The Impact of HIV/AIDS on Teaching and Learning.

A study of the Eastern Cape Department of Education.

By

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November 2007

DECLARATION

I hereby declare that this research project that I am submitting for the degree of Masters in Public Administration of University of Fort Hare has not been submitted by me before for any other degree or examination at any other University. It is my own work and information from other sources has been acknowledged.

ABSTRACT

The main objective of this study is to investigate the impact of HIV/AIDS on teaching and learning in the district of King William's Town within the Department of Education in the Province of Eastern Cape. The analysis that follows points to the critical importance of viewing the prevalence of HIV/AIDS among educators in relation to the factors that impact on teaching and learning. Education is an essential ingredient of the socio-economic development of any country, and educators are a vital part of any nation's educational system.

If educators are sick, or absent from school, or leave the profession, the nation stands to lose. Analysing the extent and severity of HIV/AIDS among educators without looking at the overall teaching and learning environment in schools provides a partial understanding of the immense educational challenges that the schooling sector faces. The central argument that runs through this study is that the analysis of HIV/AIDS among educators should be linked to the material conditions in schools. The evidence presented in this report shows that the health of educators is a source of concern because the prevalence of HIV/AIDS is high.

To achieve the objective of the study, a literature review and empirical research were conducted. During the empirical research, a self-administered questionnaire was sent to 7 identified schools from King William's Town schools as a sample of Department of Education. The impact of HV/AIDS on teaching and learning was investigated to see if these are in line with what the literature reveals. Descriptive statistics and methods were used to analyse the data and to find responses to the research questions and objectives. The research showed that, the determinants are

multiple: behavioural, HIV/AIDS knowledge deficit and lack of self-efficacy skills, secondly, it is time for sociologists, psychologists and others to work with educators to understand the sexual context within which life skills are taught, to collect rigorous data and reliable information, and to apply what is learned to HIV programmes in the education sector.

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CHAPTER 1

1. BACKGROUND AND DEFINITION OF STUDY

"The spread of the HIV/AIDS epidemic has undermined human capacity and weakens a country's potential for sustained economic growth and poverty reduction. In the most severely affected nations, the disease reversing the gains of economic development and shortening life expectancy." USAID 2003

The education sector is thought to be particularly hard hit by HIV/AIDS because both the demand for and supply of education are affected. Not only do children drop out of school because of HIV/AIDS, thus reducing demand for educators, but educators, school managers and education policy-makers are themselves dying of AIDS, thus reducing supply. Education is crucial to the creation and enhancement of human capital, which is essential for sustainable development. Despite the lack of empirically based studies on the impact of HIV/AIDS on the education sector, a few studies suggest that the impact may be significant. It is estimated that the education sector will experience high morbidity and mortality due to HIV/AIDS and consequently the attrition of educators.

In Eastern and Southern Africa, where the HIV/AIDS epidemic has been prevalent for longer, the impact of HIV/AIDS on the education sector is evident. A Zambian study showed that educator mortality was 39 per 1000, a figure considered 70 percent higher than that for the adult population aged 15-49 years. (Human Science Research Council Report for Education Labour Relations Council, 2005: 2)

The World Bank projected that 40 percent of Malawian education personnel working in urban areas would die of AIDS by 2005; 100 Tanzanian primary school educators would die of AIDS each month. Estimates are that by 2006, 45 000 trained educators will be needed to make up for those lost to AIDS, while in Botswana death rates from AIDS increased from 0.7 per 1 000 in 1994 to 7.1 per 1 000 in 1999 (Human Science Research Council Report for Education Labour Relations Council, 2005: 3). A 1999 educator demand and supply projection model in South Africa suggested that AIDS would add to existing high levels of educator attrition and that the cumulative attrition rate may require replacement of as many as 60 000 educators by 2010. Another South African study found that the educators' mortality is expected to grow over time.

While AIDS mortality among educators was estimated to be about 0.64 percent in 1999 in KwaZulu-Natal, it is expected to rise to around 5 percent by 2010 (Human Science Research Council Report for Education Labour Relations Council, 2005: 3). If the normal attrition rate of 6 percent, observed in 1999 was to hold constant over time, then it is hypothetically possible that gross attrition could climb significantly by the end of the decade (Badcock-Walters, et al.2003). All these findings suggest that the education sector may very well be experiencing higher than expected mortality due to AIDS.

The effects of HIV epidemic do not end with issues of staff mortality. The performance of the whole education system can be affected by educators' morbidity, which can lead to extensive disruption of activities and the impact of the epidemic on morale, internal and external disharmony (Cohen, 2002). Sickness can result in high rates of educator's absenteeism; long-term and persistent absenteeism can be

disruptive to the education system. No in-depth research has yet been undertaken that would allow robust estimates to be made on the effects of the HIV/AIDS epidemic on the overall number of days lost through increased educator absenteeism. However, of the available estimates, it is assumed that each infected educator loses a total of 18 months of working time.

The impact of HIV/AIDS has major implications for education systems, for example, when an educator dies, some education departments takes too long to substitute an educator. Some of the schools cope by combining classes, thus increasing the learner to teacher ratio. Thus the workload for the remaining educators increases, which compromises the quality of individual attention to learners. This in turn has serious implications for the intellectual capacity and skills of future generations. The gains of economic development are being reversed because of the slow progress African countries have made in educating children. Another challenge for the education sector is that the HIV/AIDS epidemic generates orphans. This is because most people become infected between the ages of 15 and 24 years, and many die when their children are still very young, leaving orphans who require extra emotional support from educators – a need that is unlikely to be met in large classes (Human Science Research Council Report for Education Labour Relations Council, 2005: 3).

This study, concentrates on the education sector, because it is directly or indirectly responsible for the training of all civil servants, making the need for its continuous normal functioning vital for government in the short- and long-run. Moreover, education plays a pivotal role in economic growth and development. The sector also comprises the largest number of employees in most African development and

African states. Taken together, these three factors arguably make education the most important branch of the civil service. However, research gaps and strategies identified likely can be applied to the entire civil service-agriculture, health, law enforcement, and others.

1.1 The Statement of the Problem

HIV/AIDS impacts the civil sector, especially the education sector, in a significant manner. Educators are said to be particularly vulnerable to infection because of remote postings, geographic and social mobility. For example, reports of teacher and student absenteeism, and attrition, lend support to this assumption. One social problem which concerns and influences South African (and other African) organisations is the curse of AIDS. In sub-Saharan Africa it is devastating families, communities, and hope. So far 17 million people have died of AIDS. (Management Principles, *A Contemporary Edition for Africa*, 3rd Edition: 75). At least 25 million may follow in the next few years. South Africa has now the largest number of people living with HIV/AIDS in the world, about twenty per cent of its adult population, up from thirteen percent in 1997.

The concerns that the education sector, and especially human resource personnel, have about the epidemic revolve around the fact that schools will soon have to deal with a workforce where one-third is infected by HIV/AIDS and where a school can lose key people, as well as twenty-five to fifty per cent of its workforce. The education sector in South Africa is legally obliged to support HIV/AIDS infected / affected personnel. Heavy casualties from AIDS in the Eastern Cape (due to the province being rated amongst poorest provinces) implies that this and the next generation of young people will not receive the education they need to become

productive members of society. Young people will be unable to find employment either in the private or public sector, and will experience difficulty starting their own entrepreneurial endeavours.

1.2 The Objective of the Study

This study seeks to:

- identify the effects of HIV/AIDS on teaching and learning of educators and learners respectively in the King William's Town District;
- make recommendations with regard to the identified effect.

1.3 Literature Review

In South Africa, the 2004 National survey indicated that there was an increase in HIV prevalence from 24.8 percent in 2001, 26.5percent in 2002 to 27.9 percent in 2003 and 29.5 percent in 2004. It was further estimated that the number of South Africans living with HIV/AIDS has increased from 4.7 million (with 189,000 babies) in 2001 to 5.6 million in (96,228 babies) in 2003. HIV prevalence in Eastern Cape has increased from 21.2 percent in 2001 to 23.6 percent in 2002. In 2002, Nelson Mandela Metropolitan Municipality had the highest prevalence (i.e. 32.6 percent), followed by Alfred Nzo District Municipality with 28.3 percent, 25.3 percent in Chris Hani District Municipality and Cacadu District Municipality with the lowest prevalence 16.8 percent.

HIV prevalence trends based on the national survey show that the HIV epidemic in South Africa has evolved rapidly into a mature stage and that the rate of progression varies in each of the 9 provinces. In Eastern Cape, even though 72.3 percent of scholars had received HIV education 54 percent had 2 or more partners, 28.8 percent used a condom while 13 percent had sex while they had used alcohol and

drugs (Eastern Cape Department of Health, HIV and Syphilis Antenatal Sero-prevalence Survey in Eastern Cape 2004, Year 7 No 28: 4).

The public sector is arguably the largest employer in Sub-Saharan African countries, and the education sector makes up the lion's share of that. Heavy casualties from AIDS imply that this and the next generation of young people will not receive the education they need to become productive members of society. Young people will be unable to find employment either in the private or public sector, and will experience difficulty starting their own entrepreneurial endeavours.

According to the report, African universities are now operating in a worsening socio-economic environment. A recent study of several universities in Benin, Ghana, Kenya, Namibia, South Africa and Zambia found an "overwhelming atmosphere of ignorance, secrecy, denial and fear of stigmatisation and discrimination in relation to AIDS"(Science in Africa, *Africa's First On-Line Science Magazine,* May 2002:1). The impact of the pandemic on demand for education was less clear, however, at schools, the population would continue to grow despite being reduced by HIV/AIDS. But girls' access to education had been curtailed by HIV/AIDS, as they were more likely to be retained at home to care for sick relatives.

Government reform and advancement has been difficult to sustain in many Sub-Saharan African countries, irrespective of AIDS. Uganda, for example, realised that AIDS was a problem early on, and did something about it, reducing AIDS prevalence substantially more than any other African country. Malawi is creating management information systems to keep track of critical skill losses and possibilities to fill those skilled positions. And they are creating educational

scholarship to fund college degrees for critical staff. Education could play a critical role in HIV/AIDS prevention but the pandemic's devastating impact threatens to derail any such effort, the World Bank warns in a new report. "HIV/AIDS is draining the supply of education, eroding its quality, weakening demand and access, drying up countries pools of skilled workers and increasing the sector' costs" ('Education and HIV/AIDS: A Window of Hope' released on 7 May 2002).

1.4 METHODOLOGY

1.4.1Research Design

Mouton (1996:107 defines a research design as " a set of guidelines and instructions to be followed in addressing the research problem".

The design of the investigation however may reduce the possibility of the issue undermining the results to be attained; it is therefore imperative for this study on this chapter to highlight some of the methodological consideration upfront. However, it will be important to note the rationale and methodological approach to the objective of the study. In trying to identify the approaches that will respond to the objective, this section of the proposal is organised accordingly.

Firstly, formative research is going to be undertaken using focus groups and key informant interview methods among educators in the above mentioned schools. These qualitative methods will help to determine the themes that will be included in the questionnaire.

Secondly the institutional questionnaire by the principal or rector involved in them undertaking some archival research to look up school records to obtain the information required.

1.4.2 Methodological Considerations

1.4.2.1 Ethical Considerations

The participants' confidentiality will be guaranteed and safeguarded at all costs. The participants will not be forced or coerced into providing information any information they are not at liberty to disclose or they are not comfortable with.

The researcher will also assure the participants that no physical or psychological harm will happen to them as a result of their participation in the research; in other words, there will be no reprisal whatsoever. This implies that the researcher proposes to uphold all ethical standards in pursuit of the findings.

1.4.3 Cost and Time

The geographical location of King William's Town district school could result in higher cost in travelling and accommodation on the part of the researcher. Because of rural areas and bad roads within the district, a normal vehicle could be detrimental to the research.

1.4.4 Operationalisation

This study employed a triangulation of several research methods both qualitative and quantitative methods will be used in addressing its key objective. Denzin coined the term *triangulation* to refer to the use of multiple methods of data collection (Mouton and Marais 1990: 91).

This section of the chapter presents general information on the sample, instrumentation as well as data collection and general approach to data summary and analysis.

1.4.5 Procedure

The research will be a study of Impact of HIV/AIDS on teaching and learning in the King William's Town District schools i.e. private high schools, public high schools and one Further Education and Training College.

1.4.6 Population

For the purpose of responding to the objective of this study, the population that is envisaged for sampling are educators and learners of the 500 King William's Town District schools, i.e 387 primary schools, 2 private high schools, 110 public high schools and 1 FET College but as stated in paragraph 1.5.5, this study will only focus on high schools and FET College.

1.4.7 Quota Sampling

A sample of a population is used to simplify the research, to save time, to cut costs and above all, it is manageable. Quota sampling is the non-probability sampling equivalent of stratified sampling with the added requirement that each stratum is generally represented in the sample in the same proportion as in the entire population (Bailey, 1987: 93). This type of sampling is chosen because each stratum will be represented.

The sample size will be made up of at-least 18 members: 7 Principals taking one from each high school and FET College, 14 Educators taking two from each high school/FET College and a group of grade 12 Learners taken randomly from the high schools and FET College. The schools around King William's Town will be identified as follows: 1 high school from Breidbach location, 2 high schools from Zwelitsha location, 1 high school from Bhisho location and 2 high schools and FET College from King William's Town itself and these locations covers a wide spectrum when it comes to diversity in South Africa (Bhisho & Zwelitsha covers the Xhosa speaking population, Breidbach covers the Afrikaans speaking population and King William's Town is perceived as an English dominated population).

1.4.8 Document Analysis

In the proposed study, various other sources of evidence will also be used. These sources will include various documentation such, as attendance registers for educators and learners, marks schedule and previous results.

