PRINT: ISSN 0970-9274 ONLINE: ISSN 2456-6608
J Hum Ecol, 46(3): 319-330 (2014)
DOI: 10.31901/24566608.2014/46.03.07

Exploring Knowledge of and Burden Felt by High School Learners with Parents Living with HIV and AIDS

Reyagalaletsa Tom and Pilot Mudhovozi

University of Venda, Thohoyandou, South Africa

KEYWORDS HIV and AIDS. Orphans. Learners. Support Group. South Africa

ABSTRACT The study ought to investigate the burden felt by children of AIDS patients. A cross-sectional descriptive survey was conducted. Stratified random sampling was used to select 83 learners (grade 8 = 14; grade 9 = 20; grade 10 = 20; grade 11 = 29) from four grades. A questionnaire was used to collect data. Descriptive statistics were used to analyse data. The study found that most of the learners had knowledge of the HIV positive status of their parents. Challenges that the learners experienced include discrimination, stigmatization, heavy family responsibilities and psychological distress. Strategies for reducing the burden include the introduction of HIV and AIDS programme in the community, peer support and counselling. Future research with a wider sample for generalisability of findings is recommened.

INTRODUCTION

Sub-Saharan Africa has the highest rate of new infections, people living with AIDS and deaths resulting from AIDS compared to other regions in 2006. South Africa, situated in the Sub Saharan region had approximately 5.5 million people living with AIDS (UNAIDS 2006). Consequently, this resulted in high rates of death due to AIDS in the year 2005. Between 1997 and 2006 for instance, the South African Department of Health (2009) reports that the annual number of registered deaths rose by 91%. The rise was most significant (170%) among the 25-49 years age group in the same nine-year period. Further analysis of the above figures shows that between 1997 and 2004, the death rate among men aged 30-39 more than doubled while among women aged 25-34 more than quadrupled (AVERT 2009). The inability to moderate cultural circumstances is believed to be a factor in the high and rising HIV prevalence among relatively older women. The tragedy of this scenario is that most HIV-infected South Africans do not know about their HIV status (Mwamburi et al. 2005). It was noted that social stigma associated with HIV and AIDS was the major impediment. However, recent studies suggest that HIV prevalence now appears to be stabilised and even declining slightly. The drop is believed to be due to a change in safer sexual practices among the more sexually active age group (AVERT 2009).

According to Pembrey (2009), South Africa has the fastest growing epidemic in the world. In May 2001 at least 4.7 million South Africans were reported to be HIV positive. Infection rates varied by Province: 8.7% in Western Cape, 29.3% in Gauteng, and 36.2% in Kwazulu-Natal. The survey estimated a national prevalence rate of 11.4%, with the predominantly rural Free State province being the most severely affected (14.9%). HIV and AIDS prevalence amongst 15-49 age groups was 15.6%. The same study found that 13% of children in South Africa aged 2-14 years old had lost a mother, father, or both and that 3% of households were headed by a child between the ages of 12-18 years. AVERT (2010) states that at the end of the year 2007, there were approximately 5.7 million people living with HIV in South Africa, with almost 1000 AIDS deaths occurring every day. A recent survey estimates that almost half of all deaths in South Africa, and 71% of deaths among those aged 15 and 49 are caused by AIDS (Pembrey 2009).

The problem of children starts long before the death of a parent. Death is merely the culmination of a period of sickness, often followed by inadequate family guidance and emotional support to education (Gabriel et al. 2009). A decline in school enrolment has been observed in many sub-Saharan countries and is widely reported (Editor 2003). When a parent becomes ill, the education of the child is disrupted (De Wagt and Connolly 2005). A study conducted in Ugan-

Address for correspondence:
Dr. Pilot Mudhovozi
Department of Psychology
University of Venda, Private Bag X5050,
Thohoyandou, 0950, South Africa
E-mail: peemudhovozi@yahoo.com

da shows that 26% of children reported a decline in school attendance and 25% reported a decline in school performance when parents become ill. The study also revealed that parental illness lowers school attendance because children stay at home to care for sick parents. They also reported to have increased household responsibilities and need to care for younger children. In addition, children affected by HIV and AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services (Richter 2010).

The spread of HIV and AIDS in many of the countries of sub-Saharan Africa has greatly exceeded the most pessimistic projections of a few years ago. The region reported to be most affected by AIDS and subsequently the one with the most children orphaned by the disease is sub-Saharan Africa (PlanUSA 2008). It was estimated that about 40 million African children were to be orphaned the year, 2011. For instance, Nigeria was reported as leading with 1,800,000 children orphaned due to AIDS, followed by South Africa with 1,100,000. This is approximately one child in every 14 seconds (PlanUSA 2010). Furthermore, an estimated 1600 children are born with HIV every day. Nine out of 10 newly-infected children live in sub-Saharan Africa, as do every 8 out of every 10 women living with HIV and AIDS. Across sub-Saharan African countries, AIDS is taking a devastating toll in human suffering and death. The AIDS pandemic is disrupting social systems, exacerbating poverty, reducing productivity, wiping out hard-won human capacity, and reversing development gains (Kelly 2000).

In sub-Saharan Africa, fewer children are enrolled in schools as a result of poverty, being orphaned, trauma or the stigma of having an infected parent or a close relative (USAID 2001). Without anyone to care for them, orphaned children face the threat of malnutrition, family breakups, health problems and discrimination. They often lose property that once belonged to their parents and end up on the streets (PlanUSA 2010).

Also, children, especially girls and orphans drop out of school to take care of sick family members or to support their families. On the other hand, a disproportionate number of orphaned boys fend for themselves on the streets (USAID 2001).

