

CAUSES AND EFFECTS OF THE NON-DISCLOSURE OF HIV/AIDS BY EDUCATORS: IMPLICATIONS FOR SCHOOL MANAGEMENT

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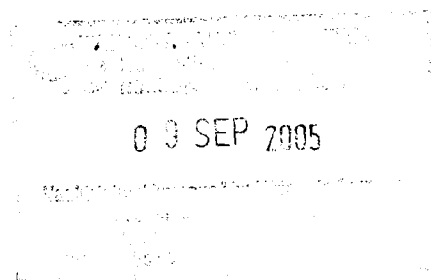
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SUMMARY

The purpose of this study is to determine the causes and effects of the non-disclosure of HIV/AIDS status by educators and its implications on the management of schools. The aim is achieved firstly by conducting a literature study on the causes of the non-disclosure of HIV/AIDS status and the effects thereof on the school system and the management by the principal. Secondly, an empirical investigation is conducted on the implications for school management in mitigating the effects of the non-disclosure of HIV/AIDS status by educators at schools. Finally, recommendations are made on how educators can be encouraged to disclose their HIV/AIDS status.

Findings from the literature study indicate that the level of disclosure of HIV/AIDS status is very low. Educators and learners affected and infected cannot be supported as they are only known to a chosen few. The level of absenteeism among educators and learners seems very high, which lead to increased workloads on other educators and makes it difficult for principals to carry out their duties. Substitutes educators cannot be employed due to temporary and long unspecified sick leave. The quality of teaching and learning is affected, which impacts negatively on learner performance. Health Advisory Committees, awareness programmes and management strategies for the mitigation of the HIV/AIDS stigma at schools are important in the light of dealing with the causes and effects of non-disclosure.

The findings from the empirical investigation indicate that the majority of respondents are not aware of the educators who are infected and affected by HIV/AIDS. Schools are in possession of HIV/AIDS policies, but indications are that they are not effectively implemented. School management strategies for mitigating the HIV/AIDS stigma are to be formulated to enhance HACs to be functional in an effort to create a conducive environment that enables the disclosure of HIV/AIDS status. Recommendations of this study urge schools to encourage educators to talk openly about their HIV/AIDS status.

OPSOMMING

Die doel van hierdie studie is om die oorsake en gevolge van die nie-bekendmaking van MIV/VIGS-status onder opvoeders en die implikasies daarvan op die bestuur van skole te bepaal. Hierdie doelwit word bereik deur eerstens 'n literatuurstudie te doen oor die oorsake van die nie-bekendmaking van MIV/VIGS-status en die effek daarvan op die skoolsisteem en op die hoof se skoolbestuur. Tweedens word 'n empiriese ondersoek gedoen oor die implikasies vir die skoolbestuur ten opsigte van die versagting van die uitwerking van die nie-bekendmaking van opvoeders se MIV/VIGS-status. Laastens word aanbevelings gedoen oor hoe bekendmaking van hul MIV/VIGS-status onder opvoeders aangemoedig kan word.

Uit die literatuurstudie word daar bevind dat die vlak van bekendmaking tans laag is. Geaffekteerde opvoeders en leerders kan nie ondersteun word nie, aangesien hulle aan min mense bekend is. Die afwesigheidsinsidensie by opvoeders en leerders is hoog, wat weer lei tot 'n verhoogde werkklas by opvoeders; dit maak dit moeilik vir skoolhoofde om hul plig na te kom. Plaasvervangers kan nie in diens geneem word nie as gevolg van tydelike en lang ongespesifiseerde siekteverlof. Die gehalte van onderrig en leer word benadeel, wat leerder-prestasie nadelig beïnvloed. Op skoolvlak is Gesondheidsadvieskomitees, bewussynsprogramme en bestuurstrategieë vir die versagting van die MIV/VIGS-stigma belangrik vir die hanteer van die oorsake en gevolge van nie-bekendmaking.

Die bevindings wat voortspruit uit die empiriese studie dui aan dat die meeste respondente onbewus is van MIV/VIGS-positiewe opvoeders. Skole besit wel 'n MIV/VIGS-beleid, maar aanduidings bestaan dat hierdie dokumente nie suksesvol geïmplementeer word nie. Strategieë moet vir die bestuur van skole opgestel word om die MIV-stigma te versag deur Gesondheidsadvieskomitees te bemagtig om funksioneel te wees om 'n klimaat te skep wat die bekendmaking van HIV-status bevorder.

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CHAPTER ONE

ORIENTATION

1.1 INTRODUCTION

The HIV/AIDS pandemic has become the most pressing world-wide concern of this century. Its effects have had and continue to have devastating effects on whole communities. Schools, as parts of communities, are also affected by this pandemic. The causes of the disease and the consequent effects on people infected and affected at schools have become serious matters of concern. As a result, schools are forced to embark on activities to mitigate the causes and effects of this pandemic. The educators' non-disclosure of their HIV/AIDS status is the focus of this study.

This chapter provides an orientation to the study by focussing on the problem statement and the research methodology.

1.2 PROBLEM STATEMENT

The effects of the HIV/AIDS pandemic at schools pose major challenges. Among other things, schools have to deal with high rates of absenteeism by both educators and learners who are infected and affected by HIV/AIDS. HIV/AIDS impacts schools through its effects on educators, learners and parents through the loss of skilled educators, changing patterns of enrolment, high rates of absenteeism and the consequences of disintegrating families (Crewe, 2000).

The seriousness of the effects of the HIV/AIDS pandemic at schools is evident in the infection rate among educators. Crewe (2000) posits that the National Department of Education suggests a rate of 14%, while the South African Democratic Teachers' Union (SADTU) suggests a higher rate. There is possibility of is that a significant number of new educators who enter the teaching profession will already be infected with the disease and that there

will be an incremental rate of educators dying in the early years of their careers (Crewe, 2000; Badcock-Walters, 2003).

HIV/AIDS, being largely sexually transmitted, is both difficult to talk about and to control, and is particularly dangerous because of the long incubation period between infection and evident illness. As a result, educators and other personnel who are infected may try to transfer to other areas or, once visibly ill, "abscond" and disappear (Shaeffer, 1994). Harvey (2000) cites the SADTU, which postulates that ten educators die of AIDS every month and that about 30% are in the age group 40-49 years, while more than 10% are under the age group 30 years.

The preceding exposition highlights the challenges faced by the entire education system due to the incidence of HIV/AIDS at schools and especially among educators. However, the major challenge relates to schools with regard to, firstly, supporting both infected and affected educators and, secondly, dealing with regular absenteeism, low morale and productivity because of illnesses related to HIV/AIDS. Planning the school programmes and activities by school management is extremely difficult when absenteeism and long leaves are a constant feature of educator attendance.

More of a challenge for school management is the fact that HIV/AIDS is not a notifiable disease and no person can be forced to disclose his or her status (Department of Education, 1999:7). As a result, it is difficult for school managers to plan properly, especially when substitute educators have to be found for educators who are regularly absent.

Schools have to deal with a lack of capacity to provide counselling and support in the event of infected and affected educators being willing to disclose their positive status (cf. Crewe, 2000). However, disclosure of HIV/AIDS status by affected and infected educators would facilitate the execution of management programmes at schools.

Sanders (2001) argues that time has come for school communities to be encouraged to talk openly about their HIV/AIDS status, which will be of great help to both infected and affected individuals. In fact, the Department of

Education (1999) recommends a holistic programme for life skills and HIV/AIDS education as a way of encouraging disclosure.

Disclosure of HIV/AIDS status is, however, a contentious phenomenon. On the one hand, disclosure can help affected people to obtain medical services and support, ensure better protection of self and others, promote acceptance and responsibility, help reduce social stigma and reduce suspicions and stress from keeping everything secret (African Women in Science and Engineering, 2001:12).

Clearly, in a school environment, disclosure can promote acceptance of people infected and affected by HIV/AIDS. It can also promote a better understanding and acceptance of HIV/AIDS as a disease like any other and thus promote the support and care of infected and affected people. Disclosure by educators can also promote the same for infected and affected learners, their parents and the community, since educators will be role models regarding the acceptance of HIV/AIDS.

Maile (2003:80) asserts that disclosure would promote trust among colleagues and between educators and the school manager, and that, for instance, if an educator has a chronic illness, the principal may be able to adapt his or her recruitment and selection criteria, job classification, job assignment, employee assistance programme, and some other relief mechanism. Thus disclosure allows the school to offer support and understanding.

On the other hand, disclosure can lead to possible stigmatisation and rejection (African Women in Science and Engineering, 2001:12; *UCFS News:2003*), while non-disclosure can result in lack of support, risk of infecting others, suspicion when symptoms begin to show and stress as a result of gossip (African Women in Science and Engineering, 2001:12; *Kaiser Daily HIV/AIDS Report*, 2003). Maile (2003:80) asserts in this regard that if HIV/AIDS status is not disclosed, it could lead to speculation and such speculation could be harmful to the educator.

It is clear, however, that non-disclosure of the HIV/AIDS status by infected and affected people is still a prominent feature. Obviously, this will be the case in schools.

This exposition raises the following questions,

- What are the causes and effects of the non-disclosure of HIV/AIDS status by educators at schools?
- What are the implications for school management in mitigating the causes and effects of non-disclosure of the HIV/AIDS status by educators at schools?
- How can schools create conditions for disclosure of HIV/AIDS status by educators?

1.3 AIMS OF THE RESEARCH

The research aims can be operationalised thus:

- to examine the causes and effects of the non-disclosure of HIV/AIDS status by educators at schools;
- to investigate the implications for school management in mitigating the causes and effects of non-disclosure of the HIV/AIDS status by educators at schools; and
- to recommend how schools can create conditions for disclosure of the HIV/AIDS status by educators.

1.4 RESEARCH METHOD

1.4.1 Literature study

Primary and secondary sources were studied to gather information on the causes and effects of non-disclosure of the HIV/AIDS status by educators, as well as to determine implications for school management in the mitigation thereof. DIALOG and ERIC searches were conducted to locate relevant

sources. The following key words were used: HIV/AIDS; HIV/AIDS and school management; disclosure and non-disclosure of HIV/AIDS status; barriers to disclosure and consequences of non-disclosure; HIV/AIDS and educators, strategy; strategic management and operational management.

