

**FACILITATED FAMILY INTERVENTIONS IN THE HIV/AIDS
LIFE SKILLS PROGRAMME IN MTHATHA SCHOOLS.**

BY

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DEDICATION

In loving memory of my parents:-

My dearest father Carmichael Ntombini

1924 – 1968

My loving mother Ivmond Ntombini

1926 – 2004

My precious mother-in-law Eunice Swana

Date of birth not known; died in 2000

MAY THEIR SOULS REST IN PEACE

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- Last, but not least my husband, Geoff, for his assistance, support and encouragement, together with all my children and grand children.

DECLARATION

I, Sekela Margaret Swana, hereby declare that the work: "Facilitated family interventions in the HIV/AIDS life skills programme in Mthatha schools" is my original work. Sources consulted or cited are acknowledged in the text as well as in the list of references.



S.M. Swana



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ABSTRACT

This study was aimed at improving knowledge, attitude and practices of teachers, parents and learners on HIV/AIDS issues in Mthatha schools in Eastern Cape. The specific objective was to promote mental health in the form of improved family communication about HIV/AIDS issues and also to promote the value of psychological interventions among Xhosa families in the Eastern Cape. The target population was drawn among teachers and families of the learners in two schools (urban and rural) in the Mthatha district of Eastern Cape. All participants were given an HIV/AIDS life skills intervention programme for about nine weeks. Quantitative data was collected from a structured questionnaire and qualitative data from a focus group interview.

The findings revealed a general improvement in HIV/AIDS knowledge, attitude and practices. Teachers seemed to be more knowledgeable than parents and learners with regard to HIV/AIDS issues. Learners manifested resistance to change in their practices though all participants preferred abstinence or safer sex than the use of condom.

Learners seemed resistant to change sexual practices though all participants preferred abstinence or safer sex above condom usage.

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CHAPTER ONE

1. Introduction

Community psychology's goal is to improve life in communities in a country plagued by various forms of illness, trauma, oppression, unemployment, poverty and crime. According to Seedat, Duncan and Lazarus (2001) community psychology tends to be defined by its philosophy, ideological assumptions and approach. In its concern the following are mentioned:

- Extending mental health services to all citizens, in particular the historically unserved, underserved and oppressed.
- Transforming the way in which the genesis and development of psychological problems are conceptualized and understood.
- Providing a contextual analysis that take cognizance of social issues and addresses environmental stressors.
- Radicalizing the praxis of psychological service delivery to include prevention initiatives, and
- Redefining the role of psychologists towards a broader public health portfolio that embraces the functions of advocacy, lobbying, community mobilization, community networking, and policy formulation (Seedat, 2001: p.3).

The above notion concurs with the views of Orford (1992) and Edwards (1999) that the community psychology movement is an attempt to take psychology to the people, especially historically, economically and socially underprivileged communities, to help themselves through improved social welfare, education, health, networking and development of projects. The mental health and the social action models choose the community to be their unit of intervention in “empowerment of the under classes within the existing socio political order of society” (Seedat, et al. 2001, p.5).

In working with community psychology Orford (1992) mentions eight principles to be followed viz:-

- Assumptions about the causes of problems: An interaction, over time, between person and social settings and systems, including the structure of social support and social power.
- Levels of analysis: From micro-level to macro, especially at the level of the organization and the community or neighbourhood.
- Research methods: This includes quasi-experimental designs, qualitative research, action research and case study methods.
- Location of practice: As near as possible to the relevant, everyday social contexts.
- Approach to planning services: Proactive “seeking out” assessing needs and special risks in a community.
- Practice emphasis: On prevention rather than treatment.

- Attitude to sharing psychology with others: Positive towards formal and informal ways of sharing including consultation.
- Position on working with non-professionals: Strongly encouraging of self- help and non- professionals and seeks to facilitate and collaborate. He refers to Lewin's (1951) famous equation: $B=f(P, E)$ i.e. behaviour is a function of the persons, the environmental and the interaction between the two.

The emphasis of this study therefore is to adopt a community psychology orientation in order to find out existing needs, which are not currently being met that may result in the escalation of HIV/AIDS rate, despite HIV awareness campaigns. The present study will anticipate problems and prevent them in the Mthatha district schools of the Eastern Cape, while networking with parents with regard to school issues. The aim is to follow community psychology principles of sharing the fruits of psychological understanding and knowledge as widely as possible within the Xhosa community. Pillay (2003) views community psychology as the answer to many of the social and psychological problems that exist in South Africa.

1.1 Motivation for study to be undertaken

This thesis is an extension of earlier research on parental involvement in sex education programmes in schools (Swana, 2001). The findings of the study confirmed the lack of formally organized sex education programmes

in schools and that parents were not eager to be involved since sex-related issues were normally viewed as a taboo in Xhosa culture. Teachers felt that they had not done enough to encourage parent-involvement in the programmes development. The recommendations were that the learners and parents should be encouraged to discuss the various topics offered by the sex education programmes in schools.

Parents could even be encouraged to list what they have discussed on their children's homework books and write down their comments or inputs.

During the past two years, that is 2002 and 2003, programmes on HIV/AIDS life skills were introduced in some schools in the Mthatha district focusing on promoting HIV/AIDS awareness to teachers, learners and general school community, encouraging preventive measures on the spread of HIV/AIDS as well as the care and support for all HIV/AIDS affected and infected children. Educators were trained by the district coordinator and were expected to go back to schools and teach the prescribed programme. Learners involved in peer education training were expected to educate their peers on HIV/AIDS.

The research findings provided motivation to extend the study by facilitating greater involvement of parents in the life skills programmes on HIV/AIDS in schools. Donald, Lazarus and Lolwana (1997) state that in any society, parents have to own what takes place in the education of their

children. Schools are set up by society for the specific purpose of teaching, learning and the development of the society's youth. " We are society, schools and the schooling process should rightfully be experienced as ours- as owned by us" (Donald, et al., 1997,p.21). This reveals that there should be networking amongst teachers, students, their community and the society at large. According to the above-mentioned authors, capacity building and empowering people to engage in decision making at all levels of education is a challenge that needs to be faced by all.

Uwalaka and Matsuo (2002) show that many learners and educators have died of AIDS despite the truth that two decades have passed since HIV/AIDS programmes took root in Africa. The recent reports (Country Report, 1999 and Tsvere, 2004) indicate that educators often have a negative attitude towards HIV/AIDS programmes because they are also affected. According to Bundy and White (1990); Hubley, (1990); Evian, (1991); Swana, (2001) and Ndegwa, (2002) the research confirms that adolescents report poor communication with parents about sexuality matters.

Ng'weshemi, Boerma, Bennet and Schapink (1997) propose that the survey conducted in schools should involve children, parents and teachers and assess knowledge, attitudes, practices and risk perception in relation to

sexual behaviour and HIV/AIDS. Kerry Cullinan reports (Daily Dispatch, 07/06/04) that the changing of people's sexual behaviour seems to be crucial in preventing the spread of HIV/AIDS and a range of factors collectively influence people's behaviour, including their families, neighbourhoods and culture. A possible way forward lies in addressing the culture and context in which relationships take place. Therefore, a good parent-child relationship, as the first step, should not be ignored in dealing with HIV/AIDS life skills programmes in schools.

According to Ollendick and Prinz (1994), 80% of teens are reported to be sexually active before age 19, yet only a quarter to a third use condoms and still fewer use condoms consistently. Adolescent population, across geographic and socioeconomic lines, is probably already "seeded with the HIV infection". Furthermore, the behaviour of many teens presents a fertile arena for the spread of the HIV epidemic. It is clear that interventions must be in place if we are to prevent this catastrophe. Hence, the attention of preventing HIV amongst the youth is well deserved (Ollendick and Prinz, 1994).

Swana (2001) showed the necessity for schools to involve parents or families of learners as partners in fighting HIV/AIDS pandemic among adolescent challenges of Mthatha District in the Eastern Cape. According to Carter and Mc Goldrick (1980) the adolescent challenges the family

daily with new style, new language, new mannerisms and new values for behaviour, therefore parental empowerment on dealing with their adolescent is inevitable. Parents have been disempowered by various factors including poverty. Donald, et al (1999), illustrate direct and indirect effects on parenting as inadequate access to health services, poor parental education, large families and unemployment. Research has linked parental rearing styles to adolescent behaviour (Taris & Semin, 1998). It is suggested that parents' styles of interaction profoundly influence the psycho-social maturation of their children, as well as the children's behaviour .

Olufemi & Olufemi(2003) state that a holistic approach in fighting the spread of HIV/AIDS in South Africa and Africa includes the fighting of family dysfunction. Van Niekerk and Prins (2001) state that psychology, as a mental health discipline, faces the challenge of helping to reconstruct and develop a nation rendered psychologically dysfunctional by apartheid. Social transformation cannot be considered without recourse to the complex set of social and economic processes and personal behaviours that shape, constrain, deny, inhibit and facilitate mental health and well-being. The latter authors further mention the fact that family murders or suicides are likely to increase when people become aware of their HIV status and the effect thereof on their families (Van Niekerk & Prins, 2001,p.12). Their statement concurs with Coombe (2002) who states that the education sector has a special responsibility with regard to the HIV/AIDS pandemic.

It is general agreed that at both national and international levels, over the past three years, four principal areas of concern have emerged for sector partners. For example;

- **Prevention:** helping prevent the spread of AIDS.
- **Social support:** Working with others to provide a medium of care and support for learners and educators affected by HIV/AIDS, including orphans and other vulnerable children.
- **Protection:** There is a need to protect the education sector's capacity to provide adequate levels of quality education. This can be achieved by stabilizing the teaching service and improving educator skills, and responding to new learning needs, and
- **Management:** Harnessing, acquiring and developing capacity to manage the sector's response to this crisis.

This makes it imperative to initiate family interventions in HIV/AIDS life skills programmes in schools.

1.2 Statement of the problem

The spread of HIV/AIDS in South Africa includes fighting of family dysfunction (Olufemi & Olufemi 2003). The changing of people's sexual behaviour seems to be critical in preventing the spread of HIV/AIDS as well as the range of factors that have been mentioned earlier on this chapter (Cullinan, 2004).

This is a follow-up study on how Xhosa families interact with their children and the extent to which they involve themselves in HIV/AIDS programmes in schools as a way of "giving psychology away" to the people (Rappaport, 1987).

1.3 Definition of key terms

1.3.1 Community psychology

Community psychology is concerned with extending mental health services to all citizens, particularly the historically disadvantaged and oppressed. The goal of this type of psychology is to improve the quality of life in communities.

1.3.2 Family intervention

Within the context of this study the family is defined as any parent-adolescent dyad. Family intervention refers to the active participation of parents in the school system and the education of their children.

1.3.3 Adolescents

As the term used in this study, 'adolescent' refers to learners who are participating in this study doing grade 7, and limited to between 12 – 17 years of age.

1.3.4 Life skills programme

This refers to the interventions done by schools and the South African government to combat or minimize the rate of teenage pregnancy and HIV/AIDS. The aim is to disseminate information about desirable behaviour with regard to sexuality. The focus is on family interventions that reduce sexual risks and enhance positive health behaviour.

1.3.5 Mthatha District

This is the region in the Eastern Cape, which used to be known as the Transkei. The majority of people in this region are Xhosas; hence the focus of this study is on the interaction of Xhosa families with their children in this region.

1.3.6 KAPS

This refers to the abbreviations used for knowledge, attitude and practices of teachers, parents and learners on HIV/AIDS issues.

1.4 Aims of the study

This study has three aims:

- The promotion of mental health in the form of improved family communication about HIV/AIDS issues
- Evaluation of improved knowledge, attitude and practices of teachers, parents and learners on HIV/AIDS issues.
- Promoting the value of psychological interventions among Xhosa families in the Eastern Cape.

1.5 Research design

1.5.1 Methodology

The methodology will consist of outcome evaluative action research including a structured questionnaire on knowledge, attitude and practices about HIV/AIDS within the school and its interaction with the parents. A qualitative focus group interview was also done with a group of approximately ten educators and parents respectively.

1.5.2 Target population

The target population will be teachers, learners and families of the learners in the schools where HIV/AIDS life skills intervention programmes have been conducted within the district of Mthatha.

1.5.3 Study area

The study population will be drawn from one school in the rural area and one in the urban area of Mthatha.

1.6 Resume

As has been discussed in this chapter, the life skills programmes in the schools show the necessity for family interventions where parents work

together with teachers in fighting the spread of HIV/AIDS in communities. In order to establish a positive relationship between children and their parents, teachers should involve parents in the school's programme and allow parents to decide about what should be taught to their children with regard to sexuality matters. The attitude of teachers towards HIV/AIDS should improve so that they can deal with sexuality education without reservations.

This chapter also defines some of the concepts dealt with, so as to clarify their meaning within the research. The next chapter is the literature on family interventions as part of community psychology.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 Introduction

As the HIV/AIDS epidemic nears the end of two decades, it continues to have profound social, psychological, political and economic consequences in South Africa. HIV/AIDS is the leading cause of death among persons between 25 and 49 years old. Therefore there is a desperate need to develop and sustain effective preventive interventions for members of populations that engage in HIV risk behaviours. According to Peterson (1998) community psychologists can help fulfill this need in making influential contributions to HIV prevention. Seedat, Duncan and Lazarus (2001) concur with Petersen (1990) in that community psychology has a quest to retain and develop its commitment to social transformation, especially in terms of addressing the needs of the historically marginalized groups.

2.2 Theory and practice in community psychology

Community psychology in South Africa came to be associated with broad democratic movements, seeking to dismantle oppressive state structures and ideological state apparatuses, which were also embodied in the

disciplinary practices of the social and medical sciences during the previous colonial and apartheid eras. In the 1980's community psychology formally emerged in South Africa, embracing radical challenges to the traditionally discriminatory foundation, theory, method and practice of psychology. The social action model, among most radical perspectives in community psychology, suggests empowerment of the disadvantaged classes within the existing socio-political order of society. Community psychology accords community empowerment more immediate values than the transformation of the broader processes and structures that perpetuate social inequalities.

The theory, method and practice of community psychology can be synergized to promote local development in an ethical and responsible manner. Community psychology is used as an attempt to make psychological theory and practice relevant for the South African context, particularly the oppressed and exploited majority in South Africa. Its central premise is the importance of developing theory, research and intervention that locates individuals, social settings and communities in a particular social cultural context. According to Seedat, et al (2001) community psychology regards whole communities and not only individuals, as possible clients. There is an awareness of the importance of the interaction between individuals and their environments in terms of causing and alleviating problems.

All the approaches in community psychology have the common goal of improving the human condition and promoting psychological well being by applying knowledge and methods of study, research, intervention and evaluation from the broader disciplines of psychology and the social sciences in community or organizational contexts. According to Peterson (1998) community psychologists have pioneered prevention approaches that may be useful to address the effects of social networks, social structure and community organization on HIV risk behaviour. Prevention programmes are intended not only to change individuals but also to alter social context, for example, families, schools and community settings. The above argument on community psychology leads to the discussion of models of community psychology.

2.2.1 Models of community psychology

Edwards (2002) came up with six different yet overlapping and interrelated models of community psychology viz:- indigenous, social action, mental health, ecological, organizational and phenomenological models. These models, abstract representations of reality, constitute a diversity of contexts through which community psychological reality may be viewed and become valuable depending upon timing and context.

2.2.1.1 The indigenous model

Edward (2002) argues that the original indigenous forms of community psychology include the following fundamental interrelated concepts:

- **Communal psyche:** The central emphasis on the communal psyche is expressed in the idiom “*umntu ngumntu ngabantu*” which can be interpreted in many ways, for example, a human being becomes a person through others or only through you do I become, I am because we are. This is representative of a community psychology.
- **Communalism and/or collectivism** is expressed in such concepts as “*ubunye*”, “*simnye*” and “*ubudlelwane*”. This is a community psychology that begins and ends in the community. We are one.
- **Humanism** is expressed in the practice of “*ubuntu*”, which implies essential caring, respect and beneficial humane relationships. Treating others with *ubuntu* is a fundamental way of promoting community health, welfare, education and development and recently it has become a South African “buzzword”.
- **Spirituality** is affirmed in a fundamentally religious worldview. This is expressed in the performance of communal rituals and sacrifices (to remember one’s ancestors and God). The purpose is to

prevent hazardous situations and promote health beliefs and practices for the children, family and the community.

- **Ecology**-There are ecological influences on community health and illness. The importance of promoting order and preventing disharmony is implied in the notion of maintaining a healthy balance and is conveyed in the term "*ukulungisa*" which is common amongst the indigenous and traditional healers. These are in the form of traditional doctors (*izinyanga*) who are usually men and often specialize in herbal medicines and the traditional diviners (*izangoma*), who are usually women and specialize as diagnosticians through their mediumship with the ancestral shades.

Abathandazeli or faith healers have become increasingly popular in modern times and are able to provide their local community with a communal-spiritual circle that addresses many needs and is accompanied by healing rituals, which include drama, music and dance. This is a marvelous form of community psychology where community development, healing and education are harmoniously integrated (Edwards, 2002,p.11).Gumede (1990) cited in Edwards (1999) estimates that 80% of black patients visit traditional healers before going to the doctor or hospital.

2.2.1.2 The social action model

The social action model is typically revolutionary, psychosocial and socio-political in orientation. It is an action against oppressive structures in order to liberate, empower, educate and develop oppressed communities. It has been a peaceful revolution in the South African community as a whole in the prevention of illness, active struggle against unfair discrimination, power, abuse, oppression, injustice and violence. Pillay (2003) asserts that prevention rather than remediation is becoming a priority in the struggle against apartheid and oppression hence there is a demand of community psychologists to apply their knowledge and skills towards liberation.

2.2.1.3 The mental health model

The mental health model attempts to improve the mental health of communities living in clearly defined catchment areas. Mental health as defined by the World Health Organization (WHO) is not merely the absence of mental illness but a positive state of total physical, psychosocial and spiritual well-being (Edwards 1999).

To heal means to make whole, to transform from illness to health. Africans are always in search of life enhancement in terms of an increase in being.

