social capital highlights the potential of situations or contexts to influence the outcomes of individuals' actions.

How much do human and social capital add to individual health?

A study conducted in Russia by Rose (1999), as to what extent health varies with involvement and or exclusion from social capital networks, revealed that human capital was the *primary* determinant. Social capital, whether generic, situation-specific or simply a new label for social integration, was a *major* determinant of health.[3] The evidence consisted of individual-level data about self-assessed physical and emotional health drawn from a social capital questionnaire. Multiple regression analysis showed that on their own, human capital and social capital each account for notable variance in health. In the composite model, each retains major influence, demonstrating that social capital makes an independent contribution to health.

[3] In my opinion Social Capital networks are important and may provide hope but they are not the major determinant of health.

Significant social capital influences include involvement or exclusion from formal and informal networks, friends to rely on when ill, control over one's own life, and trust. Significant human capital influences, besides age, include subjective social status, gender and income. Estimates of impact show that social capital increases physical and emotional health more than human capital; together they can raise an individual's self-reported health from just below average to approaching good health. On the other hand, lack of social capital reduces physical and emotional health and exposes people to HIV/AIDS. This was observed in a study conducted by Campbell and Williams (1999) of underground workers on South African gold mines. Firstly, the living and working conditions on the mines were dangerous and stressful. The majority of mine workers lived some distance from their homes and families and they would spend months before going home, yet visits from wives and girlfriends were extremely limited. Men were deprived of the love and support of their families. As a result responsible men who had been celibate for too long would fail to control their desires for sex when they encountered commercial sex workers. The study also revealed that lengthy celibacy might lead a man to consider homosexual relationships, which would not have been considered under other circumstances. Unrequited sexual urges might also lead a man to take unnecessary risks in the township near the mines, by seeking out women whose friends or brothers might beat him up or steal his money (Campbell and Williams, 1999).

The continued practice of dangerous sexual relations by mineworkers could be a result of limited opportunities for emotional support and intimacy. Research in both Europe and America has found a significant correlation between levels of social support and safe sex. For example, gay men in Norway were far less likely to engage in unprotected sexual intercourse if they lived in a supportive social environment. In conditions where they felt lonely and isolated, flesh-to-flesh contact came to symbolize a form of emotional intimacy that may have been lacking in other areas of their lives (Campbell, 1997).

Campbell (1997) observed a correlation between social support and risk-taking behaviour. Mine workers spoke at length about the loneliness of being away from their families and the reduced opportunities for intimate social relationships, which led to the desire for them to have flesh-to-flesh contact (without condoms). While

hostel room-mates, underground team mates, and men from the same home village appeared to constitute support systems in certain contexts, mine workers were adamant that male friends could not make up for the loss of female partners and children within a homely domestic setting. For example, one mineworker who was suffering from TB ascribed the distance from his wife as one of the main reasons for his poor health.

The above analysis indicates that both human and social capital influence individual behavior and contribute to individual health. At the micro level, the emphasis is on the individual's ability to mobilize resources through local network institutions, e.g. community based organizations, extended families and social organizations (see Table 1 below). Of huge importance is the need to facilitate access to networks by the marginalised. A key challenge is to identify local social networks/institutions, understand them and their relationship to the poor, and where appropriate, build and strengthen them.

Table one: Examples of possible social networks in rural communities

Level	Family	CBOs/NGOs	Religious structures	Traditional/ ethnic structures	Political parties
Micro (household/ community level)	Nuclear/ extended family Caste and class structures	Credit union Cooperative Gardening club Creche group Association of traditional healers	Groups associated with specific place of worship (church, synagogue, mosque, temple) Priests	Village headman Local elders	Local branches
Macro (Government)	National level	Provincial level	District level	Circuit	ABET

					centre
		Departments of Education, Health, Labour, Agriculture			

Table 1 Adopted from http://wwwkhanya-mrc.co.za/march-newslater.htm (2003:3)

The principles outlined in table 1 above are relevant to this study of how rural ABET centres address the challenges of HIV/AIDS. Traditionally, in many rural areas worldwide, as observed by Kaleeba, the founder of the AIDS Support Organization, illness is a family matter and everyone wants to help out. Family links are tight and binding. As such, relatives, friends and community members would soon know about the situation, would respond and help the family in need, and would provide the sick with an emotionally supportive family context in which to be ill (Ankrah, 1991). It should be mentioned, however; that AIDS challenges this traditionally understood process because of the stigma attached to the disease. Families are increasingly less willing to maintain such levels of care.

Traditional healers share the responsibility of care giving in the African context. Though not seen as allies by the modern medical sector, it is estimated that 70%-80% of South Africans, especially in the rural areas, will at some point in their lives consult a traditional healer. Ankrah (1991:976) argues that traditional healers are important links to the people, not only because of their herbal treatment but also because they respond to the psychological, physical and spiritual, as well as case management needs, with perhaps the only affordable and accessible healthcare and social services that the majority of the families of AIDS persons will have. ABET practitioners could link up and utilize them to educate and counsel people in prevention and behavioural change strategies.

On a macro level, the National government, Provincial government, Department of Education and the Department of Health, Department of Labour and Department of Agriculture, provide services and resources in terms of funding, learner support

materials and human resource training. In the Limpopo Province, most ABET Centres are Public Adult Learning Centres which are subsidized by government. The learners do not pay fees, rather the Department of Education provides the learner support materials and pays the educators. The Department of Health also provides health services, and nurses at the clinics sometimes run workshops in the communities to sensitise people about health-related matters such HIV/AIDS.

2.5 Conclusion

Chapter two has drawn on and built upon the works of selected authors. The purpose of the review was to provide the reader with sufficient background about the theoretical context of the study, which would help him/her to understand the responses to the HIV/AIDS epidemic which follow in chapters three and four. The review also provides a base from which the reader can appreciate the responses of the ABET centres to HIV/AIDS (chapters six to ten).

The next chapter in this thesis reviews the findings of other researchers regarding key aspects related to strategies for HIV/AIDS prevention and support. These aspects include the social context of HIV/AIDS, theories of coping with stressful events, a range of responses to HIV/AIDS, for example denial, stigma, condom use and voluntary testing and counselling and finally, gender and HIV/AIDS.

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

This section reviews the findings of other researchers regarding strategies for use in addressing the challenges of HIV/AIDS. The researcher will discuss HIV/AIDS in context, looking at it as a social challenge. Theories of coping with stressful events in general, and more specifically with chronic life-threatening illnesses such as cancer and Tuberculosis (TB), will be examined. Subsequently, the question is raised as to what extent coping models and theories are relevant to coping with HIV, especially in rural areas, whether HIV/AIDS diagnosis has unique qualities not shared by other serious illnesses and what the consequences of these special qualities are for dealing with the infection. I will then examine a range of responses to the HIV/AIDS epidemic, for example stigma, denial, condom use and voluntary testing and counselling. Other themes for discussion in this review will include gender and HIV/AIDS

3.2 HIV/AIDS as a social challenge

HIV/AIDS is much more than a medical condition - it has a social, economic and political impact from which no one is immune (Levi, 2002). HIV/AIDS has given rise to tremendous social challenges. More than any other disease, HIV/AIDS has the potential to disrupt many facets of the social fabric. For example, studies by Barnett and Whiteside (2002:271-294), Coombe (2000) and others have shown that HIV/AIDS has an economic dimension in that it affects the most economically productive portion of our population, that is adults of working age who often have young children and elderly parents, and often strikes more than one household or family member. It is a youth problem, with many young people being denied access to knowledge and appropriate health services, as well as a gender issue, because of the inequalities in relationships and attitudes towards women. It is also a poverty

problem, because if people's basic needs are not being met, they are more vulnerable to engaging in risky behaviour. In addition, AIDS is also a security issue, since the virus that leads to AIDS flourishes in times of conflict, civil strife and uncertainty (Levi, 2002).

In South Africa, as in the rest of the world, there is evidence that productivity is declining in all sectors due to illness on the job, absenteeism due to personal or family illness, and funeral attendance. Hardest hit are mineworkers, some 45% of whom were reported to be HIV positive in late 1999 (Coombe, 2000).

Several studies have shown how the epidemic affects everything from households to the public and private sectors of the economy. Barnett and Whiteside (2002:228) point out that in Thailand, one-third of rural families affected by AIDS experienced a reduction in agricultural output, which threatened their food security. Another 15% had to take their children out of school, and over half of the elderly people were left to take care of themselves. In urban areas of Cote d' lvoire, food consumption went down 41% per capita, and expenditure on health care more than quadrupled (UNAIDS, 2000). The commonest scenario worldwide is when family members in urban areas fall ill, often returning to their villages to be cared for by their families and thus adding to the call on scarce resources and increasing the probability that a spouse or others in the rural community may be infected. Families make sacrifices to provide treatment, relief and comfort for a sick breadwinner.

It is important to mention that, inasmuch as it goes unnoticed by agencies and politicians, the impact of HIV/AIDS in rural communities is insidious. Barnett and Whiteside (2000:228) observed that, in parts of sub-Saharan Africa where the epidemic appears to have peaked, rural households were facing health care costs which they could not meet without selling assets or going into debt. Households faced labour shortages, particularly on their farms, reducing their ability to access food in quantities and of quality necessary for active and healthy lives.

In addition to losing material things, there has also been a breakdown of social solidarity and social bonds amongst rural households and communities (Rugalema, 1999). However, it should be noted that the thinning of the social fabric (as observed

by Lunderberg and Over in Barnett and Whiteside {2000:229} does not happen equally because such events have gender and class dimensions. For example, men have more access to assets than women. The wealthy have more resources to call upon and for longer than the poor and these resources are of a different order. The poor call on credit, while the wealthy can call on more informal transfers, with extended repayment periods, because they are known to be people 'of substance'.

In a similar vein, Nettleton (1995) and Gilbert and Walker (2002) also established that social inequalities in terms of social class, socio-economic status, gender and race, put some individuals and groups in situations of increased vulnerability to disease, especially HIV/AIDS. They highlighted that socio-economic status is a good indicator of burden and disease in that the lower the socio-economic status of a community the more likely it is to be unhealthy. The relationship between social inequalities and health will be discussed in detail in subsequent sections of this chapter.

The impact of HIV/AIDS has been most obvious in the health sector. People with HIV/AIDS have a range of health care needs. Most HIV-related conditions can be managed effectively at the primary care level, and basic treatment and care can improve the quality and length of life. However, as the disease progresses, demands change. Care is needed for both acute, treatable illnesses and terminal conditions. There is increased demand from young adults who under normal circumstances would not be users of health care. Barnett and Whiteside (2002:308) point out that, even before the HIV/AIDS epidemic, the Health sector had difficulty in meeting medical care needs. If only a proportion of needs were met, HIV/AIDS would consume a huge share of public health budgets. Barnett and Whiteside (2002:309) also note that HIV/AIDS compromises capacity for health care through its direct and indirect impact on employees. Health workers, for instance, through sexual exposure are at risk of HIV infection, and there is an occupational risk of other infections, particularly tuberculosis. There is also a marked impact on the morale of health workers as workloads increase dramatically. Stress and 'burn out' are exacerbated by factors such as high mortality among children, young adults and colleagues, and perceived risk of infection.

In many sectors, HIV/AIDS has brought about reduced labour quality and supply, as well as and longer periods of absenteeism. Losses in skills and experience result in a younger, less experienced workforce, and subsequent production losses. These intensify existing skills shortages and make training and benefits more costly (Loewensen and Whiteside, 2001). Along with lower productivity and profitability, tax contributions also decline, while the need increases for public services (UNAIDS, 2001).

Employees in all sectors have been affected by the epidemic, potentially reducing their capacity to deliver services. For example in the education sector, Barnet and Whiteside (2002:311) commented that smaller numbers of children need education. Fewer children are born and many HIV-infected infants do not survive to school age. Enrolment is further affected by household economic difficulties and the need for children's labour. Furthermore, AIDS creates learners with new special needs at all levels, thus creating new roles for the educators as well. Examples of the special needs include orphans, children exposed to infectious diseases and emotional trauma because they live with and care for family members with HIV/AIDS, children who are discriminated against or isolated because they or their families are infected, and children in households where a parent is ill or has died, or where orphans have been taken in, and who face difficulties. This means that the traditional roles of the education system in cultivating numeracy and literacy will have to be supplemented by supporting and nurturing large numbers of children in crisis, giving them life and survival skills from an early age (Barnett and Whiteside, 2002).

In terms of supply, all teachers are at a greater risk of HIV infection because of their status and income, which create opportunities for high-risk behaviour (Barnett and Whiteside, 2002). As a result, large numbers of teachers and other employees have become infected with HIV. Absenteeism by a single teacher impacts on large numbers of children. Furthermore, loss of individuals at leadership level, including planners, school inspectors and principals, may further compromise the quality and efficiency of the education system (Barnett and Whiteside, 2002).

Similar analyses can be made of any sector of government. The basic problem is that services are more difficult to supply and in some sectors demand increases. As a

result of the deaths of people during their prime years, there are losses in production and taxes, in human capital and leadership at all levels. In addition, increased illness and death leads to a decrease in staffing and efficiency in security forces, especially amongst middle-ranking army officers, police and other security forces. This can lead to a perception that politicians are ignoring the greatest problem facing their citizens (Barnett and Whiteside, 2002).

Individuals and organisations worldwide have mobilised to meet these challenges. There have been many innovations, some successes, many costly failures and many lessons learned along the way (Parker, Dalrymple and Durden, 2000). As the disease has advanced over time it has become possible to appreciate its complexity, and also to begin to understand what needs to be done to minimise its impact on societies, communities and individuals.

According to the South African Department of Health (March 2000), HIV/AIDS affects disadvantaged communities sooner and more severely than other communities. This trend is linked to a number of social factors that contribute to HIV/AIDS infection, including lack of access to health and social services, poverty, labour migration, rapid urbanisation, unemployment, poor education, illiteracy, language barriers, the culturally-induced inferior position of women, crime, political instability and war. In South Africa, there is a very high prevalence of sexual harassment and rape (an estimated 370,000 women are raped every year in South Africa), with some women being subjected to violent sexual assault that exposes them to HIV/AIDS and other sexually transmitted diseases (STDs) (SAFAIDS, 1998).

HIV/AIDS reduces average life expectancy and results in higher proportions of orphaned children. According to the 1999 Progress Report, South Africa is one of seven countries where the number of children orphaned by HIV/AIDS between 1994 and 1997 increased by more than 400%. In Kwazulu-Natal Province, it is estimated that in the year 2000 there were between 197,000 and 278,000 HIV/AIDS orphans - that is 5.8-8.8% of all children in the province. By 2015, when the epidemic is expected to peak, orphans will constitute between nine and 12% of the total population of South Africa, or about 3.6-4.8 million children. HIV infection places an additional burden on under-resourced health services, and results in the need to look

into home-based care and other networks of care and support for people who have developed AIDS (Parker, Dalrymple and Durden, 2000).

Throughout history, as observed by Parker et al (2000), communities have responded to environmental exigencies such as floods, earthquakes and famine by rapidly organising interventions, systems and practices to deal with these problems. Such responses are also occurring in relation to HIV/AIDS, but the gradual, insidious and complex nature of the epidemic has meant that responses have emerged slowly (Department of Health, 2000). In South Africa, communities have experienced the rise of youth groups that address peers on HIV/AIDS issues and prevention strategies, and care groups that provide support to families and individuals affected by HIV/AIDS, for example the National Association of People Living with HIV/AIDS (NAPWA).

On the same note, based on the absence of a cure or vaccine, the effort to reduce the rate of HIV/AIDS infection should be directed to education and support of people who are already infected. Support and care for infected people is vital for the success of prevention and control programmes (Karon et al., 1991; Levi, 2002). Most important of all is that the willingness to protect others may well depend on the support those infected receive themselves (WHO, 1992).

The overall purpose of supporting somebody, who is ill or may be experiencing the loss of a loved one or loss of a job, is to help him or her to cope. According to Meursing (1997), an HIV diagnosis is an event that heavily taxes coping resources of individuals and those they live with. Therefore, it is important to understand how people cope with such a serious life event and what is needed to improve coping.

3.3 Coping theories

Stressful events are, for some people, part of everyday life. They may be external events, such as a quarrel with neighbours, or internal, like painful and frightening memories. The impact of stressful situations and experiences depends in large part on

how the individual copes with them (Meursing, 1997). Lazarus and Folkman, in Taylor (1986), define coping as the process through which a person manages demands, internal or external, that are appraised as taxing or exceeding the available resources. Coping is a dynamic process, which involves a series of reciprocal responses between the individual and the environment. Thus, coping responses are not a momentary occurrence but rather they form a chain of interactions, which take place over time. Emotional responses are part of this interaction. For example, anger or depression can be seen as an outcome of the impact of a stressor, but also as an attitude with which an individual confronts a stressor (Taylor, 1986). When an individual is confronted with a new event, a first step towards coping with it is to make a primary appraisal of the event, that is, to determine whether this event poses a threat to the individual or not. If the event is indeed judged to be threatening then the individual would assess what resources and potential coping strategies are available to deal with the stressor (Folkman and Lazarus, in Meursing, 1997). If the individual judges that sufficient resources are available to deal with the stressor, he or she is likely to engage in problem-focused coping, also called 'active-behavioural' coping by Wolf et al. (1991). This means that the person tries to deal with the problematic situation itself, for example by seeking information, planning, taking direct action or seeking help.

If the individual judges that he/she at present has insufficient resources to control or otherwise deal successfully with the stressor, the next step may be to increase these resources, for example by finding more information or rallying sources of social support. However, a sense of powerlessness and lack of control over the stressor may also cause the individual to turn to 'emotion-focused coping'. This type of coping attempts to deal not with the stressor itself, but with the emotional strain it evokes. For example, the individual may re-interpret the stressor more positively, ventilate negative emotions or resort to denial of the stressor (Folkman and Lazarus, in Meursing, 1997). Though many stressors evoke coping responses of both kinds, one or the other coping style is generally dominant in individuals. The choice of coping style is not solely determined by the nature of the problem at hand; either coping style may become so dominant it develops into a personality feature. Thus, some individuals have a very active approach to problems they meet in their daily life,

while others avoid difficult situations as much as possible (Folkman and Lazarus, in Meursing, 1997).

Regarding HIV/AIDS, warnings about its growing threat date back to the early- and mid-1980s, but many people, from members of affected communities to leaders of global organizations, have failed to take these warnings seriously. In some cases, the denial has been deliberate. Most people are reluctant to acknowledge the relevance of AIDS to their own lives because of the shame and fear that surround this fatal disease, and the discrimination directed to those affected (Meursing, 1997). Not surprisingly, the great majority of individuals who suspect or know they are infected do not wish to disclose their status publicly. In the absence of support, most people shrink from telling their spouse or partner that they have HIV. Families protect their loved ones from disclosure during and after illness and death, and those who care for them often collude in the denial (Folkman and Lazarus, 1991; Meursing, 1997).

Coping Styles.

Several researchers, such as Bandura (1995), Helman (1990) and Lewis (1966), have identified factors which influence coping style among individuals. Bandura (1995) states that the degree of control individuals feel they have over a stressor is central in the subsequent orientation towards taking action to master the problem itself, or towards reducing emotional strain. The extent to which individuals believe they can organise and execute the courses of action required to deal with events he calls 'self-efficacy beliefs'. These beliefs are the outcome of the balance between situational demands posed by a stressor on the one hand, and a number of intra-personal and contextual variables on the other hand. Relevant intra-personal variables influencing perceived self-efficacy are personal coping skills and biological resilience or vulnerability. Important contextual variables are the availability of social support and material resources for coping (Bandura, 1995).

Access to practical and material resources, such as money and appropriate services, is very important for coping with a stressor, both in a practical and a psychological sense (Meursing, 1997). For example, Billing and Moos (1981) found that American

families with a higher level of income and education used more active, problem-focused coping strategies in dealing with life problems than families from lower socio-economic backgrounds. These findings suggest that access to adequate material resources is associated with more problem-oriented coping, which in turn may be linked to a heightened sense of control or self-efficacy. In contrast, socio-economic conditions where lack of resources is a permanent fact of life - possibly over generations - may decrease a person's self-efficacy beliefs. In the same way that Helman (1990) links poverty to a low sense of control over health, Lewis (1996) asserts that individuals who live in poverty experience a lack of personal control over life stressors, which results in a short time perspective and short term problem-solving strategies.

These authors' studies are relevant to the present research which examines ways in which rural ABET centres address the challenges of HIV/AIDS prevention and support in Limpopo Province of South Africa. Rural communities are often at a disadvantage in terms of access to resources, with implications that poor people in rural communities who are vulnerable to HIV/AIDS infection may not succeed in developing problem-focused coping strategies. Because of their sense of powerlessness and lack of resources, they are more likely to turn to emotion-focused coping.

The second major environmental influence on self-efficacy, as presented by Meursing (1997), is the availability of social support. Practical, material information and emotional support from friends and family increase the instrumental means to deal with a problem, and can act as a buffer against emotional strain, thereby increasing perceived self efficacy. Even when a person initially judges a stressor to be beyond control, this judgement may well be revised once adequate social, material and emotional support prove available. Thus, social support can stimulate active, problem-focused strategies, while lack of social support may result in the use of emotion-focused strategies. The relevance of this to the present study is that ABET practitioners can provide social support to people living with HIV/AIDS by visiting them, and encouraging others to do so, listening to them, offering advice and providing knowledge through AIDS education. In terms of material support, ABET centres could start income generating activities to help increase individual and family

income. In terms of informational support, ABET centres could act as venues for perusal of print materials such as leaflets, booklets, posters and stickers. With regard to emotional support, ABET practitioners may not offer counselling services because they lack proper training, but they can connect PWAs to organizations that offer such services.

Next to the support a social environment may provide or withhold, self-efficacy beliefs may be influenced by social models that provide an opportunity for vicarious learning. Thus, a person's sense of self efficacy can grow by seeing others similar to him/herself succeed by perseverance. This factor is very relevant to this study since research has shown that exposure to people living with HIV/AIDS, both in media and through personal contact, is informative and emotionally supportive. It engages people on a personal level and gives a face to the disease (Parker et al., 2000).

According to Bandura (1977), the example of successful social models may transmit knowledge, skills and strategies to achieve desired ends. Social persuasion employed by a trusted communicator (such as a counsellor) can also strengthen the belief that one has 'what it takes' to succeed, thus increasing motivation for sustained effort. Most importantly, self-efficacy is built upon performance experiences. Success, and particularly success achieved in the face of adversity, increases self-efficacy beliefs. In some persons, self-efficacy beliefs may become a more or less permanent feature of one's personality (Bandura, 1977).

Lack of resources to a great extent affect/limit the self-efficacy of individuals in the rural areas. On the other hand, they have social and emotional support from friends and family (social capital), which helps them to deal with problems such as HIV/AIDS. Therefore it is important that ABET practitioners build on and make use of the available social networks in order to address the challenges of HIV/AIDS in the rural areas.

3.4 Denial, stigmatisation and discrimination

In the previous section I discussed coping theories and factors which influence coping style among individuals. In this section I will discuss stigmatisation of people living with HIV/AIDS as a coping mechanism. Campbell (2003:110) looked at denial and stigma as psychological defences that protect people from what threatens to become an intolerable level of fear and anxiety by leading them to deny that they are at personal risk from overwhelmingly frightening problems.

She observed that part of this process involved projecting fears of one's personal vulnerability onto stigmatised out-groups, and in the process dissociating oneself from a sense of personal risk from the feared problem.

Stigma is itself an important part of the history of any epidemic. Barnett and Whiteside (2002:66) define stigma as "a social process; a feature of social relations reflecting the tension, conflict, silence, subterfuge and hypocrisy found in every society and culture." Aggleton and Parker (2002:8) define stigma as "a quality that significantly discredits an individual in the eyes of others. It is a form of power over people and indicates disrespect for those people". Goffman (1963:3) wrote, along the same lines, that a person with a stigma is reduced in people's minds from a whole and usual person to a tainted, discounted one and that there was a distancing of the stigmatised person from the non-stigmatised, 'normal' people.

In a study conducted by Webb (1997) in South Africa, to determine attitudes towards 'people with AIDS' ('PWA'), trends of stigma, fear and ignorance predominated. In response to the question 'what should happen to people living with AIDS?' participants in the study answered that 'they should be killed,' or that 'they should be isolated'. Similar levels of stigmatisation were apparent in Natal communities, where over 70% of respondents wanted to see PWA either killed or isolated (Francis, 2001).

The response that PWA should be killed is extreme, but it has been a worldwide reaction to the epidemic. Webb (1997) cites an example in Britain in the mid-1980s where overt homophobia often culminated in hysterical press reports advocating the killing of PWA and isolation of homosexuals. In Zimbabwe, a member of parliament proclaimed that 'if a pregnant woman is found to have AIDS she should be killed so that AIDS ends with her'… Similarly, in Ghana respondents in knowledge, attitude, practices and beliefs (KAPB) surveys often advocated 'injectables' to kill PWA (Webb, 1997).

In the context of HIV/AIDS, stigma is mostly simply defined as negative thought about a person or group based on a prejudiced position[4]. The 'undesirable differences' and 'spoiled identities' that HIV/AIDS related stigma causes do not naturally exist, they are created by individuals and by communities (UNAIDS 2001). In other words, AIDS-related or AIDS stigma refers to prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, and the individual groups, and communities with which they are associated. HIV/AIDS-related stigma builds upon, and reinforces, earlier prejudice, and it plays into and reinforces existing social inequalities - especially those of gender, sexuality and race.

Studies on stigma have demonstrated that women with HIV may be particularly stigmatised by society (Bunting, 1996, in Wojcicki and Malala, 2001); and women, in general, are stigmatised with regard to their sexuality and sexual behaviours. Aggledon (2000) noted that, HIVAIDS-related stigma is perceived as 'a mark of shame' where the carrier of the virus is blamed, devalued and significantly discredited. Stigma also derives from HIV/AIDS' association with some of the most elemental parts of the human experience: sex, blood, disease and death. It is associated with behaviours that may be illegal or forbidden by religious or traditional teachings, such as pre- and extra-marital sex, sex work, homosexuality and injection during drug use (www.AIDS stigma.net, UNICEF, 2001).

[4] To feel prejudice towards an individual or group is to hold an adverse opinion or belief without just ground or before acquiring sufficient knowledge (Blumenfield, 2000).

When feelings of stigma, prejudice and stereotypical beliefs move into the realm of behaviour, the result is discrimination (Francis, 2001). Discrimination (as described by Blumenfield, 2000, in Francis, 2001) refers to the negative treatment of an individual or group of people as it denies individual or groups equal treatment. It occurs when a distinction is made about a person that results in their being treated unfairly and unjustly on the basis of their actual or presumed HIV status, or their belonging, or perceived belonging to a particular group. An example of this is when people living with AIDS are denied access to certain jobs such as teaching on the basis of prejudice and stigma.

HIV/AIDS-related stigma and discrimination is widespread. In Africa, as in other parts of the world, such stigma results in rejection, denial, and discrediting, and consequently leads to discrimination, which inevitably leads to the violation of human rights - particularly those of women and children (UNAIDS, 2001). It is expressed around the world in a variety of ways, including:

- Ostracism, rejection, and avoidance of people with AIDS.
- Discrimination against PWA.
- Compulsory HIV testing without prior consent or protection of confidentiality.
- Violence against persons who are perceived to have AIDS or to be infected with HIV.
- Quarantine of persons with HIV (www.AIDS stigma.net).

Gilmore and Somerville (1994:1342) explain that a common response when confronted with a frightening or intolerable situation is to attempt to flee or escape from it, or attempt to control it by inactivating or destroying it. By stigmatising the other we flee from the reality that we are all affected by HIV/AIDS. The fear generated by the stigma of HIV/AIDS ostracizes the individual, family and relatives. It divides communities where those same communities could help and care for each other. Stigma effectively silences many people for fear of the consequences to themselves within society, even more so where the stigma of HIV/AIDS builds on "already stereotyped and stigmatised communities" such as homosexuals and prostitutes (Gilmore and Somerville, 1994:1349), what Pierret (2000:1592) refers to as 'double stigma'. This exacerbates the difficulty of being open about the disease and hinders people from seeking medical help. This dilemma is clearly expressed by Campbell (2003:5):

> Given the stigma and terror that surround the disease in the public imagination, people live in fear of rejection by their communities and formal health services, and fear for their children. Because of fear of rejection, people living with HIV/AIDS are often reluctant to seek out or access services, opting instead to live without support or treatment. Those who disclose their status often become victims of violence, either from partners or family members, or from communities where HIV is regarded with fear, denial and stigma.
>
> Campbell (2003:5)

Sex workers in Summertown, a pseudonymous mining town near Johannesburg, said that if they were HIV positive they would never tell anyone for fear of gossip and abuse, as well as fear of rejection, loss of clients and loss of love from regular partners. Campbell (2003) noted that it was sentiments such as these that made many people afraid to discover their HIV status, or when they did discover their status, to keep it a secret, even from close family members and neighbours. As a result, people chose not to disclose their HIV status, and deaths were generally attributed to other causes, such as drinking too much, or tuberculosis. Friends and relatives often collude in HIV/AIDS denial, as a gesture of support towards the affected individual or family.

Worldwide, the most common response to the epidemic has been the desire to see PWA isolated, both socially and geographically. In a study conducted by UNICEF (2001) on the extent of perceived and enacted HIV/AIDS-related stigma in Zambia, India, Ukraine and Burkina Faso, the desire for isolation of PWA was a common theme. In Zambia, people in the community frequently reported putting physical distance between themselves and people suspected of having HIV/AIDS. Not shaking hands, not sitting next to such people in buses, not sharing food and drinking utensils were all signals of rejection. In India, where an individual was known to have HIV/AIDS, the community was said to slowly reduce contact with the household. In some instances, in India, loud proclamations about the person having AIDS were made locally to isolate and reject people, and there were extreme examples of mass rejection (Francis, 2001). Govender (1992, in Francis, 2001:4) cited an instance in India where on learning that a man was HIV positive, the whole community joined together to buy him train tickets and forced the man and his family to leave for Mumbai. In a South African study conducted with family planning clients in Johannesburg, 68.2% of respondents felt that AIDS patients should be isolated in hospital wards (Francis, 2001).

Extreme forms of discrimination and stigma towards people known or suspected to be HIV positive are also suspected or experienced in health care settings (UNICEF, 2001). Several reports reveal the extent to which people living with HIV/AIDS were discriminated against by the health care system.

For example, PWA are reported to have been denied drugs, left in a hospital corridor, called names, subjected to degrading treatment and to have experienced breaches of confidentiality when medical staff were known to inform people attending the clinic about the HIV status of others. Stigmatisation in a health care setting is often evident in the negative attitudes of nurses, ward persons, doctors and technicians (UNICEF, 2001; Aggledon, 2001).

Furthermore, AIDS is an illness that is stigmatised owing to certain characteristics. Many people talk about AIDS as a 'divine punishment', 'the new leprosy' and 'the curse of modern times' (Pierret; 2000:1593). A moralizing discourse about deviant behaviour and lifestyles places the blame on the infected. In Zambia, Shona words used to describe people living with HIV/AIDS are '*Zayero'* (prostitutes) and '*Mombwe'* (for men having sex with many women). Politicians in Zambia have been reported as making stigmatising remarks such as "HIV/AIDS is only transmitted through reckless behaviour" (Pierret, 2000). PWA as such are depicted as being socially immoral. Churches in Zambia preached morality, condemned immoral behaviour and viewed HIV/AIDS as a punishment from God. Comments such as '…you are paid back for your misbehaviour, you deserve such suffering; you are paying the price of your disobedience to God' were common. In Uganda some churches imposed mandatory testing before marriage (UNICEF, 2001:9-14; Goldin 1994).

In Burkina Faso, HIV stigma carries clear religious and sexual connotations. HIV is perceived as a disease of 'unfaithfulness', 'of refusing God", "of sinners', '*c*urse from God', and of 'sexual wandering*'*. Religious and community leaders have been identified as perpetuating stigma by blaming and talking about retribution for immoral behaviour.

Those infected were likened to Disciples of Satan, and PWA were shunned in churches. In India one woman was told not to burn her husband on the funeral pyre but to electrocute him as the smoke would pollute the air (UNICEF, 2001). Pragge (1995) in Francis (2001) wrote about one family in Cape Town which could not find an undertaker to remove a body of a person who died of HIV/AIDS or a catholic church in which to hold a requiem mass.

These stereotypes and stigmas, as noted by Francis (2001:5), mark out PWA and become so ingrained that they are not seen as contestable. Those who are HIV negative or unaware of their HIV status, project themselves as representative of humanity, or the norm, by labelling people who are HIV positive as 'sexually immoral', 'drug addicts' or 'others'.

Campbell (2003:192) noted that this stigmatisation has driven the disease underground in many contexts, and serves as a major obstacle to HIV-prevention, given that HIV-positive people are far more likely to disclose their status and seek help and advice if they live in communities that are tolerant and supportive of people carrying the virus. People living with HIV/AIDS often prefer to hide the nature of their problem out of fear –fear of rejection, but also in many contexts fear for their personal safety.

In response to the fundamentalist approaches of some of the religions of the world, who represent AIDS as divine punishment for transgressing religious and moral principles and values, Gilmore and Somerville (1994) cite the Episcopal Bishop of New York, who repudiated the notion that AIDS is a divine retribution:

> If God is really punishing people with sickness for their sins, don't you think the perpetrators of war, terrorism, and nuclear destruction would at least get herpes?
>
> (Gilmore and Somerville, 1994:1350).

On the other hand, where HIV/AIDS results from deviant sexual behaviour and in defiance of social values, stigma may be an unconscious survival tactic that reinforces positive societal values. Individually, as well as socially, stigma can be a means of protection. With so overwhelming an epidemic, stigmatising HIV/AIDS may be an unconscious action to preserve a community from eradication in a relatively constructive manner.

Confronting stigma

AIDS stigma is effectively universal, but its form varies from one country to another, and the specific groups targeted for AIDS stigma vary considerably. However, it should be noted that whatever its form, AIDS stigma, characterised by silence, fear, discrimination and denial, fuels the spread of HIV/AIDS. It undermines prevention, care and support; it also increases the impact of the epidemic on individuals, families, communities and nations.

For those reasons, stigma must be confronted.

This section gives recommendations for tackling stigma and discrimination, as suggested in a meeting entitled "Stigma and HIV/AIDS in Africa; Setting the Operational Agenda". The meeting was convened in Dar es Salaam Tanzania, June 2001. It was attended by 80 participants representing organisations of people living with HIV/AIDS, physicians, nurses, researchers, communications specialists, community workers, faith based organisations and UN agencies from 15 countries, primarily from Eastern and Southern Africa.[5] They specified different categories of instrumental people which included leaders at all levels, PWAs, human rights advocates, family, health care settings and communications as having a clear responsibility to create a more open society free from stigma, silence or denial about the epidemic.

Leadership

Leaders at all levels, not just those in government, but also religious and traditional leaders, were called upon to encourage supportive attitudes and responses to all those living with and affected by the epidemic. In particular, leaders were called upon to acknowledge that they were personally, as well as professionally, living with and affected by the epidemic as much as any one else in society. The delegates felt that by discussing HIV/AIDS openly and sensitively and then taking action, leaders could make a difference.

People living with HIV/AIDS

The active involvement of persons living with or affected by HIV/AIDS is central to the fight against stigma. However, the responsibility is not theirs alone: all individuals and all sectors of society must accept the moral obligation to fight stigma and to promote openness, acceptance and solidarity.

[5] Details of the meeting can be found on HIV/AIDS: Advocacy for stigma and HIV/AIDS in Africa. The production is a product of UNAIDS, Health and development networks (HDN) and the Swedish international Development Agency (SIDA)

Human rights

Existing human rights instruments (notably international conventions, treaties, covenants and national legislation) confirm that discrimination against people living with HIV/AIDS, or those thought to be infected, is a violation of their human rights. These instruments also provide an array of formal mechanisms to monitor and enforce HIV/AIDS-related rights and rights of people living with HIV/AIDS, and to redress discrimination. Participants suggested that complementary strategies were required within homes and communities, health care settings, religious organizations and various communications media, both to prevent prejudicial thoughts being formed and to address or redress the situation when stigma leads to discriminatory action, negative consequences or denial of services.

Stigma and the family

The participants pointed out that stigma within the family, or directed toward an affected family, was the most debilitating form of stigma and the hardest to address. By inhibiting open, honest communication, stigma made disclosure within the family difficult; yet without disclosure, prevention and care would be almost impossible.

Families and communities are deeply intertwined in the African context. As such, they require support in preventing stigma, which would further enable their natural caring role. This would promote self-esteem for PWAs and their carers, and avoid vicious cycles of self-stigma.

The meeting prioritised the following key responses within families and communities which are relevant and could be applied by ABET practitioners in addressing the problem of HIV/AIDS in rural centres. It was suggested that:

- Life skills education and counselling should be promoted to help HIV-infected and affected people/learners cope with stigma.
- An essential 'package' of services, including voluntary counselling and testing (VCT) and follow up care, be made available to all. This would enable individuals to learn their sero-status and provide support for deciding whether to disclose their status to other family members.

- Awareness should be raised so that families and communities can access interventions, such as prevention of mother-to-child transmission, care and support services as they become available, or hold authorities accountable if not available

Stigma in health settings

People working on the frontlines of HIV/AIDS care and prevention have both the responsibility and an opportunity to overcome stigma within their profession and workplaces. Their professional codes of ethics and conduct, social and professional authority, and their ability to act as educators and role models for their communities, all place them under an ethical obligation to be 'change agents' for reducing stigma. Unfortunately, experience shows that health care institutions and individuals sometimes perpetuate stigma by stigmatising and discriminating against people, despite their professional codes. Furthermore, health care workers who are (or are presumed to be) HIV positive may suffer discrimination from colleagues and from their communities.

Stigma and the religious sector

The religious sector (churches, mosques, religious schools, lay groups religious NGOs, and ecumenical groups) has far-reaching influence throughout Africa and the rest of the world. They therefore have a responsibility to provide care, comfort, and spiritual support to individuals and communities who are HIV-infected or affected. In particular, religious leaders must play an active role in disseminating preventive messages and in leading the fight against stigma wherever it occurs.

The Dar es Salaam meeting suggested that the religious sector should:

- Ensure that religious leaders are 'AIDS competent' by including HIV/AIDS-related subjects, including counselling skills, in their pre- and in-service training.
- Integrate holistic care and support programmes in service and education activities, including life-skills for youth, home-based family care, support groups for infected and affected persons, and support for orphans.

- Identify religious language and doctrines that are stigmatising, and promote alternative language that is caring and non-judgemental.
- Promote humanitarian and spiritual values of compassion for marginalized and stigmatised groups.

Stigma and communications

While mass media such as radio, TV, print, and the Internet can unintentionally promote stigma, they can serve as powerful tools to help reduce it. Given their potential to shape the attitudes, values and perceptions of large numbers of people, communicators have a responsibility to create clear messages about HIV/AIDS, to report accurately, and to do so in a sensitive and non-stigmatising manner.

With regards to communications, the Dar es Salaam meeting suggested that the mass media should;

- Build skills and capacity for journalists, editors, producers, AIDS activists, communicators and people working in the field of HIV/AIDS.
- Provide resources for sustained communication about HIV/AIDS that effectively reduces stigma.
- Develop media standards for reporting on HIV/AIDS in a non-judgemental and non-stigmatising manner.
- Hold communicators (both individuals and their organizations) accountable for upholding the above standards through broad-based monitoring mechanisms developed on a national/regional basis.

Promoting hope and acceptance is a key response to stigma at all levels of society. In contrast, doing nothing about stigma can only contribute to the growing death toll, as well as to distress and reduced quality of life.

All those with influence and authority within society have a responsibility, individually and collectively, to act in order to reduce stigma about HIV/AIDS within their spheres of influence. Accountability - based on transparency, honesty and openness - is a key component in improving HIV/AIDS prevention, care and support efforts, and to bring them to more people on an on-going, sustainable basis.

Furthermore, while stigma and discrimination may never fully be eliminated, the recommendations suggested above would go a long way towards reducing them, and building the responsibility and accountability that is particularly needed among the rural population. Unfortunately, in South Africa, as indicated in chapter one, explicit and strong commitment of leaders at all levels, especially those in government, are lacking. Leaders have become embroiled in needless controversy and futile confrontations, instead of taking action and discussing HIV/AIDS openly. Some religious leaders in South Africa have also been identified as perpetuating stigma, talking about HIV/AIDS as 'punishment from God' for immoral behaviour.

However, on a positive note with regards to PWA, in South Africa there are a number of people working under the banner of the National Association of People Living with HIV and AIDS (NAPWA). These people, as will be discussed later in chapter three, use their life stories as a powerful motivating force to make the general public aware of HIV/AIDS (Parker et al., 2000).

The South African government, as indicated in chapter one, also extended a National HIV/AIDS and Life-skills programme to all primary schools and ABET centres. This was designed to help HIV-infected and affected learners to cope with HIV/AIDS–related stigma (Crewe, 2000).

Finally, as discussed in chapter one, mass media such as radio, TV, and local news papers in South Africa have also have served as a powerful tool for communication about HIV/AIDS, for example the television soap opera *Soul City,* and this could help to reduce stigma in South Africa.

3.5 Voluntary Counseling and Testing (VCT)

The previous section discussed coping on a psychological level as a mechanism for dealing with HIV/AIDS. I discussed stigma and discrimination as a coping mechanism, with negative repercussions on individuals, families and communities. I described the context in which stigma occurs and recommendations were made for tackling it. In the next section I am going to examine counselling and testing as a strategy for prevention and care for people with HIV/AIDS. I will look at the benefits of counselling and testing, the reasons why people rarely go for testing and, finally, I will briefly review the successful VCT programme in Uganda.

By the year 2000, most of the 34.3 million people worldwide who were living with HIV did not know they were carrying the virus. The proportion was highest in the countries worst affected by the HIV epidemic. There are several reasons for this state of affairs, including ignorance, lack of suitable counselling and testing services, and, as already mentioned, the widespread stigma attached to AIDS, which can result in rejection and even violence against people known to be HIV-positive. People also fear that a positive result means an immediate 'death sentence', although this need not be true[6] (UNAIDS, 2000).

A study of sex workers in the Hillbrow Berea/Joubert Park area of Johannesburg (Wojcick and Malala, 2001) found that sex workers had reasons for choosing not to go for HIV tests. Many who did go for tests chose not to return for the results. Wojcick and Malala (2001:114) argued that sex workers were aware that they were at high risk of contracting HIV/AIDS and their not coming for results for an HIV test was a coping strategy in the already tense and difficult world of sex work. Many feared that that if they were HIV positive, their lives would be miserable, as they would be depressed and forced to leave work. They felt that they were better off not knowing their sero-status than dying of worry (Wojcicki and Malala, 2001).

[6] Studies have shown that in a developing country someone who has just been infected with HIV can expect to live nine years on average before falling seriously ill and to survive up to a year beyond that, even in the absence of antiretroviral therapy (UNAIDS, 2002)

As daunting as the barriers to HIV testing are, studies have shown that it is important to tackle them. When people learn their infection status early on, there can be important benefits for both prevention and care. People who discover they are HIV-negative can take more energetic measures to remain uninfected. People in a stable relationship who test positive for HIV can take steps to protect their partner from becoming infected through sexual transmission and avoid mother to child transmission (MTCT) of the virus. Access to life-prolonging treatment is also a powerful incentive for testing[7]: The family stands to benefit when an infection is discovered early enough to permit advanced planning for the financial security of the survivors.

Finally, important benefits to the community flow from HIV counselling and testing, especially when people with HIV feel safe enough to be open about their infection and become involved in the fight against the epidemic. People living with HIV can bring first-hand experience to AIDS action and help neighbours, institutions and policy-makers face up to the reality of the epidemic (UNAIDS, 2002).

Voluntary HIV testing and counselling can help break the vicious circle of fear, stigma and denial. The benefits are both individual and collective and extend beyond the immediate value of knowing one's own infection status. UNAIDS (2000, and 2002) refer to a successful VCT programme in Uganda, where the first AIDS information Centre (AIC) for anonymous VCT was opened in Kampala in 1991. By 2001 the AIC had grown from a single site to 51 centres, and had tested more than half a million people. Since 1997, the AIC has offered rapid testing with same day results, along with related services such as management of sexually transmitted infection. Costs are subsidized, and, for at least one day per week, VCT is free. The AIC showed that couple testing could be implemented if approached carefully and consistently. The proportion of people requesting VCT as couples from AIC increased from 8% of all clients in 1992 to nearly a third in 2001, with about a quarter of these couples requesting HIV testing prior to marriage. According to a UNAIDS report of 2002, thousands of HIV-positive and HIV-negative people who tested at the centre joined the Post Test club, which not only offered health care and other services, but sent them

[7] New research shows that even in developing countries, inexpensive medication can improve survival and help an HIV-positive person to stay healthy and productive longer. This initiative is the one that has finally persuaded the Department of Health to roll out ARVs in some areas.

into the community to spread information about HIV prevention. Between 1992 and 1998, club members, trained during four-day courses to become peer educators, reached over 180,000 people and distributed 1.2 million condoms. It is important to mention that, to a great extent, individuals like these managed to combat the invisibility of the epidemic in Uganda by giving it a human face - as will be highlighted in the discussion of the Ugandan experience in the next chapter.

Unfortunately, HIV testing facilities in South Africa are still far from adequate. In many places, especially in rural areas, it is not possible to get a test. In others, the quality of the counselling is poor. Often clients have reason to fear that their results will not be kept confidential. People may be tested for HIV without their knowledge or against their will, and employers or family members may be told of a person's HIV status - all flagrant violations of human rights. Testing without prior counselling is especially common in medical facilities; doctors sometimes choose not to inform infected patients that they have HIV for fear of depressing them.

It should be mentioned, however, that even where testing and counselling services of reasonable quality are available, the stigma may be so strong that people choose not to know their HIV/AIDS status, which is their right. Improving the quality and availability of testing services must therefore go hand in hand with efforts to diminish the fear and rejection of people with AIDS, and with the establishment of policies and practices to ensure confidentiality of HIV test results and related information.

In this section I examined Voluntary HIV/AIDS counselling and testing as key components of prevention and care programmes. In prevention, VCT helps people to learn about how HIV is transmitted, to practise safer sex, to get an HIV test, and, depending on the result, take steps to avoid becoming infected or infecting others. Within care programmes, HIV test results and follow up counselling mean people can be directed towards relevant care and support services, such as treatment for tuberculosis and sexually transmitted infections, family planning and, where indicated, treatment for opportunistic infections, treatment with antiretroviral drugs and prevention of mother to child transmission. In addition, wider access may lead to greater openness about HIV/AIDS and less stigma and discrimination (UNAIDS, 2001).

3.6 Knowledge, attitudes and beliefs surrounding HIV/AIDS

Most studies in Southern Africa, as observed by Wojcicki and Malala (2001:99-121), have indicated that awareness and knowledge regarding HIV infection and mechanisms for transmission are high. For example, In a study of Zulu women in Durban, Abdool Karim et al (1991) noted that 95.9% knew about heterosexual transmission of HIV and 97.5% knew about condom usage as a means of prevention. In her studies with adolescents in Kwazulu Natal, Varga (1997) found that 81.2% knew that AIDS was fatal, 96.5% knew that it was sexually transmitted and 78% believed that HIV infection could be prevented through condom protection.

However, despite high levels of basic knowledge, millions of people around the world are still vulnerable to HIV/AIDS (UNAIDS, 2000:40). Pockets of ignorance and misinformation remain, even in the worst affected populations, and in many contexts further education may be needed (Wojcicki and Malala, 2001:99-121). For example, in a study done in the South Africa town of Carltonville in 1997, only 40% of men or women knew that an individual could live with the virus for many years without any outward sign of infection. Around a third of respondents were mistakenly convinced that all HIV-positive people would show symptoms of their infection, while a quarter had no idea what to expect (UNAIDS, 2002; Campbell, 2003). Some women (prostitutes) in a study done by Wojcicki and Malala (2001:99-121) in Hillbrow (Johannesburg) indicated that they used traditional medicines to protect themselves against HIV/AIDS and STDs, and some believed that if a man 'looked healthy' or if he was confident, then it was impossible for him to be HIV positive.

Several reasons have been put forward to explain this. Studies have shown that the right information about HIV/AIDS transmission and prevention has sometimes been denied to young people on the grounds that they are, or should be, sexually abstinent[8]. Studies have shown that in many places young people are more vulnerable than their elders because they are less likely to know enough about HIV to protect themselves[9] (UNAIDS, 2000; Luyirika, 2000).