1.4.2 Empirical study

1.4.2.1 Aim

An empirical investigation was conducted to determine the causes and effects of non-disclosure of the HIV/AIDS status by educators and management implications in the mitigation thereof. A quantitative research approach was used in the study. According to Stubbs (2005, <http://www.mori.com/quantitative/index.shtml>), quantitative research incorporates the statistical element designed to quantify the extent to which a target group is aware of, thinks this, believes that or is inclined to behave in a certain way. This study employed this approach because statistics would be used to quantify the research population's responses to the subject of inquiry.

1.4.2.2 Measuring instrument

Information gathered from the literature study was used to develop and design a questionnaire to gather information from the target population.

1.4.2.3 Population and sampling

The target population consisted of school principals (N=300) in the Sedibeng District's Gauteng Department of Education's districts 7 and 8. The sample size was informed by guidelines offered by Leedy and Omroyd (2005:207) and by Strydom and Venter (2002:201).

1.4.2.4 Pilot survey

The questionnaire was pre-tested with a selected number of respondents from the target population. This assisted in ensuring that the questionnaire was relevant, unambiguous and appropriate to the study. The pre-test population did not form part of the final research population sample.

1.4.2.5 Statistical techniques

The Statistical Consultancy Services of the Vaal Triangle Campus of the North-West University assisted with the analysis and interpretation of data collected. The SAS-programme was employed to process the data by computer.

1.5 ETHICAL CONSIDERATIONS

The prescribed research request form of the Gauteng Department of Education, obtained from the Department's website (<http://www.education.gpg.gov.za>), was completed and submitted to the Department for approval to administer the research questionnaire to the target population.

The questionnaire was accompanied by a covering letter, requesting respondents to complete it and assuring them of the confidentiality with which their responses would be handled (Schumacher & MacMillan, 2001:196).

Due to the sensitive nature of the HIV/AIDS topic, care was taken to assure the respondents that data collected from them would be treated with the utmost sensitivity and confidentiality. This necessitated the questionnaires to be self-administered, and thus only the researcher interacted with the principals of schools.

1.6 FEASIBILITY OF STUDY

The study is feasible as it deals with a relevant and topical issue at schools and in communities. Literature sources are adequate and the area of research is accessible to the researcher. It was noted, however, that due to the nature of HIV/AIDS and related issues of perceptions surrounding it, data collection would need the utmost care and meticulous handling.

1.7 CHAPTER DIVISION

Chapter 1: Orientation

Chapter 2: Causes and effects of educators' non-disclosure of their HIV/AIDS status: implications for school management in mitigation thereof

Chapter 3: Research design

Chapter 4: Presentation of result, analysis and interpretation

Chapter 5 Summary findings and recommendation

1.8 SUMMARY

This chapter presented the general orientation to the study and outlined the problem statement and the method of research. The next chapter explores the causes and effects of non-disclosure of the HIV/AIDS status by educators and the implications for school management in mitigation thereof.

CHAPTER 2

CAUSES AND EFFECTS OF EDUCATORS' NON-DISCLOSURE OF THEIR HIV/AIDS STATUS: IMPLICATIONS FOR SCHOOL MANAGEMENT IN MITIGATION THEREOF

2.1 INTRODUCTION

The HIV/AIDS pandemic affects school communities through its effects on the lives of people infected and affected by the disease. Just as the disease affects the overall well-being of infected people, so does it affect the overall well-being of schools. These effects range from the affected performance of individuals to the performance of the school in its attempt to deliver effective education. In essence, teaching and learning are adversely affected.

Just how adverse the effects of the HIV/AIDS pandemic are on the performance of schools can be seen in how it affects the management thereof. This is mainly due to the fact that HIV/AIDS is not a notifiable disease and thus people infected and affected by the disease cannot be forced to disclose their status. Therefore the main barrier to effective school management is the non-disclosure of HIV/AIDS status by infected and affected people.

This discussion highlights the phenomenon of non-disclosure of the HIV/AIDS status by people infected and affected; the causes and the effects thereof and implications for school management.

2.2 HIV/AIDS AND NON-DISCLOSURE OF STATUS

Non-disclosure relates to not disclosing information of any kind under any circumstances. In the case of non-disclosure of HIV/AIDS status, non-disclosure refers to the right of people infected or affected to be protected from their status being disclosed for any reason without their knowledge, and permission by anybody under any circumstance (Department of Education,

1999). A number of issues are involved in this phenomenon and an insight into them is therefore imperative, *inter alia*, HIV and AIDS, opportunistic diseases and non-disclosure.

2.2.1 HIV and AIDS

HIV is described as a viral infection caused by the human immunodeficiency virus that gradually destroys the immune system, resulting in infections that are hard for the body to fight (1 UP HEALTH, 2002). According to Oeding (2005:18), HIV is a parasite that invades the T-lymphocytes in the body, which are responsible for the protection of antibodies that protect the body from infections and induce the lymphocytes to produce more HIV instead of antibodies. HIV is thus a kind of pathogen that reproduces by taking over the machinery of the cells and finally causes AIDS (Ferri, Richard, Roose & Schwendeman, 2003).

HIV therefore weakens the body's immune system so that a person suffers easily from diseases that use the opportunity of the weakened immune system and these diseases are called opportunistic diseases (Kelly, 2000b:16).

AIDS is the final and most serious stage of the HIV disease, causing severe damage to the immune system and beginning when a person infected with HIV has a t-cell count below 200 and is defined by numerous opportunistic infections and cancers (1 UP HEALTH, 2002). Thus, Aids.org (<http://www.aids.org/factSheets/101-what-is-aids.html>) defines AIDS as a syndrome of opportunistic infections occurring in a person infected with HIV.

2.2.2 Opportunistic diseases

When a person is infected with the HIV disease, the body's immune system weakens and eventually breaks down, leaving a person open to the hazards of a myriad of opportunistic infections (Kelly, 2000c). Opportunistic diseases are therefore infections that invade a person's body due to the weakened immune system. Among other diseases, opportunistic diseases include dry cough, swollen lymph glands, memory loss, depression, neurological

disorders, tuberculosis, pneumonia, gastro-enteritis, meningitis and cancer (Kelly, 2000c).

An understanding of what HIV, AIDS and opportunistic diseases foregrounded an exposition of causes and effects of non-disclosure of the HIV/AIDS status. The next section delves into the causes of non-disclosure of the HIV/AIDS status.

2.3 CAUSES OF THE NON-DISCLOSURE OF THE HIV/AIDS STATUS

Various reasons exist for the non-disclosure of HIV/AIDS status by people infected and affected with the disease. The main causes cited relate to amongst others, denial, lay and culturally determined beliefs, religion, fear of stigmatisation and fear of discrimination.

2.3.1 Denial

Denial is an emotion or a focused copying style characterized by the use of distractions, blocking or blunting techniques, and non-acceptance of the HIV/AIDS diagnosis and its consequences (Coetzee & Spangenburg, 2002:213). In addition, Coetzee and Spangenberg (2002:214) indicate that denial can also be viewed as an adoptive response that allows the individual to cope with an initial shock, while buying time to make the necessary cognitive adjustments. However, denial is only one way of dealing with the HIV/AIDS threat (Grundling, 2002:19).

From this definition of denial, it is apparent that people will firstly, deny the existence of the disease and secondly deny the status of being infected once they know their status (UNAIDS, 2000:10). This is because it is scary for instance, to sit around thinking about death and easier to live in denial and think "it's not going to happen to me" (Ndaki, 2004), although Fisher (2004) argues that HIV/AIDS is not a death sentence.

Milner (1991) asserts that ignoring the existence of HIV/AIDS, neglecting to respond to the needs of those living with the HIV infection and failing to acknowledge the burgeoning epidemic in the belief that HIV/AIDS "can never

happen to us” are some of the most widely repeated responses of denial. Consequently, denial fuels stigmatisation by making those few individuals who acknowledge being infected with HIV/AIDS appear abnormal and exceptional (UNAIDS, 2000:12).

According to Muwakki (2001), many analysts believe that denial is one of the primary reasons for the increase in infection rates, especially among gay men and black women. UNAIDS (2000:14) further indicates that denial can also discourage voluntary testing among many people, which may in turn exacerbate the potential risk of HIV transmission within the community. Such action undermines prevention, care and support. Aduda and Khouri-Dagher (2000) warn that denial of the HIV/AIDS problem is compounded by a lack of immediate physical evidence of illness.

This exposition quite clearly shows that denial as a cause of non-disclosure of HIV/AIDS status is a matter for concern. This is especially when issues around voluntary testing, practising safe sex and living positively are considered.

2.3.2 Lay and culturally determined beliefs

This aspect entails how people hear and interpret messages and information about HIV/AIDS and the fact that these messages and information appear to be understood at different levels. For instance, Kelly (2000a) asserts that information about the causes of HIV/AIDS and how it is transmitted is portrayed at the level of educational programmes with scientific messages, while at the traditional level, which is much deeper and more influential, information about the disease and its causes is interpreted in terms of the cultural world of taboos, obligations and sorcery.

It is generally assumed that members of identifiable cultural groups share similar beliefs, values and worldviews, and that these denominators may be reliably used to develop culturally sensitive ethical guidelines (Lindegger & Slack, 2002:19). In this regard, according to Levine and Ross (2002:99), many cultures do not see the danger of the disease and even if they do, they are unable to protect themselves against it due to cultural laws and practices.

Some of the cultural practices predisposing people to the risk of HIV infection include, among others, encouraging more than one sexual partner, polygamy and traditional medicine (Levine & Ross, 2002:99). Deep-rooted aspects of African life also contribute to the spread of the disease, with *inter alia*, infection often occurring when a girl has her first penetrative sexual encounter (Serpa, 2002:44). For example, in Malawi, an elderly man is often called to have intercourse with girls on the last day of their initiation rituals, while in Swazi culture, a man is allowed to marry as many wives as he wishes, while in the initiation practice for girls, in a practice referred to as the “Hyena”, a girl's uncle is required to break her virginity before she can be allowed to have a relationship (Wajibu, 2002 & Kelly, 2000a). According to Minnie, Prins and Van Niekerk (2002), this holds severe implications for the spread of HIV/AIDS, since these men do not use condoms.