According to Edwards (2002) mental health care interventions may be extended as follows: -

- Tertiary prevention is indicated prevention to reduce illness, disability and handicap typically in persons at high risk
- Secondary prevention is selective prevention to reduce prevalence and duration of illness in person at risk.
- Primary prevention is universal intervention to reduce incidence of illness in persons of potential risk.
- Primary promotion is universal interaction to promote and improve health.
- Secondary promotion refers to interventions to improve human rights, empowerment and health promotion advocacy for all persons, particularly in case of disempowerment.
- Tertiary promotion refers to interventions to improve meaning, self and social realization and actualization and other higher level of survival needs.

2.3.1.4 The ecological model

The ecological model is concerned with person-environment relationships, systems, fit and harmonization in order to optimize and recycle resources through constant dynamic community changes. Orford (1992) sees behaviour as a function of person-environment relationships. He further

behaviour as a function of person-environment relationships. He further comments that community psychology is about understanding people within their social worlds and using this understanding to improve people's well being. A continuing balance is needed in environmental and social relations.

The ecological model is valuable in its correction of mainstream- Western style psychological over-emphasis on the person rather than person-environment relationships. Only through social interhuman relationships (*ubuntu*) are directions, in which community is already changing, revealed (Edwards, 2002, p.16).

Mutual aid groups are most relevant in South Africa today in families that are broken down, alcoholism that is rife and unemployment which is high. They form support structures for change and healing. Through the ecological model, interdependence in community interventions is promoted. A collective interrelated sense of community is essential.

2.2.1.4 The organizational model

2.2.1.5 This model works at managing change in group processes and team building amongst all stakeholders in the organizational setting. Views on empowerment

and development are shared with community stakeholders within various sectors.

2.2.1.6 The phenomenological model

This model is concerned with improving experience sense of community relationships in individuals, couples, families, groups, community and society.

Along with the inevitable stress, trauma and political conflicts, South Africa is currently in a major process of development, reconstruction and transformation. A renewed sense of community has become possible. There is a considerable work towards re-establishing and celebrating caring human relationships (*ubuntu*), community collectivity (*ubunye*) and togetherness through diversity (*simunye*). There are simultaneous movements towards Africanisation and globalization as the South African community re-affirms its collective and international sense of community (Edwards, 2002,p.17).

According to the phenomenological model, all models are prototruth approximations of reality, pieces of jigsaw puzzles, voices in stories. They inevitably freeze and distort the communally lived world while on the other hand they help clarify experience through second order description

phenomenological model reminds us to be more perceptive towards changing community reality in the quest to improve community life.

2.2.2 South African community psychology

Community psychology briefly refers to the psychology of, with, by and for the people, which begins and ends in the community. After many years of struggle against apartheid, South Africa became a full democratic state on the 27th of April 1994. This marked a triumph for the community psychology movement in its struggle against all forms of injustice, oppression and violence. This is a specially observed in its struggle for a democratic, liberatory psychology which is contextually relevant for all South Africans in their ongoing struggle against crime, unemployment, poverty, HIV/AIDS, illiteracy, inadequate shelter, malnutrition, corruption, abuse of power, many other social ills and violence in all its forms (Edwards,1999,p.20). This view concurs with that of Pillay (2003) where he stated that since the election of a democratic government in 1994, there has been a major transformation in all sectors of South African society, including the discipline of psychology. There have been extensive changes in the theory, method and practice of psychology. Change was inevitable because prior to 1994, psychology was dominated by norms and standards developed by whites.

During the apartheid years, the practice of psychology within black communities was relatively unknown, the majority of registered psychologists in South Africa before 1994 were white and middle class. One of the major tasks facing the present government (post 1994) is addressing the inequalities of the past and building a democratic society (Seedat, et al., 2001). With the new South African constitution and reforms in the legal system, both democratization and political freedom are largely achieved and assured. The aim of addressing historical disadvantages should ensure that sectors and groups who were previously discriminated against and marginalized achieve equality in the new social order. In order to achieve this, the principles of 'access' refers to establishing mechanisms by which groups can have recourse to previously denied resources, 'redress' refers to the attempt to correct historical imbalances in power and resources, and 'equity' refers to achieving parity, fairness and equality in the distribution of power and resources (Seedat, et al., 2001).

Community psychology provides theories and practices that can be used for the mass interventions needed in the transformation of an oppressive system. By working towards social change, community psychology can assist in the political and ideological changes ahead, and it can facilitate greater citizen participation.

It can provide a more relevant psychology and that facilitates the process of social change in the move to a post-apartheid South Africa where there is an improvement in the well being of all South Africans (Seedat, et al., 2001,p.33).

Community psychology focuses on preventing rather than treating dysfunction. It adopts an ecosystemic framework which places emphasis on the individual and the context (Donald, Lazarus & Lolwana, 1997). Edward (1998) argues that traditional views, customs and practices must be considered in the healing of mental illness as part of an ongoing development cycle of community psychological interventions. Community psychological services should include “networking, education and development projects” (Edwards,1998,p.79).

Community psychology is very relevant to the South African context since psychologists are able to engage in social issues such as HIV/AIDS, teenage pregnancies and parental guidance. Social cultural conceptualization is important in terms of community interventions. For example, it enables the psychologists to understand the role of *izangoma* in the African culture and possibly incorporate these indigenous healers into the therapeutic or intervention process.

Many community psychologists have pioneered prevention approaches that may be useful to address the effects of social networks, social structure and community organization on HIV risk behaviours. Prevention programmes are intended not only to change individuals but also to alter the social context for example in families, schools and community settings. Behavioural skills and resources needed for HIV prevention are not viewed exclusively within individuals but also as part of people's environments. From an ecological perspective, these HIV interventions are needed to develop competent environmental settings and competent communities (Levine & Perkins, 1997).

An ecological perspective on HIV/AIDS prevention is warranted to combat the threat of HIV infection. Peterson (1998) views community psychology as probably more receptive to the concept of social ecology than most areas of psychology and it is here that the contribution of HIV prevention through community psychology may be achieved.

2.2.3 Community psychology interventions in the fight against HIV/AIDS

Interventions should have a psychological sense of the community. They should be evaluated whether they enhance or impair a psychological sense of community. Social norms are central to the sense of community. Levine

(1998) mentions the fact that if we are to be broadly effective in preventing undesirable end states, preventive interventions must contribute to normative change. In simple terms, the members of a society should act in an appropriate manner in a given situation. When norms are accepted people have then a basis for a sense of community.

Preventive efforts that change norms will result in a different social climate, a common culture and structures that support the behaviour prescribed by the preventive intervention. An effective preventive intervention goes beyond affecting individuals (Levine,1998). Without community consensus, a successful program may falter.

Preventive programmes should identify, evaluate and promote synergistic effects and consider how to modify counter-acting forces. Intervention programmes should contribute in producing changes in social norms. These programmes should be implemented in such a way that they have an impact on complex social structures. It is not enough to influence individuals only but to think of possible reinforcements for preventive behaviour in the social environment. These reinforcements should ensure that others are prepared to use the intervention, and that social structures and other forms of support are available in the environment over a period of time. Programmes that support people to encourage each other to use the

preventive approach will be more effective than if the intervention is geared only to affecting an individual's knowledge (Levine, 1998,p.203).

Intervention in schools should include cultural values. Modifiable risk factors, including institutional arrangements that create risk, should be identified to make the intervention programme effective. In addition to cultural value effective preventive intervention should be built on the understanding of the psychological sense of community in those contexts. This understanding should take into consideration that the norms and values of a particular culture change over time.

Community psychology aims at mass interventions and purports to prevent psychological problems before they arise. This makes it an attractive alternative to individual psychology in the Western sense, where one person is seen at a time. These interventions focus on sexual behaviour, which is an interpersonal activity. Current research focuses on changes in sexual risk acts, successful HIV interventions with adolescent have addressed a set of social cognitive and social skill mediators to change risk behaviours (Rotherman-Borus, Gwadz, Fernandez & Srinivasan 1998).

An interventive perspective should go beyond an emphasis on individuals, into a fuller appreciation that Africans live their lives in a communal sense rather than an individualistic one.

According to Wood and Geismar (1989) strategies of intervention and actual interventive activities and techniques must be tailored and fine-tuned to the needs of each individual family. This assertion shows that the interventions chosen must fit the family's ethnicity or culture, as well as their values and belief system (Wood & Geismar, 1989,p.166). The above notion draws the discussion to the family as an agent of social change.

2.3 Families as agents of social change

The family has a central role in social life. Governments and politicians use the family as an indicator of the health and strength of social life. Politicians fear that any weakening of family life will in some way sap the vitality of that particular nation.

In defining the family, Wilson (1985) refers to it as a group related by blood or by law, living together or associating with one another for a common purpose, that purpose being the provision of food, shelter and the rearing of children. This definition concurs with the view of Turk and Kerns (1985) when they refer to families as groups composed of members who have mutual obligations to provide a broad range of emotional and material support.

who have mutual obligations to provide a broad range of emotional and material support.

The family is seen to play a key role in helping the individual to learn the social behaviour required by society, for example, a child receives its primary socialization in the family. It binds the individual into the fabric of the society. Within the family unit, a child will learn the patterns of behaviour expected in certain social roles, for instance, gender roles. It provides physical and economic support for the child during the early years of dependence. Both society in general, and social scientists in particular, see the socialization process as significant. According to Leslie and Korman (1989) socialization moulds the child's biological potential into the pattern of functioning that we call human personality. This statement concurs with Wilson's (1985) reference to a family as having a crucial role in maintaining stability in society by moulding our identity and the development of our personality. Socialization covers all learning, including the indirect and unanticipated learning that occurs whenever a child observes its parents or other interactions. Thus, the child learns socially disapproved as well as approved behaviours and masters the nuances that are not taught in school, in college or in apprenticeship.

According to Leslie and Korman (1989) socialization into masculine and feminine roles begins almost from the moment of birth and greatly

influences male and female relationships. This difference in socialization produces different personality patterns in males and females. Males are encouraged to become assertive, active and goal-orientated whilst females are encouraged to become passive, dependent and relationship orientated. This sex-role stereotyping is reinforced and perpetuated also outside the home; for example, one is particularly exposed to this in school and the society at large. Gender inequality is one of the pertinent issues that need to be redressed in South Africa, especially post-1994.

Interventions in the family structure serve to support adults as parents who can provide the direction and structure needed by the children for adequate socialization and emotional growth. Socialization among families may differ from culture to culture; hence the following discussion is on different family forms.

2.3.1 Different forms of families

There are cultural differences in family forms. Family forms vary according to the traditions and culture of particular societies. It is not good to judge other family systems by the standards of the present but it is also a fact that these cultures need to change. For the purposes of this study, two different types of family forms will be discussed, namely: the nuclear family and the extended family.

2.3.1.1 Nuclear family

The nuclear family is the basic building block in a family structure. In this setting the home is composed of a mother, father and children. It is common in Western countries and is also becoming the custom in some other countries, which have contact, in one way or another, with the Western world. Modern society is mainly composed of these small "social cells" or nuclear families, which are gradually becoming smaller size. However this study also take into consideration single-parent households.

Hlatshwayo (1996) describes the nuclear family as a social unit in society consisting of a married couple and their children. This implies that the nuclear family basically comprises the father, the mother and their children. The nuclear family is also referred to as the monogamous family, which means a family consisting of one husband and one wife at a time, and their children. He distinguishes between two interpretations of the nuclear family which are not essentially different in composition, but which rather involve a different point of view.

- Firstly, every person belongs to a family of orientation in which he or she is born and reared and which include his father, mother, brothers and/or sister.

- Secondly, every normal adult also belongs to family of procreation, which is established by marriage and includes the person's spouse and children.

Although the structure of the family has not shown many changes through time, the formation of the family has undergone considerable modification as a result of a dynamic and rapidly changing society. Ezewu (1986) as cited by Hlatshwayo (1996, p.72) says that traditionally the family was a unit of both production and consumption as all family members contributed to the common family pool. The modern family has become more of a unit of consumption. As soon as children reach an age at which they are able to support themselves, they leave home and become "external producers" who no longer contribute to the common family pool.

2.3.1.1.1 Advantages of the nuclear family

Hlatshwayo (1996) refers to a nuclear family as having the following advantages:

- The nuclear family posits a permanent heterosexual relationship based on the innate physical and psychological needs of the father and mother.

- It is easier for the parents in nuclear family to regulate the size of their family (number of children).
- Closer companionship exists in the nuclear setting because husband and wife depend on each other for companionship and children depend mainly on their parents for affection and socialization.
- A wife can enjoy more love from her husband and also husband from his wife. Each one strongly focuses on the other without the interference of any third party, with the exception of their children. This enhances the relationship of love between parent and child.
- In the nuclear family the father's authority becomes highly effective. The father-child-reciprocity is manifested since there are no other superior figures, which might temper with the father's status and thereby weaken his authority.
- The father is the only "*iqhude*" (crowing cock) within the nuclear family setting. He is self-assertive and has a positive self-image; hence he exercises his paternal responsibility with

ebullience since there are no other powers within-his family which threaten to subjugate him.

- The limited number of the family members in the nuclear family enhances privacy for the family members.
- The size of the modern housing is more suitable for the smaller nuclear family.
- The nuclear family has a positive influence on birth control (an affordable number of children).

2.3.1.1.2 Disadvantages of the nuclear family

The following can be regarded as disadvantages of the nuclear family:

- In a nuclear family the possibility of loneliness exists because of the limited number of family members. This may make either of the parents more susceptible to the temptation of engaging himself or herself in extramarital relationships.
- The emergence of the nuclear family has increased the incidence of orphanhood. When biological parents die there are no extended

family members to adopt the children and it is difficult to 'transplant' these children to a foreign environment where there are no immediate blood relatives.

- Despite the harmonious intertwinement in the nuclear family it has also proved to be the one with the highest rate of family dissolution. In the event of altercations between spouses there is no mediator (family head) to intervene and marriages are more likely to be dissolved.
- In the nuclear family setting children are deprived of the situation where they may observe their parents' example of respecting their grandparents and thereby learning how children should respect parents.
- The custom of levirate, which improvised for widowed women, does not feature in the nuclear family. This may induce the widow to form relationships with males not approved by the family.

2.3.1.2 Extended family

This is the combination of nuclear families through the parent-child relationship. Such combination produces residential units of three or more generations- at least grandparents, parents and children (Leslie and Korman, 1989, p.32).

Extended family systems emphasize blood ties between parents and children or between brothers and sisters. The child growing up within the extended family learns to accept the authority of the oldest members of the family. It involves both economic and emotional obligations to the extended family. Extended family relationships have a strong impact on family structure and functioning.

The parent or parents become overly connected to their families of origin. They struggle with issues of control and find themselves unable to maintain their separateness from parents or siblings or achieve sufficient emancipation from parents. Care-taking responsibilities for children are ill defined. This lack of clarity about roles creates conflicts between parents and children.

2.3.1.2.1 Advantages of the extended family

The extended family has always played an important role in black society and has influenced almost all aspects of the black culture. Among the early black people the role of the extended family was to emphasize the importance of the bond of kinship in African societies. This is not the case in Western societies.

According to Myburgh (1991) cited in Hlatshwayo (1996, p.68) the following can be regarded as advantages of the extended family:

- Numerous activities are carried out jointly by the members of the family. During the process they learn values, respect and trust. They realise that success in the community is communal in nature.
- All the members of the family usually work collectively. The working members contribute economically whilst the elderly (non-working) members care for the household and the children.
- The loss of income or possessions in an extended family does not have serious detrimental effects on the particular family because there is "sharing" in all family matters. It requires only minor adjustments as extended family members come to the aid of the family member or members in distress.

- The child in the extended family is usually referred as ‘our child’ and not only the child of the biological parents. This indicates that the child is taken care of by all the adults in the extended family.

- The extended family is advantageous especially for orphans. In the case of death of biological parents, other adults in the extended family will automatically take care of the orphaned children. In the event of the death of a father it is expected that the elder brothers or half-brothers would be responsibly for the widow and the children. This is taken for granted because of the custom of “*ukungena*” (levirate).

- The eldest male in the extended family is the “*umninimuzi*” (family owner). In instances of disputes between family members the “*umninimuzi*” serves as a mediator. In the event of an altercation between a married couple, he would be the one to intervene with great prudence and give appropriate advised to the couple.

- Upbringing of children occurs at a wider scale in the extended family. The parents are not the only parties that are involved in

also involved. Grandparents teach children traditional skills and crafts and tell them folklore stories.

- The constant meeting with other relatives in the extended family leads to the establishment of strong family ties.

2.3.1.2.2 Disadvantages of the extended family

Ezewu (1986) cited in Hlatshwayo (1996,p. 72) views the following as disadvantages of the extended family:

- There is a bigger likelihood of quarrels, because the extended family consists of a large number of family members as compared to the nuclear family.
- There is a greater possibility within the extended family for husband and wife to have divided loyalties regarding their own families.
- Children may be indulged and spoilt by members outside the immediate family and hence their own parents' authority may be undermined.

- Elderly family members may pass on outdated traditions, attitudes and prejudices.
- The bond of love between husband and wife may be negatively interfered with if the husband fails to care adequately for his wife because he concurrently has to support his parents or other family members.
- The family head may wish to exercise his authority and powers over younger married couples, thereby subjugating the prerogative of the husband over his own wife. This may confuse the wife as to whose authority she has to abide to.
- In the extended family the multiplicity family members dilutes the intimate relationship, that is, are apparent in the nuclear family.

2.3.2 Components of families

Turks and Kerns (1985) refer to families as having the following components: -

- (a) Structure
- (b) Functions and assigned roles

- (c) Modes of interacting
- (d) Resources
- (e) A life cycle
- (f) A history
- (g) A set of individual members with unique histories.

Each of these components of families needs to be considered when discussing health, illness and families: -

- The structure or configuration of a family

This refers to characteristics of the individual members that make up the family unit including gender, age distribution, spacing and size or number of members.

- Function

This refers to the tasks the family performs for society and its members (such as education, economic production).

- Assigned roles

These concern the prescribed responsibilities, expectations and rights of the individual members. Thus one family member may be designated the role of breadwinner, another an overseer of health-care and still another the manager of the household operations. Roles do not have to be mutually exclusive and they seldom are. For example, in most families the mother is the custodian of health as well as the manager of the household.

- **Mode of interaction**

This relates to the style adopted by the family members to deal with the environment and with one another in both problem solving and decision-making.

- **Resources**

These include general health of the family members, social support and skills, personality characteristics and financial support. These resources will influence the way that the family interprets events.