HIV and AIDS Awareness

Knowledge of HIV and AIDS among youth is generally good (Hartel 2005; Shisana et al. 2014). However, a study by Harvey (1997) showed that among Zulu- speaking grade 10 learners, more than a third reported being sexually active, with some having more than one partner. Furthermore, less than half of all students (42 percent) acknowledged that having one uninfected partner was an effective preventive measure. Almost a quarter of the learners reported having been treated for a sexually transmitted disease in the past. The study further revealed that more than 50 percent of the sexually active learners never used a condom. The misconceptions about condoms resulted in the rejection of their use (Hartel 2005; Shisana et al. 2014).

The government's strategy emphasizes promoting public awareness and delivering life skills and HIV and AIDS education (Media Club South Africa 2010). According to the report, the many AIDS awareness campaigns run by the government and Non Governmental Organizations (NGO's) such as Love Life and Soul City are bearing fruit. It further reports that there is now a high level of awareness among youth on HIV and AIDS that is around 90 percent. In addition to Love Life and Soul City, the other campaign that has been successful in the past was Khomanani. It was a government led communication campaign that provides an awareness-raising drive to mobilize individuals and organization to respond to challenges of HIV and AIDS, tuberculosis, and sexually transmitted diseases.

Burden on Children

According to Gabriel et al. (2009), the first areas to be affected when a child is orphaned are their academic performance and self-concept. A good quality education is considered one of the key defenses against HIV. Studies in many countries have linked higher education level with increased HIV/AIDS awareness and knowledge, higher contraceptives use and greater communication on HIV prevention among partners. Evidence shows that secondary education can significantly reduce pupil's vulnerability to HIV. Since those years of schooling boost skills and good opportunities they need to achieve greater economic independence, schooling acts as a

protective factor (USAID 2001). Overall, literature indicates that HIV and AIDS affect learners in a multi-faceted way.

Orphanhood by AIDS has been associated with low self concept due to stigma by society (Gabriel et al. 2009). Self concept is how a person characteristically feels about oneself. The main factors determining the formation of self concept of an individual are the environment as well as people with whom the individual lives (Meyer et al. 2003). These people are regarded as significant others and they include parents, teachers, peers, and siblings. For example, if parents praise and love a child, if playmates respect and give attention to the individual, he/she forms a picture of himself/herself as a desirable person and hence develops a positive self-concept. On the other hand, if the parents and peers reject and criticise the individual and are indifferent, this leads to a negative self-picture resulting in inferiority feelings. Relations with family members and peers may, therefore, influence the child' personality trait (Gabriel et al. 2009). In most cases AIDS kills both parents, the child can therefore be left isolated, with no one to give love and praise; this can lower a child's self-concept and in turn can have a negative impact on academic performance (Gilborn 2003).

People in the community may discriminate against children who have family members with HIV, who have been orphaned by AIDS (UNICEF 2014). Neighbours may keep a distance for fear of infection and often gossip about the infected parents, while peers may tease and isolate the children (Gilborn 2002). Children may not perform to their full potential and they may face stigma and discrimination at school (UNICEF 2014). The discrimination puts children at higher risk of abuse and social exclusion, and they may be denied basic needs such as having their school fees paid (Coombe 2001).

HIV and AIDS have led to the emergence of child-headed households in which there is no adult and where children must fend for themselves (AVERT 2009; Bennel et al. 2001). They help with household chores, take care of the sick, or care for younger siblings. These responsibilities foreshorten normal childhood and interfere with schooling because often the child may be forced to be absent from school (Gilborn 2003). Pembrey (2000) asserts that children may have to work to supplement household income, reduced when ill adults cannot work and savings are spent on medical treatment. Some children often lack inheritance rights, are forced to leave school and, as a result of poverty, may resort to crime or prostitution. Some may be forced into early marriages or begging in the streets. A significant number of children are at risk of contracting HIV themselves through virtually inescapable income-generating prostitution. One learner reported that "you need money for school and it's expensive, or your parents may be unemployed" (Lewis 2009). The learner further reported that they get attracted to a man with money, not knowing that he is infected. That is one of the reasons they contract the virus at a young age.

Children who watch their parents suffer and die undergo severe emotional distress. The psychological impact of witnessing a parent dying of AIDS can be greater than for children whose parents die from sudden causes. In the context of AIDS, there may be long periods of stress, suffering and uncertainty before the parents die. Worries about future survival can add to a child's already high stress levels (Coombe 2001). Children may feel that life is unfair and be asking themselves questions like: "What am I going to do now that my father and mother are dead?", "Who's going to take care of me?" The child may also believe that because his/her parents died of AIDS, therefore they were immoral people. Ongoing emotional distress can lead to problems such as depression and aggressive behaviors. Some may be so traumatised by what they experienced when their family died of AIDS that they find it difficult to learn at school (Pembrey 2009). This may further complicate their situation as they may end up dropping out.

Loss of parents may often leave a child with no other options, but to stay with extended families. The emotional loss they experienced at the death of a parent is compounded by the relocation they subsequently undergo (Bennel et al. 2001). With the increase in mortality among adults, the burden of caring for orphans is often carried by grandparents, who may find it hard to cope physically and economically. Other children may have to go and live with other extended family members like aunts or uncles, who also live with children of their own (Coombe 2001). Within the new surrogate family, orphans are frequently at a disadvantage compared with biological children. These orphans often come last in line when food is being apportioned, carry a

disproportionately large share of household chores, and do not participate in school to the same extent as children who are not orphans (AVERT 2009, 2010). They also experience greater health risks than non orphaned children and are more likely to be stunted and malnourished. Due to these circumstances, these children may be forced to run away to the streets and as a result drop out of school.