There are also widespread beliefs that males are biologically programmed to need sexual relations regularly with more than one woman, and often concurrently (Leclerc-Madlala, 2000; Minnie *et al.*, 2002:57-58). Mere ignorance of the mechanics of seropositivity, reinforced by traditional aspects of African culture, can also foster mother-to-child infection. For instance, when a child dies, the mother is obliged to become pregnant again within three months, and even in cases where a woman discloses her HIV positive status to her husband, he is likely to continue conjugal relations with her, while refusing to be tested himself (Leclerc-Madlala, 2000; Serpa, 2002).

Minnie *et al.* (2002) and Leana (2000) highlight the notion that traditional healers largely divine the cause of illnesses, including AIDS, to witches and sorcerers, the ancestors and to “non-mystical” factors of their clients. In this regard, Wajibu (2002) cites an HIV positive man who asserts:

“... the elimination of stigma and discrimination has to start from the top. Our leaders have to admit that AIDS is real and it has killed thousands of our brothers and sisters. We know that discarding a tradition is something that our ancestors won't smile at, but the present situation demands that we do away with all those cultural practices that will deny our children a life”.

It can be concluded that the lay and cultural beliefs are the very foundation upon which people, especially Africans, are influenced to perceive the nature of the HIV/AIDS disease.

2.3.3 Religion

Forsythe (1999:13) submits that many religious leaders take the spread of diseases such as the black death and AIDS as a sign of God's anger and therefore blame the victims for their own illness, with some suggesting that AIDS is "God's way of controlling population numbers" (Levine & Ross, 2002: 98). The following cited sentiments best capture this religious view of HIV/AIDS (Heald, 2002; Handler, 2001; UNAIDS, 2001):

"AIDS is a punishment sent by God, as Sodom and Gomorrah. Today we have all kinds of unnatural things – homosexuality and Satanist cults who practise cannibalism, ritual murders and bestiality. Christ is the one who said that those who do such thing are cursed already. Unless we discover ourselves, we are a lost people. The whole country prays to God for deliverance."

"AIDS is a disease, not a sin, though some might acquire the disease through sinful behaviour."

Levine and Ross (2002) found in their research that students consistently reported that Muslim respondents believe themselves and other followers of the Islamic law to be protected from HIV infection because of Islam's rules on sexual conduct. This is almost as though Muslims are immunised by belief. Some religious beliefs assert that a condom remains an instrument which invites debauchery and adultery (Forsythe, 1999).

Some religious leaders have a somewhat contradictory attitude towards people with HIV/AIDS, since while stating that "Jesus did not come for the righteous but for sinners" many of them clearly regard people with HIV/AIDS as "promiscuous" wrong-doers and, as a result of such attitudes, it is not surprising that many people with HIV/AIDS feel that they can no longer attend religious services (Muwakkil, 2001).

It can be concluded from this exposition and on the basis of religion being central to many people's lives and the positions occupied by educators in society, that it is the greatest single cause of non-disclosure of the HIV/AIDS status by educators, as well as the main source of fear of stigmatisation and discrimination.

2.3.4 Fear of stigmatisation

According to *The American Heritage Dictionary of the English Language* (2000), stigmatisation refers to characterising or branding as disgraceful or ignominious. In this sense, stigmatisation relates to the attachment of a negative meaning to an idea, event or activity and thus branding as disgraceful being the fact of being infected or affected by HIV/AIDS. In this regard, Tewksbury and Mcgaughey (1997) postulate that stigmatisation involves disidentification and depersonalisation in that undesirable attributes are used to designate scapegoats and thus, mainstream society disidentifies with people carrying or are at risk of the HIV/AIDS disease.

Fear of stigmatisation is perhaps the most serious cause of non-disclosure of peoples' HIV/AIDS status. Health Minister, Manto Tshabalala-Msimang opines that stigma isolates people living with the disease and deprives them of care and support and maintains that: "... stigma harms, it silences communities and individuals... and increases their vulnerability" (News 24, <http://www.journ-aids.org/reports/01122002b.htm>). In this regard, in a study by Stewart, Pulerwitz and Esu-Williams (2002), respondents overwhelmingly agreed that a key manifestation of stigma is the social isolation and ridicule experienced by people with HIV/AIDS or people suspected of having HIV/AIDS, as evidenced by these responses:

"There are those who will tell you face to face that you are no longer needed in their friendship, those who will just isolate you."

"People make jokes about HIV-positive people and point fingers at them. ... There are so many with AIDS and so much gossip too."

People in South Africa are aware of HIV/AIDS, but most of the people are still not open about the disease. People do not talk openly about HIV/AIDS in many school situations, communities, churches and even in hospitals. There is silence when family members and friends die of HIV/AIDS, and most people living with HIV or AIDS are not open about AIDS or their HIV status (Heywood & Barrett-Grant, 2003:43). This is mainly because people living with HIV/AIDS are judged negatively and blamed for their illness (Pulerwitz, Greene, Esu-Williams & Stewart, 2004). In fact, according to these researchers, the main concern is fear of stigmatisation in social interactions that take place at the workplace, which includes interactions that occur during down time, such as during meals or travel, and how people's perceptions of stigma in the community permeate and influence their perceptions about stigma in the work environment.

Dickinson (2003) indicates that HIV/AIDS is a heavily stigmatised and tabooed disease, largely because it is sexually transmitted, thus loading infection with moral and cultural judgements. Even when such judgements can be put aside, sex remains an embarrassing topic for many and a subject that is invariably difficult to discuss openly and unreservedly.

Maile (2003) opines that it is difficult to disclose one's HIV/AIDS status because of the prevailing stigma. The stigma is exacerbated by the attitudes that people have to HIV-positive educators. The negative attitudes emanate from the association of the HIV-positive status with promiscuity. It is held that HIV-positive educators got what they deserved because they were promiscuous (*AIDS Alert*, 2001:13).

According to Maile (2003:79), talking about sex matters is probably and certainly in extreme cases, a taboo in most African cultures. This is usually the case if the infected person is younger because young people cannot talk openly about sex matters with adults, and as a result, people in general are not candid about sexual matters and do not show their sexuality freely.

The African context is silent about sexual matters in public discussions. However, there are forums in which Africans talk about sexual matters, for

example, they use special forums such as initiation and virginity-testing forums (Sithole, 2001:2). In multi-racial organisations, this problem is even worse because of racial stereotypes that exist against other races. For instance, it is a common belief among white South Africans that black South Africans are promiscuous, hence the higher prevalence of HIV/AIDS among the Blacks, which means that, in such instances, disclosure will be tantamount to confirmation of the stereotype (Maile, 2003).

The Prime Minister of Tanzania, the Honourable Sumaye (UNAIDS, 2001:12), urged further investigation into the complexity of the stigma. In particular, he noted a lack of understanding of the causes of the stigma:

“If we are going to address stigma, we must first understand it. We should focus our attention on understanding what causes us as a society to react in this way to people living with HIV/AIDS- people who are suffering enough, either physically or mentally to be challenged yet again by the judgement of others, by the very people who, yesterday, were their neighbours and who should be reaching out to them today. Only when we understand the cause, can we hope to help our fellow men and women (to) react in a more compassionate and humane manner.”

He stressed the need for political leaders to speak on the sigma and acknowledge that they are personally and professionally affected by HIV/AIDS.

The seriousness of stigmatisation is best illustrated by the fact that if one or two AIDS activists come out of the closet and admit their HIV status in public, they are easily targeted as objects of community and communal anger. This can be seen in the death of Gugu Dhlamini, obviously due to her disclosing her HIV status (Ateka, 2000; Raubenheimer, 1999; Uys, 2000:152).

Clearly, disclosure of HIV/AIDS status would serve to dispel all these aforementioned effects and eliminate the stigma and discrimination attached to the HIV/AIDS pandemic. In the light of the benefits that accrue from disclosure,

Paxton (2002:565) recommends that HIV-positive people should be encouraged to gain the confidence and support needed to come out and publicly discuss what it is like to live with a life-threatening condition that carries with it so much stigmatisation. Dickinson (2003) also argues that it is important to note that, while the highly stigmatised nature of AIDS means that people are unwilling to discuss the disease openly, this does not mean that people do not know or think they know who has AIDS.

Jones (2000:14) adds that with regard to AIDS, concerns of the South African people are largely that the stigma surrounding the disease be removed and that people begin to tackle the problem in an honest, straightforward manner.

Related to the fear of stigmatisation is the fear of discrimination, which is also a cause of non-disclosure of HIV/AIDS status.

2.3.5 Fear of discrimination

UNAIDS (2002:17) indicates that throughout much of the developing world, bonds and allegiances to family, villages, neighbourhoods and communities make it obvious that stigma and discrimination, when and where they appear, are social and cultural phenomena linked to actions of whole groups of people, and are not simply the consequences of individual behaviour. It also needs to be remembered that an African person is seen as a person in a group, not as an individual. Secrets are kept within families, but not from families (Uys, 2000:164). Maile (2003:80) emphasises that educators living with HIV/AIDS are a vulnerable group that needs protection from discrimination; hence legislation is enacted to deal with discrimination.

Discrimination occurs despite the legislation enacted to prohibit it. In the work situation, vulnerability to discrimination emanates from the unequal power between the employer and the employee. To support this claim, the South African Law Commission (1997:29) argues and states that:

“Despite a widely accepted point of view that discrimination is ineffective at eliminating HIV from the workplace, there are

increasing reports of discrimination of HIV positive teachers in employment, in the public and private sectors.”

The seriousness of HIV/AIDS-related discrimination is evident. In one research project, which found that fewer than 10% of the respondents agreed with the statement that educators with AIDS are discriminated against by Ministry officials, school management or others (Bennell, Hyde & Swainson, 2002:86). Consequently, Heywood *et al.* (2003:40) posit that discrimination has made it easy for people to blame others without protecting themselves, because people like to believe that HIV infection only happens to gay people or sex workers and people who “sleep around”.

Parker, Aggleton, Attawell, Pulerwitz, and Brown (2002) reports that while there is little overt discrimination, many teaching staff are clearly concerned about the risks of working with infected educators. Various incidents were reported concerning the sharing of cooking and eating utensils and toilet facilities. In some schools, very ill educators continue to work for fear of being talked about as infected (Parker *et al.*, 2002).