1.4.9 In-depth Personal Interviews and Questionnaires

Semi-structured one on one qualitative and quantitative interview will be held with the role players. This will involve, posing a series of open-ended questions to all the role players. The interview is an alternative method of collecting survey data. One advantage of interviews is the fact that, respondents seem more reluctant to turn down an interviewer standing on their doorstep than they are to throw away a mail questionnaire. Secondly, structured questionnaires will be used together with interviews. It is necessary to supply respondents with standardised instructions on how to complete the questionnaire and to explain what is expected from them.

The following people will be respondents: School Principals, Educators and Learners, to determine, to what extent the HIV/AIDS impact on teaching and learning. The information gathered will be recorded.

1.4.10 Mode of Observation

To understand the experiences of educators and learners as revealed through the research process, the study will utilise the data sources of non-participant observation and self-reporting. One of the data sources to be utilised is that of non-participant observation. The study will observe the participants while doing fieldwork. The field notes that the researcher make will help the study to develop ideas and questions to verify understanding of the information gathered during the research process. Henning et al, (2004) define these kinds of field notes as 'soft' notes consisting of experience of the field. These notes will therefore include

personal thoughts of a researcher, feelings and impression in response to some discussions.

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

In order to understand the researchers' influence on the data, the study will employ the advice the advice of Denzin and Lincoln (2000). They are of the opinion that it is advisable in conducting qualitative research to use the process of crystallisation. They state that in employing the crystallisation process, the researcher describes the same process from different points of view and this might reduce the likelihood of misinterpretation. "Crystals grow, change, alter … crystals are prisms that reflect externalities and refract within themselves, creating different colours, patterns and arrays, casting off in different directions" (Denzin & Lincoln, 2000; 5). The advantage of observation is that real-life behaviour can be perceived, studied and verified. Misunderstanding can also be clarified on the spot.

1.4.11 Data Collection and Analysis

In collecting data, the researcher will abide to the three principles of data collection when doing case studies as postulated by Yin (2003). This will be the use of multiple sources of evidence, creating a case study database and maintaining a chain

of evidence. Through the process of triangulation a (Yin, 2003:100) "converge of evidence" will be developed when the data is analysed.

The data will be analysed qualitatively by relying on "theoretical propositions" (Yin, 2003:111) as espoused in the literature review. These propositions will assist to focus attention on the date, which, will assist in the answering of the research questions. The results will be presented in narrative format (Winegaard: 2004).

Trochim (2002), states that qualitative validity can be judged on the criteria of credibility, transferability, dependability and conformability. This proposed research would be credible because it will clearly represent the views of the participants who will be given an opportunity to read draft scripts before the dissertation is finally submitted.

The criteria of conformability will be upheld, as the researcher will document within the methodology chapter the procedures used for checking and re-checking the data. Copies of all sources of data will be kept and will be made available in the public domain for scrutiny. The criteria of dependability will be supported as a chapter of the dissertation and will be focused on describing the context and environment. This will ensure that other researchers wishing to replicate a similar study will be made aware of context, which could influence their results. Transferability or the degree of generalisation will be upheld by ensuring that the researcher declares and clearly describes the research context and makes all assumptions overt.

1.5 Limitations

The limitation of this study is the likelihood that some educators may be reluctant to participate /may give inaccurate information as HIV/AIDS is a rather sensitive topic.

1.6 Delimitations

The study will focus on the impact of HIV/AIDS on the performance of educators in the Eastern Cape Department of Education. The study will be confined to the King William's Town area because of time and financial constraints.

1.7 Research Chapters

Chapter 1

This chapter will be composed of the background to the research, the problem statement, purpose and objectives of the study, significance of study, in other words this chapter will provide an overview of the entire research.

Chapter 2

Chapter two will deal with literature review, meaning which a historical analysis will be forwarded regarding the impact of HIV/AIDS on the performance of teachers in schools.

Chapter 3

This chapter will deal with the research methodology, i.e. the methods employed to collect the data used, the research design or plan and data analysis will also receive attention in this chapter.

Chapter 4

In chapter four, the summary of data will be presented, i.e. the research findings and interpretation will be made known.

Chapter 5

This chapter will focus on the overall conclusions found from the research, the possible solutions to problems or challenges that would have been uncovered. The recommendations as to how similar situation could be dealt with in future and conclusion.

1.8 Definition of Terms

Vulnerability - Refers to those aspects of an organisation that make it more or less likely that usual levels of illness and or death will have negative effect on organisational performance (Barnett & Whiteside, 2002).

Death Rate – Death rate refers to the number of deaths as percentage of the population total.

Impact Mitigation - Refers to the steps taken by an organisation to minimise the impact of HIV/AIDS on its ability to deliver its service.

1.9 Acronyms

AIDS	- Acquired Immunodeficiency Syndrome
EDO	- Education Development Officers
DoE	- Department of Education
FET	- Further Education and Training
HIV	- Human Immunodeficiency Virus
ILO	- International Labour Organisation
MRC	- Medical Research Council
NGO	- Non-Governmental Organisation
PWA	- Person living with AIDS
SASA	- South African School act
SGB	- School Governing Body
STD	- Sexually Transmitted Disease
STI	- sexually Transmitted Infection
USAID	- United States Agency for International Development
VCT	- Voluntary Counselling and Testing
WHO	- World Health Organisation

1.10 Conclusion

The introduction gives a brief background to the area of study and the rationale. The problem statement was formulated. The research method to be used is also indicated. In the next chapter, the study will discuss the Impact of HIV/AIDS on Teaching and Learning. The discussions will include research findings from international scholars, and arguments will be supported from this pool of research publications to analyse the local context.

CHAPTER 2

2. HISTORICAL ANALYSIS

2.1 Introduction

In chapter 1, the research problem, aims, and research methodology were outlined and put into perspective. This chapter explores the impact of HIV/AIDS in schools, disclosures, discrimination and safety measures.

AIDS is likely to become the most serious health hazard of the century. This is evident by statistics on infection and deaths (UNAIDS, 2000:3). According to a global estimate of the HIV/AIDS epidemic. The current infection rate of HIV worldwide is about 42 million people, approximately 29,4 million adults and children are living with HIV across Africa south of Sahara (UNAIDS, 2003:3). The infection rates in schools is not known although national statistics shows that people between the ages of 15-38 are most vulnerable to HIV infection (Morrel, Unterhalter, Moletsane & Epstein, 2001:51). This implies that educators and learners are included in the vulnerable group (Berold, 2000: 1). Learners and educators cannot be isolated from this health hazard. The education sector needs information about conditions that encourage the spread of HIV/AIDS and how best to protect those at risk (Coombe, 2000:26).

2.2 The Impact of HIV/AIDS on Society

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

and communities, organisations and management, the curriculum as well as resources (Smart, 2003).

South Africa is considered to have one of the fasted growing epidemics in the world, with approximately 1600 people being infected every day. Currently in South Africa alone, more than 3.5 million people are infected with HIV (approximately 10% of the population), and this number is expected to rise to between 6 and 10 million people within 15 years (Call, Riedel and Hein, 2002). The need for urgent steps focussing on the youth to address this enormous problem is evident from the following statistics. The level of HIV infection amongst pregnant adolescents younger than 20years was 6,7% in 1994 and rose to 12,7% in 1997, and to alarming 21% in 1998, an increase of 655 within one year (Department of Education, 2001{9}). These statistics are disturbing in terms of adolescent risk behaviour in the face of HIV/AIDS and the challenge it poses to the education system.

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

Of the more than fifteen thousand new cases of AIDS reported daily in South Africa, it is estimated that 10% are children (UNAIDS, 1998{b}). In 2004 almost 25% of all new infections in South Africa are among the youth (McKay, 2004). Unfortunately,

statistics alone do not fully present the grim reality of HIV/AIDS. Even well written, carefully considered prevention programmes cannot anticipate the contextual factors in which they will be presented.

HIV spreads fastest and farthest in conditions of poverty, powerlessness and lack of information (Issues in world Health, 2001). There are almost 18 million children under the age of 18 in South Africa of which an estimated 605 live in poverty and are nutritionally vulnerable (Smart, 2003). Worldwide, the AIDS epidemic is most severe in the poorest countries, where the disadvantaged and people with few opportunities, services and support systems, are at greatest risk.

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

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

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

Countries may only experience the demographic effects of HIV/AIDS years after the height of the epidemic. According to a UNESCO report published in April 2001 (UNESCO, 2001). The HIV/AIDS epidemic will have a greater impact on the size of the population of several developing countries than the Second World War had on any society. Robertson and Ensink (1992) seem to support this report by saying that in South Africa the increasing prevalence of HIV seropositivity in woman and children indicates that we are on the brink of an AIDS epidemic of the proportion of that which has swept through other African countries. The increased demand for care stretches already overburdened health and education systems. With infection rates reaching a third of the population, and as many as half of the young in some countries, no institution will remain untouched.

One example of this impact is the number of orphan's peaks seven to ten years after seroprevalence. It is estimated that worldwide there are approximately 13 million AIDS orphans. By 2005 South Africa alone had more than 800 000 AIDS orphans (Call et al., 2002; Giese et al., 2003). The future estimations are 24,3 million children orphaned by HIV/AIDS by 2010 and 40 million by 2020 (Smart, 2003). Dependency ratios may worsen due to AIDS-related illness among adults. The number of widows may increase, and their socio-economic situation may deteriorate. Household

composition will change as middle-aged parents die, and grandparents are left to raise young children (Department of Education 2001{a}; Hunter and Williamson, 2001; Smart 1999).

The HIV/AIDS epidemic in Southern Africa is not expected to peak until 2010-2020, after which it is anticipated that incidence and prevalence will begin to decline. Because orphaning follows deaths by 8 to 10 years, orphaning is likely to remain high until 2030 (Richter, Manegold and Pather, 2004). HIV/AIDS thus has demographic effects on aspects such as total population loss, population growth rates, crude death rates, fertility rates, life expectancy, age distribution, infant and child mortality, dependency ratios, gender ratios, widow (er) hood, household composition and/or co-residence (Hunter and Williamson, 2001).

In addition to these demographic issues, HIV/AIDS also threatens to reverse the socio-economic gains made by developing countries. It affects production as well as household income and expenditure, it poses major health problems for health systems and health care practices and it diminishes the capacity of societies to provide essential services and to plan for the future (Barolsky, 2003; UNESCO, 2002). These socio-economic effects have an impact on social services, the well-being of individuals and households, demand for labour, urban poverty, agricultural production, health care and school enrolment. More households will be facing poverty because of lost productivity and loss of access to markets. Child labour will increase inside and outside the home because of the scarcity of adult labour. The death of a parent or another adult in a household quite often affects the nutritional status of surviving children by reducing household income and food expenditure (Call et al.,

2002; Juma, 2001). Hence, the AIDS epidemic not only hampers development, it reverses it by destroying productive capacity and widening the gap between rich and poor (UNESCO, 2001).

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

Barnett and Whiteside (1996) report on work carried out by the World Bank. They argue that the effect of HIV/AIDS is quite difficult to pick up even in societies where the epidemic is advanced. They also argue that the impact is reduced by the coping mechanisms of individuals and families. When an adult in the household dies, girls of this family are less likely to be in school, which could, according to this World Bank study, have long-term implications for female literacy and human capital (Bernett and Whiteside, 1996). It is thus vital to recognise and support the role of the family and community in educating young people about HIV/AIDS. In many countries, the majority of young people who need to learn about prevention are not in school (Giese et al., 2003; UNESCO, 2002). Hunter and Williamson (2001) state that the following aspects of HIV/AIDS have an impact on families: the loss of family members (death,

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

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

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

already an increased burden and stress on extended family structures. Many grandparents and relatives are looking after young children and some of the problems they experience also lead to school absenteeism and dropout rates (Juma, 2001). Richter, Manegold and Pather (2004) concur that orphans may be additionally disadvantaged by their pre-existing low socio-economic status at the time of their parents' death as well as by their biological distance from breadwinners and decision makers in the households in which they are placed.

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

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

could have a vast influence on how supportive the community is towards the HIV/AIDS programme at the school, which in turn influences the learners' experience of this programme. Hunter and Williamson (2000) summarise the broader macro impact of HIV/AIDS: the vulnerabilities of children, families and communities are compounded by the geographic concentration of the pandemic. "Vulnerable children are cared for by vulnerable families who reside in vulnerable communities" (Hunter and Williamson, 2000: 18).

2.3 The Impact of HIV/AIDS on Teacher Performance

Sub-Saharan Africa has been devastated by the HIV/AIDS pandemic. Recent estimates by the World Health Organisation show 29 million people are infected, with an additional 2.5 million being infected annually and cumulative AIDS-related deaths at 13.7 million. Although only 10 percent of the world's population lives in Sub-Saharan Africa, nearly 10 percent of the world's HIV-positive population lives there.