The 1999 South African October Household Survey revealed that as many as 35 percent of rural African children between the ages of six and seventeen years do not attend school (Richter 2010). In 2000, a survey of 771 AIDS-affected households in three provinces found that more than 10 percent of households removed girls from school compared to 5 percent who removed boys. These findings show that HIV is reducing numbers of children especially girls in school (UNAIDS 2004).

The prevalence of HIV and AIDS and its impact is likely to put more pressure on some learners to remain at home to care for ailing family members, do household chores, or find employment. Other learners have to care for their siblings in child-headed households, they may be absent because they don't properly eat and therefore become sick (Weideman et al. 2007). Motala et al. (2007), however, note that HIV and AIDS is more likely to have a greater impact on the school attendance of older children rather than the younger ones. A decline in school enrolment is one of the most visible effects of the epidemic. This has an effect on HIV prevention, as a good basic education is among the most effective and cost effective means of preventing HIV infections (AVERT 2010). Lewis (2009) states that in many places the cycle repeats itself. HIV and AIDS leads to dropping out of school, which further result in a low chance of finding a good employment and therefore dependence of women on men.

Pupils in the context of HIV and AIDS face many livelihood problems including lack of lunch, clothes, parents, and a favorable school environment (Kakuru 2006). Others are compelled to go without learning materials such as books, and school uniform. In addition, children in the context of HIV and AIDS may be under nourished due to lack of financial support. This can result in lack of concentration at school and a range of other symptoms which affect the ability of a learner to engage effectively in the learning process (Weideman et al. 2007).

Lessening the Burden on Children

It is reported that South Africa has over 28 000 schools reaching approximately 11.5 million children. The education system is therefore the one that is well suited for child well being and development (Meintjies and Griese 2004). Schools are relatively accessible to children and it is where they spend a significant proportion of their time, over a period of several years at school. According to UNESCO (2004), understanding what HIV infection is, how it is spread, is said to be the precondition for changing the behaviour that causes it. Furthermore, it mentions that knowledge does not guarantee behaviour change but it can be an essential base. It can reduce misconceptions, lesson vulnerability and also provide knowledge about what to avoid in order for one not to get infected.

Schools have a responsibility to help learners develop skills which equip them for positive social behaviour and for coping with negative pressures of HIV and AIDS (Kelly 2000). According to Tillotson and Naharaj (2001), South African learners are aware of HIV and AIDS but are confused by the many myths relating to the disease. This prevents them from protecting themselves. Porteus (2001) adds that although young people know a lot about HIV; how it is transmitted, the symptoms, and diseases related to HIV and AIDS as well as how it is prevented, a large number of them do not act upon this knowledge and as a result, the incidence of HIV infection among youth continues to rise. Management of HIV and AIDS awareness programs is therefore of importance in schools (Tillotson and Naharaj 2001). The authors seem to agree with each other when it comes to schools being an important source of information and therefore behavioural change. However, like UNESCO (2004) mentioned, it is up to a learner to act upon the knowledge so as to bring a positive behavioural change. Schools merely provide the knowledge and the rest is up to learners.

According to Louw et al. (2001), the Department of Education should be willing to assist both affected educators and learners, even if it is only by giving emotional support. In this way, learners will be able to restructure their lives and take precautionary measures to avoid contracting HIV. The support can also be achieved through formation of school support group whereby learners affected by HIV and AIDS can

support each other. This can also be formed in the community (Tillotson and Naharaj 2001). Educators should allow learners affected to take their medication when necessary and learners who develop behavioural problems should be assisted to cope with the emotional trauma associated with HIV infection (Louw et al. 2001).

Most educators dealing with HIV and AIDS awareness programs state the need to be trained to handle the program efficiently and acquire skills to help learners who are affected or infected (Coombe 2000; AVERT 2010). Coombe (2010) adds that educators need constant in-service training, they feel that there's a need for further training to keep abreast with the developments of HIV and AIDS awareness programmes. Training educators in HIV and AIDS awareness programm will empower the teachers to meet the challenges posed by HIV and AIDS in schools (Sergiovanni 1994).

HIV voluntary counselling and testing (VCT) programs are available in South Africa. It is reported that the number of VCT sites in South Africa has increased significantly in recent years, with 4,172 operational by November 2006 (AVERT 2010). VCT programmes serve the purpose of providing the community with access to HIV testing so that they can know their HIV status. In this way, it contributes to the prevention of new infections because even if one tests negative, the associated counselling may help the individual identify high-risk behaviour and therefore positive behaviour change may result (AIDSInSite 2010). VCT programmes also help to normalise and destigmatise HIV and AIDS. Frequently, employees approach the clinics only once they have fully-blown AIDS and when it might be too late to begin an effective treatment (AngloGold Ashanti Annual Report 2006). To counter this, the report stated that it is important that employees attend VCT centers, know their status and understand how either to prevent themselves from contracting HIV in the future or how to deal with the disease should they test positive. VCT centers can therefore contribute towards reducing a number of orphaned learners and thereby the effects of HIV and AIDS on their schooling.

The antiretroviral drug treatment was made available to the South African public in 2004 by the Government so that HIV-positive people can maintain their health and often lead relatively normal lives. Unfortunately, though, not every South African has access to this treatment. When everyone can access this treatment, this can reduce the alarming rates of AIDS deaths, and therefore reduce a number of orphans throughout the country (AVERT 2010). In a debate at the 5th international AIDS society (AIS) conference on pathogenesis, treatment and prevention in Cape Town it was stated that ARVs not only treat HIV infection but also prevent new infections, and eventually eradicate the virus almost entirely (Africa Good News 2009).