This and many incidents of discrimination clearly indicate the causes of non-disclosure of HIV/AIDS status by people infected and affected by the disease. The causes of non-disclosure of HIV/AIDS status sadly result in adverse effects on people living with HIV/AIDS, whole communities and school communities. It becomes necessary, therefore, to explore the effects of HIV/AIDS at schools.

The next section explores the effects of HIV/AIDS at schools.

2.4 THE EFFECTS OF HIV/AIDS AT SCHOOLS

Schools, just like the human body, function as a system with different interconnected parts. The effects of HIV/AIDS on schools are mainly the weakening of the school system through the infection of learners and staff and the consequent weakening and disruption of the whole school system. This is manifested by the disease's effects on the school system and management, on educators and learners.

2.4.1 The effects of HIV/AIDS on the school system and management

The school system is affected by the effects of HIV/AIDS on learners and their families, staff and their families, as well as the overall utilisation of the school and its resources to deliver effective teaching and learning. The following are the manifestations of the effects of HIV/AIDS on school systems (Tamukong, 2004; Lund, 2002; Govender, 2001; International Institute for Educational Planning/UNESCO (IIEP), 2003; Bennel *et al.*, 2002):

- educator absenteeism and eventual deaths disrupting the provision of education;
- educator absenteeism due to the need to care for relatives and to attend funerals of relatives, colleagues and people close to them;
- low educator morale and motivation as a result of, *inter alia*, trauma of dealing with the loss of colleagues and learners and increased workloads as a result of absenteeism, illness and weakness of their colleagues;
- learner enrolment declining as learners drop out to care for their sick parents, siblings and relatives;
- increase in orphans and an increase in child-headed families;
- traumatised learners as a result of being affected or infected;
- shortage of resources as a result of reduced enrolment and effects on school fees; and
- the need for continuous redeployment of staff to temporary vacancies created by absenteeism and illness of colleagues.

These effects of HIV/AIDS most certainly affect the management of schools. It can be inferred that school management would struggle with, *inter alia*, strategic and operational planning exercises due to uncertainty and lack of knowledge of when certain events would occur. For instance, it would be difficult to arrange for substitute educators in the event of temporary and long

illnesses of staff. It would also be difficult to plan for school projects due to educators' low morale and motivation, absenteeism and long illnesses. In the case of absences not longer than 15 days, school management would not be able to employ substitutes due to conditions of leave and employment of educators (Department of Education, 1998).

Coombe (2000a:4) argues that many principals, and by implication, school management, are not yet sufficiently trained or supported to be creative about school management and this will become worse as the pandemic takes hold due to the loss of experienced educator-mentors and the dependence of schools on younger and less experienced educators. Schools will thus be faced with a situation of embattled school leadership.

It is clear that the manifestation of the effects of HIV/AIDS at schools is bound to have an adverse and depressing effect on school communities. They are even more adverse when considered in terms of educators and learners.

2.4.2 The effects of HIV/AIDS on educators

According to Bennel *et al.* (2002) apart from reducing educator supply and quality of education, educators who are HIV positive are likely to become sick and eventually die and with the eventual onset of AIDS-related illnesses, affected educators will be frequently absent and, when they are at work, many are likely to find it difficult to be effective classroom educators. The epidemic also indirectly affects teaching and other staff, in that morale and motivation fall because of high levels of morbidity and mortality among colleagues and workloads increase due to higher levels of AIDS-related absenteeism and vacancies, and educators (especially women educators) who have to look after sick relatives, which could result in increased absenteeism and generally low performance levels

HIV/AIDS also affects the performance of educators at schools. Firstly, educator *AIDS-related morbidity* is one of the most serious effects of the epidemic on school systems as sickness lowers teaching quality and results in higher rates of educator absenteeism and longer-term, persistent absenteeism, which is particularly disruptive. Secondly, lower educator morale and

motivation can result from, among other things, trauma related to having to take on extra work-related duties to cover for sick colleagues, having to care for sick colleagues, relatives and learners and having to deal with the emotional and financial effects of the pandemic (cf. Coombe, 2000b; Bennel *et al.*, 2002).

Thirdly, discrimination impacts negatively on educators. Bennel *et al.* (2000) opine that educators living with AIDS in Africa are seriously discriminated against by school managers, teaching colleagues and students, and there are high levels of secrecy and denial among teaching staff concerning the likely extent of HIV infection and clinical AIDS at their schools. This is due the level of stigma attached to HIV/AIDS and as a result, educators are not prepared to reveal their HIV status for fear of adverse reactions among colleagues, the community as a whole and at some schools, which results in very ill teachers continuing to work for fear of being stigmatised and discriminated against (Coombe 2000b).

Finally, Tamukong (2004:7) enumerates non-completion of curricula, financial crises due to purchases of anti-retroviral drugs, continued payment of salaries for absent and underproductive educators as other effects of HIV/AIDS.

These effects on educators translate to learners receiving poor quality of education due to weak and traumatised educators and high dropout rates among learners, as they do not see educators for long periods of time (Tamukong, 2004:7).

2.4.3 The effects of HIV/AIDS on learners

The effects of the HIV/AIDS pandemic on learners are manifested by increases in the number of orphans, child-headed households, children looking after sick family members, which in turn, translates to learner absenteeism and loss of education opportunities (cf. Coombe, 2000b; Bennel, *et al.*, 2002; International Institute for Educational Planning [IIEP], 2003).

Bennel *et al.* (2002) declare the following about the status of orphaned children:

“The large majority of orphans continue to reside with members of the extended family. Their living conditions are often very poor ... When they are residing with ‘other relatives’, it is frequently suggested that their inferior status results in discriminatory behaviour against them by other household members ... Not only are they frequently denied access to food and medical care, but they are expected to do more work than the household’s own children ... Female orphans are particularly vulnerable and instances of sexual abuse of girls in such situations are not uncommon ... unsupported female orphans being forced into marriage by their guardians”

Bennel *et al.* (2002) list behavioural problems associated with orphaned children at schools, the most common of which are:

- Behavioural problems that affect relationships with educators and learners (disruptive and aggressive, withdrawn, crying in class). At one school these researchers were told

“Orphans in this school are de-motivated. They are not free, they don’t mix, and if you joke with them, they fight. They react aggressively to others sometimes as a defence mechanism. If we sing a burial song in class, some cry”.

- Poor concentration (including falling asleep in class) often aggravated by hunger and/or tiredness.
- Poorly dressed and with no school uniform.
- At secondary schools, problems with homework; in unsupportive home environments, orphans find it difficult to complete homework assignments on time and to the required standard.
- Physical and/or sexual abuse by adults living in the carer’s household.
- General isolation at school and/or the community at large - Learners whose parents are affected or have died of the disease seem not to be part of the

school community, though teachers try by all means to bring them close. Others end up leaving the school.

Quite clearly, the conditions relating to orphaned children are not conducive to their learning effectively and, as such, it can be concluded that they would eventually drop out of school and end up in situations like prostitution, child labour and criminal activities.

In light of this exposition, it is clear that dealing with causes and effects of HIV/AIDS is generally challenging. It would be even more challenging to do so in the face of the fear of disclosing the HIV/AIDS status.

This implies the need for a sensitive and aggressive action to address this situation at schools. School management has to mitigate the causes and effects of non-disclosure of HIV/AIDS status by people infected and affected by the disease at schools, especially by educators, due to the centrality and significance of their role and work at schools. The implications for school management in mitigating the causes and effects of educators' non-disclosure of their HIV/AIDS status are explored in the next section. Attention is focussed to legislative provisions regarding HIV/AIDS.

2.5 IMPLICATIONS FOR SCHOOL MANAGEMENT IN MITIGATING THE CAUSES AND EFFECTS OF EDUCATORS NON-DISCLOSURE OF THEIR HIV/AIDS STATUS

2.5.1 Orientation

The education sector can only do its best to mitigate the effects HIV/AIDS through the creation of a well managed learning environment in which life skills, personal choice and low risk behaviour can be taught and sustained. The effective management of systems and the people in them will reduce or remove many of the conditions that make education a high-risk environment one of which is non-disclosure of HIV/AIDS status, which is a common element of schools in the midst of the HIV/AIDS pandemic (cf. Badcock-Walters, 2001).

Educators play an important part in this. Firstly, educators themselves can be important role models in the alleviation of the effects of HIV/AIDS. Secondly, educators can play a major role in dispelling the myths and beliefs surrounding HIV/AIDS by being role models of disclosure and exemplars of safe living in the event of being infected.

Creating an environment that is conducive to educators being at the forefront of the disclosure of HIV/AIDS status is therefore important and can play a significant role in the mitigation of the effects of the pandemic itself. It is thus imperative for school management to take cognisance of this.

An understanding of legislation and policy directives becomes the necessary starting point for schools in creating the type of environment that is desirable in the mitigation of causes and effects of educators' non-disclosure of their HIV/AIDS status.

- ***The National Education Policy Act 27 of 1996*** (Department of Education, 1999)

According to this Act, the following are policy provisions for HIV/AIDS at schools:

- *Non-discrimination and equality*

No learner, student or educator with HIV/AIDS may be unfairly discriminated against, rather, they should be treated in a just, humane and life-affirming way. Just as learners and students with HIV/AIDS should be allowed to lead a full life and be afforded an opportunity to receive an education to the maximum of their ability, educators with HIV/AIDS should lead a full professional life with the same rights and opportunities as other educators.

- *HIV/AIDS testing, admission of learners and appointment of educators to institutions*

No educator may be denied the right to be appointed in a post, to teach or to be promoted or to face dismissal on account of his or her HIV/AIDS status. This is informed by the fact that there is no medical or

scientific justification for routinely testing learners or educators for evidence of HIV infection.

- *Disclosure of HIV/AIDS-related information and confidentiality*

All persons with HIV have the legal right to privacy and consequently, no learner or educator is legally required to disclose his/her HIV status to the school. Voluntary disclosure of a learner or educator's HIV/AIDS status to the appropriate authority should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair dismissal is not tolerated. However, a holistic programme for life-skills and HIV/AIDS education should be established to encourage disclosure.