- **Family history**

This refers to sociocultural factors as well as prior history of illness and modes of coping with stress. The history of the family will affect the ways families interpret and respond to various events.

- Life cycle

Families also have a life cycle that changes over time. The family progresses through a reasonably well-defined set of phases of development beginning with a courtship phase and ending with the death of parents or parent figures. Each phase is associated with certain developmental tasks, the successful completion that results in somewhat different levels of family functioning.

- Individual members

Families are comprised of individual members who have unique experiences beyond the family. They have their own unique conceptions and behavioural repertoires that account for a substantial portion of what is observed within the family contexts.

The above family characteristics are assumed to influence a variety of important health and illness issues over the entire life span. It is hypothesized that the family will play an important and necessary role in

the development of the individual's health-related attitudes and behaviours. To determine how families transmit attitudes about health, symptoms and illness, it is necessary to consider each of the above-mentioned characteristics of families.

2.3.3 Problems facing the families

According to Janzen and Harris (1986) there is a relationship between poverty and the problems of the families. Poverty is seen as clearly a cause of family problems particularly where the family has lived in poverty for a generation or longer. The problems of family functioning in poverty-stricken families will not be resolved without certain changes in the family's poverty status. Poverty-stricken families have variously been labeled 'disorganized' 'multi-problem', 'hard-to reach' and 'hopeless' (Janzen & Harris, 1986, p.113). Such labels prompt images of the kinds of parents and children that inhabit the family structure and the kind of relationships they have with one another, the ways they cope with family life in general and their own specific problems and the ways they engage with the outside world. Though these labels may in a sense be accurate, they are in another sense more appropriate to the ways social workers and other practitioners have responded to them.

The problems of the family may become the central handicap in its ability to extricate itself from poverty or its other problems. Poverty-stricken

families lack connection with the outside world. Encounters with institutions such as churches, schools and health services are dreaded and avoided. They tend to have a diminished self-esteem. There is a lack of knowledge of what may be available to them or how to make use what is available. Children receive minimal affirmation or recognition for their efforts in school. In poverty stricken families the relationship between the adults are characterized by distance and conflicts. In most case this translate into transient behaviour. The husband and the wife interact with each other primarily as parents, minimally as spouses. There is a lack of clear consistent norms and rules for child behaviour. There is a discrepancy in terms of the limits defined by parents. For example one norm may not be necessarily upheld by the other parent. Behaviour is regulated by injunctions on a particular piece of behaviour but with no further explanation about why it should be substituted. Children consequently have no consistent guides for behaviour that they can internalize and thereby become self-regulating, either in the parent's presence or away from them.

Parents are constantly required to regulate the activity of the children, leaving them totally enmeshed and absorbed in childcare and less free to meet their own needs. They feel overburdened and overwhelmed. They do not use available enrichment or educational groups that could offer them psychological support to reduce stress in their familial ties.

According to Elliot (1996) most of these families follow traditional patterns in family relationships. The men are usually given the role of being breadwinners whilst the women are involved in child rearing and the general management of the household.

Amongst black families, unemployment brings poverty, dependence and renders its constituents powerless. However, it places the unemployed and their families outside structures that are usually taken for granted in day-to-day living. Elliot (1996) further states that male unemployment deprives families of their primary means of economic support, which results in inappropriate sexual behaviours, such as incest. It also results in the children's poor performance at school. Broderick (1993) asserts that low-status parents have little influence and even if they attempt to participate in the school system they find that their opinions are ignored. They realise that decision-making, especially on school policies and practices, are on a remote level from their influence. For example, even if they find out that school rules and curricula are sometimes ill-suited to their children's interests or needs, they find it difficult to intervene.

The foregoing argument clearly indicates the fact that the outcome of the child is the responsibility of the family and is dependent on the amount of communication that takes place amongst family members.

2.3.4 Parenting styles in modern society

In traditional black society the family setting was mainly patriarchal, with the father as the dominant figure of authority. As the principal figure of authority all activities and procedures in the family were controlled by him. The latter is referred to as an authoritarian parenting style. Western culture, however, brought about changes in the absolute authority of the father with the emergence of parents with a permissive or democratic parenting style. Jarvis (1983) cited in Hlatshwayo (1996) states that parenting styles are changing at a varying pace. This means that there is constant flow of new knowledge and skills acquired by the parents. As soon as changes occur in the culture of a group of people, the manner in which parents educate and discipline their children will have to be reassessed and rephrased. It is therefore essential to explore the different parenting style in modern society against the background of a traditional black family system in terms of which roles, interactions, objectives and values are defined.

The following are the parenting styles: -

Authoritarian parent style

According to Margow and Oxtoby (1987) cited in Hlatshwayo (1996) the authoritarian parent is the one who is in control and decides on all

activities and procedures in the home. He expects total obedience from the child. His attitude and behaviour is prone to dictatorship. He sets pre-ordained limits that have to be adhered to unquestioningly. He does not entertain dialogue about rules and principle with his children and as a result the child is hardly ever given the opportunity to state his own views. There is a considerable psychological distance between an authoritarian parent and the child. This also extends to the limited intensive communication that takes place in the family structure (Hlatshwayo, 1996,p.94).

The authoritarian parenting style entails a cold, dominant educational atmosphere. The parent is intolerant and in many aspects makes high demands on the child. The child who fails to meet these demands is dealt with harshly. Children who have been intolerantly reared become passive people without much initiative. This is as a result of continual correction that has smothered the child's initiative. He has learnt that mistakes are not tolerated. Authoritarian parents are usually lacking in praise and criticism and tend to be aloof. These parents tend to shape, control and evaluate the child's behaviour and attitudes in accordance with absolute standards. This kind of upbringing is characterized by rigid disciplinary measures. For example, if children revolt against parents' authority or question it in any way, obedience is exacted from them by punishment. In

this instance corporal punishment plays a dominant role (Hlatshwayo,1996, p.94).

Children from authoritarian families generally manifest one of the following two behavioural patterns:

- They are often troubled by feelings of inadequacy, inferiority and shame. Creativity and effective problem-solving behaviour patterns are absent in these children because they are not given the opportunity to take risks and solve problems independent of their parents' approval. Their relationship patterns are generally characterized by an immature dependency on other people. They are hesitant to take responsibility and do not accept challenges unless they are assured of success beforehand.
- They rebel against the parents' strong authority, especially during adolescence. They become defiant, negative and aggressive, and rebel against all forms of authority. Serious clashes usually occur and they are in conflict with their parents.

Dornbusch (1987) cited in Hlatshwayo (1996) states that children who grow up in an authoritarian household tend to be moody, unhappy, retiring, uninterested, inhibited and irritable. They are less self-reliant, creative,

intellectual curious, mature in moral judgment and flexible than children who are exposed to other parenting styles. These children are usually shy, lacking in self-confidence and have a negative opinion of the parents, with the result that they may gradually become increasingly rebellious towards their parents' parenting style. They express their resentment in negative, provocative and challenging behaviour that may culminate in serious conflict.

2.3.4.1 Permissive parenting style

Parents who resort to a permissive parenting style are usually exceedingly tolerant, non-controlling and non-threatening towards their children. Permissive parents take a passive role and give complete freedom for group and individual decisions relating to group procedure and participation. The parent makes it known that he is available when required but takes little initiative. He uses little punishment and tends to accept the child with all his impulses, desires, drives, action and immature behaviour. The parent imposes few demands regarding responsibility and the child is left to regulate his own activities.

Permissive parents rarely make demands or impose restraints on the child but grant him a considerable degree of freedom. There are virtually no limits set on the child. Children with permissive parents often feel

vulnerable. They are not ready and mature enough to use their unlimited freedom wisely, with the result that they develop a sense of uncertainty and insecurity. They are often inclined to be impulsive and to display a lack of self-reliance and self-control. They also seem to be selfish and lacking in terms of social responsibility and appreciation for what parents or other people do for them. If things do not go their way, they tend to become demanding and impatient and are quick to reproach their parents for their uninvolved and failure to provide guidance (Hlatshwayo, 1996,p.96)

As a result of inadequate self-actualization children from permissive parents are not great achievers because from a young age very little was demanded or expected from them.

2.3.4.3 Democratic parenting style

The democratic parent is also called the accepting and understanding parent because he accepts the child as he is, and realizes the value of democratic communication with the child. The parent regards the child as an equal. The parent has a companionable attitude and takes the child's wishes and desires into account.

Democratic parents set clear limits and lay down categorical rules, but they are prepared to discuss these and the reasons for imposing them with

their children. They set a premium on autonomous and disciplined behaviour, yet they are accepting, flexible and understanding. Communication is encouraged. They try to see the child's point of view and listen to logical reasoning. They also assist the child to see the logic behind acceptable and non-acceptable behaviour. These parents are sensitive for their children's emotional needs and try to understand their heartache, anger or disappointments before they announce judgment and mete out punishment.

Parents allow children to participate in matters concerning the family and verbal give-and-take is encouraged. The characteristics of a democratic parent are inductive disciplinary behaviour. The parent avoids a direct conflict of interest with the child by trying to make the child see the sense of his/her reasoning by explanation and discussion. This is also accompanied by giving reasons for the desired behaviour and by pointing out the consequences of unacceptable behaviour.

Children from democratic parents have been found to meet independent behavioral expectations and are socially responsible and independent. They are capable of stating their views because they are assured of their parents' love for them. They communicate easily and with openness and adjust well to diverse situations. Parents who are democratic in their parenting style promote responsible and independent behaviour by

- Giving the child the opportunity to be independent whilst maintaining communication with, interest in and adequate control over him.

- It is a suitable model for the child to identify himself/herself with, because the relationship is based on mutual respect and love.

- It is also a model that allows a reasonable independence or independence within certain limits, that is autonomy within a democratic setting.

The above-mentioned factors reveal that parenting styles have a marked influence on the development of a child and can inhibit or enhance the child's attainment of independence and self-reliance as an adult. However it is relevant to bear in mind that the parents' behaviour subsumes a combination of different parenting styles.

2.3.5 Family communication about sexuality

The term "communication" is defined as an exchange of ideas or expressions to enhance mutual understanding between people (The Random House Thesaurus, 1984, p.147). Tubbs & Moss (1991) regard communication as 'the process of creating a meaning between two or more people'.

Through communication, the partners involved are constantly suggesting meaning in their relationships, which convey certain messages to both of them. Among the three forms of communication mentioned above there is a transactional form of communication, which entails not just a two-way flow, but also numerous other processes such as both verbal and non-verbal, occurring simultaneously. Lauer and Lauer (1994) refer to verbal communication as 'what' is said and non-verbal communication as to 'how' is said.

Communication between parents and children about sexuality seems to have a negative connotation. Viewed from the perspective of the above paragraph the "how" communication by parents is a matter for deeper scrutiny. Rice (1992) assumes that the parents feel threatened in talking about these issues with their children. They think that the sex education has an effect of arousing curiosity among their children, thus creating the desire to experiment with sex. This assumption borders on the fact that the less information about sex children are exposed to; the less likely they are to practice it. The inability of parents to communicate with children about sex causes them to be the victims of inaccurate sex information from their peers and thus gets them to become victims of, for example, HIV/AIDS.

Jaccard, Dittus and Gordon (1998) have characterized the communication process between parents and their children in terms of five communication dimensions:-

- The extent of communication (measured in terms of frequency and depth).
- The style or manner in which information is communicated.
- The content of communication.
- The general family environment, for example the overall quality of the relationship between parent and teenager in which communication takes place.

The five communication dimensions listed above clearly indicate that not all communication dimensions make sense to the child. Factors such as time, place, content and the manner in which communication is made, are all important factors. For effective communication between the parent and the children, the above-mentioned dimensions, should be observed and taken into account.

In modern society parenthood is very challenging because of the following reasons:

- Parents are required to master attitude and techniques that differ considerably from the ones they learned from their parents.

- Today parents nurture their children in a pluralist society, characterized by diverse and conflicting values.
- Parents have to compete with several other factors that may influence the child, for example the school, church, peers, television, movies and books.
- Experts in child rearing disagree among themselves and this aggravates the confusion.

Chetty (1998) cited in Mandondo (2002) maintains that parenthood is associated with child rearing and that it must be specific to certain norms (p.10). Parents are integral to schooling. This indicates the important role played by parents in moulding a child to become a unique person. It also clearly indicates the influence parents have on their children.

2.3.5.1 Parental involvement in schools

The theory of parental involvement maintains that before the child goes to school, the parent contributes in many ways to the development of the child. For example, by the time the child goes to school, he has the ability to play, to observe the rules of safety, to use toilet facilities, to move about, to wash himself, to utter words, to mention a few ethical and aesthetic living skills. He has the concept of wrong or right and knows

parents, especially the mothers to children. Every child becomes a member of a family on the strength of the bond of love that exist between the parents. Since parents have the obligation of helping the child towards adulthood, they must have an important say in the education of their children.

The following are some of the important factors, which may influence parental involvement in education.

2.3.5.2 Socio-economic status of parents

Sills cited in Mzoneli (1991) maintains that professional educators tend to talk “to” parents rather than “with” them. Some parents will thus develop an inferiority complex educationally (p.38). They may feel that educators will not listen to them and that they as parents are not capable of understanding the complexities of the school educational programme. This is a practical problem with black parents who are illiterate or semi-illiterate.

These parents may come to the parents’ meeting reluctantly, fearing that their views will be regarded as naïve, uninformed or unimportant. The school can help resolve this dilemma by assuring parents that this is the forum whereby their concerns and view points are encouraged.

Some parents may not come to the parents' meeting because of personal circumstances. These include factors like working conditions, lack of transport, and lack of confidence in the ability to contribute ideas or fear of rejection by the principal or teacher.

2.3.5.3 The parent-teacher relations or attitudes

The attitude of a parent towards education goes hand-in-hand with his involvement in the education of the child. The child whose parents have a positive attitude to education will have positive results in his academic achievement. The attitude of the parents towards the school depends on the attitude of the principal towards the active involvement of the parents in the school affairs. It is essential that the principal understands and accepts the right of parents to organize themselves in to a collective force for implementing change.

Furthermore, parents are likely to be willing and effective supporters of the school in which the principal helps to provide encouragement and professional direction to their quest for meaningful participation.

2.3.5.4 Lack of communication between parents and policy-makers.

In order for education to satisfy the needs of the nation, it is essential that policy-makers should consult parents before the decision-making process. There are decisions which are taken without considering the environment of the child. For example, according to the Department Circular No.31 of 1998, all students who failed standard 10 should repeat this

class in a newly established type of school, namely the Finishing schools. These schools are available in the urban areas only. Consequently, children in the rural areas have problem of getting into a finishing school.

2.3.6 Categories of parental involvement

Mandondo (2002) mention three forms of parental involvement:

- Co-operation
- Partnership
- Participation

2.3.6.1 Co-operation

It must be recognized that the quality of education and teaching in schools improves with an improvement in the quality of co-operation between educational authorities in the school and parents. A strong relationship should be established between parents and educators. They are in pursuit of a common goal, namely effective teaching and to achieve it they have to cooperate with one another on all levels in the school. Parents do not have to be well educated to help. For real co-operation parents and educators have to share skills and information with each other and to do so in an open, honest way, which includes recognition of each other's limitations in knowledge and expertise.

Mandondo (2002) states that the following aspects have to be taken into account for real co-operation between parents and teachers to exist:-

- Parents and teachers need each other. They are in pursuit of a common goal, namely, effective educative teaching, and to achieve it they have to co-operate with each other.
- All people need to pull or push to the same direction to achieve the goals desired.
- One of the basic requirements for the co-operation between home and school arises from the recognition of how much they have to learn from one another. They have no alternative but to keep the communication channels between them open for the sake of the child's education.
- Co-operation implies the active involvement that arises from the parent's interest in the child's welfare.
- Co-operation will improve if education is regarded as a key avenue to economic advancement as well as having a value of its own. Lifelong co-operation and participation with educational processes must be viewed as providing inestimable benefits to self, family and community. For a school to become meaningful and purposeful for the student, it must become an integral part of the family consciousness.

2.3.6.2 Partnership

There is a growing acceptance of and support for the view that when professionals and parents share some of the same goals and work together in an active partnership, things can really begin to happen. The principle of partnership in management is of utmost importance and is based on a fundamental relationship of trust and openness between partners.

A successful partnership depends on parents and educators trusting each other, being aware of and understanding each other's needs and aspirations, communication, effectively and having a say in the education of the child, with due consideration of each other's field of expertise. Therefore, partnership requires working in a team, which implies co-operation, not confrontation, integration not isolation and continuity not competition.

According to Jetkins (1988) and Kruger (1989) cited in Mandondo (2002,p.24) true partnership involves working jointly to educate the child in the fullest sense of the word. It involves the building up his:-

- Sense of self-worth
- Social skills
- Human understanding
- Thinking capacity

- Reasoning
- Self-discipline

Oosthuizen (1992) cited in Mandondo (2002) asserts that parents should become more actively involved in the teaching of programmes in schools. When parents become involved in the instructional process, they are more likely to make schools a priority for their children and their children are likely to better their performance. This enhanced achievement by the child may be due to the following:-

- The lessening of distance between the goals of the school and those of home.
- The positive changes in teachers' attitudes resulting from the greater sense of accountability when parents of their children are visible in the school.
- His or her increased sense of control over his/her own destiny when he/she sees his/her parents actively engaged.

As parents visit the schools, knowledge about the students is increased. Parents are in better position to assist the school in helping the student to the fullest. Sound partnership between the school and the home is highly recommended.

2.3.6.3 Participation

Through participation the parent can restore his/her natural right in education. Participation does not mean that every one participates in everything, but rather those

parents are sufficiently represented on all levels. There must be reinforcement of participation by the whole school. Parent involvement impacts on learners' achievement when that involvement is meaningful to parents.

The parent can restore his natural right in education through participation. According to Dekker and Lemmer (1993) cited in Mandondo (2002,p.26) participation does not mean that everyone participate in everything, but rather that parents are represented on all levels of schools management. Gains are reported when parents are involved as supporters and reinforces of their child's school learning and when parents are told about their children's school progress.