So many HIV and AIDS studies in South Africa and globally have been carried out especially targeting adults. Fewer researches have been done on the effects that the disease has on children's schooling. More so, the survival chances of children born with the disease continues to rise due to Anti-Retroviral drugs (ARVs), community awareness, voluntary testing and counselling services (Gabriel et al. 2009) as this increases the number of infected and affected children who need psycho-social support. A considerable number of such children are presumed to be in school. The therefore sought to fill the information gap on the effects of HIV and AIDS on schooling.

Goal of the Study

The study sought to investigate the burden felt by high school learners with parents affected by HIV and AIDS.

Research Questions

The study was guided by the following questions:

- Are learners aware of HIV and AIDS and its consequences?
- What challenges do learners whose parents have HIV and AIDS experience?
- What strategies should be used to reduce the challenges?

METHODS

Research Design

In the present study, a descriptive survey design was used to describe data through the use of numbers (Key 1997). The descriptive survey design was employed to guide in planning and implementing the study in a way that ex-

plored knowledge of and burden felt by high school learners (Burns and Grove 1993). The design describes systematically the facts and characteristics of the population and area of interest, factually and accurately (Isaac and Michael 1983; De Vos et al. 2005).

Sample

The population in this study comprised of all learners at a high school in Thohoyandou community. It consisted of day learners and the grades ranged from grade 8 to grade 12. The sample had 83 learners (grade 8 = 14; grade 9 = 20; grade 10 = 20; grade 11 = 29) who were drawn from four grades. There were 49 female and 34 male learners. The sample did not include grade 12 learners as they were writing final year examinations.

A stratified random sampling method was used to select the participants. Huysamen (1994) describes a stratified random sampling as the one that is composed of various, clearly recognizable, non-overlapping sub-populations or strata which differ from one another in terms of the variable in question. The four grades were the strata from which the participants were drawn.

Procedure

Permission to carry out the study was obtained from the Head of the school and the date for the administration of the questionnaires was agreed upon. The learners were randomly chosen from grade 8 to 11 with the help of one of the educators. During data collection an informed consent was obtained from the learners. The participants were then informed of the procedure used and what was required of them. Afterwards, the questionnaires were then group administered in a hall. Group administered questionnaire ensured that the researchers were present to give instructions and clear up possible uncertainties to the learners (De Vos et al. 2005). A total of 83 questionnaires were distributed and all were returned. Thus, a questionnaire return rate of 100 percent was realised.

Measuring Instrument

The self-developed questionnaire was used in the study. The questionnaire had two sections. Section A gathered the demographic profiles of the participants. Section B had items on learners' awareness of HIV and AIDS, the challenges faced by learners whose parents were affected by HIV and AIDS and suggestions for reducing the negative impact of HIV and AIDS. A questionnaire is a highly structured data collection instrument whereby each respondent is asked much the same set of questions (de Vaus 1996). It ensured that same questions were presented to all participants at the same time, saving time for the researcher. Since the participants filled the questionnaires on their own, the opinions or the visual clues of the researcher did not influence them to respond to the questions in a certain manner.

Data Analysis

The study used descriptive statistics which include frequencies and percentages to analyse data. Descriptive statistics provide simple summaries about the sample and the measures (Trochim 2006).

Ethical Considerations

The researchers obtained permission to conduct the study from the school principal. Consent to participate in the study was obtained from both the school that acted in loco-parentis and the individual learners. The participants were informed about the purpose of the study and participation was voluntary. Anonymity and confidentiality were maintained throughout the study. Participants were assured that data were to be used for academic and research purposes only. These measures were taken to improve the quality and honesty of responses, and to encourage participation in the study as well as protect the participants' privacy (Reaves 1992). The participants were therefore informed that they were not required to write their names on the questionnaire.

RESULTS AND DISCUSSION

Fifty-nine (71%) of the participants were aware of HIV and AIDS and its consequences. The remaining 24 (29%) had information gaps on HIV and AIDS (Fig.1). Table 1 shows that the common challenges that are experienced by learners affected by HIV and AIDS include heavy

family responsibilities, drop in school performance, rejection and discrimination. Table 2 shows that the common strategies for reducing the challenges faced by learners affected by HIV and AIDS include the establishment of HIV and AIDS programme at community level, peer support and counseling.

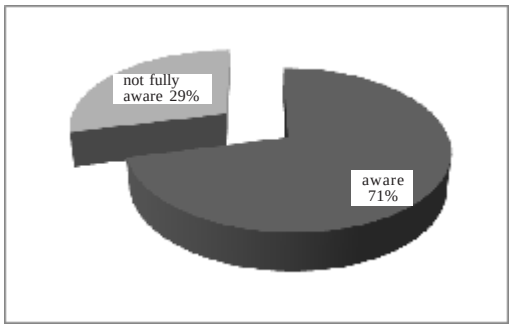

Fig. 1. Knowledge of HIV and AIDS and its consequences

Table 1: Challenges experienced by learners with parents living with HIV and AIDS

Challenge	*Frequency*	*Percentage*
Discrimination	54	65
Rejection	68	81.9
Isolation	7	8.4
Stigmatisation	27	32.5
Heavy family responsibilities	82	98.8
Drop in school performance	70	84.3
Late arrival at school	13	15.7
Psychological distress	40	48.2
Caring for sick parents	13	15.7
Worried that parents will die	5	6