- *A safe school environment*

Since HIV cannot be transmitted through day-to-day social contact and although the risk of HIV transmission in the school is significant, all schools should implement universal precautions to prevent the spread of all infections transmitted by blood, including HIV. Therefore, schools should have holistic programmes that include training learners and educators in first aid. This should obviously be accompanied by a programme for education in all HIV/AIDS-related information so as to dispel myths and misconceptions about the risks involved in the spread and prevention of HIV/AIDS.

- *Education on HIV/AIDS*

A continuing HIV/AIDS education programme should be implemented in all schools. This should be integrated into a life-skills programme and should be age-appropriate and accurate. Parents should be informed of and be involved in this programme.

- *Duties and responsibilities of learners and educators*

The code of conduct adopted for learners at a school should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission. Educators have a particular duty to ensure

that the rights and dignity of all learners and educators are respected and protected.

- *Refusal to study or work with people with HIV/AIDS*

Accurate information should be provided to learners, educators and parents, especially on how HIV/AIDS is spread as well as on associated myths and fears. This should be coupled with counselling where necessary. Refusal to study with a learner(s) or to be taught by an educator(s) or to work with someone with HIV/AIDS should be resolved by the principal with the help of the school governing body and the Health Advisory Committee, after the persons concerned have been counselled.

- *The Health Advisory Committee*

Each school should establish its own Health Advisory Committee (HAC), and where the establishment of such a committee is not possible, the school should draw on expertise available to it within the education and health systems.

The HAC is a sub-committee of the school governing body. This committee can be constituted out of prominent members of the society e.g. politicians, health workers, religious leaders, traditional leaders, business people, educators and learner representatives. The committee is entitled to elect its own chairperson who should preferably be a person with knowledge in the field of medical or health care professions.

The main objective of the HAC is to advise the school governing body on all health matters, including HIV/AIDS, to be responsible for developing and promoting a school plan of implementation on HIV/AIDS and to review the plan from time to time, report back and update the school governing body on the latest developments. This is especially with regard to progress made on efforts to assist learners and educators affected and infected by HIV/AIDS. Its function is also to

plan around new scientific knowledge as it unfolds and take charge of matters relating to the prevention of HIV transmission.

With its main objective, the HAC has to raise HIV/AIDS awareness and prevent the further spread of the HIV virus within the school communities. Kelly (2000b:13) suggests that the HAC should ensure it never defaults in its responsibilities to persons living with HIV/AIDS and take whatever actions needed to ensure that members of a school community who live with the disease can live full, productive and happy lives.

The Health Advisory Committee may as far as possible use the assistance of community health workers led by a nurse, or local clinics and should be entirely responsible for provisions relating to the prevention of HIV transmission in the school's code of conduct.

As a sub-committee of the school governing body, the HAC must ensure that there is a policy on HIV/AIDS. The school policy must be developed to ensure a consistent and equitable approach to the prevention of HIV/AIDS among learners, educators and their families, and to the management of the consequences of HIV/AIDS, including the care of the learners and educators living with HIV/AIDS, and should be in compliance with existing laws regarding HIV/AIDS, and where necessary, insert existing laws on discrimination, working conditions, and safety and health (ILOAIDS, 2003).

Finally and most important, the HIV/AIDS policy of the school must address the following critical priorities identified by the department of education:

- prevent the spread of HIV/AIDS;
- care and support for learners and educators;
- protect the quality of education; and
- manage a coherent response to the challenge of HIV/AIDS.

The activities of the HAC are also informed by and concretise the provisions of the South African Schools Act.

- ***The South African School Act 84 of 1996*** (Department of Education, 1996)

According to Section 20(1) of this Act, the governing body of a school must promote the best interests of the school and strive to ensure its development through the provision of quality education for all learners at the school. This implies that a school must exercise all the necessary measures to ensure that quality education takes place. This among other things, means abiding by all the laws and regulations pertaining to the provision of fair and non-discriminatory practices towards people with HIV/AIDS, including learners and educators.

- ***Employment Equity Act 55 of 1998*** (Department of Education, 1998)

This Act makes provision for the following:

- No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, *HIV status*, conscience, belief, political opinion, culture, language and birth.
- Medical testing of an employee is prohibited, unless legislation permits or requires the testing, or it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job; and
- Testing of an employee to determine that employee's HIV status is prohibited, unless such testing is determined justifiable by the Labour Court in terms of section 50 (4) of the Act

These legislative provisions set the tone for mitigating the causes and effects of non-disclosure of HIV/AIDS status and imply putting into place the necessary interventions, among other things, preventing HIV infections and reducing risks of infection.

2.5.2 Measures to mitigate the causes of non-disclosure of HIV/AIDS status

Schools need to be safe settings in which teaching and learning can occur free from the threat of violence, bullying and sexual abuse. Thus, schools must be ready to tackle gender and other forms of social inequality and take action to protect people living with and affected by HIV/AIDS from stigmatisation and discrimination. Mitigating the causes and effects of non-disclosure of HIV/AIDS includes:

2.5.2.1 Preventing HIV infection

Preventing HIV infection implies taking all necessary and reasonable measures to stop the spread of HIV, which needs and makes committed high-level leadership essential. This necessitates that schools reach learners and young people through school based and external HIV/AIDS education programmes (Coombe, 2002b):

- developing policies addressing HIV/AIDS education;
- providing HIV/AIDS-related knowledge and skills to all young people, including those at special risk;
- linking young people to relevant health services; and
- supporting activities that reduce overall vulnerability to HIV/AIDS, for example by ensuring protective school environments or by reaching out to girls, young people who use drugs, young migrants, refugees and asylum seekers and young people whose economic circumstances cause them to exchange sex for money, drugs or material benefits.

This can be done by, among others, leadership and advocacy based on sound knowledge, as well as on a quality situational and contextual analysis of (cf. UNAIDS, 2002:39; Coombe, 2000b):

- patterns of sexual behaviour, cultural practices and beliefs, and sub-cultural norms among young people, which can be used to collect and

develop useful data and information on sexually-transmitted illnesses and pregnancy rates among young people, age at first sexual intercourse and patterns of substance use;

- the availability and use of condoms and services;
- safety and security of the school/ community; and
- social/economic factors and cultural practices relevant to risk attitudes related to education about HIV/AIDS, sexual and reproductive health, and discrimination at schools and in the community.

For HIV/AIDS education programmes, this collection of data would be used to help young people develop personally-held value systems, which would empower them to make correct and safe choices by providing information and inculcating skills that would help self-protection, promote behaviour that would strengthen their capacity to prevent personal disaster, enhance the capacity to draw others back, reduce the stigma, silence, shame, and discrimination associated with the disease (Coombe, 2000b; UNAIDS, 2002). The fundamental purpose of all educational programmes should be to develop values and attitudes that say “yes” to life and “no” to premature, casual, unprotected or socially unacceptable sex and sexual experimentation.

2.5.2.2 Reduction of risk

Reducing the risks of HIV infection and the spread thereof emphasises the need for good quality prevention education programmes because they result in the adoption of positive behaviours, including a delay of the age of first sex, an increase in the use of condoms among young people who are sexually active, a reduction in the number of sexual partners, a reduction in alcohol and drug use in particular and they have an effect on the environment, particularly in improving health, safety and security in educational settings and elsewhere within communities (UNAIDS, 2002:41).

In this regard, Coombe (2002b) argues that while information is necessary, knowledge alone is not sufficient to protect educators and learners against

HIV/AIDS. What is needed is an interactive process of teaching and learning that helps educators and learners acquire the knowledge, attitudes and skills to enable them to take greater responsibility for their own lives, resist negative pressures, minimize harmful behaviours and make healthy life choices. Therefore, life-skills and HIV/AIDS education should not be presented as isolated learning content, but should be integrated in the whole curriculum and be presented in a scientific but understandable way with appropriate course content being available for the pre-service and in-service training of educators to cope with HIV/AIDS at schools.

It is important to note that good quality risk-reduction education relies on trained and skilled human capacity, with teachers and others being properly trained, supervised and monitored in their work (UNAIDS, 2002:44). This would facilitate the removal of controversies for educators as well as for the community resulting from the sensitive nature of the learning content.

2.5.2.3 Reducing vulnerability

Vulnerability to HIV infection occurs when people are limited in their ability to make and effect free and informed decisions and it is determined by political factors such as (UNAIDS, 2002:47):

- the lack of will to respond effectively to the epidemic;
- economic factors such as poverty;
- education factors such as lack of good quality schooling and contextual factors such as dominant gender roles and expectations;
- violence and conflict, family breakdown or lack of “connectedness” to family, school or community; and
- environment factors such as absent or inadequate health and social services (UNAIDS, 2002:47).

UNAIDS (2002:47) argues that education in and of itself can reduce vulnerability to HIV/AIDS by enhancing literacy and the general educational

level, by enhancing a sense of connectedness and security, and by providing access to trusted adults, and that young people with more education are more likely to use condoms than peers with less education and are less likely to engage in casual sex. Therefore schools can be outstanding places for promoting the rights of children and young people, thus aiding in HIV/AIDS risk-reduction.

UNAIDS (2002:48) further asserts that HIV/AIDS-related vulnerability reduction works best in an enabling environment and when it builds on strong foundations which can include a legal infrastructure guaranteeing the provision of education and health services, together with policies and procedures guaranteeing human rights. Maile (2003:80) opines that to create legitimacy of disclosure, HIV/AIDS policies require support from political leaders. Therefore, multi-pronged and co-ordinated strategies are more effective in reducing vulnerability than single 'once-off' approaches. This includes building health policies around HIV/AIDS, building supportive environments, supporting community action and establishing young person-friendly health services (UNAIDS, 2002:48).

Schools and education can enhance access to services relevant to young people, including treatment for sexually transmitted infections, to voluntary and confidential counselling and testing, HIV/AIDS treatment and care. Within schools, trained staff can identify early warning signs of harmful drug use and maintain strong links with local health centres and other community organisations can help students link the knowledge and attitudes they learn at school with actions to protect themselves (UNAIDS, 2002:49).

