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RESERVE

# **Advanced Level Students' Perceptions of the Causes and Effects of HIV/AIDS: A Case Study of Masvingo Urban High Schools, Zimbabwe**

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## **Abstract**

*The present study sought to establish A-level students' perceptions of the causes and effects of HIV/AIDS. The rationale for the study was to establish the extent to which A level students understand issues related to HIV/AIDS. The sample was made up of 100 A-level students - 68 males and 32 females. A questionnaire was used to collect the data. The 7.5 SPSS package was used to analyse the data. Findings revealed that students had a lot of accurate factual information about HIV/AIDS but at the same time they had some misconceptions. It was recommended that relevant stakeholders facilitate HIV/AIDS awareness and necessary attitude change among students both theoretically and practically. There is still more room for research on this aspect.*

## **Background to the Study**

Today the world is facing the AIDS menace. The pandemic threatens everyone in Zimbabwe as well as in many other parts of the world. The first case of AIDS in Zimbabwe was identified in 1985 (National AIDS Policy, Zimbabwe 1999). AIDS (Acquired Immune Deficiency Syndrome) is a sexually transmitted disease (STD) that can also be transmitted through blood or from mother to child (Jackson, 1992). It is caused by a virus called Human Immunodeficiency Virus (HIV). Jackson (1992) reports that of all the regions in the world, Sub-Saharan Africa (of which Zimbabwe is part) is the most seriously affected. The Zimbabwe National HIV/AIDS Policy Document (1999) points out that HIV/AIDS has reached unprecedented crisis levels in Zimbabwe. It is estimated that 25% of people aged between 15 and 49 years are infected with the HIV virus that causes AIDS.

In an effort to respond to the AIDS pandemic, a national programme of action has been in place since the mid-1980s under the leadership and guidance of the National AIDS Coordination Programme (NACP) within the Ministry of Health and Child Welfare. The NACP requested all Ministries, parastatals and organizations to join together in the fight against the spread of AIDS. In 1992, the Ministry of Education and Culture responded by demonstrating its concern for the young through the development of a comprehensive national HIV/AIDS Education Programme for schools. This programme was developed by the Curriculum Development Unit (CDU) of the Ministry of Education and Culture with assistance from UNICEF (United Nations Children's Fund). The programme is called AIDS Action Programme for Schools. Under this programme, AIDS textbooks for Grade Four up to A-level developed.

The importance of education in AIDS prevention underlines the Ministry of Education, Sport and Culture's responsibility to train the youth through dissemination of factual information as well as facilitating the development of relevant attitudes and behaviours which will result in young people's ability to effectively avoid HIV infection.

In the light of the foregoing, the AIDS Action Programme for Schools is an innovative and comprehensive effort to address the specific challenge of influencing individual development and behaviour change in a deeply personal way.

In view of the efforts exerted by the Government in general, and the Ministry of Education, Sport and Culture in particular, to confront the HIV/AIDS pandemic, the researchers sought to establish A-level students' perceptions of the causes and effects of HIV/AIDS. Perceptions are such an important area to study because they influence people's lives. In this regard students' perceptions influence their behaviour in relation to HIV/AIDS. The researchers undertook to study perceptions of A-level students because studies at other secondary school levels, Junior and Ordinary Level, have been undertaken by the Ministry of Education and Culture in collaboration with UNICEF. Moreover, the group of students investigated falls within the category (15-24 years), which is most vulnerable to HIV/AIDS infection as documented in the AIDS Policy Document of 1999. Furthermore, the group studied (A-level students) is a critical transition group (between childhood and adulthood). As such, establishing their perceptions may make the ground fertile for stakeholders to map out appropriate interventions for the youth in relation to combating the AIDS pandemic. Schmidt (1993) argues that it is important to understand the

ways in which students perceive HIV/AIDS and comprehend the conclusions they draw from these perceptions if the school is to benefit the student.

## **Purpose of the Study**

The study sought to establish A-level students' perceptions of the causes and effects of HIV/AIDS, with special focus on A-level students in Masvingo Urban High Schools. The aim was to establish the extent to which A-level students understood issues relating to causes and effects of HIV/AIDS. Causes and effects were examined in terms of the biomedical, social, religious, political, and economic perceptions of the A-level students relative to the HIV/AIDS pandemic. Specifically, the study sought to establish the extent to which such perceptions are determined by gender, age, former school type, exposure to HIV/AIDS education, and sources of information available to the students.