[8] The reality of young people's sexuality is far more complex. Many young people begin their sex life at very early ages (UNAIDS, 2000).
[9] But probably not in South Africa because HIV/AIDS programmes are more directed at youth

Generally speaking, people with more education lead healthier, more productive lives, because they have greater access to information than those who are illiterate or uneducated, and they are more likely to make well-informed decisions and act on that information (UNAIDS, 2000). Educational level may determine the ability to comprehend the vulnerability, risk behaviour, efficacy of intervention, benefit of behaviour change and thus the ability to change behaviour (Rogers, 1983; Janz and Becker, 1984; Boyer and Kigels, 1999). Numerous studies have shown that better educated girls tend to start having sex at a later stage (Kiggundu, 2001). Similar results were found in Uganda and Zambia; the more education boys had, the more likely they were still to be virgins by the age of 18. In Zimbabwe, the more education women had, the less casual sex they had. These results suggest that the best educated people in countries hardest hit by the AIDS epidemic may be shifting towards less risky behaviour. This has encouraging implications for the future course of the epidemic (UNAIDS, 2000). This development will, if sustained, hopefully translate into a replenishment of the much-needed human capital that has otherwise been decimated by the pandemic.

It is important to mention at this juncture that education and information are fundamental human rights. For that matter, when children and young people are denied the basic information, education and skills to deal with HIV- whether because of religious practices, social mores or cultural adherence - they are much less empowered to reduce their own risk of infection.

Several studies have been conducted that seem to support the view that knowledge and positive attitudes are key components in the process of behaviour change. With appropriate knowledge and attitude, people evaluate their risk for a particular disease and change behaviour accordingly (Janz and Becker, 1984). Taking condom use as a case in point, several studies have come to the conclusion that knowledge and positive attitudes are essential in determining it (Mauldon and Luker, 1996). For an individual to use a condom, he must perceive himself to be at risk and believe and accept that a condom is an effective means of preventing HIV/AIDS and other STDs.

On the other hand, parallel studies worldwide have identified negative attitudes towards condoms as the main reasons for non-use (Friedland et al., 1991). Despite the fact that knowledge and attitude are essential to achieve appropriate behavioural change, numerous studies have also highlighted that knowledge or attitude alone are insufficient for this to happen (Mauldon and Luker, 1996; Bartlet, 1981; Wojcicki and Malala, 2001). In a study conducted amongst South African black gold-miners, it was found that miners had substantial knowledge about HIV/AIDS infection, other STDs, about the mechanisms of transmission and the protective measures required, but only 32.6% of respondents used condoms (Campbell, 2003). Despite the awareness of difficulties and dangers of their job, including the risk of HIV infection, the prostitutes in the study done by Wojcicki and Malala (2001) indicated that they did not use condoms with regular clients, or with clients who offered more money. This was also clearly highlighted by Evian (1992), who indicated that with poverty, sex becomes a commodity to sell Expecting an individual to take initiatives to prevent an infection today, which will remain silent and only cause ill health in 7-10 years time, is probably expecting too much from an individual who is faced with uncertainties of day-to-day survival.

Similarly, in another study of adolescents, it was found that despite adequate knowledge and good intentions to stay safe, reinforced by widespread HIV education, consistent condom use remained sporadic and did not increase (Brown, 1994, in Kiggundu, 2001).

These studies serve to indicate that correct knowledge does not always translate into accurate behavioural changes. Motivational factors, perceived susceptibility and normative factors are also relevant (Kiggundu, 2001).

Socio-economic status

Apart from knowledge and positive attitudes, social-economic factors influence the environment under which behaviour change may take place. Factors, which include food, shelter, clothing and social support, address the basic human needs. As discussed in chapter one, under 'HIV/AIDS in social context', without a conducive socio-economic environment, appropriate health-related behaviour change might be difficult to achieve (Janz et al, 1984; Rogers, 1983).

Miners' perceptions of health and HIV

The fact that correct knowledge does not always translate into behavioural change was further illustrated by Campbell 2003 (25-26), in her study of miners' perceptions of health and HIV. Campbell (2003) reported that in 1995, levels of HIV among mineworkers were estimated to be in the region of 22%, with heterosexual sex being the dominant mode of transmission. Management at the mines was making strenuous efforts to educate workers about AIDS, with educational videotapes, pamphlets and posters. Preventive behaviour was also promoted through free supplies of condoms. However, it became clear to Campbell that among men interviewed these information-based programmes were having only a limited effect. Each man reported having seen the mine's educational video tape on HIV/AIDS; each was also aware of the pamphlets and posters providing information about HIV/AIDS and how to prevent it, and of the free supply of condoms. Every person said that HIV/AIDS was transmitted during unprotected sex, and that condoms would prevent its transmission. Most people said it was incurable. Beyond these basic facts, however, understandings of HIV/AIDS were patchy and often contradictory (Campbell, 2003:25) .

Campbell sought to illustrate that knowledge about HIV/AIDS was more complex than a series of 'facts' of the kind that information-based health education programmes sought to impart. Her study showed how these factors were located within a complex and detailed web of ideas concerning health, sexuality, traditional values and healing systems - with all these ideas constructed in social conditions that shaped and constrained individual sexual choices. Campbell (2003:25) noted that while miners were often in possession of the basic facts about HIV, which they had internalised through health education programmes, these facts were embedded within a range of doubts, qualifications, contradictions and uncertainties, which served to blunt the factual message imparted by the programmes. She observed that health education messages were not simply passively accepted by their audiences, but had to compete with alternative beliefs, experiences and logics, that in most cases would be more compelling than the information the health educator sought to impart.

Many miners admitted to having had heard of HIV/AIDS on the radio, but they remained unsure about its existence because they had never seen anyone suffering from it. Some people asserted that the disease did not exist, or that it existed in the countries to the North but not in South Africa, or that traditional healers could cure it. They cited the major symptoms of HIV/AIDS as sores on the body, and when asked to estimate the time-lapse between infected sexual contract and appearance of sores, people often answered in the region of two weeks to two months. Most significantly, for all their exposure to the educational materials, unprotected sex with multiple sexual partners (frequently commercial sex workers) appeared to be a common practice. A similar trend is observed by Niehaus and Johnson (2004) at Bushbuckridge, where, despite an increase in AIDS-related deaths and HIV/AIDS, publicity through awareness by *Love Life* campaign, villagers seldom spoke about HIV/AIDS in public, and both men and women still engaged in multiple sexual liaisons.

Knowledge, attitude and practices pertaining to traditional healers in relation to HIV/AIDS

In this section I shall look at the perceived role of traditional healers in relation to HIV/AIDS and their contribution toward the prevention of HIV/AIDS and support of people living with HIV/AIDS.

Traditional healers fall into three broad categories: The traditional doctor or '*inyanga',* the diviner or the '*isangoma'/dingaka'* and the faith healer or the '*umprofethi'/umthandazi'* (Goosen and Klugman, 1996; Thornton, 2002).

The traditional doctor or *inyanga* is a male who uses herbal remedies based on African traditions of medicinal use of herbs and other medicine preparation to treat diseases. On the other hand the *Dingaka* (Sotho) or diviner, also called *isangoma* (Zulu) or *amgqira* (Khosa), or *maine* (Venda) is often a woman who operates within a traditional religious context, and acts as a medium for communication with ancestors (Goosen and Klugman, 1996).

They are ritually initiated into a healing cult and are possessed by spirits who guide them through dreams and revelations, as well as by controlling divinatory rituals (throwing the bones) that result in diagnosis of the client's problem or source of their illness. The *umprofeth* or *umthandazi* (faith healer) integrates religious ritual and traditional practice. They generally use prayer alone or in combination with holy water, candles, ashes and other aids to prayer. They also tie woollen bands around their wrists, waist and ankles for protection from evil forces. Thornton (2002:5) observed that the distinctions between the herbalist, diviners and faith healers are often blurred, and all are considered to be African traditional healers in contrast to bio-medically trained personnel. Moreover, any individual healer may combine roles of diviner, herbalist and/or faith healer. Depending on circumstances, South Africans, especially in the rural areas, will at some point visit a healer in one of the categories mentioned above, while others move from healer to healer until they achieve the desired results.

Several studies (Goosen and Klugman, 1996; Thornton, 2002) have shown that traditional healers are the most widely used health practitioners throughout Africa, and the great majority of people with AIDS consult them at one time or another, alongside western medical practitioners. In her book about her family's struggle with AIDS, Kaleeba, the founder of the AIDS support Organisation (TASO) in Uganda, speaks of a desperate search for a local cure when her husband became bedridden. She says:

> If I heard that there was a healer in a particular part of Uganda I would drive there and come back with a bottle or jerry can of preparation. I would go from place to place as people told me of effective healers and preparations. Relatives were bringing medicines by jerry cans too and soon there were medicines for wrappings, sniffing, drinking and so on… Chris took all these remedies faithfully alongside the medicine he had been given in hospital.
>
> (Ankrah 1991:972)

A similar response was found in Campbell's (2003) study amongst mineworkers, most of whom, she established, consulted a wide range of healers without any tension or sense of contradiction. These included practitioners of western biomedicine, including hospitals, clinics, pharmacies and general practitioners in private practices, and traditional healers including *sangomas* (diviners), *inyangas* (herbalists) and *umprofeti* (faith healers).

> They said that they would go first to a biomedical doctor who would give them an injection. That took away the pain and 'put the disease to sleep'. However, biomedical treatment did not kill the 'eggs' that were the root cause of the problem. After this they would consult a traditional healer who would administer an enema and other herbs that would go inside of the person and take out the disease' and also purge the patient in the process.
>
> (Campbell 2003:27)

This implies that people strongly associated illness with having impurities in the body and believed that traditional healers were more skilled in dealing with dirt or pollution of the body. (Campbell, 2003).

With regards to HIV/AIDS, mineworkers believed that traditional healers could heal AIDS. They said, "AIDS is centred around sores, and black people are really good when it comes healing sores*"* (Campbell, 2003:26).

Mineworkers believed that traditional healers could eliminate the disease altogether if detected in its earlier stages. Apart from eliminating the disease some people believed that traditional healers could provide preventive medicines, which would then 'block' diseases, particularly sexually transmitted infections (STIs) from entering a person. Such treatment would make the use of condoms unnecessary.

Like many people in Africa who associate HIV/AIDS with witchcraft, some mineworkers believed that supernatural factors played a role in the development of ill-health, with illness resulting from an enemy bewitching the victim, particularly an acquaintance or relative who might be jealous of some good fortune the victim had experienced. In contexts where poverty and unemployment were high, jealousy of mineworkers' relatively well-paid jobs was not uncommon. They believed that traditional healers played a key role in diagnosing and restoring the social disharmony that could have led to the development of the disease. Many mine workers believed that, as soon as they learned that they were HIV positive, they would simply have to consult those traditional healers who claimed to have a cure for AIDS. The traditional healer would then treat them with medicine (Muti) that would cleanse the blood and flush the virus out of the system.

It is important to mention that such beliefs are not limited to mineworkers in South Africa. They have been found to exist among many people worldwide, especially in rural areas. For example, Lathan (1993) and Umeh (1997) reported cases in countries such as Uganda, Tanzania and Rwanda, where AIDS was blamed on bewitchment or a curse from the gods due to some moral transgression.

Traditional healers' responses to HIV/AIDS

In a study of traditional healers in Mpumalanga and Gauteng provinces, Thornton (2002) revealed that all traditional healers interviewed had knowledge of HIV/AIDS, and had consulted with other traditional healers about it. All believed that they had a positive role to play in responding to the epidemic, and some felt that HIV/AIDS could be 'cured' with traditional medicines, herbs or rituals. They were aware of the dangers of the re-use of razor blades and porcupine quills that were used to make small cuts in the skin in order to rub traditional medicines into the body. It was revealed that some traditional healers were well informed about HIV/AIDS and how to prevent it. They believed they had a positive role to play alongside biomedical professionals - in giving patients advice about sexual health-promotion, and also in the care of people living with AIDS, including the provision of psychological support and advice about diet.

Many healers connected HIV infections and the symptoms of AIDS, with 'traditional' illnesses - such as those said to be acquired from sex with someone who has recently attended a funeral without appropriate 'cleansing' rituals, or with a woman who had had a recent abortion or miscarriage. Traditional healers believed that AIDS was not a new disease but had existed 'traditionally' in African communities. Thornton (2002:9) highlighted the assimilation of the symptoms of HIV sero-conversion, and early symptoms of AIDS with 'traditional' symptoms of illness acquired through contact with 'polluted' persons, as a potent reason for many traditional healers to believe that they could treat HIV/AIDS in they way they always treated other traditional conditions. Some traditional healers reasoned that if HIV/AIDS was an 'old' disease, then the spirits would reveal a cure. Those who claimed to have a cure, or who treated it with traditional medicines, had experienced a dream or revelation that they believed gave them the knowledge to treat HIV/AIDS, as was common with other diseases.

Some traditional healers, however, believed that AIDS came from 'whites,' or from outside of Africa, and was therefore not 'traditional.' Because of this, it could not be 'seen' by ancestral spirits that send dreams and revelations through divining. This meant that it could not be diagnosed, and could not be cured by African herbs. Others argued that HIV/AIDS was the result of many people abandoning traditional African cultural practices, and that return to 'traditional ways' would eliminate it. In their view, traditional society was much less sexually promiscuous, and the existence of more stable marriage and practices such as virginity testing helped to limit such diseases, whatever their origin. The very resistance of AIDS to treatment of any kind compelled several healers to argue that only a return to tradition and to traditional healing would be effective in controlling its spread.

In Africa, it is estimated that about 80% of people rely on traditional medicine for their health-care needs, both in urban and rural settings. Many public health experts conclude that it makes sense to build collaboration between the formal health system and traditional healers. According to UNAIDS (2002:156), collaboration with traditional healers can help dispel many myths that prevail about the causes of HIV/AIDS, as well as countering spurious claims about 'miracle' AIDS cures. It is believed that traditional healers' involvement could be a useful channel through which an otherwise hard-to-reach sector of the grassroots community could be accessed for both appropriate HIV prevention counselling and STI care (Campbell, 2003). However, as pointed out by Thornton (2002: 18), so far very little has been achieved in attempting to bring about the collaboration between medical practitioners and traditional healers, because of differences in orientation to the patient, social hierarchies, professionalism, and, in some cases, racism.

3.7 Gender and HIV/AIDS

In this section I will discuss gender roles; the impact of HIV/AIDS on women and what makes women particularly vulnerable to HIV infection. I will also discuss ABET programs as a potential path to women's empowerment.

What is 'gender'?

While sex is biological, gender, according to UNAIDS (2000), is socially defined. Gender is what it means to be male or female, and how that defines a person's opportunities, roles, responsibilities and relationships.

When talking about HIV infection, a person's gender is one of the most powerful determinants of individual risk. Gender biases affect both sexes, in a multitude of ways. However, this discussion will be on the risk and vulnerability associated with being female. This is because although HIV does not discriminate against those it infects, the prevalence of HIV/AIDS has been noted to be on the increase amongst women in South Africa and worldwide (Wojcick and Malala, 2001).

Furthermore, this study is about addressing the challenges of HIV/AIDS prevention and support in ABET centres. As mentioned above, in the Limpopo Province, there are more women participating in ABET activities than men (Kiggundu, 1999). Thus, it is important to look at the extent to which the epidemic affects women, and what could be done to reduce their vulnerability to HIV/AIDS.

The position of women in South Africa

Gilbert and Walker (2001) cite a baseline study of poverty in South Africa which shows that the country has a poor record in terms of social indicators and income inequality. About half (44%) of South Africans were poor. Nearly 95% of poor people were African (South African Health Review, 2000:3). While population estimates based on the 1996 census reveal similar numbers of men and women living in urban areas, in non-urban areas, 53 % of the population are women. As pointed out by Gilbert and Walker (2001:14): "Women predominate in rural areas, which are the poorest" Moreover, a household headed by a woman, regardless of geographical location, is more likely to be poorer than one headed by a man.

What makes women so vulnerable to HIV infection?

Before going into detail about what makes women so vulnerable, I will look at the extent to which the epidemic has affected women. According to UNAIDS (2000), a decade ago women seemed to be on the periphery of the epidemic. Today they are at the centre of concern. The World Health Organisation (WHO) estimates that almost

half of all newly infected adults are women. Estimates are that over 14 million women word-wide are infected, about four million of whom have died. As infections in women rise, so does infection in the infants born to them. As of December 2002, women accounted for 50% of all people living with HIV/AIDS worldwide, and for 58% in sub-Saharan Africa (UNAIDS, 2003). In some of the worst affected countries, HIV-infected women outnumber men by as many as sixteen to one in the younger age groups (UNAIDS, 2001). As elsewhere in Southern Africa, the female black population is the most susceptible to infection. 55% of all HIV positive adults in South Africa are women, and women are infected at an earlier age than men (Wojcick and Malala, 2001).

Behind these statistics are women from traditional families caught in the terrible bind to produce children, and unable to admit that they have contracted the virus from a husband who is unfaithful. There are teenage girls from very poor homes whose only way of staying on at school is to barter sex with teachers or 'sugar daddies' who will pay for fees, books and uniforms (UNAIDS, 2001; Nthabiseng and Tlou, 2001; Common Wealth Secretariat, 2002).

According to UNAIDS (2001), HIV does not strike at random, and over the years research has shown what makes people vulnerable. Where once the focus was solely on personal risk behaviour, today it is recognized that there are factors beyond the control of the individual that encourage risk behaviour and make it difficult for people to protect themselves. These factors, as previously discussed under HIV/AIDS in the social context in chapter one, include poverty, discrimination, lack of education and opportunity, and, crucially, the subordination of women, all of which put young females at even greater risk than males.

Besides being a personal tragedy, the disproportionate risk for women has enormous social implications, since they are the principal guardians of future generations, the carers and nurturers of society. Based on that background, the focus of this discussion will be on the risk and vulnerability associated with being female. Studies suggest that gender inequality could explain the higher rate of infection among women compared to men. Even in countries such as South Africa, where gender equality is entrenched in the constitution, the reality of women's lives in the home, relationships and broader

society is far from equal. Inequality between men and women manifests itself, among other ways, in unequal employment opportunities, unequal access to wealth, unfair division of labour in the household and generally unequal power relations. It also manifests itself in violence against women, including battery and rape (Phaladze and Tlou, 2001).

Sexual subordination

In South Africa, as in many other societies, there is a significant power differential between men and women, supported by a social and cultural system that supports control by males. Males are expected to initiate relationships, and sexual assertiveness in women is often stigmatised. The gender power differential is compounded by age differences. Women typically marry or have sex with older men, who have been sexually active longer and hence are more likely to have become infected themselves. Men often justify the selection of young adolescent girls, even female children, on the grounds that they are less likely to be infected with HIV/AIDS (Jackson, 2002; Nthabiseng and Tlou, 2001).

Many countries, which promote monogamy and mutual fidelity, and discourage multiple casual partners as a societal norm, have also encouraged these values as a primary AIDS prevention strategy. Some societies, however, expect women to adhere strictly to this norm while tacitly condoning male deviation from it. Women are expected to have one lifetime sex partner, while men are expected to have more than one partner. Fidelity protects against HIV/AIDS only if it is completely mutual and life-long. It creates an illusion of safety for individuals who are monogamous but who cannot be certain about their partners

Furthermore, in some cultures, women are not permitted to talk about sex to men, or to negotiate safer sex practices, for example the use of condoms. To do so may have serious repercussions, ranging from stigma to fear of violence or abandonment. Men resist the use of condoms because they think that it will interfere with fertility and pleasure (Mzaidume, Campbell and Williams, 2000; Wocjick and Malala, 2001) Moreover, it is very difficult for both men and women to introduce condoms into an existing relationship, because the very suggestion of condom use carries with it an indication of infidelity or other behaviour that could threaten the security of the

relationship (Wood and Jewkes, 1998; Gupta, 2002). Despite this, many HIV/AIDS prevention and family planning programmes have expected women to assume responsibility for the prevention of both pregnancy and STDs, including HIV infection, in a context in which they have limited control over when, with whom, and how they engage in sexual activity (Wood and Jewkes, 1998).

Biological vulnerability

Research has shown that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than for men. As compared with men, during intercourse women have a bigger surface area of mucosa exposed to their partner's secretions. Furthermore, there is generally a higher concentration of HIV in semen than in the sexual secretions of a woman. This makes male-to-female transmission more 'efficient' than female-to-male.

Younger women are at even greater biological risk. Their physiological immature cervix and scant vaginal secretions put up less of a barrier to HIV. There is evidence that women become more vulnerable after the menopause. However, tearing and bleeding during intercourse, whether from 'rough sex', rape or prior genital mutilation multiplies the risk of HIV/AIDS infection (UNAIDS, 1997).

A final important biological factor is untreated STDs in either partner, which multiplies the risk of HIV transmission by up to ten-fold. Between half and four-fifths of STD cases in women go unrecognised because the sores or other signs are absent or hard to see and because women, if they are monogamous, do not suspect they are at risk (UNAIDS, 1997; Nthabiseng and Tlou, 2001).

Social and economic vulnerability

Compounding women's biological vulnerability to HIV infection is a host of cultural, legal and economic factors that put them at special risk. In many societies girls face discrimination from birth onwards. Historically, in South Africa girls had less access to education, information and skills training than boys. For example, in South Africa in 1995, 23% of African women aged 25 years or more had no formal education at all, compared to 16% of African men. Over a quarter of African women had not passed grade 5, compared to one fifth of African men (Gilbert and Walker, 2001). A

household survey conducted in 1995 found that 31% of African women had not studied as far as they wanted, or had dropped out of school because of pregnancy.

Women's position is worsened by the fact that unemployment rates are higher for women than men in all racial categories. As adults, women have limited opportunity for employment. For example, in 1995, 47 percent of economically active African women and 29 percent of African men were unemployed, compared to only 4 percent of white men and 8 percent of white women. On average, women earn between 72 and 85 percent of what men with similar education earn, and women continue to predominate in low skilled and low paid occupations. Only 22 percent of all managers are women, and half of these are white (Gilbert and Walker, 2001).

The above mentioned figures indicate that young African women are the poorest, the most economically marginalized and least educated sector of the South African population, thus placing them at the 'bottom of the health pile' and rendering them vulnerable to HIV/AIDS and other diseases, in terms of their race, gender and class position (Susser and Stein, 2000).

The rural woman in particular in South Africa, like those in the rest of Africa, may find herself economically dependent upon her husband, and without any leverage at all. Women cannot own or inherit land and property in their own names; they have limited access, if any, to finance for their own business ventures, and often limited access to health care services. Gilbert and Walker (2002) pointed out that women in South Africa are more economically disadvantaged than men in all those areas through which people in general may access resources. When in paid employment they earn less and are more likely to be in low status jobs than men.

The rural African woman is highly disadvantaged. Many are left behind in the rural area with their children for reproduction purposes, and frequently become 'heads of households'. The low status of women in society overall is compounded by being single. The social worth of women as noted by Campbell (2000) is 'proven' through the ability to have and keep a male partner, in addition to the possible economic benefits of this relationship. In a society where having multiple partners has been a defining feature of successful manhood, Mager, in Jewkes et al. (2003) noted that

single women are regarded as potential usurpers and are relatively socially isolated. With high stakes attached to having a partner, even if it is a shared partner, and in a prevailing climate of multiple partnerships, there is an ever-present fear of abandonment. Many women would find dictating condom use or sexual refusal under such circumstances to be difficult (Jewkes, Levin, Loveday and Kekana, 2003).

Violence against women

Several studies (Jewkes, Levin and Penn-Kekana, 2002; Watts and Garcia-Moreno, 2000) have shown that physical, emotional, and sexual violence against women within the home is widespread in Southern Africa. According to World Health Organization data, one in five women in Limpopo province have experienced violence from an intimate male partner (Watt and Garcia-Moreno, 2000). Violence, especially rape, is a risk factor that is inadequately recognised or addressed. Violence against women makes women vulnerable to HIV through forced, or coercive sexual intercourse with an infected partner (Jewkes et al, 2003). In some cases, young girls are targeted for rape because of the belief that sex with a virgin will cleanse a man of infection (Leclerc- Madlala, 1997). In South Africa, an estimated 370,000 women are raped every year, and violence against women is widespread including assault and rape from partners, family members and boyfriends. Yet it is estimated by the South African Police service that only one in thirty-five rapes is reported. Rape has the lowest conviction rate of all crimes of assault (Shifman, Madlala and Smith, 1997 in Wojcick and Malala, 2001).

Prostitution constitutes another situation in which women are unusually vulnerable to HIV infection, yet for multitudes of women without skills or resources, it offers the best opportunity for making a living. Sex workers may lack knowledge about HIV and how to protect themselves, but even if well-informed they may find it hard to insist on safe sexual practices for fear of violence, or fear that an unwilling client will take his business elsewhere. However, in some places, prostitutes have banded together to demand condoms from all clients. Ironically, these women may enjoy more protection than housewives who have no ‘social permission’ to request or negotiate safer sex (UNAIDS, 1997).

Finally, AIDS presents women with another dilemma in their sexual relationships. Safer sex - in particular the use of condoms - is incompatible with pregnancy, and those who want a child and yet who believe they are at risk of contracting HIV therefore face painful choices. In South Africa, as in many African societies, a woman's social status, perhaps even survival, depends on bearing children, and where personal desire and social pressures coincide with high levels of infection, the choice for women is particularly cruel (UNAIDS, 2001).

Impact of HIV/AIDS on women

UNAIDS (2002), outlines several ways in which HIV/AIDS affects women. In this section, I will discuss those which apply to the South African situation and are relevant to the study. Because women are sexually, economically and biologically vulnerable to HIV/AIDS, they are often stigmatised and blamed for causing it. Women are frequently identified as reservoirs of infection, or as vectors for transmission to their male partners and their offspring. This inaccurate view, as observed by UNAIDS (2002), is harmful in a number of ways: it fails to focus on men's equal responsibility to prevent HIV/AIDS; it prevents programmes from developing services which meet the needs of women; and it underlies some research and intervention strategies which have been designed more to protect men from women than to enable women to protect themselves.

Many people assume that if a woman has HIV infection, she has had multiple partners or engages in prostitution, and that such behaviour stigmatises her. This may lead to being dismissed from employment or not being hired, evicted from homes, abandoned by husbands, and denied custody of children.

Most societies, including South Africa, rely on women to be voluntary caregivers for their families, as well as occupational caregivers for the community. Older women may be expected to assume a major care giving responsibility, while at the same time the adolescent daughter may be kept out of school to care for young children or other family members who are ill. The expectation that women will provide most of the care for people with HIV infection results in high stress, especially if such care must be provided in addition to other work, including paid work outside of the home and

family-centred work, such as subsistence farming. Such stress is compounded when the women become ill themselves, often with no one to care for them. In Uganda, as noted by Ankrah et al. (1998:971), when a woman falls ill or shows symptoms before her partner does, she is more likely than he to be sent back to her relatives or be abandoned (UNAIDS, 2002). Furthermore, women of a childbearing age are at risk of transmitting HIV to their unborn infants. Pregnancy, delivery and lactation generate special health care needs, yet women have limited power to negotiate or to enforce strategies to reduce their risk of HIV/ AIDS infection.

Responding to reality: agenda for action

If the vulnerability of women to HIV infection is to be reduced, both men and women must work to counter gender discrimination and the subordination of women. Policy makers, community leaders and other people in positions of power must recognise the connection between women's economic and social status and their vulnerability to HIV infection. Men and women need to reassess the way they see themselves and each other, the way they relate as husband and wife, partners, lovers, brothers and sisters, parents and children, colleagues and friends. Specific to the question of AIDS, Ankrah (1998) suggests an urgent need to re-educate or to re-socialize African men about African women and vice-versa. She stresses the need for them to learn to communicate with each other about feelings and about sex, and further suggests that men and women need to work out a new accommodation that seeks to enhance rather than overpower the other.

Because AIDS kills, the demand should be for behavioural change that endures for a long time and becomes a lifestyle. The customary and legal rights of males to an unlimited number of partners should be challenged as a value.

Inequality between men and women fuels the spread of HIV/AIDS. Unless the interaction between HIV infection, cultural values and the rights and needs of women is recognised, the fundamental change required to stem this pandemic is unattainable. To rectify the woman's situation, Danziger (1989 in Ankrah, 1991), suggests a greater need for greater access to information about AIDS and HIV, help for women through support networks and improved access to counselling.

Finally, UNAIDS (2002) indicated three issues which should be addressed to enable women to protect themselves: improving the social and economic status of women, providing a method over which they have sufficient control; or getting men to adopt safer sex.

3.8 Condom use as an HIV/AIDS prevention strategy

In the absence of a cure or vaccine, health education and behaviour changes like abstinence, being faithful to one partner and condom use, have stood out as the important, cost effective and practical interventions for prevention of the spread of HIV/AIDS (Johnson, 1988; Kiggundu, 2000). Condom use forms one of the key components of preventative strategies (Allen, Simelela and Makubalo, 2000). Several studies have confirmed that condoms are highly effective in the prevention of the transmission of HIV/AIDS. Barnett and Whiteside (2002:42) referred to condom use as the most available and effective biomedical intervention, if properly used.

However, it is important to mention the reality that not all people insist on condom use. Some of the cultural reasons for not using condoms are that they block the flow of fluids involved in sexual intercourse and reproduction. Furthermore, it is believed that condoms prevent the ripening of a foetus. The implication of this notion is that semen is needed to form or ripen the growing foetus in the womb, and that condoms interfere in the process of natural development (Maelane, 2002). In a study conducted at Acornhoek, in the Limpopo Province, by Thornton (2003:2) traditional healers were reported as declaring that condoms could cause a dangerous 'back up' of semen in the male and therefore lead to illness. Others believed that condoms could come off and 'disappear' inside the woman.

Studies worldwide have shown that condom use in marriages is not well tolerated. A study in Kwazulu Natal revealed that "knowledge of condoms was almost universal but they were not acceptable in marriage" .It found 79% rejected condoms in marriage and had never used one with their spouse. Statements such as, 'if my regular partner gave me a condom I could not accept it. It means she is a prostitute,' and 'There was no need for condoms since I trust my partner' were reported. In studies in Papua New Guinea, Jamaica and India, women reported that bringing up the issue of condom use,

with its inherent implication that one partner or the other had been unfaithful, could result in violence (Gupta, 2002).

Apart from cultural reasons, both men and women present different reasons for not using condoms. Several studies (Campbell, 2003; Wojcicki and Malala, 2001) have shown that women's economic dependence on men, their high poverty levels and lack of access to opportunities and resources, contribute to their powerlessness to insist on condom use. This is because the men can withdraw their economic support if women refuse to do what men want. For women, especially rural women, the economic or social consequences of insisting on safe sex in terms of lost trust, abandonment or abuse, could be more threatening than the risk of contracting a disease.
Lack of information about sexual matters and about their bodies also prevents women from using condoms. For example, rural women from South Africa and urban women from India reported not liking condoms because they feared that if a condom fell off inside the vagina it could get lost and perhaps travel to the throat or another part of the body (Gupta, 2002).

Studies (Barnett and Whiteside, 2002) have shown that even if people have the knowledge, they may not have the incentive or the power to bring about health-enhancing behaviour change such as condom use. A study of sex workers in a Southern African industrial community that employs a large number of migrant workers, revealed that condom use was extremely rare, despite the fact that most people knew the 'facts' about HIV/AIDS. Women said that they lacked the economic power to insist on condom use if paying clients refused to use them**.** Poverty prevented them from turning away clients who refused to use condoms. They also lacked the psychological confidence to insist on condom use in a strongly male dominated culture and noted that if a woman refused sex without a condom, the client would simply find a more willing woman in the shack next door (Mzaidume, Campbell and Williams, 2000). In other words, their problem was exacerbated by lack of unity among sex workers. To that effect, suggestions have been made that in order for a pro-condom campaign to be successful, women would need to present a united front in the face of reluctant clients, (Wojcicki and Malala, 2001; Mzaidume et al., 2000).

Studies have shown that men object to condom use on the grounds that they set up barriers between partners and reduce pleasure. Other studies have shown that men in Southern Africa regularly do not want to wear condoms; whilst others have indicated that men have their masculinity intimately tied with 'flesh to flesh' sex (Webb, 1997).

> Workers view flesh-to-flesh sex as necessary for a man's good health in order to maintain balanced levels of blood/sperm within the body. Informants spoke of the way in which the build up of sperm led to a range of mental and physical problems. Flesh-to flesh sex was regarded as the only pleasurable way of meeting male sexual desires. With condoms being seen as cold and unpleasant… masculinity associated with physical strength and bravery, serve as a key coping mechanism whereby miners deal with harsh and dangerous working conditions of underground mining
>
> (Campbell et al, 1998:52)

In a paper reporting resistance to condoms and transmission of HIV/AIDS in Southern Africa, Thornton (2003:3) reported that many people in South Africa believed that lubrication on condoms or so-called condom oil was absorbed by both men and women during sex with condoms and that this led to impurity of the blood that could only be treated with traditional medicine. Some people feared 'worms' in packaged condoms that could be seen if a small amount of water was placed in the condom and it was held up to the sunlight. Others said that condoms could 'get inside' women or that they could 'blow up in the uterus' and cause damage or deaths. Some feared that the semen that ought to flow out is forced back into the man's blood by the condom and thus caused a new form of illness. Some people suggested that sex with a condom was not really sex at all (Stadler, 2002).

Pilot programs in the past few years have shown that the female condom is a viable HIV prevention option for women (and in some contexts, men). Made of polyurethane plastic, it requires no special storage. It can be inserted into the vagina several hours before sex, and it can be used with oil-based or water-based lubricants. For these reasons, the female condom can be of particular value in HIV prevention among sex workers. In a study by Campbell (2003: 112) sex workers said that if a client was drunk enough it was often possible for a sex worker to insert a female condom without him noticing. They said that if a woman put on a female condom a couple of hours before drinking, it would mould to the shape of her vagina and remain fairly

well positioned, provided she remembered to move the flap aside when she urinated. However despite the fact that sex workers frequently expressed a preference for female condoms, they are expensive and currently not distributed as part of any state or non-government organization (NGO)-funded HIV–prevention programme.

In this section I looked at condom use as a preventive mechanism against HIV/AIDS. It was noted that by far the most common method of prevention mentioned spontaneously by people in many studies is condom use. I noted that there was a wide variation in condom use around the world and even within communities. I examined the different reasons presented by both men and women for non-condom use. It was noted that the rate of condom use remains low in some areas. There are relatively low rates of condom use for very high-risk encounters.

This section is relevant to the current study of ways in which rural ABET centres address the challenges of HIV/AIDS, because most men in the study area live and work in the mines and in towns (Johannesburg, Pretoria, Polokwane and Thohoyandou) and return home as often as every weekend, or as little as once or twice a year. On the other hand, the women in the study, being poor, illiterate and unemployed, may be unable to insist on condoms since they are dependent on the men. These women may also engage in transactional sex with multiple partners for economic reasons, as noted in studies by Campbell (2003), Wojcick and Malala (2001) and Webb (1997).

3.9 Conclusion

This chapter has reviewed international and South African literature with a view to highlighting the effect of HIV/AIDS on the social, economic, and political dimension. In South Africa like in many other countries, HIV/AIDS affects disadvantaged communities sooner than other communities and there is need to educate and support people who are already affected and infected with HIV/AIDS. Different coping theories were discussed and it was highlighted that sometimes denial and stigma are looked at as psychological defences with negative repercussions for individuals, families and communities. HIV/AIDS-related stigma is widespread and leads to rejection and discrimination. As such, people with influence and authority within

society should individually and collectively act in order to reduce stigma surrounding HIV/AIDS within their sphere of influence. Furthermore, voluntary counselling and testing were looked at as key components of prevention and care programmes which could help break the vicious cycle of fear, stigma and denial.

It was noted that despite high levels of basic knowledge regarding HIV/AIDS, millions of people are still vulnerable because of ignorance and misinformation among women, youth and people in lower socio-economic groups because they are not exposed to the publicity provided to make them aware of health matters (Evian, 1992). As such they are less empowered to reduce their own risk of infection. Finally, as elsewhere in Southern Africa, women's subordinate status in patriarchal society and their economic dependence on men greatly increase their vulnerability to HIV/AIDS. Condoms have stood out as the most important, cost effective and practical interventions for prevention of the spread of HIV/AIDS, however, it was noted that there are relatively low rates of condom use for very high-risk encounters.

CHAPTER FOUR

Strategies used in other countries to address the challenges of HIV/AIDS in rural communities: lessons for South Africa.

4.1 Introduction

AIDS traditionally has been regarded as a medical and health problem, and, as discussed in chapter one, there has been a continued inclination on the part of policy makers to fight AIDS through the health and medical systems. However, researchers such as Levi (2002), Schneider (2002), Crowthers (2001), Barnet and Whiteside (2002) and others have shown that HIV/AIDS is more than a medical condition- and in order to deal with it effectively there must be an understanding of the cultural, economic, and social structures in which HIV/AIDS is embedded. They also suggest that measures to stop HIV/AIDS should be a collective balanced, social, biomedical, and scientific effort. Different strategies have been used in different countries to fight the HIV/AIDS epidemic. In this chapter I will look at HIV/AIDS educational programmes and how they are being conducted in other countries, especially in rural communities, and how they relate to the South African situation.

I will talk first about the challenges of delivering HIV/AIDS education in rural communities and the general strategies which have proven effective for the Emory project, an HIV/AIDS education programme in Georgia (USA). Since cultural beliefs tend to influence health attitudes, practices and response to the health delivery system, I will present criteria for culturally sensitive HIV/AIDS education in rural areas. I believe that these are relevant to the study because one of the roles of ABET in the fight against HIV/AIDS word-wide, and in South Africa, is awareness raising and the provision of HIV/AIDS education. The next area of concern then would be how HIV/AIDS education should be conducted to suit people in the rural areas. HIV/AIDS education programmes exist worldwide. The question that stands out is whether they are relevant for the rural areas of South Africa. Next, HIV/AIDS prevention strategies

adopted by Uganda and Botswana will be discussed. I will discuss how Uganda has managed to control its HIV epidemic during the past 15 years, and I will give a detailed account of a pioneering initiative by the Islamic Medical Association of Uganda's AIDS prevention Programmes (IMAU). I will suggest the reasons for the HIV/AIDS prevalence in Botswana and attempts by government to combat it, and finally I will examine lessons that could be drawn by South Africa from the experiences of Uganda and Botswana.

4.2 Delivering HIV/AIDS education in rural communities.

Historically, the AIDS pandemic has entered its third decade and is certain to be a lifelong issue for many individuals. Since there is currently no cure, and no vaccine available to prevent HIV infection, the only realistic way of controlling the spread of AIDS is through prevention and education (Umeh, 1997). HIV/AIDS has expanded into populations that previously experienced low sero-prevalence rates. For example in the United States of America, in exploring the changing demography and growing sero-prevalence rates, a new challenge faces the country, that of HIV/AIDS in rural communities (Umeh, 1997; Tucker et al., 1991).

Numerous investigators have found that rates of high-risk sexual behaviours in rural people are much higher than rates in most urban AIDS epicentres (Flemming et.al., 1987). This may be due in part to the lower socio-economic strata in the rural areas. Hernandez (1993) observed that in most African countries, people, especially women in the lower economic strata, lack information and so may be ignorant about AIDS. As I noted in the previous chapter, even when they are aware of HIV risk, they lack the power to change the sexual behaviour of their partners on whom they depend economically. They are usually afraid of being abandoned or of physical violence should they increase their bargaining power in heterosexual relationships (Shayne and Kaplan, 1991).

Growing urbanization in most African countries also contributes to a changing demography. According to Basset and Mhyloyi (1991), most men leave their families behind in rural areas to go to the cities, where they form relationships with other women, only to return to the rural areas to infect their wives. This trend is also visible

in South Africa where, as observed by Ankrah (1991:971), husbands establish new sexual liaisons in the urban centres; many form new families and thus marginalize or abandon the rural household altogether. Nevertheless men still demand their matrimonial rights whenever they return to the rural household. This freedom of mobility and simultaneous access to sexual partners in the urban and the rural environments heightens the possibility that men will spread the virus to their wives in the village (Ankrah, 1991).

In South Africa there is a wide range of educational programmes which focus on HIV/AIDS prevention, the most common ones being through community theatre (plays, songs and dances), the mass media; including television (Soul City), radio (community radio talk shows); and print media (Parker et al., 2000). However, most of these programmes are inaccessible to people in rural communities and even if they were made available to them they might not be applicable to their situation. Clearly, health educators who hope to make an impact on the pandemic must respond with prevention and education programmes inclusive of rural areas and sensitive to rural residents (Umeh, 1997).

In recent years recognition of the need for collaborative educational models that cover large rural geographic areas has emerged (Chang-Yit et al., 1992). Responding in an effective way, as observed by Parker et al. (2000), demands that educational efforts examine the challenges of providing rural HIV/AIDS programmes, as well as strategies to overcome constraints such as illiteracy, poverty and unemployment.

Unique Challenges Of Rural Communities

Educators who provide HIV/AIDS education in rural areas are faced with unique challenges worldwide. For example, many rural communities retain traditional values, and are not diverse ethnically or racially. Church traditional leaders and family play a central role in daily life. Fewer residents have acquired the formal education of urban residents. Geographic distance and limited resources may result in increased reliance on other community members. Social support is often channelled through informal social networks, rather than the formal structures of urban areas. Therefore, new ideas such as the use of condoms, or alternative lifestyles such as abstinence, made more

public by the AIDS pandemic, may not be easily tolerated in rural communities that rely heavily upon conformity (Nelson, 1993).

Umeh (1997) observed that community responses to HIV in urban areas are significantly different to those in rural areas. Education interventions must be sensitive to these differences. For example, in rural communities, traditional roles based on heterosexual relationships are usually the norm, and there is increased stigma and fear of homosexuality. HIV status is often hidden and undisclosed due to fear of isolation and rejection from the community. This denial is evidenced by the rural community's attitude portraying HIV/AIDS as an urban or outside issue (Umeh, 1997) or, as put by Meursing (1996) 'for the sinful others'.

According to Umeh (1997), HIV sero-positive members of these communities are often invisible and remain isolated from support systems. Individuals may be fearful of seeking testing, treatment, or support services in rural areas for fear of public exposure. This fear may then prompt mistrust of local agencies' abilities to maintain confidentiality, leading to under-use of HIV-related services.

In the USA, HIV/AIDS was historically identified as a disease for gay men or intravenous drug users. In most African countries, it was identified as a disease of promiscuous people, since HIV is primarily spread through sexual intercourse (UNAIDS, 1998). Urban HIV/AIDS education efforts initially experienced significant barriers of denial, like those now confronting rural communities (Umeh, 1997). This denial in some communities facilitated a corresponding lack of ownership of HIV/AIDS as a public health threat. Given earlier low rural sero-prevalence rates, many rural communities maintained a level of denial that became a barrier to HIV/AIDS education (Umeh, 1997). Therefore, the development of any educational outreach targeted to facilitate a rural response to HIV/AIDS must focus on efforts to decrease fear and stigma, while increasing a sense of community ownership of the pandemic. Such educational efforts must be sensitive to the cultural differences of rural individuals.

Further complicating HIV/AIDS education in rural communities is the lack of resources, both in terms of finance and staff for such education. In South Africa this is

a major problem. Most rural areas cover large geographic regions, and concentrated educational efforts, such as those organized by community based AIDS organizations, often do not exist (Umeh, 1997). In that regard Lippert et al. (1992) suggest that identifying ways to collaborate with existing organizations to provide rural education is an important and perhaps essential strategy.

Another factor mentioned by Kelly et al. (1991) as a potential problem in rural areas is the lack of local leadership. While usually not an impediment in urban areas, local leaders in rural communities may not provide adequate support for HIV/AIDS educational efforts, because HIV/AIDS may not be high on the agenda.

It should be pointed out however that in South Africa, the problem of lack of local leadership might not be applicable. This is because South African rural communities are characterised by a powerful social systems with extended families and traditional systems of leadership at the core of the system (Parker et al., 2000). Although these social systems have been considerably destabilized by the migrant labour system and by apartheid, close-knit extended families remain characteristic of the rural way of life. The role of traditional leaders in rural communities, as observed by Parker et al. (2000), remains significant. Without the support of these leaders, any prevention, support or media strategies are unlikely to make much impact. Therefore, the key to successfully mobilizing rural areas by ABET practitioners may lie in recruiting key community leaders as supporters of AIDS education.

Educational Strategies for Rural Communities

Several strategies have been highlighted by researchers for meeting the challenges of developing and implementing effective and comprehensive HIV/AIDS education programmes in rural communities. This section outlines general strategies which have proved effective for the Emory project in the USA[10]. The Emory project is an HIV/AIDS Mental Health Training Project, funded through the Centre for Mental Health Services of the Substance Abuse and Mental Health Services Administration. It was founded in 1992 to meet the need of enhancing the knowledge and skills of

[10] Despite the good ideas mentioned the author does not provide sufficient evidence that the Emory project reduced the HIV/AIDS incidence.

traditional and non-traditional mental health care providers about HIV/AIDS throughout Georgia in the USA (Umeh, 1997).

Georgia was reported by the Centres for Disease Control and Prevention (CDC) to have the eighth highest cumulative number of AIDS cases reported among the fifty states, compared to its ranking as eleventh largest in population (CDC, 1994). The project covered both urban and rural areas. The project staff had many opportunities to explore the challenges of providing urban versus rural HIV/AIDS education (Umeh, 1997). Utilizing this knowledge base, as well as the collaborative expertise of the Southeast AIDS Training and Education Centre in Georgia, strategies were implemented to meet the challenges that health educators had found in Georgia's rural communities (Umeh, 1997).

These strategies are relevant to the study because the rural communities of the Limpopo Province of South Africa experience some of the problems found in Georgia. Furthermore, educators in rural ABET centres are likely to face similar challenges in their efforts to provide HIV/AIDS education.

According to Umeh (1997) one of the most useful lessons learned was the importance of teaming with local agencies who also had vested interests in bringing AIDS education to their region. These included community-based AIDS organizations, churches, state AIDS committees and medical professional organizations.

Overall, educational strategies for fostering positive attitudes and a supportive rural environment should focus on HIV/AIDS as a rural community issue rather than an urban issue. The objective of education is to help particular participants frame the issue in a way that will result in positive community responses (Chang-Yit et al., 1992). Training should include not only basic information about AIDS, but must challenge individuals to examine and confront their fears and biases to reduce community hysteria and discriminatory acts towards PWAs and their families. The outcome of such educational outreach generally includes more community HIV/AIDS ownership.

Forster et al. (1993) assert that the cultural beliefs of a community influence health attitudes, practices, and responses to the health delivery system. Therefore to be effective, AIDS education must be delivered in a manner that is respectful of cultural differences inherent in rural settings. Educators must be prepared for negative misinformation, especially about the sexuality of women and gay men (Crochet et al., 1993). Similarly, individuals may hold a variety of group-specific misconceptions about HIV/AIDS, such as beliefs that the disease is exclusively a disease of promiscuous people and misinformation about how the AIDS virus is transmitted, for example, the belief held by some men that a person suffering from AIDS can be cured if he sleeps with a virgin girl (Crocteau et al., 1993).

To address this misinformation appropriately, the educational AIDS message must be delivered in a culturally competent manner that makes effective use of skills, resources and knowledge that are pertinent and responsive to the cultural values and norms, strengths, needs, and self-determined goals of the audience (Umeh, 1993).

Rural Training Strategies devised in the Emory Project

The Emory project utilized a number of strategies to overcome many of the challenges faced by AIDS educators in rural communities. Specific strategies include a training approach that addresses each of the following areas of successful AIDS education; establishment of a collaborative training network; pre-training research and preparation; culturally sensitive execution of training targeted to audience; evaluation of delivered trainings; and maintenance of funding for training events (Umeh, 1997). Table 2 provides an overview of general training strategies for rural communities.

Table two: Delivering HIV/AIDS education in rural communities: Strategies

DELIVER EDUCATION THAT IS CULTURALLY SENSITIVE/AFFIRMING ¨ Prepare for negative misinformation ¨ Make effective use of community skills, resources and knowledge ¨ Respect cultural values and norms ¨ Reinforce strength and self-determined goals of the community ¨ Appreciate unique, culturally relevant needs of the community
DEVELOP EDUCATIONAL PROGRAMMES THAT FOSTER POSITIVE ATTITUDES ¨ Frame the message in ways respectful of the community ¨ Include basic information on HIV/AIDS ¨ Utilize techniques that comfortably challenge fears and biases
PRE-TRAINING RESEARCH AND PREPARATION ¨ Ascertain audience educational needs ¨ Identify who will compose the training audience ¨ Appreciate literacy level of training participants ¨ Find out the training background of the target audience
EXECUTION OF TRAININGS ¨ determine training format (didactic experiential, panel discussion, etc.) ¨ determine the length of training ¨ incorporate local leaders and/or persons affected by aids into the training as speakers ¨ encourage audience participation
EVALUATION OF TRAININGS ¨ Utilize pre-training and/or post training evaluation format ¨ Determine training participants' satisfaction, evaluate training participants' knowledge and attitudes ¨ Consider longitudinal evaluation for assessing behavioural changes
FUNDING ¨ Collaborate with local agencies funded to provide continuing education ¨ Utilize volunteers to decrease staffing costs ¨ Research for grant support

SOURCE: Umeh (1997:174)

Education is a vital component of the national comprehensive outreach of HIV-related prevention and service delivery. The changing demography of the pandemic in the USA called attention to the need to include rural regions in the outreach programme, and to design education targeted to rural communities. Although the obstacles in effectively reaching rural audiences with AIDS education are significant, the strategies outlined above proved effective for the Emory Project in meeting the challenge of delivering rural AIDS education. Such education, delivered in a culturally sensitive manner, is essential to the task of changing common misconceptions and myths about HIV and AIDS which remain prevalent in many rural communities today. The researcher believes that similar strategies could be applied by ABET practitioners in rural ABET centres in the Limpopo Province of South Africa.