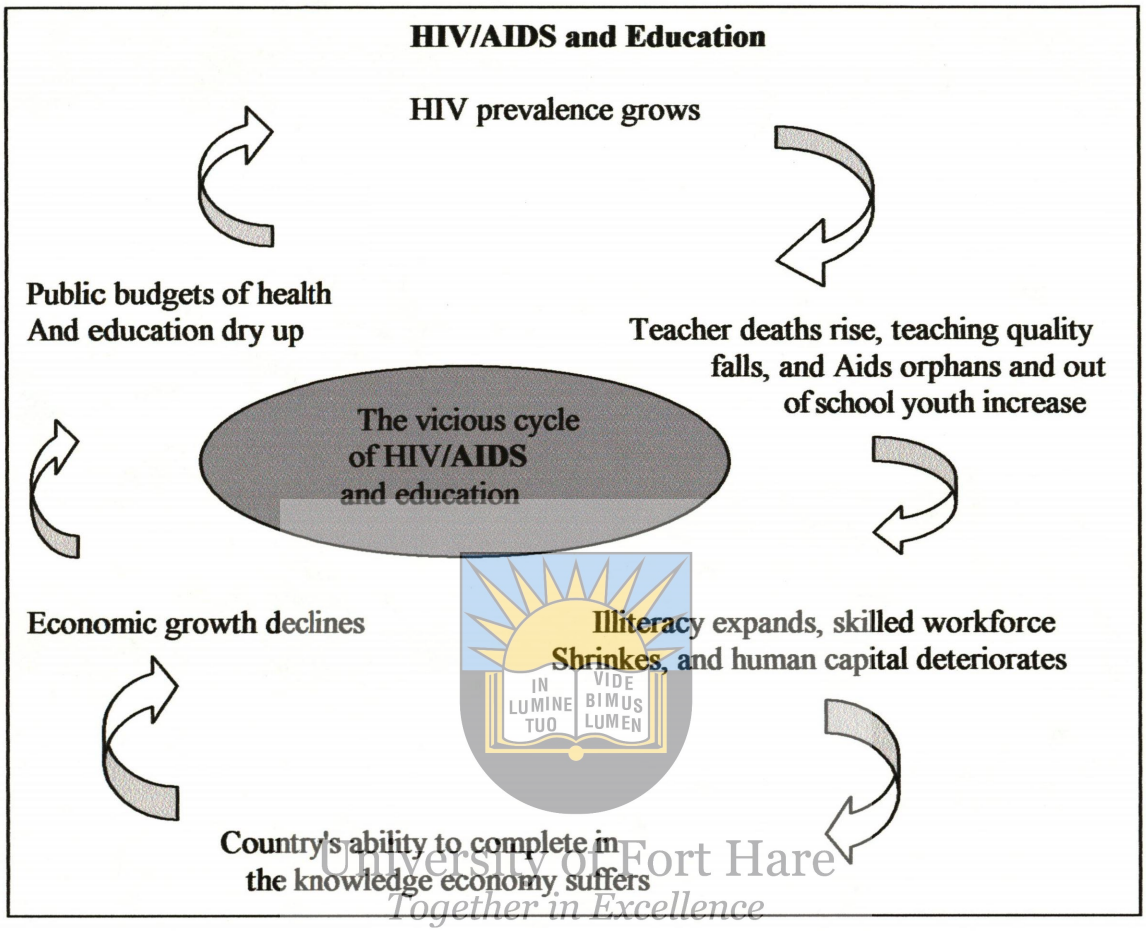
(Mitigation HIV/AIDS' Impact on Teachers and Administrators in Sub-Saharan Africa, Working Paper Series: 2)

One emerging area of concern is the impact on education sector, not only on high school teachers (including University professors) and school administrators, but also on civil servants in Ministries of Education. Although figures are not widely available, preliminary statistics are frightening. Teacher attrition from AIDS is estimated to be highest in Kenya (25 000), Nigeria (22,100), South Africa (44,900), Uganda (14,900) and Zimbabwe (16,200). (Mitigation HIV/AIDS' Impact on Teachers and Administrators in Sub Saharan Africa, Working Paper series: 2). Since 200,000 of Sub-Saharan Africa's 650,000 teachers are projected to die from Aids by the year 2010. (Mitigation HIV/AIDS' Impact on Teachers and Administrators in Sub-Saharan Africa, Working Paper Series: 2). At present, more than half of education positions are

unfilled. Globally, it is estimated to cost $ 1 billion annually to compensate for the loss and absenteeism of teachers from AIDS. (Mitigating HIV/AIDS' Impact on Teachers and Administrators in Sub-Saharan Africa, Working Paper Series: 2). Estimates suggest that an infected teacher losses about six months of professional working time before developing full-blown AIDS, while an average of one year lapses between the onset of clinical AIDS and death: teachers experience about 18 months of increasing disability before leaving the school system.

(Mitigating HIV/AIDS' Impact on Teachers and Administrators in Sub- Saharan Africa, Working Paper Series: 2)

An important question, what does the loss of large cadres of teachers, school administrators, and civil servants in education, mean to sub-Saharan countries? To begin with, the public sector is arguably the largest employer in sub-Saharan African countries, and the education sector makes up the lion's share of that. Heavy casualties from AIDS imply that this and the next generation of young people will not receive the education they need to become productive members of society. Young people will be unable to find employment either in the private or public sector, and will experience difficulty starting their own entrepreneurial endeavours. Loss of administrators and civil servants will remove skilled workers from the bureaucracy that manages education. Public employees remaining will be pushed to the limit, trying to cover work previously performed by others. Productivity will decline precipitously, not only from deaths, but also from absenteeism among those affected or caring for relatives. Advances in economic development and growth will be reversed, perhaps for decades into the future. Development will not be sustained.



(Mitigating HIV/AIDS' Impact on Teachers and Administrators in Sub-Saharan Africa Working Paper Series: 3)

In the past, many believed that the loss of teachers, school administrators and civil servants would not be terribly devastating, essentially self-correcting, for at least two reason: first, they believed that the civil service employment was fairly low-skilled and that the vast pool of unskilled workers in many countries could be easily trained to replace those lost to the system.

Secondly, they argued that the population devastated by AIDS necessitated a decrease in administrators and teachers, so the system would maintain its equilibrium. Those holding these beliefs are clearly wrong. The pool of unskilled labour generally cannot be converted to education sector employees, and those who could be trained require

more skills than can be transferred in a short time. Even if they could be trained, they are likely to be absorbed into higher paying jobs in the private sector, the non-governmental organisations, or development agencies. On the second point, it is true that millions of children are out of school and dying due to AIDS. In fact, by the year 2010, between 10 percent and 20 percent of primary school age children will be lost to AIDS. But it is also true that there are many more who are not infected, but have become orphaned, drafted into the labour force to help parents, have become care-givers for infected relatives. These children still have educational needs, but they simply cannot access the traditional system given their circumstances.

National government need to devise strategies for preventing AIDS impact on teachers, school administrators, and civil servants where they can, and to manage the consequences of the epidemic on the education sector that are already well underway. Formal strategies are now required as a pre-requisite for receiving funding from the Global AIDS and for loans from the World Bank. A national strategy will require:

- stemming further attrition in the ranks of teachers, school administrators and civil servants through prevention;
- to train a cadre of workers to replace those lost in the public sector;
- re-engineering the workforce to cover functions affected by attrition; and
- re-engineering ministries, universities and educational bodies to make
- them more efficient and effective in the light of changing the workforce.

Government reform and advancement has been difficult to sustain in many Sub-Saharan African countries, irrespective of AIDS. Overlaying the effects of the AIDS epidemic makes the educational workforce issues even more problematic for policy-

makers. Ironically, the AIDS epidemic might compel African governments to rethink government and education generally, perhaps with positive outcomes. Uganda, for example, realised that AIDS was a problem early on, and did something about it, reducing AIDS prevalence substantially more than any other African country.

Most countries initially relegated the management of the epidemic to the ministries of Health with little involvement from or concern about other ministries, including Education. With assistance funding now flowing to many countries in Sub-Saharan Africa, disease management has now been made the responsibility of the national AIDS commissions. This strangely, in hindsight, only makes sense if the epidemic is solely a health problem, requiring prevention and training. But the downwardly spiralling effects of AIDS on the education workforce itself require a broader strategy. Thus far, Sub-Saharan African policy-makers and the international community are just beginning to address the problem and few countries have crafted responses to it.

The Global Aids fund, for example, has yet to award funding to countries wishing to pursue education workforce capacity building strategies, focusing instead on prevention and treatment. Malawi has become pro-active on the issues and is exploring the possibility of providing Anti-Retroviral (ARV) drugs to its employees to extend their work-life. Malawi is creating management information systems to keep track of critical skill losses and possibilities to fill those skilled positions. And they are creating educational scholarship to fund college degrees for critical staff.

Policy-makers in the international community are implementing programmes to raise awareness of and stimulate action around the AIDS issues above, but these are still in

their infancy. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) now operates a website clearinghouse addressing HIV/ AIDS Impact on education. The International Labour organisation offers a programme HIV/AIDS and World of Works, that focuses in part on educational institutions and workforce issues; the World bank has let contracts for studies in this arena, and organisations like the association for the Development of Education in Africa have held conferences on the topic. Major strategic approaches employed or at least being considering by national governments to combat AIDS might cluster as follows:

- information/data availability for planning, decision-making, and evaluation;
- capacity building to ensure efficient short-term responses, maintaining the smooth functioning of the system;
- constructive partnerships for generating a comprehensive effort to combat the spread of AIDS; and
- resource intensive long-term initiatives to stabilise workforce supply and guarantee appropriate prioritisation of development issues in South Africa.

The strategies above consider two factors: implementation viability in political and economical terms, and their effectiveness as policy instruments to mitigate the pandemic's impact on teachers and civil servants. Education could play a critical role in HIV/AIDS prevention but the pandemic's devastating impact threatens to derail any such effort, the World Bank warns in a new report. "HIV/AIDS is draining the supply of education, eroding its quality, weakening demand and access, drying up countries pools of skilled workers and increasing the sector' costs," the report 'Education and HIV/AIDS: A Window of Hope' released on 7 May 2002, said.

In the Central African republic, 85 percent of teachers who died between 1996 and 1998 were HIV-positive, and they died 10 years before they were due to retire. Education administrators were also affected. At least 12 percent of South Africa's administrative personnel were estimated to be HIV positive. Teacher absenteeism and non-performance could also be attributed to the largely ignored psychological effects of the pandemic.

(Science in Africa. *Africa's On-line Science Magazine*, May 2002:1)

In Zambia, more than two thirds of survey sample of teachers with relatives who were ill with or had died of AIDS were unable or unwilling to talk about the problem with friends of family. (Science in Africa. *Africa's On-line Science Magazine*, May 2002:1). Such isolation, coupled with fear about their own HIV status, took its toll on teachers and their ability to teach. According to the report, African Universities are now operating in a worsening socio-economic environment. A recent study of several universities in Benin, Ghana, Kenya, Namibia, South Africa and Zambia found an "overwhelming atmosphere of ignorance, secrecy, denial and fear of stigmatisation and discrimination in relation to AIDS". (Science in Africa. Africa's first On-line Science Magazine, May 2002:1). The impact of the pandemic on demand for education was less clear, however, as the school are population would continue to grow despite being reduced by HIV/AIDS. But girls' access to education had been curtailed by HIV/AIDS, as they were more likely to be retained at home to care for sick relatives.

"In some countries the epidemic contributes to making the education system itself a source of risk, especially for girls," the report said. In one Ugandan district, 31 percent of schoolgirls surveyed reported being sexually abused, mainly by teachers. " The specific costs of the HIV/AIDS to the education sector. Now beginning to be estimated, are large," the report said.

Zambia has reported the cost of replacing the teachers who have died of HIV/AIDS at US $25 million between 2000 and 2010, and Mozambique's estimate is about twice as much. Country responses to this worsening crisis included skills-based health education. (Science in Africa. *Africa's first On-Line Science Magazine*. May 2002: 1).

After a school health education programme in Uganda yielded little progress in attitudes and behavioural change, the education ministry adopted a life project for primary and secondary schools. Consequently, Uganda's AIDS Commission reported a fall in the rate of new infections of almost 50 percent among 15 to 19 year olds, the report observed. The World Bank is working with partners to support countries throughout Africa in assessing the impact of HIV/AIDS on their education systems and planning appropriate responses such as the skills-based school health programmes.

According to Current Issues in Comparative Education, volume 3, 1 of 2000 by Carol Coombe, states,

"it is within the impact of HIV/AIDS on the education system of catastrophe, challenge and loss that South Africa's department struggle to maintain their balance. Until government's impact assessment is completed late in 2000, experience in the region, information form other sectors, demographic analysis, and anecdotal information provide clues about how HIV/AIDS is likely to compromise education quality in South Africa.

2.3.1 Learners: Declining and Changing Demand for education

There are currently just over 12 million learners at school (50.5% female) in South Africa, in about 30,000 primary and secondary schools (Department of Education, 2000a). As HIV/AIDS reduces the number of parents 20 to 40 years old, numbers of orphaned children increase, and poverty deepens, school enrolment rates are expected to decline. Dropouts due to poverty, illness, lack of motivation and trauma are set to

increase, along with absenteeism among children who are heads of households, those who help to supplement family income, and those who are ill.

There may be greater demand for a chance, flexible out-of-school education by learners returning to education after absence as caregivers or wage earners. On the other hand, these demands may be offset by fewer births and more deaths of under-fives, and the fact that family units will have less disposable income for fees, voluntary funds, transport, books and uniforms. Unless state provisioning changes to meet more complex learning demands, more young people will be functionally illiterate and unqualified.

2.3.2 Educators: Reducing supply and Quality of Education

The education service, the largest occupational group in the country, includes 375,000 teachers, 5,000 inspectors and advisers, and 68,000 managers and support personnel (Department of Education, 2000a, pp. 157-161). At least 12 per cent of all educators are reported to be HIV positive (Abt Associates, 2000). In southern Africa an HIV positive person without access to drugs dies within seven years of infection. That means that over 53,000 educators will die by 2010, or between 88,000 and 133,000 educators if prevalence reaches 20 or 30 per cent. (Current Issues in Comparative Education, Volume 3, Number 1, December 1, 2000: 18).

Many others will be ill, absent and dying, or pre-occupied with family crises, and school effectiveness is bound to decline. Job mobility of educators is likely to increase, and as teachers die or leave the service for better jobs elsewhere, student/teacher ratios will decline. But the supply-demand equation is complicated. Teacher recruitment

targets may be lower than at present if enrolments decline or do not grow as expected. Given uncertainty about likely levels of chronic morbidity, mortality and other types of 'wastage,' it is difficult to make teacher requirement projections with any degree of confidence. In any case, new recruits cannot make up for the loss of the education service's most experienced senior teachers, managers, teacher educators, professors, and science and mathematics specialists.