## **Methodology**

### **Sample**

The participants in the present study were 100 A-level students. There were 32 girls and 68 boys. Their ages ranged between 17 and 23 years.

### **Instrument**

A questionnaire was used. The questionnaire comprised three sections. Section A was on background information while Section B largely focused on students' perceptions of the causes of HIV/AIDS and Section C focused largely on students' perceptions of the effects of HIV/AIDS. The questionnaire had both open and closed-ended questions. Closed questions helped in eliciting specific and straightforward information, while the open-ended questions enabled the respondents to express their views freely, without restrictions.

The instrument was piloted with only five students who were excluded from the final sample. The rationale for doing this was to test how long it would take respondents to complete it, to check whether all questions were clear and to enable the researchers to remove any items, which did not yield usable data. In addition, pilot-running the instrument served to validate and standardise the instrument.

### **Procedure**

Permission to carry out this research was obtained from the Regional Director.

of Education for Masvingo Region. A copy of the letter from the Regional Director was shown to the Headmasters of Masvingo Christian, Mucheke, and Victoria High Schools a day before data collection. This was to make sure the data collection was official and unquestionable to local authorities and others. The stratified random sampling procedure was used to select the subjects. The researchers personally administered the questionnaire.

## **Data Analysis**

Data collected were presented in the form of tables. The data were analysed using both qualitative and quantitative methods. Quantitatively, data collected were translated into figures. The 7.5 SPSS Computer Package was used to analyse the data. Qualitatively, the data collected were subjected to evaluative descriptions.

## **Results**

Tables 1.1 to 1.5 show students' responses, by frequency, to items on causes of HIV/AIDS on the collapsed Likert scale. The following key applies to the tables presented: AG= Agree, NS= Not sure, DS= Disagree

**Table 1.1: Students' Responses to Biomedical Causes of HIV/AIDS**

N=100

Variable (item)	%AG	%NS	%DA	Total%
2.1 Laboratory experiments in the USA	9	46	45	100
2.6 TB	12	25	63	100
2.7 Poor diet	3	8	81	100
2.8 An artificial virus	33	37	30	100
2.11 Mosquito bites	7	9	84	100
2.14 Unsafe drinking water	2	9	89	100
2.15 Heredity	33	26	41	100
2.22 Spraying insecticides	2	4	94	100
2.24 Breast feeding	40	23	37	100
2.28 Donating blood	33	15	52	100
2.29 A germ (virus)	85	9	6	100
2.30 Contact with infected blood	82	13	5	100
2.31 Using contaminated needles / razor blades	91	1	8	100
2.33 Reusing a condom	47	34	19	100
2.34 Using the bush toilets	6	6	88	100
2.35 Air and water pollution	5	9	86	100
2.42 Sharing toilet seats	7	19	74	100
2.43 Transfusing blood from an infected person	90	4	6	100

Table 1.1 shows that the respondents perceive biomedical factors as the chief causes of HIV/AIDS infection. Significant to note are: using contaminated needles/ razor blades (91%); transfusing blood from an infected person (90%); a germ (virus) (85%); and contact with infected blood (82%). It is noted that out of the 18 biomedical causes proposed on the questionnaire, the majority (over 80%) of respondents agreed with the four mentioned above as the causes. The respondents reflected mixed feelings on whether HIV/AIDS is caused by an artificial virus, heredity, donating blood, breast feeding and reusing a condom.

On whether they agreed or not that HIV/AIDS is caused by laboratory experiments in the USA, the majority (45%) of respondents were not sure.

**Table 1.2: Students' Responses to Social Causes** N=100

Variable (item)	%AG	%NS	%DA	Total%
2.3 Prostitution	94	4	2	100
2.4 Homosexuality	61	25	14	100
2.9 Lack of education of its causes	57	10	33	100
2.12 Sexual promiscuity	58	20	22	100
2.16 Polygamy	69	18	13	100
2.18 Sex at an early age	70	18	12	100
2.19 Rapists	84	9	7	100
2.20 Having multiple sex partners	87	6	7	100
2.21 Sharing bath water	10	14	76	100
2.23 Kissing	21	28	51	100
2.25 Sharing blankets with an infected person	9	13	78	100
2.26 Eating from the same plate of food with an infected person	7	10	83	100
2.27 Exchanging clothes	11	11	78	100
2.32 Greeting people with dirty hands	7	6	87	100
2.36 Rural to urban migration	23	13	64	100

The table reveals that the majority of the A-level respondents perceived sexual activities in general and sexual immorality in particular as the main causes of HIV/AIDS within the social causes category.