4.3 HIV/AIDS: Uganda's open secret

Uganda's approach to HIV/AIDS has been specifically chosen for this study because it is one of the countries worst hit by HIV/AIDS. However, it has managed to achieve tremendous success because of the aggressive way in which government, non-government organizations and individuals dealt with the epidemic. Knowledge of Ugandan experience may be useful for South Africa. Some of the strategies used might be adapted by the government in general and ABET centres in particular.

In the 1980s when AIDS first appeared in Uganda, Ugandans mused at its emaciating effect and gave it the euphemistic name of 'slim'. The first cases of AIDS were documented from the Rakai District of South Western Uganda in 1982. 1988 saw clinically defined cases throughout the country (Barnett and Whiteside, 2002).

Uganda was the first country to openly acknowledge the existence of the disease and to conduct an aggressive campaign towards its prevention (Umeh, 1997). Uganda began a public debate about 'slim' in the media from 1985. The government of Tito Okello, who took power after the fall of Obote and before the Museveni government came to power, was the first to initiate steps to control the disease. As a next step, Museveni's government set up a committee whose main brief was to organise the Ugandan response to AIDS under the chairmanship of a one Dr. Sam Okware. This

committee came to be known as 'The National Committee for the Prevention of AIDS'. President Museveni was neither the first to discuss AIDS publicly, nor the first to make it a matter of public debate, but his government moved swiftly after 1987 to develop a comprehensive response that eventually involved all sectors of Ugandan society. Some people have argued that Museveni's wake-up call to the epidemic had a Cuban connection. In 1986, Cuba already had in place quarantine against immigrants with the virus. It was then that Museveni sent a contingent of Ugandan soldiers to Cuba for military training, Three quarters of the soldiers were promptly sent back by the Cubans because they had tested positive. A terse message was sent to Museveni: 'better do something or else you won't survive in power for long' - presumably due to the high rate of infection in the army.

By 1994, 1.7 million Ugandans were infected with the HIV virus (Africa Report, May/June 1994). The total Ugandan population of 17 million was directly and indirectly affected: mortality and morbidity rates reached huge proportions. Whole communities were decimated, and the country was threatened with destitution, economic devastation and social disruption.

The reasons for Uganda in particular experiencing such a large epidemic were summarised by Barnett and Whiteside (2002:116) as being the breakdown in political order and economic collapse during Idi Amin's military dictatorship (1971- 1979) followed by two years of political malaise (1979 – 1981)[11] and Dr Milton Obote's ill-fated second term (1982-1985). This political adventurism eroded people's sense of political, social, as well as financial security and continuity. The need to survive in such conditions created a sense of hopelessness and turned many into risk-takers. Women, already dis-empowered, were thus socially, economically and politically alienated further. The result, as noted by Barnett and Whiteside (2002:116), was that exchanging sex for food, goods or protection became necessary for survival in unstable times. Deterioration of health and education contributed to an environment in which disease could spread. People did not have access to treatment for sexually

[11] The fall of Idi Amin created a power vacuum such that in less than two years Uganda was led by no less than three presidents and a military junta of five, none of whom were elected by the people. (Professor Yusufu Lule – 3 months, Lukongwa Binaisa QC – 9 months, the junta of five – 5-7 months).

transmitted infections and other diseases. Understandably, then, Uganda became very susceptible to the rapid spread of HIV.

While the picture was bleak, Uganda is known today for its innovative approaches to HIV prevention. Uganda's 'success' in confronting the epidemic, as pointed out by Barnett and Whiteside (2002:116), owes much to the government's initial frankness in dealing with it on the international stage and to President Museveni's strategy of 'selling' HIV/AIDS as one of the areas needing foreign investment. In face to face interaction with Ugandans at all levels, President Museveni emphasised that fighting AIDS was a patriotic duty requiring openness, communication and strong leadership from the village level to the State House (Hugle, 2002). The President's charismatic directness in addressing the threat placed HIV/AIDS on the development agenda and led the country's HIV infection rates to decrease and prevalence rates to fall from 14% in the early 1990s to 9% in 2001. Health workers in Uganda are optimistic that this trend can be sustained as long as the country remains vigilant (*Sowetan,* February 5, 2001).

It has been argued that Uganda's falling HIV prevalence was due merely to measurement bias or a 'natural die-off syndrome', however, Hugle (2002:2) argues that the fall-off was rather mainly due to a number of behavioural changes that have been identified in a number of surveys and qualitative studies. The argument above has not settled the issue, however, because some have postulated that the decline in sero-prevalence in Uganda was primarily a result of so many people succumbing to the disease, that the rate of new infection was simply outweighed by the numbers of AIDS deaths. Yet a number of other African countries, such as Zambia, Zimbabwe, and Western Kenya, experienced nearly as large, and at least as severe, an epidemic as Uganda's, yet prevalence has not declined.

In addition to other socio-cultural political elements, the most important determinant of the reduction in HIV incidence in Uganda appears to be delayed sexual debut. Uganda's President set the example for the nation with his matter-of-fact approach to dealing with the HIV threat, and inspired thousands of community, religious and government leaders to talk candidly to people about delaying sexual activity, abstaining, being faithful, *zero grazing* (sticking to one partner), and using condoms.

Many of these elements appear to be absent or less significant in other African countries that have not yet seen significant sero-prevalence declines, such as Zimbabwe, South Africa, Botswana, Kenya and Malawi (Hugle, 2002).

The thrust of Uganda's HIV Programme was prevention. The government was quick to realise that it could not afford to adopt a treatment-oriented approach and thus urged the population to prevent HIV by changing high-risk behaviour. Initially, infected people were stigmatised, but strong government media education programmes encouraged people to be tested for HIV and be open about their status. By removing stigma surrounding the disease, Ugandans moved to assist the victims of HIV. They started referring to HIV as their *open secret* or *"our illness"* and *"the illness which affects us all"*.

There was candid national media coverage of all aspects of the epidemic, radio being a key instrument in bringing the message to the population. In addition, high level government officials, priests, community leaders and musicians acknowledged their HIV-positive status, lending support to the government's drive to heighten AIDS awareness among the population.

In order to coordinate and facilitate HIV/AIDS prevention, the Ugandan government created the Ugandan Aids Commission (UAC), which advocates a multi-sectoral approach to HIV/AIDS, that alleviates pressure on the Department of Health by making it everybody's responsibility to deal with the pandemic, not just the Department's. This has been a key component in the success of Uganda's strategy. The UAC prepared a National Operational Plan to guide implementing agencies, sponsored Task Forces, and encouraged the establishment of AIDS Control Programmes in other ministries, including Defence, Education, Gender and Social Affairs. As of 2001, there were also reportedly at least 700 agencies - government and non-governmental - working on HIV/AIDS issues across all districts in Uganda (Hugle, 2002).

Other projects, such as the 'AIDS in the Workplace' project, implemented by the Federation of Uganda Employers, the Care and Advocacy for Persons with HIV/AIDS, provided by the AIDS Support Organisation (TASO), and the AIDS

Prevention Project, developed by the National Resistance Army of Uganda, have established Uganda as a fertile environment for resourceful approaches to AIDS prevention.

The opening of the first AIDS Information Centre for anonymous confidential voluntary counselling and testing (VCT) services in 1990, in Kampala, also contributed to the decline in HIV/AIDS incidence and prevalence. People came voluntarily to the centres to test for HIV/AIDS. By 1993, as an increasing number of people became interested in knowing their sero-status, the AIDS Information Centre opened branches in three other major urban areas (Jinja, Entebbe and Mbarara), for easy accessibility. The AIC pioneered provision of 'same day results', using rapid HIV tests, as well as the concept of 'Post Test Clubs' to provide long-term support for behaviour change to anyone who has been tested, regardless of sero-status. Uganda was unique in Africa in the emphasis it placed on VCT, at a time when the global programme on AIDS and other international organizations were not yet recommending it as a prevention strategy (Hugle, 2002).

Linked to high-level political support, an aggressive public media campaign and community-based face-to-face communication for behaviour change, was a strong emphasis on empowerment of women and girls; targeting youth in and out of school; and aggressively fighting stigma and discrimination against people living with HIV/AIDS. By 1989, teachers had been trained to integrate HIV education and sexual behaviour change messages into curricula. At the same time, the country's President and his political movement had attempted to empower women and youth by giving them more political voice, introducing a law in parliament which required women to make up a minimum one-third of the members, and four members representing youth in Parliament. Youth-friendly approaches promoted partner reduction through talking about delayed sexual debut, remaining abstinent, remaining faithful to one uninfected person if one had already started, 'zero grazing' and condom use (Hugle, 2002).

Early and significant mobilization of Ugandan religious leaders and organizations resulted in their active participation in AIDS education and prevention activities. Mission Hospitals were among the first to develop an AIDS care and support programme in Uganda (Hugle, 2002). The Islamic Medical Association of Uganda's

AIDS-prevention Programme (IMAU) was yet another pioneering initiative, focussed on the country's growing Muslim community. In 1990, IMAU piloted an AIDS education project in rural Muslim communities that evolved into a larger effort to train leaders and lay community workers.

For the purpose of the study, a detailed account of IMAU's activities will be presented, because IMAU achieved considerable success (UNAIDS, 1998). In addition, IMAU's activities and experiences are particularly relevant to the study because they can be linked to the activities carried out in ABET centres in South Africa.

The Islamic Medical Association Of Uganda (IMAU)

The Islamic Medical Association Of Uganda (IMAU) was established in 1988 to provide support to Muslim health professionals. It aims to improve the health of the people of Uganda in general, and the Muslim community in particular. (UNAIDS, 1998). IMAU pioneered the first AIDS prevention programme for Uganda's growing Muslim community, which makes up 20% to 30% of Uganda's 17 million people. Thus, there was a need not only to increase knowledge of HIV transmission and prevention, but also to acknowledge the dangers associated with certain traditional Muslim practices that have the potential to increase the risk of exposure to the HIV virus. These practices include ablution of the dead (if individuals fail to use protective gloves when cleaning bodily orifices), male circumcision (as sometimes practiced in the rural areas with one unsterilised razor being used for several infants) and polygamy (although there was no evidence associating polygamy with increased risk of HIV in the Ugandan Muslim community).

After only two years, baseline and follow-up surveys revealed that community members showed a significant increase in correct knowledge of HIV transmission and prevention, as well as increased knowledge of risks associated with some Muslim practices of circumcision and ablution. The survey also showed a significant reduction in self-reported sexual partners and an increase in self-reported condom use. IMAU succeeded in integrating Islamic religious values and wisdom with scientific medical information on HIV/AIDS. As a result of its excellent work, IMAU was chosen by UNAIDS for documentation as an example for best practice, which could serve as a model for other countries with similar problems.

AIDS Education

The misery and human suffering that AIDS brings is a serious concern for Muslim leaders. In September 1998, IMAU took the lead in uniting the Muslim response to the AIDS epidemic by holding a National AIDS Education Workshop.
This workshop, funded by the Ministry of Health's AIDS control Programme and the World Health Organisation (WHO), shaped the Muslim community's role in responding to the AIDS epidemic. It was during this workshop that the Chief Khadi was prompted to declare a *Jihad,* or 'holy war', on AIDS. This declaration of support from the highest level of Uganda's Muslim community was a critical first step in mobilizing the Muslim community in the fight against AIDS (UNAIDS, 1998).

Following the National Workshop, IMAU organized AIDS education workshops for *Imams* - spiritual leaders of mosques - in several districts. Extensive dialogue between health professionals and religious leaders at these early workshops revealed the need to design an AIDS education project to reach Muslim families through educators trained with and sanctioned by Imams. IMAU's initial effort to mobilize Muslim communities in the fight against AIDS took the form of the Family AIDS Education and Prevention Through Imams project (FAEPTI). This innovative project helps Imams to incorporate accurate information about HIV/AIDS prevention in their spiritual teaching, and trains teams of community volunteers to provide education, basic counselling, and motivation for behaviour change through individual home visits (UNAIDS, 1998).

According to UNAIDS (1998), the project worked with leaders of 850 mosques and trained 6,800 community volunteers who made personal visits to 102,000 homes. As HIV is spread primarily through sexual intercourse, modifying current or future sexual behaviour is the focus of IMAU's effort to prevent HIV transmission. It should be mentioned, however, that influencing sexual behaviour is a delicate task and discussing this private part of people's lives may be taboo. Fortunately, people are more open in discussing sexual behaviour when they understand that their health and that of their family and community are at stake. IMAU's AIDS education efforts begin with the understanding that preventive interventions in Muslim communities are more likely to succeed if the message 'bearers' are trusted members of the community, such as religious leaders. FAEPTI was followed by Community Action for AIDS Prevention (CAAP) in Kampala, which was conceived as an urban companion to FAEPTI. CAAP workshops trained teams from churches, as well as mosques, plus social groups such as bicycle transporters and market vendors to pass on information about HIV/AIDS through their interaction with the public at market stalls and while delivering passengers to their destinations. The project design takes into account the density of urban populations and focuses on community groups as well as individual families.

In most parts of the world, the majority of new HIV infection is in children and in young people between 15 and 24 years of age. IMAU developed an AIDS education programme for Muslim youth to address a lack of information in this most vulnerable sector of Uganda's population.

The Madarasa AIDS Education and Prevention Project, funded by the United Nation's Children's fund (UNICEF), worked with 350 Madarasa schools. Madarasa schools are informal schools attached to mosques and teach young people important principles of Islamic culture and behaviour. Each school is attended by approximately 50 children, ranging from 5 to 15 years of age. Classes include in-school as well as out-of-school youth. Madarasa teachers are Imams and some are members of the Uganda Muslim Teachers Association.

IMAU and UNICEF developed an AIDS education curriculum of 36 lessons, each of which can be covered in a 40-minute session on a Saturday or Sunday morning. The

curriculum is tailored to be age-appropriate for classes of mixed age groups. The AIDS education is taught alongside the religious topic addressed that day. The curriculum includes:

- Understanding adolescence,
- Adolescent friendships,
- Peer pressure,
- Understanding sexuality,
- Facts and myths about HIV/AIDS,
- Islamic teaching on safe sex,
- Responsible healthy living,
- Breaking the stigma,
- Peer counselling,
- Building positive dreams,
- Discussing AIDS with parents.

Madarasa students learn about HIV/AIDS transmission, prevention and control. They are shown how to care for AIDS patients and encouraged to help people with AIDS in their own communities. Teachers and their assistants organize activities that include music, drama and games. Parents and guardians are encouraged to talk to their children about HIV/AIDS. The Madarasa school AIDS education curriculum is for the youth but it very relevant and can be adapted by the ABET Programmes in the rural communities of South Africa to meet the needs of the adult learners. For example, 'understanding adolescence' could be adapted to 'understanding your partner'; 'discussing AIDS with parents' could be changed to 'discussing AIDS with a partner' or 'discussing AIDS with children.'

Income Generating Activities

Studies have shown that there is a direct and indirect link between poverty and HIV/AIDS infection. Poverty encourages - or even forces - sexual-risk taking and limits girls' capacity to be critical about sexual partners. Furthermore, poverty greatly contributes to HIV risk as it limits the family's capacity to supervise the girls and protect them against sexual abuse (Meursing, 1997). Income-generating activities (IGA) have been introduced in rural communities to alleviate poverty in many developing countries. IGA are a popular component of FAEPTI in Uganda. IMAU

believes that increasing individual income is an important factor in reducing the likelihood of HIV infection.

Families with higher incomes are more likely to educate their children. Their children in turn are more likely to find gainful employment and understand the dangers of high-risk behaviour. Lack of meaningful activity is often cited as a condition that puts young people at risk of AIDS (UNAIDS, 1998). The relationship between poverty and AIDS was also stressed by Sheik Bifamengo who said that; "Poverty fuels AIDS and AIDS brings poverty. If we are to fight AIDS we must develop our communities." One family AIDS worker in Uganda remarked that, if women have their own income, they are more likely to buy things that they want with their own money. They are less likely to go outside their marriage looking for someone else to provide the things they desire (UNAIDS, 1998).

It was on these grounds that FAEPTI included income-generating activities as one of the strategies for use in the prevention of HIV/AIDS and helping people already infected to continue living positively with AIDS. There are several income-generating activities that participants are involved in. These include stone crushing, bricklaying, honey collecting and selling fruits and vegetables. One interesting factor about these projects is that most of them do not require much start up capital. For example, at the start of FAEPTI projects, volunteers were given money to buy two hens. This was later modified and each was given two female goats. In many cases the hens and goats multiplied to benefit the volunteers. Other IGA were started from the sale of the multiplied goats and hens.

One example of a successful CAAP project is in Katanga, one of the most densely populated areas of Uganda. Every home in the area has suffered the effects of AIDS, not to mention other fatal illnesses such as cholera, dysentery, malaria, and typhoid. Groups have been formed to help women start income-generating activities so as to be able to support themselves. The women meet weekly as a group, for fellowship and to develop self-respect as women. Women from different religious affiliations enjoy coming together to learn. The leaders vary the topics of the weekly meetings and sometimes bring in guest speakers. They talk about AIDS and also have lessons on

hygiene, recycling waste into fuel briquettes, cooking, and how to wear the Ugandan traditional dress ('*Busuuti*') (UNAIDS case study, 1998).

Women's Empowerment

Studies have shown that there is an important link between a woman's ability to make choices about her life and her susceptibility to HIV infection (Umeh, 1997). Women participating in IMAU's AIDS education projects say that they have learned self-respect and this helps them avoid high-risk behaviour. They also say that having their own source of income has made it easier to stand up for themselves, in the face of unfaithful husbands (UNAIDS, 1998). This hopefully reduces the risk of infection.

IMAU involves women at every level of its AIDS education activities. The Imam is required to have a female and a male assistant, and Family AIDS Workers (FAWs) comprise equal numbers of men and women. Women volunteers are said to be the most interested and effective participants since female FAWs find they are willing to confide in them about important matters regarding HIV/AIDS that they would never raise with their husbands or the Imam.

Encouraging the formation of women's groups and offering incentives for IGA is at the heart of IMAU's effort to empower local women. IGA keep them from looking outside marriage for other partners to contribute to their financial needs, such as school fees. Women also say that if they are financially dependent on their husbands, they fear standing up to them because the husbands may throw them out, leaving them destitute. This is one reason why women who suspect that their husbands have been unfaithful do not refuse their advances or insist they wear a condom (Gupta, 2002; Mzaidume, Campbell and Williams, 2000).

An earlier study conducted by Kiggundu (1999) found that IGAs formed an elective component in the ABET curriculum and there were several IGAs in the Limpopo Province. These could be developed and increased in number so as to empower women in the rural communities and to help people living with HIV/AIDS. For example, vegetable gardens enable the people to feed their families well. This improves the nutritional status of families, of people living with HIV, and could reduce opportunistic infection. For example, the Ikhwelo Project has enhanced and

assisted learners to establish SMME and agricultural ventures. These income generating ventures, such as planting and selling vegetables, making peanut butter for sale in the community and poultry farming - to mention but a few - lead to the reduction in poverty. Many learners get an income and are able take care of their families (Interview conducted with the Ikhwelo Project Manager at the National offices of Project Literacy in Pretoria by researcher in 2001, see appendix two).

People living with HIV/AIDS (PWA)

PWAs have a key role to play in any strategy designed for prevention and support (Parker et al., 2000). In South Africa, it is government policy that PWAs should be included whenever possible in policymaking and the delivery of programmes.

In Uganda, IMAU and other AIDS support organisations encourage PWAs to share their experience of living with HIV, with the many HIV positive people they come into contact with (UNAIDS1998). Respecting and protecting the rights of those infected by HIV was inspired by public events such as candlelight memorials and World AIDS Day observances. At the beginning of the epidemic, in 1989, Philly Lutaaya, a celebrated Ugandan musician based in Sweden went public about his status. He returned to Uganda and devoted his last days to giving testimonies in schools, colleges, churches and other public places. A major in the Ugandan army also talked openly about his infection and how he used condoms to avoid infecting his wife. A protestant minister disclosed that he learned of his infection when his first wife died, and talked publicly about using condoms to avoid infecting his new wife. In his analysis of the situation, Hugle (2003:6) pointed out that openness on the part of the President, other government and community leaders and prominent activists led to a remarkable acceptance and non-discriminatory response to AIDS.

In South Africa, there are a number of people working under the banner of the National Association of People Living with HIV and AIDS (NAPWA). These people also use their life stories as a powerful motivating force to make the general public aware of HIV/AIDS (Parker et al., 2000). This type of public disclosure can go a long way towards challenging attitudes, and encouraging acceptance of PWAs by the community. As well as being informative and emotional, disclosure engages people on a personal level and gives a face to the disease (Parker et al., 2000). ABET

practitioners could apply the same principles in their effort to help people living with HIV/AIDS in rural and urban communities.

Networking

According to UNAIDS Case Study 1998, IMAU'S projects do not screen blood for HIV or dispense food and medicine to family members with AIDS. When people say, "We are already sick. What can you give us?" or "We want to know if we have HIV." IMAU volunteers usually refer such people to the AIDS Support Organization (TASO), and other organisations such as the AIDS Information Centre.

IMAU realized at a very early stage that networking with other organizations is invaluable in the fight against HIV/AIDS. Similarly, ABET centres might not offer material support or clinical services to families with AIDS, but could help them network with other organizations that do offer these services.

Much has been done in Uganda to confront the AIDS epidemic. IMAU's AIDS Education and Prevention Project, and the Madarasa AIDS Education and Prevention Project, have contributed to significantly higher levels of awareness of HIV/AIDS in Muslim communities. It is clear that the recent reduction in Uganda's prevalence is due in part to this increased awareness (UNAIDS, 1998). For example, there has been a boost in condom use across the country. In the Masindi and Palisa districts, for instance, condom use with casual partners in 1997-2000 rose from 42% and 31% respectively, to 52% and 53%. In the capital, Kampala, almost 98% of sex workers surveyed in 2000 said that they had used a condom the last time they had sex (Hugle, 2002). Nevertheless, many rural areas still lack information about HIV/AIDS control and prevention. Changing risk behaviour is a slow process and AIDS education efforts have a long way to go, particularly in reaching Uganda's young people.

Alleviating poverty continues to be a key element in the struggle. Increased family income means better schooling for children and more choices for parents. IMAU's income-generating activities have shown that small-scale community projects contribute to changes in attitude and behaviour. Women in particular become empowered to make important decisions that protect the health of their families (UNAIDS, 1998). However it is should be noted that the success attained by IMAU

through FAEPTI and the Madarasa AIDS Education and Prevention Project may be partly attributed to the strict religious teachings and practices which emphasise morality and fidelity among Muslims. Such practices may be more difficult to reinforce in other religious faiths.

Uganda's experience underlies the fact that even the rampant HIV/AIDS epidemic can be brought under control. The axis of any effective response is a prevention strategy that draws on the explicit and strong commitment of leaders at all levels (including religious leaders), that is built on community mobilisation and that extends to every area of the country (UNAIDS/WHO, 2001).

4.4 HIV/AIDS and Botswana

In the previous section I looked at Uganda as one of the countries that was worst hit by HIV/AIDS. I highlighted some of the reasons for the high degree of susceptibility and I emphasised the reason for the reduction in HIV incidence as being the aggressive way in which the Ugandan government, NGOs and individuals dealt with the HIV/AIDS epidemic. Finally, I examined the activities of The Islamic Medical Association Of Uganda (IMAU) in providing AIDS education and prevention among the country's growing Muslim community. In this section I am going to examine the impact of HIV/AIDS on Botswana, the reasons for the high degree of susceptibility and what is being done to combat HIV/AIDS in Botswana. During the discussion I will look at the similarities and differences between the two countries' approaches and how each relates to the South African situation.

Botswana has been chosen for this study because, as in South Africa, a substantial number of people in Botswana still face abject poverty, unemployment and disease despite, as observed by Forcheh and Setlhare (2001:184), the remarkable growth in the economic and social sectors of the economy over the last quarter of a century. Trends in the rate of morbidity and mortality due to most of the dominant diseases of the eighties have continued to rise in the last decade. In addition, AIDS has emerged from being an unknown cause of mortality before the mid eighties, to become the overall leading cause of mortality in the population (Forcheh and Setlhare, 2001).

Similar to the Ugandan situation of ten years ago, and the existing South African situation as discussed in chapters one and two of this thesis, the epidemic in Botswana has assumed devastating proportions. According to UNAIDS/WHO (2003), HIV prevalence has reached extremely high levels without signs of levelling off. Botswana has one of the highest recorded incidences of HIV infection in Africa. The percentage rate of HIV infection was estimated to be the highest in the world, at 35% amongst its 15-29 year age group (UNDP, 2000). At the time of writing, in mid 2004, at least 38.08% of the adult population (aged 15-49) were living with HIV/AIDS, including 170,000 women. Studies carried out in 2001 showed that one in three adults were already infected and the life expectancy at birth was estimated to be 39 years, instead of the 71 it would have been without AIDS (Barnett and Whiteside, 2001).
According to the Botswana National Strategic Framework for HIV/AIDS (2003-2009), the HIV/AIDS epidemic continues to worsen, contrary to the projections that HIV prevalence rated would plateau at around 25%. HIV prevalence for pregnant women aged 15-49 years in Botswana did, however, decrease marginally from 36.2% to 35.4% in 2002 (Government of Botswana, 2003). In all districts the prevalence rate among pregnant women attending antenatal clinics is more than 20%, with some exceeding 50%. Botswana has a relatively young population with about 60% of the approximately 1.8 million people aged less than 45 years old. It is estimated that about 258,000 Batswana are now living with HIV and AIDS and high morbidity and mortality rates due to HIV/AIDS saw Botswana slip down the UNDP Human Development Index rankings from 71st place in 1996 to 122nd in 1999/2000.

As a result of this situation the government of Botswana, like the government of Uganda, and unlike the South African government, declared HIV/AIDS a national emergency, strengthened leadership structures, introduced new interventions and continued to advocate an expanded multi-sectoral national response to the epidemic. Like the President of Uganda, Yoweri Museveni, who conducted an aggressive campaign towards the prevention of HIV/AIDS and set up a committee whose main brief was to organise the Ugandan response to the challenge of AIDS, the president of Botswana, Festus Mogae, declared HIV/AIDS a national emergency and began to chair the National AIDS Council, the policy making body on HIV/AIDS. In the same year, the National AIDS Coordinating Agency was established to lead the co-ordination of the multi-sectoral response (Mogae 2004, SARPN). Furthermore, the

government of Botswana is committed to building an educated and informed nation. To this end, education and health care remain priority areas for the nation.

Impact of HIV on Botswana

As discussed in chapter one of this thesis under 'HIV/AIDS in context', the costs of unmitigated spread of the HIV virus in Botswana have gone beyond being just a health problem. HIV/AIDS has had devastating effects on the development of all sectors in Botswana. Social costs include high levels of stress on families, loss or reduction of adult skills and increased pressures on children and the elderly to take on caring roles with consequent threats to income and savings (Preece and Ntseane, 2001). Heavy burdens are placed on women, firstly, because funds that could have been allocated to development programmes have been diverted to health, and secondly, because women in the entrepreneurial sector are often the main caregivers to AIDS patients. HIV/AIDS overshadows all life in Botswana, and all programmes have to be viewed through the prism of this scourge and its effects (Phaladze and Tlou, 2001).

The cost of health, the shortened life expectancy, the loss of skilled human resources, and the effect on women as primary care givers to the ill, all impact negatively on the country's overall development plans. A recent study conducted by the Central Statistics Office, the *Botswana Aids impact Survey 2001* BAIS 2002), reports that 38% of people in the 15 to 49 year age group are HIV/AIDS positive. Caring for the ill consumes the health care facilities (up to 60% of hospital wards are occupied by AIDS patients), and Community Home Based Care Programmes, with women as the primary caretakers. In the following section I will briefly discuss the situation in Botswana and the areas that have been affected by HIV/AIDS.

Impact on the economy: Botswana's workforce, like that of South Africa, largely falls within the sexually active population. With a national HIV prevalence of around 35%, the number and quality of people available to work will decline over the next 5-10 years. Thus, as noted in the National HIV/AIDS Strategic Framework 2003-2009, the return on government's efforts to promote foreign direct investment, diversify the economy, and create employment for Bastwana, may be negatively affected if no action is taken. As in all African countries, apart from this decline in the productive

workforce, the epidemic has increased poverty and human suffering, and weakened the government's capacity to deliver essential services and sustain human development.

Demographic Impact: Several studies, for example, Forcheh and Setlhare (2001) and Phaladze and Tlou (2001), suggest that the structure of the population and its growth rate continue to be altered as a result of the HIV/AIDS epidemic. Mortality across all age groups is on the rise in Botswana and life expectancy has declined. It is estimated that by 2010 life expectancy could drop as low as 29 years (Botswana Human Development Report, UNDP, 2001). According to the National HIV/AIDS Strategic Framework 2003-2009, if nothing is done to halt the deepening of the epidemic, one-third of Botswana's adult population could die over the next 8-12 years and the structure of the population will shift to increasing numbers of very young and very old, as has occurred in the Rakai district of Uganda. This is a similar scenario to the one that threatens South Africa.

Impact on Health: The nation's health system, as noted by Forcheh and Setlare (2001), is being stretched to the limit and an increasingly large proportion of the sector's resources are now being devoted to the care of AIDS patients. Current interventions are geared towards ensuring that the HIV/AIDS epidemic will not exacerbate the massive burden of caring for and treating HIV and AIDS, will not consume health resources and facilities, and not seriously limit the ability of the health care system to execute its mandate and deliver even basic services to the society at large.

Impact on Education: High levels of morbidity and mortality among teachers threaten to reduce the number of classroom hours being taught, the quality of teaching and the learning environment, as well as the delivery-capabilities of the system. With the growing number of children either infected or affected by the epidemic, school enrolments have declined due to dropouts, increased illness, or children having to care for family members or earn additional family income - as was the case in Uganda. Those who remain in the classroom and who see friends and teachers affected by the epidemic are traumatised and suffer a decreased ability to learn.

Impact on households: The immediate impact of HIV/AIDS on households in Botswana includes increased health expenditures and loss of income. It is estimated this will eventually push at least 5% more households below the poverty line**.** Since the disease affects mostly those in the 15-49 age group, families have lost their most productive members to the disease, with implication for food production and household income levels (Hope, 1997). Coombe (2000:12) reports a similar situation in South Africa, where the annual death rate in the workforce was forecast to rise from 5 to 30 per 1000 workers.

Orphans: Currently there are an estimated 78,000 orphans in Botswana, and projections indicate that by 2010 more than 20% of all children will be orphaned. The capacity of the extended family to absorb these orphans will be stretched to the limit and may even collapse when the present generation of grandparents die (Government of Botswana, 2001 HIV Sero prevalence Sentinel Survey). This Occurred in Uganda and it resulted in an increased number of street children.
These implications are presumed to have been a strong incentive for government and non-government organisations (NGOs) to take seriously their role on HIV prevention measures (Preece and Ntseane, 2001).

Reasons for a high degree of susceptibility in Botswana
Several interdependent determinants have been identified as driving the spread of the HIV/AIDS epidemic in Botswana. These can be grouped under four broad headings: Socio-economic determinants; Socio-cultural determinants; Demographic mobility; and Stigma and denial. These will be discussed in turn below.

Socio-economic determinants
Key socio-economic factors are largely represented by a cycle of real or perceived need and exploitation. On the one hand, people with high levels of disposable income are at risk due to their ability to exploit situations of relative inequality or exert unfair advantage in the pursuit of sex. On the other hand, rising poverty levels indicate that many people are unable to meet their daily needs, often forcing them to adopt high-risk survival strategies. Recent estimates put the proportion of households in Botswana below the poverty line at 22%. In the urban areas it is at 11.7%, while in the rural areas it is 27.1%. Botswana is one of the fastest growing economies in the world

and is in the UN's upper-middle income category. It has also done well in terms of human development. For example, the adult literacy rate is 75% and 96% of primary school age children are in school. The country has a well-developed decentralised primary health care system.

Until recently the population of this semi-arid country depended on subsistence agriculture and cattle farming. Economic growth due to the discovery of diamonds has led to rapid urbanisation. Of the estimated 1,496,0000 people in the country, 729,000 or 48% live in urban areas. This figure has increased from 18% in 1981 and unemployment has also risen. The estimated unemployment rate in 1994 was 21%, and was higher among women than men. Despite rapid economic growth, income distribution is highly skewed. The richest 20% of the population receive 59% of the income; the poorest 40% only 12% of the total income (UNDP, 1998)

Socio-cultural determinants

Important factors under this heading include the socially reinforced subordination of women, which underlies many aspects of their vulnerability, especially their relatively weak position in being able to make decisions about sex and their lack of economic empowerment. The social acceptance of 'sexual networking' (cultivation of multiple sexual relationships in a variety of environments) by men is also fundamental and further underscores the subordination of women in Botswana (Phaladze and Tlou, 2001). Initiatives are ongoing to strengthen the legal and ethical environment to support the empowerment of women and youth. Access to and abuse of alcohol, particularly among youth, has been shown to increase the incidence of casual, unprotected sex, thus having a significant influence on the spread of HIV/AIDS in the country (Botswana Development Report UNDP, 2001).

Demographic mobility

Traditionally the Batswana were a mobile population, moving between their villages, on lands of crops and 'cattle posts' - remote grazing areas around which cattle are kept. The urban areas now provide a fourth destination, and the development of a good all weather road network has greatly assisted population mobility (Barnett and Whiteside, 2001). Consistent movement of family members between cattle post, fields and the town often leave children of school-going age unattended for extended

periods of time so that they can continue with their education. Such an environment, as pointed out by the Botswana National Strategic Frame work for HIV/AIDS (2003-2009), lacks the appropriate structure and supervision for young children, possibly increasing their risk of contracting disease. Botswana is also a corridor for transport of goods from South Africa to Zambia, the Democratic Republic of Congo, Angola and Malawi, as well as from Namibia to its eastern neighbours, all of which share the high prevalence rates that characterise the pandemic in Southern Africa (Botswana National Strategic Frame work for HIV/AIDS 2003-2009).

While the country is stable politically, socially it is in flux. Between 1971 and 1996, the proportion of ever-married women fell steadily from 63% to 39%. The percentage of teenage pregnancies has remained constant at about 15% of teenagers (Barnett and Whiteside, 2001). Rapid economic growth, an expanding transport network, population mobility, urbanisation, cross border trade and inequality are all characteristics of a risky environment. The population of Botswana is highly susceptible to HIV infection and the data shows that the epidemic is now generalised and very serious indeed.

What is being done to combat HIV/AIDS in Botswana?

The government of Botswana has developed multisectoral strategies to combat HIV/AIDS. For instance, while recognising that resources are severely limited, Botswana, an upper-middle-income country of less than 2 million people, spent US $70 million on HIV/AIDS programmes in 2002. The government's response to the problem has been to initiate AIDS education programmes, as well as medical measures. These medical intervention measures are aimed mainly at pregnant women. This is to try and reduce the number of mother-to-child infections (SARPN-HIV/AIDS, 2004). However, as in Uganda and other African countries, this programme was slow to take off because women were unwilling to test due to their fear of being stigmatised.

In addition to the national programme for universal access to free AZT and nevirapine for all pregnant women, the government provides free infant formula for mothers who choose to formula feed. The introduction of lay counsellors has helped to increase the number of women counselled and tested. As in Uganda, the government of Botswana established solid partnerships with the international community, the private sector,

NGOs, Community Based Organisations, Faith Based Organisations, the youth, women's groups, people living with HIV/AIDS as well as academic institutions. By July 2004 more than 90% of women going to the antenatal care clinics were being pre-test counselled. To further minimise transmission of HIV in the community, treatment of sexually transmitted infections was strengthened. As a result there was a downward trend in the prevalence of STIs (SARPN-HIV/AIDS, 2004).

Information, education and communication (IEC) on HIV/AIDS are crucial components of a comprehensive package of prevention services required to reduce the number of new HIV infections. IEC includes, but is not limited to, activities such as mass media campaigns, school-based AIDS education, and peer education programmes, which aim to bring about changes in knowledge and behaviour that reduce the risk of HIV exposure and infection. Botswana has established a 25-member Behaviour Change and Communications Advisory Board to advise on Programmatic issues (UNAIDS, 2003).

Furthermore, Botswana appears to be in the vanguard of regional efforts to promote life-skills-based education. Before embarking on a major effort to engage schools in the response to HIV/AIDS, Botswana undertook baseline studies to inform programme development. On the basis of this research, the country incorporated HIV/AIDS into subject curricula at all levels, produced self-instructional booklets in Sestwana and English, and introduced teachers to life-skills-based education.

In addition, the country has initiated the Teacher Capacity-Building Programme, a national distance learning television programme that targets teachers and students in primary, secondary and tertiary institutions. Modelled on Brazil's successful *TV Escola*, the programme has provided TV sets and video machines to 325 of the country's 979 schools, technical colleges and educational centres.

It is important to mention that Botswana has put much effort into bio-medical and scientific research projects. For example, with the assistance of Baylor College of Medicine, University of Pennslvania and Harvard AIDS Institute, Botswana carried out research on development of resistance to ARV drugs, viral structure of the local strain, response to certain drug combinations in children, use of anti-retroviral in breastfeeding mothers, and tuberculosis. In addition to these areas of research, these

partners were also helping in the training of the health care providers in the area of HIV/AIDS (SARPN- HIV/AIDS, 2004).

President Mogae (2004) noted that prevention of new infections alone was not sufficient. It was for that reason that the government introduced antiretroviral (ARV) therapy in public health facilities at no cost to citizens. In sub-Saharan Africa, where the World Health Organisation (WHO) estimates ARV coverage to be approximately 1%, the greatest success in reaching patients in high-prevalence countries has occurred in Botswana and Uganda, which report coverage of 7.9% and 6.3% respectively, as of December 2002.

As of July 2004, 14 000 people were reported to have been enrolled, of which 9 000 were receiving antiretroviral drugs in government health facilities and a further 5 800 in private health facilities (SARPN-HIV/AIDS, 2004). There was a possibility that the 12 sites offering ARV would be increased to 18 by the end of 2004. This would extend coverage significantly. Botswana has made important health strides in reaching HIV-positive pregnant women, by availing public health services with ARVs prophylaxis. Botswana has committed itself to making ARV available nationwide over the next five years. In South Africa, by contrast, where infection rates are among the world's highest, WHO reports that ARV treatment in the public sector was effectively nil in 2002 (UNAIDS, 2003). Research has also shown that there has been an increase in condom use in Botswana: 88% for men and 75% for women (UNAIDS, 2003). In 2002, Botswana procured 31 million condoms through the public sector, leading to the distribution of 44 condoms per sexually active person (aged 15-59), and the country also established quality assurance mechanisms for its condom distribution programmes (UNAIDS, 2003).

Botswana, like all other countries in Sub- Saharan Africa, has identified numerous barriers to a more effective and comprehensive response to the HIV epidemic and is actively tackling some of the challenges involved. The first hurdle is the lack of awareness that HIV can be transmitted from an infected mother to her child, and that measures exist to reduce the risk of transmission. A large information campaign was launched to ensure that women were aware of the possibilities for preventing transmission from mothers to infants before attending a clinic, thus decreasing the amount of counselling time needed to relay basic information.

In addition to insufficient resources, there is a lack of human resources and technical capacity in many areas of HIV Programming, especially at local level. According to UNAIDS (2003:78), this shortfall in human resources has become a major concern, and a human resource plan has been developed to try to address it. Similarly, in South Africa, the main challenge to implementation relates to capacity, especially with respect to health workers' clinical skills to manage patients with TB, STIs and opportunistic infections. To respond to capacity limitation, South Africa has made additional public funds available to provide training to health workers.

Another major challenge that has been identified in Botswana as seriously hampering efforts to turn the tide on the epidemic is stigma and discrimination. Botswana observes that stigma is preventing a scale up of prevention of mother to child transmission (PMTCT), as many women fear enrolling in PMTCT Programmes due to fear of negative reaction from their partners (UNAIDS, 2003). According to the 2002 Sentinel Surveillance Report, it was estimated that over 35% of all adults aged between 15-49 in Botswana are HIV positive and yet most of them, like most South African adults, do not know they are positive. Stigma and denial create an environment maintaining the potential for increased infection, as well as limiting the ability of people to live positively and responsibly with HIV/AIDS. However, the level of public awareness of HIV/AIDS and its socio-economic implications is believed to have risen considerably. There is more public discussion and openness than in the past three years. Community leaders have become active proponents of various HIV/AIDS programmes (SARPN-HIVAIDS, 2004). This, as observed in Uganda, assists to break down barriers and promote common understanding by the general public. The demand for voluntary counselling and testing increased, giving hope that the epidemic was coming out into the open.

Lately, as noted by Keeton in the *Sunday Times* of 9th May 2004, when AIDS treatment became widely accessible, the Botswana government shifted from the voluntary counselling and testing model used in South Africa and most African countries, to offering routine HIV testing for patients. The country's decision, according to the *Sunday Times,* has in some clinics tripled the number of people being tested and, as mentioned by Botswana's Health Minister Lesego Motumi, it would save lives through early diagnosis. The Health Minister, however, admits that there is

a small percentage who would rather die than know their status. This is doubtless due to the fear and stigma associated with HIV. As noted by Keeton, "with access to antiretroviral AIDS is no longer regarded as an imminent death sentence". *Sunday Times* of 9th May 2004.

To this effect, the South Africa's Aids Law Project lawyer, Jonathan Berger, pointed out that routine testing reaches out to patients, while VCT reaches out to communities. As such it was suggested that a combination of both models would be the best solution for South Africa, creating a climate in which HIV testing is routinely offered to patients, along with thorough counselling, since antiretroviral treatment is being rolled out in South Africa as well (*Sunday Times*, May 9 2004).

4.5 Conclusion

In this chapter I reviewed the challenges faced by rural communities in relation to HIV/AIDS as being lack of information and lack of power and resources to change their sexual behaviour and that of their sexual partners due to their low social-economic status. I talked about the growing urbanisation which leads to many men leaving their families to go into to the cities where they form relationships with other women only to return to the rural areas to infect their wives. I mentioned that HIV/AIDS education in rural communities is complicated by, among other factors, the geographic distance, limited resources and denial that facilitates a corresponding lack of ownership of HIV/AIDS as a public health threat.

Educational strategies that proved effective for the Emory project in the USA were discussed. These included networking with community leaders, and utilising existing local agencies. Since the cultural beliefs of a community influence health attitudes, practices, and responses, it was recommended that education must be delivered in a manner that is respectful of cultural practices inherent in the rural setting and should make effective use of community skills and resources and knowledge. South Africa faces similar challenges, and I have indicated where similar strategies could be applied by ABET practitioners in the Limpopo province to address the challenge of HIV/AIDS.

Furthermore, I examined the experiences in Uganda, a country that was hard hit by HIV/AIDS (HIV/AIDS rate of 14%), but managed to achieve tremendous success because of the explicit and strong commitment of leaders at all levels, aggressive public media campaigns, community based, face to face communication for behaviour change and the strong emphasis on empowerment of women and girls (most of which are lacking in South Africa).

In the last section I reviewed HIV/AIDS in Botswana. Statistics showed that Botswana has the highest infection rate in the world and this has led to devastating effects on the development of all sectors in Botswana. I discussed the reasons for a high degree of susceptibility to HIV/AIDS, highlighted what the government has done to combat HIV/AIDS in Botswana, and pointed out that the government's response to the problem has been to initiate AIDS education programmes in the media and in schools, as well as medical measures. These medical intervention measures are aimed mainly at pregnant women, so as to try and reduce the number of mother-to-child infections and at distribution of ARVs in public health facilities at no cost to citizens.

I examined the challenges that have been identified in Botswana as seriously hampering efforts to turn the tide on the epidemic. I emphasized insufficient human resources, stigma and discrimination as being the major impediments. However, it should be noted that the problem of HIV/AIDS in Botswana is not unique. Most of the problems experienced exist in South Africa and the rest of sub- Saharan African countries. As such, some if not all of the strategies employed in Botswana are relevant to the South African situation.

Uganda, Botswana and South Africa have much in common, in that a substantial number of people in these countries face abject poverty, unemployment and inequality, leading to the epidemic assuming devastating proportions. The impact of HIV/AIDS on Botswana in relation to the economy, health, education, demography, and orphans is similar to that of Uganda and South Africa, but that is where the similarity ends. These countries have responded differently to the HIV/AIDS epidemic. Unlike the government of Uganda, which openly acknowledged the existence of the disease and conducted an aggressive campaign at a very early stage

(1985), the government of Botswana had a very late start. [12] South Africa, on the other hand, was slow to react to the AIDS crisis and was embroiled in a series of controversies resulting in disunity and conflict, as discussed in chapter one of this thesis.

Furthermore, similar to President Museveni who conducted an aggressive campaign and set up a committee whose main brief was to organise the Ugandan response to the challenge of AIDS, President Mogae declared HIV/AIDS a national emergency and began to chair the national AIDS Council. President Mbeki, on the other hand, engendered public confusion and undermined the government anti-AIDS campaign by assembling a panel of dissident scientist in South Africa to ponder the relationship between HIV and AIDS which, as discussed in chapter one, diverted attention and resources from prevention and ameliorative action planned by the Department of Health and Welfare's AIDS Directorate.

While the government of Botswana introduced medical measures as early as 1999 (MTCTP, free infant formula for mothers who chose to formula feed), the South African government had to be forced to extend its offer of Nevirapine to all its health facilities after the TAC brought a court action against the health minister and her provincial counterparts.

The Ugandan government and the government of Botswana established solid partnerships with the international community, the private sector, NGO community-based organisations and religious organisations. On the other hand, in South Africa, many of the latter are at loggerheads with government policy.

However, it is important to mention that the South African government, like the government of Botswana, has of late increased spending on HIV/AIDS prevention programmes in schools and communities, hospital treatment and community care programmes. For example, in Gauteng almost 5000 people have started anti-retroviral treatment since the roll out began in April 2004. And as mentioned in the *Star*

[12] It was only in 2000 that the government declared HIV/AIDS a national emergency and established a national AIDS coordinating agency to lead the coordination of the mult-sectoral response (AARPN-HIV/AIDS, 2004).

(Tuesday August 24 2004), the Gauteng Health Department is confident that it will reach its projected target of 10 000 patients on treatment by 2005.[13]

Finally, in terms of response to the HIV epidemic, insufficient resources, especially with respect to health workers, stigma and discrimination were identified as barriers to a more comprehensive response. South Africa, like Botswana, has made additional public funds available to provide training to health workers and there is more public discussion and openness than in the past three years. This from the Ugandan experience breaks down barriers and promotes common understanding by the general public.

As in Uganda, Botswana has incorporated HIV/AIDS into subject curricula at all levels of education and introduced teachers to life-skills-based education. In South Africa through collaboration between national department of education and health, a National Project Committee for HIV/AIDS and life skills has been established and it has been extended to all primary schools. This should be adapted and extended to rural ABET centres as well so that illiterate adults have comprehensive HIV and AIDS education that will enable them to remain uninfected, and know how best to deal with HIV/AIDS in their communities.

[13] At Johannesburg hospital, chief executive officer Sagie Pillay said the hospital had already reached its target of 1000 patients on treatment and was booking appointments well into 2005.

CHAPTER FIVE

RESEARCH METHODS

5.1 Introduction

This chapter sets out the research design, including the methods that were used to gather, organize and analyse information for this study. The chapter is arranged into three parts. The first part describes the research design, the case study approach, the methods that will be used to gather information, and triangulation techniques. The second part describes the research setting and sources of information. The third part explains how information was coded, organized and analyzed.

5.2. The research design

The fundamental question explored in this study is how rural ABET centres address the challenges of HIV/AIDS prevention and support. The information generated will contribute to the formation of an informed theoretical and practical framework that rural ABET centres can draw on to address the challenges of HIV/AIDS prevention and support in the Limpopo Province. There were several focus questions that guided the interpretation and analysis of information gathered from the respondents and documents. These were:

- How do ABET centres teach learners about HIV/AIDS?
- What do ABET centres do to support people living with HIV/AIDS?
- What are the attitudes, beliefs and practices of ABET practitioners and learners with respect to HIV/AIDS prevention practices and care issues?
- How do attitude, beliefs and practice impact on the centre's ability to address the challenges of HIV/AIDS prevention practices and support issues?
- What are the strengths, weaknesses, opportunities and threats in current rural ABET programmes with respect to the challenges of HIV/AIDS prevention and support?