Table 2: Suggested strategies for reducing the challenges

Strategy	*Frequency*	*Percentage*
HIV and AIDS programme in community	63	75.9
Counselling	33	39.8
Peer support	47	56.6
Non-discrimination	7	8.4
Non-judgemental treatment	9	10.8
Remedial classes for affected children	9	10.8
Medication for affected children	9	10.8
Parents' openness about their HIV positive status	20	24.1
Provision of basic materials	7	8.4
Carer for sick parents	6	7.2

The following key findings of this research emerge as the reasons for the high HIV infections among adolescents in South Africa: more than a third of adolescents in South Africa are sexually active and that they commence sexual activity at an early age. The average age of onset for sexual activity with several partners is 15 years. Reasons may include peer pressure, curiosity, and (particularly for young girls) coercion and material gain.

Adolescents appear to have a high level of awareness about HIV/ AIDS but this has not translated into substantial behavior change. They have more than one sexual partner; between 40% and 60% of adolescents have more than one partner within a 6-month period. Few perceive themselves to be at risk, few take the need for safer sex seriously, and do not see AIDS as a personal threat, although most adolescents acknowledge the disease's severity.

Adolescents do not practice safe sex in general; use of preventative measures is poor. More than 50% of the sexually active adolescents never used a condom. Less than 10% use a condom regularly during sexual intercourse. Failure to practice safe sex is related to pressure to engage in early and unprotected intercourse, pressure to have a child, lack of access to user-friendly reproductive health services, negative perceptions about condoms, low perceptions of personal risk, and low perceived self-efficacy in preventative behavior. Amos et al. (2008) agrue that many young people receive conflicting messages about sex and sexuality: nonpenetrative sex is not considered to be proper sex; widely believed myths reinforce negative attitudes about safer sex and contraceptive use; most adolescents make decisions about engaging in sex without having accurate information and access to support and services; they lack knowledge and negotiation skills in sexual relationships; and many do not acknowledge the disease to be a problem in their area or in their race group.

The issues that are discussed next are the learners' awareness of HIV and AIDS and its consequences, how it impacts on the affected learners and strategies for reducing the impact of HIV and AIDS.

Awareness of Parents' AIDS Diagnosis

The study showed that the majority (71%) of the learners were aware of HIV and AIDS and

its consequences. This finding is supported by Hartel (2005) and Shisana et al. (2014) who mentioned that the knowledge of HIV and AIDS among youth in South Africa is generally good. Furthermore, it concurs with the report by Media Club South Africa (2010) who indicated that the level of awareness among youth on HIV and AIDS is around 90 percent**.** This could be attributed to successful awareness campaigns mounted by HIV and AIDS organizations which have been reported to be successful. However, in some schools, learners are still getting pregnant and contracting HIV even though the level of awareness is so high (Ghosh 2014).

Challenges Experienced by Learners with Parents Living with HIV and AIDS

Discrmination, Stigmatisation and Isolation

The study revealed that most of the learners felt rejected (82%) and discriminated (65%) against by other learners. However, 33% of the learners felt that stigmatisation still existed. The findings are supported by Carr-Hill et al. (2002) and Kalaivani and Sundara (2014) who indicated that prejudice and stigma may cause social exclusion. This in turn depreciates the children's emotional well-being, which consequently interferes with their ability to learn. People in the community may discriminate against children who have parents with HIV or orphaned by AIDS (UNICEF 2014). Children may not perform to their full potential and they may face stigma and discrimination at school. Gilborn (2002) concurs that neighbors may keep a distance for fear of infection and often gossip about the infected parents while peers may tease and isolate the children. Furthermore, Coombe (2001) mentioned that discrimination puts children at higher risk of abuse and social exclusion, and they may be denied basic needs such as having their school fees paid. Kimani et al. (2002) supports this by adding that when a child feels rejected, discriminated against or stigmatised, this leads to a negative self-picture resulting in inferiority feelings. As in most cases, AIDS kills both parents, leaving the child isolated, with no one to give him/her love and praise.

Effects on Learning

The study revealed that 84% of the learners believed that HIV and AIDS lead to a drop in school performance among the affected learners. Sixty-five percent felt that it lead to absenteeism while 16% indicated that it lead to reporting late of learners to school. These findings are supported by Pembrey (2009) who stated that some children may be so traumatised by what they experienced when their family died of AIDS that they find it difficult to learn, thereby leading to drop in their school performance (Pembrey 2009). Furthermore, other children affected and made vulnerable by AIDS are forced to miss school often, or arrive late at school (Kakuru 2006). The situation is worsened by the fact that children orphaned by AIDS are often denied their rights such as the rights to education, health care, and safe place to live. Some of these children may not have relatives to take them in, leaving the eldest child to head the household and care for younger siblings (Bennel et al. 2001; Gilborn 2003). They often lack inheritance rights, and are therefore forced to leave school. As a result of poverty, they may resort to crime and prostitution (AVERT 2010; PlanUSA 2010). Children may drop out due to the cost of schooling. When a family member becomes severely ill, scarce economic resources may be spent on medical treatment. One or more children are taken out of school in order to save money for medicines or alternative treatment (ibid). Carr-Hill et al. (2002) also adds that children with HIV and AIDS may be kept from school as parents may see the cost of schooling as unnecessary if the child is not able to attend or performs badly due to illness

Always Worrying and Feeling Depressed

The study revealed that more male than female learners mentioned that HIV and AIDS affect learners at home in that they are always worried and feeling depressed. The difference in the opinions between males and females was statistically significant. In a patriarchal society, the gender difference stem from the fact that the male children are expected to take care of the siblings. This normally happens in situations when the members of the extended family refuse to look after the orphans. These findings are supported by Coombe (2001), who mentioned that children who watch their parents suffer and die undergo severe emotional distress. In the context of AIDS, there may be long periods of stress, suffering and uncertainty before the par-

ent dies. Worries about future survival can also add to a child's already high stress level. Consequently, this impacts negatively on the academic performance of the children.