2.3.3 Trauma in Classroom

The HIV/AIDS pandemic will have a traumatic impact on all educators and learners. The work of educators--both those who are HIV positive and those who have developed full-blown AIDS--will be compromised by periods of illness. Once they know they are HIV positive, many are likely to lose interest in continuing professional development. Even among educators who believe they are not infected or do not want to be tested, morale is likely to fall significantly as they cope emotionally and financially with sickness and death among relatives, friends and colleagues, and wrestle with the uncertainty about their own future and that of their dependents. Most educators will have to take on additional teaching and other work-related duties in order to cover for sick colleagues.

Although discrimination is illegal, stigmatization of infected learners and educators is a deeply rooted response. HIV/AIDS will have a traumatic impact on learners. Children are being abused and young women are subject to violence. Many live in families that are overextended and are under pressure to contribute to family incomes as poverty deepens. They are losing parents, siblings, friends and teachers to the disease. Many

will have to move long distances to find new homes. For others, there are no homes at all. As a result, learners are increasingly absent from school and distracted.

2.3.4 Management: Embattled leadership

Educational management capacity is fragile at national, provincial, district and school levels. The system is finding it difficult to attract skilled managers. Many principals have not yet received sufficient support or training to enable them to be creative about local management of education. The situation will become worse as the pandemic takes hold. In the private sector, some companies are already training replacements for skilled technical and managerial personnel they expect to lose to HIV/AIDS. Similar strategies are not yet in place in education. In addition to the loss of managers, the system will lose experienced senior teacher-mentors and teacher educators in universities and colleges whose career experience cannot be replaced. Institutions will depend on younger, less experienced educators and the quality of teacher education will decline.

2.4 Discrimination

The concept of discrimination is clarified in legal terms as unfair or fair discrimination. Unfair discrimination is defined as treating a person differently in a way that violates his or her fundamental dignity as a human being who is inherently equal in dignity (Bray, 2000: 48). Joubert and Prinsloo (2001: 180) list HIV/AIDS as one of the grounds for unfair discrimination. Therefore, treating a person in a different way because he or she is HIV positive constitutes to unfair discrimination. It is stipulated in the National policy on HIV/AIDS for Learners and Educators in the Public Schools and Students and Educators in Further Education and Training Institutions (Section 3 (1) that no learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly). It means that educators must

guard against unfair discrimination towards anybody suspected of having HIV/AIDS, whether an educator or learner.

Discrimination can only be considered fair on reasonable and justifiable grounds. In a nutshell, discrimination against HIV positive people can only be fair when there is reasonable and justifiable threat or danger to the health and well being of others. Joubert and Prinsloo (2001: 114) point out that special measures taken towards HIV positive learners and educators must first take into account their best interest and that of other learners and educators. It must also be done in line with legal provisions and ethical guidelines provided. All learners and educators have a right to protection.

The international Human rights Law in the context of HIV/AIDS provides general principles of non-discrimination and control over HIV/AIDS (Patterson & London, 2002: 1). Equally important, international Human Rights Laws on HIV/AIDS provides a framework for laws and policy formation on HIV/AIDS. It also determines acceptable reaction towards people with HIV/AIDS and provides guidelines in which the performance of different countries is measured in relation to public health issues and policies. In the school situation, the HIV/AIDS policy for particular school must be drafted in line with the general principles stated in the International human rights Laws on HIV/AIDS.

2.4.1 Attitudes towards HIV positive people

According to Valdiserri (2002: 1) discrimination towards people with HIV/AIDS is not a unique public reaction towards sick people. In the past, people with diseases like leprosy and syphilis were also discriminated against and their condition was regarded as punishment for their immorality. Similarly, there are people who view HIV/AIDS as a punishment from God for immoral behaviour (Kanyoro 2001: 1, Benn 2001:5,

Nzioka 1996: 3 & Serio, 1999:3). People with such views are bound to have a negative attitude towards HIV positive people.

Furthermore, HIV is related to human behaviour that is undesirable and unethical. This triggers emotions such as anger, fear, disgust, avoidance and discomfort towards people with AIDS (Herek, Capitanio & Widaman, 2002: 2). Fear played a double role in the study done by Mbanya et al (2001: 3). Mbanya et al (2001: 3) point out that patient's fear stigmatisation and discrimination while medical practitioners fear being infected since they have misconception of the way in which the virus is transmitted. Research done by Herek et al (2002: 1) on HIV related stigma trends between 1997 and 1999 in USA has revealed that there is increased misconception concerning the disease. Some hold the judgmental opinion that people with AIDS get what they deserved. The reason for the persistence of the misconception on the mode of HIV transmission could be that people do not trust the information received from scientists and medical experts. The belief that HIV/AIDS can be transmitted through casual contact seems to continue to exist.

2.4.2 HIV/AIDS Stigma

All over the world people with AIDS are stigmatised and go through some form of discrimination in one-way or other. Nowell and Van der Merwe (2003: 48) describe stigma as irrational responses directed towards HIV positive people. These responses include being shunned by family members, being discriminated against in places of work, unfair medical treatment, funeral homes refusing to take remains of HIV victims or violence (Herek et al, 2002: 1). There are also cases where HIV positive children have been discriminated against unfairly in schools. In addition, there are laws in some countries that discriminate against HIV positive people, for instance

compulsory blood testing of newborn babies, prisoners and immigrants. In the case of immigrants this law violates human rights and freedom of movement (Dussault, 1999: 1).

HIV related discrimination comes from stigma attached to the disease. The stigma is associated with shame, which comes as a result of linking the disease with inappropriate sexual behaviour, disgrace, blame and dishonour (Morel et al, 2001; 56, De Cork & Mbori-Ngacha, 2002: 6). In addition HIV/AIDS stigma is also linked with certain groups of people referred to as risk groups. Patterson and London (2002: 1) observe that the category of people in the risk group of infection were those already discriminated against and marginalized even before the HIV/AIDS era. The risk group category of people includes immigrants, prostitutes, promiscuous people, prisoners, drug addicts and homosexuals (Levine 2002; 95 & Dussault, 1999: 1). Stigma is attached to people belonging to groups perceived to be at a high risk while in reality AIDS affects professional adults in their prime, religious people, casual labourers as well as truck drivers (Kanyoro, 2001; 1). Linking HIV risk with a particular category of people creates a false illusion of safety since everybody is vulnerable to being infected, more so with the existing misconception of the mode of transmission of the HIV virus.

According to Sihlangu (2000; 23) some participants in the study explained that stigma was due to ignorance of the disease and predicted that with appropriate knowledge, the levels of stigma attached to the disease would decline. Others believed that once a cure has been found HIV/AIDS will be just like any other disease and people will no longer be stigmatised. Few believe that if people disclose their HIV positive status

openly the issue of stigma would cease. In spite of these views, misconception of the transmission is the main cause of stigma.

Valdiserri (2002; 2) and Herek et al (2002: 1) suggest that since stigma is the result of the misconception of transmission of the HIV virus, educating the public on how HIV/AIDS is not transmitted could help in eradicating stigma attached to the disease. Policies and programmes should be adapted to help root out stigma. Education programmes must incorporate discrimination as a measure for the effective reduction of stigma. At present, prevention programmes fail to address the issue of discrimination in schools (Dussault, 1992: 2). Although the law can be used to protect people with HIV/AIDS from discrimination, it cannot protect them from stigma associated with the disease.

2.4.3 HIV Testing

HIV testing is done to establish the negative or positive status of people. It can be voluntary which requires consent or routine mandatory that do not require consent. Both HIV-negative and HIV-positive people can benefit from testing. For unaffected people negative results offer a chance to practice or continue practicing safe behaviour to maintain the seronegative status. Infected people get the opportunity of being assisted medically and psychologically through counselling (De Cock & Mbori-Ngacha, 2002: 9). Voluntary testing was encouraged in Uganda with the aim of providing support for both HIV positive and negative people after testing (Peterson 2003: 3). This helped in reducing the stigma that discouraged people from being tested. People are more likely to go for testing if the condition responds to their needs instead of being threatening and judgmental (Valdserri, 2002: 1).

Testing is an important exercise because the knowledge of an individual's HIV status may help stop further spreading of the virus and re-infection of the HIV positive person (Valdiserri, 2002: 2). However emphasis on counselling and consent has reduced the practice of testing. Secondly, denial of the existence of HIV/AIDS has a negative impact on testing. According to De Cock, Mbori-Ngacha and Marum (2002: 5) more people go for testing in developed countries where anti-retroviral drugs are available to the public. In such countries HIV positive people benefit from testing, the more people go for testing the less the stigma.

Mbanya et al (2001: 1) confirm from their study that the majority of patients refused to be tested because of the stigma associated with disease, fear and ignorance. At times the doctors tested the patients without their permission or awareness. In most countries mandatory testing is not necessary done to assist the infected person but as a prerequisite for job employment, migration insurance policies etc. According to Joubert and Prinsloo (2001: 115) the law prohibits testing of learners or educators for HIV/AIDS as a prerequisite for admission or employment. Although the Policy on HIV/AIDS (par 4.3) states that there are no medical reasons for routine HIV testing for learners, the practical advantages could be as follows:

- school management is able to identify learners and educators in need of counselling and moral support;
- testing for HIV positive status can help curb the spreading of the virus, given that some people may infect others without the knowledge of their own positive status;
- learners in need of medication that helps to ease the symptoms can be identified through routine testing;

- learners have a choice of getting into sexual relationships with the knowledge of the HIV status of their partners;
- HIV/AIDS prevention measures may be taken more seriously if learners become aware that they are also at the risk of contracting the virus.

In brief, AIDS related stigma and discrimination remain an immerse barrier to the effective fight against the pandemic. It undermines the care, support and increases negative effects on individuals, communities and nations. Stigma and discrimination discourage disclosure of the seropositive status of an individual to their next of kin and friends (Herek et al, 2002; 2, Johnson, 2003: 1 & Hawkins, 2003: 1). This is because the stigma could lead to rejection and negative reaction towards HIV positive people.

2.4.4 Disclosure

Leaders at all levels including school principals have the responsibility of creating an open society that is from stigma, silence and denial about the epidemic (Berold, 2002:1). However the negative attitude people have towards the infected persons discourages disclosure. The study done by Nowell and Van der Merwe (2003: 53) shows that the majority of employees who disclosed their HIV positive status received negative treatment from their colleagues. The negative responses were expressed in the form of fear, avoidance and even abandonment in some cases. This resulted in a decline of job satisfaction, motivation levels and self-esteem of the seropositive employees. The minority who received positive reaction from their colleagues experienced reduced stress, anxiety and were motivated to go on.

Fear of stigma and of a negative attitude and behaviour towards HIV positive employees do not only discourage patients from disclosing their status but also deprive them of involvement in HIV/AIDS programmes at their work place (Nowell & Van der Merwe, 2003: 54). Participation in HIV/AIDS programmes is voluntary, therefore those who join the programme are suspected by their colleagues to be HIV positive. This discourages people from becoming involved. Nowell and Van der Merwe (2003: 54) are of the opinion that compulsory participation in HIV programmes, remove stereotyping and misconceptions that lead to developing negative attitudes.

The majority of participants feel that the law failed to protect them and their rights in terms of job losses, discrimination and stigma (Nowell & Van der Merwe, 2003: 54). In the study there was no mention of policy or other forms of guidelines that could be used as a frame of reference to protect HIV positive employees from being discriminated against and stigmatised. The fact that there was no confidentiality after the disclosure of the employees' HIV status signifies that section 6.2 of the policy guideline for HIV/AIDS was not observed. Section 6.2 of the National Policy on HIV/AIDS states that voluntary disclosure of a learner or educator HIV/AIDS status to appropriate authority should be welcomed in an enabling environment where confidentiality is ensured and unfair discrimination not tolerated.

Furthermore, there was no support system in place for employees after the disclosure of their status. Although a few people got positive support from their colleagues, the majority of the participants were discriminated against and stigmatised. The effect of stigma is so strong that HIV/AIDS positive people are prepared to forego treatment

and counselling in order not to be exposed (Hawkins, 2003: 1). Disclosure does not benefit the victims; in most cases the condition became worse. The weakness of the study is that the author concludes that there is stigma in places of work in South Africa and stigma has negative consequences on the well being of HIV-positive workers. However, there are no suggestions of ways in which to address stigma.

2.5 Disclosure of HIV status in Schools

The National Policy on HIV/AIDS for schools and colleges (Section 6{1}) expressly states that no learner or educator will be forced to disclose his/her HIV status. Despite this prohibition, section 6.2 encourages voluntary disclosure of learner or educator HIV status to the appropriate authority. Learners older than 14 years may disclose their HIV status voluntarily, while parents of learners younger than 14 years may disclose the information on their behalf (National HIV/AIDS Policy for Schools and Colleges par 6.2). In the event of voluntary disclosure, it is in the best interest of the learner or student with HIV/AIDS if a member of the staff in the school or institution who is directly involved in the duty of care of the learner is informed of his/her HIV status (section 6.3). The staff directly involved with the learner must be informed because of the need of alternative care hr or she will be required to offer when the learner is removed from the family environment. The educator may disclose his or her HIV status to the principal or head of institution.

Unauthorised disclosure of the learners' or educators' HIV status could lead to legal consequences if the information is released without the consent of the victim (HIV positive learner or educator), or if the information is disclosed to a person not directly

involved with the learner or educator, or when learners and educators are forced to disclose their HIV status. In the event of the disclosure of the HIV status, the school authority has the duty of keeping the information confidential to avoid legal liability. Educators and learners must accept that there will be people who are HIV positive in their midst (Govender, 1999: 1). An environment free from unfair discrimination should be cultivated. Those who disclose their seropositive condition must not be discriminated against unfairly.