Mitigating the causes and effects of HIV/AIDS non-disclosure needs to be situated within a context of well co-ordinated school programmes. This implies establishing a management strategy for dealing with the causes and effects of HIV/AIDS. The following section presents the essence of a school management strategy in this regard.

2.5.3 Implications for school management: A management strategy for mitigating the causes and effects of HIV/AIDS

To deal more effectively with the management strategy for mitigating the causes and effects of non-disclosure of the HIV/AIDS status at schools, it is imperative to gain insight into what a strategy is. Concepts pertinent to a strategy are exposed first.

2.5.3.1 Concept definition

- *Strategy*

Tutor2u (http://www.tutor2u.net/business/strategy/what_is_strategy.htm) defines strategy as the direction and scope of an organisation in the long term, which achieves advantage for the organisation within a challenging environment through its use of resources to fulfil stakeholder expectations. The essence of a strategy addresses the following key issues:

- Where is the school at the present moment?
- Where is the school trying to get to in the long term?
- What kinds of activities are involved in trying to get there?
- How can the school perform to get there?
- What resources (skills, assets, finance, relationships, technical competence and facilities) are required in order to get there?
- What external, environmental factors affect the organisation's ability to get there?
- What are the values and expectations of those who have power in and around the organisation?

A strategy implies that the school must engage in a series of actions to formulate an approach to mitigate the causes and effects of non-disclosure of HIV/AIDS by educators.

- *Strategic management*

Tutor2u (http://www.tutor2u.net/business/strategy/what_is_strategy.htm) defines, strategic management in its broadest sense as taking "strategic decisions" - decisions that answer issues addressed by the strategy. Strategic management thus involves managerial decisions and actions that help to ensure that the organisation formulates and maintains a beneficial fit with its environment. This implies actually turning strategy into organisational action.

- *Operational strategy*

An operational strategy is concerned with how each part of the business is organised to deliver the corporate and business-unit level strategic direction. Operational strategy therefore focuses on issues of resources, processes and people (Tutor2u, http://www.tutor2u.net/business/strategy/what_is_strategy.htm). This implies that an operational strategy is much more short-term and deals with the school's operational issues, i.e. day-to-day issues. This would entail for example, daily observation and recording of incidents relating to the causes and effects of non-disclosure of the HIV/AIDS status of people.

- *Operational management*

While strategic management addresses the long-term strategic direction of the school, operational management addresses the implementation of the operational strategy within the strategic management framework. Ryan (1999:12) adds that operational management is short-term, tactical and specific, action-orientated and focused on implementation and results.

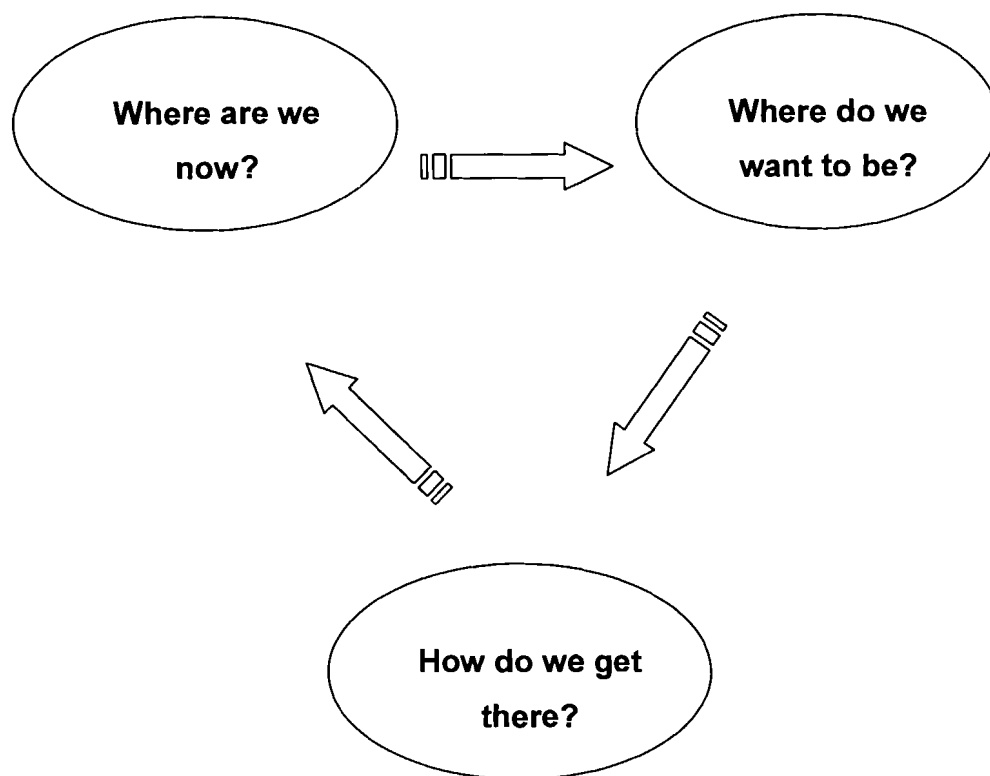
On the basis of this exposition, it is clear that mitigating the causes and effects of HIV/AIDS calls for a strategy at school, in order to facilitate the management thereof, both strategic and operational.

2.5.3.2 A school management strategy

One point that has emerged clearly from the problem statement is that of non-disclosure that raises some concerns relating to the HIV/AIDS status of infected and affected educators at schools. A school management strategy therefore outlines an approach and activities the school can develop to

mitigate the causes and effects of educators' non-disclosure of their HIV/AIDS status. Based on the definitions of strategy and strategic management, operational strategy and operational management, a school management strategy can be operationalised in the following diagram:

Figure 2.1 A school management strategy



In terms of figure 2.1 the management strategy entails the school's self-evaluation in terms of where it is at the present moment and where it wants to be (cf. Tutor2u, http://www.tutor2u.net/businessstrategy/what_is_strategy.htm). Thus the school engages in answering the three fundamental questions depicted in figure 2.1. These questions direct the school to engage in the following exercise (cf. Tutor2u, http://www.tutor2u.net/businessstrategy/what_is_strategy.htm):

- **Where are we now?**

This question prompts an assessment of the school's present status regarding the causes and effects of educators' non-disclosure of their HIV/AIDS status. This assessment seeks basically to examine if the school is at the stage

where there is full disclosure of the HIV/AIDS status. The answers to this question will determine the school's next step in the mitigation of causes and effects of non-disclosure. For instance, if the answer shows a stage where there is disclosure or there is still non-disclosure, the next question will be addressed with an eye to the final stage of the strategy.

In essence, this stage involves school environmental scanning – both internal and external. Included in this stage is the determination of the school's passion or vision regarding causes and effects of HIV/AIDS as well as the mitigation thereof, including the values and expectations of those who have power in and around the school (cf. Tutor2u, [http://www.tutor2u.net/businessstrategy /what is strategy.htm](http://www.tutor2u.net/businessstrategy/what%20is%20strategy.htm)). Therefore the school seeks to determine, firstly, what will make it easy to achieve its vision and, secondly, what will make it difficult to do so.

In the light of the causes and effects of non-disclosure of the HIV/AIDS status by educators, school management is faced with a difficult task due to the fact that educators infected and affected by HIV/AIDS fail to come out of the closet and talk openly about their status, as indicated in (2.3.4). At this stage, school communities living with or suspected of being HIV-positive are stigmatised, isolated and deprived of their rights to care and support (2.3.5). The major concern is the secrecy and silence infused with denial among the teaching and learning staff (2.4.2).

- **Where do we want to be?**

School management needs to work towards the standards set by the school vision, in order to continue to provide education of quality to all those who wish to learn, while trying to deal effectively with the effects of HIV/AIDS. This means putting HIV/AIDS at the core of thinking about and providing education in order to reduce rates of absenteeism, supporting and taking care of those infected and affected by HIV/AIDS and finally of combating stigmatisation and discrimination.

To address this, the school at this stage, deals with activities pertinent to getting where they want to be. This entails setting targets and concretising the

set vision and mission. With regard to the causes and effects of non-disclosure, the school sets target for achievement. For instance, a possible target might be the achievement of disclosure, eradicating stigmatisation and discrimination, as well as dispelling myths. Included could be benchmarking issues relating to prevention, risk-reduction and reducing vulnerability through identifying best practices from within and outside the school (cf. Tutor2u, <http://www.tutor2u.net/business/strategy/benchmarking.htm>).

Through the implementation of quality formulated strategies in the best interest of the management of HIV/AIDS at schools, conducive environments need to be created as indicated in (2.5.1) to encourage educators to be at the forefront of disclosure, enabling them to talk openly and freely about their HIV and AIDS status without fear of being stigmatised or discriminated against.

This would be of great help to both infected and affected individuals to accept HIV/AIDS as a disease like any other disease. On the other hand, with more education and understanding of the disease, school communities would be able to come to the fore about their HIV/AIDS status and form part of the advocacy.

- **How do we get there?**

Determining how the school gets there entails outlining priorities for action, developing and implementing plans for achieving the school's target, that is mitigating causes and effects of non-disclosure. This stage would involve determining resources (skills, assets, finance, relationships, technical competence and facilities) required. This would also entail determining and setting clear performance and success criteria (cf. Carter & McNamara, http://www.mapnp.org/library/plan_dec/str_plan/str_plan.htm#anchor1243528).

The school's strategy at this stage would include the provisions of the relevant legislative framework. The role of the HAC in terms of quality assurance, monitoring and evaluation is critical at this stage, since it must be clear how the school will know when it has reached its target or achieved its purpose. Thus, the strategy will contain tracking devices for successful implementation

of the strategy (cf. Carter & McNamara, http://www.mapnp.org/library/plan_dec/str_plan/str_plan.htm#anchor1243528).

Management strategies need to accommodate all stakeholders in measures to mitigate the causes of HIV/AIDS as outlined in (2.5.2) to ensure skilled human capacity that would operate on the basis of informed decisions. As a result, the school and community would benefit a lot from voluntary disclosure.

This exposition makes it clear that the school management strategy entails structuring school processes in such a way that measures are taken to mitigate the causes and effects of non-disclosure of the HIV/AIDS status by people infected and affected by the diseases, in particular, educators. This strategy should contain elements of HIV/AIDS prevention as embodied in the legislative framework. In essence, a school management strategy covers all those activities the school undertakes to mitigate the causes and effects of non-disclosure.