Low Self-esteem

Fewer males (3) than females (8) stated that learners' self-esteem gets affected by HIV and AIDS. This can lower the child's self-concept and in turn can have a negative impact on performance at school and the child may end up dropping out (Gilborn 2002). The difference in the opinions between males and females was not statistically significant. According to Gilborn (2002), in most cases AIDS kills both parents, and therefore the child can be left isolated, with no one to give love and praise. This lowers the child's self-concept and in turn can affect their performance at school. Conversely, Kimani et al. (2009) mentioned that if the parents and peers reject and criticise the individual and are indifferent, this leads to a negative self-picture resulting in inferiority feelings. Relations with family members, peers and their support therefore play an important role in how children perceive themselves.

Taking Care of the Sick and Doing Household Chores

More female (7) than male (3) learners mentioned that taking care of the sick and doing household chores affect learners' studies at home. However, the difference was not statistically significant. This is no surprising because of the fact that usually females are culturally brought up to take care of the household chores. Children in the context of HIV and AIDS may be forced to help with the household chores, take care of the sick or care for younger siblings. Some may have to find employment to supplement household income, reduced when the adult can no longer carry on working because of illness (Pembrey 2001). These chores interfere with schooling as a learner may be too tired to do homework later in the evening (Weideman et al. 2007). Bennel et al. (2001) and Gilborn (2002) add that these responsibilities foreshorten normal childhood and interfere with schooling because often the child may be forced to be absent from school.

Lack of Learning Material and Good Nutrition

More males (4) than females (2) indicated lack of learning materials such as books and school uniform affected learners. On the other hand, more females (5) than males (2) mentioned lack of good nutrition as one of the challenge. There was no statistical significance difference between males and females. These findings are supported by Kakuru (2006) who stated that pupils face many livelihood problems including lack of learning material such as books, school uniform as well as lunch at school. Furthermore, Weideman et al. (2007) mentioned that children in the context of HIV and AIDS may be undernourished due to lack of financial support. This result in lack of concentration at school and a range of many other symptoms which affect the ability of a learner to engage effectively in the learning process. AVERT (2009, 2010) states that due to HIV and AIDS, orphaned children may be forced to go and stay with extended families. These orphans may come last in the line when food is being proportioned. They also experience greater health risks than non-orphaned children and are more likely to be stunted and malnourished. Due to these circumstances, these children may be forced to run away to the streets and as a result drop out of school

Reduction of the Burden of Learners Affected by HIV and AIDS

The study revealed that more female (32) than male (16) learners suggested that the school start an HIV and AIDS awareness programme. There was a difference in the opinions of males and females. These findings are supported by Kelly (2000) who mentioned that schools have a responsibility to help learners develop skills which equip them for positive social behaviour and for coping with negative pressures of HIV and AIDS. However, Porteus (2001) is of the opinion that although young people know a lot about HIV; how it is transmitted, the symptoms, and diseases related to HIV and AIDS as well as how it is prevented, a large number of them do not act upon this knowledge and as a result, the incidence of HIV infection among youth continues to rise.

Equal numbers of both males (10) and females (10) suggested that there must be an HIV

and AIDS counsellor at the school. There was no significant difference in the openions of males and females. These programmes serve a purpose of providing the community with access to HIV testing so that they can know their HIV status and counseling, should an individual test positive (AIDSInSite 2010).

It emerged from the study that learners who are affected by AIDS must form a support group at school. There was no significant difference between males' and females' opinions. These finding are supported by Tilloston and Naharaj (2001) whose study revealed that the support for those affected by AIDS can be achieved through formation of school peer support group.

The study suggested that other learners must be taught to accept and support those affected by AIDS. However, the gender difference was not dicernible. Although the literature does not support these findings, Louw et al. (2001) stated that the Department of Education should be willing to assist both affected educators and learners, even if it is only by giving emotional support.

CONCLUSION

The study concludes that learners affected by HIV and AIDS experience challenges that negatively impact on their schooling. The challenges are experienced both at home and at school. The school should design a comprehensive programme to address stigmatisation and discrimination experienced by learners affected by HIV and AIDS. Members of the extended family in particular and the communities at large should be mobilised to give material and psychosocial support to children affected by HIV and AIDS. The teachers need to be equipped with the skills to identify and support learners affected by HIV and AIDS.

LIMITATIONS OF THE STUDY

The findings of this study may not be generalized to all schools in South Africa as the results may be peculiar to a secondary school that took part in the study. However, they may be generalised to schools that are similar to the chosen school. Further study with a bigger sample drawn from more schools need to be conducted in order to get more generalizable results.

REFERENCES

AfricaGoodNews 2009. Using ARVs to Eradicate HIV/AIDS. From <http://www.africagoodnews.com/health/arvs_wipe_out_aids.html> (Retrieved on 10 February 2010).

AIDSInSite 2010. Voluntary Counselling and Testing. From <http://www.healthinsite.net/corporate/aids/html_web_files/web3.html> (Retrieved on 10 February 2010).