Case Study

'Case study' is used in research to mean the in-depth study of a problem or a situation, whether or not it has a direct implication for practice (Gailbraith, 1998). Case study design was used for the collection, analysis and reporting of data. It provided the logic that would link the initial study questions to the ultimate conclusions drawn from the study. According to Yin (1984:23), "…case study methodology is an empirical enquiry that investigates a temporary phenomenon within its real life context; when the boundaries, phenomenon and context are not clearly evident; and in which multiple sources are used". This is in line with Merriam (1988), who defines a case study as an intensive description and analysis of a phenomenon or a social unit, such as individual, group, institution or community. In contrast to surveying a few variables across a large number of units, a case study tends to be concerned with investigating many if not all variables in a single unit by concentrating upon a single phenomenon or entity (the case). This approach seeks to uncover the interplay of significant factors that are characteristic of the phenomenon. In this study, the phenomenon under investigation is the ways in which rural ABET centres in Limpopo Province address the challenges of HIV/AIDS prevention and support.

A case study seeks holistic description and interpretation. According to Guba and Lincoln (1981:371), the content of a case study is determined chiefly by its purpose, which typically is to reveal the properties of the phenomenon under study. If conducted over a period of time, the case may be longitudinal; thus changes over time become one of the variables of interest (Merriam, 1988). This study, however, was concerned with describing a phenomenon, as it existed at the particular time of study. Case studies are particularly useful when there is little knowledge about a problem or an issue, as they may provide new insights into complex situations or organisations. A review of literature reveals that no studies from an adult education perspective have been done in relation to addressing the challenges of HIV/AIDS prevention and support by rural ABET centres in South Africa.

The exploratory nature of the case study method helped me to explore hidden issues that were crucial for addressing the challenges of HIV/AIDS prevention and support in rural ABET centres. The case study method was an effective tool to study both the

context and complexities of the ways in which ABET centres address the challenges of HIV/AIDS prevention and support. The case study design is useful for gathering rich and varied data, by making use of a variety of data collection techniques. It allowed me to use multiple methods of data collection, in turn providing access to a wide range of facts, values, attitudes, ideas and opinions. This multiple method of data collection allowed data to be cross-referenced, and difficulties and tensions to be observed, noted and explored. The methods used in this study included interviewing, observation, document analysis, and critical incident review. These are described in more detail later in this chapter.

The process of conducting a case study consisted of several steps, as outlined by Merriam (1988:109). The first was the selection of the cases to be analysed, done purposively not randomly. In this study particular rural ABET centres were selected because they exhibited characteristics of interest to the researcher. The next step was to collect data using the range of data collecting techniques mentioned above. As information from various sources was collected, I aggregated it; that is, abstracted generalities from particulars and looked for patterns characteristic of most of the data, then organized and classified it into manageable units. According to Merriam (1988:110), case study data can be organized chronologically, categorically, or placed within a typology. In this study I used categories suggested by the research questions and other issues raised in the review of literature. The final step in the process was the writing of case study narratives, which were a readable and descriptive picture of ways in which rural ABET centres address the challenges of HIV/AIDS prevention and support.

As with other research strategies, case studies have limitations, which counterbalance their strengths. According to Merriam (1988:109), some of the limitations of case studies are:

- Case studies can be expensive and time-consuming.
- Training in observation and interviewing techniques and/or documentary analysis is necessary.
- Case study narratives tend to be lengthy documents, which policy makers and others have little time to read;

- Writing the narrative to meet the needs of potential - though perhaps unknown - readers is not easy.
- Findings from case studies cannot be generalized in the same manner as findings from random samples; generalisability is related to what each user is trying to learn from the study.

Despite these limitations, the case study method is a particularly useful methodology for exploring an area or practice which was previously not well researched or conceptualized. Finally, case study, which has as its purpose the description and interpretation of a unit of interest, can result in abstractions and conceptualizations of a phenomenon that will guide subsequent studies (Merriam 1988). Such was the purpose of this particular study.

Triangulation: An analytical tool

I adopted triangulation techniques and principles to assist with collection, analysis and interpretation of the data, and also to ensure as high a degree of validity as possible in the study. Following guidelines offered by Cohen and Manion (1989:269-286), discussed more fully later in the study, I relied on triangulation between sources and methods. Triangulation structures employing multi-method approaches facilitate a fuller understanding of "the richness and complexity of human behavior by studying it from more than one standpoint…" (Cohen and Manion, 1989:269). Triangulation maximizes orthodox notions of validity through crosschecks provided by information from different perspectives, yet not at the cost of suppressing different and sometimes conflicting viewpoints (Cohen and Manion, 1989). This was congruent with the choice of the case study approach employed in this study. Multi-method approaches help to overcome understandable but dangerous researcher tendencies to rely on favoured research methods. They also reduce the chance that information gathered is essentially an artifact of a particular method.

5.3 Methods of data collection

Methods that were used in the collection of data were in-depth, semi- structured interviews, focus groups, critical incident review,

participant observation and archival evidence in the form of documents examined.

In-Depth Interviews

Because of the sensitivity of the content, I made use of semi-structured interviews to collect data from ABET directors, coordinators, facilitators and ABET Learners (key role players). Saunders et al. (2000:247) state that semi-structured interviews provide the researcher with the opportunity to 'probe' answers, where the researcher wants the interviewee to explain, or build on their responses. This is very important because it may lead the discussion into areas that the researcher had not previously considered, but which are significant for the understanding of the phenomenon under study.

I conducted the interviews myself, thus cutting down on the cost of hiring and training interviewers. Moreover, the use of interviewers could lead to errors resulting from misinterpretation of questions, thereby causing a variance in the answers given and thus limiting the validity of the research. Interviews were constructed in a way which was suitable for semi-literate or illiterate respondents, especially learners. Respondents were able to express themselves in their vernacular (*Tshivenda*) after which I, with the help of an interpreter, translated responses into English.

The validity of the interview schedule was enhanced by the fact that the interpreter was oriented to the entire study prior to the actual interviews. This helped the interpreter to acquire knowledge, which greatly minimized misinterpretation of the questions. Personal interviewing also allowed informal observations to be made of the verbal and non-verbal reactions, especially the facial expression of the respondents and other body movements (body language) accompanying the verbal responses.

A tape recorder was used to record interviews, and these were transcribed at a later stage. In cases where it was not possible to use the tape recorder (for unpredictable reasons such as lack of batteries or tapes), notes were taken by hand.

Focus groups

Focus groups are a form of group interviews in which a researcher facilitates a small group of people who may not already know each other (Cohen, Manion and Morrison 2003). The group discusses a topic proposed by the researcher which should stimulate

discussion and debate. The participants interact with each other rather than with the interviewer, so that the views of participants can emerge. The data emerge from the interaction of the group. Focus groups, as observed by Cohen, Manion and Morrison 2003, are contrived settings, bringing together a specifically chosen sector of the population, in this case ABET learners, to discuss a particular given theme or topic. The focus group is economical on time, producing a large amount of data in a short period of time, but it tends to produce less data than interviews with the same number of individuals on a one-to-one basis (Cohen, Manion and Morrison, 2003). There is freedom to raise issues or be silent, and the meeting provides a stimulating and supportive environment in which to generate, test and share controversial topics. Disagreement is acceptable and consensus unnecessary.

As highlighted by Denscombe (2003:168), focus groups are a useful way of exploring attitudes on non-sensitive, non-controversial topics. They can excite contribution from interviewees who might otherwise be reluctant to contribute, and, through their relatively informal interchanges, they can provide insights that might not otherwise have come to light through the one-to-one conventional interview. On the negative side, as Denscombe (2003:169) points out, it may be difficult to record the discussion that takes place, as speakers interrupt one another and talk simultaneously. As with all group interviews, there is a possibility that people will be reluctant to disclose thoughts on sensitive, personal, political or emotional maters in the company of others, or that extrovert characters can dominate the proceedings and bully more timid members of the focus group into expressing opinions they would not admit to in private. In this study I tried to provide an opportunity that allowed individuals to express their opinions. However, in two predominantly male ABET centres, Matangari and Rivoni, there was a tendency for men to dominate the proceedings.

Regarding the size of the group, Denscombe (2003) citing Morgan (1988), points out that too large a group becomes unwieldy and hard to manage. He suggests between four and twelve people per group. In this study, with the exception of the Mutangwa Manugu centre, which raised 16 participants, the focus groups were between five and eight participants.

Sampling in focus groups was purposive not random. The learners were selected according to their availability, proximity and their willingness to participate in the focus group interviews.

Critical Incident Review

In addition to interviews I asked respondents to provide critical incidents as a way to gain insight into the challenges of HIV/AIDS prevention and support in ABET centres. According to Brookfield (1994), critical incidents are brief reports that describe events that are recalled vividly and easily because of their particular significance for the respondents. Using a critical incident questionnaire, the researcher developed a series of questions that focused on critical moments or actions in the ABET centres, as judged by the learners and educators. These questions were deliberately framed to elicit description of specific events, rather than asking for general observations about ways in which rural ABET centres addressed the HIV/AIDS challenge. As such, they had an advantage of being non-threatening to respondents, yet still productive of revealing responses (Brookfield 1994).

Observation

As I interacted with the respondents, direct and non-participatory observation was taking place. Observation was useful in exploring topics that were difficult and uncomfortable for the respondents to discuss, for instance, attitudes towards each other, or interest shown in their work, skills in operation and the centres' learning climates. Notes were made immediately after meetings. Cohen and Manion (1980:105) note a fear that the observer's judgement will be affected by her close involvement in the group. I was careful not to become emotionally involved in matters at the centres.

The following aspects were observed:

- The centre environment;
- The surroundings of each ABET centre;
- The appearance of the building in which classes were held;
- Facilities and equipment, as well as their condition;
- Services at the centre, and whether or not they were being used.;

- Learners' behaviours (arriving on time, participating in learning activities, assisting each other in accomplishing tasks etc,);
- The level of commitment expressed by both educators and learners in class;
- Decision-making and communication within the centres and between the district ABET office and the centres.
- Relationships between different role players and their interactions;
- Links with the community and with service providers in the area.

Observations were again given to the informants for feedback and to query whether tentative conclusions were accurate.

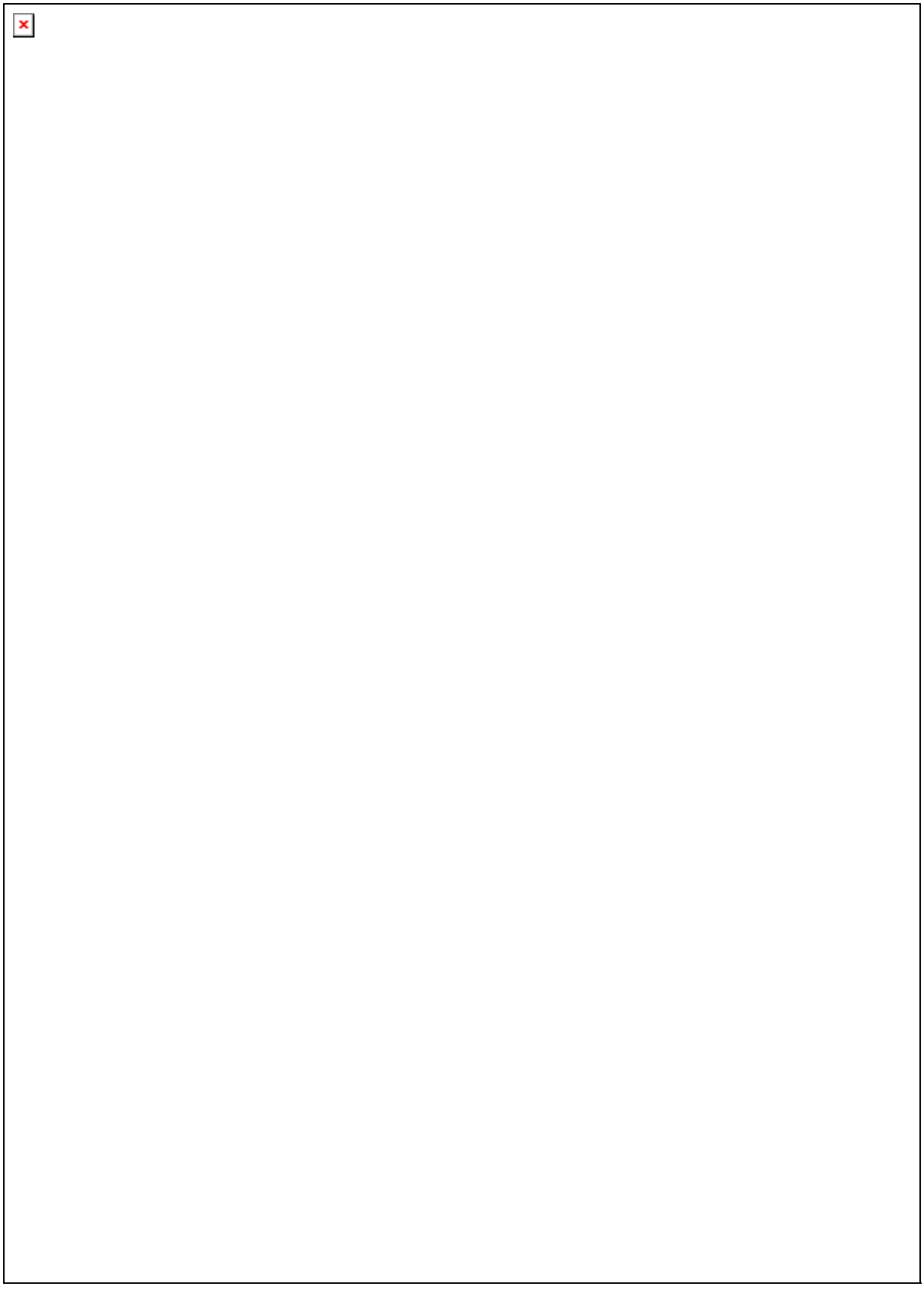
Documentation

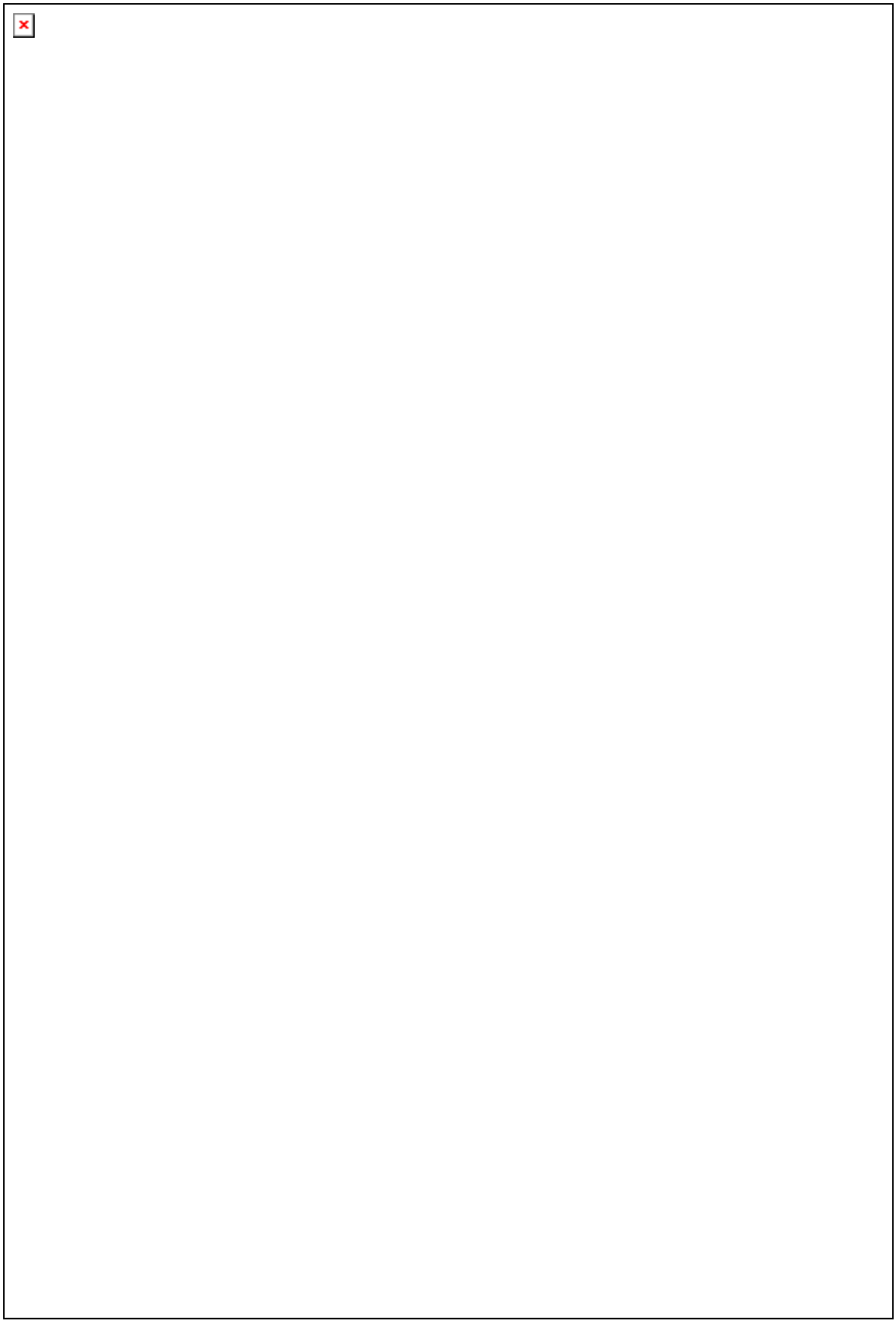
Documents also assisted in supplementing information from interviews and observation. Documents, such as National and Provincial ABET policy, curriculum frameworks and study materials, helped to enrich the data obtained from interviews, discussions and observation.

5.4 The setting of the study

The research was undertaken in the Limpopo Province of South Africa. For ABET administrative purposes, the Limpopo Province is sub-divided into seven specific regions namely: the Western, Central, Northern, North Eastern, Eastern, Southern and Bushbuckridge. These regions are also referred to as region 1,2,3,4,5, 6 and 7 respectively.

Vhembe district (Northern region) was selected because it was familiar to me. I lived in Thohoyandou (the district capital of Vhembe district) for five years, and I had also conducted two studies in the region, namely: 'The nature and role of ABET in enhancing women's contribution to socio-economic development' (1998) and 'An exploratory study of the factors that contribute to the lack of science teachers in Thohoyandou Sub-region.' (1996)





The predominantly rural Vhembe district is characterised by a high rate of illiteracy, poverty and unemployment. In many respects it is typical of rural areas in the former homelands of South Africa. The researcher however had to be careful of over-generalisation because the areas and regions could differ from one another in, for example, the existence of development projects, number of ABET centres and HIV/AIDS prevalence. At the beginning of the study, the study region comprised six districts, namely Malamulele, Mutale, Sekgosese, Soutpanberg, Thohoyandou and Vuwani, as indicated in figure 1.1. However, by the end of the study, several changes had taken place. Region 3 was changed and was now called Vhembe district and the six districts were called circuit areas.

ABET centres in Vhembe district

When this research began, in January 2002, it was difficult to get the actual numbers of Public Adult Learning Centres (PALCs) in the region, partly due to restructuring in the provincial ABET department, and the difficulty of keeping track of those centres that had collapsed. Records were generally poorly kept in the region. In addition, the Provincial Department of Education and Training, which was responsible for paying the salaries and transport of adult educators, decided in 2001 to close down most of the PALCs within the province, because of lack of funds. The idea was met with resistance from educators, who decided that rather than keeping just a few centres open it would be better to close all of them temporarily.

Besides PALCs, there were two types of ABET centres in the region. There were the Rivoningo pilot centres and Ikhwelo pilot centres. *Rivoningo* is a Tsonga word meaning 'light'. The Rivoningo pilot centres were sponsored by the European Union (EU), who piloted six of the eight learning areas adopted by the Department of Education ABET Directorate. These included, Mathematical Literacy, Mathematics and Mathematical Science (MLMM), Language Literacy and Communication (LLC), Natural Science and Technology (NS), Human and Social Science (HSS), Economics and Management Science (EMS), Life Orientation (LO). They were aimed at equipping learners with knowledge, attitudes, skills and critical capacity to participate fully in all aspects of society.

Ikhwelo is a Zulu word-meaning 'whistle' or 'awaken'. Ikhwelo pilot centres were sponsored by USAID and the European Union (EU), and were run by Project Literacy (PROLIT), a non-government organisation (NGO). They were contracted to do so by the Department of Education (DOE). The major difference between the Rivoningo and the Ikhwelo centres is that the curriculum used in the Rivoningo Centres was restricted to the '3 Rs', while the Ikhwelo centres, in addition to literacy and numeracy, were piloting small, medium and micro-economic programmes (SMME), and agriculture. The initial goal of the Ikhwelo Project was to enhance the social and economic capacity of adult learners in the Limpopo Province. The Provincial Department of Education and Training was responsible for paying the salaries of adult educators and the transport costs of learners in all centres. The European Union took care of educator training (which mainly took the form of workshops), learning materials and equipment in the eight sponsored pilot projects.

There were eight Ikhwelo centres in Vhembe district, distributed as follows; one Ikhwelo centre in each of Sekgosese, Soutpanberg, Malamulele and Mutale districts, as well as two in Thohoyandou and Vuwani districts. There was only one European Union (Rivoningo) centre in Vhembe district. At the time of the study, the only centres which were operating in Vhembe district were the Eight Ikhwelo centres.

Sampling Procedures

The area from which the sample was selected comprised all six circuit areas in Vhembe district namely; Malamulele, Mutale, Sekgosese, Soutpansberg, Thohoyandou and Vuwani (according to boundaries by he Department of Education and Training) (See table 3.1). This was done to ensure that the results were representative of the district and, for convenience, to minimise the cost of the research.

Four Ikhwelo centres in Vhembe district were selected for the sample because they were the only centres that were operating without major disruptions (most of the PALCs were facing closure because of lack of funds). These were Makahlule centre from Malamulele circuit area, Mutangwa Manugu from Vuwani circuit area, Matangari from circuit Mutale, and finally Mbaleni from Thohoyandou circuit area.

In addition to these four centres, the researcher undertook a case study in a non-governmental adult education centre for the blind, which had an active HIV/AIDS project. This allowed for a comparative exploration of the projects in order to assess ways through which different rural centres/projects addressed the challenges of HIV/AIDS prevention and support, and to examine good practices which could be applied by ABET centres in addressing the challenges of HIV/AIDS prevention and support.

Table Three: shows the centres, which will be visited, per circuit area

AREA	IKHWELO	NON-GOVERNMENTAL ADULT EDUCATION CENTRE	TOTAL
Malamulele	1		1
Mutale	1		1
Thohoyandou	1		1
Vuwani	1		1
Soutpanberg		1	1
TOTAL			5

5.5 Sources of information

Preliminary meetings were held with ABET practitioners in the region to discuss the feasibility and/or relevance of the study. This phase helped in generating a cooperative climate, and ideas as to how the study should take place. The meetings were with the District Co-coordinators Circuit Area Managers, Centre Managers, Educators and Learners.

District Co-ordinator

The Co-ordinator of Vhembe district was included in the sample because he dealt with the general co-ordination of the district, processing of claim forms, training of tutors, monitoring or attending meetings on behalf of his district, compiling reports, supervising and giving support to the district, planning budgets, and conflict resolution at district level. He provided information regarding activities of the

different ABET centres in Vhembe district, in terms of existing policies, strategies and resources in the district.

Circuit Area Managers

There is one Circuit Area Manager in each of the six circuit areas in Vhembe district. The role of the Circuit Area Manager was to establish centres, recruit learners, attend meetings, process claim forms, write circulars, employ tutors and centre managers, give support to the centres, run workshops for staff development, co-ordinate districts, establish centre governing bodies and resolve conflict at circuit level. Only Circuit Area Managers from the areas in which the centres were selected were included in the sample.

Centre Managers

There was one centre manager in each ABET centre. Centre managers were included in the sample because they were concerned with the daily running of the centres. They dealt directly with the educators and were able to provide information regarding the activities that took place and the problems experienced in their centres.

Educators

Purposive sampling was used to find educators who initiated strategies, either successful or unsuccessful for addressing HIV/AIDS. Educators dealt with the day-to-day running of the specific ABET classes and therefore were assumed to have firsthand information on the implementation and outcomes of the learning activities in specific learning areas. They dealt directly with the learners, teaching and guiding them and therefore were able to provide information about existing strategies and infrastructure in their centres, to address the challenges of HIV/AIDS prevention and support. Interviewing educators also helped the researcher to establish their attitudes and beliefs and what they were doing with respect to HIV/AIDS prevention and care.

ABET Learners/Project beneficiaries

Irregular attendance of ABET classes makes it impossible to get an exact sampling frame of learners. Thus, instead of using random sampling, purposive sampling was used. The learners were selected according to their availability and proximity. All the learners' available/present at the centre on the day of my visit were included in the

sample. The learners formed part of the sample because they were direct participants in and beneficiaries of ABET Programmes. It was assumed that they were in a position to provide information regarding their knowledge, attitudes, and practices with respect to HIV/AIDS prevention and care.

5.6 Ethical consideration

The University Postgraduate Committee approved the proposal. The ethical clearance was also obtained from the Human Research Ethics Committee (Non –Medical); the clearance number was H040204 (see Appendix six).

Implicit in this study's research design and reporting has been the intention that ethical considerations be thoroughly integrated into every aspect of the study. The main points of concern, frequently categorised in discussions on qualitative research, are noted below and the ethical rationale employed stated:

No harm to the participants: The respondent's voices were sought throughout the study. Respondents expressed themselves in Tshivenda after which with the help of an interpreter, the responses were translated into English.

Anonymity and confidentiality: I sought permission from the District Coordinator of Vhembe District and the Circuit Area Managers. I clearly stated the intent of the research- investigating the ways in which rural ABET centres address the challenges of HIV/AIDS prevention and support. This was again reiterated in the focus group discussion with the ABET learners. To ensure privacy, anonymity and confidentiality, real names of individuals were excluded in the study and the findings chapter avoided disclosing personal details that could be innocently reported, and misconstrued.

Voluntary participation: Participation was completely voluntary. A condition for participation was agreement that their views could be shared; An indication was made that those who did not wish to participate in the study would not be affected in any way regarding future attendance and/or participation in the ABET programmes at their centres.

Informed consent: I explained to the respondents that participation was voluntary and that not participating in the study would not hold any negative consequence for them. I told them that they could withdraw from their agreement to participate in the study at any time. I sought permission to take notes and make tape recordings of our discussions. Verbal consent was obtained from the respondents. I also assured the respondents that there was no risk involved for them since their real names would not be used in the study (See appendix five). The District Coordinator and Circuit Area Managers retained information sheets, which contained my names, addresses and contact telephone numbers (appendix four).

Ethical considerations, as an integrated whole, can therefore be located through the study; the aim was to conscientiously report and give recommendations based on theory and findings, in an open but considerate format.

5.7 Data processing, analysis and presentation

Analysis was interwoven with data collection from the beginning. This was important because problems associated with huge analysis at the end of the study were avoided, especially the difficulty of collecting additional information to fill in gaps and the inability to write interim reports. Secondly, early analysis allowed the researcher space to cycle back and forth between thinking about data and generating new strategies for collecting new, often better, data, interpreted in the light of the themes which emerged as central to the study (Miles and Huberman, 1994). The research results were written up in the form of five case studies, including the independent project, followed by a discussion of the main trends, which emerge within and across them.

This was essentially a qualitative study, therefore the major portion of the information was subject to processing techniques suited to qualitative data gathering. Processing and analysis was done manually.

First steps

Qualitative data analysis methods, as suggested by Miles and Huberman (1994), during the early stages of research help organise data for later intense analyses. My starting point was to convert field notes into 'write-ups.' This was done to produce intelligible products that could be read and commented on by anyone.

A document summary form was prepared at the beginning, based on and similar to a data matrix, but with space for freehand notes and questions. *A contact summary sheet* was used to capture main concepts, themes, issues and questions from each interview or observation. This was a single sheet with some focussing or summarising questions about a particular field contact, used to develop an overall summary of the main points

Self-memos

According to Saunders et al. (2000), self-memos allow the researcher to make records of the ideas that occur to him/her about any aspect of the research. The researcher wrote memos:

- when writing up interview or observation notes, or producing a transcript of the event;
- when categorising the data;
- when analysing data and when in the process of writing.

Ideas would occur to the researcher in an interview or observation session. In this case the researcher would record the idea very briefly as a margin note and write it as a memo after the event. It was useful to carry a reporter's notebook to record the ideas, whenever and wherever they occurred. The memos were written in simple note form, however, as suggested by Miles and Huberman (1994), the memos were dated and cross-referenced to appropriate places in the researcher's written-up notes. Memos were filed together and were also updated as the research progressed, so that the researcher's bank of ideas continued to have currency and relevance (Glaser, 1978; Robson, 1993). Alongside the creation of self-memos, the researcher maintained a researcher's dairy to record ideas and the researcher's reflection on these ideas, as

well as showing the researcher's intentions about the direction of the research (Saunders, 2000).

5. 8 Member checks to increase validity issues

The research was conducted under the supervision of a staff member appointed by the School of Education at the University of the Witwatersrand. The researcher presented tentative interpretations and conclusions to a group of postgraduate students in Adult Education at the University in order to allow interpretations to be scrutinised for their accuracy and validity, and to explore alternative interpretations and conclusions. Connections and discrepancies between participants' experiences and theories of adult education and change were also explored in this process. The researcher also made use of organisers of HIV/AIDS support projects and ABET practitioners in Vhembe district as an informal committee to ensure continuous advice and monitoring, and also for them to be able to access the findings and recommendations of the research.

5.9 Conclusion

This research study was designed to investigate activities, knowledge and attitudes in a particular social context; therefore it was appropriate to use a case study approach. This chapter has described the methods used to gather data for the cases and the rationale for selecting them. It gave an overview of procedures and the sample selected for the study, and considered how the data was analysed.

The next five chapters present the findings of this study. Chapter 11, the final chapter, discusses the research findings and draws conclusions to the research.

CHAPTER SIX

INTRODUCTION TO THE CASE STUDIES

6.1 Introduction

The previous chapter presented the research design and the manner in which the research was conducted. It included a description of the participants in the sample and the limitations of the design. The five subsequent chapters present data gained from the case studies. In constructing these five case studies, the researcher asked questions about the organizational structure of the centres and the responsibilities of the role players. She observed the geographical setting and infrastructure, enquired into the activities at the centre and drew up a profile of the educators and learners. She also asked learners and educators about issues related to HIV/AIDS prevention and support in the ABET centre.

Each case study contains an account of respondents' awareness of HIV/AIDS, sources of knowledge about it, education and support needs and ways of coping with it. In addition, it examines respondents' views on HIV counselling and testing, traditional healers and their treatments, networks and partnerships, community challenges, culture and HIV/AIDS, stigma, condom use, gender and HIV, as well as awareness of the national policy for HIV/AIDS for educators and learners. The case studies provide an account of the ways in which HIV/AIDS is either confronted or denied in rural ABET centres in the Vhembe District of Limpopo province, how challenges are encountered and, finally, it looks at learners' and educators' ideas and suggestions about what should be done to address the challenge of HIV/AIDS prevention and support in rural ABET centres.

The case studies are presented in a specific order starting with Makahlule centre in chapter five, Matangari (chapter six), Mbaleni (chapter seven), Mutangwa Manugu (chapter eight), and Rivoni (chapter nine), reflecting a continuum from least to most successful in addressing the challenges of HIV/AIDS prevention and support. The final analysis of the case studies is in chapter eleven, the final chapter of the thesis.

6.2 Case study 1: Makahlule Abet Centre

"We presently have so much on our plates, we have left those HIV/AIDS issues to the Departments of Health and Welfare."

(Regional Coordinator Region 3) (Vhembe District)

Before visiting Makahlule ABET centre I interviewed the District ABET Coordinator, Mr Masingita, who explained the organisational structure of ABET centres and secured appointments for me with other ABET Centre Managers in other districts in the region.

Organizational structure

Mr Masingita explained that as District Coordinator his major responsibilities were to establish centres, recruit learners, attend management and community meetings, process claim forms, write circulars, employ tutors and centre managers, give support to the centres, run workshops for staff development, co-ordinate districts, establish centre governing bodies and resolve conflict at district level. One Centre Manager was appointed to each ABET centre. Mr Mukhuba, the Centre Manager in Makahlule ABET Centre, was a qualified ABET educator with a teacher's diploma and held an ABET certificate from the University of South Africa (UNISA). He was in charge of the daily running of the centre and dealt directly with the educators. Mr Masingita said that Mr Mukhuba ran an effective establishment that had a positive influence on the community and contributed substantially to the eradication of poverty.

As in other ABET centres, a six-member centre governing body (CGB) was appointed to oversee the smooth running of the Centre and also represent community interests in its governance. The learners viewed the CGB in a positive light because its members helped them to access water for an agricultural project on the school grounds. The CGB also assisted in the acquisition of a plot of land for the project, bought materials and acquired sewing machines for sewing projects. There were six educators at Makahlule Centre, four women and two men. Four held a teaching diploma while two held pre-school certificates, and all had attended several workshops in ABET where they were trained in methods of teaching adults. These educators dealt with the day-to-day running of the centre, and taught and guided the learners.

After the interview, the District Coordinator and I arranged to visit Makahlule Centre. From the district office at Malamulele, I traveled a distance of about 37 kilometers to the centre in the district co-coordinator's car.

Geographical setting and infrastructure

Makahlule Centre is one of the Ikhwelo pilot centres. It is located in the Malamulele district, close to the Punda Maria Gate of the Kruger National Park. We traveled on a tarmac road before we turned off into a narrow, winding gravel road, bordered by long thorn bushes, which took us to the Centre. It was during the rainy season so the road had many ditches and potholes, necessitating slow driving that meant when we arrived it was approaching five o'clock in the evening. The District Coordinator explained that the Centre was temporarily using the facilities of Makahlule Primary School for the academic component of the programme. The school was a brick building enclosed by inexpensive wire fencing. Despite the fact that there was no electricity or water, the school was clean and well maintained.

On subsequent visits I discovered that the Centre had been given a piece of land by Chief Maluleka and had erected its own buildings. To get to the new Centre, we passed through the dry, flat, grassless land of Malamulele over a very dusty road. As we passed through we noticed the dryness of the area, caused by the heat, as well as poverty. The way was punctuated with grass-thatched huts, which I learned had been built by women. We passed cotton, cabbage and maize farms, with evidence of compost being used, and the farms were thriving despite the drought. Passing the large Makuleka irrigation dam, we later turned onto a mud road that wound to the Centre. The administration block[14] was completed and next to it were classrooms, which were still at the foundation phase. The Centre Manager explained that the structure had been erected with the remaining funds from the Ikhwelo Project, however, they had run short of funds to complete the classrooms. They hoped that by January 2004 they would be operating from their own premises.

There was nobody around who could tell us the whereabouts of the Centre Manager, the educators or the learners and we drove about looking for them, but in vain.

[14] A two- roomed building, one room was to be used as a storeroom, while the larger room was to be used as a meeting place.

We tried the Centre Manager's home and they told us that he had left home very early in the morning. On our way back to the Centre we met him with some learners who told us that they had spent the whole day in the field. We asked whether we could meet with him, the educators and the learners. We headed to the field where the other learners had been left completing the digging of an irrigation trench. The Centre Manager called all the learners (over 35 in number) and we all sat down on the grass (the field was not ploughed). The District Coordinator introduced me to the learners and told them about the purpose of my visit. I greeted them and expressed my appreciation at their giving me a chance to speak with them, despite the fact that it was very late and they must have been tired after the day's work.

Profile of learners at Makahlule Centre

According to the Centre Manager there were 121 registered learners in the Centre, from ABET level one up to level four. The ratio of men compared to the women was very small. The centre manager explained that most men do not have time to attend literacy classes because they have to provide for their families, so they go to urban areas to look for jobs. The table below shows the number of learners in each ABET level.

Table four: Learner registrations, Makahlule Centre.

Levels	Male	Female	Total
One	2	30	32
Two	1	31	32
Three	0	42	42
Four	0	15	15
Total	**3**	**118**	**121**

However, according to the records provided by the District Office, there were 89 learners. To explain the discrepancy, the Centre Manager said that learners temporarily dropped out during the course of the year but they always came back at examination time. He explained that some learners went to pick cotton at the irrigation scheme nearby, others getting temporary employment as cleaners in bed and breakfast establishments near the Kruger National Park. Many were unemployed and they attributed that to their poor educational background. Many women relied on

money sent home by their husbands, some on child support grants while others survived on income generating activities established at the ABET centre. The learners were mostly married housewives, mothers or grandmothers between the ages of 30-50 years. Many of them were the heads of households as their husbands were working in Thohoyandou, Polokwane and Gauteng.

Activities at Makahlule ABET centre

The centre manager explained that the days of operation for the Centre were Monday, Tuesday and Wednesday from 14h00 to 16h00. During those periods the educators offered several learning areas, including small micro and medium enterprises (SMME) and Applied Agriculture and Agriculture Technology (AAAT) as elective subjects. They also offered Language, Literacy and Community (LLC), LLC1 Tsonga, LLC2 English, Mathematical Literacy and Mathematical Sciences (MMLMS), Natural science **(**NS), Life Orientation (LO), Human and Social Sciences (HSS) and Economic Management Science (EMS) as fundamental learning areas. The elective learning areas are offered at all levels. In addition to the electives, LLC1, LLC2 and MLMMS are offered at level one and two, while HSS, LO, EMS, and NS are offered at level three and four.

Table five: Learning areas offered at the Centre at different levels

Learning Area	ABET level 1	ABET level 2	ABET level 3	ABET level 4
LLCI (Tsonga)	X	X	X	X
LLC2 (English)	X	X	X	X
MMLMMS	X	X	X	X
NS			X	X
HSS			X	X
LO			X	X
EMS			X	X
SSME (elective)	X	X	X	X
AAAT (elective)	X	X	X	X

During my first visit in June 2002, I noticed that the learners were in the process of de-bushing and fencing the land for a vegetable production venture. The Project did not have water on site but Makuleke Dam was nearby. On the day of my visit to the Centre, the learners had just completed the heavy task of digging a three-kilometer trench through which water from the dam would reach their piece of land. Through the Centre Manager, the learners told me that they were running a successful fruit juice business. They bought concentrated juice and they then diluted and bottled it for sale to the local schools and community. They also made jam and had a sewing project, making sofa covers, cushions and curtains, though they had only one sewing machine. The learners were very proud that they could make jam, sew and draw up business plans. They felt that they had become wiser and had learnt how to run a business which had taught them self-sufficiency. The learners believed that they were equipped with skills that would make them employable.

Constraints

The Coordinator highlighted some of the problems experienced by ABET practitioners in the district. He indicated that ABET centres lacked proper facilities in the form of buildings in which they could conduct their progammes. He noted that they used primary school buildings where adult learners had to sit on small uncomfortable chairs made for young school children. He also mentioned a shortage of resources in terms of funds and qualified teaching staff which, he said, impacted negatively on service delivery. The Centre Manager also highlighted a shortage of resources and believed that if the Centre was upgraded, learners would reap more benefits, for example their potential for self-employment would improve, so reducing poverty in the community. Interestingly, the learners were in agreement with this view, indicating that they if they had their own facilities they could spend more time at the Centre, since they would be able to attend classes and participate in income-generating activities earlier in the day, and have time to attend to their families in the afternoons. The Centre was only opened in the afternoon after the formal primary school closed. The learners felt that their time in class was short and it put pressure on them. They felt they could not achieve as much as they set out to do in the given time. When I visited the Centre again in August 2003, that problem had been solved.

The educators, on the other hand, highlighted that they were not paid regularly. They expressed the hope that the Department would resolve the issue. They also felt that SMME activities would be enhanced if they received supplies and equipment. The educators felt that their task would be made easier if they had sufficient learning materials. Asked who was responsible for providing learner support materials, the educators said that it was the Department of Education. However, books and other learning materials always arrived late, and when they came they would not be enough for all learners. During my third visit, the Centre Manager said that they never received a pump, which was to be used to irrigate the fields and the pipes that were delivered were not the right size. He said that they had cleared the land and dug the irrigation trenches but had not planted yet because they did not have water. However, they were thinking of using other simple irrigation methods, for example the bucket method that they had adapted from Kenya.

During my first visit, several issues related to HIVAIDS and the community were raised by the District Coordinator, and later on similar issues were talked about with ABET educators and learners as well. The responses from all respondents are highlighted below under relevant sub-headings.

HIV/AIDS awareness

When asked what ABET centres were doing to address the problem of HIV/AIDS prevention and support in the area, the District Coordinator said that despite the fact that HIV/AIDS was a serious problem in their community, it was neither dealt with by the educators at the centres nor the Regional Department of Education. He said that this was not their area of specialization and he felt that they lacked the knowledge and the resources to deal with it. This was confirmed when I interviewed the Regional Coordinator, who simply said that, "*We presently have had so much on our plates. We have left those HIV/AIDS issues to the Department of Health and Welfare*."

The picture painted by the learners was different from that painted by the educators and learners. While the District Coordinator said that HIV/AIDS was a serious problem, learners maintained that HIV/AIDS was not yet a serious problem in their community. They were of the view that the people in their community were not yet affected by HIV/AIDS. They said that people usually died of Tuberculosis (TB) and

diarrhea but not HIV/AIDS. The learners confirmed that their educators never talked about HIV/AIDS in class. However, they also indicated that they were full of fear of the disease because they did not understand what it was. They had heard that many people in other areas were dying of it.

Sources of knowledge about HIV/AIDS

The District Coordinator was well informed about the resources in the district which could help people living with HIV/AIDS and mentioned the health centres in almost every other village where expectant mothers could get medical advice and support. He also talked about Malamulele Hospital where community members sought medical help and where young social workers, according to him, "are doing a great job of counseling and supporting people with HIV/AIDS." He added that there was an initiative by the Department of Education whereby nurses would be employed to train qualified unemployed teachers about HIV/AIDS and he singled out the youth of the community who had taken charge of fighting HIV/AIDS by conducting workshops and dramas. He concluded that these services were quite accessible to the people in the community, though the Centre Manager and learners at Makahlule centre said that they had never heard of the youth group.

The ABET District Coordinator indicated that *Soul City* materials supplied by the Ikhwelo project were available in the ABET centres, though they were available only in English so learners were not able to read and understand them on their own. Furthermore, the educators who were needed to read and interpret them did not have the time or interest to do so. The learners noted their main source of information about HIV/AIDS was radio, newspapers and television.

Education and support needs

When I asked the District Coordinator about the educational and support needs of the learners, he indicated that most mothers would want to be taught about how HIV/AIDS was transmitted and could be prevented. He added that some learners might be HIV-positive and yet did not know how to cope with it. He said that learners were shy and did not feel comfortable discussing the issue of HIV/AIDS. The educators also said that learners did not want to talk about HIV/AIDS amongst themselves because it was frightening. However, on interviewing the learners, the

contrary was discovered. Far from being too shy to talk about HIV/AIDS, all were keen to learn more about it, imploring this researcher to give them information about the symptoms and how to cope the disease. They indicated that people had promised on several occasions to come and talk to them about HIV/AIDS but they never came. *"Now that you are here, we are not letting you go without telling us some thing about this HIV/AIDS"*, they said.

It was already late in the evening after a long, tiring day in the field and some of the women had not eaten all day. Others indicated that they had to prepare supper for their children yet they were willing to sit for another forty minutes to listen to what they referred to as 'invaluable' information about HIV/AIDS. This in itself showed their desperation to learn about HIV/AIDS. It was also a clear indication that nobody in the Department of Education or Department of Health had attempted to address the issue at length. The learners posed challenging questions to which I tried my best to provide answers.

One of the reasons presented by the ABET District Coordinator for not teaching people about HIV/AIDS prevention and support in the ABET centres, was that the educators were not knowledgeable. He pointed out that the educators lacked basic information about the causes and symptoms of HIV/AIDS, a lack of knowledge he attributed to their not having been exposed to any form of training. The educators themselves indicated that they were occupied with other activities, such as sewing, making fruit juice and jam, and, during the time of my visit, de-bushing and fencing land for a vegetable production venture, leaving them little time for anything else. They were also short staffed and learners came to the centres for only three afternoons a week and, in the opinion of the educators, leaving insufficient time for both the academic and the income-generating projects. The learners, on the other hand, expressed a desire to know more about HIV/AIDS. Learners in this centre were quite uninformed about HIV/AIDS, for example feeling that people with the disease should be kept in isolation. They were convinced that prostitutes in towns were largely responsible for the spread of HIV/AIDS and some were convinced that traditional healers could cure HIV/AIDS.

Problems encountered

Asked to highlight the difficulties encountered by ABET practitioners in attempts to address the challenge of HIV/AIDS prevention and support, the District Coordinator pointed out that it was not easy to teach elderly people. Culturally, it was an insult for a young person to discuss sex-related issues to people old enough to be a parent. Moreover, Makahlule was a small community and most of the people were related to one another. What made it even more difficult was the fact that these young educators were not trained in ways of dealing with such sensitive issues. However, the desire to learn remained strong. Although the learners admitted to being a bit nervous, as one learner clearly put it: *"This is one problem we cannot shy away from. Whether we feel comfortable discussing it or not is immaterial."* In contrast to the coordinators' and educators' view, the learners expressed an urgent need to learn about HIV/AIDS.

In terms of supporting people living with HIV/AIDS, the District Coordinator repeated that he was not in any way involved in the support of people living with HIV/AIDS. In support of this statement the educators asked, '*How can you support some one when you are so helpless yourself?* A similar response was given when I asked why the educators never talked about HIV/AIDS with learners, to which they answered that they did not understand 'that thing'. Understandably, though perhaps not justifiably, the educators felt that they could not expose their ignorance of the subject to their learners. Moreover, they felt there were people who were experts in the field who could properly address the issue.

Coping with HIV/AIDS

The District ABET Coordinator admitted that he was not aware of any learner living with HIV/AIDS. He spent little time with the learners and, asked how people coped with it, he answered by asking: "*What can you do when you are not in the know?"* He said that he believed people never talked about HIV/AIDS because, inasmuch as it existed in their communities, they did not recognize it since they really did not know what it was. The District ABET Coordinator was quick to add that coping with HIV/AIDS would be difficult, bearing in mind the challenges of poverty, lack of basic amenities such as clean water, food, and electricity, and lack of access to information.

The District coordinator did indicate that resources such as condoms were available at public places, though people never made use of them. Literature, in the form of pamphlets, was also available but people never read them since, as indicated above, they were written in English, Zulu or Sotho - and not Tsonga, which is the local language. He once again indicated that ABET practitioners did not directly provide any support to people living with HIV/AIDS because people never spoke openly about their status. The learners agreed that they did not know of anybody in their community who was living with the disease, because people never talked openly about their condition. The learners concurred with the District Coordinator that, even if people were to disclose their status, people with HIV/AIDS would not have access to practical and material resources and support because it was not readily available in their community.

Existing Knowledge, Attitudes and beliefs surrounding HIV/AIDS and people with HIV/AIDS

When asked whether they knew anything about HIV/AIDS, the learners said that they had heard about it but they lacked knowledge. They remained unsure about its existence because they had never seen any one suffering from it. They were unsure about the causes, symptoms and prevention. When I asked them whether sufferers should be kept in isolation, they agreed that they should be isolated. They believed that one could contract the disease by hugging and kissing a person who had it.

As noted in chapter three, many black South Africans, especially those who come from rural areas, believe that supernatural factors play a role in the development of ill-health, with illness resulting from an enemy bewitching the victim, particularly by an acquaintance or relative who might be jealous of some good fortune the victim had experienced (Stadler, 2002; Thornton 2002, Campbell 2003,). The learners at Makahlule centre also concurred that many people in the community believed that HIV/AIDS could be caused by witchcraft, and that these people would go to traditional healers for help. Asked for their own view about the subject, learners were non-committal/unsure, yet when asked whether witch doctors could cure HIV/AIDS, all learners answered in unison '*NO'*. That gave me the impression that while they believed that HIV/AIDS might be caused by witchcraft, it could not be treated.

Stigma and denial

According to the ABET District Coordinator, individuals who suspect or know that they are infected do not wish to disclose their status publicly. Families protect their loved ones from disclosure during and even after illness and death, and those who care for them collude in denial. This was clearly illustrated by one of the learners who pointed out that people in the community were dying but they could not bring themselves to admit that their relatives were dying of HIV/AIDS. She said that she had seen many emaciated people but they usually claimed that they had been bewitched. And so they end up visiting and dying at the *Sangomas.* Upon being asked what they thought about such people, the learners said that they suspected that such people could have died of AIDS. The District Coordinator pointed out that people were still reluctant to acknowledge the existence of AIDS in their lives because of the shame and fear that surrounded the disease, and the discrimination that would be directed to those infected.

Some South African studies (Webb, 1997) have shown that with regard to attitudes towards people with AIDS, stigma, fear and ignorance predominate. Webb noted that in the rural Natal communities, high levels of stigmatization were apparent; over 70% of respondents wanted to see PWA either killed or isolated. Responses included; *they must get what they deserve…shoot them'; give them fatal injection for AIDS; kill the person because he might transmit the disease to other people; shoot them there is no cure you can do nothing for them' (*Webb 1997:168). The learners at Makahlule were not as aggressive as those in Webb's study but they also indicated that PWA should be kept in isolation away from other community members, because they feared that they would transmit the disease to others.