One of the well-known published incidents of unfair discrimination is the case of Gugu Dlamini, a South African woman who was killed by villagers for bringing shame to the community by revealing her positive status in public (Dussault, 1999: 1). The environment in which she disclosed her HIV status was hostile, unreasonable and in denial of HIV/AIDS. For an enabling environment to be created in such schools it is essential to analyse school principals' understanding of the meaning and effect of HIV on learners and educators. This means that the school principals' awareness of human rights related to HIV/AIDS is essential if they are expected to encourage disclosure.

2.5.1 Argument against Disclosure

A study done by Herek et al (2002: 3) in USA indicates that support for policies that demand disclosure of the positive status of people belonging to the risk group declined between 1997 and 1999. Many AIDS researchers and community-based advocates continue to oppose policies such as name reporting of HIV-infected individuals. The argument is that on going fears of prejudice and discrimination is rational, realistic and still plays a significant role in personal decisions to seek HIV testing and counselling. Similarly None Governmental Organisations in South Africa refuse to accept the government proposal of making HIV positive status mandatory

(Henderson, 1999: 1). The argument is that since there is stigma and misconception attached to HIV/AIDS compulsory disclosure will have negative consequences on the infected and affected individuals.

In the school situation, learners and educators are not forced to disclose their HIV positive status. However, they are encouraged to disclose their status voluntarily in an environment free from unfair discrimination (Joubert & Prinsloo, 2001: 115). Sihlangu (2000: 23) reveals that some participants give stigma as a reason for keeping their HIV positive status confidential. Furthermore, disclosure of ones' HIV positive status would not be rewarding in a situation where there is no counselling facilities, information or protection against discrimination.

2.5.2 Argument for Disclosure

The government's argument for disclosure is that some African countries are progressing in curbing the spreading of HIV/AIDS by calling out the disclosure of positive status of individuals (Henderson, 1999: 2). Open declaration of HIV status may in some cases reduce stigma and violence towards people living with AIDS. At the same time, HIV positive people cannot benefit from care programmes if they remain silent about their condition. The research done by Sihlangu (2000: 23) revealed that the majority of participants support disclosure. The reasons for advocating for disclosure include awareness of the disease, extended counselling and other forms of assistance to people with AIDS. In the case of Uganda, open talk about the HIV/AIDS pandemic has brought a national response, which has resulted in the most successful attempt in Africa south of the Sahara to reduce HIV/AIDS the prevalence of (Serpa, 2002: 44). It was a strategy used to fight discrimination and reduce stigma attached to the disease (Peterson, 2003: 2). In another argument for

disclosure, De Cork and Mbori-Ngacha (2002: 5) maintain that the unique and special type of treatment extended to people with HIV/AIDS could be a factor that encourages the stigma attached to the disease.

Issues such as confidentiality, analogous to secrecy and anonymity, may not be protective as intended but could promote silence and denial of the existence of the epidemic. For example, the majority of the Caribbean public was in denial of HIV/AIDS because they had never seen HIV positive people, as their condition had been kept confidential as was required by government policy (Hawkins, 2003: 1). Strict disclosure rules may also create a barrier between known infected cases, and undiagnosed and uninfected ones. Failure to disclose positive status limits the rights of unaffected people to remain HIV-negative and reduces the chances of infected people to benefit from treatment and prevent further infection or infecting others.

Mbanya et al (2001) confirm from their study that majority of patients refuse to be tested because of the stigma associated with the disease and fear and ignorance. At times during the research the doctors tested the patients without their permission or awareness. In most countries mandatory testing is not necessarily done to assist the infected person but as a prerequisite for job employment, migration insurance policies etc. According to Joubert and Prinsloo (2001: 115) the law prohibits testing of learners or educators for HIV/AIDS as a prerequisite for admission or employment.

2.5.3 School Policy on HIV/AIDS

Schools need to be made safe environments in which teaching and learning can take place. It is recommended that every school have an HIV/AIDS policy, which is drafted in line with the principles of the National Policy, universal precaution

procedures, and one that suits the specific institution (Sutliff & Bomgardner 1994: 54). The policy should also seek to create an environment in which people with HIV will be treated in a just, humane and life-affirming way. The public perception, social norms, rights of parents and management obligations are factors that should be taken into account when drawing up the policy (Joubert & Prinsloo, 2001: 116).

The policy can be used as a guide in admitting learners, staff development and personnel policies (Curcio & Berlin, 1996: 23). It should ensure that:

- the rights of all learners and educators are respected;
- learners and educators with HIV are managed appropriately;
- further HIV infection is prevented;
- a non-discriminatory and caring environment is created.

In addition, schools must adopt a code of conduct for learners, which identify unacceptable behaviour that creates the risk of HIV infection (HIV/AIDS Policy section 10.2). Acts of violence such as rape, injuries from sexual abuse, stabbing and tattoos must be prohibited. The National policy (section 4 – 5) also protects the educator by prohibiting the following:

- HIV testing without the educator's consent;
- making HIV testing a prerequisite for appointment;
- mandatory disclosure of the educators' HIV status;
- demotion or dismissal as a result of the educator's HIV positive status;
- any form of unfair discrimination against the educator because of their HIV status.

2.6 Conclusion

In this chapter, the impact of HIV/AIDS on educators, learners and quality of education was discussed. An account of the research findings on knowledge of HIV/AIDS and perception of risk is given. Socio cultural factors that fuel the spreading of HIV/AIDS were also explored. In addition, issues such as discrimination, disclosure in schools was dealt with. The next chapter will cover the empirical study. Interviews held with principals, educators and learners in the King William's Town District of the Eastern Cape Province would be reported. Interview question summaries of interview responses and the interpretation of data produced will be reported

CHAPTER 3

3. EMPIRICAL INVESTIGATION

3.1 Introduction

In chapter two, a detailed literature review on the impact of HIV/AIDS on teaching and learning was discussed. Research done on the knowledge of HIV/AIDS on different groups of people was analysed and the different perceptions of risk in contracting HIV/AIDS explored. Factors that fuel the spreading of HIV/AIDS such as the social and cultural influence of sexual behaviour, sexual practices and poverty were examined. Discrimination, disclosure and safety in schools in regard to HIV/AIDS were discussed.

In this chapter, the researcher intends to describe the steps taken to collect data. The study will also describe the research method chosen and rationale behind the choice of this method for the study. Research participants, methods of data collection and data analysis selected for the study are also discussed. Lastly, research findings will be presented.

3.2 Context and Setting

The context and setting of this study was discussed in detail in the first chapter. This section serves as a summary of the context and setting in order to stay focused on the purpose of this study. The context of this study is influenced, however, not only by the impact of HIV/AIDS in education sector, the std 10/matric results are also affected in the Eastern Cape and they are not good as the other South African provinces. Since the HIV/AIDS has a vast impact on society and education system as discussed in Chapter 2, the study had to take these influences into account while investigating learners' experiences.

3.3 Research design

The study employed a triangulation of several research methods. Firstly, the researcher held a meeting with the key stakeholders in trying to conceptualise and inform them about the study and its execution. This ensured a 'buy-in' into the research process by all stakeholders and was necessary to achieve a high response rate. As much collaboration as possible took place throughout the study.

Secondly, formative research was undertaken using key informant interview methods among educators and learners within the region. These qualitative methods helped to determine the themes to include in the questionnaire.

Thirdly, and most importantly for the present report, a cross-sectional survey among educators and learners employing the second-generation surveillance method that combines the measurement of behavioural biological indicators within the same study was used. A behavioural risk questionnaire-based survey was conducted.

Fourthly, and finally, completion of the institutional questionnaire by the principal or rector involved them undertaking some archival research to look up school records to obtain the information required.

3.4 Data Collection

The case study does not claim any particular methods for data collection or data analysis (Merriam, 1998). Yin in Merriam (1998; 290 is of the opinion that "the case study is a design particularly suited to situations in which it is impossible to separate the phenomenon's variables from their context'. The aim in collecting data regarding the experiences of educators was to investigate these expectations, and then to try and place them in their relevant context (Lindegger, 1999).

This aim is a large part of what interpretive research is all about. The study needed to be able to define and describe the experiences of educators and learners, but also to place these experiences in the context of how they impact on their daily dealing with HIV/AIDS issues. In this section, the study will discuss the way of collecting data in terms of selection of data sources, selection of cases and the methods of data collection.

3.5 Instruments used in data collection

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

3.5.1 Individual questionnaires

The questionnaire was developed during a lengthy process: As a first step, indicators were identified based on epidemiological and prevention intervention models (FHI 2000; Mertens, Carael, Sato, Cleland, Ward & Smith 1994; Rietmeijer, Lanky, Anderson & Fichtner 2001). Secondly, the design of the questionnaire was informed by information collected during a series of qualitative interviews (with educators and in-depth interviews with students) that dealt with range of education issues, including work-related aspects. Thirdly, the questionnaire also reflected the needs of the Provincial Department of Education.

The actual questionnaire administered during the study consisted of the following components:

a) Biographical data of the respondent;

b) Socio-economic status

c) Teaching responsibilities and work load;

d) Impact of HIV/AIDS on educators and their work;

e) Absenteeism from work;

f) Training and support received by educators;

g) HIV/AIDS knowledge;

h) Communication about HIV/AIDS;

Using the educator questionnaire as a basis, a much shorter questionnaire was developed for use among students. Obviously a number of sections dealing with work-related experiences were not applicable to students. The questionnaire schedule is attached in appendix (1).

3.5.2 Interviews

In this study, interviews are used to collect data. Cohen and Manion (2000: 269) describe an interview as a two-person conversation initiated by the interviewer with the intention of obtaining specific information. Likewise, Borg and Gall (1989: 219) define an interview as a purposeful interaction between two people focused on one person trying to get information from the other. It involves direct verbal interaction between individuals. Semi-structured interviews were used to produce information.

The questions were pre-tested in a pilot study to check clarity and identify threatening questions. Appointments for interviews were done telephonically and the interviews were conducted in the principal's offices. The researcher explained to the people concerned the purpose of the interview. The researcher started with focus group of school (A), i.e Grade 12 learners and conducted interviews with them and probing them with questions like sharing their thinking about the high failure rate in relation with the impact of HIV/AIDS and their experiences in dealing with that. A permission to record

the interviews has been asked and the advantages of using an audio-tape recorder was explained of which is that of reducing the tendency of selecting data favouring the researcher's bias and can be played back and studied thoroughly (Cohen & Manion, 1995: 271). The duration of the interview was about 30 minutes. The same exercise was done with schools B; C; D; E and school F.

The interview method was chosen because it enables the researcher to obtain important information that cannot be gathered from observation. Since the purpose of the study is to investigate the impact of HIV/AIDS in teaching and learning and to determine the principals/educators and learners' understanding and interpretation of HIV/AIDS and their attitude and response towards disclosure, discrimination and safety issues, the interview is used to achieve the objectives of the study. The researcher was able to investigate how the principals/educators and learners understand and interpret HIV/AIDS, their perception and reaction towards disclosure and their response to safety measures stated in the policy by asking them questions related to these objectives.

Furthermore, interviews are also a flexible and adaptable method that gives room for probing participants' responses to gather more in-depth information about their experiences, attitude, concerns and feelings. It also allows the participants to clarify and elaborate on responses to achieve accurate answers (McMillan & Schumacher, 1997: 263). In the process of interviewing more detailed data can be obtained. The interview schedule is attached in appendix (2).

3.5.2.1 Advantages of using interviews to collect data:

- Well conducted interviews can produce in depth data that may not be obtained from using questionnaires;
- Interviews are flexible, giving room for the interviewer to adjust to each participants;
- Interviews allow follow-up on incomplete or unclear responses by asking additional probing questions;
- Interviews can be used with different respondents, such as illiterate ones or those too young to read and write;
- Verbal and no-verbal behaviour can be noted in a face-to face interview.

3.5.2.2 Disadvantages

- The responses given by participants may be subjective and biased due to eagerness to please the interviewer, or the interviewer may seek out answers that support preconceived views by asking leading questions;
- Interviews are time-consuming, labour intensive and expensive; this limits the number of participants that interviewed in comparison to mailing questionnaires to a large number of people;
- Depending on the subject of the interview, the participant may be uncomfortable with the interview and unwilling to report true feelings.

The interview schedule is attached in appendix (1). The researcher used semi-structured interview format to produce data because it enables the researcher to frame questions that will supply the knowledge required (Cohen & Manion, 2002; 270). In structured interview the content and procedures are organised in advance, sequence and wording of the questions are predetermined (Cohen & Manion 2002: 273).

In semi-structured unlike structured interview there are no choices from which the respondent selects the answers, although the questions can be rephrased to allow individual response (McMillan & Schumacher). In this study open- ended questions are used to provide a frame of reference for respondents answers and their expressions, there is no restriction on the content or the manner of the interviewee's reply (Cohen & Manion 2002: 275). The interview schedule is divided into three sections. Section one consists of questions on knowledge of HIV/AIDS. The questions in this section are posed with the purpose of finding out the principals' level of factual knowledge on HIV/AIDS and establishing how they foresee the impact of HIV/AIDS on the learners and educators in their schools in respect to teaching and learning. Section two comprises questions on human rights in regard to HIV/AIDS. The intention of the questions in this section is to investigate the principals' attitude towards people with HIV/AIDS and their opinion on the disclosure of one's positive status. The last section is safety precautions to be taken to reduce the risk of contracting the HIV virus. Questions in this section will assess the planned strategies the principals have put in place to cope with the epidemic.