Amos O, Awolowo O, Odimegwu C 2008. HIV/AIDS-Related Beliefs, Perception and Sexual Behaviours in metropolitan Cape Town, South Africa. From <http://www.//epc2008.princeton.edu> (Retrieved on 10 February 2010).

Anglo-Gold Ashanti Annual Report 2006. Prevention and VCT at Tau Tona. From <http://www. anglogold. com/subwebs/informationfor investors/reporttosociety/vct.htm> (Retrieved on 10 February 2010).

AVERT 2009. HIV and AIDS Statistics for South Africa. From <http://www.avert.org/aids-impact-africa.htm> (Retrieved on 13 January 2010).

AVERT 2009. HIV and AIDS in Africa. From <http://www. avert.org/aids-impact-africa.htm> (Retrieved on 13 January 2010).

AVERT 2010. The Impact of HIV and AIDS in Africa. From <http://www.avert.org/aids-impact-africa.htm> (Retrieved on 10 February 2010).

Barker L 1998. *Doing Social Research.* 2nd Edition. New York: Mc Graw-Hill Book Company.

Bennell P, Chilisa P, Hyde K, Makgothi A, Malobe E, Mpotokwane K 2001. The Impact of HIV/AIDS on Primary and Secondary Education in Botswana: Developing Comprehensive Strategic Response. From <http://www.unesco.org/en/efareport/reports/2002-efa-ontrack> (Retrieved on 10 February 2010).

Black R 1999. *Doing Quantitative Research in the Social Sciences*. London: Sage Publications.

Burns N, Grove SK 1993. *The Practices of Nursing Research Conduct Critique and Utilization.* 2nd Edition. Washington D.C: W.B. Saunders Company.

Carr-Hill R, Katabaro KJ, Katahoire AR, Oulai D 2002. *The Impact of HIV/AIDS on Education and Institutionalising Preventive Education.* Paris: International Institute for Educational Planning/UNESCO.

Coombe C 2000. Family Health International Education. From <www.ovcsupport.net/sw476.asp> (Retrieved on 22 January 2010).

Coombe C 2001. *HIV/AIDS and the Education Sector: The Foundations of Control and Management Strategic in South Africa.* Pretoria: University of Pretoria.

Coombe C 2001. *HIV/AIDS and Trauma among Learners: Sexual Violence and Deprivation.* Pretoria: University of Pretoria.

De Vaus DA 1996. *Surveys in Social Research.* 4th Edition. Melbourne: Allen and Unwin Pty Ltd.

De Vos AS, Strydom H, Fouche CB, Delport CSL 2005. *Research at Grass Roots: For the Social Sciences and Human Service Professions.* 3rd Edition. Pretoria: Van Schaik Publishers.

De Wagt A, Connolly M 2005. Orphans and the impact of HIV/AIDS in sub-Saharan Africa. *Food, Nutrition and Agriculture,* 34: 24-31.

Editor 2003. Impact of HIV/AIDS on Education in the Sub-Saharan Africa. From http://ajol.info/index.php/eamj/article/viewfile/8775/1904> (Retrieved on 14 January 2010).

Educational International 2007. HIV and AIDS as Major Global Issue. From <http://www.ei-ei.org/hivaids/en/articlehow.php?id=69andtheme=hivaids> (Retrieved on 14 January 2010).

Gabriel KC, Cheboswony M, Kodero HM, Misigo BL 2009. *The Self-concept and Academic Performance of Institutionalised and Non-institutionalised HIV/AIDS Orphaned Children in Kimusu Municipality.* Eldoret: Moi University

Garbers JG 1996. *Effective Research in the Human Science.* Cape Town: Creda Press.

Gilborn LZ 2003. Making a Difference for Children Affected by AIDS. From <http://www.unicef.org/sowc06/pdfs/africa_orphans> (Retrieved on 15 March 2009).

Ghosh P 2014. Babies Having Babies: Teenage Pregnancies Destroying Lives Futures South African Girls. From <http://www.ibtimes.com.> (Retrieved on 20 March 2014).

Hartel CG 2005. HIV/AIDS in South Africa: A Review of Sexual Behaviour Among Adolescents. From <http://en.wikipedia.org/wiki/HIV/AIDS_in_Africa> (Retrieved on 14 January 2010).

Harvey L 1997. A discourse on ethnograph. In: AS Lee, JI De Gross (Eds.): *Information Systems and Qualitative Research.* London: Chapman and Hall, pp. 207-224.

Huysamen GK 1994. *Methodology for the Social and Behavioural Sciences*. Halfway House: Southern Book Publishers.

Isaac S, Michael WB 1983. *Handbook in Research and Evaluation: For Education and the Behavioral Sciences.* 2nd Edition. San Diego: Edits Publishers.

Kakuru DM 2006. *The Combat for Gender Equality in Education: Rural Livelihood Pathways in the Context of HIV/AIDS*. Wageningen: University of Wageningen.

Kalaivani G, Sundara RT 2014. Social stigma of HIV/AIDS parents: Infected and affected children. *Social Science*, 4(2): 6-8.

Kelly MJ 2000. What HIV/AIDS Can do to Education, and What Education can do HIV/AIDS. From <http://www.sedos.org/english/kell_i.html.> (Retrieved on 14 January 2010).

Key JP 1997. Research Design in Occupational Education. From <www.okstate.edu/ag/agedcm4h/academic/aged5980a/5980/newpage2.htm.> (Retrieved on 14 January 2010).

KidsHealth 1995. HIV and AIDS. From <http://kidshealth.org/parent/infection/std/hiv/html.> (Retrieved on 14 January 2010).