Both the educators and the learners pointed out there might be people with HIV/AIDS in their community, but they did know them, because people with HIV/AIDS would not approach them with their problems for fear of being victimized and discriminated against. The learners remarked that an acquaintance could even sue you if you approached him in such matters. He would demand: "*Who told you that I have HIV/AIDS? Are you a witch? I will sue you for spreading rumors about me. Drop those untrue allegations or else..."* This in itself is frightening and could explain why ABET practitioners, or other members of rural communities, were not forthcoming

when it came to providing support to people with HIV/AIDS. People tend to keep their distance, and, as one educator stated: "*we try not to interfere so much in people's business"*

Networking

In terms of networking, the District Coordinator mentioned that Malamulele hospital and the Youth Group sometimes organized HIV/AIDS campaigns to which they would invite both learners and educators. He also indicated that people from *Soul City* came once in a while, and spoke to the people, though only women usually attended these meetings. Men claimed not to have time for such meetings, regarding them as being unimportant for them, and consequently missed out on important and relevant information.

Local chiefs occasionally asked nurses to come and talk to people during community gatherings, known as '*Vandla'* or *'Xivijo* in Tsonga.[15] The nurses would then provide basic information about HIV/AIDS. However these visits would be 'once-off' encounters - and not a sustained education strategy. Moreover, although attendance was expected, it was not compulsory, and people would make excuses not to attend them. In an informal discussion, one community member pointed out that there was usually too much to discuss in the limited time given for the meeting, so they ended up having just a few minutes to talk about issues such as HIV/AIDS. This point suggests that HIV/AIDS was not considered an issue of priority, and it could explain why community members were still ignorant about issues pertaining to HIV/AIDS.

Culture and HIV/AIDS

Several challenges face the people in this rural ABET centre. According to the District Coordinator, ignorance, unemployment, poverty and adventurous youths are the major challenges faced by the people in his district. Asked what he meant by 'adventurous youth', the District Coordinator responded that young school dropouts did not have anything to do: "*So they get bored and the only type of entertainment for them is sex and they also experiment with drugs. These problems to a great extent contribute to the spread of HIV/AIDS in this community."* The learners also talked

[15] This is when all community members, both men and women, meet to discuss issues pertaining to the community.

about their husbands who went away to work in urban centres and would establish sexual liaisons with women there, yet still demand their marital rights when they returned to their homes - without agreeing to the use of condoms. The learners bemoaned the fact that they were economically dependent upon their husbands, and they could not refuse their husbands' advances, even if they were aware that their husbands had been having extra-marital affairs.

With regard to the broader social context, Susser and Stein (2000:1043) have noted that

> ... Advice to be monogamous is hardly likely to be heeded in such circumstances; Polygamy has been the rule of many African societies and is still common in many. In addition, the involuntary migration associated with men's employment away from home, experienced by almost all families in rural and semi-rural areas is associated almost inevitably with casual and extra-marital encounters, and not only for the men. As a result of all these factors, extra-marital sex is frequent among men and widely tolerated, if not enjoyed by women.
>
> Susser and Stein (2000:1043)

This picture painted by Susser and Stein (2000) is not in any way different from the responses provided by the learners at Makahlule centre.

Gender and HIV/AIDS

HIV/AIDS affects both men and women in the community, however the District Coordinator observed that women were the more vulnerable. He pointed out that unemployment led to poverty, which gave rise to frustrations and insecurities about themselves and ultimately drove them to extremes like prostitution in order to get money. This validates the argument that poverty and unemployment place people at greater risk of acquiring HIV. In particular, since women are forced into sex work and relationships of dependency, they are vulnerable to coercive sex (*Soul City*, 2000). Thus, social and economic vulnerability put women in this community, like any other community in South Africa, at risk of getting HIV/AIDS, something the learners also pointed out.

In a representative sample pilot study conducted in Uganda in 1989 by Ankrah and Ouma, to which 144 women responded, similar explanations were given for women's vulnerability. Among these were the lack of decision-making power in matters of sex;

wives' susceptibility to infection from husbands, to whom traditions permit multiple partners; the necessity to use sex as an economic resource; and a sense of helplessness because of ignorance of ways to change their social situation (Ankrah 1991).

Another factor that makes women in this community vulnerable to HIV/AIDS was rape. Learners and educators believed that there was an increase in rape cases in their communities, especially of young girls. They attributed the increase to the common belief held by some rural men that young girls do not have HIV/AIDS. Leclerc-Madlala (1997:28) has pointed out that, in some cases, young girls were targeted for rape because of the belief that sex with a virgin would cleanse a man of infection.

Asked to show how HIV/AIDS affected women in the community. The District Coordinator answered that, apart from dealing with the death of peers, women also dealt with the death of their close family members (husbands, children, parents). He added that women had the responsibility for nursing the sick within their families. In addition, they faced the economic burdens of health care, funeral costs and loss of income when breadwinners became ill. Furthermore, women were left with the responsibility of caring for the children of their dead relatives, a factor which would increase their desperation, as they usually did not have the resources to care for their own and others' children. These views closely conform to opinions expressed by women in Zimbabwe, who recognized that women were the primary health care givers, putting them at risk of transmitting HIV to their unborn infants, and that pregnancy, delivery and lactation generated special health care needs, leaving women to be adversely affected through lack of adequate provision of services. Despite all this, women had limited power to negotiate or to enforce strategies to reduce their risk of HIV infection (Mahmoud et al., 1990, in Ankrah 1991).

Condom use

The learners talked about their fears and expressed their powerlessness to protect themselves. For example one woman explicitly stated: *'there is no way we can protect ourselves*.'' Other learners expressed their fears that: " *we do not have control over our bodies. We cannot say 'No' to our husbands. It is a sign of disrespect... Our men do not want to use condoms yet they sleep with prostitutes in towns... we can be faithful but we are not certain about our men"*

These remarks point to a differential between men and women, which exposes women to HIV/AIDS. Women are frightened to introduce condoms in a relationship because men would become angry and suspicious of them and accuse them of infidelity. This is in line with Jewkes et al. (2003), who confirm that suggesting condom use may be seen as tantamount to implying or admitting infidelity, with condoms being associated with prostitution, promiscuity and disease. In addition, they may be seen as an implicit challenge to a male 'right' to have many women.

National policy on HIV/AIDS for learners and educators

A policy of the Ministry of Education seeks to contribute towards promoting effective prevention and care within the context of the public education system. The District coordinator indicated that he knew about the National AIDS Policy for Learners and Educators, but added that it had not been given the exposure that it deserved. The educators, on the other hand, were aware of the existence of the policy but were not familiar with the content. The learners had never heard about it and did not know what it meant. Asked whether the practices in rural ABET centres were in line with the policy, The ABET District Coordinator answered in the negative. There were no activities pertaining to the HIV/AIDS prevention and support taking place in the ABET centres in his district, even though the policy stipulates that learners must receive education about HIV/AIDS in the context of life-skills education as part of an integrated curriculum.

Recommendations on how to address the challenges of HIV/AIDS prevention and support, especially amongst women in the community

In suggesting educational strategies that would be relevant to the people in the community, the District Coordinator suggested that educators needed to be empowered through training to communicate with learners when addressing HIV/AIDS. He said that this training should involve increasing the educators' awareness through workshops and forums. He also emphasized the involvement of the community leaders (counselors and chiefs), civic organizations, and development forums, NGOs and youth organizations in workshops where HIV/AIDS was discussed. He further recommended that education should place emphasis on HIV/AIDS-related issues. Prevention programmes were a particularly urgent priority

in rural areas, where HIV prevalence was still not as high as in other areas. Particular attention should be paid to reaching those who were most susceptible to infection, including women. He added that SMMEs had to be encouraged to provide some form of employment for women and make them less dependant upon men. He singled out vegetable projects and bakeries as good projects to be managed by ABET learners. These could help to improve both the financial and the nutritional status of women in this community, mirroring Kinghorn and Steinberg (2000:27) who hold that changing the social and economic status of women could be a major contribution to reducing the spread of HIV infection and increasing the ability of households to cope with its impact. Empowering women educationally and economically would reduce their dependency on partners who put them at risk, and would have an important impact on their ability to negotiate safer sex practices.

6.3 Conclusion

This chapter has attempted to describe a rural ABET Centre which caters for poor unemployed women, whose activities include numeracy, literacy, income generating and skills development activities. The centre was located in a deep rural setting about 80 km from Thohoyandou. The picture presented was one of a community gripped by poverty and limited employment opportunities. The district coordinator, educator and learners expressed a feeling that HIV/AIDS was not yet a serious problem in their community. Lack of concrete activities in the ABET Centre to address HIV/AIDS underlines such feelings. The community lacked appropriate knowledge regarding HIV/AIDS and how to relate to and/or deal with infected community members. There were no activities pertaining to HIV/AIDS awareness at the centre, but there was an expressed need from the learners to know more about HIV/AIDS.

The educators lacked the zeal and resources to integrate HIV/AIDS awareness into centre activities. Thus, opportunities to address the challenges of HIV/AIDS through existing centre activities and community and other social networks have not been utilized. The lack of awareness, denial and stigma, as well as social-economic conditions of the community, remain challenges to the development of appropriate strategies to address the challenge of HIV/AIDS by this rural ABET centre. These challenges are further explored in the subsequent case studies.

CHAPTER SEVEN
CASE STUDY 2

7.1 Matangari Center

"It [HIV/AIDS] is not something we ever think or talk about''

(Learners at ABET level 1)

Like Makahlule, Matangari Centre is an Ikhwelo centre. It is located in the Mutale circuit area twenty-eight kilometers from Thohoyandou. Unlike Makahlule Centre, which had no satellite centres, Matangari Centre has three satellite sites: Mutale agricultural estate, Mphalaleni, and Matangari. Mphalaleni satellite uses the facilities of Matangari Secondary School, while Matangari is located in Ndidivhani Primary School. The Mutale satellite is located in the Mutale agriculture estate itself. A total of 81 learners were registered in the three centres. The gender distribution is indicated in the table below:

Table six: Learner registrations at Matangari Centre

Levels	Male	Female	Total
One	1	11	12
Two	6	15	21
Three	5	18	23
Four	5	20	25
Total	**17**	**64**	**81**

There are eight educators, comprising four males and four females. The centres are open on Mondays, Tuesdays and Fridays from 2:00 pm to 4: 00 p.m.

Prior to visiting the Centre, I telephoned the District Coordinator, who told me that he would not be available for a meeting since he had to attend a workshop at Potgietersrus. However, he granted me permission to visit the centres and made arrangements with the Centre Manager on my behalf. He also made arrangements for me to talk to one of the educators responsible for teaching life-skills in the Centre.

From the main road I drove on a dusty gravel road for about three kilometers to Matangari Secondary School. The school structure was in a good state of repair and, unlike Makahlule Centre, Matangari had both electricity and running water. The school was very clean and well furnished. It had a well-equipped computer room and library. I arrived at 9h30 in the morning and the secondary school pupils were all seated quietly in their classes. I was told that the adult learners were out in fields and that they attended classes only in the afternoons. On being greeted by Mr. Matodzi, one of the teachers of Matagari Secondary School, I introduced myself and told him the purpose of my visit, upon which he told me that he was the mastermind and initiator of the Matangari ABET project, and acting Centre Manager of Matangari Centre.

After introducing me to the school principal, Mr. Matodzi led me to the library where I conducted a short interview with him. He began by telling me that the area was plagued by unemployment and poverty and that, in his opinion, providing literacy alone would be of no use to community members. He said that the land surrounding the school had an irrigation scheme so they had decided to make use of it to eradicate poverty in a wide area. This is somewhat similar to the utilization of the Makuleke Dam water at Makahlule Centre, used to start a vegetable gardening project. He explained that he, together with some community members, had taken the initiative to request Mazivhandila Agricultural College to train both the learners and educators in agricultural skills. The government had provided the money for training and had established a farming project in 1999, well before the Ikhwelo Project was launched. Chief Nyamandeka provided the land and the plot was irrigated by the Matangari irrigation scheme. This was evidence of community participation in the initiation and running of this project.

He explained that the Ikhwelo Project, to which both Makahlule and Matangari ABET Centre belonged, was conceptualized as a three-year pilot project and emanated from the need for a fully productive, literate and numerate rural and urban population. He further mentioned that Ikhwelo focused on the development of skills by adult learners in two elective areas, Agriculture and Small, Medium and Micro-enterprises (SMMEs). The goal was to provide adults with the skills to become more self-sufficient, while earning recognized academic qualifications. Mr. Matodzi said that

the community had benefited from the project and the participants had acquired knowledge and gained skills. Unlike the Makahlule Centre, where only a handful of people supplemented their incomes from the SMME and agricultural activities of the Centre, in Matangari Centre, forty to fifty people had earned a living from the practical activities. According to Mr. Matodzi, the project had empowered a previously disadvantaged group of people and had rebuilt their hope and enhanced their potential.

On a sad note, Mr. Matodzi reported that the Ikhwelo Project had come to an end the previous month, but not before an office was built for the Project with some of the outstanding funds. Some of the achievements of Ikhwelo were making their own compost, and planting and selling vegetables (sweet potatoes) and dry maize to their community and neighboring villages. He said that in the previous year they had planted chilies, which they sold to community members and netted R 7000. They also planted maize for domestic use. He said that the amount of land available was small and this affected the yields. Furthermore, there had been a drought in 2003 so they could not grow a greater variety of vegetables.

Interview with an ABET educator

The acting Centre Manager referred me to an ABET educator at the satellite centre who taught life skills to the ABET learners. After bidding him and the principal farewell, I proceeded to the satellite centre, which uses the facilities of Ndidivhani Primary School. The centre was not far from Matangari Centre but the road was made of gravel and was waterlogged in several places (it had been raining), and I passed between farms and bushes. The school is located in a rural area and serves a predominantly black farming community. As I entered the school premises, in contrast to the dry conditions in Makahlule, where learners were building an irrigation trench, I could not miss the steady stream of water that flowed in a concrete irrigation channel alongside the school's broken fence. I was later told that community members drew water from that stream and the school and the community also used it for irrigation purposes. The water was used for washing and cleaning but was not deemed safe for cooking or drinking.

The first thing I saw as I approached the Ndivhani School compound was the familiar two-roomed store and administration block built by the Ikhwelo project as a "going away" present. The outside walls of the store were painted in bold red letters with the words 'Matangari Adult Centre'. On the other sides of wall there were paintings of mealies (maize), cabbages, hoes and so on. The two rooms contained filing cabinets, a desk, and two chairs, with books piled up in corners, this furniture and equipment having been provided by the Ikhwelo Project. As in Makahlule, there was no electricity or running water. The school buildings were in a good state of repair and were clean. Sitting on broken chairs and crates, in hats and pinafores, and equipped with cooler boxes, several women from the neighbourhood had set up an informal tuckshop. Primary school learners came here during breaks to buy sweets; '*magwinyas'* (home made snacks), potato crisps and cool drinks.

When I arrived at the school Miss Tondani, one of the educators, was already waiting for me. She welcomed me and led me to her office in the storeroom She gave me the single chair while she sat on a trunk, and we commenced the interview.

Demographic profile of educators and learners

There were thirty learners altogether; twenty-four women and six men, quite a small number when compared to Makahlule Centre's 118 learners. Despite the comparatively small number of learners, there were six educators, four men and two women. The same educators taught in the other two satellite sites as well. This satellite centre was unlike Makahlule in that it had male educators and learners, albeit the women learners still outnumbered the men. Ms Tondani later explained that the agricultural activities in which the centre was involved attracted the men.

When I asked her about the qualifications of the educators, she said all the educators were university graduates. This was in contrast to the Makahlule Centre, where none of the educators was a university graduate. Miss Tondani herself held a Bachelor of Arts, a UED and an honours degree in economics. She said that she did not have an ABET certificate, but she explained that two of her colleagues were working towards an ABET certificate through UNISA.

Activities at the Centre

Unlike Makahlule ABET Centre, which offered literacy at all levels, Matangari Centre only provided literacy at levels 1, 2, and 4. The learning areas offered were LLC 1, LLC 2, Tshivenda and English respectively, MMLMMS, NS, HSS, EMS as core learning areas and SSME and AAAT as electives as indicated in table seven below.

Table seven: Learning areas offered at the centre at different levels

Learning Area	ABET level 1	ABET level 2	ABET level 3	ABET level 4
LLCI (Tshivenda)	X	X		X
LLC2 (English)	X	X		X
MMLMMS		X		X
NS		X		X
HSS		X		X
EMS		X		X
SSME (elective)	X	X		X
AAAT (elective)	X	X		X

Unlike Makahlule Centre, Matangari does not offer Life Orientation. While the main income-generating activities at Makhahlule were sewing and making fruit juice and jam, the practical activities at Matangari were poultry farming and growing chillies. In addition, learners at Matangari earned money from performing cultural dances during festive seasons, and at weddings and parties. Ms Tondani explained that twenty-five learners worked in the Mazivhandila agricultural college project, while 14 women sold vegetables and fruits. In Makahlule, such projects were just being initiated and had not borne fruit at the time of writing.

Ms Tondani felt confident that their project was successful and she cited the improvement in the learners' literacy and numeracy rates, as well as their proficiency in English. Similar claims about success were expressed by the educators in

Makahlule. Good relationships prevailed between the educators and other role players at the Centre, and the educators were involved in the door-to-door recruitment of learners.

Interview with ABET learners of Matangari Centre

At the time of my visit, the learners were not at the Centre but were working in the Mazivhandila Agricultural College Plant Project, about four kilometers away from the Centre, along a tarred road. The Project was a spectacular scene, with a plant nursery under shade cloth covering over five hectares of land. We went to the office, which was being used by several people connected to the project, were given chairs and greeted. Ms Tondani introduced me to the supervisor, who was also a learner at Matangari Centre, told him the purpose of my visit and requested that I be allowed to talk to some of the learners. The supervisor sent somebody to call the learners from their work, while he arranged a place where we could sit and talk. Five men and three women arrived and sat in a circle.

The learners indicated that they had managed to pass two elective courses, but they had not been able to reduce poverty because they had not been able to start group activities for self-employment or income generation. They confirmed what Mr. Matodzi had said earlier: that they had started agricultural activities and had planted maize on the demonstration plot used by the agricultural officers two kilometres away from Matangari Centre. However, their claims to success were more modest than those made by the Mr. Matodzi, saying that they did not have sufficient implements and their productive capacity was poor. They also mentioned lack of fertilizers as a factor in their low maize production. Shortage of resources and financial constraints, as in the Makhahule Centres, impacted highly on the implementation of the project activities and the realization of its aims and objectives

HIV/AIDS prevalence awareness

In contrast to the view of the District Coordinator at Makahlule Centre, that HIV/AIDS was a serious problem, Mr. Matodzi, the Acting Centre Manager of Matangari Centre, reported that it was not a big problem in his area. He claimed that it was mostly people from Zimbabwe and Mozambique who came to work on the farms who had the disease and who then spread it among the local population. He added that

it was people who came from Johannesburg, and the soldiers from the army barracks, who died of HIV/AIDS. The educators, on the other hand, said that HIV/AIDS was a big problem but people were very ignorant about it. This was in contrast to the view of the educators at Makahlule, who felt HIV/AIDS was not yet a serious problem in their own community. Similarly, learners strongly believed that it was not a problem in their community and they viewed it as a disease associated with prostitution and excessive alcohol consumption.

Sources of knowledge about HIV/AIDS

Mr. Matodzi said that people from Khomanani Health Care project, a local NGO, came to teach learners about the disease and ways to prevent it. He said that they emphasized 'ABC' and they also cared for the poor and people with HIV/AIDS. He mentioned the trauma centre at Tshilidzini regional hospital (32 km away), where people could go for testing and counseling because the local clinic did not have such resources or facilities.

Unlike Makakhule, where the educators admitted that they did not teach HIV/AIDS prevention and support, one educator at Matangari said that she touched on HIV/AIDS when teaching Natural Science. She said that she used group work, gave tasks and used pictures and books provided by Project Literacy and *Soul City*. The Department of Education also provided flip charts and books. The Natural Science educator said that apart from the basic information that she gave during the Natural Science period, there was no organized HIV/AIDS programme for the learners because learners were not interested in the topic: *"When you talk about HIV/AIDS people think that you have it. This reflects badly on an individual because people would think that one was promiscuous."*

Two of the educators said that they never talked about HIV/AIDS in class because they did not see the need. Others said the churches told people how to live in order to avoid HIV/AIDS. When I asked them about the resources available in the area to help people with HIV/AIDS they said that there was no clinic in the vicinity. I was surprised to learn that the nearest clinic was only two and a half kilometers away. The educators were not aware of the activities of the Khomanani Health Care Project, which had earlier on been mentioned by the acting Centre Manager.

Learners at ABET level one (all of them women) said they had never seen or heard of anyone with HIV/AIDS. They admitted to having heard about it over the radio and one learner said that she had heard people talking about HIV when she was visiting her sister at Musina (a town bordering South Africa and Zimbabwe), but it did not make sense to them. They said that their educators never talked about HIV/AIDS to them. This group was oblivious to HIV/AIDS and its associated problems: "*It is not something we ever think or talk about."*

Learners at ABET level four in the same centre reported that in addition to the hospital, Radio Phalaphala (local radio), church and workplaces, they had heard about HIV/AIDS from their Natural Science educator. They said that they were taught about abstention, using condoms and being faithful to one partner. They also said that the educator warned them against touching blood without gloves, and sharing razorblades and face towels. They were also taught how to give support and care to people with AIDS, for example giving them nutritious food. I wondered why such information was not given to learners at ABET level one, upon which I was told that the Natural Science educator incorporates HIV/AIDS issues in the learning area, and Natural Science was not taught at level one.

Unlike the learners at ABET level one who were oblivious of the danger of HIV/AIDS, the learners at ABET level four believed that people in their community were affected by HIV/AIDS. One learner admitted to having seen a person with HIV/AIDS, three had seen an infected person on television, but the rest had never seen one. When I asked them where people in their community could go for help and/or information about HIV/AIDS, they mentioned Mutale Health Centre, less than five kilometers from the Project. They said that there were nurses and social workers there who could provide help and support to people with the disease.

HIV/AIDS education and support needs

Ms Tondani, the Natural Science educator, said that learners needed to know that HIV/AIDS existed and was a serious disease, and that even if a person was AIDS free, it was possible to be infected. There was a need for people to know how to take care of themselves. Ms Tondani emphasized that the learners needed to know that people with HIV/AIDS were still friends and that it was their right to get treatment.

Learners at ABET level one did not know what a person with HIV/AIDS looked like and they wanted to know the symptoms. They wondered whether HIV/AIDS could affect old people. Learners at ABET level four reported that they had gained much from the discussions in class. For example, one learner said that he had learnt that to be infected did not mean that one was going to die and that one did not get AIDS through sex only, but that there were also other means of transmission. However, the learners wanted to know about how to deal with an infected person, and wondered whether there would ever be a cure. One learner wondered how a newborn baby could remain virus-free when a mother was infected.

When I asked them whether ABET practitioners provided support to people living with HIV/AIDS, the learners pointed out that even if they wanted to, ABET practitioners were helpless since they could not identify people who needed help and they were busy with other things at the Centre. This excuse was similar to the one given by the District Coordinator of Malamulele District, concerning the Makahlule educators. However, one learner mentioned a community member, Shonisani Ndou, who provided home-based care.

Knowledge, attitude and beliefs surrounding HIV/AIDS

Mr. Matodzi was not actively involved with learners on a daily basis and could not tell me much about learners' knowledge and attitude towards HIV/AIDS, but from the little he had gathered, some people did not believe that HIV/AIDS existed and those who believed lacked adequate knowledge about HIV/AIDS. When describing the attitude of the learners towards HIV/AIDS, Ms Tondani, the Natural Science educator, said that:

> *Some learners say that it was not true; others get shocked, while others feel embarrassed they do not want to hear about it. When you introduce the topic they take you away. They never come up with sensible questions. They ask sarcastic questions such as 'you mean we should stop sleeping with our women because of this HIV/AIDS?'*

However, she explained that there was a small group that believed and promised to take precautions.

When I asked the learners whether people with HIV/AIDS should be isolated, the learners at ABET level one, who lacked basic information about HIV/AIDS, answered that they should. Like the learners at Makahlule, they were confused and unsure about what to believe or say. The learners at ABET level four said that sufferers should not be isolated. The learners at ABET level four knew that one could not get HIV/AIDS by hugging or kissing, or by using the same toilet as an infected person. They knew that an infected mother could pass on HIV to her baby. Despite their knowledge, learners at ABET level four admitted that were scared to openly talk about HIV/AIDS because: "*people tend to think that you are infected if you know so much about the topic, more especially if you explained the symptoms and illustrated the pain. People would be wondering how you know about the pain if you have not experienced it."* This could explain the learners' attitude as described earlier by their teacher Ms Tondani: "*they take you away, never come up with sensible questions and they ask sarcastic questions..."*

Neither educators nor learners had a sense of the magnitude of the HIV/AIDS problem. Some did not believe that HIV/AIDS existed, while others thought that it affected only foreigners or people from towns and cities. Like the learners at Makahlule, Matangari learners believed that prostitutes and men working in Johannesburg were largely responsible for the spread of HIV/AIDS. Similar responses were recorded by Campbell (2003:124) in a mining community near Johannesburg: "AIDS is spreading because of the prostitutes. You meet a woman and tell her that you want sex and she takes you to her house. Sometimes you are a group of guys and she will sleep with all of you…' (Campbell 2003:124)

Some learners at level four said that they believed that HIV/AIDS existed but community members and co-workers did not believe that it did. Whilst some said they felt comfortable discussing issues pertaining to HIV/AIDS with fellow learners and co-workers, others felt uneasy about doing so. On the other hand, learners at level one - just like the learners at Makahlule - insisted that I tell them something about HIV/AIDS. I tried to decline, saying that it was their educators' responsibility, but

they would not take no for an answer. One elderly woman went and stood by the closed door and said that "*Ha'i* ; *athinga tendi inwi ni tshi fhirela hunwe uswika nitshi mmbu dza nga hahezwi zwithu zwivhidzwa HIV/AIDS"* meaning that she would not let me pass unless I taught them first about that 'thing' called HIV/AIDS. I relented and gave a brief presentation, telling them what HIV/AIDS was and how it is spread. I said that the problem was there with them, cautioning them that they should not feel it was apart from them, but with them. Even if they were not infected, their children, husbands or close relatives could have it. At this point some learners started shaking their heads saying "*ingasivhe"* - meaning that it was 'impossible'.

I asked eight learners to come to the front of the class. I chose five of them to form a circle, placed the remaining three in strategic points of the circle. I then told the circle of five to hold tightly as the three enemies were going to push and try to enter or break their circle. This was done three times, as a demonstration of the enemy HIV trying to attack the white blood cells and eventually overcoming resistance and blending in with the white blood cells (WBC), the function of which I explained. I reminded them that HIV had no cure and that the solution was to avoid being infected. I briefly told them of how to care for an AIDS patient, explaining that if they wanted to know their HIV status they could go to Donald Hospital, which was less than 12 km away from the centre. The learners had many questions, which I could not address because of the time factor. However, the educators made a commitment to carry on from where I had left off. The learners were very excited. They thanked me and promised that if I ever went back to their Centre they would bring '*Murambo*' (sweet potatoes) for me. The presentation took only 25 – 30 minutes.

Coping with HIV/AIDS

As was the case with Makahlule Centre, all learners at Matangari Centre echoed what the educator had said earlier: that there were no people living with HIV/AIDS in their Centre. Only one learner boldly said:

> *We know for sure that there are people who have died of AIDS in our community and we know that there might be people who are infected with the virus but the problem is that people never share their experiences and they do not talk openly about their condition. Others do not think that they have HIV/AIDS - they think that they have been bewitched.*

HIV testing

When I asked the level four learners how they felt when a person talked about HIV/AIDS, they said that they felt scared. One learner said that talking about it aroused in him the urge to take an HIV test. At this all the other learners laughed, saying that they would never go for testing because they felt testing for HIV/AIDS could change their lives completely, especially if they tested positive. This resonates with findings by Wojcick and Malala (2001:114-115), where respondents feared that if they tested positive, lives would be miserable as they would be depressed and forced to leave work The compelling reason for not testing was fear of confirming a sero-positive status and the perceived results: suffering, rejection by other people, and, ultimately, premature death. Some learners, however, suggested that educators should encourage people to go for testing.

Traditional healers and treatment

Unlike the learners at Makahlule who were positive that traditional healers could not cure HIV/AIDS, when asked whether traditional healers could cure HIV/AIDS, the learners at ABET level one argued that since traditional healers could cure all sorts of ailments, they could cure this one as well. In their opinion, HIV/AIDS was not in any way different from other diseases suffered by people in their community. Five of the level four learners were unsure, while the other three did not believe that traditional healers could cure HIV/AIDS. One argued, "*we do not have a Venda name for that disease, maybe traditional healers could have been able to cure it if they had a name for it*." While another one confidently argued that HIV/AIDS has been in existence but it was commonly known by a different name (*'Makomma'*): "*HIV is the same as 'Makomma' disease. It is acquired when a man sleeps with a widow or woman sleeps with a widower during mourning periods. It has been treated by traditional healers for many years."* This is similar to findings by Thornton (2002:9), reported in chapter three, that many traditional healers in Mpumalanga Province connect HIV infections and the symptoms of AIDS to traditional illnesses, such as those said to be acquired from sexual relations with someone who has recently attended a funeral without performing appropriate 'cleansing' rituals, or with a woman who had recently had an abortion or miscarriage and with STIs. Traditional healers in Acornhoek, Limpopo Province, believed that breaking a taboo against sexual relations during periods of

mourning leads to a disease called *Umahamba nendlwala,* characterized by sweating, tremors, fever, feeling of hotness, and weakness (Thornton, 2003).

Anthropologists Stadler (2002) and Thornton (2002) report that traditional healers in Gazankulu and Mpumalaga were convinced that AIDS was not a new disease, but "a manifestation of diseases which were well known and curable, particularly those that are caused by inauspicious sexual relations..." (Stadler, 2002:9). According to these healers, Aids has reached epidemic proportions because of the lack of control that people exercise over sexual relationships in ignorance, or defiance, of traditional sexual taboos. Thus a diagnosis of AIDS could be based on observation of behavior rather than physiological symptoms. AIDS, promiscuity, transactional sex, and witchcraft are woven into a single thread (Stadler, 2002:9). When asked whether sleeping with a virgin or an animal could cure AIDS, all learners - like the Makahlule learners - laughed and said that it was a 'white lie.'

Condom use

The learners at ABET level 1 did not know what a condom was used for. They said that they usually saw a box of small round things in a silver packet, called 'condoms', at the clinic. But they always wondered what they were used for. They said that young girls usually picked them out of the box and within no time the box would be empty. When I enquired why the learners never asked the young girls about the condoms, they replied that they could not risk asking the girls for fear of being ridiculed and insulted in public. The learners at ABET level 4 knew what condoms were but the female learners in the group said that their husbands/partners resented them. The male learners admitted to not using condoms because they felt they made sexual intercourse impersonal and unfulfilling.

Networks and partnerships

Ms Tondani reported that ABET practitioners did not network with organizations that offered support services to people living with HIV/AIDS, however, the Centre was allied and networked with local community leaders. Civic leaders were very supportive of their programmes and whenever they held functions at the Centre, the civic provided chairs and tents. They also encouraged community members to attend ABET classes. Two civic members were also members of the Centre Governing Body

and the chairperson of the CGB was a civic member. However, she said that they were not active and '*they sometimes do not attend CGB meetings'*. Chief Nyamande was supportive and provided them with land and during the '*Khoro*' or '*mutangano'* (traditional gatherings). He motivated the educators and encouraged community members to enroll for adult literacy classes.

Community challenges, culture and HIV/AIDS

When asked about the challenges faced by people in the community, Ms Tondani mentioned poverty and unemployment, which resulted in poor standards of living. She said that, "*people, especially young women, behaved as prostitutes, which rendered them susceptible to HIV/AIDS*." Furthermore, many people were unemployed. The youth resorted to drinking and using drugs. Worse still, there was widespread incest and child abuse, and to make matters worse these cases were rarely reported. This exposed women and young children to HIV/AIDS. When asked about the problems experienced in their communities with respect to HIV/AIDS, learners echoed what the educator had said earlier. They said that there was too much poverty in their area and women turned to prostitution to get money to support themselves and their children. Learners also blamed rich married men who gave young girls money and later made them sleep with them. Learners indicated that when people got drunk they slept with whomever they came across. Similar problems were mentioned at Makahlule.

When I asked whether traditional leaders (indunas) talked about HIV/AIDS, the learners pointed out that they did not. It was men who escorted the chief during community visits who talked about it. They later explained that: *"It is traditional policy that chiefs do not talk about 'petty' things. They delegate."* Similar inference was made at Makahlule. The fact that HIV/AIDS was regarded as petty by the chiefs, and perhaps the people themselves, was shocking to me, but it helped explain the people's response to the pandemic in this community.

Stigma and denial attached to HIV/AIDS

AIDS was stigmatized owing to certain perceived characteristics. For example, some learners at Matangari Centre viewed it as a disease associated with behaviors such as prostitution and excessive alcohol consumption. These characteristics may account for

the rejection of and discrimination against HIV-infected persons (Pierret, 2000). Some learners indicated that AIDS was a curse issued by God and community members would not feel comfortable providing support to cursed people. People in Matangari did not even feel comfortable talking about HIV/AIDS and did not want to be associated with the disease in any way. One learner however said, *"I always encourage young people to do sports instead of hanging around the streets smoking dagga"*. That same learner reported that when he introduced HIV/AIDS into a conversation, people would ridicule him and try to change the topic.

Gender and HIV/AIDS

When asked whether HIV/AIDS equally affected men and women, Ms Tondani, rather surprisingly, said that men were more vulnerable because they drank a lot. As at Makahlule, the learners pointed out that HIV/AIDS affected both men and women, but they agreed that women were more affected because, as one learner put it, *"women are weaker vessels so they are most vulnerable"*. The learners said that many women were unemployed and resorted to prostitution in order to earn a living. One woman lamented that, *"poverty makes prostitutes of us"*. Their husbands also abandoned those who were married, leaving them to fend for themselves and they struggle to feed their children. Similar findings were established in an informal settlement on the outskirts of Durban in 1995, and reported on by Susser and Stein (2000). When asked who was most at risk, the women immediately replied that it was women, saying that this was because their partners had other women and they themselves were dependent on men for support. They made the point that if they had jobs, they would be able to refuse sex to men who refused to use condoms. As noted in chapter three Ankrah (1991:971) noted that rural African women were highly disadvantaged, usually finding themselves economically dependent upon their husbands without any leverage, such as an independent income. They lacked the right of ownership, control over, or adequate access to land and cash. Many were left behind in the rural areas with their children and became heads of households. This scenario was observed at both Makahlule and Matangari Centres.

National Policy on HIV/AIDS for learners and educators

Most learners, like those at Makahlule, did not know about the National Policy on HIV/AIDS. One learner laughed at this and he said that he knew it. When I asked what he knew about it he said with all confidence that it was 'Abstain, Be faithful and Condomise'. It is interesting to note that upon asking him whether the practices in the rural ABET centres were in line with the presumed National Policy on HIV/AIDS, (i.e. Abstain, Be faithful and Condomise) he said that they were not. While the learners laughed at the response, it confirmed my fears that people in this community were in denial of the dangers posed by HIV/AIDS.

Challenges faced

Most of the problems highlighted by both educators and learners were similar to those mentioned at Makahlule. For example, they lacked their own facilities in which they could conduct their programmes. Matangari Centre was housed at Ndidivani Primary School and learners had to sit on small uncomfortable chairs. They also lacked information and learning materials about HIV/AIDS. Those materials that were available, for example the *Soul City* materials, were written in languages such as English and Zulu, and not Tshivenda - the language spoken in the area. This problem was not mentioned at Makahlule because the educators had not started talking about HIV/AIDS, and they had not seen the need for related materials. The educator also said that there was a tavern close to the school that contributed greatly to the problem of alcoholism and drug abuse. Another problem was the widespread problem of incest and child abuse, mentioned earlier.

Recommendations on ways to address the challenges of HIV/AIDS prevention and support

Ms Tondani recommended that an organization be set up to provide information to community members. To address the lack of materials and information about HIV/AIDS, she suggested that the government should work on the translation of books and other materials on HIV/AIDS into Tshivenda. She also suggested that the government should build a clinic for the community - an existing clinic is two and a half kilometers from the Centre - to help the people with HIV/AIDS and other diseases, to provide counseling services as well as provide information to the community members. She recommended that, in order for the community members to

understand the seriousness of the problem, HIV/AIDS should be raised at every civic meeting and church gathering.

Learners, meanwhile, recommended that educators dedicate a special period in the week to discuss HIV/AIDS issues. They suggested that educators should use videos so that they could see what happened to people with AIDS. Learners also suggested that educators should invite PWA to talk to people. Following the discussion with the learners I thanked them for their time and cooperation, and they asked whether I could come again and talk to them about HIV/AIDS. I bade them farewell and the educator and I left. On our way back to the educator's home, she said that the learners' responses were meant to please me. She said that she did not believe the things most of the learners had told me because, whenever she started discussing HIV/AIDS related issues in class, they would make fun of it, with the exception of only a few learners.

7.2 Conclusion

This rural ABET Centre serves predominantly rural unemployed women, but because of the successful agricultural projects, it has also uniquely attracted six men. The Centre provides literacy and numeracy training as well as an integrated agriculture and poultry farm management skills. Similar to Makhahule Centre, this Centre experiences lack of human and financial resources to support its activities. At this Centre there was a tendency to characterize HIV/AIDS as a 'disease of others'. For example, the acting Centre Manager claimed that it was mostly farm labourers from Zimbabwe and Mozambique who were infected with HIV/AIDS. This tendency to characterize HIV/AIDS as a disease of others was not unique to Matangari Centre. Below it will be seen that educators and learners at other centres presented HIV/AIDS as being a problem in Mutale District where Mantagari is situated, and not a serious problem in their own communities. Campbell (2003:123) referred to this as 'othering':

> This 'othering' is common both locally and internationally and it serves as a psychological defense, protecting the individual from anxiety through externalization of the threat on to identifiable out-groups such as homo-sexual or commercial sex workers, resulting in a sense of unrealistic optimism about one's own vulnerability (Campbell 2003:123).

While the women at this Centre expressed lack of awareness of HIV/AIDS, the men indicated that they were aware of HIV/AIDS and were aware that it was affecting their community. Educators and the Centre Manager expressed different views regarding their perception of the magnitude of HIV/AIDS problem. Educators, particularly those responsible for teaching the women, despite their perception of HIV/AIDS being a large problem, did not talk to the learners about it. All learner groups exhibited general lack of appropriate knowledge about HIV/AIDS and expressed eagerness to know more about HIV/AIDS, with the main aim of preventing its spread in their community. There was reluctance on part of learners to openly discuss HIV, due to fear of being stigmatized or labeled infected with HIV.

Constraints and challenges in addressing the challenges of HIV/AIDS in this Centre included poor networking, unemployment among especially the youth, poverty, drug and alcohol abuse and lack of awareness campaigns. Like Makahlule Centre, existing socio-economic opportunities in the community, which could be harnessed by ABET to deal with the challenges of HIV/AIDS, were essentially underutilized.

CHAPTER EIGHT

CASE STUDY 3

8.1 Mbaleni Adult Learning Centre

"We have included it in our business plans for the centre."

(Educator for Life Skills at Mbaleni Centre)

Before I visited Mbaleni ABET Centre in Vhembe district, I sought permission from the District Coordinator of Thohoyandou District. On telephoning her to arrange an appointment she informed me that she was willing to assist but she was at Makopane attending a one-week workshop on materials development. We made arrangements to meet at Protea Park Hotel in Makopane, where the workshop was being held and to which several ABET officials from across Vhembe District had come. The Thohoyandou District Coordinator explained that she was new to the job and that there were many things she had to familiarize herself with. She explained that ABET had been 'sidelined' for a long time, and did not have a budget that enabled them to mobilize financial resources. She said that she occasionally visited the centres in her region and believed that the visits motivated both educators and learners. However, she lamented the fact that, like other Department of Education officials, she spent a great deal of time in workshops and never had time for implementation. She gave me permission to visit Mbaleni Centre, writing a note introducing me to the Centre Manager and the educators, requesting them to give me all the help I might require. I thanked her and she promised to keep in touch.

On the 10th march 2003 I made a second visit to Vhembe, and this time met the District Coordinator in her spacious office. There were papers and books scattered all over the table and some were piled up in one corner. She beckoned me to sit on one of the chairs, apologizing for the untidiness of the office. She explained that she had been in and out of the office attending seminars and workshops and explained that the Department of Education was engaged in a restructuring process. Plans were underway to align ABET with general education at provincial and national level. All District Coordinators had received letters informing them of their transfer to the

region. The restructuring was going to have a devastating effect, with some ABET centres possibly having to close.

Findings

Educators

Ms Shoni, the District Coordinator, explained that educators in the centres were qualified, but inexperienced. She explained that they were newly qualified teachers who could not be absorbed in the formal sector and did not have any experience in teaching. She said that 80% of the educators had ABET certificates awarded by the University of Venda. A few held an ABET certificate or a diploma from UNISA. This is in contrast with educators at Makahlule and Matangari Centres, none of whom held an ABET certificate. Educators at Matangari Centre, however, had degrees. Ms Shoni explained that there were 8 educators at Mbaleni Centre, but unlike Makahlule where there were more male than female educators, and Matangari where there were an equal number, all the educators at Mbaleni were female. When I asked why this was the case, the coordinator explained that it could be that the income-generating activities (sewing and bead-making) at Mbaleni did not attract male educators. She also added that female adult learners were more comfortable with female educators.

The Coordinator commended the educators for their commitment to ABET, saying that educators did not look at the Ikhwelo Project as an extra duty they were not required to do. However, she was quick to point out that educators could be committed, but if education officials did not acknowledge their role then it became difficult to do their jobs: "*We are such a small section we do not have much say.*" Educators at both Makahlule and Matangari Centres also noted the lack of departmental support for ABET and its effect on the morale of educators and learners. She added that the department did not monitor centres adequately, and expressed her determination to help the educators to sustain ABET programmes at their centres. She said that she visited each centre once a month and at the end of all the visits she called a meeting of the educators where they would discuss issues of interest and ways of improving on the delivery of ABET. The educators were always motivated by her visits.

Clearly keen on her work, the District Coordinator was interested in issues pertaining to HIV/AIDS. She promised to hold a meeting with the educators and inform them of her interest and support. While she herself did not have the skills to design HIV/AIDS education, she was in a position to employ skilled people. She then excused herself because there was an important meeting she had to attend. She saw me out of the office and I proceeded to Mbaleni Centre.

On my third visit to Thohoyandou District, five months later, I found that several changes had been effected. Region 3 was now called Vhembe District and the original six districts in Venda were now called 'circuits', whilst District Coordinators were called 'Circuit Coordinators'. Ms Shoni and some other Circuit Coordinators had been transferred to different posts at the District Office. Some had been promoted, for example Mr. Masingita, Circuit Coordinator of Malamulele circuit area, had been promoted to overall ABET coordinator of Vhembe District. Others had been demoted, for example Ms Shoni was transferred to a clerical officer's post at the District Office.

I managed to speak to the new Circuit Coordinator of the Thoyandou circuit, Mrs Matumba, who explained that she and the other new coordinators had no experience whatsoever in ABET. She said that since she had taken over office in April 2003, she had not visited any of the centres because she had been busy with orientation, workshops and seminars. This was confirmed when I visited Mbaleni Centre, less than one kilometer away from her office. The educators said that they had only met Mrs Matumba once, in April, at a meeting when she was introduced as the new Circuit Coordinator.

The geographical setting and infrastructure

Mbaleni ABET Centre is situated at Makwarela, 5 kilometres from Thohoyandou. The tarmac road from Thohoyandou, the main trading and administrative centre of former Venda, runs through Sibasa, a residential area formerly reserved for whites, and the Makwarela location five kilometers away. The road passes Makwarela clinic, within walking distance of the centre, before the turnoff to Mbaleni Primary School where the ABET centre is located. The soil is rich and red and the vegetation is lush, green and dense, with shade trees next to the school buildings. As I approached the school I noticed that the paint was peeling off the walls. I later learned that the school

buildings were being renovated and new buildings being constructed. This Centre, unlike Makwarela and Matangari, had both running water and electricity. Though under construction it was clean and well maintained. Men and women were hard at work, but they spared a moment to greet me, before directing me to one of the buildings where the adult learners were seated, writing their examinations. Two of the eight educators, and the Centre Manager, were helping the learners who could not read the fine print of the exam paper. The Centre Manager explained that she had been on her feet since morning trying to help the learners to read the questions. Four other educators were basking in the sun, trying to get a bit of warmth from the last rays of the evening sun.

The Centre Manager explained that Mbaleni Adult Learning Centre is an Ikhwelo centre, like Makahlule and Matangari. The Centre uses the facilities of Mbaleni primary school after hours, and serves a peri-urban population[16]. Unlike Makahlule, which was far from health facilities, Mbaleni Centre was just a stone's throw from Makwarela Clinic, and several private medical practitioners had their offices nearby. Donald Fraser hospital, a district hospital, was 15 kilometers away, while Tshilidzini, a regional referral hospital, was 20 kilometers away.

Demographic profile of the learners at Mbaleni Centre

The Centre Manager provided the statistics broken down in Table eight, below:

Table eight ABET Learner registrations at Mbaleni centre.

Levels	**Male**	**Female**	**Total**
One	0	20	20
Two	1	20	21
Three	0	20	20
Four	1	52	53
Total	**2**	**112**	**114**

[16] A peri-urban settlement is close to a small town, it is densely populated and it has access to resources such as electricity, running water, and social services.

Most of the learners were women between the ages of 30 and 50 years old. Unlike Matangari, where a significant number of men were attracted by agricultural activities, there were only two men at Mbaleni Centre. On asking the Centre Manager, also a woman, why there were such a small number of males, she said that men wanted to work and earn money. They felt it was a waste of time to study when they had families to care for.

Most learners were single mothers, and those who were married had husbands working away from home. Unlike the women at Makahulule and Matangari Centres, who relied on income sent home by their husbands to support their families, many of the women at Mbaleni were earning meagre wages as domestic workers. Some sold vegetables, and others did work in offices as cleaners. The Centre Manager estimated that about 40% of the learners were unemployed and said that in the Ikhwelo Project, the Provincial Department of Education, in collaboration with Project Literacy, had tried to improve the livelihoods of the learners by introducing activities such as sewing, beadwork and mat-weaving. They had also tried to exploit the tourist industry by encouraging women to open shops and stalls along the roadside to sell handcrafts to tourists. However, she pointed out that there was no money to finance these income-generating projects and explained that at a certain stage the learners had tried to network with the Department of Agriculture but without much success, because the Department of Education lacked the personnel to support and coordinate such initiatives.

During my third visit to the Centre I was told that almost half of the learners had left because they had found temporary employment working at a sports stadium that was being renovated. However, as was the case with Makahlule Centre, the educators assured me that the learners would be back in time for examinations, as many in these centres interrupt their programme in order to take up short-term employment or to attend to family problems.

The activities at the Centre

The Centre Manager told me briefly about the activities at the Centre, saying that they offered Small Medium and Micro Enterprise (SMME) and Applied Agriculture and Agricultural Technology (AAAT) as the elective learning areas. They also offered

LLC 1 and 2 in Tshivenda and English respectively, Mathematical Literacy and Mathematical Sciences (MLMMS), Natural Science (NS), Human and Social Sciences (HSS), Economic and Management Science (EMS) and Life Orientation (LO) as the core subjects. Apart from LO, all the learning areas offered are similar to those offered at Makahlule and Matangari. In addition to the electives LLC1, LLC2 and MLMMS are offered at level one and two. While HSS, LO, EMS, and NS are offered at level three and four as shown in table nine below.

Table nine Learning areas offered at the centre at different levels at Mbaleni

Learning Area	ABET level 1	ABET level 2	ABET level 3	ABET level 4
LLCI (Tshivenda)	X	X	X	X
LLC2 (English)	X	X	X	X
MMLMMS	X	X	X	X
NS			X	X
HSS			X	X
LO			X	X
EMS			X	X
SSME (elective)	X	X	X	X
AAAT (elective)	X	X	X	X

In addition to literacy and numeracy, the Centre was involved in a variety of activities, but unlike Matangari, none agricultural. Their main activity was sewing and they specialized in making '*Miwenda' (*Venda traditional dresses), dolls, cushions, curtains, tablecloths, bags and toilet covers. They wove grass mats and offered cleaning services. The learners cleaned carpets and sofas, new houses, and yards after funerals. Plans were underway to open a car wash, but at the time of the interview there was not enough space to mount this project. The Area Manager said that in the following year they would stop operating in the school and they were going to move to their own premises at Makwarela Community Creche. This would enable them to

have proper storage facilities for their study materials, and learners would also spend more time at the Centre, since it would be open in the morning, so enabling them to initiate a variety of income-generating activities. They hoped to make mobile shacks for classrooms and set up a car wash. The Centre Manager indicated that such projects would reduce the rate of absenteeism and dropouts:

> *These adult learners have family responsibilities: they have children to feed and take to school so they usually drop out to go and look for jobs to get money to take care of their children. We do not blame them that is why we try to come up with money generating activities to try and help them out.*

The Centre Manager explained that learners do not pay fees but rather get free learning materials from the Department of Education, as was the case with Makhahlule and Matangari Centres.