**Table 1.3 Students' Responses to Religious (spiritual) Causes**  
N=100

Variable (item)	%AG	%NS	%DA	Total%
2.5 Witchcraft (runyoka)	4	19	77	100
2.10 Evil spirits (mamhepo)	5	6	89	100
2.38 Not believing in God	11	12	77	100
2.39 Not believing in ancestral spirits	5	7	88	100
2.40 Sinning against God	14	9	77	100
2.41 Avenging spirits (ngozi)	2	1	97	100

Table 1.3 indicates that the majority (over 75%) of respondents did not attribute HIV/AIDS to religious (spiritual) causes.

**Table 1.4: Students' Responses to Political Causes** N=10

Variable (item)	%AG	%NS	DA%	%Total
2.2 Biological warfare	28	45	27	100

The findings in table 1.4 indicate that a substantial (45) percentage of subjects on variable 2.2 were not sure whether HIV/AIDS is caused by biological warfare.

**Table 1.5 Students' Responses to Economic Causes** N=100

Variable (item)	%AG	%NS	%DA	% Total
2.13 Poverty	44	14	42	100
2.17 Unemployment	43	17	40	100
2.37 Economic hardships	43	17	40	100

Table 1.5 shows that respondents had mixed feelings about whether economic problems lead to HIV/AIDS. This could suggest that the respondents were not well informed about HIV/AIDS and the economic factors that exacerbate HIV transmission.



**Table1.6: Additional Information on Causes of HIV/AIDS.**

Here the data was categorized since the question was of a free-response nature.

**N=100**

<b>Cause category</b>	<b>Frequency</b>
Biomedical	29
Social	48
Religious	3
Political	1
Economic	16
Non-responses	3
<b>Total</b>	<b>100</b>

Table 1.6 above shows that the majority (77%) of respondents ascribed HIV/AIDS to social causes and biomedical causes, in keeping with findings from the closed-ended questions. Notable among social causes were having multiple sex partners, unprotected sex, lack of self-control, not valuing one's body, teachers falling in love with schoolgirls, and going out with 'sugar daddies'. The biomedical causes stated include accidents, transfusing blood from an infected person, caring for HIV/AIDS patients without protective equipment like gloves, and mother to child transmission. On the economic realm, respondents indicated that poverty (16%) and unemployment (16%) compel people to indulge in prostitution to earn a living.

Tables 2.1 to 2.6 show responses, by frequency, to items on effects of HIV/AIDS on the Likert scale.

**Table 2.1: Responses to Biomedical Effects of HIV/AIDS N=100**

Variable	%AG	%NS	%DA	%Total
3.1 Death	100	0	0	100
3.2 Sickness	95	5	0	100
3.3 Loss of appetite	74	18	8	100
3.4 Loss of weight	96	2	2	100
3.5 Loss of hair	75	16	9	100
3.6 Reduced growth of beard	32	44	24	100
3.7 Infertility	31	26	43	100
3.8 Genital sores	73	17	10	100
3.10 Fall in life expectancies	96	2	2	100
3.11 Overcrowding in hospitals	88	3	9	100
3.13 Increase in cases of TB	58	28	14	100

The table shows that all the subjects perceived death as a consequence of HIV/AIDS. The other main biomedical effects identified by the respondents were sickness (95%), loss of weight (96%), fall in life expectancies (96%), overcrowding in hospitals (88%), loss of hair (75%) and loss of appetite (74%).

**Table 2.2: Responses to Social Effects of HIV/AIDS N=100**

Variable	%AG	%NS	%DA	%Total
3.9 Decline in population growth rate	94	4	2	100
3.14 Setting up of home-based care programmes	92	8	0	100
3.21 Rise in the number of school dropouts	70	13	17	100
3.22 Isolation of people with HIV/AIDS	54	16	30	100
3.23 Families split	77	11	12	100
3.24 Increase in accusations of witchcraft	66	9	25	100
3.25 Increase in the number of orphans	96	2	2	100
3.27 Rise in youth crimes	31	17	52	100
3.28 Rise in levels of prostitution	44	13	43	100
3.29 Early marriage for girls	30	19	51	100

3.35 Low academic achievement for HIV/AIDS orphans	76	17	7	100
3.36 Increase in demand for social welfare services	90	8	2	100
3.37 Mushrooming of AIDS support organizations	74	19	7	100
3.39 A lot of publications on HIV/AIDS	90	8	2	100
3.26 Destruction of the family structure	84	8	8	100
3.40 Positive change in sexual behaviour	55	30	15	100

The table indicates decline in population growth rate (94%), the increase in the number of orphans (96%), setting up of home based care programmes (92%), destruction of family structure (84%), increase in demand for social welfare services (90%), a lot of publications on HIV/AIDS (90%) and low academic achievement for HIV/AIDS orphans and sufferers (76%).