2.3.6.4 The interaction between schools and families with regard to HIV/AIDS life skills programme

The HIV/AIDS life skills programme in schools does not intend to replace the moral teaching of parents to their children. It is designed to give children the facts and knowledge about human sexual relationships. Page(1990) suggests that educators must work as partners with parents in the delivery of sexuality education to children. Such programmes afford participants the opportunity to pose questions, increase their level of sexual information, evaluate their attitudes, rectify myths and inaccuracies, evaluate options and make decisions in a non judgemental environment (Miller, Forehand & Kotchick, 1999,p.53).

Parents should be recognized as an integral part of the school system. Teachers should be prepared to listen to them and train them to take a more active role in the education of their children. Jennings (1992) assumes that when parents' messages are consistent with those given by teachers, children are far more likely to absorb them hence parents and teachers should work in collaboration. Schools should promote partnerships which will increase parental involvement and participation in promoting the social, emotional and academic growth of children (Osborne & De Onis 1997). Bundy and White (1990) suggest that schools are there to supplement the parents' efforts.

Family life education according to the Natal Education Department (1990) suggests that the programme offered by schools should reflect the needs and values of the school and the community. The school should discuss both the content and method of teaching sex education with its parent community before implementing the programme. All parents have their own moral, religious and ethical positions on subjects and have the right to know both what is being taught and how it is being taught. Parents need not be rigid but instead should be acquainted with the changing times. They should acquire knowledge about skills of dealing with their children at different developmental stages. They have to understand problems and challenges brought by these developmental stages through which their

children undergo and work hard to empower themselves through the skills acquisition.

Wilson (1991, p.66) has the following strategies for family intervention in the school programme:-

- Teachers should find some opportunities to interact with a range of parents from a variety of backgrounds, listen to them and learn from them.
- Teachers should inform parents ahead of time about the specific content, aims and underlying values of the programme.
- Parents should be involved as members of an ongoing advisory committee that reviews programme content and approves all print and audio-visual resources for the students
- Invite parents to a meeting so that they can find out more about the programme and view a sampling of the films planned to be used.
- Assign homework that children can complete together with their parents. Homework activities can balance the roles of home and school by supporting the parents as primary sex educators of their children. The simple act of doing homework together results in increased family communication about sexuality. If the homework assignment is designed the right way, that communication will involve active listening and sharing of opinions on both sides.

- At the end of the programme, the teachers should send parents an evaluation form that is designed to get the parents' input about the effectiveness of the program.
- Offer programs directly to parents to help them become more effective life skills educators.

The above-mentioned strategies can serve as guidelines to family intervention in schools and can improve communication among family members. Life skills programme can provide parents with skills in order to perform their God-given duty with regard to parent-child relationship.

According to Kalafat and Illback (1998) family support programs arose in response to the ongoing effect of poverty, joblessness, poor health care, substance abuse, divorce, teen pregnancy and other socially disintegrative factors. These programs provide a wide variety of emotional informational and instrumental assistance. The basic premise for progress rests on evidence that children's sense of self and achievement is tied to that of their parents, and that the quality of parents' lives is affected by the resources and environment of the community in which they live. The above-mentioned authors also mention the fact that the family support programs enable us to recognize that the child service system tends to be fragmented, in accessible, duplicative and ineffective. It shows evidence for the efficacy of preventive versus remedial crisis-oriented programs.

Although schools contribute to the social and academic development of children, they cannot make up for the lack of resources many students experience outside of school and that parental involvement in the education process can have significant positive effects on their children's achievement.

The school-based family resource and support programs enhance the participation of families to enable children's readiness for learning and this is achieved by empowering families to access a variety of services and resources, and to forge cooperative links among families, schools and communities (Kalafat & Illback, 1998,p.574).

Hlatshwayo (1996) refers to black people as traditional, social and community orientated. They engender a feeling of solidarity resulting in most of the duties in the community being communal in nature. There is little or no encouragement of individuality as this would be in conflict with cultural stability and group solidarity. Hlatshwayo (1996) stresses the fact that communalism is a common feature of the black culture with communal practices like "*ilima*" (communal labour) and "*inqhina*" (communal hunting), etcetera (p.64). In black culture all activities such as "*ukulima nokuvuna*" (tilling and reaping of the fields) are activities performed in a collective manner.

A Xhosa proverb, "*Umntu ngumntu ngabantu*" (a person is a person because of others) refers to black people doing tasks together. The term "*ubuntu*" can be defined as a spiritual idea, which directs the life experiences of black people. Direct translation of the word "*ubuntu*" into one English word is not possible because it encompasses values such as humaneness, reliability, honesty, courtesy, respect for authority and various other positive values. Educational implications of "*ubuntu*" are, inter alia, an acceptance of the reality of cultural differences and a cautious view of intergration at school level. "*Ubuntu*" explains the emphasis on the communal life which permeates every aspect of black culture, that is, extended family, the kinship system, communal land and, in particular, the tribal system (Hlatshwayo, 1996,p.65)

The above notion concurs with the principles of "inclusive education system" with its three independent practical components, namely:

- A support network, which is formed by individuals who support another in the formal and informal ways including school-based support systems, education support services in the education district and a partnership with the community organizations.

- Interactive consultations and collaboration which include individuals with a variety of abilities who work together to plan and

implement programmes for a diversity of learners in regular schools or learning centres.

- Co-operative learning which refers to the creation of a classroom learning atmosphere in which learners with various abilities and interests can realize their potential (Dednam, 1999,p.2).

The above information ensures the necessity for family intervention and promotes the notion that “schooling process should rightfully be experienced as ours-owned by us” (Donald, et al, 1997,p.21). Networking among parents, teachers and learners is inevitable for the learning culture in local schools to take place.

2.4 Resume

This chapter has focused on theory and practices of community psychology. It has provided knowledge on how different levels of models of community psychology can be of practical use in giving away psychology to the people, and families in particular. Family interactions have been discussed and how the families can form partnership with school in fighting HIV/AIDS in the communities have been analyzed.

Chapter three will describe the research design of the study.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1 Introduction

This chapter pays attention to research methodology used in this study and this includes research methods, techniques and procedures followed in conducting this study.

The research methodology is concerned with the researcher's ultimate goal and general plan for achieving these goals. The objectives of this study were three fold, namely:-

- The promotion of mental health in the form of improved family communication about HIV/AIDS.
- Evaluation of improved knowledge, attitude and practices concerning HIV/AIDS
- Promoting the value of psychological interventions among Xhosa- speaking families.

3.2 Research design

The research design is the overall plan or strategy by which questions are answered or hypotheses tested. It provides the answer to the question, "what are the means which I shall use to obtain the information I need?" (Mckendrick, 1993, p.256).

The research design is referred to be a plan of action aimed at the expanding of knowledge.

A social action evaluative research approach was used. The general aim was to investigate the effectiveness of family intervention in the HIV/AIDS life skills programme in schools. According to Weiss (1972) evaluative research is concerned with finding out how well the action programs work. It represents the application of social science research methods to discover information of importance to program practice and public policy. When there is a serious interest in finding out how well the program is working, the investigation can proceed by several routes (Weiss, 1972, p.5).

Evaluative research can take place in the context of action research whereby it does not only involve the participants but also takes steps towards changing conditions (Sarantakos, 1998).

The aim of this study therefore was to change the conditions in local schools and communities through improving family interventions in the HIV/AIDS life skills programme.

The assessment technique was both qualitative and quantitative whereby both questionnaire and focus group interviews were administered so as to assess and monitor people's opinions about the HIV/AIDS programme in schools.

3.3. Sampling Technique

A sample is defined as a selection or portion or subset of the population that represents the entire population. Sampling is a process of selecting the sample regarding phenomena in a way that represents the population of interest (Berg 2001). The researcher, worked with selected Grade 7 learners, their teachers and parents in two schools, randomly selected from urban and rural areas in the Mthatha district of the Eastern Cape.

Grade 7 learners were chosen in these schools as target population because they were still maturing towards adult life. As emerging adolescents they were expected to make informed decisions about relationships and were at a developmental stage that caused them to become more interested in the opposite sex as they grow older (Haines, 1999,p.33). The learners' ages ranged from eleven to seventeen years. According to Ketterman (1994) puberty is commonly established by age eleven or twelve. From about age six to age twelve children are busy growing physically, mentally and socially. They are learning sense of duty and should discover what happens when they fall short in being responsible. Successful parents set up policies, establish consequences and allow natural consequences to go into effect. By these methods, children are being prepared for the independence of adolescence (Ketterman, 1994, p.158).

Parents must communicate clearly and regularly regarding children's strengths and weaknesses, assets and liabilities, if children are to receive the help they need to become healthy independent adults.

3.4 Research Instruments

3.4.1. Pre-test questionnaire

3.4.2. HIV/AIDS life skills programme

3.4.3. Post-test questionnaire

3.4.4. Focus group interview

A research questionnaire is the most common research instrument. It comprises a series of questions that are filled in by all the participants in a sample. The investigator may wish to elicit information from the subjects to supplement findings and compare with other observations (Treece & Treece, 1982; p.277).

3.4.1 Pre-Test Questionnaire

The pre-test questionnaire consisted of questions from “skills for life Grade 7 learners book”. What was added were variables such as age, gender, status and language. The respondents were asked to rate their knowledge, attitude and practices (behaviour) with regard to HIV/AIDS on a Likert scale, that is, a five point scale scored as follows: -

1 = Strongly agree (SA)

2 = Agree (A)

3 = uncertain (not sure) (U)

4 = Disagree (D)

5 = Strongly disagree (SD)

The main aim of this questionnaire was to establish base-line data concerning respondent's knowledge, attitude and practices about HIV/AIDS.

3.4.2 HIV/AIDS Life skills Programme

This programme was taken from "Grade 7 learner's book- Skills for life" by Elizabeth Haines. A questionnaire was designed. Lessons on Unit 22 on HIV/AIDS (pgs 82-89) were conducted under the following headings: -

1. What is HIV? What is the difference between HIV and AIDS?
2. How quickly does HIV/AIDS spread?
3. Facts about HIV/AIDS
4. The ways in which HIV/AIDS spread
5. Don't become infected with HIV/AIDS

The programme was administered for nine weeks. Parents and teachers worked together with learners on the same lessons. Different dates were set for each school.

3.4.3 Post-Test Questionnaire

The questionnaire used for this study is the same as the pre-test questionnaire. The main purpose of this questionnaire was to evaluate how the HIV/AIDS life skills programme

was received by the learners, teachers and parents, whether there were significant changes in their knowledge, attitude and behaviour (practices) with regard to HIV/AIDS.

3.4.4 Focus group interview

The group interviews were used mainly as a vehicle for gathering information and providing a new dimension for gaining perspective, for verification and for the observation of group dynamics in operation. Focus group interviewing is a qualitative research technique for collecting data from a small number of participants, usually six to ten, who are interviewed in a group rather than individually.

Focus group discussion is conducted as an open conversation in which each participant may comment, ask questions from other participants or respond to comments by others, including the interviewer. Focus group research is a means of yielding data to complement data gathered through quantitative approaches such as the sample survey.

According to Ferreira and Ruth (1998) the aim of focus group interviewing is to allow the direction of a discussion to be influenced by the special concerns of the participants, by the natural "climate" of the group and by the group interviewer or moderator. The format of focus group interviewing is thus generally flexible but will vary according to the directive or non-directive role of the interviewer. A focus group interview generally involves eight to twelve individuals who discuss a particular topic under the direction of a professional moderator, who promotes interaction and assures that the discussion remains

on the topic of interest. A typical focus group session will last about two hours (Bickman & Rog, 1998,p.505).

In focus group there is a minimum of artificiality of response, unlike in survey questionnaires that ask for responses expressed on 5-point rating scales or other constrained response categories. Focus group responses have a certain ecological validity that is not found in traditional survey research.

Sarantakos (1998) refers to a focus group as a post-research method that can explain trends and variances, reasons and causes, through the views of the respondents. In the focus group interview people have an opportunity to think aloud about their private perceptions of issues or events, sometimes coming to new understandings through interaction with others in the group and fresh insight into how people construct their worlds.

Krueger (1993) asserts that the goal for using focus group interviewing is to gain reactions to areas that need improvement or general guidelines on how an intervention might operate.

In this study the researcher decided to have two sets of group interviews namely:- with educators and parents. For the purpose of this study the focus group was used as a supplement to the questionnaire on HIV/AIDS issues to get participants' understanding of and perspectives on these issues.

The focus groups discussed the three aims of this study namely:-

- Promotion of mental health in the form of improved family communication about HIV/AIDS issues.
- Evaluation of improved knowledge (information) attitude (beliefs) and practices (behaviour) on HIV/AIDS issues.
- Promoting the value of psychological interventions among Xhosa families in the Eastern Cape by a way of formulating a school policy on HIV/AIDS that would suit the needs of the individual community.

The questions were in the following form:-

1. After this programme do you think it necessary that family members should communicate in their homes about HIV/AIDS issues and parents involve themselves in school programmes?
2. Do you perceive yourself as having gained more information about HIV/AIDS after this programme that may lead you to be able to communicate differently about sexuality with your children/learners?
3. Is it necessary that traditional Xhosa families be taught about psychological interventions, for example, what to do when one of the family members is infected? What policy should your school follow regarding a teaching approach about HIV/AIDS to learners/children.

The interviewer changed the mode of questioning whenever there was a need to do so.

3.5 Procedure for administration of the research instrument

- (a). A request letter for permission to undergo a research study on HIV/AIDS in schools of Kwa Sabatha Dalindyebo District was written to the District Director (Appendix I).
- (b). Permission was obtained from the District Director of Education Department in Kwa Sabata Dalindyebo (KSD) District (Appendix II).
- (c). A covering letter which briefly describes this study was delivered to the two schools involved, that is, E.W. Pierce Junior Secondary School and Mkwezo Junior Secondary School. (Appendix III)
- (d). The following instructions were given to the respondents:-
 - (i). This is a questionnaire that needs to be completed by everybody. The aim is to find out information on HIV/AIDS issue.
 - (ii). Do not write your name on the questionnaire.
 - (iii). Answer these questions as honestly as possible.
- (e). The questionnaire is divided into four parts namely:-

Section A: demographic Information

Section B: questions on knowledge about HIV/AIDS

Section C: questions on attitudes on HIV/AIDS

Section D: questions on sexual practices

(f). The questionnaires were administered in both schools during the first week of the nine week-programme and random allocation was done to determine which school to start with.

(g). The teaching process took place as follows:-

(i). During the first week the learners and teachers of the urban school were taught information about HIV/AIDS issues so that they could gain more knowledge. After being taught learners were required to interact with their parents in the form of classwork and homework exercises. Parents and educators had to monitor and reward them.

(ii). The same procedure was followed for the next two weeks. Information on different types of attitudes and different behaviors that led to HIV/AIDS infection was discussed.

(iii). During the third week different behaviours that led to HIV/AIDS were also discussed in the classroom with teachers. Learners were required to discuss with parents and parents had to give their own opinions and feed back.

(h). On the fourth week the post-test questionnaire was given to all the respondents in both urban and rural schools.

(i) The same procedure that was with the urban school (E.W. Pearce School) was repeated in the rural school (Mkhwezo School).

(j). On the eighth week respondents in both schools were post-tested

The above procedure is represented by the following table: Numbers from 0-8 represents weeks.

	0	1	2	3	4	5	6	7	8
Urban	Pretest	Test 1 On knowledge	Test 2 On attitude	Test 3 On practices	Post test	No test	No test	No test	Post test
Rural	Pretest	No test	No test	No test	Post test	Test 1 On knowledge	Test 2 On attitude	Test3 On practices	Post test

Table 3.5

(k). On the ninth week eight educators and parents were selected among the respondents to form two focus groups i.e. focus groups of eight educators and eight parents in each school. Through focus groups, the researcher was able to find out what participants felt, thought and knew about the focus of inquiry.

The participants had an opportunity to listen to each other's contribution, which sparked new insights or helped them develop more ideas about the topic.

(1). During focus group interviews, discussions were recorded on tape with the consent of the group. Discussions took place for about an hour in each of the two groups.

3.6 Statistical analysis

Non-parametrical statistical analysis was performed with the Statistical Package for the Social Sciences (SPSS) using Kruskal-Wallis analysis of variance for ranked data and Chi-square tests of significance.

3.7 Resume

This chapter has dealt with research methodology for a facilitated family interventions in the HIV/AIDS life skills programme in Mthatha schools. Information about the knowledge, attitudes and behaviours of Grade 7 learners, educators and parents of Mthatha schools on HIV/AIDS was obtained through the use of a self-administered questionnaire and focus group interviews with the parents and educators.

CHAPTER FOUR

4. DATA ANALYSIS, RESULTS AND DISCUSSION

4.1 Introduction

This chapter focuses on data collected through qualitative and quantitative research methods. The analysis of the data was conducted bearing in mind the main objectives of the research. They are as follows:

- To promote mental health in the form of improved family communication and HIV/AIDS.
- To evaluate the improved knowledge, attitudes and practices of learners, educators and parents on issues pertaining to the spread of HIV/AIDS.
- To promote psychological interventions among Xhosa families of the Eastern Cape within South Africa.

4.2. Data description

All participants were Xhosa speaking people. Two schools, one from an urban area and another from a rural area, were selected as a sample. Twenty grade seven learners with their parents and teachers were randomly selected from the two schools. The data originated from a questionnaire, which was administered as pretest, posttest1 and posttest 2 and two focus groups with teachers and parents being interviewed.