I made my second visit to Mbaleni Adult Learning Centre in November 2003 and discovered that the Centre had moved to its own premises. I was later told that the buildings belonged to the community. The Centre Governing Body (CGB) negotiated with the Civic Association and was allowed to use the facility without paying rent. Originally it was a crèche but was under-utilised because there were only five learners. The educators later indicated that they were very excited about the buildings because they and the learners could come and go as they pleased, at any time. It was a reasonable structure with four classrooms and a well-secured storeroom that had been built for them by Project Literacy with the funds remaining from the Ikhwelo Project. There was a lot of open ground which they planned to use for income generating activities, such as vegetable production. This Centre, unlike Makahlule and Matangari, did not have an accessible water supply. The educators indicated that they needed a borehole, an extension to the fence and a secure gate before they could start a gardening project.

Upon arrival at the Centre I found both educators and learners busy in their various classes. The Centre Manager greeted me, placing chairs for us under a shade tree and briefing me about the Centre. She told me that since the beginning of the year, they had been busy with skills training and the process of moving to their new premises.

They had spent three weeks learning sewing. Eight learners had been trained and these would train the others. One week was spent on bead making. Learners were trained by trainers from the 'Talking Beads' project in Pretoria. They were also trained in mat and basket making by trainers from the Venda Training Trust.

During both visits, the Centre Manager avoided answering any questions related to HIV/AIDS. On both occasions, when I asked her whether they were doing anything to address the challenges, she referred me to the educator who taught Life Skills. This gave me the impression that not all educators were involved in the HIV/AIDS awareness education. Like the educators at Makahlule and Matangari, the Centre Manager felt that it was not her responsibility to deal with HIV/AIDS awareness and related activities, but the responsibility of the Life Skills educator. I was introduced to Ms Tshifhiwa, the educator responsible for Life Skills. A young lady of 22 years, she was a confident and dynamic speaker, with a very good command of English.

By the time I finished my interview, some learners had finished writing their examination. The educator invited five of them to speak to me and though tired from two hours of writing they agreed. It was after five o'clock in the evening and the Centre had to be closed for the night. However, the educator offered to continue the interview in her home, which was just a few blocks away.

HIV/AIDS prevalence/awareness

When I had asked the District Coordinator whether HIV/AIDS was a problem in her area, she said that it definitely was, but as far as she knew they had not done anything as a Department of Education in Region 3 to address the challenge. However, she said that centres offered Life Orientation as one of their subjects, and the issues of HIV/AIDS were incorporated in the learning area. She continued to say that:

> *I am aware of the magnitude of the problem and I really get concerned but the problem is that we do not have time for it. We have so much on our plate already. But I am hoping that once I have put my house in order,* [referring to the district office], *it is something I will seriously think about. I have seen so many people die of HIV/AIDS because of ignorance and I feel that as educators we must take up responsibility and make our communities aware of the dangers of HIV/AIDS.*

In contrast to Makahlule Centre, where educators and learners felt that HIV/AIDS was not yet a serious problem in their community, the Life Skills educator at Mbaleni acknowledged that it was a serious problem and learners were aware of it. She said that most learners were single mothers, and those who were married had husbands working away from home. She indicated that it was possible that these husbands exposed their wives to HIV/AIDS because they lived for most of the year far from their families and so probably had several sexual partners. She also told me that many of the learners were participating in Makwarela African National Congress (ANC) women's project. In this project they volunteered to work in hospitals and clinics, assisting with patient care, for example washing patients and making their beds. There they came to realize that HIV/AIDS really existed. The educator said that when the learners returned from volunteer service they had shocking stories to tell. This firsthand experience of caring for people with HIV/AIDS was unique in comparison to the learners in other centres.

Sources of knowledge about HIV/AIDS

When asked whether she had undergone any formal training in HIV/AIDS education, without hesitation the educator replied: '*I have no formal training but I am just gifted'*. However, unlike the educators at Makahulule and Matangari, Ms Tshifhiwa had attended several workshops on HIV/AIDS at Tshilidzini Training College, the University of Venda and the Technical College of Venda. When I asked her how she got to know about workshops, she said that she got the information from her fiancé, who worked as a peer educator in the South African Police Service. In response to the question of what resources were available in the area to help people with HIV/AIDS, she mentioned Makwarela Clinic, where nurses would invite learners and other community members and advise them on health-related issues. The Civic Association also had a forum where they invited PWA to address people. The educator encouraged learners to attend such meetings. This knowledge of resources available to support PWA was in contrast to the educators at both Makahlule and Matangari, who were not aware of any organization that dealt with HIV/AIDS in their vicinity.

Using the educator as an interpreter, the learners told me that they had heard a lot about HIV/AIDS from the radio, TV, Civic Association, ANC Women's League and at the clinic. Unlike the educators at Makahlule, who never talked about HIV/AIDS-

related issues with their learners, those at Mbaleni, when asked whether they discussed the issues with their educator in class, answered in unison '*ngamanda'* meaning 'a great deal.' They said that they were frightened because so many people were dying of the disease and indicated that they talked about its causes, prevention and symptoms. However, they pointed out that they would like to know more about where the disease came from, and they would like to acquire counseling skills.

HIV/AIDS education and support

When I asked what was being done in the Centre to address the problem of HIV/AIDS, the District Coordinator said that Life Orientation educators were integrating HIV/AIDS related issues in their curriculum, though she was doubtful whether they were effective since they lacked resources and had not undergone any relevant training. She said there was a need in the centres for HIV/AIDS issues to be addressed specifically. In her opinion ABET practitioners had a very superficial understanding of HIV/AIDS and there was a need to know more. The Life Orientation educator confirmed what the coordinator had said, that her role was limited to raising HIV/AIDS awareness issues. She had incorporated these into the curriculum and discussed them at length with the learners during Life Orientation classes. This was quite different from the situation at Makahlule, where HIV/AIDS issues were not discussed at all, and where no efforts had been made to incorporate such issues in the curriculum.

With regard to providing support to people living with HIV/AIDS, the District Coordinator doubted whether ABET practitioners had ever made a concerted effort to do this. The Life Orientation educator, on the other hand, said that having an organized group at the Centre to support PWA was in the pipeline: "*We have included it in our business plan for the Centre".* She was of the view that more could be done by the Centre to address the challenges of HIV/AIDS in the community, for example by providing HIV/AIDS-related counseling and home based care training as well as income-generating projects such as vegetable gardens, to support affected families. However, by my third visit to the Centre a year later, these ambitious plans had not been implemented. Thus despite attempts to improve the awareness of HIV/AIDS among the adult learners few, if any, practical initiatives have been taken to support the community. This shortcoming is similar to Makahlule and Matangari Centres.

Knowledge attitudes and beliefs surrounding HIV/AIDS

Ms Tsifhiwa said that learners talked openly about HIV/AIDS in class, asking question about the causes, symptoms and how they could protect themselves from the virus. The learners were concerned about its spread but they felt helpless: "*How can I convince my husband to use a condom? He is a womaniser but I cannot leave him… I do not have a job and I have children. How will I survive?"* The educator said that it was not easy to mobilize and support PWA because few people would admit to being HIV positive. She narrated one incident where she approached a community member who had recently lost a husband and a two-year-old daughter. She tried to confront her about issues related to voluntary counseling and testing for HIV/AIDS, but the woman insisted that a malicious neighbor had bewitched both her husband and daughter.

Most learners at Mbaleni were aware that HIV/AIDS existed in their community and could infect anyone, married or not. This attitude contrasted markedly to that observed at Makahlule, and among level one learners at Matangari, who were ignorant of and/or denied the problem of HIV/AIDS. The educator pointed out, however, that that some learners thought that it was only people who were promiscuous who got HIV/AIDS. I spoke about how common this perception was, and I mentioned that in Zambia, for example, Shona words are used to describe people living with HIV/AIDS as '*zayero'* (prostitute) and *'mombwe'* (men having sex with many women). Politicians in Zambia have been reported as making stigmatising remarks such as '*HIV/AIDS is only transmitted through reckless behaviour'*. PWA are depicted as being immoral. In the Ukraine the media also reported that 'Aids' was not just a disease, it was a 'sanitary inspector', which helped rid society of people who have led an immoral way of life (UNICEF, 2001).

As in Makahlule and Matangari Centres, learners were not shy to talk about HIV/AIDS with me. In contrast to some learners at Matangari, who asserted that the disease did not exist, that it existed in the North but not South Africa, learners at Mbaleni believed that HIV/AIDS existed in their own community. Unlike learners at Makahlule and ABET level one learners at Matangari, who recommended that PWA should be isolated, Mbaleni learners were against the idea of isolating PWA because they knew that one could not catch AIDS by hugging, kissing, from the toilet seat and

from sharing food or cutlery with an infected person. They were also aware that an infected mother could pass on the virus to an unborn child.

Coping with HIV/AIDS

When asked whether there were people living with HIV/AIDS in centres in her circuit, the District Coordinator said that none had yet been reported. She said that learners had little knowledge pertaining to HIV/AIDS and she was of the view that people with it would not talk openly about their condition. As far as she knew, ABET practitioners had not started networking with other organizations that offered help to people living with HIV/AIDS. She said the subject was still not openly acknowledged, serious as it was.

The educator, on the other hand, said that she did not know of anyone who had HIV/AIDS in the Centre, but she indicated that she had 'seen' many in the community. She said that PWA within the community were not discriminated against because people were aware of the disease and they sympathized with them. However, later, when asked whether PWA in their community shared their experiences and/or talked openly about their condition, she said they did not, for fear of being discriminated against. However, she indicated that if they were to come out and disclose their status, they would have access to practical and material support from the Makwarela Clinic, the ANC Women's League and Donald Fraser Hospital.

The learners, meanwhile, said that they knew of people in their community living with HIV/AIDS but they did not talk openly about their condition. They were of the view that if people could open up then they would have access to practical and moral support from the clinic, hospital and the ANC women's league. This was in contrast with the view given by the learners at Makahlule who felt that even if PWA were to disclose their status, they would not have access to practical and material resources and support because they were not readily available in their community, or might be withheld.

HIV counselling and tests

In Mbaleni Centre, learners felt that HIV counselling and testing were important. Ms

Tshifhiwa said that the emphasis in HIV/AIDS education should not be on how one acquired HIV/AIDS, but on encouraging people to go for tests. There should be psychologists to talk to people and to counsel them before and after testing. She said that everywhere ABC was being emphasized, but "*people ignore the reality*." She added that the nurses in the nearby Makwarela clinic were "cruel", that they unconsciously discouraged testing because there was no confidentiality or privacy. This mirrors the findings of other researchers in South Africa who found that although tests for HIV/AIDS are often accessible, counselling is rare and confidentiality not always maintained.

Traditional healers and treatment

Learners at Mbaleni Centre, like those at Makahlule, were sure that traditional healers could not cure HIV/AIDS, and despite the stories circulating in the community, they did not believe that one could be cured if one slept with a virgin or an animal.

Networks and partnership

The Coordinator believed that ABET practitioners were not networking with other organizations and individuals in matters pertaining to HIV/AIDS. She recommended that the issue should be addressed head on and suggested that experts should be invited on a specific day for all learners at a particular centre. She pointed out that in addition to HIV/AIDS being discussed during Life Orientation and Human and Social Sciences (HSS), they needed days devoted to HIV/AIDS awareness, whereby invited guests and PWA could come and talk to learners and other community members. She suggested that in order to address the challenges of HIV/AIDS prevention and support, especially amongst women, specific HIV/AIDS seminars should be run and all women invited - even those who did not participate in ABET.

While the District coordinator believed there was no networking or partnership, Ms Tshifhiwa indicated otherwise. She had quite a range of networks through her fiancé in the South African Police Service (SAPS), and she and most learners were involved in the activities of the ANC women's League. Ms Tshifhiwa also indicated that once a person living with HIV/AIDS from Warmbaths had been invited by the Civic Association to address the community, saying that learners and other community members had benefited from the visit.

Community challenges, culture and HIV/AIDS

When I asked about the challenges faced by people in the community, the District Coordinator said that it was lack of knowledge. She said that, as far as she knew, educators were developing HIV/AIDS awareness among their learners by providing basic information on HIV/AIDS. Asked about the challenges faced by people in her community, Tshifhiwa said that: *"People are aware of HIV/AIDS they know that it kills yet there is no behavioral change and husbands are resistant to use condoms*." She suggested that it might take a long time to introduce behavioural change, and for this to become a lifestyle. She suggested that there should be a forum for couples to be taught about HIV/AIDS-related issues, since women found it difficult to implement what they learnt about HIV/AIDS without the support of men. She further pointed out that poverty and unemployment remained significant challenges, saying that young unemployed women tended to be promiscuous in order to survive financially. In the two previous chapters, reference was made to the ways in which poverty generates the sale of sexual services, and how the nutritionally weakened bodies of the poor provide a higher risk of catching HIV/AIDS.

The educator suggested that the department of education should organize a thorough training programme, which would run for more than a week for both educators and learners on issues pertaining to HIV/AIDS. She pointed out that it was officials from the Department of Education who already had the knowledge, who got the chance to go for training, and when they came back they did not have time to disseminate the information.

Stigma attached to HIV/AIDS

When asked whether PWA in the community shared their experiences and/or talked openly about their condition, the educator said that they did not, for fear of being discriminated against. The learners also said that they thought many people had died of HIV/AIDS but none of them admitted to having HIV/AIDS. They said that their relatives came up with "stories" about the causes of death. The learners thought that many PWA in their community did not open up for fear of discrimination. As in the two previous case studies, AIDS deaths were generally attributed to other causes, for example people would say: '*she died from drinking too much'*, or '*he died from tuberculosis' (*Campbell, 2003:111).

Condom use

The learners at Mbaleni Centre, like those at Makahlule, argued that their husbands refused to wear condoms. Some men equated the use of condoms to "*eating a sweet wrapped in a plastic paper*." Furthermore, the learners were doubtful about the effectiveness of the condoms distributed free of charge by the Department of Health. They believed that they could easily break due to exposure to the sun at the distribution points.

Gender and HIV/AIDS

All respondents agreed that HIV/AIDS affected both men and women, but they observed that women were more vulnerable. All respondents gave slightly different reasons to justify their responses. The District Coordinator, for instance, pointed out that women were not allowed to question men's infidelity. She explained that women mainly got infected from polygamous spouses or from boyfriends (men friends) who supported them financially in the absence of spouses who worked in towns or cities. The educator indicated that it was culturally acceptable for men to have more than one partner. On top of that, husbands had extra-marital affairs. Worse, many husbands worked in Gauteng (a largely urbanized province), where they slept with several partners and on returning home refused to use condoms. Women remained in a predicament because they did not have jobs and depended on their unfaithful husbands for survival. This situation is not unique to women at rural ABET centres. Several studies, for example (Wojciki and Malala, 2001), have indicated that women's subordinate social and economic status, and their resultant dependence on men, contribute to unsuccessful attempts at negotiating sexual behaviour and initiating safer sex practices, such as the use of condoms.

Learners also concurred with both the Coordinator and Educator, saying that inasmuch as AIDS affected both men and women, it was the women who were more vulnerable because they had less control over their lives. Learners portrayed women as powerless, as dependant on men/husbands who were not faithful. Studies have examined the sexual behavior of young girls, single women, wives and sex workers. Irrespective of a woman's social or working position, men tend to make most of the decisions regarding safer sex practices in sexual exchanges (Campbell et al., 1998).

The learners pointed out that when the breadwinner died, women were left with a great responsibility to take care of the children. Some men deserted their wives when they discovered that they were HIV positive.

National Policy on HIV/AIDS for learners and educators.

The District Coordinator said that she knew about the National Policy on HIV/AIDS for learners, notably that while the policy was relevant and applicable to rural ABET centres, it should be handled sensitively. She was of the view that the practices in rural ABET centres were in line with the policy. Ms Tshifhiwa also knew about the existence of the National Policy on HIV/AIDS for learners and educators, having been given a copy during a workshop she attended at the University of Venda, but she had not read it. As for the learners at Mbaleni, like those at Matangari, when asked whether they knew about the document, they said that they had never heard of it. They could not tell whether it was relevant and applicable to their Centre, nor could they tell whether the practices at the centre were in line with the policy.

Challenges faced

Most of the challenges highlighted by Ms Tshifhiwa applied to Makahlule and Matangari Centres. She highlighted some reasons why little had been done so far and what she foresaw might hinder future activities. She said there were many flaws in the ABET system which affected HIV/AIDS education. For example, in the first instance, educators were not motivated because there was no job security. They were contracted for one year at a time. She suggested that if the Department of Education could contract them for four or five years, this would motivate them to make long term plans. Also, she saw a problem of submitting payment claims every month and the delays in their being settled. Educators did not stay for long because salaries were not assured: "*Imagine getting a September cheque in November!!*" She went on to say that there was no continuity in ABET because educators and officials kept changing.

She also talked about the time constraints imposed by the ABET curriculum, saying that there was no time to run an effective programme because *"we usually recruit learners in February, start classes in March, and in April we are closed. This leaves no time for any other activity and it also leads to excessive failure in literacy and numeracy at all levels."* Classes for all learning areas are held for only 6 hours a

week, that is two hours on Monday, Tuesday and Wednesday. Learners did not attend all six hours because of other commitments. In terms of tutors' qualifications and ability, the educator pointed out that there was a chronic shortage of staff trained in Life Orientation. There was only one person to handle this important task at Mbaleni Centre.

The educator highlighted the problem of lack of learner support material. She said the Department of Education did not provide materials for the prescribed learning areas: "*The government says that we educators should create our own. This, in my opinion, makes us educators helpless and demotivated. Where do they expect us to get motivation and the means?"* When asked about the difficulties experienced in her attempts to address the challenge of HIV/AIDS prevention and support, the educator again mentioned the time factor, explaining that two hours allocated for classes had to be divided equally amongst eight learning areas. They always negotiated amongst themselves as educators, leading her to ask: "*there is limited time to teach both the theory and practice of life orientation. I can only teach for 30 minutes. What can one do within such a short time?'*

The educator suggested that the Department of Education in collaboration with the Department of Health should introduce a curriculum about HIV/AIDS and special time should be set-aside for it. Furthermore, in order for educators to be effective they should be provided with training in HIV/AIDS specific care and support and counseling programmes. It should be noted that, despite the problems she encountered, Ms Tshifhiwa was attempting to address the problem of HIV/AIDS. She said that she used the syllabus of Life Orientation designed for the day school. However, she was quick to point out that a book meant for primary school learners would not be suitable for adult learners. To supplement the syllabus she cut clippings from newspapers and magazines and used them as learning materials. She also had a book from Project Literacy entitled *Positive People*, *Managing HIV/AIDS in the Work place*, which she found useful. She used the *Soul City* materials (pamphlets, charts and magazines), which had been provided by Project Literacy, keeping them at home and carrying them to school everyday as there were no storage facilities there.

This lack of storage space was one of the chief reasons why the ABET staff wanted to

get their own premises. They could not display charts or pictures on the classroom walls because the classrooms belonged to the primary school and the walls were already covered with learning support materials for the primary school children. She added that even if there were space on the wall, some of the pictures would be sensitive and inappropriate for primary school children to look at. She went on to say that she could not distribute books to learners because there were not enough of them[17].

Partly in an attempt to overcome these shortages, she explained how she attempted to integrate the learning areas. For example, if there was an extract in English comprehension about HIV/AIDS, she used it for Life Orientation and vise versa. She also used role-plays to stimulate dialogue on how women could approach and convince their partners to use condoms. By my third visit a year later, the Department of Education had started supplying books and other learner support materials. For example, in Life Orientation the learners had been given copies of *Manage your life, life orientation ABET level 4 (see appendix 3)* and each learner had a personal copy to take home. Furthermore, the educators indicated that with the new management at the District Office, their salaries were coming on time, which was encouraging for them. The educators mentioned that electricity had been installed in the ABET Centre, meaning that the learners could operate their sewing machines at the Centre and not at the educator's home. Educators and learners alike hoped that proper security could be installed in their premises.

Recommendations

When asked what they thought ABET centres could do to address the issue of HIV/AIDS in their community, learners responded by saying that ABET practitioners should increase the HIV/AIDS awareness campaign, and women should be taught thoroughly how to protect themselves. Educators should invite experts from other places to come and talk to the learners. They also suggested that PWA should be invited to the Centre to speak to them.

[17] It is important to mention that during my second visit, the problem of accommodation had been solved because the Centre had got its own premises and Ikhwelo had built a secure storeroom where they could keep their learner support materials and other resources.

Learners suggested that educators should work together with the ANC Women's League, because they believed that women learned a great deal there. The League held workshops for women where they were taught to network, stand up against domestic violence, speak up against child abuse and create jobs by forming small income generating projects. The League provided capital and training, and supplied free books and soap. Women were taught how to protect themselves from HIV/AIDS and were encouraged to go for testing. On Women's Day, celebrated nationally on the 10th of August, the women sang and performed on stage HIV/AIDS related songs and dramas. They also made door-to-door visits, persuading women to join the League. Learners were of the view that they would benefit more if ABET practitioners networked with the ANC Women's League. The learners suggested the ABET practitioners should raise funds to develop income generating projects which would also provide employment opportunities for learners who are mostly women.

During my second visit, Ms Tshifhiwa explained that a directive had been passed by the Department of Education to all schools, including ABET centres, stipulating that all educators should spend the last fifteen minutes of each lesson talking about HIV/AIDS. She said that she was not sure about other educators but she had implemented it in her classes and her learners talked about the disease openly. She suggested that each centre should have a 'pep talk' or help line where they could write letters or make telephone calls to get information about HIV/AIDS. She recommended that all facilitators needed to be trained in HIV/AIDS education, not only Life Orientation educators.

8.2 Conclusion

This case study has described how a peri-urban ABET centre is dealing with the challenges of HIV/AIDS. The demographic profile of this Centre is of a younger population when compared with the two previous centres. As with those centres, literacy and numeracy activities form the core of the curriculum, in addition to vegetable growing, sewing, mat carpet and bead making, introduced as skills development and income-generating activities.

In this Centre, all role players were aware of HIV/AIDS and they believed it was a serious problem in their community. Learners had heard much about it from the radio, television, and the local clinic, as well as from their Life Orientation classes. Many learners were members of the ANC Women's League and most of them had been exposed to PWA when they volunteered to work in hospital and clinics assisting with patients' care.

As with the educators at Makahlule and Matangari, most educators at Mbaleni did not address the issue of HIV/AIDS, feeling it was the responsibility of the Life Orientation educator - irrespective of the lack of learner support materials from the DOE. Despite the fact that she had had no formal training in HIV/AIDS, she was keen and had attended several workshops on the subject. She had ambitious plans of establishing a support group and home based care training, though unfortunately these plans could not be implemented because of lack of support from other educators and the regional office.

Finally, the Life Orientation educator and learners exhibited openness in talking about HIV/AIDS, yet they also indicated that disclosure of one's HIV status could result in discrimination and stigma. The respondents said that, despite the awareness that existed in their community, no sexual behavioural change had occurred. Promiscuity and resistance to condom use was still rampant. Poverty and unemployment exacerbated the adverse conditions. Women were perceived to be vulnerable due to their dependency on men and the polygamous cultural practices acceptable in the community.

CHAPTER NINE
CASE STUDY 4

9.1 Mutangwa Manugu Centre)

"We make awareness on HIV/AIDS and our learners have benefited from it"

(Educators)

"It is ourselves, our husbands, our children who are dying of this 'minimini' [this whatever they call it] we have to have all the knowledge so as to be able to help ourselves and our future generation or else we perish."

*(*Learner)

Mutangwa Manugu Centre is another Ikhwelo centre located in the Vuwani District. Unlike Makahlule and Matangari, which were quite remote, Mutangwa Manugu, like Mbaleni, is in close proximity (approximately ten kilometers) to Thohoyandou, the main trading and administrative centre in region 3. It is *en route* to Makhado, a sizeable town with good facilities. There is good infrastructure in terms of roads and information technology. Prior to visiting the Centre I visited and interviewed the District Coordinator, Mrs Ramaliba at the District offices at former Ramaano College of Education. From the interview I learnt that there were two Ikhwelo centres in her district, of which Mutangwa Manugu was one. After the interview I expressed my gratitude and the District Coordinator gave me clear directions to Mutangwa Manugu Centre. I bade her farewell and set off for the Centre.

Geographical setting and infrastructure

Mutangwa Manugu Centre is located in Tsianda village. From the district office I traveled five kilometers on the highway linking Makhado and Thohoyandou, before reaching the turnoff that took me to the school. Tsianda village is on the crown of a steep hill, in countryside that is grassy and well treed, dotted with traditional thatched homesteads as well as cinder block houses. Many homes had banana, avocado and mango trees. From the main road I drove for approximately two kilometers up a steep gravel road, carefully, to avoid children playing in the road.

Mutangwa Manugu primary school, which was the premises of the ABET Centre, is on the outskirts of the village, a well maintained building, with electricity and a water tap in the central courtyard. The school was bounded on one side by a road and people's homes, on the other by a hill covered with thick vegetation, and beautiful scenery. Inexpensive wire fencing enabled visibility on both sides of the fence. A large sign visible to motorists and pedestrians displayed the school's name at the main entrance. The schoolyard was a bit overgrown.

Upon arrival at Mutangwa Manugu Primary School, I was welcomed and greeted by the Centre Manager, Ms Mudau. She told me that the District Coordinator had telephoned her earlier in the day and informed her of my visit to their Centre. A pleasant woman, and smartly dressed, she introduced me to the educators who were standing nearby before directing me to a classroom. The Centre Manager told me there were 62 learners (60 women and 2 men). Like Matangari Centre, Mutangwa Manugu Centre also had two satellite centres, in this case Makumilele with fifteen learners, and Water Affairs with twenty-five. Unlike Matangari Centre, there was little evidence of active community involvement in the initiation of the Ikhwelo Project and its day-to-day operation.

Activities in the Centre.

Ms Mudau, the Centre Manager, explained that the Centre used the facilities of a primary school after hours. In addition to literacy and numeracy, their main activities were vegetable production. The manager indicated that the vegetable garden had impacted positively on the lives of the learners and the broader community because it had reduced the incidence of malnutrition and thus contributed to better health in the community. That had greatly improved the learners' standing in the community and boosted their self-esteem. She explained that they had a problem with goats destroying their vegetable gardens because the site had no fence, a problem not experienced at the other centres, which had proper fencing. Another activity was blue laundry soap production, which learners sold locally. Together with plans for a bee farm, these projects were unique to this Centre and showed the potential to develop practical remedies to alleviate poverty amongst the learners and community. When I asked what they were doing to address the problem of HIV/AIDS in their Centre, the Centre Manager suggested that she invite the other educators to join her so that they

could assist in answering some of the questions. I welcomed the suggestion and five educators joined us.

Interviews with Educators at Mutangwa Manugu Centre.

After exchanging a few pleasantries, we proceeded straight to business. There were nine educators in the Centre but, like Mbaleni, not one was male. All the educators were qualified primary school teachers, as in the previously mentioned centres, however, unlike Makahlule and Matangari, the educators at Mutangwa Manugu held an ABET certificate from the University of South Africa (UNISA). One of their courses was Health Adult Education and they had considerable knowledge about HIV/AIDS related issues such as managing HIV/AIDS in the work place and the community. All the educators of Mutangwa Manugu were particularly well qualified, in that all of them were computer literate and one of them held an additional qualification in accounting and bookkeeping.

The interview was long but the educators were cooperative, and they attempted to provide answers about ways in which they were addressing the problem of HIV/AIDS prevention and support. Afterwards I thanked them and they led me to another classroom where the learners were waiting for me.

The demographic profile of the learners at Mutangwa Manugu Centre

Unlike Makahlule, where interviews were conducted in a field, the interview at Mutangwa Manugu took place in a well-organized classroom with learners seated at a round table. There were sixteen learners in all, fifteen women and one man. I invited the educator responsible for Life Orientation to interpret for us. The learners at this Centre, as at the previous ones, were respectable married housewives, mothers and grandmothers, in their thirties, forties and fifties, who had been unable to complete their schooling in their youth. They turned to the ABET Centre for a range of reasons: to learn English, to become more literate and numerate, to acquire skills and certificates to make them more employable, to help their children with school work, and to meet and talk to other women like themselves. As was the case with Makahlule, Matangari and Mbaleni Centres, most women at Mutangwa Manugu were single heads of households. Their partners worked in ‘town’ (Thohoyandou,

Polokwane or Gauteng) and returned home as often as every weekend or as seldom as once a year.

The Centre Manager and the learners themselves explained that most learners lived in poverty. There was a high unemployment rate. Like the women at the peri-urban ABET Centre Mbaleni, some women at Mutangwa Manugu earned wages as domestic workers. Others sold fruits and vegetables along the main road and at the school. Some had small projects such as *spaza* shops[18], while others worked as farm labourers on 'white' farms and plantations, to supplement other sources of income. This additional income included child support grants, relatives' old age pensions and disability grants of close relatives who have been declared unfit for gainful employment due to ill health. The Centre Manager attributed their being unemployed or underemployed to their poor educational background, as well as to limited unemployment opportunities in the rural communities.

The group of learners who were interviewed said that they had managed to acquire knowledge and some skills. They were numerate and literate and had acquired skills such as soap production, which they could apply to improve their lives and their chances of employment. One learner proudly declared that: "*before I registered as an adult learner I was unable to do things on my own. Communication in English was very difficult, but now I feel proud to be able to do things on my own. I can read and write especially in my mother tongue, Tshivenda without much assistance. I can also fill in forms without much assistance."* They said that the educators had taught them how to draw up a business plan and how to start their own small businesses. They were taught how to prepare soil for crops. One learner said that attending ABET classes helped her a lot because she was able to produce quality vegetables, and also to help her children with schoolwork. The learner went on to say that her involvement in adult education had changed her life and that of her children. She was of the view that once she was fully educated, she would inspire her children to become educated too. The learners were also hopeful that the Centre's vegetable garden would help to reduce poverty and improve the nutritional status of their families. Thus, unlike the

[18] A *spaza* is vernacular for a small, unregistered shop set up in a home or in a stall next to a road.

learners at Makahlule Centre, but like those in Matangari Centre, the project initiated by Ikhwelo had some practical impact in improving the lives of the learners.

HIV/AIDS prevalence and awareness

Upon asking whether HIV/AIDS was a problem in the community. The District Coordinator said HIV/AIDS was a worldwide problem and she believed that her community was no exception. When I asked the educators the same questions they answered in unison: '*yes*'. Learners, too, were aware of the existence of HIV/AIDS but not with specific reference to their community. Both educators and learners distanced themselves from it, claiming not to know of anyone in their immediate family or community who had AIDS. They knew, or suspected, there were AIDS-related illness and deaths in other communities nearby. The learners noted that at funerals, where it is customary to announce the cause of death, relatives of the deceased would say that s/he had died of T.B, pneumonia, or diarrhoea, or that s/he had been bewitched, but there was no mention of the possibility of HIV/AIDS.

The District Coordinator explained that they had not started a comprehensive program related to prevention of HIV/AIDS. But as at Mbaleni Centre, the educators responsible for teaching Life Orientation incorporated HIV/AIDS issues in their learning area. Asked what role ABET centres played in addressing the problem of HIV/AIDS prevention and support, the District Coordinator narrated a case which had happened two months prior to my visit. She said that one of the learners approached one of the educators and told her about her husband who was suffering from an HIV/AIDS related illness. The learner told the educator that she was not coping because she did not have money to buy food for her husband and children. She needed some moral support because it was emotionally draining taking care of her husband, yet she had to do all the household chores and look for food for the children. The educator told her colleagues that the learner needed some support to deal with the challenges she faced, so they arranged a visit to the learner's home. They were not well received by the learner's husband, who asked them what business it was to them that he was sick. They were patient with him because they realized that they had to gain his trust first. They explained that they had come to support the family because they cared for them. After a few visits the husband's attitude improved and he started accepting the help offered. The educators and learners prepared food, washed clothes

and cleaned the house. As the husband's health deteriorated, they brought in a pastor to pray for him. When the husband died, the educators and learners helped to make the funeral arrangements and they were at the funeral to support their friend. The community realized the importance of group acceptance and support and to some extent this changed their attitude towards HIV/AIDS and people with HIV. This was practical home-based support that highlighted the role ABET centres can play in supporting HIV/AIDS afflicted individuals and family.

The District Coordinator attributed the educators' and the learners' positive attitudes to the short sessions they had about HIV during Life Orientation. The educators in support of coordinator said that they taught their learners about AIDS: "*We make awareness on HIV/AIDS and our learners have benefited a lot from it*". The educators at Mutangwa Manugu used HIV/AIDS pamphlets, magazines and newspapers. They brought pictures of people with HIV/AIDS in different stages/states. They also took the learners to the nearest health centre to be addressed by health practitioners.

It is important to note that at Matangari and Mbaleni Centres, only one educator was singled out as the person responsible for 'Life Orientation' training. Yet at Mutangwa Manugu Centre, all educators employed there expressed a sense of urgency and personal commitment to teach learners about HIV/AIDS. When I asked the Mutangwa Manugu educators what they were doing to support people living with HIV/AIDS, the educators, like those at Mbaleni, truthfully replied that "*at this stage we do not know people who are infected, we just teach all the learners.*" Unlike the Matangari learners, who shied away from the topic, the Mutangwa Manugu learners discussed the HIV/AIDS issues. The learners indicated that their educators talked about the causes of HIV/AIDS, symptoms and prevention of HIV/AIDS in class. They made it clear that even though the topic scared them, they felt free to talk about it with the educators. The learners expressed the need to know more about what HIV/AIDS really was, how it was transmitted and how to care for people with HIV/AIDS in their own homes, for example the type of food to give them. I found that learners were eager to talk to me about HIV/AIDS, expressing interest in the treatment of sores and opportunistic illnesses, and questioning the government's contribution to treatment. They asked about AZT and its role in reducing mother-to-child transmission of HIV.

They believed that they had a role to play in preventing the spread of HIV, and supporting people living with AIDS.

Unlike the Makahlule and Matangari educators, who felt that it was not their area of expertise, all the educators at Mutangwa Manugu expressed confidence in their knowledge of the basics of HIV/AIDS prevention and care. They explained that they had gained their knowledge in a certificate course for ABET teachers offered at UNISA, in which they had been trained to include HIV/AIDS awareness and prevention messages in the standard curriculum. These educators used their UNISA notes, and the Life Orientation books provided by the Department of Education as resources.

Sources of Knowledge about HIV/AIDS and support for PWA

According to the District Coordinator, nurses from the local clinics were sometimes invited to the Centres and occasionally educators took the learners to the nearest health centres, where they were taught about HIV/AIDS. The nurses supplied free condoms and even demonstrated how to use them. This was quite different from the level one learners at Matangari, who were not familiar with condoms and were baffled by the small shiny packets at the clinic, usually taken by youths. Learners at Mutangwa Manugu, as at Mbaleni, had access to the clinic. They went there at any time of the day to seek advice and medical care. There was also a regional hospital, Tshilidzini Hospital, where learners went for specialist medical advice and admission in case of complications. Despite the availability of information about HIV/AIDS from the local health services and their educators, in discussion with me the learners expressed the need to know more about what it really was, how it was transmitted and how to care for people with it in their own homes - for example, the type of food to give them. Learners at Mbaleni expressed similar needs.

While the learners at Matangari had no idea as to where people in their community could go for support and/or information pertaining to HIV/AIDS, the learners at Mutangwa Manugu mentioned the caregivers at Hamutsha, fifteen to twenty kilometers from the Centre. These supported HIV-positive people through counseling, providing treatment for opportunistic infections, testing for HIV and discussion on home-based care. The learners also mentioned the Full Gospel Church at Tsianda, five

kilometres away. Congregants also provided home-based care services while social workers from Tshilidzini Hospital were known to be distributing food parcels to infected and affected people.

Educational and support needs of individuals in ABET centres

The District Coordinator pointed out that the ABET practitioners needed a well organized programme, specifically to deal with HIV/AIDS related issues: "*There are so many gaps which have to be filled*". For example: 'the history of HIV/AIDS; how did it come to be?' 'Why do people have to point fingers at each other?' and 'How to care for an HIV/AIDS patient and how to treat and live with them'.

Knowledge, attitudes and beliefs surrounding HIV/AIDS

With regard to widespread beliefs, the District Coordinator said that some community members in Mutangwa Manugu shared the belief that traditional healers could cure HIV/AIDS. She went on to explain that people's beliefs influenced their actions. People denied that they or their relatives had HIV/AIDS, instead saying they had been bewitched or cursed. Often they gave a detailed explanation of the nature of the curse: "*No ever one mentions AIDS. Many seek help from traditional healers instead of going to the hospital. Others believe that prayers can help, while some men still think that sleeping with a virgin could cure AIDS."*

Stadler (2002:6) notes that access to knowledge about HIV/AIDS is structured according to age, educational status and mobility. In a study of a rural village in the Lowveld, he found that older men and women had been startlingly unaware of AIDS until very recently. According to him, AIDS was still perceived as a young person's disease, and public educational interventions, such as the controversial *Love Life* campaign, took place in media popular among youth but not accessible to adults, especially those unable to read print messages. Stadler found that community workshops, which raised awareness of HIV/AIDS, and outreach visits by health workers, took place sporadically, but again were usually targeted at youth.

While the Distinct Coordinator's view and Stadler's research findings provide a plausible picture of HIV/AIDS awareness in rural areas in general, adult learners interviewed in Mutangwa Centre in late 2002, who had received HIV/AIDS education

from their educators, showed sound basic knowledge of HIV transmission and prevention. They also knew where they could go for help or information about HIV/AIDS. A new cohort of learners, who were interviewed in 2003, before HIV/AIDS education was underway at the Centre, demonstrated far less knowledge, with a few indicating that AIDS was probably caused by witchcraft. Their educator considered it her duty to teach learners about HIV/AIDS, though she confided that she did not want to *"scare the learners off by starting the 2003 school year with a discussion about AIDS"*.

The learners interviewed in 2002 believed that they had a role to play to prevent the spread and support people living with HIV. For example, one learner pointed out that *"We have to know everything because this is our battle we have to fight it. So we have to be armed"*. On asking what she meant by that, she responded: *"It is ourselves, our husbands, our children who are dying of this 'minimini'* [this whatever they call it] *we have to have all the knowledge so as to be able to help ourselves and our future generation or else we perish."*

Coping With HIV/AIDS

The educators mentioned that there were HIV/AIDS community support groups and health workers who visited people with HIV/AIDS in their homes, if they disclosed HIV-positive status. The educators also indicated that with the knowledge they had acquired, they would be willing to network with other organisations and support any individual who presented themselves with HIV/AIDS. They said that since they were working part time, they were planning to use some of their morning hours to conduct house-to-house visits and educate people about HIV/AIDS. During my first visit to the Centre in September 2002, the learners were not sure whether there were HIV positive people amongst them, because people never went for testing. However, on my second visit, six months later, learners were positive that there were people living with HIV/AIDS in their community. They said that they accepted them but it was the infected people who became withdrawn. The learners said that the attitude of the infected people made it difficult for them to provide support. However, two of the learners pointed out that they had seen people who had revealed their status and who talked openly about it.

HIV tests

Tests for HIV/AIDS were accessible at Tshilidzini Hospital, some ten kilometres away. However, there was uncertainty among the learners about whether counselling was available. Despite earlier claims by the District Coordinator and educators that nurses from the local clinics supplied free condoms and provided medical advice and care to the community members, the learners doubted that health workers at the clinic maintained confidentiality. They suspected that they would be given dismissive, perhaps even humiliating treatment if they presented themselves at the clinic with sexually transmitted diseases (STDs). Mistrust and suspicion of health workers seemed to be prevalent. For example, it was rumoured that private doctors practicing in Thohoyandou deliberately infected their patients by using a contaminated needle for injections. Thus, the women reasoned that even if condoms were used as health workers advised, the risk of infection was still great.

The learners also said that they would not feel comfortable going to the clinic for an HIV test, even if they went with a partner or friend. They feared that they would be seen by other members of the community and suspected of being infected. Even if they were tested, they said they would not go back for the results, because that would mean confronting a painful and difficult reality. HIV/AIDS tests, they said, were *"a death sentence*". This negative attitude towards the HIV/AIDS tests was similar to that expressed by learners at Matangari Centre, and for similar reasons: the lack of a cure and the stigma and discrimination against people with HIV/AIDS within the community. Thus, individual learners at Mutangwa Manugu did not deny the existence of the epidemic, but explicit knowledge of their HIV status would only increase their difficulties. They feared having to change their lives. Seen in this way, not going for a test, or not returning for the result, is a coping strategy, albeit not a very constructive one.

Traditional healers and treatment

The District Coordinator mentioned that most people in her community believed that traditional healers could actually cure AIDS. When I interviewed learners, I found that some mentioned rumours that if one went to a traditional healer at an early stage one could get cured. The learners insisted that *sangomas* were helping people with HIV/AIDS, believing that traditional medicines could help protect them against it, or

provide palliative treatment. Similar beliefs were highlighted in the previous chapters among traditional healers in Gauteng, Mpumalanga and Kwazulu Natal (Thornton, 2002). Despite assertions that the traditional healers could help people who consulted them during the early stages of the disease, none of the learners believed that a *sangoma* could actually cure AIDS. As with the learners at all the other centres, these did not believe that having sex with a virgin or with an animal could cure an infected person.

Condom use

As was the case at Makahlule, Matangari and Mbaleni Centres, the female learners at Mutangwa Manugu echoed what the female educators had highlighted earlier: men resented discussing the topic of HIV/AIDS and refused to use condoms. The learners argued that their husbands did not want to wear condoms, rather insisting on 'flesh to flesh' sex, because they believed it was necessary for good health. If a woman requested that her partner use a condom, the man would perceive this to be a challenge to his authority. He might infer that she had been sexually unfaithful to him, possibly calling forth a violent reaction, such as that described by Lecher Malaya (2000:29), that: "women can expect a beating not only if they suggest condom usage, but also if they refuse, curtail a relationship or are believed to be thinking about someone else".

The learners at Mutangwa Manugu echoed learners at Mbaleni, claiming that condoms were not reliable, especially those which were put in open places and public toilets. They often broke and they could not be re-used. Government-issued condoms were said to be thin, too small, or to have holes in them, and were suspected of being rejects from other countries. Why else would they be given away free? Suspicion of condoms may have been linked in people's minds to earlier campaigns to reduce the black population (Webb, 1997: 75-6; Stadler, 2002:5). One learner, an older man, believed that condoms issued by the government were infected with HIV/AIDS. He proposed that they should be boiled before use, a suggestion that was ridiculed and dismissed derisively by female learners in the group.

Unlike the Matangari learners, who were not even familiar with the male condoms, the learners at Mutangwa Manugu expressed interest in the female condom, indicating

that they could deceive their husbands and protect themselves by using them. They lamented that female condoms were not freely available at the local clinic. Although they are available in some pharmacies in South Africa, female condoms are extremely expensive, even for relatively wealthy middle-class women. In a study conducted by Susser and Stein (2000), women became enthusiastic when asked if they would use one, saying that they would definitely use something over which the woman had control. The women in the study asked the researchers to provide samples as soon as possible, and requested that the Minister of Health make female condoms available: "*…We need them here, and we will show that they can work,"* said one woman (Susser and Stein, 2000).

Networks and partnerships

The educators explained that they worked well together at the Centre, and they had the support of the principals of Mutangwa Manugu Primary and other neighboring schools, as well as the civic leaders who mobilized and encouraged learners to attend ABET classes. The community involvement and support for the Centre was similar to that highlighted by educators at Matangari and Mbaleni Centres. The educators also said that they solicited donations (transport whenever they needed to go somewhere, cold drinks when there were functions, and cash) from community businessmen. Community members also helped to catch those who stole vegetables from their gardens. Such community cooperation and support is similar to that observed at Matangari and Mbaleni. The learners engaged in cultural activities (dances, drama), where awareness was raised about HIV/AIDS. One educator emphasised the importance of these activities: "*the fact that we are educating the mothers means that we are educating the nation. Because mothers transfer whatever knowledge we give them to their children."* In support of the educators, the learners also said that they were interested in networking with organizations that dealt with HIV/AIDS. As at Mbaleni, they mentioned that they had formed the intention of going from house to house telling people about HIV/AIDS and offering support to the sick and orphans. However, they felt that they needed more information and/or knowledge before they could do this.

Community challenges, Culture and HIV/AIDS

The challenges outlined by the District Coordinator, educators and learners in Mutangwa Manugu Centre were: poverty, unemployment, violence against women

and rape. These were similar to those raised by respondents in the previous case studies. The educators at Mutangwa Manugu pointed out that, when providing HIV/AIDS education, they tried their best to be sensitive and not oppose the cultural values and norms of the community. For example, they indicated that they were always careful when talking about the issue of being faithful to one partner because they were aware that culturally it was acceptable for men to have more than one wife. They knew that learners were already involved in polygamous marriages and the situation could not be reversed, hence the sensitivity.

Stigma and denial

The District Coordinator mentioned that even if some of the learners were HIV positive, they would find it difficult to disclose their status to others. They feared that to do so would expose them to prejudice and other penalties. The learners affirmed this when they said that if they were to fall ill, they would disguise or deny any symptoms of disease for as long as possible to avoid the bad opinion of their family and neighbours. Some felt that they could not admit HIV positive status, even to a very close friend or family member. Being positive implied wrongdoing and would cause great embarrassment to the family.

Gender and HIV/AIDS

In response to questions about whether HIV/AIDS affected both men and women in their community, as with respondents in the other Centres, the District Coordinator, educators and learners affirmed that both men and women were affected, though in this case it was mostly women, especially married women. Once again, different respondents gave different reasons for their response. For example, the District Coordinator pointed out that women suffered most because they had to take care of their husbands after they had been taken ill, as well as seeing to the wellbeing of other family members. She said that women in such a situation became overburdened and that most were financially dependent on their husbands, afraid to stand up to them because they would be abandoned. She also pointed out that women never demanded that an HIV test be done before having sex with a new partner.

The educators, on the other hand, said that married women were more vulnerable to HIV/AIDS because "*women are more faithful than men. Most women stick to their husbands while the husbands sleep around".* Yet these women could not refuse a

partner's advances or insist that he wear a condom. As at other centres, the educators mentioned that poverty made women in their community promiscuous, pointing out that unemployed women resorted to extramarital sexual relationships for economic security.

The learners also affirmed what the District Coordinator and educators had said earlier, that both men and women were affected but that women, more especially married women, were more vulnerable. This was in contrast to the perceptions of the educators at Matangari, who felt that men were more vulnerable due to such risk-taking behaviour as drinking alcohol and promiscuity. Studies have shown that people often knowingly engage in sexual behaviour that places their health at risk (Campbell, 2003).

As in other centres, female learners were well aware that their husbands were involved in extramarital affairs, yet they felt there was nothing they could do about it. One woman said she would choose death over disgrace: "*I would rather die than lose my husband, what would my children and relatives think of me? It is better for my children to look at my grave than I desert them".* Another one said: *"I cannot leave my husband because I would starve".* The learners also put the blame on culture: "*it is because of our culture whatever happens as a woman I am supposed to stick by my husband I do not want to be a disgrace to my children and my community".* The women lived in fear, yet they were unwilling to leave their husbands because of the damage this would do to their reputations.

The learners also mentioned that in their culture people did not talk about sex because it was a private matter saying that as a woman one had to respect whatever a man said. If the husband resisted the use of a condom, there was nothing much the wife could do. I asked the women why they felt so helpless, to which the response was: "*the life we live is very complicated. Our men work far away from home. They have mistresses and sometimes sleep with prostitutes, yet they will never agree to being tested let alone using condoms*".

National policy on HIV/AIDS for learners and educators

Concerning The National Policy on HIV/AIDS for learners and educators, the District Coordinator said that she was aware of the existence of the policy and was familiar with its content. She believed that the policy was relevant and applicable to rural ABET centres. However, she did not think that the practices in rural ABET centres were in line with national policy, especially since the educators lacked knowledge and skills to deal with HIV/AIDS. Still, the Department had not made any provision for them to receive training. The educators indicated that they were familiar with the policy and thought it relevant and applicable to rural ABET centres. Unlike the District Coordinator, they believed that the practices in their rural ABET Centre were in line with policy. They particularly mentioned the phrase which talks about not denying admission to, or continued attendance of a learner at a school or centre because of a learner's perceived or actual HIV/AIDS status. They also pointed out that, despite their lack of appropriate training and resources, they were incorporating HIV/AIDS-related issues in the Life Orientation learning area. Learners, on the other hand, were not familiar with the policy and did not comment on it.