**Table 2.3 Responses to Religious (spiritual) Causes of HIV/AIDS  
N=100**

Variable	%AG	%NS	%DA	%Total
3.24 Increase in accusations of witchcraft	66	9	25	100
3.33 Seeking for spiritual remedies	61	28	11	100

The table shows that the majority of the respondents identified increase in accusations of witchcraft and seeking for spiritual remedies as the effects of HIV/AIDS.

**Table 2.4 Responses to Political Effects of HIV/AIDS N=100**

Variable	%AG	%NS	%DA	%Total
3.15 Setting up of an HIV/AIDS Policy	79	15	6	100
3.16 Collection of AIDS Levy	80	10	10	100
3.38 Introduction of AIDS Education	91	7	2	100

The table shows that the main political effects identified by the respondents were the introduction of AIDS education in both primary and secondary schools (91%), collection of AIDS levy (80%) and the setting up of an AIDS policy (79%).

**Table 2.5: Responses to Economic Effects of HIV/AIDS N=100**

Variable	%AG	%NS	%DA	%Total
3.18 Decline in productivity for companies	65	16	19	100
3.19 Loss of skilled manpower	80	5	15	100
3.20 Increase in child labour	46	19	35	100

Table 2.5 indicates that the main economic effects that the subjects identified include loss of skilled manpower (80%) and decline in production for companies (65%).

**Table 2.6: Responses to Psychological Effects of HIV/AIDS N=100**

Variable	%AG	%NS	%DA	%Total
3.30 Infected people feel angry or shocked	74	12	14	100
3.31 Infected people may engage in revenge sex	83	12	5	100
3.32 Self-rejection by infected people	74	18	8	100
3.34 Hopelessness	86	4	10	100

Table 2.6 shows that the main psychological effects identified by the subjects were hopelessness (86%), engaging in revenge sex (83%), anger and shock (74%) and self-rejection and deciding to commit suicide (74%).

**Table 2.7 Additional Information on the Effects of HIV/AIDS  
N=100**

The data presented in the table is a summary of diverse responses to open ended questions.

Effect category	Frequency
Biomedical	11
Social	38
Religious	3
Political	2
Economic	24
Psychological	22
<b>Total</b>	<b>100</b>

Table 2.7 above shows that most respondents identified social effects (38%) of HIV/AIDS; followed by economic effects (24%). Social effects included stigmatization of HIV/AIDS patients and orphans, increase in the number of street kids and social deviance. Economic effects included rise in poverty levels for the infected and affected. Effects presented were well articulated.

## Discussion

The study showed that the respondents largely perceived HIV/AIDS as having biomedical and social causes. The perceptions of the biomedical causes of HIV/AIDS suggest that respondents were well informed. This is because the causes indicated by respondents are supported by literature. For example, United Nations Programme on HIV/AIDS (UNAIDS) (1999) notes that infected blood and the sharing of contaminated needles can transmit HIV/AIDS. Foster (1990), Jackson (1992) and UNICEF (1992) also indicate that HIV/AIDS is transmitted through infected blood, infected instruments like razor blades and needles and from mother to child during pregnancy or at birth or during breastfeeding.

On social causes, the major causes cited were prostitution, having multiple sex partners, and rapists. Respondents thus cited sexual activities, especially when they are unprotected, as the main cause. The perceptions of the respondents are supported by Kaleeba (1991) who notes that HIV/AIDS is mainly transmitted through sex and adds that because AIDS has sex connotations, those who suffer from it are stigmatized. Regarding casual contact, respondents generally

felt that one cannot contract HIV/AIDS through this, for example, greeting people with dirty hands, sharing the same plate of food with an infected person, and sharing bath water.