4.2.1. Demographic information

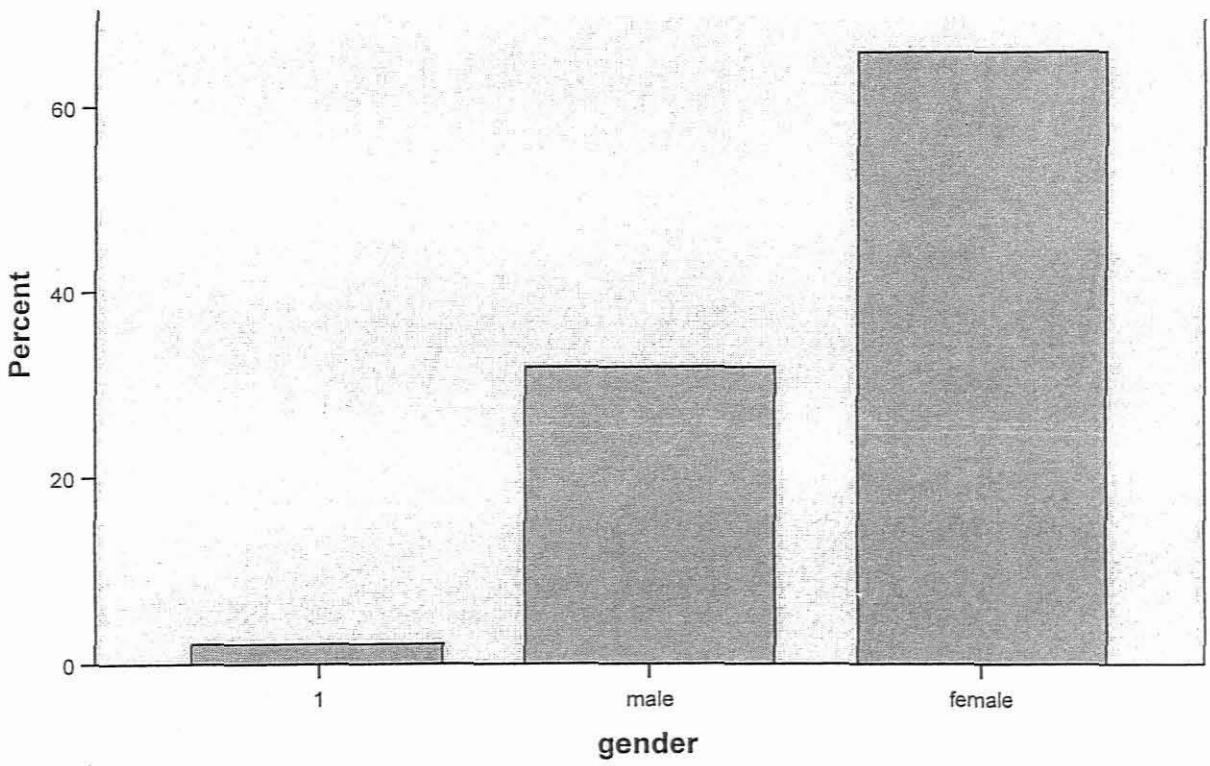
This data is presented in the tabular form of frequency tables and bar charts.

The following is the biographical data of the participants of school, which is predominantly in the urban area.

Table 4.2.1.1. A table and a bar chart displaying the gender of participants in school 1

(E.W. Pearce Junior Secondary School)

Gender	Frequency	Percentage
Missing data	1	2.1
Male	15	31.9
Female	31	66.0
Total	47	100



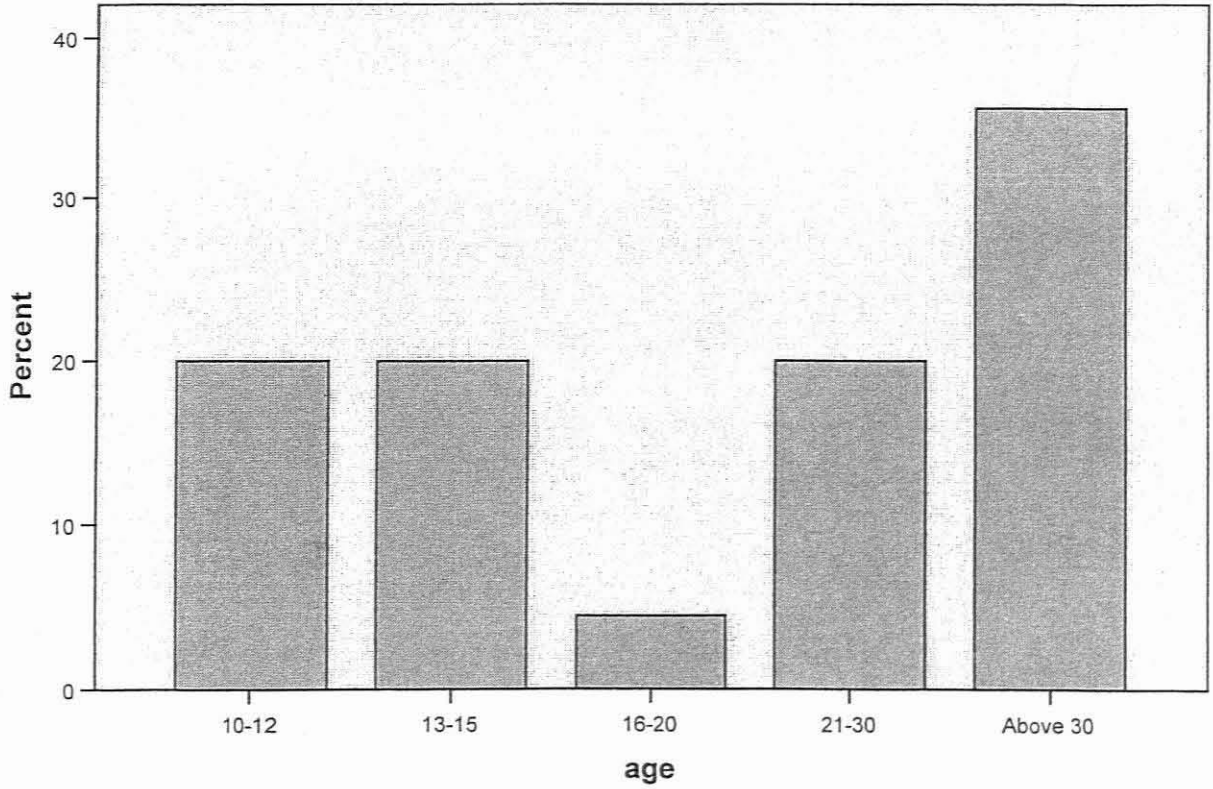
Bar chart on the gender

There were more female participants (66.0%) than male participants (31.9%).

Table 4.2.1.2. A table displaying the ages of the participants in school 1

Age	Frequency	Percentage
10-12	9	19.1
13-15	9	19.1
16-20	2	4.3
21-30	9	19.1
Above 30	16	34.0
Total	45	95.7
Missing System	2	4.3
Total	47	100

age



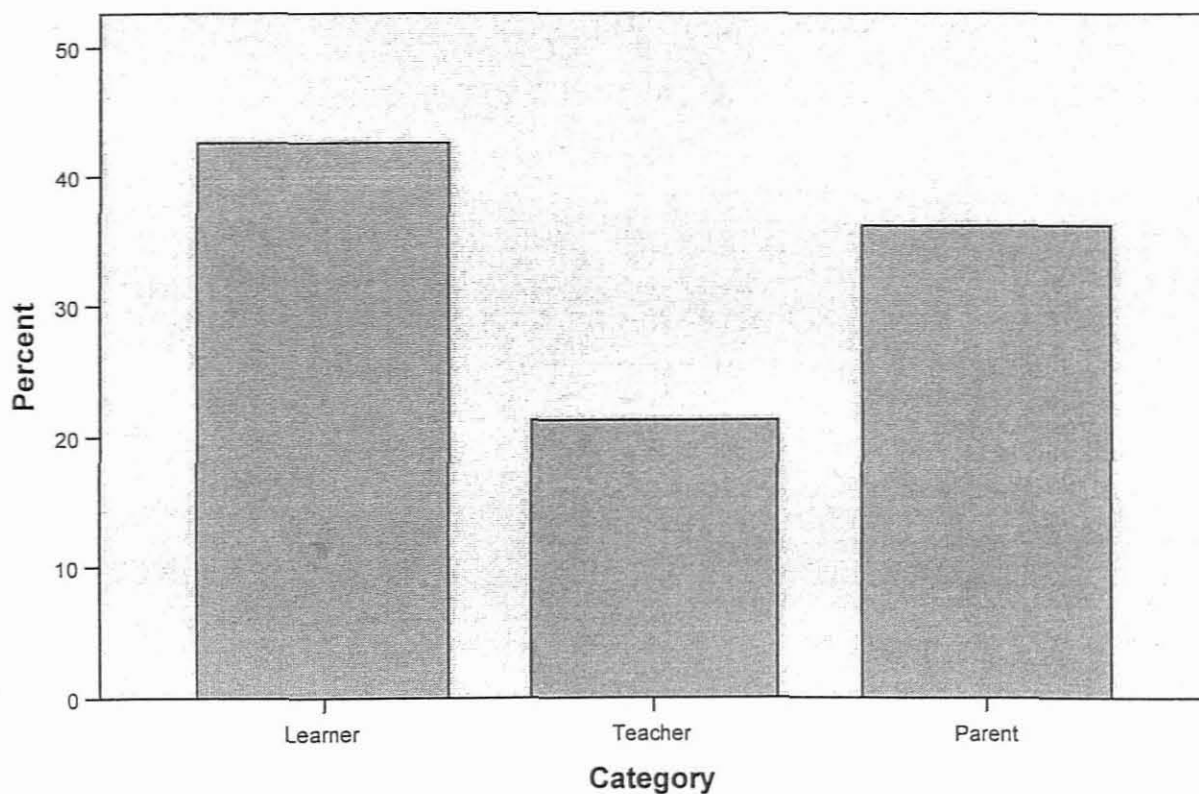
Bar Chart

More participants fall in the above 30 age category (34.0 %).

Table 4.2.1.3. A table and bar chart displaying the category of the participants in school 1

Category	Frequency	Percentages
Learner	20	42.6
Teacher	10	21.3
Parent	17	36.2
Total	47	100

Category

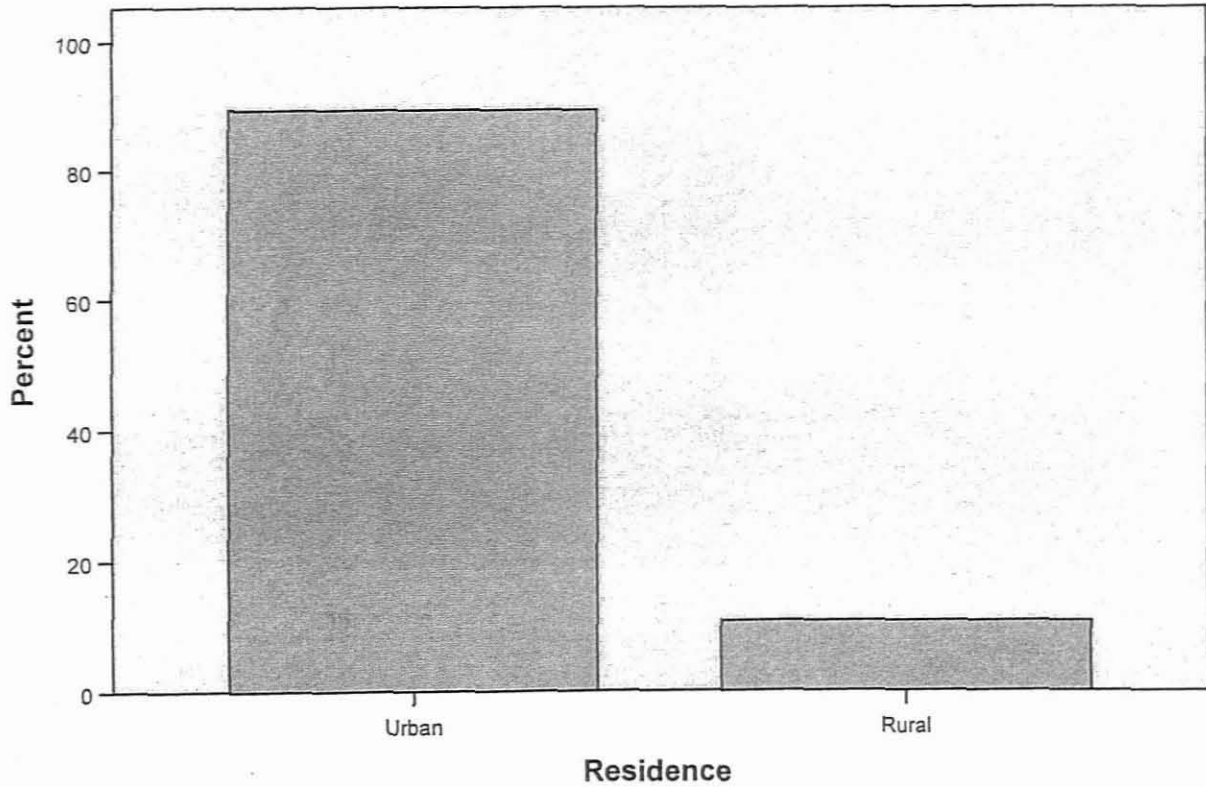


Bar chart on the category of participants

More learners than parents and teachers (42.6 %) participated in the study.

Table 4.2.1.4. A table displaying residence of the participants of school 1

Residence	Frequency	Percentage
Urban	42	89.4
Rural	5	10.6
	47	100



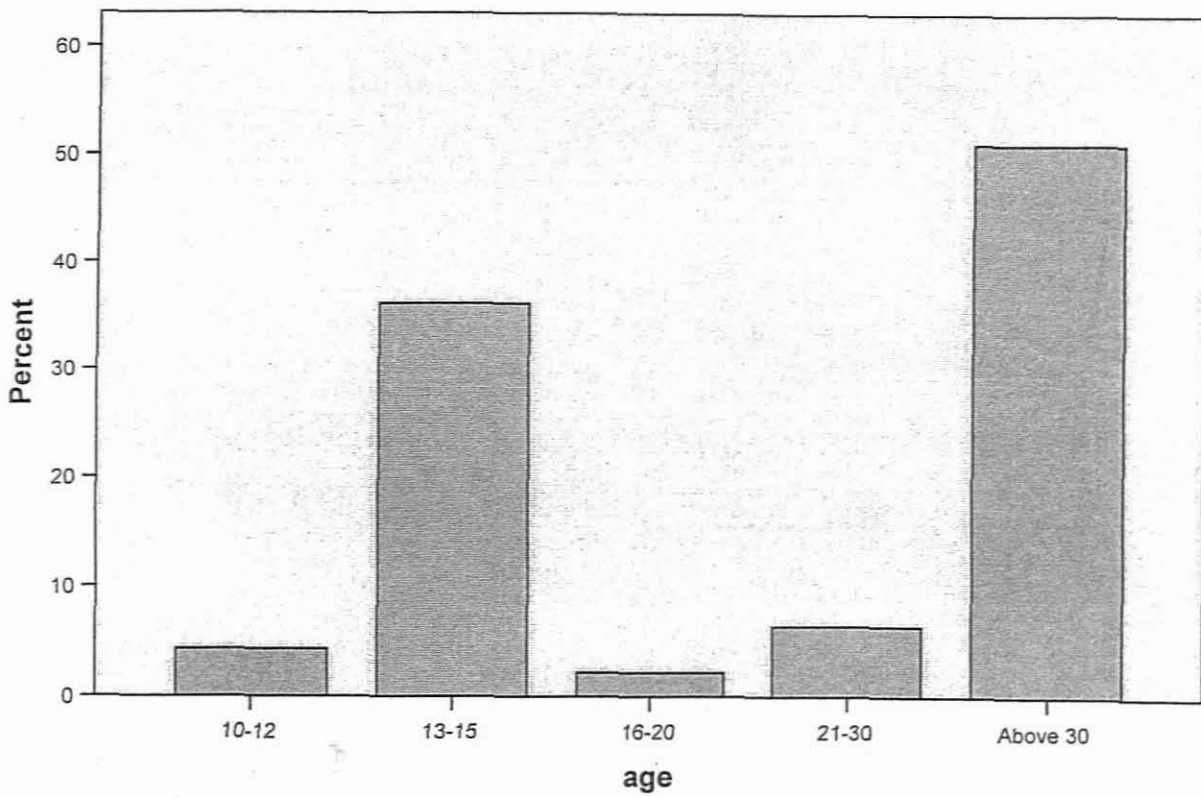
Bar chart on the residence

Though the school is in the urban area there seems to be 10.6% of the participants that are staying in the rural area while schooling in the urban school.

The following is the biographical data of school 2, which is predominantly in the rural area.

Table 4.2.1.5. A table displaying gender of participants in school 2.

Gender	Frequency	Percentage
Male	13	27.7
Female	34	72.3
Total	47	100



More participants fall in the above thirty age category (51.1%) and 36.2% were learners whose ages range between 13-15 years.

Table 4.2.1.6 A table displaying the category of participants in school 2

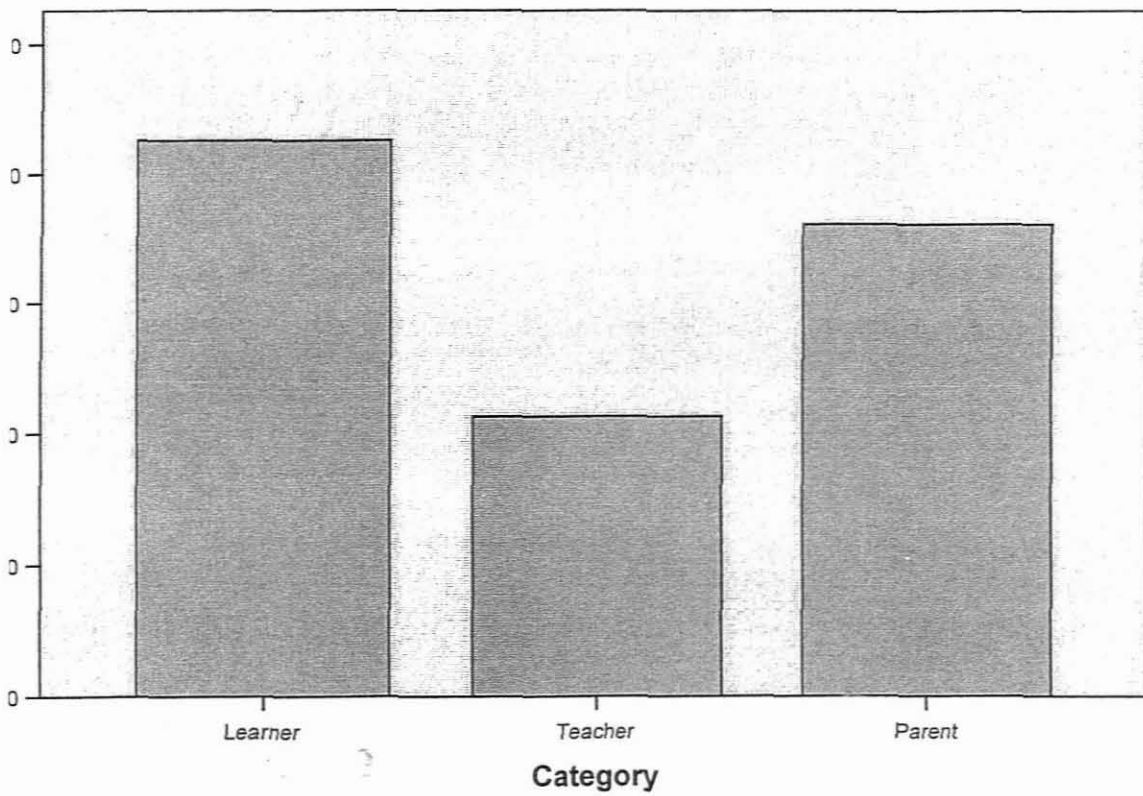
Category	Frequency	Percentage
Learner	20	43
Teacher	10	21
Parent	17	36
Total	47	100



There were more female participants (72.3%) than male participants (27.7%) in the rural area.