2.6 SUMMARY

This chapter exposed the causes and effects of non-disclosure of the HIV/AIDS status by educators. It is clear that implications for school management in mitigating the causes and effects of non-disclosure call for a holistic approach that not only deals with educator non-disclosure, but focuses on the whole school. It is also clear that the school management strategy makes it possible to deal with HIV/AIDS issues in a coherent and co-ordinated manner.

The next chapter presents the empirical research design.

CHAPTER 3

EMPIRICAL RESEARCH DESIGN

3.1 INTRODUCTION

In the previous chapter, a literature study was undertaken with regard to the definition and conceptualisation of non-disclosure of the HIV/AIDS status by educators. The causes and effects of educators' non-disclosure of their HIV/AIDS status and the implications for school management were explored. In this chapter, the research design with regard to the research method and the development of the research is presented.

3.2 THE EMPIRICAL STUDY

The empirical study specifically aimed to examine the actual causes and effects of non-disclosure of the HIV/AIDS status by educators at schools, as well as the management implications in the mitigating thereof.

The quantitative research methodology was used in this study. Quantitative research is defined as a formal, objective and systematic process where data is used to obtain information about study phenomena (Stubbs (2005, [http://www.mori.com/quantitative /index.shtml](http://www.mori.com/quantitative/index.shtml))). For this purpose, a questionnaire as a research instrument was used to collect data from school principals.

3.2.1 The research instrument

3.2.1.1 The questionnaire as a research tool

A survey questionnaire is a formalized schedule for collecting data from respondents (Erwee, 1994:28). Questionnaires serve a vital information-gathering purpose and represent a sizable investment. It is noted, however, that questionnaires are limited by certain disadvantages, especially in a subject of this nature, that is, HIV/AIDS and disclosure of the status thereof

(Leedy & Omroyd, 2005:185). However, in this study, the questionnaire was chosen for its advantages, especially the anonymity factor, and among other advantages, relatively low costs of administering it, the ability to cover a large geographic area and the ability to reach a large sample (Delpont, 2002:172).

The use of the questionnaire was also justified by the ease with which it could be administered, since the target population was deemed accessible and homogeneous enough and would as a result, be comfortable with understanding it (cf. Wolf, 1997:422).

3.2.1.2 Questionnaire design

Questionnaire design is a well organised and thorough process. According to McMillan and Schumacher (2001:258), this involves preparing and constructing items and formatting the questionnaire.

In this study, the questionnaire preparation involved the delineation of concepts associated with causes and effects of educators' non-disclosure of their HIV/AIDS status and the implications for management in the mitigation thereof. The objectives for data collection were determined as finding out the actual situation regarding HIV/AIDS disclosure at schools, as well as management measures aimed at mitigating the causes and effects of non-disclosure.

Constructing questionnaire items in this study was based on the consideration of such principles as making items clear, avoiding double-barrelled questions, making sure questions are relevant, writing short and simple items and avoiding negative and biased items or terms (McMillan & Schumacher, 2001:258).

McMillan and Schumacher (2001:265) contend that there are many questionnaire formats, among other things, writing items and using boxes for respondents' answers, as well as using contingency questions.

The general layout of the questionnaire (Annexure 1) in this study included dividing the questionnaire into two sections, namely section A, which outlined

biographic and demographic data, and section B, which consisted of items relating to the causes and effects of non-disclosure of the HIV/AIDS status and implications for school management in the mitigation thereof.

Section B was constructed to consist of two categories of questions. The first category of questions (questions 1-15) consisted of questions investigating causes and effects of the non-disclosure of the HIV/AIDS status by educators. The second category of questions (questions 16-29) consisted of questions investigating implications for school management in mitigating causes and effects of non-disclosure of the HIV/AIDS status by educators

Various response scales were used and these were dependent on the nature of the question. A standard response scale was not possible since questions sought to elicit various kinds of responses. A number of questions used contingency questions as follow-up to questions, for example, if yes, how regular?

The questionnaire was finalised and edited for correctness and precision. Once there was satisfaction in this regard, it was decided to pilot the questionnaire.

3.2.1.3 Pilot survey

Pilot studies are usually considered to trial investigations of specific research problems that will be treated more intensively at a later date (Erwee, 1994: 26). For this purpose, the questionnaire was first scrutinised by the study leader. After that, pre-testing was done with a smaller sample of respondents (n=20) who paralleled the characteristics of the larger population sample to be surveyed more intensively and on a larger scale at a later stage. Pre-testing was done in the manner intended for the final survey.

The pilot survey yielded useful information regarding the wording of some questionnaire items as well as the format, contingency questions and relevance of items. The questionnaire was then finalised and prepared for distribution.

3.2.1.4 Questionnaire distribution

The final questionnaire was then distributed to the sample population. Three hundred questionnaires were distributed. These were accompanied by a covering letter, aimed at urging respondents to complete the questionnaire and complete all sections. The letter also gave an assurance in terms of confidentiality and anonymity of respondents completing the questionnaire. As questionnaires were personally distributed, the respondents got first-hand orientation. The process took three weeks for distribution, completion and collection.

3.3 POPULATION AND SAMPLING

The target population consisted of school principals (N=300) in the Sedibeng District's Gauteng Department of Education's districts 7 and 8. The number of schools was pegged at 300, based on information received telephonically from the two districts' registry officials. Consequently, the sample consisted of all school principals (n=300) in the two districts as informed by guidelines offered by Leedy and Omroyd (2005:207) and Strydom and Venter (2002:201) that, in terms of this population size, it was not necessary to sample.

3.4 RESPONSE RATE

Questionnaires were distributed to 300 principals in the Sedibeng Districts in Gauteng Province. Table 3.1 shows the response rate.

Table 3.1 Response rate

Questionnaires	Quantity	%
Distributed	300	100
Received	272	90.7

3.5 ADMINISTRATIVE PROCEDURES

Approval to conduct research at schools was requested from the Gauteng Department of Education using the prescribed request form found in the department's website, viz., <http://www.education.gpg.gov.za>.

3.6 FOLLOW-UP ON QUESTIONNAIRES

A follow-up on questionnaires that were not returned in time was done personally. Various reasons were forwarded for failure to complete and return them, among others, they were reportedly misplaced. Consequently, less than 100% retrieval was attained (cf. table 3.1).

3.7 STATISTICAL TECHNIQUES

The North-West University: Vaal Triangle Campus' statistical services processed the data collected by means of a computer using the SAS-programme. The SAS programme was used to find the frequencies and means according to the PROC FREQ (frequency procedures). An analysis of data with the use of frequencies and percentages was done to determine the level of responses.

3.8 SUMMARY

This chapter outlined the research design with regard to the research method, the development of the research and the pilot study description.

Finally, the questionnaire was used as research instrument because of its advantages and was distributed and collected personally from schools. The next chapter will submit the data analysis and interpretation.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The previous chapter outlined the empirical research design with regard to the purpose of this research and the research methodology. This chapter presents an analysis and interpretation of research data collected through a questionnaire to determine the causes and effects of educators' non-disclosure of their HIV/AIDS status and its implications for school management.

4.2 GENERAL INFORMATION

4.2.1 Review of respondents

A total of 300 questionnaires were distributed to principals of schools. The return rate of usable questionnaires was 90.7% and was therefore representative of the sampled group. It was noted, however, that the less than 100% return rate was the result of some principals being occupied with administrative duties associated with the re-opening of schools after the vacation holidays. There was also a feeling of reluctance to complete the questionnaire, perhaps due to the sensitive nature of the issues addressed by the questionnaire. The response rate was, however, deemed usable in line with Diem's contention (2002) that a response of 50 to 60 percent is often considered an acceptable return rate for survey research and can be considered a "usable" response rate.

4.2.2 Biographical information

A distribution of the biographical information of respondents as indicated in Section A is explained by means of frequency and percentage counts across the target population.

4.2.2.1 Gender of respondents

Table 4.1 illustrates data on the gender of the respondents. Out of the total number of respondents, the majority were females (58.5%) compared to male respondents (39.3%). This implies that there are more female than male principals at schools. This could have implications regarding the management of disclosure of the HIV/AIDS status of educators, since this is still a sensitive issue in people's lives, mainly due to the different management and leadership orientations of female principals compared to that of their male counterparts.

Table 4.1 Data on respondents' gender

Responses	Frequency	Percentage
Male	107	39.3
Female	159	58.5
Null Responses	6	2.2
Total	272	100

4.2.2.2 Phase in which respondents teach

For the purpose of this study, the phase levels in which in which respondents teach are divided into four categories, namely foundation, intermediate, senior and further education and training (FET). The question was included to find out if principals were involved in actual classroom teaching activities. This would help in gaining an understanding of their involvement with both educators and learners who are infected and affected by HIV/AIDS.

Table 4.2 depicts data relating to phases in which respondents teach. From the data collected, it can be seen that the majority of the respondents (87%) answered this question. The responses indicate that all phases were represented. This indicates that almost all principals are actually involved in classroom teaching activities and are thus in a position to have an understanding of the causes and effects of non-disclosure of the HIV/AIDS

status by educators as by implication, they interact with educators at that level. The highest number of respondents (34.6%) was from the FET institutions, followed by respondents in the senior phase (23.9%), intermediate phase (19.9%) and foundation phase (17.6%). This implies that no phase was left out during the distribution of questionnaires, with an exception of the 4.0% null response, which means that data gathered can be regarded as representing a spread across all school phases and can thus be regarded as authentic for schools.

Table 4.2 Phases at a school

Responses	Frequency	Percentage
Foundation	48	17.6
Intermediate	54	19.9
Senior	65	23.9
FET	94	34.6
NR	11	4.0
Total	272	100

4.2.2.3 Type of school

There was an almost equal division between respondents in the primary and secondary schools. There were 47.1% principals from primary schools and 46.7% from secondary schools, while the minority (4.4%) were in combined schools, that is, primary schools that have grade eight. There were few (1.3%) null responses.

The distribution of respondents across school types indicates an almost equal composition of primary and secondary schools. This implies that data collected in this research can be seen as being inclusive of different school

types in the research area and implies, therefore that school principals are appropriately placed to be able to deal with the causes and effects of non-disclosure of the HIV/AIDS status by educators across the population of schools.