Respondents largely failed to perceive the link between the causes of HIV/AIDS and economic factors. Less than 50% of them could not agree that economic factors such as poverty and unemployment lead to HIV/AIDS. The Zimbabwe National AIDS Policy Document (1999) points out that poverty is, in a way, a cause of HIV/AIDS because it can expose one to the risk of contracting HIV through prostitution. The document further notes that poor health care accelerates the progression of HIV into AIDS. The findings on the economic causes of HIV/AIDS suggest that the respondents had limited conceptions of the causes.

The research findings show that the respondents, for the most part, did not attribute HIV/AIDS to spiritual causes. The finding concurs with Jackson's (1992) perspective on the youth, that youths of today, particularly those with higher levels of education, are likely to accept a germ theory of disease. Respondents were largely unsure whether HIV/AIDS is a product of political warfare. The sentiments of the respondents on political causes are in keeping with the speculations that are going on with regards to where AIDS came from. Foster (1990) notes that no one knows where AIDS came from and this could explain why 45% of the respondents indicated that they were not sure.

The findings reveal that while respondents had a lot of correct factual information about the causes of HIV/AIDS, they also had some misconceptions about the epidemic. For example, 33% of respondents indicated that HIV/AIDS is caused by heredity and donating blood, yet it has been established that one cannot get HIV/AIDS through these. UNICEF (1992) notes that donating blood is completely safe and that AIDS cannot be genetically inherited but is acquired. The existence of misinformation about HIV/AIDS is cited by World Health Organization (WHO) (1994) which states that because AIDS is a new disease, there are a lot of myths and misconceptions surrounding it.

The other major finding was that the respondents perceived HIV/AIDS as having biomedical, social, religious, political, economic, and psychological effects. On biomedical effects, the major effects were death, sickness, loss of weight, fall in life expectancies, and overcrowding in hospitals. All the respondents cited death as a consequence of HIV/AIDS and this is in agreement with what Kaleeba (1991) says, that HIV/AIDS has got death implications. Foster (1990) and Jackson (1992) also depict death as the most devastating effect of

HIV/AIDS. Death comes about as a result of sickness due to HIV/AIDS. The loss of weight comes about due to loss of appetite brought about by sickness (Bijlsma, 1996). The Zimbabwean *Daily News* of 15 November 2001 reports that as a result of the rise in death rate, life expectancies have fallen.

Respondents identified the following as the main social effects: a decline in the population growth rate, increase in the number of orphans, destruction of the family structure, increase in demand for social welfare services, a lot of publications on HIV/AIDS and low academic achievement for HIV/AIDS orphans and sufferers. The social effects cited by respondents are also cited elsewhere UNICEF (1992) [cited by Mwamwenda (1995)] reports that there are more children in Africa than elsewhere who have become orphans due to their parents having been victims of HIV/AIDS. UNAIDS (1999) also reports that the number of orphaned children and families headed by children is increasing due to parents dying of HIV/AIDS. *The Herald* (Zimbabwe) of 10 May 1993 says that there is disruption of family life when parents become ill and die. Casey and Thorn (1999) note that orphaned children either drop out of school or are marked by absenteeism and this impacts negatively on their academic achievement.

Findings from the current study suggest that respondents perceived HIV/AIDS as having religious effects. The major religious effects they cited were increase in accusations of witchcraft and seeking for spiritual remedies. This is related to Jackson (1992) who points out that accusations of witchcraft causing HIV/AIDS are likely to occur. This association of witchcraft with AIDS is also presented by UNAIDS (1999) which notes that because AIDS is frequently associated with immoral behaviour, some people suffering from full-blown AIDS would rather say they are bewitched.

Respondents perceived HIV/AIDS as having political effects and the major effects were the setting up of an AIDS Policy, collection of AIDS Levy, and the introduction of AIDS Education in both primary and secondary schools. The National AIDS Policy Document (1999) points out that the AIDS pandemic has stimulated a national response and the response has assumed the form of policy formation to combat the pandemic.

Respondents also viewed HIV/AIDS in terms of its economic effects, mainly loss of skilled manpower, decline in productivity for companies, and an increase in health care costs. Aids Counseling Trust (ACT) (1998) which states that HIV/AIDS results in increase supports these findings in health care costs and loss of skilled manpower.

The main psychological effects identified by respondents were hopelessness; that infected people feel angry or shocked and may engage in revenge sex; and that they may experience self-rejection. These psychological effects are supported by Foster (1990) and Jackson (1992) who note that infected people may experience feelings such as shock, anger, hopelessness, and the feeling that they cannot die alone. Irvine (2001) also states that the possible mental health consequences of HIV/AIDS infection are anxiety and depression while Ontario (2001) adds that HIV/AIDS infection can be very stressful.