Table 4.2.1.7 A table displaying the ages of the participants of school 2

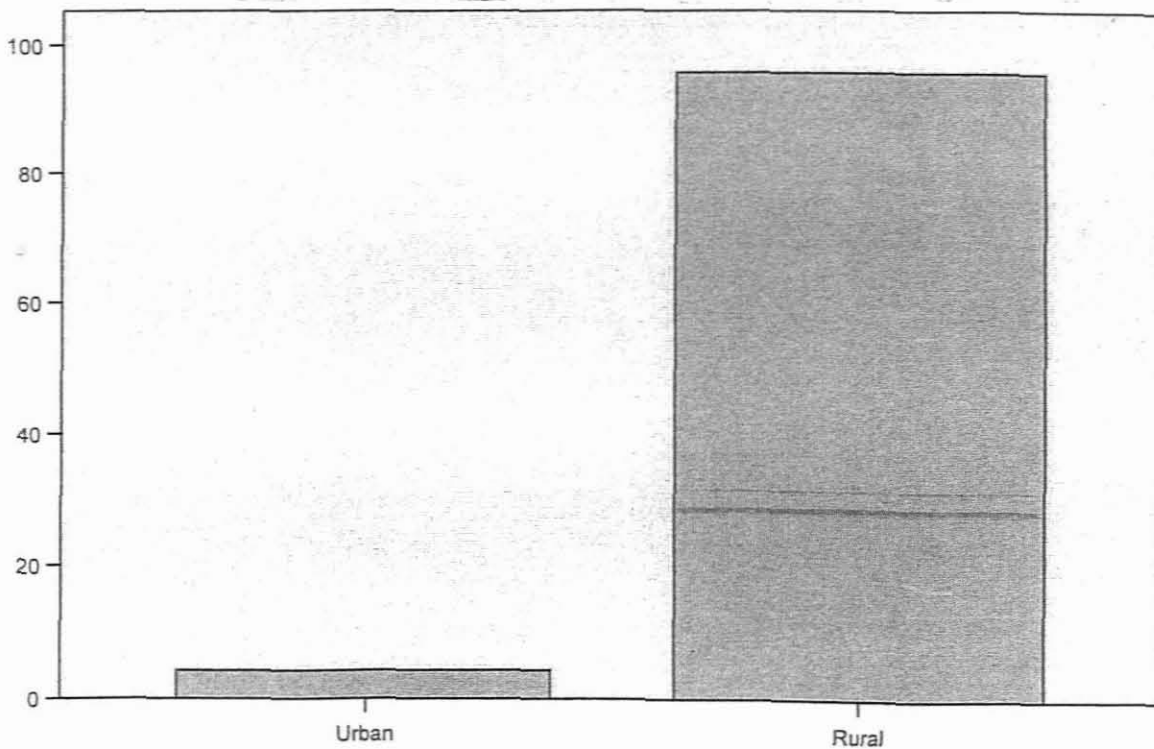
Age	Frequency	Percentage
10-12	2	4.3
13-15	17	36.2
16-20	1	2.1
21-30	3	6.4
Above 30	24	51.1
Total	47	100



Learners were more enthusiastic for the study than parents and teachers.

Table 4.2.1.8 A table displaying residence of school 2

Residence	Frequency	Percent
Urban	2	4
Rural	45	96%
Total	47	100%



Bar chart

School 2 is a rural school and 96% of participants were residents in the rural area. Only 4% of urban residents were schooling in the rural area

4.2.2 Quantitative analysis of data and results

In the results that follow, summary mean tables are followed by a short interpretation and discussion of results on the knowledge, attitude and behavioral practices about HIV/AIDS of the two interventions i.e. urban area (E.W.Pearce School) and rural area (Mkhwezo School) at the pretest, posttest1 and posttest 2. The following are comprehensive summary results: -

Table 4.2.2.1 Results of the knowledge about HIV/AIDS of all the participants.

This table refers to Kruskal-Wallis Analysis of knowledge scores for all participants, namely learners, parents and teachers at pretest, posttest 1 and posttest 2.

Test	N	MEAN RANK
KNOWLEDGE Pretest	96	88.99
Post test 1	76	166.72
Post test 2	69	115.17
Total	241	

Chi - Square	53.498
df	2
Asymp.Sig	.000

Chi - Square analysis yielded a statistics of 53.5 which was highly significant ($X^2 = 53.5$, $p < .01$)

From inspection of table 4.2.2.1 it is clear that there were increases in knowledge for all participants over time.

Table 4.2.2.2 Results of the attitude of all the participants towards HIV/AIDS information.

This table refers to the Kruskal-Wallis analysis of attitude scores for all participants: learners, parents and teachers at pretest, posttest 1 and posttest 2.

Test	N	Mean Rank
ATTITUDE Pretest	96	83.90
Post-test 1	76	156.62
Post-test 2	69	133.38
Total	241	

Chi- Square	49.708
Df	2
Asymp. Sig	.000

Chi-Square analysis yielded a statistics of 49.7 which was highly significant ($X^2 = 49.7$, $p < .01$)

From inspection of table 4.2.2.2 it is clear that there were increases in attitude for all participants over time.

Table 4.2.2.3 Results of behavioural practices of all participants that may contribute towards HIV/AIDS. This table refers to the Kruskal- Wallis analysis of practices scores for all participants: learners, parents and teachers at pretest, posttest 1 and posttest 2.

Test	N	Mean Rank
PRACTICES Pretest	96	113.23
Post test 1	75	119.51
Post test 2	69	131.69
Total	240	

Chi-Square	2.886
df	2
Asymp .Sig	.236

Chi- Square analysis yielded a statistics of 2.9 which was not significant ($X^2 = 2.9$, $p = .24$)

Though table 4.2.2.3 overall results show that there was no significant increase in practices for all participants over time, mean rank observations indicate a slight change in

both post test 1 and post test 2 which indicates that the intervention had a positive effect on the behavioral practices towards HIV/AIDS over time.

Table 4.2.2.4.results of parents on both schools. This table refers to the Kruskal-Wallis analysis of the scores for knowledge, attitude and practices of all parents in both schools at pre-test, post test1 and post test 2

	Test	N	Mean Rank
Knowledge	pretest	36	36.58
	Post test 1	28	68.84
	Post test 2	29	38.84
	Total	93	
Attitude	Pretest	36	34.49
	Post test 1	28	61.91
	Post test 2	29	48.14
	Total	93	
Practices	Pretest	36	40.57
	Post test 1	27	43.93
	Posttest 2	29	56.26
	Total	92	

Statistics	Knowledge	Attitude	Practices
Chi- Square	28.413	16.497	5.978

Df	2	2	2
Asymp. Sig.	.000	.000	.050

From table 4.2.2.4 it was observed that there was significant change in knowledge ($X^2 = 26.4, p < 01$) and attitude ($X^2 = 16.5, p < 01$). There seems to be no significant change in practices ($X^2 = 6.00, p > 01$).

Table 4.2.2.5 the results of all teachers in both schools. This refers to the Kruskal-Wallis analysis of the scores for all teachers' knowledge, attitude and practices at pretest, post test 1 and post test 2 in both schools:-

	PREPOST	N	Mean Rank
Knowledge	pretest	20	18.15
	Post-test	12	36.13
	Post test 2	10	10.65
	Total	42	
Attitude	pretest	20	15.20
	Post test	12	36.08
	Post test 2	10	17.80
Practices	pretest	20	24.30
	Post test	12	23.75
	Post test 2	10	13.20
	Total	42	

STATISTICS	KNOWLEDGE	ATTITUDE	PRACTICES
Chi- Square	26.443	122.734	6.131
Df	2	2	2
Asymp. Sig.	.000	.000	.047

From inspection of table 4.2.2.5 it is clear that there were significant increases in knowledge ($X^2 = 26.0$, $p < 01$); in attitude ($X^2 = 22.7$, $p < 01$) and in practices ($X^2 = 6.1$, $p < 01$).

Table 4.2.2.6 the results of all learners in both schools. This refers to the Kruskal-Wallis analysis of the scores for all learners' knowledge, attitude and practices at pretest, post test 1 and post test 2 in both schools:-

Test	N	Mean Rank
Knowledge pretest	40	37.94
Post test 1	36	60.57
Post test 2	30	65.77
Total	106	
Attitude pretest	40	35.51
Post test 1	36	60.99
Post test 2	30	68.50
Total	106	
Practices pre test	40	48.21
Post test	36	53.94
Post test 2	30	60.02
Total	106	

STATISTICS	KNOWLEDGE	ATTITUDE	PRACTICES
Chi -Square	16.967	23.188	2.563
df	2	2	2
Asmp. Sig.	.000	.000	.278

From table 4.2.2.6 it was observed that learners' scores in the two schools significantly increased only in knowledge ($X^2 = 17.0, p < .01$); and attitude ($X^2 = 23.2, p < .01$). There was no significant change in learner's practices ($X^2 = 2.7, p > .01$)

Table 4.2.2.7 Results of all participants of the first intervention (E.W.Pearce school in the urban area). This table refers to the Kruskal- Wallis analysis of the first intervention (E.W. Pearce school) in urban area with knowledge, attitude and practices of all participants at pretest, posttest 1 and posttest 2.

	TEST	N	Mean Rank
Knowledge	pretest	48	40.26
	Post-test	40	91.44
	Post test 2	35	58.17
	Total	123	
Attitude	pretest	48	40.84
	Post test	40	85.49
	Post test 2	35	64.17
	Total	123	
	Test	N	Mean Rank
Practices	Pretest	48	64.08
	Post test 1	39	59.51
	Post test 2	35	60.17
	Total	122	

STATISTICS	KNOWLEDGE	ATTITUDE	PRACTICES
Chi-Square	45.623	34.839	.434
df	2	2	2
Asmp. Sig.	.000	.000	.805

From the inspection of table 4.2.2.7 it is clear that there were significant increases in knowledge ($X^2 = 45.6$, $p < 0$,) and attitude ($X^2 = 34.8$, $p < 01$) only. There was no significant change in practices ($X^2 = .43$, $p > 001$) after the first intervention.

Table 4.2.2.8 Result of all the participants of the second intervention (Mkhwezo school in the rural area). This table refers to the Kruskal-Wallis analysis of second intervention (Mkhwezo School) in the rural area with regard to knowledge, attitude and practices of all participants at pretest, posttest 1 and posttest 2.

Test		N	Mean Rank
Knowledge	pretest	48	49.10
	Post test 1	36	74.93
	Post test 2	34	57.84
	Total	118	
Attitude	pretest	48	43.41
	Post test	36	71.17
	Post test 2	34	69.87
	Total	118	

Practices	pre test	48	50.49
	Post test	36	60.74
	Post test 2	34	70.91
	Total	118	

STATISTICS	KNOWLEDGE	ATTITUDE	PRACTICES
Chi-Square	11.961	16.113	.7223
df	2	2	2
Asymp. Sig.	.000	.000	.027

From the inspection of table 4.2.2.8 all participants' scores on knowledge, attitude and practices changed significantly: knowledge ($X^2 = 11.9, p < .01$); attitude ($X^2 = 18.1, p < .01$) and practices ($X^2 = 7.2, p < .01$)

As observed in all the results of the tables above, even if not all analyses were significant, there seems to be a trend towards a positive effect of the HIV/AIDS life skills programme to all the participants, namely learners, parents and teachers in both the urban and the rural areas. The time factor between the two interventions seemed to have impacted negatively on some of the results.

4.3 Results of the qualitative data

The following are the findings of the focus group interviews of the parents and teachers. The findings showed a positive impact of the HIV/AIDS life skills programme and necessity of future family psychological interventions in schools programme. They resulted in an improvement in knowledge, attitude and behavioral practices of all participants as shown below.

The researcher interviewed parents and teachers of both schools and their comments emanated in the following themes:

- Importance of the programme
- Learner-teacher-parent communication on HIV/AIDS
- Necessity of psychological interventions in schools where parents and teachers would work together in partnerships.
- Formation of school policy with regard to HIV/AIDS in schools

4.3.1. Importance of the programme

Both parents and teachers in the two schools evaluated the programme as excellent. They strongly supported the programme, indicating that it caused a remarkable change in the behaviour of their children. A parent from the rural area commented that her son was very mischievous but ever since he started with this programme he manifested improved

behaviour. One of the parents from the urban area enumerated what she had learnt from the programme by making the following statements.

- “In this programme I learnt that:-
 1. To use a condom cannot protect you against AIDS.
 2. AIDS is not a punishment from God
 3. You cannot get AIDS by touching somebody’s skin.
 4. You can be infected with HIV even if you have sex with only one person.

The programme was very helpful to me and has given me facts to teach all my children not only the one you have chosen.”

One teacher commented that the programme had taught her to be very cautious about how she should conduct herself with regard to sex so as to avoid contracting HIV/AIDS. “I thought the programme was meant for learners, I nearly missed important information for my life and my future. I feel sorry for the teachers who showed lack of interest” she commented.

The negative comment about the programme was that it took a short period of time and that it should have started early in the year and questionnaires should be in both Xhosa and English. Both parents and teachers complained that such a good programme should not have been available to a few sample of learners because the majority of learners had missed such important information, especially those in Grade 8 and 9 because they were already experimenting with sex. It should also be taught as early as the foundation phase.

The overall comments were of the opinion that the programme should continue even in 2006 as early as February.

4.3.2 Learner-teacher-parent communication about HIV/AIDS.

Both parents and teachers experienced difficulty in talking about sexuality matters to learners. One teacher commented that, “though we are expected to teach life skills including HIV/AIDS it becomes very difficult to us as Xhosas to talk to children about sex. In our culture we were taught that sex is a taboo, so it becomes difficult now that we are expected to talk and teach it (*Hayi iyasinzimela mpela* i.e. to be realistic we are really experiencing problems). We don’t even allow learners to ask many questions on such topics. I think it is better if you as a Psychologist, you come and assist us. As a result with you they respond positively and show their curiosity, and yet with us they become very shy.”

Parents had the same notion that as parents it is not permitted by our culture to talk about ‘*ukulala emntwaneni* (to have sexual intercourse),’ but such programmes are liberating our mindset. Some teachers felt that it should solely be the duty of a parent to talk about HIV/AIDS since the topic is value laden, while parents commented that the teachers are being trained to teach and the government has been running workshops for them.

Communication about sexuality seems to be problematic with Xhosa speaking people.

4.3.3. Necessity of psychological interventions in schools to form parent-teacher partnerships.

Both parents and teachers felt it necessary that they should work together. One parent from the urban area listed the following reasons: -

- “ What is being taught to our children should be of concern to me because I also teach my child HIV/AIDS, I should know whether what the teacher teaches is the same as what I teach at home. It may confuse the child if we, as parents and teachers, teach the child different things.
- It will also benefit the child if he is not taught by one person, that is, the teacher, but also by the parent. To be taught by both the parent and the teacher would be a sign to the child that he or she is cared for and what is taught is very important. I, personally, think that parents should be written letters that will let them know of any decision taken by the teachers, because it is clear to me that we as parents do not have time to attend the school meetings, especially that meetings are held during the busiest hours of the day. At least if such meetings were held during weekends then maybe it could be easy for us parents to attend. During weekends I feel we are all free as parents.”

One parent from the rural area felt that their children should be given homework instead of them coming to school. “If you, as teachers, give our children homework as has been done with this programme and you see to it that we sign our children’s homework books,

it would make things easy because we are also working during the day, so it becomes very difficult for us as parents to attend meetings at school.”

Some parents prefer that well-known experts in HIV/AIDS should be invited at school at least twice a term to talk to their children about HIV/AIDS. Parents can be invited to workshops at school so that they can also get knowledge, may be that would improve their communication with their children on such matters. The majority of parents felt it necessary that knowledgeable people on the subject must be invited. Parents and teachers should be part and parcel of the proceedings. They should know what is taught to their children.

Some parents and teachers complained of groups like ‘Love Life’ whom they refer to them as emphasizing condoms instead of abstinence. Some parents felt that psychologists are only people who can deal with HIV/AIDS lessons appropriately because they call ‘a spade a spade’.

4.3.4 Formation of school policy with regard to HIV/AIDS

Parents and teachers in both schools prefer that abstinence be emphasized in the school policy on HIV/AIDS. Some parents suggested that learners should be taught Christian principles and know that their bodies are the temples of God. Therefore they should keep themselves pure and that abstinence is the only medicine that is better than any pill. Emphasis should be put on the contagiousness of the disease and learners should engage

in sexual intercourse within the marriage discourse. It was also suggested in the school policy that certain reinforcements should be given to girls who keep themselves virgins until they pass Matric or they are 18 years old.

Peer counselling should be included in the school policy where learners should be taught counselling skills so that they can counsel those who are HIV positive and should be taught signs of an infected person. All parents should be involved in the school policy to come and interact with teachers, assisting them on such lessons.

One teacher suggested that HIV/AIDS lessons should be taught, starting from gender differences, that God created male and female for a purpose. Children will conceptualize sexual orientation early in life and will have right perception about manhood and womanhood. Lessons should start from foundation phase, so that learners can be able to make right choices early in life.

Children should always tell their parents what has been taught and how they have been taught about HIV/AIDS so that parents should assist in correcting wrong perception and misinformation as early as possible. Every week a parent must have at least one lesson on HIV/AIDS that he/she has discussed with his/her child.