Challenges in attempts to address HIV/AIDS prevention and support

Asked what difficulties they encountered in attempts to address HIV/AIDS, the District Coordinator said that educators were in desperate need of relevant learning and teaching materials. The District Coordinator also mentioned the lack of teaching aids (pictures, charts etc), and explained that that this affected the teaching and learning process because she knew that pictures that illustrated a problem and stimulated discussion were an effective way of dealing with sensitive topics.

The District Coordinator, Ms Ramaliba, pointed out that some educators took the initiative in developing their own materials and teaching aids, since they did not get support from the department. She said that some ABET practitioners were not knowledgeable on issues pertaining to HIV/AIDS and were not conversant with methods of dealing with sensitive topics such as sex and death. Some were in denial, while others were very supportive of people with HIV/AIDS. Lack of adequate skills to communicate issues related to it was not unique to this Centre. The coordinators of Makahlule and Mbaleni also felt the need for more training in HIV/AIDS issues.

As at Mbaleni, the educators pointed to the lack of suitable materials issued by the Department of Education related to HIV/AIDS. They said that they had to move from one place to another looking for materials and other teaching aids such as charts, magazines, pamphlets and magazines. They used their own money for transport and making photocopies, thus creating a financial burden on their low earnings. Upon observing the surroundings of the classroom, I noticed that there were no posters related to HIV/AIDS. When I inquired, the educators reminded me that they held their classes in a primary school premises, so even if they had the posters they could not be displayed permanently on the walls. This echoed what the District Coordinator had said earlier, that the teaching and learning process was affected by the lack of appropriate facilities. They agreed with the District Coordinator that pictures were an effective way of teaching. However, the educators in this case could not make effective use of posters because there was no space to display and store them.

The educators said they found it difficult to address the hostile attitude of the learners towards HIV-positive people. Most learners felt that people with HIV/AIDS had brought it upon themselves. Those who had relatives with AIDS denied it. The educators often had a feeling that the learners were not always open and entirely truthful with them: "*Most adult learners do not feel comfortable discussing such sensitive issues with us, because they see us as young and inexperienced*". But as I observed during our interaction with the learners, and as pointed out by the educators themselves: "*with time, the learners start to open up*".

Recommendations on ways to address the challenges of HIV/AIDS prevention, especially amongst women in rural communities

To address the challenges of HIV/AIDS prevention, especially amongst women, the District Coordinator suggested that educators should undergo training pertaining to HIV/AIDS, so that they could get relevant and recent information, and be equipped with skills of addressing sensitive issues. She noted that Health Centres and NGOs dealing with HIV/AIDS should encourage people who were HIV positive to come and share their experience of living positively, so as to make people aware of HIV/AIDS. She argued strongly for a full programme on the subject to be provided to women from poor backgrounds so as to empower them. The educators, on the other hand, suggested that income-generating activities should be introduced to create jobs and

alleviate poverty, because they believed that poverty forced women and young girls into risky sexual activities and thus exposure to HIV/AIDS. They were of the view that if the ABET Centre could get a financial sponsor they could be in position to start projects such as agricultural projects to alleviate poverty.

The learners recommended that female condoms should be made available to them, and that men (their husbands) and other community members should be taught about, and encouraged to go for, testing. This is in line with an 'enabling approach', suggested by Campbell (2003), for mineworkers on the Witwatersrand, whereby prevention efforts target not only mineworkers, but also members of the broader communities in which they conduct their social and sexual lives. Both the District Coordinator and educators noted that, since the educators had not gone through any formal HIV/AIDS education and training, they lacked the confidence to tackle learners' fears and biases towards people with HIV/AIDS. Educators could only provide basic information, as confirmed during an interview with learners. The learners said they were grateful for the HIV/AIDS education programme being provided at their Centre, but they needed a more extensive program whereby they would be taught different HIV/AIDS issues, such as the care and treatment of those infected with HIV/AIDS. They also suggested that PWA should be invited to the Centre to speak to them.

9.2 Conclusion

Like the learners in other ABET centres, women at Mutangwa Manugu Centre attended classes to upgrade their education, with the intention that this would improve their quality of life and their prospects of employment. To a considerable extent, they felt trapped by their lack of education, their poverty and their dependency on their husbands. They experienced high levels of financial insecurity.

Respondents, especially learners in this Centre, believed that HIV/AIDS was a problem, but not one with specific reference to their community. Learners had basic knowledge about HIV/AIDS. Unlike other centres, all educators employed in the Centre were actively participating in HIV/AIDS awareness, but they did not think it

was the responsibility of the Life Orientation educator alone. This was evidenced by their participation in answering questions during the interview. Educators and learners were committed to addressing the challenges of HIV/AIDS, but lack of resources hampered progress. Educators were, however, ready to use their own money for transport and making photocopies of newspaper and journal articles.

Many of these women, as in other centres studied, experienced violent abuse from their partners if they suggested condom use. The stigma attached to HIV/AIDS in their community was very strong. The women's social standing in their community depended on being a 'respectable' housewife, which implies faithfulness and obedience to a husband. Their fear of being judged, blamed and despised by others in the community, including health workers at the local clinic, meant that they were afraid to go for testing or to receive test results.

Despite oppressive structures (poverty, gender relations, ideology) in their milieu, rural women did make decisions and choices, which indicated that they were actors with some degree of power to change their situations. They attended classes at the ABET Centre to improve their education, their job prospects and their social networks. They attempted to persuade their partners to use condoms, and if they failed, they conspired (at least some of them, in a spirit of bravado) to use female condoms to protect themselves. They attempted to generate an independent income for them, to eat nourishing foods and remain healthy. As a group, they found the courage to defy the stigma of AIDS by visiting and supporting one of their number whose husband was dying from an AIDS-related illness.

CHAPTER TEN

CASE STUDY 5

10.1 Rivoni Society for the Blind

"The government should open more projects like ours so that people could get skills to do something for themselves"

(Learners)

Rivoni ABET Centre forms part of the Rivoni Society for the Blind. Unlike the other centres, Rivoni is not an Ikhwelo project and, as explained in chapter four, the main reason for selecting this Centre was to examine their seemingly positive practices regarding HIV/AIDS awareness and support, and how these might be utilized by other centres. Rivoni is a project for blind and partially blind people sponsored by the French Government and run by the Department of Education and the South African Council for the Blind. It is located in the Soutpansberg district in of the Limpopo Province, two kilometers from Elim hospital, 25 kilometres from Makhado and 60 kilometres from Thohoyandou. It is close to the highway from Giyani to Makhado.

History

Rivoni Society for the Blind was founded in June 1975 by Dr Erica Sutter, a Swiss physician based at Elim Hospital. Because of her daily contact with local residents, Dr Sutter soon realized the need for urgent measures to prevent the spread of Trachoma, a highly contagious eye-disease resulting in blindness. Housed in a small office at Elim Hospital, Rivoni started out by providing preventative eye-care service to local residents. In the early 1980s various programmes were introduced aimed at equipping visually disabled people in the area to become active participants in the economic and social upliftment of their communities. Since then, the society has expanded considerably and now includes housing and training facilities that can accommodate a maximum of 96 students at a time. From humble beginnings nearly 30 years ago, the Rivoni Society for the Blind has developed into a dynamic training facility dedicated

to the social and economical upliftment of visually disabled people in the Limpopo Province.

Geographical setting and infrastructure

The entrance to the Centre is paved and trees are planted along the sides of the road. The premises are modern brick buildings, some of which have thatched roofs. Arriving at the Centre at 08h00, I found two people seated on the visitor's bench, one sighted, and the other a blind man holding a white stick. Although his blindness prevented him from picking up non-verbal cues, I could sense that he was following the conversation from the way he was tilting his head. When the receptionist offered to show me to the Acting Director's office, he opposed the idea vehemently. The receptionist explained that he was saying that it might be him we wanted to see. Indeed, he was the ABET educator I had arranged to see the previous day. The educator, the receptionist and I agreed that it would be courteous to talk to the Acting Director and the Centre Manager first.

Activities at the Centre

The Acting Director, Mr. Ngobeni, explained that Rivoni offered vocational and development programmes to visually impaired people, as well as basic literacy services to children and adults (ABET). Prospective students could choose from three different programmes, described below.

The Rehabilitation Programme

This is considered to be the foundation on which all other programmes are built. Visually disabled people from all parts of the Limpopo Province are identified and recruited to undergo an intensive three-month Orientation and Mobility Programme. Before training starts, each student is assessed individually to ensure that he/she has accepted his/her disability and is ready to move forward. The Rehabilitation Programme deals with daily living skills, including personal hygiene, cooking and cleaning, as well as the use of public transport and shopping. Students are also taught how to use a white cane correctly. Although students receive a certificate following the successful completion of the Rehabilitation Programme, training continues in the student's home environment to ensure that he/she is able to function independently.

Project Development Programme

In this programme, learners are taught to master various skills aimed at helping them become self-sufficient. They can choose from a variety of programmes, for example technical, business or bookkeeping. The courses are offered free of charge and last anything from three to 15 days. Learners undergo theoretical as well as practical training, thereby enabling them to put to use what they have learned. After completing the programme, they can join one of the many co-operatives operated by Rivoni. Between six and ten people are accommodated in each of these income-generating projects. A wide variety of products are manufactured, including diamond mesh fencing and detergents, with agricultural, poultry and gardening projects marketing produce to local residents. Learners also become involved in home industries, including sisal weaving, leatherwork, making clothes hangers and cane lampshades. Products made in learners' homes are brought back to the Rivoni Centre and sold to visitors as well as members of the community. Rivoni assists these groups with bookkeeping, marketing, fundraising and administration, the aim being to assist each of the projects to achieve complete autonomy and self-sufficiency.

Mainstream Programme

The Acting Director explained that this Programme was introduced in 1992, owing to the increasing number of youths being denied access to schools because of age limits and the long waiting lists at special schools. Learners can only join the Mainstream Programme after completing the Rehabilitation Programme. He mentioned that before training, each learner's level of education was tested. Learners were taught to read and type in Braille, and, when they were ready, to join a school (which could take up to one year of training). Rivoni undertakes all negotiations with the relevant government departments, principals, teachers, as well as parents. When the learner is accepted, he/she undergoes an orientation programme to help him/her adapt to the new environment. Classmates are also taught how to deal with and assist a visually disabled person. The Acting Director also mentioned that programmes were developed with the needs of individual learners in mind, and could be adapted to suit specific requirements.

Concerning the daily activities at the Centre, I was referred to the Centre Manager, who explained that overall there were 40 learners, of whom 17 were women and 23 men. All learners were blind or partially sighted - the reason why Rivoni was a special ABET centre. The curriculum and teaching materials were altered to cater for the learners' disabilities. Unlike the Ikhwelo centres, where learners never pay fees, those at Rivoni Centre pay a token monthly fee of R50 for meals and accommodation. The curriculum included Braille and typing; orientation; mobility and rehabilitation; business skills; technical skills; Braille literacy, bookkeeping; business planning; business counselling; and HIV/AIDS awareness. There were two groups of learners, those who attended basic literacy, and those who did more than literacy. The learners were encouraged to become involved in income generating projects of their choice. The current projects run by the Centre were poultry production, vegetable growing and selling, fencing and other farming skills. Candles and coffins were made and sisal mats woven.

The Centre Manager pointed out that the Centre served a very large community and had projects throughout the province at Elim (the Ringetani Fence making project), Malamulele and Chabane (in the East), Sikukune, Nkowankowa, (near Tzaneen), Matoks, Giyani and Venda. Blind people of all ages were taught Braille and typing, orientation and mobility and skills for daily living. After the training, those who were interested were placed in mainstream education and training programmes. Those who did not wish to further their education, especially adults, were helped to establish income-generating projects such as tuck-shops, poultry farming, sisal processing, mat making, fence making and candle making. These activities were part of the ABET programme and they were run and coordinated by ABET educators. The Centre employed three educators, one of whom was blind, one partially sighted and one who had no visual impairment. Educators went to the various satellite centres to teach the adult learners. Young learners between the ages of 6 and 20 years came to the Centre where they were trained in Braille reading and other skills such as typing.

One of the ABET educators I spoke to, Mr Kopedi, was totally blind. He told me he was employed by the Department of Education after undergoing a competitive interview. He was placed in Rivoni because he was fluent in three languages spoken in the region: Tsonga, Sotho and Tshivenda. He taught learners to read Braille, and

taught Tsonga, Sotho and Tshivenda to learners at ABET levels 1 and 2. He held a UNISA ABET certificate and was computer literate. Mr Kopedi explained that he had taught eight learners in 2002 but in 2003 he had five learners in his class. All learners stayed at Rivoni and he taught them from four to six o'clock every day. Learners were 'project workers', in projects that included knitting sisal mats, fence making and candle making. The adult learners were literate in their home languages but they needed to learn Braille. He explained that he taught languages above ABET level 1 and 2, while Braille was taught at level 1 and 2, and emphasized that Rivoni prepared people for income-generating activities. Some learners were already running tuck-shops in kiosks provided by an American soft drinks company.

The HIV/AIDS coordinator

When I asked the Centre Manager how they were addressing the challenges of HIV/AIDS, she referred me to the HIV/AIDS Coordinator, 28 year-old Mr Chauke. Partially sighted, he was hardworking and knowledgeable, and he explained that he had worked with blind people for thirteen years. He took me to an untidy room furnished with only a table and three chairs. Apologizing for the state of affairs, he cleaned a chair for me and made space on the table so that I could put down my books and recorder.

HIV/AIDS training for Coordinator and educators

Asked whether he had undergone any form of training in HIV/AIDS Education, Mr Chauke said that he had undertaken training run by the Treatment Action Campaign (TAC) coordinators at the AIDS Consortium in Gauteng and at Elim Hospital. He had certificates from both. He also attended a workshop at Mutale in the Limpopo Province, which was facilitated by the Stepping Stone group from Zimbabwe, where he got training in counseling people with HIV/AIDS. Another of the educators at Rivoni Centre indicated that he had attended a workshop on HIV/AIDS at the Visually Impaired Rehabilitation Institution Network Organization.

Ringetani Fence-Making Project

The Centre is near Elim Hospital, just two kilometers from the Rivoni Society for the Blind. We traveled on a tarred road to the project. The Centre is easily accessible because it is situated on the main road from Giyani to Makhado. When I asked why

the Centre was located where it was, I was told that they had looked for a place that would provide easy access for both blind learners and customers. On the main road, a few meters away from the Centre, was a large sign reading '*Ringetani fence-making project',* and outside the building were bundles of fences on display for potential customers. The Project was housed in a three-roomed building, the biggest of which was the factory in which the fences were made on six machines. In one corner of the room were four rolls of meshed fence ready for sale. The other two, smaller, rooms were used as a storeroom for equipment and finished products, and as a classroom and meeting room. The latter is where I held an interview with learners.

There were five learners, four men and one woman. The woman was partially sighted, while the men where completely blind. One female, sighted educator joined us. The HIV/AIDS Coordinator introduced me and told the learners the purpose of my visit. The learners also introduced themselves. After exchanging a few pleasantries, I asked the learners whether they had ever heard about HIV/AIDS. The interview took a long time because of the interesting arguments amongst the learners pertaining to issues arising from the interview. Learners asked me every now and then for my own point of view.

HIV/AIDS prevalence and awareness

When I asked the HIV/AIDS Coordinator whether HIV/AIDS was a problem in the community, he said that it was a huge problem: *"People are dying and we suspect they are dying of HIV/AIDS, but people are afraid to disclose their status openly because of the existing HIV/AIDS-related stigma and prejudice among community members*." The educator attributed the problem to poverty and alcohol abuse, explaining that because of poverty, girls went out with older men who had money. There was a lot of prostitution in the community because of the long distance truck drivers who traveled the highway from Giyani to Makhado. He also attributed the spread of HIV/AIDS to 'stokvels', which he said had ceased to be saving clubs but instead provided entertainment for people who came for liquor and sex. Blind people, he explained, were particularly vulnerable to HIV/AIDS because people took advantage of their blindness, and they were used as sex objects. Sighted people sometimes thought that they would do the blind a favour if they slept with them. He was of the view that training would help the blind to be independent, self-sufficient

and increase their self-esteem. He emphasized the need to talk about HIV/AIDS and said that prevention was the strongest message.

When asked about what Rivoni Centre was doing to address the problem of HIV/AIDS prevention and support, he said that they had not started but they had intentions to start, especially since he had attended an HIV/AIDS workshop at the Visually Impaired Rehabilitation Institution Network Organization. He was quick to mention that there was another man who was operating independently (referring to Mr Chauke). He indicated that he would have liked them to work together but there were problems within the Centre, particularly with nepotism. The educator said that other staff members were jealous of him because he was from the Department of Education and they did not think that, being Sotho, he could teach Tsonga and Tshivenda. However, when I spoke to the AIDS Coordinator later, he indicated that there was a personal grudge between the two men and they simply could not work together.

Sources of knowledge about HIV/AIDS

The learners said that they had heard about HIV/AIDS from the media, from Elim Hospital and from their educators. They confirmed that there were people in their communities who were affected by HIV/AIDS. On asking what was being done in the Centre to address the problem, Mr Chauke said that, since August 2000, he had been running awareness campaigns within the community. He made people aware of the existence of HIV/AIDS, its dangers and how it could be prevented. An HIV/AIDS Education programme had been introduced in Rivoni Centre. Unlike any of the Ikhwelo centres, learners were formally taught about HIV/AIDS transmission, prevention and control. They were shown how to care for AIDS patients and encouraged to help people in their own communities who had the disease.

Asked what methods they used to teach the learners, he said that it was not easy to teach since he could not use pictures, which was the easiest method of teaching about sensitive topics such as HIV/AIDS. He would try to describe what was in the pictures to the learners, and encourage them to ask questions and start a discussion. He explained that it was possible to draw pictures in Braille, but due to lack of funds such pictures were not available at the Centre. He said that he made use of audiotapes provided by the Department of Education and Training about HIV/AIDS, in Tsonga,

Sotho and Venda languages. He also encouraged learners to discuss and share ideas and personal experiences.

Teaching and learning materials

While educators at Mbaleni and Mutangwa Manugu drew on *Soul City* materials, pamphlets, magazines and newspaper articles to teach adults about HIV/AIDS, the Coordinator at Rivoni Centre had more resources at his disposal. In addition to the *Soul City* materials, he used a package promoted by the *Stepping Stones Training and Adaptation Project*, a package in the form of workshop series designed to promote sexual and reproductive health. It addresses questions about gender, sexual health, HIV/AIDS, gender violence and communication, and involves learning the basic facts of HIV/AIDS and other sexually transmitted infections, as well as the ABC (Abstinence, Be Faithful, Condomise) strategy of prevention. The coordinator indicated that he found the *Stepping Stones* Training Package more comprehensive and easier to use than the *Soul City* materials (see appendix 3).

One advantage of working with the *Stepping Stones* package was felt to be that the workshops aimed to enable individuals, their peers and their communities to change their behaviour, individually and together. Based on the assumption that community-wide change is best achieved through a personal commitment to change from each of its members, the package shares information. People start talking with their friends, parents, children and - more especially - their sexual partners about sex and HIV/AIDS. Mr Chauke indicated that learners were now openly discussing the issue of HIV/AIDS and were keen to learn more. Other aspects involved in the *Stepping Stones* package are caring for infected people and behavioral change, for example the use of condoms, reduction in alcohol consumption and reduction in physical and sexual violence. The training manual was written in English but the coordinator used Tsonga (the local language) as the medium of instruction. These HIV/AIDS educational materials were not available in any of the Ikhwelo centres previously visited.

Skills development

As in the Ikwelo centres, Rivoni Centre used skill development as a strategy to help learners to become more self-sufficient. Learners were trained in fence making, weaving sisal and making candles. While learners worked they discussed HIV/AIDS-related issues, amongst other things. Mr Chauke explained that because of the high rate of unemployment and poverty in the area, there was a need for income-generating opportunities.

Knowledge, attitudes and beliefs surrounding HIV/AIDS

Mr Chauke indicated that he tried to talk to learners and to address their questions. The Coordinator proudly stated that he had noted a significant change of attitude among HIV positive people. Before the awareness campaigns they did not want to 'die alone' and would drink excessively, even deliberately spreading the disease.

The learners at Rivoni confirmed that they discussed all sorts of issues while working, for example politics and family affairs, but of late HIV/AIDS had taken a central role. This behaviour was different from that of learners at several other centres, who never wanted to talk about the subject. Discussions could be about the causes and prevention of HIV/AIDS and what one could do on discovering that he/she was HIV positive. The learners affirmed what the HIV/AIDS Coordinator had said earlier, that they knew that in order to prevent HIV/AIDS they had to abstain, be faithful or condomise. They confirmed that people from Treatment Action Campaign had come to speak to them. They said they had also been invited to several community meetings organized by the hospital and the police. The learners indicated that, despite all the information they had acquired about HIV/AIDS, they still felt frightened because there was no cure and they were still uncertain about the causes. The learners at Mbaleni and Mutangwa Manugu expressed a similar reaction.

Like the learners at Makahlule and Mutangwa Manugu, the learners spoke freely during my interview. They shared the information they had with me and discussed their fears. While learners at the Ikhwelo centres did not acknowledge the prevalence of HIV/AIDS in their own communities, learners at Rivoni Centre freely acknowledged that it was prevalent in their community. The learners at Rivoni Centre were against the idea of isolating infected people, a view similar to that expressed by

learners at Mbaleni and Mutangwa Manugu.

One learner was adamant that prostitutes were largely responsible for spreading HIV/AIDS. Many learners in the Ikhwelo centres I visited expressed this particular belief. However, learners were aware that one could not contract the disease by hugging. They were doubtful about whether kissing a person who is HIV/AIDS positive was safe, and were sure that one could not get AIDS by sharing food or cutlery with an infected person. They debated long about whether sharing a toilet could result in the spreading of HIV/AIDS. One learner insisted that if a person infected with HIV/AIDS used the toilet and left some blood on the toilet seat, and a person with a cut or open wound came and used the toilet soon afterward, the chances of being infected were high. This same learner believed that HIV/AIDS was not a new disease, that it had been around for a long time but not called 'AIDS'. Unfortunately he could not remember the name by which it was known. A similar argument was advanced by one learner at Matangari Centre, who said that HIV/AIDS previously existed under a different name and was traditionally referred to as '*Makomma*' (a disease acquired when a man sleeps with widow or woman sleeps with a widower during mourning periods).

The learners at Rivoni Centre all agreed that an infected mother could pass on HIV/AIDS to her baby, and they knew about the antiretroviral drug Nevirapine, which was being given to HIV positive pregnant mothers to prevent them from passing on the virus to their newly born babies. Like the learners at Makahlule and Mbaleni, four of the learners at this Centre knew that HIV/AIDS had no cure, while the same learner who argued about the possibility of acquiring HIV/AIDS from sharing toilets believed that traditional healers could cure HIV/AIDS.

Coping with HIV/AIDS

While respondents from the Makahlule, Matangari, Mbaleni and Mutangwa Manugu ABET Centres were positive that there were no people living with HIV/AIDS in their Centres, the HIV/AIDS Coordinator at Rivoni Centre said that there were several HIV positive people in their community. He said that they talked openly about it after they had been counselled. This openness about HIV/AIDS was quite different from the

situation even at Mutangwa Manugu, where it was believed that people would not disclose their status for fear of being discriminated against.

The Coordinator explained that after counselling, PWA in their community shared their experiences with other people and they talked openly about their condition. He said that PWA had access to practical and material resources, such as medicine for opportunistic infections and sometimes food supplements. They were given moral support and care from the nurses at the Waterval Clinic (across the road), and from Elim Hospital, two kilometres away from the main Centre and a stone's throw from the Ringetani Fence making project. This degree of trust amongst the health workers and the community at Rivoni Centres was unlike the suspicion that existed between the community members and the health workers at Makwarela Clinic near Mbaleni Centre, and the clinic near Mutangwa Manugu where learners suspected that they would be blamed and humiliated if they presented themselves at the clinic with an STD or HIV/AIDS related illness.

HIV/AIDS tests and counseling

In contrast with the beliefs at Mbaleni and Mutangwa Manugu Centres, where learners doubted that health workers at Tshilidzini hospital would maintain confidentiality regarding their HIV/AIDS status, learners at Rivoni Centre trusted the health workers at Elim Hospital. The HIV/AIDS Coordinator encouraged all community members, both blind and sighted, to go to Rivoni Centre for counseling. He arranged for people to get blood tests at Elim Hospital and networked with the TAC to organize medicine including Nevirapine for people with HIV/AIDS.

Mr Chauke told the story of two pregnant women from the community who had health problems. He approached them and advised them to go for a blood test for HIV/AIDS. He counseled them before they went for the test and when the results indicated they were HIV positive he continued with post-test counseling. He organized Nevirapine medication and immunity boosters (vitamins) for them from the TAC. Both women had babies, one of whom died shortly after birth, but the other was still alive. Asked what happened afterwards he said: "*I still organize free medication from TAC for both mothers and the baby because they cannot afford to buy medicine. If there is a workshop and/or conference for PWA in Gauteng I arrange transport for*

them to attend. They are living positively with AIDS and they have started sharing their experiences with other people". However, the Coordinator indicated that they were frustrated by the government's reluctance to supply antiretroviral drugs for PWA. He indicated that he would join the TAC when they marched to Pretoria to demonstrate at parliament in May 2003. The Coordinator further indicated that Rivoni Centre would have liked to start a home-based care centre and day care centre to assist people affected with HIV/AIDS, but they did not have the funds.

Traditional healers and treatment

Mr Chauke explained that when he first started to talk about HIV/AIDS to learners, they were afraid to talk about it because they were ignorant and they associated it with being bewitched or cursed by their ancestors. On that basis they believed that traditional healers could cure AIDS, a belief he indicated that it was not easy to change. This was confirmed when I later interviewed the learners. One learner, despite the knowledge he had acquired pertaining to HIV/AIDS, insisted that traditional healers could cure AIDS, while two others were not sure whether to believe him or not. This was unlike the learners at Makahlule and Mbaleni who held that traditional healers could not cure AIDS.

Networks and partnerships

The Coordinator indicated that in dealing with the challenges of HIV/AIDS, they were networking with organizations such as the AIDS Consortium, a Gauteng-based organization, and Treatment Action Campaign, a nationwide organization. The Coordinator invited speakers from the above-mentioned organizations to talk to learners and interested community members about HIV/AIDS. He said that they talked about important aspects of the disease, including the importance of having blood tests and how to care for people with HIV/AIDS.

He explained that he had not had firsthand experience in dealing with HIV positive people and so found it difficult to speak with authenticity about the implications. However, when people with HIV/AIDS (from the Treatment Action Campaign) talked to learners, they shared their personal experiences of living positively with HIV/AIDS. They also used real life stories as a powerful motivating force to make the people aware of its effects on their health, personal relationships and working life.

People accepted the messages from PWAs and a Treatment Action Campaign branch was launched in Limpopo Province in 2001. Due to financial constraints it had soon closed down.

Locally, Rivoni Centre networked with Akanani Tivhoneleni Vavasanti (women against HIV/AIDS), who provided home-based care. The women went to homes where there were people with HIV/AIDS, and cleaned, washed, cooked and gave them fruits and vegetables. Whenever Rivoni Centre organized an AIDS campaign, they would invite people from Tivhoneleni Vavasanti and do it jointly. They exchanged HIV/AIDS teaching and learning materials, and if there was something that was not clear, the Rivoni Coordinator called upon their assistance. He explained that people from this Tivhoneleni Vavasanti were well trained and conversant with issues pertaining to HIV/AIDS, since they had participated in various workshops, in Johannesburg and Durban.

Rivoni Centre also worked with Makombadlela youth project, a group concentrating on HIV/AIDS awareness. They visited schools, churches and other institutions where they sang and performed plays. Tivhoneleni is based at Akanani about five kilometres from Elim Hospital, while Makombandleni youth cultural group is situated at the Waterval Police Station, about two kilometres from Elim Hospital. Both of them are quite accessible to the community members. However, the Coordinator said that they stopped working with Makombandleni youth cultural group because they had applied for funding, using Rivoni's name without permission.

Mr Chauke indicated that in most cases he did not wait for people to come to the Centre, because they hardly ever came: '*We take the services to the people in our community who presumably need help"*. He was often invited by Elim Church to talk to people about HIV/AIDS, saying that he tried to address questions from the congregation. He also said that the people trusted him. When I asked him whether he networked with traditional healers, he said that he had never tried working with them and they had never contacted him.

Mr Chauke indicated that learners and the community at large benefited from the programme. Educators developed HIV/AIDS awareness among their learners and they

also provided HIV/AIDS related counseling and home based care training. They did not screen blood for HIV or dispense food and medicine, but they were networking very well with organizations such as the AIDS Consortium, Treatment Action Campaign (TAC), Elim Hospital and NGOs who provided such services. Similar though less extensive networks and partnerships existed at Mbaleni Centre, where many learners were members of the ANC Women's League. At Makahlule and Matangari, the ABET practitioners were not aware of any organization which provided such services, and did not enter into networks and partnerships.

The Centre Manager explained that the Department of Education paid the teachers and saw to the daily running of the ABET Centre. As was the case with the Ikwelo Centres Makahlule, Matangari, Mbaleni and Mutangwa Manugu, Rivoni Centre had good relationships with the local chiefs and Indunas**.** Chief Kukuze was a member of the Rivonia Board of Trustees Board of Trustees, which is influential in assisting Rivoni with fundraising.

Condom use

The HIV/AIDS Coordinator stated that at first people were reluctant to use condoms, but he believed that the attitude was slowly changing as people became aware of the danger of HIV/AIDS through training and awareness campaigns. The Coordinator also commented about the plight of the women, saying that even if a woman knew that her husband was at high risk of HIV/AIDS, she would not raise the issue of condoms for fear of a violent reaction. A similar scenario was reported in the other centres. Male learners admitted to not using condoms and female educators and learners lamented their inability to convince their partners to use them.

Stigma attached to HIV/AIDS

The HIV/AIDS Coordinator commented on the stigma attached to HIV/ADS and PWA, saying *"most people at first were afraid to disclose their status openly because of the HIV/AIDS-related stigma and prejudice which existed among community members*." The learners echoed what the Coordinator had said earlier, that some people, on discovering their HIV positive status, would go on a 'spreading spree'. One learner said that: "*At a certain stage, there was animosity directed towards PWAs and there was a sense of insecurity among community members and people did not*

trust each other". However, unlike other communities, where stigma and prejudice against PWA still existed, the learners at Rivoni were of the view that the HIV/AIDS education provided by their educators and awareness campaigns by different organizations had helped them to confront their fears and prejudices towards PWAs and their families.

Gender and HIV/AIDS

Regarding gender and HIV/AIDS the Coordinator echoed what many other respondents from Makahlule, Matangari, Mbaleni and Mutangwa Manugu Centres had said, namely that both men and women were affected but women were more vulnerable because, in his opinion, they had little control over issues related to sex in their relationships. Women were brought up to be subservient to men, especially in matters of sexual relationships. Even when a woman wanted to protect herself, she would be confronted by an entrenched culture of male-dominance that would render her powerless. While the women at Makahlule and Mutangwa Manugu felt powerless to exercise control over their safety, their health and even their lives, the workshops run by the HIV/AIDS Coordinator at Rivoni Centre helped women to say no to unwanted sexual approaches. Women were informed of their rights and were taught to stand their ground in marital relationships. In the opinion of the HIV/AIDS Coordinator, it was easier for young women to stand their ground than for older traditional women.

Learners confirmed women's vulnerability to HIV/AIDS because, as one learner put it, *"many women in our community are not married and they are not employed, they spend most of their time drinking. When they get drunk they do not mind with whom they 'sleep' and some men also take advantage of them"*. The learners suggested that the government should open more projects like theirs where people could get skills so that they could *"do something for themselves"*.

National Policy on HIV/AIDS for learners and educators

With regard to the National Policy on HIV/AIDS for learners and educators, the HIV/AIDS Coordinator said he had been given the document during one of the workshops he attended. However, he admitted that he had never had a chance to read it - a response was no different from that in the Ikhwelo centres I had visited. Since the HIV/AIDS Coordinator at Rivoni had not read the National Policy on HIV/AIDS,

he could not say whether it was relevant or applicable to rural ABET centres, nor whether the practices in their Centre were in line with it. On the other hand, the educator, like many educators at the Ikhwelo centres I had visited (apart from Mutangwa Mannugu) did not know about the policy at all. As with the learners in the Ikhwelo centres, those at Rivoni were unaware of the existence of the policy.

Problems encountered

Asked what difficulties they encountered in attempts to address the challenge of HIV/AIDS prevention and support, Mr Chauke said that in the beginning it was difficult for the people to open up. Men would say: "*you cannot tell us how to sleep with our wives".* He reported that it was particularly difficult to teach elderly men because they thought that they knew everything. Mr Chauke, like the educators at many of Ikhwelo centres I visited, was young and much of the time, though he networked with other organizations, he was working alone. He said that it was difficult to convince people about the importance of doing an HIV/AIDS blood test, saying it was easier for him to teach the youths. However, with time, he had managed to put the learners at ease and they had started talking freely about HIV/AIDS.

The HIV/AIDS Coordinator further mentioned that it was not easy to go to people with HIV/AIDS because they would ask: "*who told you that I have such a problem?"* He tried waiting for people to go to him but in vain. He then resorted to house-to-house awareness visits that proved very effective in unearthing community members who were in need of support. However, he pointed out that he was working alone since there was no budget to pay for extra staff. He said that progress was hampered because he could not cover the whole community on his own. When I asked him why he was not working with other educators at the Centre, he explained that they all had other commitments. He also indicated that he had a personal grudge with one of the educators and felt that they could not work together.

Another problem was that learners had to rely on educators to read for them because there were only a few materials translated in Braille. It was costly and time-consuming to have materials translated into Braille. However, he mentioned that he had designed his own material, which he was using to teach learners. Mr Chauke lamented the lack of finance. He said that the continuity of the programme was

uncertain since they had run short of funds. He said that he had sent applications to several government organizations and NGOs, but without any luck. Before I left I promised that I would send him a book which contained addresses of different national and international organizations where he could also apply for funding. (I sent the book a week later).

10.2 Conclusion

Rivoni Centre is a special centre in that it caters for the need of the partially and completely blind adult learners. A wide range of well-developed courses and activities exist at the Centre. Programmes, including Mobility and Rehabilitation activities and HIV/AIDS awareness and counseling, are being run successfully. Unlike the Ikhwelo centres, Rivoni Centre is relatively well resourced and enjoys a support network for its HIV/AIDS awareness programme, in the form of the Treatment Action Campaign (TAC) and the AIDS consortium, among other organizations. This has greatly enriched the Centre's HIV/AIDS awareness activities. The HIV/AIDS Coordinator had attended several training workshops regarding HIV/AIDS, unlike most educators in other centres. These included voluntary counseling and testing programmes and home-based care programmes.

Compared to other centres, the attitude and knowledge of the learners was apparently enriched by the programme, yet despite the perceived change in attitude and knowledge, the promotion and practice of safe sex among learners and the community was not perceived to have changed greatly. Male learners admitted to non-condom use, while women learners still feared openly discussing safe sex practice with their husbands, for fear of violent reaction and abuse.

Nevertheless the relative success of this Centre in addressing the challenge of HIV/AIDS prevention and support provides an indication of how modest resources, training and participation in a support network can go a long way in setting the stage for positive change in dealing with HIV awareness and support.

The last five chapters presented the findings of the study. The next chapter contains a discussion of the research results. Recommendations on how ABET centres should

address HIV/AIDS are presented and an action plan is shown that could be adopted to improve the effectiveness ABET centres in addressing the challenges of HIV/AIDS.

CHAPTER 11

WAYS IN WHICH RURAL ABET CENTRES ADDRESS THE CHALLENGES OF HIV/AIDS: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

11.1. Introduction

This study is premised on the assumption that public ABET centres, however under-resourced and ineffective they may be (Aitchison, 2000), are an important resource for HIV/AIDS education and support. This is especially so since many state ABET centres are based in impoverished rural communities, where resources such as hospitals, clinics, community centres, and even radio and television broadcasts are meagre.

In keeping with the critical education paradigm, the researcher developed a qualitative research design for this study. A series of interviews and discussions were conducted with the Regional Coordinator, District Coordinator, centre managers, adult educators and learners of five ABET centres in Region 3 (Vhembe District) of Limpopo Province. Firstly, the role of the centres in teaching and supporting PWA was examined, then the knowledge, attitudes, beliefs and practices held by educators and learners and how they impacted on the ability of centres to address HIV/AIDS.

The final chapter of this thesis discusses the major findings of the study, with a view to showing how rural ABET centres address HIV/AIDS. The geographical setting and infrastructure, organisational and operational aspects of the rural ABET centres are discussed with specific reference to the way in which they impact on the centres' ability to address HIV/AIDS. In addition, the knowledge of the learners, as well as the attitudes, beliefs and practices of both learners and educators and how these aspects influence the centres' ability to address the challenges of HIV/AIDS, are discussed. In this final chapter of the thesis, the strengths and weaknesses of the centres in addressing the challenge of HIV/AIDS prevention and support are highlighted. Finally, recommendations on how ABET centres should address HIV/AIDS are presented.

11.2 Major findings

Geographical setting and infrastructure

The centres were all located in rural areas. While some, like Makahlule and Matangari, are located in remote areas, others, like Mbaleni and Rivoni, are situated in what could be considered a peri-urban area. The geographical setting of the centre has a significant bearing on the ways ABET centres address the challenges of HIV/AIDS prevention and support. The location influences the type and nature of resources the centre can utilise. Remote rural ABET centres find it difficult to attract and retain qualified staff. Furthermore, networking and mobilizing funds are difficult because of the remoteness and lack of influential community leaders and organization. Such remote centres may even lack communication networks, such as telephones, that make it easier to access information and promote learning by collaboration with other organizations. Essential resources like learner support materials are not available in the local language of the learners, rendering those materials available ineffective with adult learners at ABET levels 1 and 2 (see appendix 3).

Perhaps as a consequence of their deep rural setting, services such as roads, electricity and the like were either very poor or non-existent. The general picture presented was one of communities gripped by poverty, engendering a sense of paralysis and disempowerment of the female population in the community. There was dependency on government delivery, even in areas where there could be expected to be a degree of self-reliance, community participation and hence, change in the ways communities respond to HIV/AIDS.

Mbaleni and Mutangwa Manugu, on the other hand, are in close proximity to Thohoyandou, the main commercial hub of the area. Mbaleni is less than five kilometres from Thohoyandou, while Mutangwa Mannugu is *en route* to Makhado, an established town with good facilities. Rivoni is two kilometres from Elim Hospital, 25 km from Makhado and 60 km from Thohoyandou. It is on the highway from Giyani to Makhado. Generally speaking, there was a better communication network in terms of roads and information technology at Mbaleni, Mutangwa Mannugu and Rivoni. Mbaleni, Mutangwa Manugu and Rivoni were far better serviced areas. Resources such as hospitals, clinics, and schools, exposed the learners/community members to

important information, as they heard more about HIV/AIDS through the media and were comparatively better placed to respond to the challenges of HIV/AIDS.

On the other hand, the advantageous location of these three ABET centres presented problems of their own. Being close to a major trading centre and attracting people from other communities and countries, such as Zimbabwe and Mozambique, meant that HIV/AIDS spread at a much faster rate than in the more rural closed communities. People here were more mobile, with the pressures of making a living more acute. It may therefore be postulated that good transport infrastructure and high mobility enabled the virus to spread rapidly into new communities. Such a heterogeneous community may exhibit less social cohesion, and thus the features of social organisation, such as trust, norms and networks that could improve the efficiency of the community to take collective action around common priority issues, including HIV/AIDS, are weak as compared to more rural closed communities. Similar trends have been observed in major trading centres in India and Uganda. In India a high level of susceptibility was associated with tribal women participating in sex work along transport routes. In Uganda, the 'shape' of the Ugandan epidemic radiated from specific centres, for instance the Kampala, Rakai district and the main communication routes from the African east coast into the general population (Barnett and Whiteside, 2002). The major trading centres and communication routes create an environment for random social mixing of different social networks.

Mann and Toruntola (1996) have argued that a better understanding of these networks is critical in the conception and development of prevention strategies. Likewise an understanding of the geographical setting and infrastructure of these centres could offer opportunities in, as well as threats, to the way in which these centres address the challenges of HIV/AIDS prevention and support. The geographical setting and infrastructure of these centres have a direct influence on the social networks and social and material resource flow within and between the centres, thus affecting the way in which the centres collectively coordinate and cooperate in their efforts to address HIV/AIDS for the mutual benefit of their communities.

Conclusion: The findings from the study show that centres were all located in rural areas, however their remoteness varied. It was established that the geographical

location influenced the type and nature of resources a centre can utilize and influenced the susceptibility and response of community members to HIV/AIDS. Discussions with both educators and learners of Makahlule and Matangari, the most far-flung centres of the five, show that the communities were in a state of denial, largely ignorant of matters pertaining to the pandemic, and inclined to uphold cultural taboos surrounding the topics of sex and death. It is imperative that ABET centres, especially those in remote rural areas, do find ways of addressing the challenges of HIV/AIDS, since the remoteness of their location and infrastructure constraints make them vulnerable to the spread, and more susceptible to the severe impact of the HIV/AIDS pandemic. Umeh (1997) suggests that strong community involvement and leadership can overcome such threats. In this study communities were supportive of the activities in the ABET centres. The chiefs provided them with land for vegetable gardens and business people provided transport for learners and cold drinks, indicating a potential for the ABET centres to become a nucleus for community action.

Organisational and Operational aspects

Studies have shown that organisational structures in the ABET centres are critical to the success of programmes (Aitchison, 2000; Baatjes, 2003). The Ikwelo centres in the study established structures that facilitated programme planning and implementation. Some of the critical organisation and operational factors in ensuring development and implementation of HIV/AIDS awareness programmes in the ABET centres included commitment of the staff to HIV/AIDS education, competence of the educators, learner characteristics, community involvement, organisational resources and operational aspects. These are discussed below.

Profile of educators

With the exception of Matangari and Rivoni Centres, whose agricultural activities and projects attracted men, learners and educators in other centres were mostly female. The gender of educators did not seem to have an influence on whether an HIV/AIDS programme was offered in a centre. Educators who had received some form of training regarding HIV/AIDS were more ready to initiate HIV/AIDS awareness programmes in their centres. For example, those at Mutangwa Manugu had participated in the UNISA ABET certificate programme. The HIV/AIDS coordinator

at Rivoni had undergone a training programme and attended several workshops run by the Treatment Action Campaign and the AIDS Consortium in Gauteng and at Elim Hospital. Another educator at Rivoni Centre had attended a workshop on HIV/AIDS at the Visual Impaired Rehabilitation Institution Network Organization. Such training and exposure contributed a great deal to providing the educators with stimulus and sense of professional responsibility to engage with HIV/AIDS. Furthermore, it is noted that the Department of Education did not provide HIV/AIDS training to any of the educators in this study. It should be pointed out that education and training is an investment and a means that not only can improve the economy, but also the health status of the people.

Conclusion: The study highlighted that with the exception of Matangari and Rivoni Centres, educators were mostly female. Furthermore, educators who had received some form of training were more ready to initiate HIV/AIDS awareness programmes in their centres. However, it should be noted that qualifications alone, without commitment to task and proper organisational structures, did not translate into effective programmes, as observed in Makahlule and Matangari Centres. Structural problems in the centres have to be addressed if investment in human capital is to be used/developed to its full potential.

Profile of the learners

Learners were predominantly female and mostly unemployed married rural women. This gives some indication of the status of most women in the rural areas in which the centres are situated. Women between the ages 30-50 are especially vulnerable to HIV infection. Most of them are married to migrant labourers, are poor, unemployed and single heads of the household for the best part of the year.

Cultural practices and the role of women as wives and child-bearers, with little or no say regarding sexual practices in relationships, also made them vulnerable to the spread of HIV/AIDS. According to Human Capital Theory, such rural women owe their inferior status to the low investment in their human capital. Adult basic education and training (ABET) is a means to develop their human capital. Through the Ikhwelo Project, the ABET centres provided literacy and numeracy classes and income generation alongside agricultural production and entrepreneurial skills

development. This was an attempt to empower women by breaking the cycle of poverty, illness and disease. However, neither learners nor educators saw prevention of HIV/AIDS as a priority issue to be addressed in ABET centres. Instead poverty and unemployment were seen as major issues.

In general, these ABET centres did not attract male learners. This could be due to the income generating activities offered at the centres: vegetable and fruit vending, weaving grass mats, bead making etc, which are seen as women's activities. Male learners did not identify themselves with the centres. Matangari Centre was the only centre with more male than female learners, because men were attracted by an agricultural project that was seen as male-oriented. Rivoni Centre also had more males than females. Perhaps it is the case that men were better able to access the opportunities for education, training and employment offered at Rivoni. The income-generating activities at this Centre, which included fence making, woodwork and coffin making, appealed to men.

Conclusion: Learners in the centres were predominantly unemployed married rural women. The picture that emerges, therefore, is one that shows that in an effort to address the challenges of HIV/AIDS, prevention and support, most ABET centres failed to attract male learners and thus deprived the centres of full community involvement. As will be shown below, ABET centres also failed to adequately promote connectedness and solidarity among groups in the communities, i.e. social cohesion. This had a negative impact on the way the centres could utilise the social capital i.e. trust, norms and networks, in order to facilitate coordination and cooperation to address HIV/AIDS amongst the communities.

Community involvement networks and partnership

Networking and partnerships with other organisations dealing with HIV/AIDS education, as was the case at Rivoni Centre, appears to result in more effective use of resources. It eliminates duplication and encourages transfer of knowledge (Nasta, 1993). Rivoni and Mbaleni networked extensively with local health institutions, HIV/AIDS prevention initiatives at provincial and national level, as well as civic organizations and NGOs within their locality and beyond.

Studies have shown that people are most likely to undergo health-enhancing behaviour change if they live in communities that offer high levels of participation in local networks and organizations which are associated with increased levels of trust, reciprocal help and support, and a positive local community identity (Norman et al., 2000). Such outcomes of community participation were evident in Rivoni Centre, where some learners begun to embrace health-enhancing behaviour change, partly because of partnerships they had with organizations such as the AIDS Consortium, and the Treatment Action Campaign (TAC). Locally, Rivoni Centre networked with Akanani Tivhoneleni Vavasanti to provide home-based care, and the Makombadlela youth project which concentrated on HIV/AIDS awareness. Similar though less extensive networks and partnerships existed at Mbaleni Centre, where many learners were members of the ANC Women's League. On the other hand, at Makahlule and Matangari Centres, ABET practitioners were not aware of, or did not enter into, any networks and partnerships with any organization which provided such services.

There is a growing consensus on the ability of social networks and social capital to influence health. Social networks, through social support, social influence, social engagement, person to person contact and improved access to material resources, have the potential to influence health related behaviours positively (Kawachi and Berkman, 2000; Erickson, 1998). Based on these assertions it is apparent harnessing social networks and social capital could be an effective of the strategy in the fight against HIV/AIDS. Community partnerships like those at Rivoni and Mbaleni strengthen community participation and support for centre-initiated HIV-prevention and support initiatives. This increases the sustainability and community ownership of initiatives.

Conclusion: In most ABET centres, practitioners did not establish meaningful partnerships with community leadership. They were not aware of, or did not enter into networks and partnership with NGOs and other civic organisations such as churches. Studies have shown that the HIV/AIDS epidemic is not only too complex to be dealt with through traditional biomedical or behavioural disease prevention, it is also too multi-faceted for any single constituency (e.g. provincial clinics or local grassroots people or ABET centres) to deal with on their own. For this reason, Campbell (2003:57) suggests that HIV-prevention projects build alliances with the widest

possible range of relevant constituencies, to ensure that a range of actors pool their resources and creativity in working to create a new approach relevant to the way the disease is manifested in a community. As shown in chapter four of this thesis, such alliances existed in Uganda and Tanzania, where national AIDS programmes enunciated policies to involve more directly the local leadership in AIDS information and education. Churches and mosques, clan councils, traditional mutual aid associations and non-governmental organisations were targeted to contribute to delivery services (Ankrah, 1991). In addition to providing an avenue for the exchange of information, strong social networks may shape community norms around gender relations, sexual negotiations and communication. The emotional support generated around these networks may reduce discrimination against PWA and create a more accepting environment for those living with the disease.

Knowledge, attitude, beliefs and practices
regarding HIV/AIDS prevention and support

HIV/AIDS awareness

This study highlighted different levels of HIV/AIDS awareness among learners and educators at the five centres. The relative success of Mbaleni and Mutangwa Manugu Centres in facilitating awareness of HIV/AIDS could be seen as an outcome of social capital developed by the Life Orientation educator who brought adult learners together, despite community denial, disapproval and discrimination against people with AIDS. The social networks provide information to group members who facilitated a collective goal. Without these social networks, the possibility of exchanging information is extremely limited, as seen at Makhahlule Centre.