3.5.3 Sample

McMillan and Schumacher (1997: 164) describe a sample as a group of subjects in the study. The sample can be selected from large group (population) or it can be a group of subjects from whom data are collected. In this study, the word *sample* will be used to mean the latter. The subjects chosen for the interview were a convenient sample. McMillan and Schumacher (1997: 169) describe a convenient sample, as a group of subjects selected on the basis of being accessible are expedient. The principals chosen were those willing to participate in an in-depth interview with the researcher. Seven school principals, two educators per school and FET College, twelve learners taken

randomly from high schools and FET College from King William's Town Region in the province of Eastern Cape were interviewed. Schools were assigned letters of the alphabet (A to G) for the purpose of differentiation; likewise all those interviewed were identified by alphabets.

3.5.4 Mode of Observation

The study utilised the data collecting instrument of non-participant observation and self- reporting mentioned in 1.5.10 in Chapter one to understand the experiences of learners as revealed through the research process. One of the data-collecting instruments was that of non-participant observation. The researcher, as an educator himself, observed the participants while doing fieldwork. The field notes that a researcher made helped to develop ideas and questions to verify his understanding of the information gathered during the research process. Henning, Van Rensburg and Smit (2004) define these kinds of field notes as "soft" notes consisting of my experience of the field. These notes therefore included personal thoughts, feelings and impressions in response to some of the discussions.

3.6 Access into schools

During pre-visits or on arrival at the school for the actual interviews, the researcher delivered the Head of Education Institution questionnaires and the information materials on the purpose of the study. Schools were visited between 9 am and 12.30 midday. However, on request of the principal, visiting times were adapted to suit the activities of the educators and learners. The school principals were given a Head of educational Institution questionnaire on which they record the number of educators and learners, and absenteeism on the day of the visit by the researcher. Follow-up was done to increase completion rates. Only those educators who consented to participate in the study were interviewed.

3.7 Quality control

Quality control in a study of this nature cannot be reduced to a single action. In effect, the quest to reduce errors in the study started with the meticulous process of questionnaire design, in order to ensure that the instrument assisted in the collection of quality data. The researcher ensured that he/she visited the correct school, assisted in setting up the interviewing process, for example, by negotiating a time and place for the interviews and checking the completed questionnaires for obvious errors. A next line of quality control occurred at the office where a third person went through the returned questionnaires to code open-ended questions and to ensure that the geographic and other details were correctly entered on the questionnaires.

3.8 Strengths

- This study is based on different sectors of schools (primary schools, public high schools, private high schools and a public FET College) and that reduces selection bias.
- The response rate on this study based on number of educators present on the day of the visit was very high for questionnaires. Bias of non-response was addressed through visits, which is seldom done in workplace studies.
- The study provides information using a combination of survey of respondents and record review used in collecting data from educational institutions, allowing for triangulation of the findings I order to increase reliability.

3.9 Limitations

- The first limitation of this study is the cross-sectional nature of the design. The impact of HIV/AIDS on the educators would have been best studied using a longitudinal design, with a series of measurements taken over time. This would have addressed potential problems related to recall bias. Cross-sectional study

design also suffers from lack of clarity on temporal sequences. For example, it is not clear whether condom use preceded HIV infections or is a result of HIV infection. However, the cost of undertaking such a study would be enormous.

- It is likely that some educators and learners missed school the day the survey was done because they were ill due to HIV/AIDS-related illnesses. Although an attempt was made to revisit the schools where the absenteeism rate was high, it was not always possible to interview all educators and learners who were absent.
- It was not possible to conduct clinical examinations to determine the percent of educators and learners with opportunistic infections as well as other clinical manifestations of HIV/AIDS related disease.
- Finally, quantitative data seldom provides depth; for this reason qualitative data collected through focus groups and review of policies will form part of a comprehensive, integrated report.

3.10 Data Analysis and Interpretation

According to Creswell (1994: 154) data analysis involves reducing and interpreting data. The collected data in the form of questionnaire was captured on a database. The database was designed with validation and consistency checks. The researcher takes amount of information and reduces it to certain patterns or themes and interprets the information.

After the capturing of data was finished, programmes were run to validate the reliability of the data. The validation included consistency checks on the extent to which the skip patterns were followed in the data collection. The validation ensured that, for example, males did not answer questions designed for females and vice versa. The quality control of the data was carried out to ensure that there were no data capturing mistakes. Suspect values were confirmed by drawing the archived physical questionnaire.

The study followed Charmaz's (2000) approach of constructivist grounded theory in the analysis and interpretation of the data. According to Charmaz, constructivism recognises the mutual creation of knowledge by the researcher and the participants, and aims for an interpretive understanding of participants' experience. A constructivists approach to grounded theory reaffirms studying people in their natural settings, and a focus on meaning while using grounded theory furthers interpretive understanding (Charmaz, 2000).

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

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

3.11 Method of Analysing and Interpretation

Different authors cite a variety of methods and "steps" to use in the analysis of collected qualitative data. For the purpose of this study, the researcher decided to integrate the views of Charmaz (2000) on constructivist grounded theory, and especially the strategy of coding, with the analytic steps of Terre Blanche and Kelly (1999). These analytic steps are not a fixed recipe to apply to the data, but serve to 'unpack some of the processes involved in immersing oneself in and reflecting on the data" (Terre Blanche and Kelly, 1999: 140). A study used steps stipulated by Terre Blanche and Kelly (1999) as the headings for discussion. What a researcher aspired to see as a result of the analysis and interpretation of this study was a compelling account of the experiences of educators and learners, an account close enough to the context so that others who are familiar with the context will recognise it as true, but far enough away to allow them to see these experiences from a new perspective. Hopefully, these experiences will contribute to future curriculum development in terms of relevance to, experience and needs of educators and learners.

3.11.1 Data Analysis Steps

Step 1: Familiarisation and immersion

From an interpretive paradigm, data is not collected as a mindless technical exercise. By the time the study had collected the data, the process of analysis was well under way and the researcher already had a preliminary understanding of the meaning of the data. Charmaz (2000) also refers to this step as the strategy in constructivist grounded theory of simultaneous collection and analysis of data. The study took all the data that the researcher collected and immerses him in it again. The researcher worked with the texts (field notes, transcript, written work) and read through them numerous times. While reading, the researcher made notes and drew mind maps to ensure that he knew the data

well enough to know where the study could find certain data and what sort of interpretation was likely to be supported by the data.

Step 2: Inducing Themes

As induction denotes inferring general rules or classes from specific instances (Terre Blanche and Kelly, 1999; 1410, the study followed a bottom-up approach to see which and follow hunches, but not force data into preconceived categories. Categories and themes arose naturally from the data, rather than having prescribed categories and trying to fit the data into these categories. Charmaz (2000) agrees that qualities researchers should ask questions

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

Step 3: Coding

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

According to Charmaz (2000), the study had to interact with data and pose questions to the data while coding. Coding helped the study to gain a new perspective on the material. At this stage of the analysis, the study had read through the data and noted those themes that seemed to transpire naturally. Now the researcher was ready to attach certain labels to the text, or through a process of coding, start to define and categories the data.

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

Step 4: Elaboration

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

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

Step 5: Interpretation and Checking

The final step is to put together the researchers' interpretation as a written account of educators and learner's experiences of impact of HIV/AIDS on teaching and learning. This involves the thesis of the data into larger coherent wholes (Mouton, 2001). The study discussed the interpretations with other people who know about the topic and some who have no knowledge of it, to consider the interpretation from their fresh perspective as well.

The study sought to find examples of other interpretations that confirmed or contradicted some of the points in the researchers interpretation. Mouton (2001: 109) calls this relating results and findings to existing conceptual frameworks or models, and showing whether these are supported or falsified by the new interpretation. The researcher again consulted the literature that the researcher studied to find similarities and contradictions to the results of this study. The discussion and interpretation of the data are captured in full details in Chapter four, as highlighted previously. Consequently, the findings will be discussed in the fifth chapter.

3.11.2 Data Discussion and Interpretation

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

- The outline of the analysis served as a mind map or summary of the themes and categories that emerged from the data.

- The study made use of examples from transcripts to illustrate the themes and categories that were identified.
- In the discussion of the themes and categories, the study utilised excerpts from literature that might support or contradict the findings.

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

3.12 Conclusion

This chapter consists of a description of the data collection process, research design, questionnaires, the sample, data analysis and interpretation. Having traced the plethora of challenges that confront teaching and learning, and having mapped out certain possible routes to engaging with the pandemic, it must be stressed that while none of these targets for engagement are new, what is emphatic in the approach of this chapter is to bring forward the issues of issues of African ownership for solution of her challenges and solutions given her peculiar environment.

South Africans should not forget therefore her early thriving communities based on traditional values of brotherhood and enduring cultures incomparable to any in the world. Moreover, while recognising strategies that will mitigate the impact of HIV/AIDS in teaching and learning, a holistic picture for engagement indicates that poverty and food shortages, gender based discrimination imbedded in various African indigenous cultures, as well as limited access to basic education are still

some of the core response imperatives that will need ongoing interventions in Education Department. In the next chapter, the findings are made known.

CHAPTER 4

4. FINDINGS AND INTERPRETATION

4.1 Introduction

An important aspect of any survey analysis is the examination of the demographic characteristics of the survey sample. Virtually all aspects of the life cycle, including sexual behaviour and morbidity, are influenced directly or indirectly by demographic factors. Very often, there is a relationship between demographic characteristics and social-economic phenomena and morbidity – for example, the relationship between age and education, the relationship between age and HIV prevalence or relationship between age and certain forms of disease and morbidity. An examination of demographic variables therefore can provide useful insight into understanding the nature of non-demographic phenomena from a sample survey.

Furthermore, a critical examination of the demographic variables from a survey provides valuable insight into quality of the survey data and hence strengthens confidence in the quality of the non-demographic aspects of the data. Two important variables in this regard are age and sex. An appraisal of the age-sex distribution of the study sample was carried out and found to be of reasonably good accuracy.

4.2 Determinants of HIV/AIDS

The main aim of this section of the report is to present data on the key factors that might be driving the HIV/AIDS epidemic in the educational sector by demographic variables. In particular, sexual behaviour is examined by age, sex of the respondents, race, qualifications, locality, and position in the school. Such

information is helpful in understanding the sexual behavioural practices of specific groups of educators, which underlie the epidemic and hence suggest possible areas of intervention to prevent and control the further spread of HIV infections in this sector.

4.3 Number of sexual Partners

Having multiple sexual partners is a major risk factor for HIV/AIDS. For this reason, the sexual behaviour of educators was investigated, and revealed that about one in five educators reported not to have had a sexual partner in the previous 12 months. A larger proportion of whites than other racial groups reported not being in a sexual relationship in the past year. Most local educators reported to have one current sexual partner.

4.4 Awareness of HIV status

The study results reveal that the majority of educators (80%) knew where to obtain VCT services. Male and female educators were equally likely to know where VCT services were provided, but few used them. Although (80%) knew where VCT services were provided, only 59% of educators had had an HIV test in their lifetime and of these 92.6% were told of their test results. Female educators were more likely than male educators to report having being informed of their HIV status.

4.5 Condom use

There were no differences in condom use by sex of educator at last sexual act. It was found that 32.0% of males had used a condom compared to 32.0% of females. Further analysis by sex controlling for age, race position in the school and income revealed differences. There was an association between condom use and age, with the younger male and female educators having higher condom use compared to

their older counterparts. For example, males between 18-24 (71.1%) were more likely to use condoms compared to females (51.9%) of the same age. Among the respondents who were between 25-34 there was a slight difference between males (45.7%) and females (40.0%). The results showed that the older the respondents the less likely they were to use condoms.

4.6 HIV/AIDS knowledge

The level of knowledge was high among both female and male educators although a few of the educators did not have accurate information or had gaps in knowledge. These areas include the mode of transmission such as through sneezing, anal sex, oral sex, and breast milk. A few educators lacked knowledge of ARVs. The majority of respondents (94.7% males and 95.9% females) knew that HIV could not be transmitted through using eating utensils used by someone else with AIDS. The majority of educators (males 96.5% and females 96.4%) did not believe that having sex with a virgin could cure HIV. However there is a small number of educators who believed this myth (1.9% males and 2.25 females). The respondents were also aware of behaviours that increase the risk of infection.

4.7 Health status of King William's Town Educators

One of the research questions involved determining reasons for attrition, including as a result of illness. Surprisingly, 10.6% of educators reported to have been hospitalised over the previous 12 months, implying that at least this number were absent from school due to illness. Educators were found to have visited health practitioners very frequently, with 59.8% having been to health practitioner the previous five months or less, 15.8% in the previous six months, suggesting that 75% of educators had seen a healthcare practitioner within the last six months.

4.8 Conclusion

A majority of respondents were predominantly women; African, older than 34 years, married, and most of them had diplomas or degrees and rated them as not well financially. They are generally had high educational qualifications but not necessarily in the learning areas they were teaching. The observed findings suggest that HIV/AIDS seriously affects the researched district i.e King William's Town. When the HIV prevalence of educators in general was compared to the general population – controlling for age and gender – male educators had lower prevalence compared to the general population and there is no exception if one looked at the response on the questioners.

What these findings suggest is that, the life skills programme might have not contributed to sexual behaviour change among educators and hence they have similar risk of acquiring HIV as the general population. Clearly knowledge is not sufficient to influence behaviour change. Self-efficacy in safe sex practices is crucial when attempting to understand behaviour change. The next chapter will focus on the overall conclusions found from the research, the possible solutions to problems or challenges that would have been uncovered in the study.

Chapter 5

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The goal of this research is to investigate the impact of HIV/AIDS on Teaching and Learning. In dealing with this impact in chapter two, a theoretical framework of the two constructs of the study, i.e impact on teacher performance and declining and changing demand for education thereof is made. This is followed in chapter three by a baseline empirical research of the impact of HIV/AIDS on teaching and learning in the Eastern Cape Department of Education. The findings are presented, interpreted and analysed in chapter four.