Learners should be taught on how to consult HIV/AIDS help line, HIV/AIDS Agencies and should visit the centers of people dying with AIDS. Learners from urban areas should visit those in rural areas and exchange their knowledge about HIV/AIDS. They should be

given time to share their views so that parents and teachers could see how much they know about HIV/AIDS.

4.4 Discussion

Both quantitative and qualitative results of this study indicated significant changes in the knowledge and attitude of all participants, (table 4.2.2.1 and 4.2.2.2) with regard to HIV/AIDS issues and there seemed to be generally positive changes in behavioural practices in all the participants (table 4.2.2.3).

Close scrutiny of the results reveals that the intervention programmes of life skills on HIV/AIDS had a positive impact in changing the participants' knowledge, attitude and practices. Such results support the research by Peterson (1998) and Seedat, et al (2002) that *community psychologists can make influential contributions to HIV prevention*. Community psychology focuses on prevention rather than treating dysfunction (Seedat, et al, 2001).

Results of parents and teachers in tables 4.2.2.4 and 4.2.2.5 on knowledge, attitude and practices showed more significant changes compared to results of learners in table 4.2.2.6. According to Mudari (1998) adolescents are vulnerable to the normative social influence of their peers who tend to discourage adoption of sex methods by encouraging negative associations to be attached to condoms and their use. Though they may have knowledge about HIV, most have not personalized the threats of AIDS. According to Levine (1998)

programmes that support people to encourage each other to use the preventive approach will be more effective than if the intervention is geared only to individuals. This study then promotes interaction between parents and teachers with regard to imparting life skills about HIV/AIDS to learners. The research (Nzima, 2002; Mandondo, 2002) promotes co-operation, partnership and participation between parents and teachers. Parents should be recognized as an integral part of the school system. This concurs with the principles of inclusive education that support networks should be formed between school-based support system and community-based organizations (Dednam, 1999).

In the qualitative results parents and teachers in both schools evaluated the programme as excellent since remarkable change in the behaviour of the learners was observed. Also in the results of quantitative data (table 4.2.2.6) the mean ranks of post test one and post test two indicated that there was remarkable change in all variables. This indicated that the programme was effective for all participants.

Qualitative results revealed that teachers and parents were still experiencing difficulty in communicating about sexuality matters to learners since Xhosa culture refers to talking about sexual matters as a taboo. Mudari (1998) states that the provision of sexual health education by parents to African youth is a challenge. Sexual matters are predominantly “taboo subjects”. This is also the case when talking about sex within the family setting, hence some communication dimensions between parents and children are suggested in this study. Jaccard, Dittus and Gordin (1998) advise parents to listen, talk to and answer their

childrens' questions as honestly as they possible can. They should take into account each child's needs, age and circumstances.

The results also support the formation of school policy in each school with regard to HIV/AIDS. Parents and teachers in both schools preferred that abstinence rather than condom-use be emphasized in school policy on HIV/AIDS. Mudari (1998) believes that if young people are given the information and skills they can be responsible citizens. She argues that awareness creation does not help young people to change their behaviour, instead AIDS education should focus on skills building. The youth should be given the skills to negotiate abstinence or safe sex. She further states that an environment should be created which encourages and enables young people to change their behaviour and to create a culture of human rights that enables them to live positively.

4.5 The resume

This research had the initial objective of changing the level of knowledge, attitude and behaviour of grade seven learners, their parents and their teachers with regard to HIV/AIDS. An in-depth analysis of quantitative data was accomplished by using the Statistical Package for the Social Science (SPSS) with Kruskal-Wallis Analyses of variance for ranked data and Chi-Square tests of significance. Focus group interviews elicited qualitative data to reflect the authentic experiences of the research participants and to ensure the validity of the information on HIV/AIDS

Both quantitative and qualitative results in this research revealed improved knowledge, attitude and behavioural practices in all participants in both schools. In the in-depth analysis of all variables, teachers seemed to be more informed than the parents. Due to culture perhaps, all participants seemed to express difficulty in communicating about sex issues.

In conclusion, both quantitative and qualitative results of the programme indicated a need for HIV/AIDS life skills by both urban and rural communities. Though the results have shown that teachers are more knowledgeable than other groups, it appears as if all the groups, namely: - teachers, parents and learners, lack sufficient knowledge with regard to HIV/AIDS life skills.

CHAPTER FIVE

5. SUMMARY OF FINDINGS, LIMITATIONS OF THE STUDY, CONCLUSION AND RECOMMENDATIONS.

5.1 Introduction

The aim of this study was to: -

- Promote mental health in the form of improved family communication about HIV/AIDS
- Evaluate improved knowledge, attitude and practices on HIV/AIDS
- Promote the value of psychological interventions among Xhosa speaking families

This chapter will discuss the following: -

- Findings
- Limitations
- Recommendations and
- Conclusion

5.2. Summary of findings

The study of understanding the general behaviour of a community with regard to the spread of HIV/AIDS is not an easy exercise to pursue because research on such a problem involves some significant complications. On the one hand, the cultural beliefs of people are of a great concern and on the other hand, there should be sensitivity to people's general beliefs regarding matters surrounding the issue of HIV/AIDS as this has a direct relationship with sexual matters. This is a subject that requires a careful approach particularly in most African communities who regard open discussion on sexual matters as a taboo.

The essence of this research concerned an investigation into family interventions in school based HIV/AIDS life skills programme. The emphasis was on interaction among Xhosa-speaking parents, teachers and learners in Mthatha schools in the Eastern Cape Province of South Africa with regard to their knowledge, attitudes and practices on issues pertaining HIV/AIDS.

5.2.1 Demographic information

In this study it is observed that there were more female participants than males both in urban and rural areas. The research (Dlamini 2005) states that gender is a source of stigma and discrimination in that more women are usually blamed for infecting their families and partners. This may also be related to the fact that promiscuity in men is accepted in Xhosa

culture and it is believed that women should be taught how to conduct themselves. They are not allowed to engage in extramarital affairs as so accepted with males. It is also stated in the literature review that Black society is mainly patriarchal (Hlatshwayo 1996).

It is also observed that parents and teachers in both schools were not very co-operative in this study. As already stated in the literature review, parents and children's communication about sexuality matters seem to have a negative connotation and there is lack of cooperation between parents and teachers (Rice, 1992, Nzima, 2002, Mandondo, 2002 and Miller, Forehand and Kotchick, 1999).

According to the place of residents, this study indicates that though some participants stay in the urban area, they send their children to attend schooling in rural areas and even some teachers stay in urban areas though they work in the rural areas. This may have affected the results of the study because there were no significant differences between the results of the two schools.

5.2.2 Quantitative and qualitative data

Post-test results in this research, after the programme was administered to both schools, revealed that all the participants showed improvement with regard to knowledge, attitude and practices on risky behaviours, though there were differences in the response to the questions. This showed that the knowledge of facts surrounding the HIV/AIDS epidemic depends on the category (parent, teacher or learner).

Both quantitative and qualitative results clearly showed that teachers were more informed about the causes of HIV/AIDS than their counterparts, namely, learners and parents. This makes sense in view of the fact that teachers are generally more enlightened than other members of the society. This formed the pattern of the general response to various questions. The findings on knowledge, attitude and practices also depends on one's area of residence. Though the results of this research show no significant differences between the urban residents and rural residents, in depth qualitative analysis of responses showed that urban residents were generally more informed about HIV/AIDS epidemic than rural people. The rural people were also less knowledgeable than urban people. These findings concur with other research (Peltzer, 2003) indicating that teachers have the knowledge and ability to teach about HIV/AIDS, but lack some material and community support. The research states that among teachers with sufficient knowledge, many feel uncomfortable discussing these issues with students especially topics related to safer sex and homosexuality.

The qualitative results as revealed by the comments of the teachers in both schools suggested an ambivalent attitude to teaching life skills about HIV/AIDS. The programme demands much caution in dealing with this and that such programmes should be started as early as foundation phase. Both parents and teachers confessed to experiencing difficulty in talking about sexuality matters to learners. Parents commented that it is not permitted by their culture to talk about sex.

Both parents and teachers concluded that parent-teacher partnerships could facilitate the implementation of such programmes, abstinence be emphasized in school policy on HIV/AIDS and learners should be taught to critically evaluate reasons for delaying sexual intercourse or practicing abstinence. These findings are supported by research (Peltzer, 2003) that the goal of life skills and HIV/AIDS education learning programmes is to increase knowledge, develop skills, promote a positive and responsible attitudes and provide motivational supports. Expected outcomes are that students will be able to demonstrate a clear and accurate understanding of sex, sexuality, gender and sexually transmitted diseases and methods; critically identify ways in which HIV/STDs can and cannot be transmitted, identify and evaluate the effectiveness of HIV/STD prevention methods, identify access and mobilize sources of assistance within a community, respond assertively to pressures for sexual intercourse, critically evaluate reasons and methods for having protected sex when/if sexually active, respond assertively to pressures of unprotected sex, accept, cope and live positively with the knowledge of being HIV-positive, show compassion, empathy and solidarity toward persons with HIV/AIDS and those affected, recognize the need to provide basic care for people with AIDS in the family and community and those affected, understand the grieving process and cope with loss (Peltzer, 2003 p.2).

The conclusion drawn here is that psychological interventions in schools are a necessity and this concurs with the community psychology movement in an attempt to take psychology to the people to help themselves through improved social welfare, education,

health, networking and development of projects (Orford, 1992; Edwards, 1999 and Seedat, et al. 2001).

5.3 Limitations of the study

The limitations of this study were as follows:

The questionnaire constituted of questions, which had leading answers such as (1) for 'strongly agree' (2) for 'agree' up to (5) for 'strongly disagree'. The general understanding of any questionnaire with leading answers is that they are pre-determined. This in itself is a disadvantage, as it does not give room for the interviewees' opinion. Hence, the focus group interview was done so that interviewees be given a chance to express themselves in such a way that a sense of originality is achieved.

Another limitation is the failure of the questionnaires to record a similar number of response to similar questions. An example is where a respondent would decline answering a question without any justification, creating a situation of a lot of missing data. In addition, the planning of administration of the questionnaire did not give a balanced rating to the number of interviewees under each category. It was noted that more learners were interviewed than teachers and further that the number of interviewees differed according to category. A focus group interview should also have been conducted with learners.

Language became a factor as there were observed differences in responses based on ones area of residents. Some people did not respond to some questions presumably because of language inefficiency. Thus, people who live in urban areas were more advantaged than those who live in rural places.

5.4 Recommendations

- Parents must be encouraged to participate in all school programmes and formulation of school policy on HIV/AIDS.
- There should be continuous interaction between teachers, parents and learners in the form of partnerships.
- Parental guidance is recommended where parents, including illiterate parents from rural areas, are empowered with life skills in order to help their children with regard to HIV/AIDS.
- HIV/AIDS awareness campaigns should be advocated more in the rural areas; further study is recommended to investigate Xhosa culture as a factor to child upbringing, which may be resulting in the increases in HIV/AIDS among Xhosa-speaking youth.
- The same study can be repeated to the same learners when they will be doing grade nine to investigate whether they still maintain the same attitude for abstinence.

5.5 Conclusion

This study investigated the intervention of Xhosa-speaking parents in an HIV/AIDS life skill programme in schools. The results indicated a need for HIV/AIDS life skills in both urban and rural schools so as to fight the scourge of HIV/AIDS. Though the results showed that teachers are more knowledgeable than parents and learners it appears as if all the groups, namely teachers, parents and learners lack sufficient knowledge with regard to handling HIV/AIDS pandemic.

The results from the two focus groups recommended that communication about HIV/AIDS should start within the family setting so as to promote mental health and improving family life. Young people should be given the skills to negotiate abstinence or safer sex. This concurs with Mudari (1998) who believes that young people should be given information and skills to become responsible citizens. AIDS education should focus on skills building and an environment which encourages and enables young people to change their behaviour should be created. For behavioral change we need to create a culture of human rights that enables the youth to live positively. The parents should listen, talk to and answer their children's questions as honestly as they possible could. In order to induce behavioral changes, prevention and education programmes should include cognitive and behavioral skills training that addresses interpersonal problem solving, planning and assertive communication.

According to Hamilton (2001) there should be strengthening of the emerging structures that are found among some communities for example the 'community auntie' notion in Uganda who provided traditional sex education to young people. Among Xhosa-speaking people there is *'inkciyo'* that promotes virginity testing among girls. Boys and men should be educated on how to respect girls and women (Perkel and Strebel, 1991).

Programmes should emphasize behavioral and cognitive skills training and ensure that health facilities are accessible, so as to empower the youth in South Africa to make healthy choices responsibly. Kelly, Murphy, Sikumma and Kalichman (1993) assume that behavior changes remain the only means for primary prevention of HIV disease. The aim of this study was to give away community psychology to the people by promoting healthy living among Xhosa-speaking families and their communities.

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7. APPENDICES

APPENDIX 1

Letters

DISTRICT MANAGER

KING-SABATA DALINDYEBO DISTRICT

MTHATHA

Dear Sir

**REQUEST FOR CONDUCTING A RESEARCH ON PARENTAL
INTERVENTION IN HIV/AIDS LIFE SKILLS PROGRAMME IN
MTHATHA SCHOOLS**

I hereby request to be allowed to conduct a research on **“Parental intervention in the
HIV/AIDS life skills programmes”**

- 1. E.W. PEARCE JUNIOR SECONDARY SCHOOL**
- 2. MKHWEZO JUNIOR SECONDARY SCHOOL**

The above two schools have been chosen randomly since the study requires one to conduct a research in two schools, one in an urban area and the other one in the rural area in the Mthatha District.

The above study is a requirement of my PH.D Study in Community Psychology at the University of Zululand.

Thank you for your consideration

Yours faithfully

S.M. Swana (Psychologist)

The Principal

Mkhwezo Junior School

Mthatha

5099

Dear Sir/ Madam

Re : Mrs S.M.Swana

The above Specialist has been given permission to conduct research on the subject HIV/AIDS and sexuality. The research is going to benefit the community and the Department equally.

Thanks

Acting CES (Special Needs Section)

The Principal

E.W. Pearce J.S.School

Mthatha

5099

Dear Sir/ Madam

Re : Mrs S.M.Swana

The above Specialist has been given permission to conduct research on the subject HIV/AIDS and sexuality. The research is going to benefit the community and the Department equally.

Thanks

Acting CES (Special Needs Section)

12 – 08 – 2005

The Principal

E.W. Pearce J.S.S

Mthatha

5099

Dear Sir or Madam

REQUEST FOR ADMINISTERING A QUESTIONNAIRE AND TEACHING A
PROGRAMME ON HIV/AIDS LIFE SKILLS ON GRADE 7 LEARNERS

I hereby request your permission to be in your school during the months of August and September for the purpose of evaluating the knowledge, attitude and behaviour of grade 7 learners on HIV/AIDS issues. The aim is also to assess family interventions in school with regard to HIV/AIDS life skills programme since such programmes are trampling on the parental and their religious values. Educators and parents will also be requested to fill the questionnaire so as to determine their knowledge and attitude in the lessons on sexuality matters as a way of formulating school policy on HIV/AIDS as a requirement of the National Government.

Thank you for your co-operation

Yours faithfully

S.M. Swana (Psychologist)

Principal

Mkhwezo J.S.S

Mthatha

5099

Dear Sir or Madam

REQUEST FOR ADMINISTERING A QUESTIONNAIRE AND TEACHING A
PROGRAMME ON HIV/AIDS LIFE SKILLS ON GRADE 7 LEARNERS

I hereby request your permission to be in your school during the months of August and September for the purpose of evaluating the knowledge, attitude and behaviour of grade 7 learners on HIV/AIDS issues. The aim is also to assess family interventions in school with regard to HIV/AIDS life skills programme since such programmes are trampling on the *parental and their religious values.*

Educators and parents will also be requested to fill the questionnaire so as to determine their knowledge and attitude in the lessons on sexuality matters as a way of formulating school policy on HIV/AIDS as a requirement of the National Government.

Thank you for your co-operation

Yours faithfully

S.M. Swana (Psychologist)

APPENDIX 11

Questionnaires

A QUESTIONNAIRE TO PARENTS, TEACHERS AND GRADE 7 LEARNERS ON PARENTAL INTERVENTION TO HIV/AIDS LIFESKILLS PROGRAMME

The purpose of this questionnaire is to evaluate the knowledge, attitude and behaviour of grade 7 learners, their parents and teachers with regard to HIV/AIDS.

The information supplied will be strictly confidential.

There are no wrong or right answers.

INSTRUCTIONS

Please answer all questions by putting an X in the appropriate box.

SECTION A

Demographic information

1.1 Gender

Male

Female

1.2 Age in years (write in actual age)

10-12

13-15

16-20

21-30

Above 30

1.3 Category

Learner

Teachers

Parents

1.4 Ethnicity

Xhosa

Zulu

Sotho

Other

Specify

1.5 Residence

Urban

Rural

SECTION B

KNOWLEDGE ABOUT HIV/AIDS

Please give your opinion on each of the following statements by placing a cross to indicate if you strongly agree (SA), Agree (A), are Uncertain (U),

Disagree (D) or Strongly Disagree (SD)

1. You can become infected with HIV from a mosquito bite.

(SA) (A) (U) (D) (SD)

2. A properly used condom protects you against HIV/AIDS

(SA) (A) (U) (D) (SD)

3. The pill can protect you against HIV/AIDS

(SA) (A) (U) (D) (SD)

4. You will not become infected with HIV/AIDS if you have sex with only one person

(SA) (A) (U) (D) (SD)

5. You cannot get HIV/AIDS from another person's blood, semen, vaginal fluids, tears or saliva touching skin.

(SA) (A) (U) (D) (SD)

6. AIDS is a punishment from God.

(SA) (A) (U) (D) (SD)

7. You can only be cured of HIV/AIDS if you have sexual intercourse with a virgin (someone who has never had sex).

(SA) (A) (U) (D) (SD)

8. You cannot get HIV/AIDS from blood transfusion.

(SA) (A) (U) (D) (SD)

9. A person cannot contract AIDS after sexual contact

(SA),(A),(U),(D),(SD)

10. It is possible to contract AIDS if a person does not sleep around and waits until marriage to have full sexual relationships

(SA),(A),(U),(D),(SD)

SECTION C

ATTITUDE TOWARDS HIV/AIDS

11. HIV/AIDS information given to learners helps them to control their sexual feelings.

(SA) (A) (U) (D) (SD)

12. HIV/AIDS information leads learners to want to experiment with sex

(SA) (A) (U) (D) (SD)

13. Infected learners should not be allowed to continue schooling.

(SA) (A) (U) (D) (SD)

14. Infected learners should tell their families about their HIV status.

(SA) (A) (U) (D) (SD)

15. Teachers should support the learners with HIV/AIDS

(SA) (A) (U) (D) (SD)

SECTION D

SEXUAL PRACTICES OR BEHAVIOUR

16. Some Grade 7 learners are sexual active

(SA) (A) (U) (D) (SD)

17. Some Grade 7 learners practice full sexual intercourse

(SA) (A) (U) (D) (SD)

18. All Grade 7 learners do have at least one boyfriend/ girlfriend

(SA) (A) (U) (D) (SD)

19. Abstinence is practically impossible.

(SA) (A) (U) (D) (SD)

20. It is safe to use condom than abstain from sex.

(SA) (A) (U) (D) (SD)

N.B. This questionnaire is designed from the following sources

1. Skills for life Grade 7 Learners book: by Elizabeth Haines

2. HIV/AIDS in your school: what parents need to know.

(Issued by the Department of Education)

APPENDIX 111

RAW DATA

RAW DATA OF THE TWO SCHOOLS

Rural and urban are represented as follows:-

R = 0

U = 1

Gender:- Female = 0

Male = 1

Learner = L Parent = p Educator = e

School 1

School 2

Pretest = 1, Posttest 1 = 2, Post test 2 = 3, e.g.