When one considers the findings pertaining to the effects of HIV/AIDS and the literature reviewed, one may conclude that respondents had a lot of accurate factual information about HIV/AIDS and its effects.

## **Recommendations**

The following recommendations are made as a result of the findings of this study:

- In view of the fact that students have reflected some misconceptions about the causes and effects of HIV/AIDS, A-level AIDS Education teachers need to help students secure accurate factual information about HIV/AIDS as well as set good role models for them to emulate. An interactive approach can lead the students at school to increase self-learning and understanding of messages pertaining to HIV/AIDS. There is need for the teachers to take cognisance of what students already know and start from there.
- There is need for A-level students themselves to revisit their misconceptions and myths about HIV/AIDS in order to come up with correct information that will guide them in making important decisions in life, especially in relation to love and sex.
- The Zimbabwean Ministry of Education, Sport and Culture should train teachers so that they can be in a better position to enrich students on HIV/AIDS matters. The Ministry is recommended to monitor and evaluate the teaching of the subject regularly to stimulate school administrators and teachers to take the subject more seriously. In addition, there is need for the Ministry to provide resources aimed at enhancing the teaching of HIV/AIDS.
- Thus, the next big challenge is that of fostering behaviour change. In view of this, the researchers recommend that UNICEF sponsor teacher-



training programmes aimed at enhancing the teachers' capacity to instill positive behaviour change in students.

- Further research could be carried out in areas not covered in this study such as: the attitudes of A-level students to the teaching of HIV/AIDS as a subject; an evaluation of the HIV/AIDS education programme in Zimbabwe; the impact of students' perceptions on their behaviour; and factors affecting students' perceptions of the causes and effects of HIV/AIDS.

## References

- AIDS Counselling Trust (1998). *Annual report and abridged accounts*.
- Bijlsma, M. (1996). *Living positively with HIV/AIDS*. Mutare, Zimbabwe: Mutare City Council.
- Casey, N. & Thorn, A. (1999). *Lessons for life: HIV/AIDS and life skills education in schools*. London: European Communities.
- Curriculum Development Unit (1992). *HIV and AIDS: A teaching guide for teachers*. Harare: Curriculum Development Unit.
- Foster, G. (1990). *Facts about AIDS*. Gweru, Zimbabwe: Mambo Press.
- Irvine, S. (2001). *Moods and fears: Depression and anxiety*. School of Community Medicine. Ashm Publications
- Jackson, H. (1992). *AIDS: Action Now: Information, prevention and support* (2<sup>nd</sup> Edition). Harare: AIDS Counselling Trust.
- Kaleeba, N. (1991). *AIDS in the family*. Harare: Women and AIDS Support Network (WASN).
- Ministry of Education/UNICEF (1996). *A report of a baseline study carried out in secondary schools in Zimbabwe for the National AIDS Action Programme for Schools*. Harare: UNICEF.
- Ministry of Education and Culture: *Methods in AIDS education: A training manual for teachers*. Harare: UNICEF.
- Mwamwenda, T.S. (1995). *Educational psychology: An African perspective* (2<sup>nd</sup> Edition). Durban: Butterworth Publishers (Pty) Ltd.

- National AIDS Coordinating Programme (1994). *Living with HIV and AIDS*. Harare: UNICEF.
- National AIDS Coordinating Programme (2000). *AIDS: Men, you make a difference*. Harare: UNICEF.
- National HIV/AIDS Policy Document (1999). Harare: Government Printer.
- National HIV/AIDS Strategic Framework (1999). Harare: Government Printer.
- Ontario (2001). *Health Facts: Living with HIV*. Ontario: Ministry of Health and Long-term Care.
- Schmidt, J.J. (1993). *Counselling in schools: Essential services and comprehensive programs*. New York: Allyn and Bacon.
- The Daily News* (Zimbabwe)- 15 November 2001.
- The Herald* (Zimbabwe)- 10 May 1993.
- UNAIDS (1999). *HIV/AIDS in Zambia*. Lusaka: UNAIDS.
- UNICEF (1999). *Children in a world of HIV/AIDS*. Harare: UNICEF.
- World Health Organisation (WHO) (1992). *Living with AIDS in the community*. Geneva: World Health Organisation.



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