Kumar R 2005. *Research Methodology.* California: Sage Publication.

Le Roux C 1999. Off to a flying star: The intricacies of Chapter One. In: A Moll (Ed.): *Introduction to Masters Studies.* Pretoria: University of South Africa, pp. 30-37.

MayoClinic 2010. HIV/AIDS. From <http://www.mayoclinic.com/health/hiv-aids/ds00005/DSECTION=causes.> (Retrieved on 19 May 2011).

Media Club South Africa 2010. HIV/AIDS in South Africa. From< http://www.mediaclubsouthafrica.co.za/index.php?option =com_contentandview= articleandid= 103:hivaidssouthafricaandcutid= 34:developmentbg.> (Retrieved on 19 May 2011).

Meitjies H, Griese S 2004. *Addressing the Impact of HIV and AIDS on Children in South Africa: Priorities for Funders and Development Agencies.* Cape Town: University of Cape Town.

Meyer W, Moore C, Viljoen H 2003. *Personology from Individual to Ecosystem.* 3rd Edition. Cape Town: Lebone Publishing Services.

Motala S, Dieltiens V, Carrim N, Kgobe P, Moyo G, Rembe S 2007. Educational Access in South Africa. From<http://www.create-rpc.org/pdf_documents/SA_CAR_EXECUTIVE_SUMMARY.pdf> (Retrieved on 19 May 2011).

Mwamburi DM, Dladla N, Qwana E, Lurie MN 2005. Factors associated with wanting to know HIV results in South Africa. *AIDS Patient Care and Sexually Transmitted Diseases*, 19(8): 518-25.

Ofeifo O, Magnus O, Julius O 2009. Analysis of Spatial Awareness of HIV-AIDS Amongst Students of Tertiary Institution in EDO State, Nigeria. From <http:www.krepublishers.com/02-journals/s-em/em/03.pdf.> (Retrieved on 19 May 2011).

Pembrey G 2000. HIV and AIDS in South Africa. From <www.org/aidsinsouthafrica.html.> (Retrieved on 19 May 2011).

Pembrey G 2009. HIV and AIDS in Africa. From <http://www.avert.org/hiv-aids-africa.htm.> (Retrieved on 19 May 2011).

PlanUSA 2008. Toolkit to Raise Awareness About Children Orphaned by AIDS. From <http://www.planusa.org/stuff/contentmgr/files-toolkit.pdf>. (Retrieved on 19 May 2011).

PlanUSA 2010. How do HIV and AIDS Affect Children? From <http://www.planusa.org/contentmgr/showdetails.php/id/2128>. (Retrieved on 19 May 2011).

Porteus K 2001. Fighting the dragon: Globalization and its attack on equity. *Quarterly Review of Educational Training*, 8(2): 8-17.

Reaves GC 1992. *Quantitative Research for the Behavioural Sciences.* Washington: John Wiley and Sons.

Sergiovanni TJ 1994. *Building Community Schools*. San Francisco: Jossey-Bass Publishers.

Richter L 2010. The Impact of HIV/AIDS on the Development of Children. From <www.iss.co.za/pubs/Monographs/No109/Chap2.pdf.> (Retrieved on 19 May 2011).

Speziale HJ, Carpenter DR 2007. *Qualitative Research in Nursing: Advancing the Humanistic Imperative.* 4th Edition. Philadelphia: Lippincott Williams and Wilkins.

Shisana O, Rehle T, Simbayi LC Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D et al. 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. Cape Town, Human Science Research Council Press.

Susser I, Steyn Z 2000. *Culture, Sexuality, and Women's Agency in Prevention of HIV/AIDS in Sothern Africa.* New York: Hunter College.

Trochim WMK 2006. Descriptive Statistics: Research Methods Knowledge Base. From <http://www.socialresearchmethods.net/kb/statdesc.php.> (Retrieved on 19 May 2011).

UNAIDS 2006. Uniting the World Against AIDS: A UNAIDS/WHO AIDS Epidemic Update. From <http://data.unaids.org/pub/EpiReport/2006/04Sub_Saharan_Africa_2006_EpiUpdate_eng.pdf.> (Retrieved on 19 May 2011).

UNAIDS 2009. Sub-Saharan Africa. From <www.unaids.org/en/countryresponse/regions/subsaharanafrica. asp.> (Retrieved on 19 May 2011).

UNESCO 2004. *UNESCO Strategies for HIV/AIDS Prevention Education*. Paris: International Institute for Education Planning.

UNICEF 2003. Girls, HIV/AIDS and Education. From <http://www.unicef.org/lifeskills/index_8657.html.> (Retrieved on 19 May 2011).

UNICEF 2014. Social Care. From <http://www.unicef.cn.> (Retrieved on 19 May 2011).

USAID 2001. Gender, Education, and HIV/AIDS. From <http://www.usaid.gov.our_work/cids_cutting_ programs/wid/pubs/HIV-final.pdf.> (Retrieved on 19 May 2011).

Tillotson J, Maharaj P 2001. Barriers to HIV/AIDS protective behaviour among African adolescent males in township secondary schools in Durban, South Africa. *Society in Transition*, 32(1): 83-99.

MESA 2004. Malawi Education Support Activity. From <pdf.usaid.gov/pdf_docs/PDACF403.pdf.> (Retrieved on 19 May 2011).

Weideman M, Goga S, Lopez D, Mayet M, Macum I, Barry D 2007. Learner Absenteeism. From <http//www.info.gov.za/view/downloadFile Action?id=79522.> (Retrieved on 19 May 2011).