Pretest Knowledge = K1 Posttest knowledge = K2 Posttest 2 knowledge = K3

Pretest attitude = A1 Posttest 1 Attitude = A2 Posttest 2 Attitude = A3

Pretest sexual practices = P1 Posttest 1 Practices = P2 Posttest 2 Practices = P3

Raw data of urban schools

Learners (L)	School 1	Age	Gender	U/R	K1	A1	P1	K2	A2	P2	K3	A3	P3
1	0	14	0	1	27	20	15	33	18	14	-	-	-
2	0	11	0	1	28	14	11	33	20	14	34	17	15
3	0	11	0	1	30	21	17	44	25	15	34	23	16
4	0	11	0	1	20	17	15	34	20	17	29	17	16
5	0	11	0	1	28	18	14	35	17	18	-	-	-
6	0	11	0	1	20	17	9	37	23	11	37	23	12
7	0	14	0	1	36	21	12	26	24	12	29	22	17
8	0	11	0	1	27	15	12	35	21	15	-	-	-
9	0	17	1	1	24	20	18	25	21	20	32	23	19
10	0	13	1	1	29	18	16	35	20	17	34	21	16
11	0	13	0	1	27	18	14	31	23	14	-	-	-
12	0	14	0	1	30	13	17	42	25	13	-	-	-
13	0	14	0	1	23	12	9	39	18	21	21	20	16
14	0	14	1	1	23	22	14	41	23	12	34	24	14
15	0	11	0	1	21	16	15	31	17	22	-	-	-
16	0	11	1	1	23	16	11	32	23	10	-	-	-
17	0	14	1	1	21	13	12	37	22	16	33	20	18
18	0	14	1	1	24	17	18	43	25	10	37	25	11
19	0	11	1	1	19	17	14	33	20	15	31	19	16
20	0	17	1	1	24	18	18	14	22	8	34	23	15

Parents													
1	0	34	0	1	28	28	17	43	23	15	35	25	11
2	0	30	0	1	32	24	22	38	5	-	26	19	16
3	0	30	1	1	23	17	13	40	25	11	40	23	15
4	0	31	0	1	18	17	9	34	20	17	28	20	13
5	0	29	0	1	27	18	10	35	17	18	28	20	13
6	0	30	0	1	20	16	16	40	18	15	31	18	9
7	0	33	0	1	30	18	16	35	23	16	18	18	17
8	0	31	0	1	26	12	9	35	23	16	26	13	21
9	0	37	0	1	23	18	17	22	22	12	43	22	13
10	0	40	1	1	23	16	15	38	22	10	18	15	13
11	0	33	1	1	34	19	19	36	20	17	-	-	-
12	0	35	0	1	22	16	14	38	24	18	34	20	14
13	0	40	1	1	24	17	17	45	25	16	41	23	14
14	0	36	0	1	29	17	17	28	19	19	27	16	11
15	0	30	1	1	21	13	14	-	-	-	24	20	17
16	0	31	0	1	10	14	10	-	-	-	39	19	17
17	0	35	0	1	30	17	17	-	-	-	23	16	16
18	0	36	0	1	30	26	16	-	-	-	-	-	-
19	0	-	-	-	-	-	-	-	-	-	-	-	-
20	0	-	-	-	-	-	-	-	-	-	-	-	-

Educators													
1	0	31	0	1	27	13	17	39	25	18	13	17	12
2	0	32	0	1	20	17	16	46	25	14	19	20	13
3	0	35	0	1	23	17	20	40	17	15	16	17	13
4	0	32	0	1	22	17	14	43	25	13	24	17	14
5	0	31	0	1	27	15	16	44	24	17	-	-	-
6	0	31	1	1	22	17	12	40	24	17	12	17	13
7	0	33	1	1	24	18	21	-	-	-	22	15	14
8	0	29	1	1	24	17	17	-	-	-	-	-	-
9	0	33	0	1	23	17	13	-	-	-	-	-	-
10	0	35	0	1	21	16	16	-	-	-	-	-	-

Raw data of the rural school

LEARNER	School	Age	Gender	U/R	K1	A1	P1	K2	A2	P2	K3	A3	P3
	2												
1	1	15	0	0	24	7	11	-	-	-	-	-	-
2	1	14	1	0	36	23	16	33	22	20	33	21	14
3	1	13	0	0	25	19	11	32	15	14	42	23	13
4	1	14	0	0	31	15	11	33	17	11	29	21	16
5	1	13	0	0	23	14	11	29	21	13	38	23	11
6	1	14	1	0	39	20	13	26	21	15	-	-	-
7	1	17	1	0	29	17	9	-	-	-	39	21	16
8	1	14	1	0	36	26	19	34	22	25	38	23	22
9	1	12	1	0	42	21	20	37	16	16	31	16	14
10	1	14	1	0	24	21	15	-	-	-	33	12	15
11	1	13	0	0	44	16	18	32	24	11	39	23	11
12	1	12	1	0	36	17	5	38	23	13	46	21	8
13	1	14	1	0	25	11	11	24	17	13	26	21	13
14	1	13	0	0	30	17	8	43	22	11	42	25	7
15	1	13	1	0	19	6	7	32	19	16	36	19	12
16	1	12	0	0	47	24	7	41	15	19	45	22	14
17	1	14	0	0	28	18	12	34	22	15	35	24	16
18	1	13	0	0	43	20	19	40	21	17	44	25	21
19	1	15	0	0	19	13	11	-	-	-	-	-	-
20	1	15	0	0	45	20	20	12	12	19	43	23	18

Parents													
1	1	40	0	0	25	12	13	-	-	-	18	18	16
2	1	35	0	0	23	16	14	36	15	15	30	25	14
3	1	32	0	0	34	17	16	35	20	9	13	17	16
4	1	36	0	0	25	11	11	24	18	16	18	19	19
5	1	38	0	0	23	19	13	32	20	17	-	-	-
6	1	36	0	0	29	17	16	29	15	16	29	16	20
7	1	50	1	0	33	16	9	32	22	8	25	12	22
8	1	50	0	0	32	19	18	33	18	17	16	18	19
9	1	37	0	0	21	18	14	25	23	16	19	19	17
10	1	47	0	0	20	18	15	-	-	-	27	17	21
11	1	62	0	0	40	13	12	36	17	8	-	-	-
12	1	33	1	0	21	16	12	41	25	12	-	-	-
13	1	72	0	0	34	17	14	42	20	16	21	20	20
14	1	42	0	0	21	12	16	-	-	-	18	15	20
15	1	46	0	0	23	18	7	35	23	12	-	-	-
16	1	46	0	0	23	18	7	35	23	12	-	-	-
17	1	32	0	0	33	21	21	-	-	-	35	22	23
18	1	32	1	0	29	19	16	-	-	-	32	21	22
19	1	31	0	0	-	-	-	35	20	17	-	-	-
20	1	-	-	-	-	-	-	-	-	-	-	-	-

Educators													
1	1	31	0	0	20	18	15	41	21	6	-	-	-
2	1	30	0	0	22	18	17	-	-	-	34	11	14
3	1	38	0	0	24	17	14	33	22	19	15	18	11
4	1	52	0	0	11	17	15	39	21	11	19	21	10
5	1	39	0	0	18	17	13	41	22	12	11	17	17
6	1	30	0	0	30	17	14	-	-	-	-	-	-
7	1	31	0	0	23	17	12	-	-	-	-	-	-
8	1	40	0	0	20	17	15	-	-	-	-	-	-
9	1	31	0	0	26	16	13	41	20	14	-	-	-
10	1	52	0	0	33	16	19	28	24	16	-	-	-

APPENDIX IV

PROGRAMME FOR GRADE 7 LIFE SKILLS ON HIV AIDS EXTRACT FROM

“SKILLS FOR LIFE. LEARNERS BOOK-GRADE 7

BY ELIZABETH HAINES

Facts about HIV/AIDS

1. You can become infected with HIV from a mosquito bite. No this is a myth.

Facts: Some diseases such as malaria spread through mosquito bites but there is no nothing to show that HIV is spread in the same way.

These are the only ways you can become infected with HIV:

- By having sexual intercourse with someone who is HIV positive, because the virus lives in men’s semen and woman vaginal fluids.
- By using a needle, syringe or razor blade that has already been used by someone who is HIV positive, because the virus lives in people’s blood.
- By contact with blood or other body fluids of someone who is HIV positive through a cut or sore.

2. A properly used condom protects you against HIV/AIDS. Yes, this is a fact.

Fact: If you use a condom correctly each time you have sexual intercourse, you will be protecting yourself against HIV and other STDs. Use one condom at a time. Two condoms used at the same time will not give you any extra protection. You can get condoms free from clinics or you can buy them from pharmacies or supermarkets.

3. The pill can protect you against HIV/AIDS. No, this is a myth.

Fact: The pill cannot protect you against HIV/AIDS. Only condoms can protect you

Against HIV and other STDs once you are sexually active.

Condoms can be used with spermicides for more effective contraception.

3. You will not become infected with HIV if you have sexual intercourse with only one person. No, this is a myth.

Fact: It is true that if you have only one partner who does not have sexual intercourse with anyone else then there is less risk of becoming infected with HIV.

But if that partner has had previous sexual partners, then you could become

Infected with HIV. Therefore, it would be best

for both of you to be tested for HIV and to use a condom while you wait for the results.

5. You cannot get HIV/AIDS if another person's blood, semen, vaginal fluid, tears or saliva touches your skin. No, this is a myth.

Facts: If your skin is broken because of a cut or an open sore and if the body fluids of an HIV-positive person come into contact with your cut or sore, then you could become infected with HIV/AIDS

6. AIDS is a punishment from God. No, this is a myth.

Fact: This is a foolish misconception. Many "innocent" people contract HIV/AIDS in various ways, including thousands of babies who cannot be considered worthy of any sort of punishment.

7. You can be cured of HIV/AIDS if you have sexual intercourse with a virgin (someone who has never had sex). No, this is a myth.

Fact: No one can be cured of HIV/AIDS by having sexual intercourse with a virgin. If an HIV-infected person has sex with a virgin will in all likelihood become infected. Scientists and doctors are working on finding a cure, but as yet there is no

proven cure for HIV/AIDS.

8. You cannot get HIV/AIDS from a blood transfusion. No, this is a myth.

Fact: You could get HIV/AIDS from a blood transfusion if the donor's blood was infected. These days, however, blood transfusion centers are very careful to take blood only from people who are not likely to have infected blood, and to test the blood for the virus.



ACTIVITY 2 How do people become infected with HIV/AIDS?

1. Work in small groups, write down two lists:

LIST 1 The ways you can become infected with HIV/AIDS.

LIST 2 The ways you can't become infected with HIV/AIDS.

4. Share your lists with the rest of the class.

The ways in which HIV/AIDS spreads

You can become infected with the AIDS virus:

- By having sexual intercourse with someone who is infected with the AIDS virus (someone who is HIV positive), because the virus lives in men's semen and women's vaginal fluids.
- By using a needle, syringe or razor blade that has been used already by someone who is HIV positive, because the virus lives in people's blood.
- By contact with the blood or other body fluids of someone who is HIV positive through a cut or open sore.
- As an unborn baby carried by a woman infected with the AIDS virus.
Babies are at risk during pregnancy, at birth and once born, through breastfeeding.

You cannot become infected with the AIDS virus through:

- Mosquitoes
- Sharing cups, plates and cutlery
- Having sexual intercourse with someone who does not have the AIDS virus
- Someone coughing or sneezing next to you
- Donating blood if the equipment is properly sterilized
- Donor blood in blood transfusions (in South Africa the blood is always tested for the AIDS virus)
- Infected body fluids touching your skin, unless you have a cut or open sore

- Kissing, hugging and caressing

ACTIVITY 3 How can I protect myself?

Work in small groups.

1. Write down how you can protect yourself from becoming infected with AIDS.
2. Share your ideas with the rest of the class.

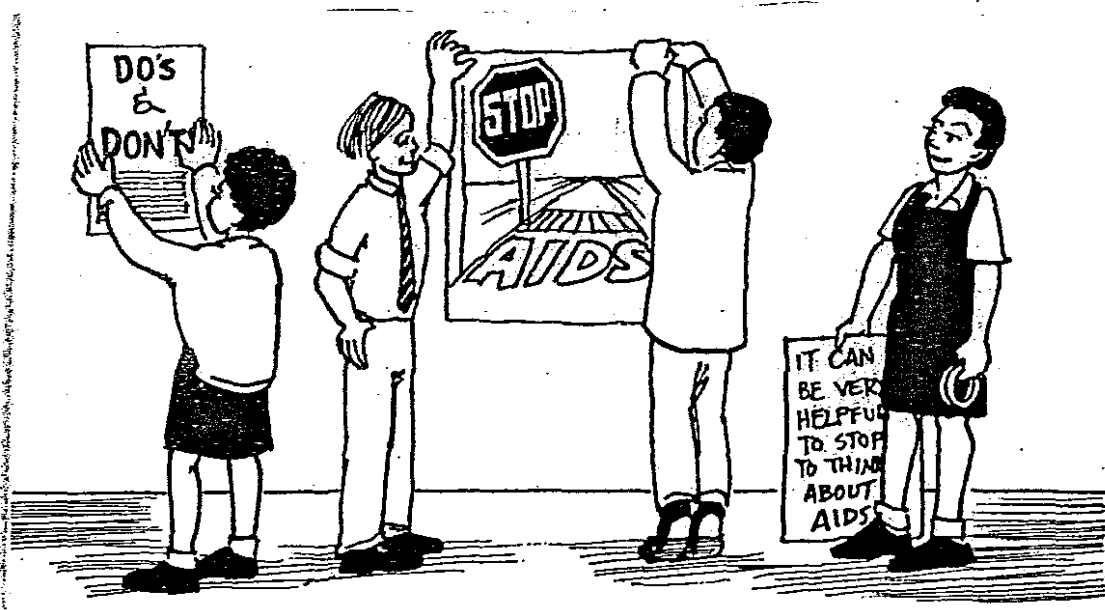
Don't become infected with HIV/AIDS

Scientists and doctors are working hard to find vaccines to protect people against AIDS and to find a cure for AIDS. They have found out a lot about AIDS, but they have yet to introduce a proven vaccine or cure. Our only hope at this time is to make sure we don't become infected with the AIDS virus.

- The surest way for young people of not becoming infected with the AIDS virus
Is to abstain from having sexual intercourse.
- Only have injections and vaccinations at clinics and hospitals.
- If you visit a traditional healer, make sure that they use a clean, sterilized blade if cutting your skin.
- Do not share a razor.

- Anyone who does have sexual intercourse needs to use a condom and they need to be sure that their partner is HIV negative, and neither of them should have sexual intercourse with anyone else.

ACTIVITY 4 Tell your friends



1. Work in pairs or small groups to make one or more of these posters.

Remember:

- There won't be lots of space on the posters, so you will have to decide on what is the most important information.
- Make the posters bright and colorful so that they catch people's attention.

Poster 1 This poster must tell young people about how people can become infected

with the AIDS virus.

Poster 2 This poster must tell young people about how people cannot become infected

with the AIDS virus.

Poster 3 This poster must tell young people can protect themselves from the AIDS virus.

3. Ask your teacher if you can stick up the posters in the classroom or somewhere else in your school.

Think about these things...

Do this task on your own.

1. If I found out that someone in my class was HIV positive, I would _____.
2. Why do you think the writers of this Learner's Book included a unit on HIV/AIDS?

If there is time, discuss your answers with the rest of the class.

(Haines, 1999, p85-89)

8. List of tables

Table 3.5: A table for procedure on the administration of the research instrument

Table 4.2.1.1: A table and a bar chart displaying the gender of participants in school 1

Table 4.2.1.2: A table and a bar chart displaying the ages of participants in school 1

Table 4.2.1.3: A table and a bar chart displaying the category of participants in school 1

Table 4.2.1.4: A table and a bar chart displaying residence of the participants in school 1

Table 4.2.1.5: A table and a bar chart displaying gender of participants in school 2

Table 4.2.1.6: A table and a bar chart displaying category of participants in school 2

Table 4.2.1.7: A table and a bar chart the ages of participants in school 2

Table 4.2.1.8: A table and a bar chart displaying residence of school 2

Table 4.2.2.1: Results of the knowledge about HIV/AIDS of all participants

Table 4.2.2.2: Results of the attitude of all the participants towards HIV/AIDS

Table 4.2.2.3: Results of behavioral practices of all participants

Table 4.2.2.4: A result of all parents in both schools

Table 4.2.2.5: The results of all teachers in both schools

Table 4.2.2.6: The results of all learners in both schools

Table 4.2.2.7: Results of all participants of the first intervention (school 1)

Table 4.2.2.8: Results of all the participants of the second intervention (School 2)