In this chapter, which is also the last chapter of the report, recommendations, conclusions and summarisation are made. More of the summary on the first four chapters is made in chapter one where the problem statement, research questions and objectives of the research are also made. Chapter five therefore focuses on how the data collected will amongst other things answer the research questions, minister to research objectives and also lay basis for general conclusions, recommendations and point out direction for further study in this regard.

5.1.2 Final Conclusions

The study set out to investigate the impact of HIV/AIDS in the teaching and learning in the King William's Town district of the Eastern Cape Province.

Absenteeism: All chronic conditions, including being HIV positive, tobacco use and high-risk drinking, were associated with higher rates of self-related absenteeism. Among HIV-positive educators, 17.1 5 reported missing over ten days compared to 13.8% of HIV-negative educators. The burden of absenteeism in

the educator labour force 9measured in total days absent) is the highest due to HIV related diseases. Educators who perceived that they had more support – from the Provincial department of education, SGB, learners' parents, unions and religious groups in the community – in their role as educator and for AIDS work/education reported significantly less absenteeism and less 'unhealthy days'. All of the above resulted negatively when it comes to the results of the learners.

Health status: The study revealed that 10.6% of educators reported to have been hospitalised within the last 12 months prior to the study. A self-reported measure was used to estimate the size of the population of educators who suffered from chronic conditions that may affect their health and may contribute to absenteeism which in turn compromise teaching and learning and may contribute to high failure rate.

HIV prevalence: The HIV prevalence among educators is high and is similar to that of the general population. The study revealed that HIV prevalence among public sector educators was 12.7%. Single educators were 2.7 times more likely to be HIV positive than married people. Educators who have low socio-economic status had a much higher HIV prevalence when compared to those in high socio-economic group. It was highest among teachers and lowest among senior educators, education specialists and principals or deputy principals.

Awareness of HIV status: Only 59% of educators had had an HIV test in their lifetime and of these 92.65 were told of their test results.

Determinants of HIV: With respect to determinants of HIV, the epidemic seem to be driven by multiple sexual partnership (particularly among men), low condom use, having sexual partners who are younger (among men), migration and mobility (spending nights away from home). Gaps in knowledge of HIV transmission exist;

specifically, these are in the areas of oral sex, breastfeeding, and incorrect information on sneezing.

5.2 Recommendations

5.2.1 Behaviour change and HIV prevalence

The key behavioural determinants of HIV infection were lack of condom use given HIV-positive status, multiple partnerships, alcohol use and age mixing. Efforts are needed, particularly targeting consistent condom use amongst all educators in all age groups as well as marital statuses, especially with non-regular sexual partners. It is recommended that the Provincial Department of Education, working with unions and NGOs, develop HIV prevention programmes targeted to educators, given that they are a captive audience.

There should be attention to educate them about the risk introduced by lack of condoms use if the HIV status of the partner is unknown. The messages should not only be about using condoms, faithfulness and abstaining but should increasingly address the issue of serial monogamy and HIV testing before engaging in unprotected sex with a partner whose HIV status is unknown to an educator, and having sexual partners within one's age group.

5.2.2 Increase HIV prevention knowledge

Having noted the gap in knowledge of HIV transmission in certain areas, it is recommended that the Provincial Department of Education, with participation of unions, design educational campaigns that place more emphasis on anal sex and oral sex in prevention campaigns to ensure that this form of sex is not considered to be safe because it is not mentioned frequently as part of awareness-raising.

Such a programme would be possible if it can be published as part of a workplace programme. Given the high rate of educators who frequently visit health practitioners, it is possible to begin such a programme as part of normal health care. The services in helping to design evidence-based interventions would prove useful.

5.2.3 Target districts with high student failure rate

The high student failure rate could be associated with the observed high HIV prevalence among educators and learners (judging by response on questionnaires and interviews), which was found to be throughout Eastern Cape, is reason enough for the Provincial Department of education to intensify targeted efforts and improve conditions that make the transmission or spread of HIV infection favourable and encourage translation of knowledge into behaviour change. Priority for HIV prevention should go to the districts like King William's Town, which is found to have HIV prevalence of 20% or more.

5.2.4 Improve self-efficacy skills

Educators are responsible for teaching life skills designed to prevent HIV infection in learners; it is crucial that they be given the skills to prevent themselves from becoming infected. It is therefore recommended that the Provincial Department of Education and unions work together to design an education programme that will equip educators with skills to negotiate safe sex. These two stakeholders may work closely with NGOs to design such a programme, which would focus on encouraging educators to seek voluntary counselling and testing of couples to know their HIV status, negotiate safe sex and stay in monogamous relationships. There are sensitive issues and need to be managed by professional counsellors. The unions and Provincial Department of

Education should establish a monitoring and evaluation system to assess whether this proposed skill-building programme leads to behaviour change and hence lower HIV infections.

5.2.5 Prevent transmission of HIV from those already HIV positive

To prevent new HIV infections, it is recommended that the Provincial Department of Education work closely with unions, NGOs and scientists to design an intervention programme to prevent HIV transmission among HIV-positive educators and learners. One such effective intervention that could be adapted for South African HIV-positive educators was tested in USA (Kalichman, Rompa, Cage, DiFonzo, Simpson, Austin, Luke Buckles, Kyomugisha, Benotsch, Pinkerton & Graham 2001).

This intervention would be designed to assist educators and learners living with HIV/AIDS to reduce their HIV transmission risks and enable them to effectively disclose their HIV status to their partners and consistently use condoms with their regular and non-regular partners. The group intervention would use a highly interactive approach that includes educational, motivational, and behavioural skills building components. The intervention would be gender sensitive and would also take into account sexual orientation of educator and learner. To ensure its relevance, the content of the intervention would be developed jointly with educators and learners who are currently living with HIV/AIDS.

5.2.6 Discourage migratory practices

The long and/ or frequent absences from home and family or stable relationships may contribute to increased risk of educators acquiring HIV infection. For this reason, it is recommended to the Provincial Department of Education and the

unions to develop a structured programme for deployment of educators to specific areas; this would entail a deliberate effort to place teachers near their homes rather than leaving it to chance. In addition, it is recommended that the tertiary institutions could increase intake of education students from rural area to mitigate the shortage and reduce the chances of urban teachers getting jobs in rural areas. It is also recommended that the Provincial Department of Education should provide financial and other incentives for them to work in those areas where they have family roots. Furthermore, the number of work-related nights that educators spend outside their homes should be reduced.

5.2.7 Establish workplace health programme

Prolonged illness associated with HIV and other chronic diseases is likely to erode the gains in improving quality education. Before the educators and learners die from AIDS and other chronic diseases, it is expected that they will not work to their fullest potential. The study has shown that absenteeism due to illness is already high. This suggests that healthy educators will be forced to take additional teaching responsibilities and this might create more stress. It is therefore recommended that the Provincial Department of Education and donor agencies establish and manage a workplace programme specifically to provide a comprehensive prevention and treatment programme for all illnesses (including HIV/AIDS and TB) but ensuring confidentiality for educators and learners.

Such a programme would include stress reduction involving counselling, assessment of workload and adjustment thereof, blood pressure and diabetes screening and treatment. A programme such as this may have several benefits: First, it may help educators and learners reduce stress; second, provide a 'one

stop' comprehensive prevention and treatment centre near the school where educators and learners can easily access it; third, reduce absenteeism from school since there will be no need to miss school to see a healthcare provider unless the educator/learner is ill; fourth, it will help monitor adherence to treatment for TB and HIV/AIDS; and fifth, access to drugs that can prolong life will be important in improving the quality of life of both educator and learner and in turn, improve the quality of teaching and learning.

5.2.8 Eliminate gender disparity

To reduce gender disparities and reduce the rate of spread of HIV, it is recommended that the Provincial Department of Education, the tertiary institutions and unions join hands with civil society to create a social environment that discourages men from engaging in risky behaviour that puts them and consequently women at risk of HIV. Despite the observation that the South African constitution prohibits gender discrimination, South Africa remains a patriarchal society, where women continue to be treated as subservient to men. In addition practices such as marital rape and marrying young girls to older men continue unabated. To change such practices, it is crucial to involve traditional and religious leaders to lead a campaign to change the traditional practices and stereotypes that increase vulnerability of men and women to HIV.

5.2.9 Potential attrition

One of the major concerns observed in this study is the large percentage of educators who indicated their intention to leave the education service. However, not all educators who indicate they intend to leave may indeed quit. The decision is probably more complicated than that. The reasons for wanting to leave were low job satisfaction and job stress and all of these can be contributory to the high

student failure rate which the Eastern cape Province is experiencing at the present moment, particularly the standard ten' students. The issues requiring resolution are: lack of career advancement and recognition and teaching structure in terms of working hours/load/policies. Concerns related to mode of discipline of students require in depth discussion by both the Provincial Department of Education and unions. This recommendation does not imply that corporal punishment should be reinstated. With respect to job stress, the discussion between the Provincial Department of Education and unions may entail teaching methods and administrative issues. The Department of Education (Eastern Cape) should also consider providing support to educators, especially those who have been teaching Outcome Based Education who report to have difficulty adapting to the new system. Other support educators indicated they needed from the Provincial Department of Education in terms of the care of ill teachers and learners, were treatment and medication, financial support (grants, medical aid), emotional support (home visits, moral support), other material support (such as food), assistance/support to schools (substitute teachers/workshops), combat stigma and discrimination, and home schooling/care centres. It is recommended that discussions be held between the Provincial Department of Education and unions in order to reduce the stress levels of educators which impact negatively in teaching and learning.

5.3 Conclusion

The sample used in the study is grossly inadequate to warrant generalisation. However, the analyses of the collected data revealed that majority of educators and learners in the study have not adequate HIV/AIDS knowledge. The majority

of schools do not have educators trained in HIV/AIDS education yet the educators play a crucial role in shaping the future of the youth and therefore, it is critical that more emphasis be placed on training educators and resources made available to assist them in educating the youth/learners on HIV/AIDS.

HIV/AIDS is changing our perception of reality as we take a long and hard look at traumas associated with the disease. It is no longer acceptable for educators to be unaware of the conditions in which South Africa's young live and learn, to fail to identify the deep personal anxieties, fears and shame associated with this pandemic, and to respond to their needs for affirmation, solace and care.

We have tried for many years to stem this pandemic. We are failing. We must now learn to live with HIV/AIDS in our schools and communities, and bring this generation of children and young people at risk safely through to adulthood. Lastly, despite the dearth of empirically based studies on the impact of HIV/AIDS on the education sector, few studies that exist suggest that the impact may be significant, with high morbidity and mortality due to HIV/AIDS and consequently, the attrition of educators predicted.

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APPENDIX 1

Learner Questionnaire

Knowledge

1. **What do you know about HIV/AIDS?**
    - What causes AIDS?
    - How does a person get infected?
    - In your opinion, is HIV/AIDS a problem in schools?
    - Do you discuss HIV/AIDS with your educators and your schoolmate?
    - Is there a particular group of people that are more at risk of contracting the disease than others?

2. **How did you get to know about HIV/AIDS?**
    - Do you believe everything you read or hear about HIV/AIDS?
    - Is there a particular thing or things you do not believe?

Human Rights

3. **What is your feeling towards people with HIV/AIDS?**
    - Do you believe that people with HIV/AIDS are responsible for their disease and get what they deserve?
    - Would you socialise with your classmate with HIV/AIDS?
    - Do other learners who are HIV positive or has AIDS have rights?
    - If yes, what rights do they have?

- If no, why do you think that they do not have rights?
- Do you think that learners and educators with HIV/AIDS should be made public?
- Would you encourage learners and educators with HIV/AIDS to discuss their status?
- Do you support policies that demand public identification of people with HIV/AIDS?

APPENDIX 2

Record No: _____

STUDY ON THE IMPACT OF HIV/AIDS ON TEACHING AND LEARNING

A SPECIAL REFERENCE TO THE EASTERN CAPE PROVINCE.

EDUCATOR QUESTIONNAIRE

The objective of this study is to collect information about the Impact of HIV/AIDS on Teaching and Learning: A study of the Eastern Cape Department of Education with special reference to King William's Town Area based public educational institutions and FET College. The questionnaire itself consists of number of sections in which you will be asked about various aspects of your work as an educator and your lifestyle. Please be as honest as possible. There are no right or wrong answers. A cornerstone of this study is confidentiality. The questionnaire cannot be linked to you and results will only be made available to the University afore mentioned. The answers will only be used for research purposes.

1. BIOGRAPHICAL DATA

1.1 What was your age at your last birthday?

1.2 Gender of respondent

Male	1	Female	2

1.3 Race group of respondent

African	1	White	2	Coloured	3	Indian/Asian	4	Other	5

1.4 What is your nationality

South African citizen only	1
Citizen of South Africa and another country	2
Non-South African citizen	3

1.5 What is your current marital status

Married – civil (magistrate)	01
Married – traditional (lobola or dowry)	02
Married – religious	03

Married – civil and traditional (lobola or dowry)	04
Married – civil and religious	05
Single – never been married	06
Married – but separated	07
Divorced	08
Living together (but not married)	09
Widower / widow	10
Other (specify):	11

1.6 How would you describe your present living arrangements, i.e. are you living alone, with relatives, with your husband, wife or a partner or with peers, friends or co-workers?