The study further showed that ABET centres in which learners and educators had a relatively good knowledge of HIV/AIDS, and where they perceived HIV/AIDS to be a serious problem in the community, were more likely to address the issues. This was evident in Mbaleni and Mutangwa Manugu Centres, where learners who showed awareness of HIV/AIDS and had first hand experience of caring for people with HIV/AIDS showed enthusiasm to learn more about it and to get involved in activities to support people with it. This lends support to Crowthers' (2001:13) observation that involvement with people with HIV/AIDS was an effective mechanism for combating

its spread, because it is then that reality begins to hit home.

At Rivoni Centre, learners acknowledged that they had heard about HIV/AIDS and had seen people in their community infected with it. This reality could have had a bearing on the relative success of the programme, in addition to factors such as the competence and training of the HIV/AIDS coordinator. Similar findings were established in Uganda (as shown in chapter four), where a reduction in HIV prevalence was attributed to behavioural changes that came about through intense personal awareness. Many Ugandans knew of a friend or relative with AIDS who would talk openly about it (Barnett and Whiteside, 2002). This is in contrast to the situation at Makahlule and Matangari Centres, where learners indicated that they had never been in contact with PWAs and did not recognise the HIV/AIDS epidemic as a problem in their communities. Learners at these centres showed poor knowledge of HIV/AIDS and the educators took no initiative in addressing issues related to its prevention or support.

Conclusion: Different levels of awareness existed in the centres resulting into varying responses towards HIV/AIDS. Practical involvement with PWAs is critical in addressing the challenge of HIV/AIDS prevention and support. Recognition of the HIV/AIDS pandemic as a community problem, by either educators and/or learners, was a significant factor in the way ABET centres responded to it. Identification of factors that influence the spread of HIV/AIDS could assist ABET centres in designing culturally and socially sensitive, yet effective, HIV/AIDS interventions.

Basic Knowledge

From the information gathered in interviews and discussions, it became evident that the quantity and quality of information available to learners at the ABET centres was quite varied, contributing to increased bonding capital (among learners) and bridging capital (between learners and other agencies) in Mbaleni, Mutangwa Mannugu, and Rivoni Centres. The study also revealed that learners' knowledge and attitudes were diverse. While some learners at Matangari believed that HIV/AIDS did not exist, in other centres, such as Mbaleni, Mutangwa Manugu and Rivoni, learners did believe that HIV existed. Those at Makahlule expressed uncertainty of its existence, claiming that they had never 'seen' anyone suffering from HIV/AIDS. This resonates with

research findings by Campbell (2003:26), that mineworkers in Carltonville, who had heard of HIV/AIDS through the mine educational programmes and on radio, nevertheless remained unsure about its existence because they had never seen anyone with symptoms.

Many learners at the centres claimed that they had never seen anyone with AIDS. This was one reason why they did not recognise HIV/AIDS as a problem in their community. Learners in all centres indicated that when people died, their HIV status was never revealed, with only the cause of death, such as pneumonia, or TB, being disclosed. This may obscure the extent to which HIV/AIDS affected the communities.

Regarding basic knowledge about HIV causes, symptoms and treatment, differences were evident in the various centres. Learners at Rivoni, Mutangwa Manugu, Mbaleni and Level 4 learners at Matangari had sound basic knowledge about HIV/AIDS. Lack of knowledge about it at Makahlule could explain why people believed that it was a result of witchcraft. But apart from the coordinator of Rivoni centre, neither learners nor educators could give an account of the magnitude of the problem in their community. This may be an indication that people are still not sufficiently informed about HIV/AIDS, or it may be a way of distancing themselves from a problem, or denying that there is one.

Many learners from different centres, apart from Mbaleni and Rivoni, believed that HIV/AIDS was other people's problem, not theirs. This reflects denial. Prostitutes and foreigners were believed to contribute significantly to the spread of the disease. As shown in chapter three, several studies have found that people locally and internationally tend to characterize HIV/AIDS as a disease of 'others'. Campbell (2003) described this behaviour as a psychological defence protecting the individual from anxiety through externalisation of the threat onto identifiable out-groups, such as homosexuals or commercial sex workers. This results in a sense of unrealistic optimism about one's own vulnerability, as with rape, commercial sex, or with excessive alcohol consumption (Campbell, 2003). According to Campbell (2003:123), an important requirement for translating knowledge into behaviour change is a feeling of personal vulnerability to HIV infection. In this study population, the 'othering' and

lack of a feeling of personal vulnerability to HIV infection, could prohibit the translation of knowledge into behavioural change.

Knowledge regarding treatment of HIV was scanty and mostly anecdotal. This may be a reflection of lack of firsthand experience of people living with it. On the other hand, it may be a consequence of the bewildering public positions on treatment taken by senior members of government. With such divergent beliefs, an intensive awareness campaign could address existing gaps in knowledge.

The ability of women to use safe sex practices within their relationships was found to be a severe challenge. This was attributed by learners and educators to cultural practices within male-dominated communities. Women's views reflected Ankrah's (1991:971) observation that women lacked decision-making power in matters of sex, were susceptible to infection from husbands to whom tradition permitted multiple partners, and felt a sense of helplessness because of ignorance of ways to change their situation. Coleman (1990) has argued that the quality of the information exchanged depends on the functionality of the relationships in which people are engaged. Women did not have confidence that men would act reliably and competently when it came to sexual relations with other women and condom-use. District officials and Centre Managers did not express confidence in the capacity of young educators, especially, to teach older adults about HIV/AIDS.

Learners at Mbaleni Centre expressed a high level of social trust in the ANC Women's League, and it appeared that women who engaged in voluntary activities organised by the League, and in meetings organised by the Civic Association, were more likely to exchange information with others, to act in concert with them, and to suggest initiatives to develop and support the community. Learners at Mbaleni, Mutangwa Manugu and Rivoni Centres expressed more confidence in their educators than those at Makhhlule and Matangari Centres, so there were some functional relationships which contributed to the exchange of information, and to learners' sense that it was possible to take charge of some aspects of their life.

Conclusion: This study has shown that openly discussing HIV/AIDS, and providing practical support for community members living with it, as was the case at Mutangwa

Manungu and Rivoni, dispels negative attitudes and beliefs about HIV/AIDS. Furthermore, the learners in all centres indicated that they wanted more information about HIV/AIDS. This provides an environment that is conducive for dealing with those areas in which the respondents lacked knowledge, and to extend existing knowledge.

Sources of knowledge about HIV/AIDS

The study highlights that there are various sources of knowledge about HIV/AIDS available in different sites. The learners in all centres cited TV, radio and newspapers as the major sources of information. The study also highlighted the importance of health workers and clinics as sources of knowledge about HIV/AIDS, these being the second most frequently cited. However, learners expressed reservations about the information and products (condoms) distributed at the clinics. The learners believed that government-issued condoms were unreliable, sometimes suspected of being rejects from other countries. The learners also doubted whether health workers at the clinic maintained confidentiality. Mistrust and suspicion of health workers was a factor in the exchange of information about HIV/AIDS.

It is worthwhile noting that the private medical practitioners (GPs) were not mentioned as sources of knowledge, probably due to the inability of the study population to access private practitioners because of their low economic status. Traditional healers were also not mentioned as a source of knowledge, despite some assertions that they could help people who consulted them during the early stages of the disease.

Some studies have indicated that family members can play an important role in disseminating information regarding the prevention of HIV/AIDS (Wilson et al., 1994). However, in this study, family members were not mentioned as a source of information regarding HIV/AIDS by any of the respondents in any of the centres. This may be attributed to cultural norms and values that prevent family members from discussing sex related matters.

Other sources of information/knowledge for learners at Matangari and Mbaleni included NGOs and churches. Religious leaders and faith-based organisations have

been said to play an active role in disseminating information in many parts of the world. For example, in Uganda, in 1990, the Islamic Medical Association of Uganda (IMAU) piloted an AIDS education project in rural Muslim communities that evolved into a larger effort to train local religious leaders and lay community workers. The Protestant Church of Uganda organised a workshop for Bishops and other religious leaders in 1991, and implemented an extensive AIDS education project in many dioceses (Huggle et al., 2002). Mbaleni Centre was the only centre that cited political organisations as a source of information regarding HIV/AIDS. This was unlike the situation in Uganda where high-level political support was believed to have set the tone in the fight against HIV/AIDS (Huggle et al., 2002).

Conclusion: In this study, the media, health workers, church and civic organisations were highlighted as the main sources of information about HIV/AIDS. Educators should utilise the local radio, newspaper as well as local TV programmes to disseminate information and should promote utilisation of health facilities and health workers as key partners in providing it. ABET centres should also seek representation in various community bodies for their voice to be heard.

Coping with HIV/AIDS

In all the ABET centres studied, apart from Rivoni Centre, claims were made by learners, educators and officials that no one had HIV/AIDS in their centres. At Mbaleni, Mutangwa Manugu and Rivoni Centres, community resources to support PWA were identified and accessible. Rivoni Centre had an on-site, in-house support centre, that provided material resources to PWA and there was a community partnership to facilitate the programme. While the district coordinator and learners at Makahlule Centre believed that little could be done to assist PWA to cope with HIV/AIDS due to lack of practical and material resources, other centres felt that networking with other community organisations and institutions would assist PWA to cope with HIV/AIDS. Apart from learners at Makahlule Centre, voluntary counseling and testing (VCT) was perceived to be important by learners, though they admitted that they could not bring themselves to use these services.

Conclusion: Issues of empathy, privacy, trust and confidentiality, related to the VCT, were of critical importance in encouraging learners and their communities to access

HIV VCT services. Most learners did not believe that empathy, privacy and confidentiality regarding VCT services existed in most health centres and hospitals. The success of Rivoni Centre in relation to the establishment and utilisation of VCT services could be attributed to the support and the trust learners received from health workers at Elim Hospital. The development of tolerant attitudes, as well as humane and effective systems of care for people with AIDS, was mentioned by Campbell (2003) as being a pillar for any prevention strategy.

Stigma and denial

Most educators and learners in all centres indicated that stigma and denial related to HIV/AIDS were rife, with contributory factors varying from one community to another. In most centres, fear of discrimination and isolation of individuals by the community greatly contributed to the reluctance to disclose HIV/AIDS, or to make use of VCT services in the various communities. This community response to the HIV/AIDS epidemic is not unique to the study area, various studies having shown that, worldwide, the most common response to the epidemic has been a community desire to see PWA isolated both socially and geographically. In a study conducted by UNICEF (2001), on the extent of perceived and enacted HIV/AIDS-related stigma in Zambia, India, Ukraine and Burkina Faso, the desire for isolation of PWA was a common theme. In Zambia, people in the community frequently reported putting physical distance between themselves and people suspected of having HIV/AIDS. Not shaking hands, not sitting next to such people in buses, not sharing food and drinking utensils, were all signals of rejection. In India, when an individual was known to have HIV/AIDS, the community was said to slowly reduce contact with the household. In some instances, loud proclamations about the person having AIDS were made in order to isolate and reject that person. Also documented were extreme examples of mass rejection (Francis, 2001). In a South African study conducted with women who attended family planning clinics in Johannesburg, 68.2% of respondents felt that PWA should be isolated in hospital wards (Francis, 2001).

The notion that HIV/AIDS is related to promiscuity and prostitution and a curse from God contributes to stigma and denial. As discussed in chapter two, similar beliefs were found to exist in several African countries. In Zambia and Burkina Faso, for example, churches preached morality, condemned immoral behaviour and viewed

HIV/AIDS as a punishment from God, with those infected likened to 'disciples of Satan'. As such, they were shunned in churches and in communities at large (Goldin, 1994).

Despite earlier claims by coordinators and educators that local clinics were supportive, learners at Mbaleni and Mutangwa Manugu suspected discrimination and stigma towards people known or suspected by health workers at local clinics to be HIV positive. They suspected that they would be given dismissive, perhaps humiliating treatment, if they presented themselves at the clinic with a sexually transmitted disease. These findings are similar to those in other studies worldwide, as indicated in a study by Aggledon (2001). PWA were reported to have been denied drugs, left in the hospital corridors, called names, subjected to degrading treatment and to have experienced breaches of confidentiality, when medical staff at HIV clinics were known to inform people attending the clinic about the HIV status of others. Stigmatisation in health care settings was evident in the negative attitudes of nurses, ward persons, doctors and technicians (UNICEF, 2001; Aggledon, 2001).

This means that HIV sero-positive members of these communities are often invisible and remain isolated from support systems. Individuals in rural areas are fearful of seeking testing, treatment, or support services, for fear of public exposure. This fear prompts mistrust of local agencies' abilities to maintain confidentiality, leading to under-use of HIV-related services. Studies have shown that in some rural communities denial has facilitated a corresponding lack of ownership of HIV/AIDS as a public health threat. Umeh (1997:171) points out that, given earlier low sero-prevalence rates, many rural communities have comfortably maintained a level of denial. Stigma, denial, isolation and rejection of PWA by communities may thus stand in the way of successful implementation of HIV/AIDS prevention and support programmes.

Conclusion: The study highlighted that stigma and denial related to HIV/AIDS was rife with contributory factors varying from one community to another. The development of any educational outreach targeted to facilitate a rural response to HIV/AIDS prevention and support must focus on efforts to decrease fear and stigma, while increasing a sense of community ownership of the disease. As observed at

Rivoni Centre, stigma and denial could be addressed through HIV/AIDS education and support programmes. The importance of HIV/AIDS education and support in fighting stigma is emphasised by Jones (2003:36), who points out that HIV/AIDS education should address the issues of stigma, discrimination, denial, rejection, guilt and anger. It is through education that a more tolerant and knowledgeable society will emerge. It is the educators' task to be a resource to help learners and to contribute to the formation of a community which is aware of the disease, and which is accepting and supportive of PWA.

Condom Use

The low rate of condom use among learners was reportedly due to several factors. The most significant barriers expressed by learners in all centres was male resistance to condoms. Such resistance is not a phenomenon unique to these centres. A large number of studies (Thornton, 2003; Webb, 1997) have shown that men objected to condoms on the grounds that they set up barriers of mistrust and suspicion between partners and reduced pleasure. As discussed in chapter two, men in Southern Africa have their masculinity intimately tied with 'flesh to flesh' sex (Webb, 1997), this being regarded as the only pleasurable way of meeting male sexual desires, and condoms being seen as cold and unpleasant (Campbell, 2003).

This study found gender relations to be one of the significant factors determining condom use in the prevention of HIV/AIDS. Being a woman was not associated with condom use (Kiggundu, 2001) and women were unable to negotiate condom use due to the cultural norms and values prevailing in the study population. Poor access to, or unavailability of female condoms hindered the promotion of safe sex, as women were at the mercy of their male partners in deciding when to use or not to use a condom.

Conclusion: Low rate of condom use was reported by learners in all centres. The study showed that men resisted the use of condoms, female condoms were not available and women were unable to negotiate condom use due to cultural norms and values prevailing in the study population. This study confirmed that knowledge alone was insufficient for condom usage to occur. Negative attitudes regarding their effect on sexual enjoyment certainly contributed to low usage. This was observed at Matangari and Rivoni Centres, where men admitted to not using condoms, despite the

knowledge they had about their being an effective preventative method for the spread of HIV/AIDS.

Traditional healers and HIV/AIDS

Beliefs about what traditional healers could or couldn't do regarding HIV/AIDS were diverse and contradictory. Learners at Makahlule Centre who lacked knowledge about HIV/AIDS were doubtful about the association between HIV/AIDS and witchcraft, and did not believe that traditional healers could cure AIDS. On the other hand, learners at Matangari Centre, with similar level of knowledge about HIV/AIDS, believed that traditional healers could cure all ailments, including HIV/AIDS.

Overall, learners from all centres acknowledged that traditional healers had a role to play in the prevention of HIV and support of PWA. They believed that traditional medicines could provide palliative treatment. Similar beliefs were established by Thornton (2002:9), in a study on traditional healers, medical doctors and HIV/AIDS in Gauteng and Mpumalanga. The traditional healers in that study also believed that they had a role to play in responding to the epidemic, and some felt that it could be 'cured' by traditional medicines, herbs or rituals. Surprisingly, despite their knowledge of HIV/AIDS, a few learners from Matangari and Rivoni Centres still held the view that traditional healers could cure HIV/AIDS, if consulted at an early stage.

Conclusion: Beliefs about what traditional healers could or could not do regarding HIV/AIDS were diverse and contradictory. While some learners and educators did not believe that traditional healers could cure AIDS, they believed that traditional medicines could provide palliative treatment. On the other hand some believed that traditional healers could cure all ailments including HIV/AIDS. This study concurs with Campbell's (2003:25) assertion that health education messages are not passively accepted by their audiences, but must compete with alternative beliefs, experiences and logics that may be more compelling than the information that the health educator seeks to impart. Recognition of the roles of traditional healers by medical science and authorities is critical if their cooperation and positive contribution to addressing challenge of HIV/AIDS prevention and support is to be achieved.

Gender, cultural practices, community challenges and HIV/AIDS

The major challenges highlighted by all respondents were ignorance, poverty, unemployment and certain cultural practices. These tallied with findings in several studies that have shown that levels of social inequality in South Africa are among the highest in the world (Campbell, 2003; UNAIDS, 2002). People's lives were characterized by extreme poverty that shadowed almost every aspect of their existence. One of the great tragedies of the epidemic is that it affects in greater numbers people who have been historically disadvantaged, such as women in rural areas.

Due to poverty, some women resort to prostitution in order to earn a living, and to support the households of migrant labourer husbands. Women in this study group portrayed themselves as being entirely dependent on men due to poverty, illiteracy and lack of employment opportunities. It has been noted that women had little or no power over what happened during sexual encounters because they were brought up to be subservient to men.

Women in the study, especially in the Mbaleni and Mutangwa Mannugu Centres, felt trapped and powerless to prevent themselves from being infected with HIV. They lived in fear of infection, yet they felt helpless or unwilling to leave their husbands, because of fear of starvation and because of the damage divorce or separation would do to their reputations. In a similar vein, Jewkes et al. (2003:126) confirmed that economic needs and dependency put women at further risk of HIV. Economically vulnerable women were highly dependant on men's financial contributions, and were thus less likely to succeed in negotiating protection, and less likely to leave relationships that they perceived to be risky.

Cultural practices, such as polygamy and circumcision aggravated the already precarious socio-economic situation that fuels the spread of HIV/AIDS in these rural communities. Alcoholism, violence against women, and child abuse, were highlighted as other factors in some of these rural communities that aggravated the spread. The migrant labour system exposed the women to the risk of HIV/AIDS from their husbands who worked in the urban areas and did not practice safe sex. Unemployed men, especially youth, resorted to drinking and use of drugs, and engaged in reckless

behaviour which presented a higher risk of contraction. These practices, and the challenges they posed towards addressing HIV/AIDS prevention and support, were echoed in all the ABET centres.

The case studies show that social capital is not always a positive resource. For example, in all centres, the norm was for 'respectable' women not to talk about sex, sexual relations, or sexually transmitted diseases with older or younger people. It is also a norm for women to respect, and acquiesce in men's decisions regarding sex, including the use of condoms. According to Coleman (1985), norms develop to permit group members some control over the actions of others when those actions have consequences for the group. In this instance, norms uphold the dominance of men in decision-making around sex, and prevent women from exercising control over their sexual health.

Conclusion: illiteracy, poverty, unemployment and certain cultural practices precipitated the spread of HIV/AIDS. Women felt trapped and powerless to prevent themselves form being infected with HIV/AIDS. The study highlighted that the most important aspect of slowing down the spread of HIV/AIDS would be to alter the broader social and material conditions that encourage high-risk sexual practices. These would include measures such a reduction in rural poverty, which makes it necessary for people to migrate in search of to work, and opportunities of employment for all. Campbell (2003: 38) argues that addressing social inequalities leading to the spread of HIV/AIDS involves on-going and long-term strategies. Furthermore, certain cultural practices should be addressed in order to reduce the spread of HIV/AIDS.

Education and support needs

Identification of educational and support needs of both educators and learners in the community is important for the planning and implementation of HIV/AIDS prevention and support programmes. Educators exhibited different levels of knowledge of HIV and how to support the community. An educator needs considerable knowledge to be a credible source of information. The greatest challenge the educators faced was how to identify community needs and interests, since people were not open about the extent of the HIV/AIDS pandemic and, in some centres, like Matangari, the learners were reluctant to talk about it. Educators in Makahlule and

Matangari had attempted at least a few initiatives to engage the community.

The general picture presented by ABET coordinators and some educators was that learners did not want to talk about HIV/AIDS, yet this research indicated that the reverse was true. In Makahlule and Matangari Centres, learners showed eagerness to learn the basic facts about HIV/AIDS. Learners in different centres spelt out specific issues regarding other aspect of HIV/AIDS that they wanted to know more about. For example, those at Mbaleni wanted to know about the origin of the disease and to acquire counselling skills. Learners at Mutangwa Manugu wanted to know more about the symptoms of HIV/AIDS, mother to child transmission (MTCT) and how to care for PWA. But this change of attitude among learners could have been due to the fact that the researcher was seen as an 'outsider', and therefore more reliable and confident than the educators who were part of the community, and thus less trusted with confidences regarding health and sex matters Whatever the case, the needs and interests of learner groups should be identified before awareness and support programmes are initiated.

Conclusion:

The greatest challenge faced by the educators was identifying community needs in relation to HIV/AIDS since people including themselves, reluctant to talk about it.[19] However during interviews with the researcher learners in different centres spelt out specific issues they wanted to know about HIV/AIDS. These points would enable the educator to focus efforts and limited resources on issues that will have the greatest impact among the learners in a given community. Issues such as the role of traditional healers in the management and support of HIV/AIDS affected people is one that needs clarification. Community sensitisation around HIV/AIDS, and destigmatisation are other issues that need to be dealt with if education and support for the community are to be successfully implemented. Lack of openness about HIV/AIDS in the communities poses a threat to planning and implementation of HIV/AIDS prevention and support programmes appropriate to the community needs.

[19] In some centres (Makahlule and Matangari) learners showed eagerness to learn the basic facts about HIV/AIDS.

National Policy on HIV/AIDS

National policy on HIV/AIDS provides a framework for the planning and implementation of HIV/AIDS awareness and support programmes in ABET centres. Its implementation also indicates a level of political commitment. Poor policy dissemination in ABET centres may be symptomatic of the absence of clear and decisive leadership in dealing with HIV/AIDS within the Department of Education and the government as a whole at the time of the study. Most educators at most centres were not following the stipulation to deal with HIV/AIDS as part of the integrated curriculum.

Conclusion: The study showed that the HIV/AIDS policy existed and was made available to ABET practitioners yet they did not read or discuss it[20]. Some practitioners were not aware of the existence of the National HIV/AIDS policy. The study shows that existence of national policy does not translate into practical, effective HIV/AIDS education programmes. This could be attributed to the lack of adequate structures and resources and political will to implement it. More resources need to be committed to operationalise of the policy. In this respect adequate dissemination, training and support of staff at all levels should be embarked on at both provincial and circuit levels. This will provide the impetus for the implementation and evaluation of the policy.

The results of such an approach are exemplified by the relative success of the Rivoni Centre. Despite the fact that the coordinator at the Rivoni Centre was not aware of the policy, the support, the commitment, networking and innovations initiated by the Centre made a significant contribution to the relative success of Rivoni Centre Nevertheless the success would probably be enhanced if a clear outcomes based framework were developed for a comprehensive and integrated HIV/AIDS prevention and support programme within the community, ABET centres and the Education Department.

[20] Most practitioners admitted to having received and kept it without reading it.

Organisational resources and constraints

This study identified the constraints faced by rural ABET centres in addressing the challenges of HIV/AIDS. The major constraints identified were lack of adequate operational funds, poor working conditions and poor staff morale, limited programme duration and contact time, lack of adequate infrastructure, low participation rates and high dropout rates, and poor networking. Similar constraints were highlighted in chapter two, as challenges which affect the effective running of ABET programmes in South Africa. These constraints directly impact on the ability of these centres to plan and implement effective HIV/AIDS prevention and support programmes

Poorly paid staff lacked the motivation to initiate HIV/AIDS education in the face of inadequate financial resources and insufficient infrastructure. But as previously mentioned, it is enthusiasm, passion and commitment that could turn a seemingly daunting working environment into an effective learning environment. For example, educators used their own money to photocopy learning materials at Mutangwa Manugu. It is vitally important that HIV/AIDS programmes select staff who have passion and commitment. AIDS activist Mkhondzenu Gumede, in Campbell (2003), argued that sustained passion and commitment by project workers was necessary to motivate action in groups of people, such as ABET learners in this study, who may have had little or no experience of engaging in collectively empowering activities. The challenge therefore is to turn round the effects of a poor working environment that weakens the ability of the staff and learners to effectively engage in HIV/AIDS prevention and support.

The prioritising of time constraints by the educators may also be indicative of the ignorance of how serious HIV/AIDS is in the community. It could also show a reluctance to change existing ways of doing things, even if these are known to be unsatisfactory. The Department of Education (DOE) needs to provide training and support to educators to enable them to integrate HIV/AIDS in the ABET curriculum.

Low participation and high drop out rates in ABET centres were linked to issues of poverty and unemployment. None of the respondents in this study mentioned boredom as a reason for non-attendance or dropping out**.** Possibly the voluntary

nature of the ABET programmes, coupled with the fact that learners did not pay fees, led them to undervalue the ABET programmes, and contributed to the instability of the programmes. There is no external pressure to attend classes, as is the case in formal schooling. Faced with other psychological, situational and structural barriers to participation, adult learners drop out and attend to other immediate and more pressing issues, such as getting employment and catering for family needs. This threatens the very existence of the centres and their impact in the community.

Conclusion:

The major constraints faced by rural ABET centres, as highlighted by the study, included lack of adequate operational funds, lack of support from the Department of Education, poor working conditions, poor staff morale, limited programme duration and contact time, lack of adequate infrastructure, low participation rates, high dropout rates and poor networking. In the face of the above constraints, proper planning and funding of the centres is required to enable them to fulfil their core functions. The DOE should develop the necessary human capital and provide appropriate infrastructure. Furthermore, ABET personnel at all levels should make programmes more attractive for learners to complete.

11.3 Key issues and action plan

The research has shown that because of the impact of the pandemic on the communities, the enormous constraints in the ABET centres and lack of appropriate support and focus from the government, it is imperative for communities, the centres, and the government in partnership to develop innovative strategies of overcoming these challenges. This may take time to achieve, yet, as highlighted by Crewe (2000) time is not on our side, and the engagement process must be expedited.

The table below highlights key issues that the study has explored in an attempt to establish how rural ABET centres are addressing the challenges of HIV/AIDS. The table further outlines the research results, recommendations and an action plan, based on the findings of the study, that could be adopted to improve the effectiveness of the strategies that the rural ABET centres are utilising in their attempt to address the challenges of HIV/AIDS.

Table 10 Table showing key issues and action plan

Key issues	Significant findings	Recommendations	Action Plan
Geographical setting and infrastructure • Communication • Infrastructure	Some centres were located in very remote areas with limited communication networks and poor social services	Improved access to means of communication to enhance social networks and social and material resource flow to the centres and communities. ABET centres' location/site should take cognisance of the existing infrastructure and accessibility to learners on inception. Phased development plans for the centres should be developed.	The government and private sectors should: -Establish phone linkages to enhance communication, exchange of information with relevant organisations. -Improve transport system/networks (roads, public buses). -Provide computers and encourage computer literacy. -Develop and implement a capital works/infrastructure development plan through funding from Department of Education and NGOs.
Organisational and operational aspects **Staff commitment and competence**	Some of the critical organisation and operational factors in ensuring development and implementation of HIV/AIDS awareness programmes in the ABET centres included: commitment of the staff to HIV/AIDS education, competence of the educators, learner characteristics, community	The Department of Education should conduct training, workshops and seminars on a regular basis. Staff training and development programmes must be drawn up according to specific needs of the educators and the curriculum. Employment constraints emphasizing performance with	The DoE and stakeholders should: -Develop, coordinate and implement ABET centre training programmes. -Establish staff training and development analysis and curriculum integration competence -Develop training and

	involvement, organisational resources and operational aspects.	key performance indicators should be drawn up for educators/coordinators. Improved conditions of employment including incentive based programmes to attract and retain educators in these rural centres should be entrenched.	development programmes. -Introduce attractive packages and work environment based on market related forces and best practices.
Profile of the learners	With the exception of Matangari and Rivoni Centres, learners and educators in other centres were mostly women	To engender social cohesion, connectedness and solidarity among groups and the communities in addressing HIV/AIDS, ABET centres need to design programme activities that attract both male and female members of the impoverished communities.	The community should actively participate in the development of centre programme activities to enhance buy-in for all groups.
Community networks and partnership	Apart from Rivoni and Mbaleni Centres, ABET practitioners did not establish meaningful partnership with community leadership. They were not aware of, or did not enter into any networks and partnerships with NGOs and other civic organisations (churches, traditional leaders etc)	ABET practitioners should encourage community involvement/input in the operational structures of the centres in decision-making regarding critical issues like programme design and implementation. -Establish meaningful working relationships/partnerships with grass roots community leadership	The DoE and ABET centres should encourage structural and formal community representations on the Centre Governing Body (CGB). ABET practitioners should establish ABET centre community forums through which the ABET centres could interact with other broad community networks to

		and other civic organizations such as churches.	promote mutual trust and reciprocity or for mutual benefit.
HIV/AIDS awareness	There were different levels of HIV/AIDS awareness. In Makahlule and Matangari, did not Recognise HIV/AIDS as a community problem. Learners indicated that they had never been in contact with PWAs. As such learners showed poor knowledge of HIV/AIDS and the educators took no initiative in addressing issues related to its prevention and support. On the other hand Mutangwa Manugu, Mbaleni and Rivoni educators who had a relatively good knowledge of HIV/AIDS and perceived it to be a serious problem in the community addressed the issue to a certain extent.	ABET practitioners should integrate HIV/AIDS awareness activities in all aspects of the centre activities. Department of Health and Welfare in collaboration with the DoE should Provide appropriate HIV/AIDS awareness programmes and information that takes cognisance of the education level, language and cultural issues of the recipients. -Give a human face to HIV/AIDS by involvement of PWA in the HIV/AIDS awareness campaigns -Create community sensitization about HIV/AIDS through an information campaign using local structures in collaboration with the centres e.g. civic organizations. -Identify high-risk behaviour including cultural practices and gender-power relationship issues. -Design programmes to specifically address these issues.	-ABET practitioners should contribute to the development of an integrated curriculum by providing basic HIV/AIDS information. -Educators should be oriented towards participatory methods of teaching. -ABET practitioners should invite PWA to be involved in public events to promote awareness. -ABET practitioners should organize community awareness programmes through HIV/AIDS ABET centre days and events.

Sources of Knowledge	Learners in all centres cited TV, radio and newspapers as the major source of information. Health workers and clinics, and churches and civic organisations were also cited. Medical practitioners and traditional healers were not cited.	ABET practitioners should utilise local radio and newspaper as well as local TV programmes to disseminate HIV/AIDS information. -Promote utilisation of health facilities and health workers as key partners in providing HIV/AIDS information. -Civic organisations and churches/faith based organisations to partner with ABET centres to share resources and expertise for coordinated promotion of HIV/AIDS awareness and support.	ABET curriculum developers and practitioners should encourage learning through major activities and dramas publicised on TV, radio/newspapers Newsletters. Community development competition through local media highlighting HIV/AIDS issues. ABET centres to seek representation in various community bodies for their voice to be heard.
Coping with HIV/AIDS	Apart from Rivoni, participants from other centres claimed that HIV/AIDS was not a problem in their centres. VCT was perceived to be important but learners admitted that they could not bring themselves to use these services because they did not believe that empathy, privacy and confidentiality regarding VCT services existed in their health centres.	ABET educators should Increase awareness of the HIV/AIDS pandemic through the use of participatory teaching methods. The Department of Health and Welfare should support community mobilisation organisations with support programmes for PWA. Promotion of VCT by the health and welfare practitioners and ABET practitioners.	Centre programme should include HIV/AIDS related community outreach programmes to support PWA and their families. The government should establish VCT services in collaboration with existing community health networks/clinics. PWA community support project

Stigma and denial	Stigma and denial related to HIV/AIDS was rife with contributory factors varying from one community to another. Learners suspected discrimination and stigma towards people suspected to be HIV positive by health workers at the local clinics.	The Department of Education should offer financial support to Community Based Research to establish factors that contribute to stigma and denial and ways in which these could be addressed. These could include: awareness campaigns and basic information. Promotion of positive living. Support to the community in dealing with PWA. Promotion of VCT, and provision of ARVs. Prominent community leaders should become involved in HIV/AIDS-related campaigns and support programmes. Strengthen PWA organisations in terms of funding and support.	The Department of Health and the DoE should carry out an intensive campaign specifically addressing stigma and denial. The government should support improvement in health practitioners' capacity and attitudes to handling PWA. The Department of Health should disseminate HIV/AIDS related statistics to specific communities via community leaders and organizations.
Condom use	Low rate of condom use was reported Male resistance to condoms being the most significant barrier expressed by learners in all centres. Women were unable to negotiate condom use due to cultural norms and values prevailing in the study population. Female condoms were not	Appropriate and culturally sensitive promotion of safe sex practices. Women's empowerment through education and reduction of poverty and dependency on men. Specific education to males regarding condom use and promotion of its use amongst them. Making available and promotion	The Department of Health should intensify its safe sex-promotion campaign and condom distribution networks through existing service-providers and other services.

	available.	of female condoms.	
Traditional healers and HIV/AIDS	Beliefs about what traditional healers could or could not do regarding HIV/AIDS were diverse. And contradictory. While others did not believe that traditional healers could cure AIDS, they believed that traditional medicines could provide palliative treatment. On the other hand some believed that traditional healers could cure all ailments including HIV/AIDS.	Traditional healers should be encouraged to promote HIV/AIDS awareness and to practice safe methods of healing to reduce HIV/AIDS spread. The role of traditional healers in addressing the HIV/AIDS challenge should be clearly communicated to community members through different forums including ABET centres	The Department of Health and DoE should encourage traditional healers' involvement in HIV/AIDS awareness projects e.g. condom distribution and promotion of safe sex practices, addressing myths about HIV/AIDS.
Gender, cultural practices, community challenges and HIV/AIDS	Illiteracy, poverty, unemployment and certain cultural practices Precipitated the spread of HIV/AIDS. Women felt trapped and powerless to prevent themselves form being infected with HIV/AIDS.	The ABET curriculum should address illiteracy, poverty, unemployment and certain cultural practices to reduce the spread of HIV/AIDS and support PWA.	ABET curriculum development units should integrate HIV/AIDS and gender related issues. The curriculum should directly address the unequal status of women in society.
Education and support needs	The greatest challenge faced by the educators was identifying community needs in relation to HIV/AIDS since people were not open and/or reluctant to talk about it. In makahlule and Matangari	Needs analysis amongst educators and learners to identify critical issues of HIV/AIDS education and support needs.	ABET Educators and Health practitioners should focus efforts and resources on issues that are critical in prevention of the spread of HIV/AIDS and support for PWA, e.g. safe sex practices, condom promotion,

	learners showed eagerness to learn the basic facts about HIV/AIDS.		denial and stigma, the role of traditional healers and leaders with regards to HIV/AIDS.
National policy	The policy exists and it is made available to the ABET practitioners yet they did not read it. (Most practitioners admitted to having received and kept it without reading it). Others were not aware of the existence of the National HIV/AIDS policy	Dissemination and education regarding the National Policy on HIV/AIDS.	The Department of Education should conduct workshops and in-service training for ABET practitioners focusing on the planning and implementation of HIV/AIDS awareness and support programmes based on the policy framework.
Organisational resources and constraints	The major constraints faced by rural ABET centres included lack of adequate operational funds, lack of support from the Department of Education, poor working conditions, poor staff morale, limited programme duration and contact time, lack of adequate infrastructure, low participation rates, high drop out rates and poor networking	Recruitment and training of appropriate staff members. Staff motivation Provision of appropriate infrastructure Make programmes more attractive to learners to complete. Improvement of working conditions	The Department of Education should provide proper planning and funding of the centres to fulfill their core function, and to develop the necessary human and capital resources

11.4 Recommendations

The study has highlighted the significance of ABET as a mechanism for incorporating illiterate and under-educated adults as active participants in the socio-economic, political and cultural life of South Africa. Despite the challenges faced by the ABET centres as highlighted in the study, ABET centres through their programmes can to play an important role in promoting health enhancing behaviour and supporting PWA in the rural communities. This is because they interact with learners on a personal basis and by using the participatory methods they are able to help adult learners to realize that they themselves have the capacity to identify how HIV/AIDS relates to them and what they can do about it.

Based on the findings of this study, several recommendations are made. These recommendations are aimed at improving the ways in which rural ABET centres address the challenges of HIV/AIDS.

- In order for HIV/AIDS education to be more effective, it must address the concerns of those who are socially and economically marginalized, such as the rural black women in the study population. It is incumbent on adult educators to encourage them to question some of the social and cultural practices that undermine their health and safety. However, it should be noted that practices are deeply rooted, and will not change overnight. Educational strategies for the short and long term are needed.

- With support from government, ABET programmes can refer women to appropriate healthcare and HIV/STD prevention services, HIV testing and counselling services, and encourage women to visit places where they can get condoms and care for STDs without embarrassment.

Community involvement networks and partnerships

- ABET Centres should expand their bridging social capital by collaborating and forming partnerships with existing organizations especially clinics, NGOs and religious organisations which are active in HIV/AIDS treatment and care, as well as awareness and prevention campaigns. This would be an effective method to address the problem of limited resources previously noted in rural communities.

- ABET practitioners should identify and involve sympathetic and influential community members, such as politicians, councillors, religious leaders and health workers. The micro level social networks, outlined in table 1 of chapter one, exist in rural areas and could be used by ABET practitioners to address HIV/AIDS prevention and support. For example, ABET practitioners could start by getting to know, and working together with, people at household level. They could ally and network with traditional leaders and religious structures. These often know the local families in depth, and community members generally respect them.

- Local pressure groups could be set up to fight HIV/AIDS in rural communities, and to support people infected with and affected by HIV/AIDS. Community based organisations and non-government organisations, such as funeral societies and *stockvels*, could help to provide capital and expertise to start small micro and medium enterprises that would provide an income for families affected by HIV/AIDS. Such ventures may be in the form of vegetable gardens, where community members would acquire skills for income-generation while at the same time solving the problem of malnutrition among children in the community.

- People living with, or affected by HIV/AIDS have an important role to play in education for HIV/AIDS prevention. They can use their life stories as a powerful motivating force to make the public aware of the disease and give it a face. They can also assist in the design and implementation of teaching programmes. Therefore, ABET practitioners should invite PWA to the centres to address and share their experiences with the learners[21].

[21] This was suggested by learners in almost all centres.

- The ABET curriculum should be adjusted so that HIV/AIDS education becomes an integral part of each learning area, and not be restricted to Life Orientation. Learners ought to be imbued with knowledge and skills, such as how to live with HIV positive people, healthy living and eating, the use of condoms, the importance of meaningful relationships, practicing honesty and faithfulness, talking about AIDS and helping the sick and the needy.

- Men, as well as women, need education about HIV/AIDS, and ways must be found to attract men to rural ABET centres. In trying to reach out to most people who are not participating in ABET activities, ABET practitioners must prioritise skills training programmes in ABET centres. To attract men into adult learning centres, income-generating skills such as welding, wire/fence making, carpentry, brick making and motor mechanics must be encouraged. To ensure successful participation, a needs assessment of potential adult learners in the community would be necessary, helping to understand the needs and interests of men. The study found that different centres have different needs, and consequently ABET practitioners should identify the needs of the learners in a particular centre. In order to ascertain these needs, policymakers and adult educators should consult adult learners about their learning needs.

- ABET educators should extend their traditional roles to respond to the needs of their communities. Educators need a paradigm shift that sees health care issues as one of the domains of their responsibility, not a territory only for health personnel. They need to involve themselves in aspects of physical, social and mental well-being, for themselves and their learners. This means that educators themselves should be well informed and trained in order to participate meaningfully or to impart information on health issues. To be well informed does not necessarily mean to be trained as a health a practitioner. Even knowledge about which health practitioners can best deal with a given situation is valuable.

- The adult educators must themselves be equipped with life skills, otherwise they cannot convey them to learners. Therefore, adult educators in this study should

improve their life skills by inviting professionals to address them, and attending appropriate workshops and seminars. However, this can only be attained by the financial support from relevant departments such as finance, education and health and welfare.

Stigma and denial

- HIV/AIDS education in adult education centres must focus on efforts to decrease fear, stigma and ostracism bestowed on PWA. ABET centres can be a safe place for learners to disclose their illnesses and fears, if educators encourage discussion of HIV/AIDS in class and outside it, provide information about care, nutrition and treatment, and themselves model compassion and tolerance. ABET centres can help to build the self-esteem of rural women, to recognise themselves as decision-makers and actors in their own right.

- In order to minimise the problem of *'othering*', ABET educators should foster positive attitudes and provide a supportive learning environment by focusing on HIV/AIDS as a rural community issue, rather than an urban or other people's issue. As such, HIV education should help learners to frame the issue in a way that would result in positive community responses.

Knowledge, beliefs and practices regarding HIV/AIDS

- Individuals hold a variety of misconceptions about HIV/AIDS. For example, beliefs that sleeping with a virgin or an animal can cure AIDS, the idea that traditional healers can cure AIDS and the misinformation about how the AIDS virus is transmitted. To appropriately address such misinformation, the educational AIDS message must be delivered in what Umeh (1997) - as discussed in chapter two of this thesis - referred to as a culturally competent manner that makes effective use of skills, resources and knowledge that are pertinent and responsive to the cultural values and norms, strength, needs and self-determined goals of the learner. In short, educators should be taught to provide HIV/AIDS

education in a manner that is respectful of cultural differences inherent in rural settings.

Gender, cultural practices, community challenges and HIV/AIDS

- According to Freirian theory, education should be cultural action for freedom, and every person should learn in order to transform his or her own environment. ABET programmes should reinforce women's economic independence by introducing women to existing training opportunities, credit facilities, saving schemes and women's co-operatives. These could be linked to AIDS prevention activities. For example, women can form a cooperative that would give them interest-free loans. With these, they can start small income generating activities and will not have to exchange sex to earn a living.

- ABET programmes should strengthen the role of older women in the prevention and control of HIV/AIDS. The empowerment of learners through education could be important for AIDS prevention. In the first instance, older women would be able to apply their new knowledge to prevent their own infection. Secondly, ABET learners, both men and women, would become an important health resource, because they would learn to discuss and negotiate with others and educate their families, neighbours and communities about HIV/AIDS prevention and care.

- ABET programmes should provide a basis for social support for women who are struggling under existing gender norms, by giving them opportunities to meet openly in communities and providing them with adequate resources.

National Policy

- A National Policy on HIV/AIDS exists but has been undermined by the government's inability to provide adequate resources and support for ABET centres to conduct effective programmes, especially those related to HIV/AIDS programmes. The prevailing circumstances under which educators work constrain

them. The only resource is to appeal to eduators' sense of responsibility so that they take a leading role in developing initiatives to overcome the constraints. This should be coupled with proper training of ABET practitioners at all levels and dissemination of the National Policy on HIV/AIDS.

Organisational resources and constraints

- To address the problem of shortage of HIV/AIDS teaching and learning materials, the provincial education department must make an effort to ensure that there are sufficient and relevant learning materials available at ABET centres. Efforts should also be made to provide learning materials in local languages, at a level accessible even to readers with limited reading ability. These resources should be laid out to maximise accessibility by learners, so that they and the community at large can read, understand and work through them on their own.

As already highlighted in the study, ABET centres lack many of the resources to effectively address the challenges of HIV/AIDS prevention and support. In light of the prevailing situation, what then need to be addressed are practical approaches and initiatives, that can be developed and implemented to enable the ABET centres to play an effective role in HIV/AIDS prevention and support.

At this level the ABET programmes hold a special brief for illiterate women in rural communities and have a de-facto responsibility of training on issues of HIV/AIDS prevention and support. Such training should not only entail the dissemination of factual information but should also facilitate the development of relevant skills, attitudes and behaviours which will result in the ABET learners' being able to effectively avoid HIV infection and support people both affected and infected with HIV/AIDS. This calls for new teaching strategies.

One way of achieving this is by the use of participatory learning methods. Recognition should be given to the wealth of relevant knowledge and experience that ABET learners possess and can share with peers and their educators. Educators should be trained in the use of participatory methods in the various ABET programme activities.

The main objective in providing education on HIV/AIDS prevention and support should be to encourage behavioural change. In HIV/AIDS Education, giving out information on its own has not been found to result in behavioral change. In fact if a learning group is continually given information by an 'expert' they are made to feel powerless and helpless and can begin to feel that the problem is not their problem at all, but some one else's.

Participatory methodology can be defined as the process in which various groups are involved in identifying their own problem, discussing solutions planning and carrying out effective action programmes. The aim of participatory education is to facilitate a process whereby the learner identifies and analyses problems and looks for solutions. In this way, new knowledge and information are introduced in a way that is relevant and practically useful to the learners (Kiggundu and Swierstra, 2002).

One important aspect of participatory methods is that the process of learning through dialogue fosters a sense of common experience. It is reassuring for anyone to discover that others share their own personal fears and problems, and with others they can look for solutions (Ministry of Education and Culture, 1995). Adult educators in these centres should focus on their learners' concerns about HIV and AIDS and take is as one of their responsibilities to deal with them. In this way the learners become more open about HIV/AIDS and thus seek solutions to and /or understanding of the challenges that they face.

Participatory methods include: role-play, poetry, song picture code, case studies, small group discussion, brainstorming, buzz sessions, panel discussion, devil's advocate, debate, to mention but a few. A brief description of the following methods is undertaken below: role-plays, poems and songs, and picture code. The descriptions briefly explain, using examples what the methods are, how the adult educator can use them and why they should be used.

Role-plays

In role-plays the adult educator encourages the learner to imitate someone else. This is often easier than having to express one's own ideas; learners may end up expressing themselves through another character (see appendix 4.1).

Role-plays allow adult learners to practice situations before they encounter them in real life. For example a role-play may be 'how to say no to sex' or 'talking to a partner about how to use a condom'. This preparation will help provide the skills adult learners need to protect themselves from becoming infected with HIV/AIDS.

Poetry and Songs

Poetry and songs are popular forms of expression among adults who find it difficult to express feelings in other ways. Poetry is a form of expression through which a poet conveys thoughts and feelings. Adult educators may use poems that are written on a topic to provoke discussion or may encourage pupils to express their own thoughts and feelings by writing a poem. Songs, too, can be used very effectively by both adult educators and learners to spread messages about HIV/AIDS in their local communities. If the tune is catchy and the message is clear, people will remember the song and the information it contains. After a poem has been read the educator can request the learners to discuss questions derived from the poem to bring home the pertinent issues (see appendix.4.2)

Picture code

A picture code is a poster-size visual aid which illustrates a problem. The problem illustrated should reflect a community concern about which people feel strongly. Adult educators can present a picture code to a group in order to encourage discussion and help the group acknowledge that the problem depicted is occurring in their own community (Ministry of Education and Culture, 1995). Picture codes were used by educators at Mutangwa Manugu Centre at the beginning of a sensitive topic to focus the attention of the group on a particular problem and to facilitate an interesting discussion. An example of the picture codes used was one about an unfaithful partner (see appendix 4.3).

It is of great importance that educators attend professional upgrading courses so that they can be oriented towards and/or trained in the use of participatory

Adult Educators should also form a network of educators where they can meet and discuss, share ideas, frustrations and fears amongst themselves. However, this could be problematic since most of the adult educators are temporary, contract employees. These ideas can be implemented if there are permanent staff members in ABET centres and continuity in leadership, consistency and dedication among ABET practitioners at all levels. Nevertheless the ABET practitioners at all levels need to position themselves strategically, by highlighting their potential role in the fight against HIV/AIDS, in order for them to lobby the Department of Education about the importance of ABET so as to get more support and funds from both government and other funding organizations.

1.5 Conclusion

This study has highlighted the ways in which rural ABET centres address the challenges of HIV/AIDS prevention and support in Region 3 (Vhembe District) of the Limpopo Province of South Africa. Using case studies of five ABET centres, the study highlighted current practices in rural ABET centres regarding HIV/AIDS prevention and support. Interviews with district coordinators, educators and learners provided a widow through which the community response to the HIV/AIDS could be viewed.

The research showed that human, social, structural and infrastructure constraints that are currently faced by the centres hinder their ability to play an effective and meaningful role in dealing with the HIV/AIDS pandemic. These constraints, in many ways, defined the manner and effectiveness in which the ABET centres and the communities have addressed the challenges of HIV/AIDS prevention and support.

Based on the findings of the study, recommendations were made that could assist ABET centres in addressing the challenge of HIV/AIDS prevention and support more effectively. In conclusion, notwithstanding the magnitude of the challenge posed by HIV/AIDS, ABET centres through an acknowledgment of their role, and in collaboration with other stakeholders, can make a meaningful contribution in curtailing the spread of HIV/AIDS and supporting the people affected by HIV/AIDS in the communities in which they operate.

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