Alone	I
With family (relatives)	2
With a partner or husband/wife	3
With peers/friends / co-workers	4

1.7 How often do you practice your religion?

Regularly (once or more a week)	1
Often (once)	2
Seldom (less than once a month)	3
Never	4

1.8 How important is religion in your life?

Extremely important	1
Very important	2
Important	3
Somewhat important	4
Not important at all	5

2. SOCIO-ECONOMIC STATUS

2.1 What is your highest educational qualification?

Type of qualification	Code
Doctorate(s)	1
Honours / Masters degree	2
First degree/ Higher diplomas	3
Diplomas / occupational certificate	4
Grade 12 / std 10 / Matric / N3 without a teacher's qualification	5
Grade 8,9,10,or 11 plus a teacher's qualification & at least two years training	6
Std 9 / grade 11 / 12	7
Std 8 / Grade 10 / N1	8
Up to std 7 / grade 9	9

2.2 What is your position in school/education system?

Teacher/Lecturer	1
Senior teacher/Senior Lecturer	2
Education Specialist/Head of department	3
CEO / Principal / Deputy	4

2.3 Who is paying your salary?

DoE	1	SGB	2	Don't know	3

2.4 Do you receive a housing subsidy?

Yes	No
1	2

2.5 Are you a member of a medical aid fund?

Yes	No
1	2

3. TEACHING RESPONSIBILITIES AND WORKLOAD

3.1 How would you describe the type of institution where you are teaching?

Primary school	1
Secondary / High school	2
Combined/intermediate	3
Special school	4
FET College	5

3.2 What subjects are you currently teaching/ lecturing?	Indicate the level you are teaching/ lecturing e.g. primary/sec.phase.
a)	
b)	
c)	
d)	
e)	
f)	

3.3 List the subjects you were trained to teach.	Indicate the level to which you were Trained to teach/lecturing e.g. primary/secondary phase
a)	
b)	
c)	
d)	
e)	
f)	

3.4 How long have you been teaching? (Number of teaching years experience)

3.5 Was teaching your first career choice prior to taking up a teaching?

Yes	No
1	2

3.6 What happened to your workload in the past three years?

Increased a lot	1
Increased a little	2
Remained more or less the same	3
Decreased	4
Don't know	5
Not applicable (occupied current position for less than three years)	6

3.7 Your workload has increased over the past three years because of

	Disagree	Unsure	Agree
a) An increase in number of learners per class	1	2	3
b) Learners' limited understanding of language used in teaching	1	2	3
c) The lack of involvement of parents in their children's education	1	2	3
d) Shortage of educators	1	2	3
e) Absenteeism among colleagues	1	2	3
f) Lack of discipline among learners (they are not paying attention)	1	2	3

4. THE IMPACT OF HIV/AIDS ON YOU AS EDUCATOR

I AM NOW GOING TO ASK YOU A NUMBER OF QUESTIONS ON HOW HIV/AIDS MAY BE IMPACTING ON YOUR COLLEAGUES, THE LEARNERS, YOUR FAMILY AND SURROUNDING COMMUNITY AND HOW THAT IN TURN AFFECTS YOU AS AN EDUCATOR.

	Yes	No
4.1 Do you know of educator (s) at this institution who are living with HIV/AIDS	1	2
4.2 Do you know any educator who died of HIV/AIDS during the past two years	1	2

4.3 Indicate whether you agree or disagree or are unsure with the following statement concerning the impact of HIV/AIDS on your institution.

	Disagree	Unsure	Agree
a) The number of learners per class increase	1	2	3
b) There is shortage of educators	1	2	3
c) Educators ability to teach effectively decreased	1	2	3
d) Educators have less time for preparation and marking	1	2	3
e) The status of the profession has decreased	1	2	3
f) Educators have to teach subjects for which they were not trained, on behalf of ill colleagues	1	2	3
g) Educators feel depressed	1	2	3

	Yes	No
4.4 Do you know of a learner (s) at this institution who are living with HIV/AIDS?	1	2
4.5 Do you know of any learner who had died of HIV/AIDS-related illness in the past two years	1	2
4.6 Do you know or suspect of any learner in your class who have been orphaned due to AIDS?	1	2

4.7 Indicate whether you agree or disagree or are unsure with the following statements concerning the occurrence of HIV/AIDS among learners and the effect of that on you as an educator.

	Disagree	Unsure	Agree
a) It increases my workload			
b) I find it difficult to teach learners			
c) I do not have enough time to attend to the educational needs of all learners in class.			
d) I get depressed			
e) I provide support (financial, physical and emotional) to affected learners.			
f) Other (specify)			

	Yes	No
4.8 Do you know of a family member (s) who are living with HIV/AIDS?	1	2
4.9 Are you currently taking care of a family member (s) who is (are) living with HIV/AIDS?	1	2
4.10 In the past two years, have you taken care of a family member(s) who have since died of HIV/AIDS	1	2

4.11 Indicate whether you agree or disagree or unsure with the following statements on whether the possible occurrence of HIV/AIDS among members of your family may have an effect on you as an educator.

	Disagree	Unsure	Agree
a) I find it hard to cope with my workload			
b) I am often absent from work			
c) I am stressed			
d) I find it hard to focus on my work			
e) I feel sad and depressed			

4.12 If you have attended funerals of people in your community who are said to have died of HIV/AIDS, how often did you attend those funerals?

More than once a month	1
Monthly	2
Every two months	3
Every three months	4
Every four months	5
Every five or more months	6

4.13 How many persons do you personally know who you think or know have died of AIDS in the past two years?

5. ABSENTEEISM

I AM GOING TO ASK YOU A FEW QUESTIONS ABOUT YOUR ABSENCE FROM WORK DURING THE PAST TWO YEARS.

5.1 About how many days were you absent from work during the past two years?

	2005		2006	
a) Number of full days absent from work:				

	2005		2006	
b) Number of half days absent from work / attendance interrupted:				

5.2 Indicate the main reason(s) for being absent from work in the past two years.

	2005	2006
Sick leave	1	1
Special leave to care for sick people	2	2
Special leave to attend funerals	3	3
Other special leave	4	4
Other (specify)	5	5

6. TRAINING AND SUPPORT

IN THIS SECTION, I AM GOING TO ASK YOU A FEW QUESTIONS DEALING WITH TRAINING AND SUPPORT IN THE BROAD FIELD OF HIV/AIDS

6.1. Are you aware of the Department of Education's policy on HIV/AIDS?

Yes	No
1	2

6.2 Have you ever seen the Department of Education's policy on HIV/AIDS?

Yes	No
1	2

6.3 Have you studies/ read the Department of Education's policy on HIV/AIDS?

Yes	No
1	2

6.4 How useful is this policy in your work environment?

Very useful	1
Useful	2
No use	3
Not applicable	4

6.5 According to your knowledge, who does the Department of Education's policies address?

		Yes
a.	Educators	1
b.	Learners	1
c.	Community	1
d.	Other (specify)	1

6.6 What are the issues addressed by the Department of Education's HIV/AIDS policy/ policies?

6.7 What are the issues addressed by the Department of Education's HIV/AIDS policy/ policies?

		Yes
a.	HIV/AIDS awareness	1
b.	Teaching educators about HIV/AIDS	1
c.	Caring and support of infected/ affected staff	1
d.	Caring and support of infected/ affected learners	1
e.	Issues concerning the rights of infected people	1
f.	Other:.....	1

6.8 Are you aware of the existence of an HIV/AIDS implementation plan in this educational institution?

Yes	No
1	2

6.9 Does the Department of Education support educators who are ill/sick, by giving sick leave?

Yes	No
1	2

6.10 Does the Department of Education address the problem of HIV/AIDS stigma in schools adequately?

Yes	No
1	2

6.11 Have you seen a copy of your union's policy on HIV/AIDS?

Yes	No
1	2

6.12 Have you read your union's policy?

Yes	No
1	2

6.13 Would you like to find more about the HIV/AIDS policies of the Department and your union?

	Yes	No
a. The Department of Education		
b. Your union (if a union member)		

6.14 Does your educational institution have a policy on sexual relations between Educators and students?

Yes	No
1	2

6.15 Does your educational institution have an AIDS committee?

Yes	No
1	2

6.16 Have you ever attended training sessions or received information regarding any of the following topics?

		Training		Information	
		Yes	No	Yes	No
a.	Life skills education	1	2	1	2
b.	HIV/AIDS education (e.g. transmission, prevention of spread, reducing stigma, safe school environment)	1	2	1	2
c.	Dealing with and caring for young people suffering from HIV/AIDS	1	2	1	2
d.	Counselling	1	2	1	2
e.	Universal precautions taken to prevent the spread of HIV	1	2	1	1
f.	Handling and management of sexual harassment	1	2	1	2
g.	The legal rights of people living with HIV/AIDS (e.g. support, privacy)	1	2	1	2
h.	The rights and responsibilities of educators in terms of HIV/AIDS	1	2	1	2
i.	Supporting the terminally ill	1	2	1	2
j.	Handling and management	1	2	1	2
k.	Handling and management of violent students	1	2	1	2

Answer the following questions

	Yes	No	N/a or don't know
6.16 During the past year did you ever present a class on HIV/AIDS	1	2	3
6.1.7 Do you feel comfortable to teach your learners/ students about HIV/AIDS	1	2	3
6.1.8 Would you be willing to teach your learners/students about human sexuality?	1	2	3
6.19 Would you be willing to teach learners/ students about not having multiple sexual partners?	1	2	3
6.20 Would you be willing to teach your learners about condom use?	1	2	3
6.21 Have you attended any professional development programmes during the past two years?	1	2	3
6.22 In your opinion, would more HVI/AIDS education workshops directed at educators be useful?	1	2	3
6.23 Do you need more training on social/welfare issues, such as dealing with violence directed at children or child abuse?	1	2	3
6.24 Does your educational institution have access to a social work service	1	2	3
6.25 Does the department of Education offer care and support programme for educators who have a drinking problem?	1	2	3
6.26 Does your educational institution have a system for replacing educators who have been absent for more than 2-3 weeks?	1	2	3
6.27 Does your educational institution have access to a social work service?	1	2	3

6.28 Indicate how much support you receive in your role as an educator.

		Disagree	Neither agree/ disagree	Agree
a.	I have the support of the Department of Education in my role as an educator	1	2	3
b	I have the support of the school-governing body in my role as an educator	1	2	3
c	I have the support of the student's parents in my role as an educator	1	2	3
d	I have the support of my union in my role as an educator	1	2	3
e	I have the support of the department of Education for AIDS work/education	1	2	3
f	I have the support of the school-governing body for AIDS work education	1	2	3
g	I have the support of the student's parents for AIDS work/education	1	2	3
h	I have the support of religious groups in the community for AIDS work/education	1	2	3
i	I have the support of my union for AIDS work/education	1	2	3

6.29 In your opinion, what support should the Department of Education provide in terms of preventing new infections amongst educators and learners?

		Yes
a.	Provide more programmes/ workshops/ manuals	1
b.	Strengthen awareness programmes/ messages	1
c.	Make HIV/AIDS part of curriculum/ dedicated classes	1
d.	Train teachers about HIV/AIDS/ healthy living	1
e.	Publicise safe sex messages (ABC)	1
f.	Other:	1

6.30 In your opinion, what support should the Department of Education provide in terms of the care of ill teachers and learners?

		Yes
a.	Provide financial support (grants, medical aid)	1
b.	Provide other material support (e.g. food)	1
c.	Provide emotional support (home visits, moral support)	1
d.	Provide treatment and medication	1
e.	Home schooling/ care centres	1
f.	Provide assistance/ support to schools (substitute teachers/ workshops)	1
g.	Combat stigma and discrimination	1
h.	Other:	1

6.31 In your opinion, what support the Department of Education provide to educators in terms of the provision of antiretroviral drugs?

		Yes
a.	Provide drugs free of charge	1
b.	Provide subsidised medication/ support medical aid funds	1
c.	Ensure drugs are accessible/ available	1
d.	Nurses/ mobile clinics to visit schools	1
e.	Other:	1

6.32 In your opinion, what does antiretroviral therapy do to a person living with HIV/AIDS?

		Yes
a.	Prolong life/ increase the numbers of years an HIV-infected person can live	1
b.	Improves the quality of life/health/ productivity of HIV-infected persons	1
c.	Improves immune system/ resistance to infections	1
d.	Delays the onset of AIDS/ keep the disease under control	1
e.	Reduces HIV infections	1
f.	Other:.....	1

7. HIV/AIDS KNOWLEDGE

		True	False	Do not know
a.	A person can get HIV by using a cup or plate that has been used by a person with HIV/AIDS	1	2	3
b.	A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV	1	2	3
c.	Having sex with a virgin can cure HIV/AIDS	1	2	3
d.	Having sex with more than one partner can increase a person's chance of being infected with HIV	1	2	3
e.	A person can be infected with HIV and still look healthy	1	2	3
f.	People can protect themselves from HIV by using correctly every time they have sex	1	2	3
g.	You can get HIV through contact with infected blood	1	2	3
h.	Coughing and sneezing DO NOT spread HIV	1	2	3
i.	A woman who has been raped has the right to receive immediate HIV-preventative treatment	1	2	3
j.	A woman can get HIV if she has anal sex with a man who is HIV positive	1	2	3
k.	A person can get HIV from oral sex (mouth to penis or mouth to vagina)	1	2	3
l.	HIV can be transmitted from mother to child through breast feeding	1	2	3
m.	Patients with TB also have HIV	1	2	3
n.	HIV-positive persons tend to get TB more easily	1	2	3
o.	Once one has started taking antiretroviral treatments for HIV/AIDS one has to take it forever	1	2	3

8.1 **COMMUNICATION ABOUT HIV/AIDS**

8.2 What is the HIV/AIDS slogan or message that you remember best? Can you tell me one?

Message/slogan dealing with abstinence	1
Message/slogan dealing with the need for faithfulness	2
Message/slogan dealing with the use of condoms	3
Message/slogan dealing with fear	4
Message/slogan dealing with hope	5
Message/slogan dealing with issues of support and care	6
Message/slogan dealing with issues of rights of HIV-positive people	7
Other	8

THANK YOU VERY MUCH FOR AGREEING TO PARTICIPATE AND ASSIST ME IN THIS IMPORTANT RESEARCH PROJECT.