Table 4.3 Data on the type of school

Responses	Frequency	Percentage
Primary	128	47.1
Secondary	127	46.7
Combined	12	4.4
Other	2	0.7
NR	3	1.1
TOTAL	272	100

4.2.2.4 Location of school

From Table 4.4, it can be seen that most respondents (81.6%) were in the townships schools while there were less than a tenth (9.6%) of the respondents from town schools and the minority (5.9%) from farm schools.

Table 4.4 Data on the location of school

Location of school	Frequency	Percentage
Township	222	81.6
Town	26	9.6
Farm / Rural	16	5.9
NR	8	2.9
TOTAL	272	100

The spread of the schools across the various localities indicates an imbalance in distribution across township, farm and town areas. However, looking at the number of schools in the Sedibeng district demographics, more schools are

located in the townships. This implies that more data on the causes and effects of HIV/AIDS and school management implications thereof, are mainly from township schools, as this is where the majority of respondents and schools are located. The historical disadvantaged situation of township schools implies more significant school management implications at those schools.

4.2.2.5 Numbers of learners at schools

Table 4.5 indicates that the majority of schools (54.0%) had enrolments of more than 1000 learners, followed by 13.2% with enrolments between 0 and 999 and 19.9% with enrolments between 0 and 800. Only 10.3% of the schools had enrolments between 0 and 500. Clearly, most respondents' schools have enrolments of more than 800 learners, and this implies that these schools could be having serious management implications as a result of the non-disclosure of HIV/AIDS by educators. This, however, does not imply that these schools have more cases of non-disclosure of the HIV/AIDS status by educators. It merely points to the onerous challenges facing principals at big schools in dealing with implications of non-disclosure of HIV/AIDS status, as well as with being infected and affected by the disease.

Table 4.5 Data on the number of learners

Learners	Frequency	Percentage
0-500	28	10.3
0-800	54	19.9
0-1000	36	13.2
0-1000 ⁺	147	54.0
Null Responses	7	2.6
TOTAL	272	100

4.3 AN ANALYSIS OF THE CAUSES AND EFFECTS OF NON-DISCLOSURE OF HIV/AIDS STATUS BY EDUCATORS

Various reasons for the non-disclosure of their HIV/AIDS status by people who are infected and affected with the disease were identified in the literature study (cf. 2.3). This has a serious bearing on schools and the management thereof. Among others, causes are related to denial, cultural beliefs, religion, fear of stigmatisation and financial implications. Identified causes seem to have direct effects at schools (cf. 2.4) mainly by weakening and consequently, disrupting the whole school system.

Respondents were requested to answer questions determining conditions at their respective schools regarding the causes and effects of non-disclosure of HIV/AIDS status. The purpose of this was to investigate empirically the perceptions of the respondents about factors that influence the non-disclosure of HIV/AIDS by educators. This section presents a summary of these perceptions as revealed by the empirical investigation.

Question 1

The purpose of this question was to find out if the respondents were aware of any educators in their schools who were HIV positive or who had AIDS.

Table 4.6 Awareness of any educator who are HIV positive or has AIDS

Responses	Frequency	Percentage
Yes	42	15.4
No	187	68.8
Not sure	43	15.8
TOTAL	272	100

According to Table 4.6, the majority of respondents (68.8%) answered with “no”, with the minority (15.4%) answering affirmatively to this question, while 15.8% indicated not being sure. This gives an impression that there are very

few educators at schools who are HIV positive or have AIDS. However, both categories of respondents who answered negatively and those who were not sure reflect the sensitivity and uncertainty regarding disclosure of HIV/AIDS status.

Question 2

This question followed up on the first question and required respondents to indicate how they knew about the status of HIV/AIDS infected educators.

From the data portrayed in Table 4.7, most respondents (84.6%) indicated this question as being not applicable. This could possibly relate to most respondents who indicated “no” or “not sure” to the preceding question. This implies that most principals do not know of educators’ HIV/AIDS status or are not comfortable with disclosing information in this regard. This is one of the causes and effects of non-disclosure of HIV/AIDS status generally. This implies that educators are not prepared to reveal their HIV status for fear of adverse reaction among their colleagues and the community as a whole (cf. 2.4.2).

This could be mainly due to the fact that HIV/AIDS is not a notifiable disease and thus people infected and affected by the disease cannot be forced to disclose their status and to the fact that infected people, have the right to confidentiality and deserve to be treated with respect. On the other hand, people will only get the support they deserve if they open up and talk freely about their HIV/AIDS status (cf. 2.5.1).

However, some respondents (Table 4.7) indicated how they knew about educators’ status. Of these respondents, most (12.9%) indicated having known through infected educators’ own disclosure, while 1.8% heard rumours and 0.7% had suspicions. This is an indication of how low the extent of disclosure is among educators. This is a cause of non-disclosure and further stigmatisation (cf. 2.4.2). Clearly then, as long as there are high levels of secrecy, teaching and learning will be compromised further on account of non-disclosure, since this will have school management implications. Put in more precisely, it will be difficult for school management to enact measures to

mitigate the causes and effects of non-disclosure and the AIDS pandemic itself.

Table 4.7 How respondents knew about educators' HIV/AIDS status

Responses	Frequency	Percentage
He/she disclosed status	35	12.9
Suspicion	2	0.7
Heard rumours	5	1.8
Not applicable	230	84.6
TOTAL	272	100

Question 3

This question sought to inquire if there were any educators in the respondents' schools who had died or retired due to a suspected HIV/AIDS-related disease. Data in this regard are presented in Table 4.8.

According to data from Table 4.8, 5.5% of the respondents acknowledged that there were educators at their schools who had died or retired due to a suspected HIV/AIDS-related disease, with the majority (62.2%) indicating that there were no educators who had died or retired due to a suspected HIV/AIDS-related disease in their schools. Of the remaining respondents, 23.5% indicated that they did not know of such educators at their schools and 8.8% indicated that they were not sure if there were educators who had died or retired due to a suspected HIV/AIDS-related disease at their schools.

Table 4.8 Data on whether there were educators who had died or retired due to a suspected HIV/AIDS-related disease

Responses	Frequency	Percentage
Yes	15	5.5
No	169	62.2
Don't know	64	23.5
Not sure	24	8.8
Total	272	100

These data indicate that most principals denied the fact that educators did get sick or die from HIV/AIDS-related diseases. This is surprising, since for instance, the SADTU reveals that the seriousness of the effects of the HIV/AIDS pandemic at schools is evident in the infection rate among educators and suggests rates that are higher than 14% (cf. 1.2). This indicates the low level of disclosure of the HIV/AIDS status by educators and is indicative of the fact that HIV/AIDS is still a disease that is highly concealed and is not openly talked about. On the other hand, some principals could have felt they would be betraying those educators who confided in them if they were to divulge information about the disclosure of their HIV/AIDS status, even though anonymity of their responses was assured. This is one of the major disadvantages of a questionnaire as a research instrument (cf. 3.3.1).

Question 4

The purpose of this question was to investigate whether there were educators who had disclosed their HIV status at their respective schools. Data in this regard are portrayed in Table 4.9.

Table 4.9 Data on educators who have disclosed their HIV/AIDS status

Responses	Frequency	Percentage
Yes	29	10.6
No	182	66.9
Not sure	57	21.0
Null response	4	1.5
Total	272	100

From Table 4.9 it can be seen that most respondents (66.9%) did not have educators who had disclosed their HIV status. A mere 10.7% agreed to this effect, while 21% were not sure if there were any who had disclosed their status at their schools and 1.5% did not respond.

Table 4.10 Data on how educators disclosed their HIV/AIDS status

Responses	Frequency	Percentage
Publicly	8	2.9
Confidentially	20	7.4
Forced to	2	0.7
Don't know	0	0
Not applicable	239	87.9
Null response	3	1.1
Total	272	100

As a follow-up to this question, Table 4.10 indicates data about how educators who had disclosed their HIV status did so. Data in this regard reveal that 2.9% of the respondents indicated that educators had disclosed publicly, 7.3% of the respondents indicated that educators disclosed confidentially, while 0.7% of the respondents indicated that educators who disclosed were forced to do so. However, a significant majority of respondents (87.9%) indicated that they did not know how educators disclosed their status.

An analysis of responses to these questions indicates clearly that disclosure of the HIV/AIDS status by educators is very low. This has major implications for the mitigation of causes and effects of non-disclosure of HIV/AIDS. For one, it implies that school management cannot plan adequately for programmes to encourage disclosure of status. It also implies that school management cannot successfully implement learning and teaching programmes regarding HIV/AIDS, basically because there is seemingly a high level of stigmatisation and fear thereof.

This confirms literature assertions that there is stigma associated with HIV/AIDS due to, among other things, fear to disclose because of curses attached to the disease, promiscuity and adultery associated with contracting the diseases (cf. 2.3.3) and culturally determined beliefs that it is mischievous to talk openly about sex acts as they are considered to be taboo (cf. 2.3.2). Other causes and effects of non-disclosure have to do with beliefs that people who are HIV positive got what they deserved (cf. 2.3.4), while on the other hand, fear of being discriminated against is another cause of non-disclosure (cf. 2.3.5).

It can be inferred from this that people do not regard HIV/AIDS like any other disease, a disease they can talk about easily in their daily lives like cancer, sugar diabetes and other diseases which are openly talked about without fear. It can also be deduced that school environments are not conducive to educators coming out clearly about their HIV/AIDS status so that they can be helped without any reservations. At this stage, it is difficult for educators to access role model characters and openly talk of their personal experiences in living with the disease. It would be in the interest of all school communities if disclosure of HIV/AIDS status by educators could be encouraged.

Question 5

The purpose of this question was to find out if principals often had to assign more work to other educators due to the continuous illness of other educators.

Table 4.11 Data on whether more work is assigned to educators as a result of continuous illness of other educators

Responses	Frequency	Percentage
Yes	88	32.4
No	141	51.8
Null response	43	15.8
Total	272	100

From Table 4.11, it can be seen that a sizeable number of respondents (32.4%) agreed that they often had to assign more work to educators as a result of continuous illness of other educators, while a significant majority (51.8%) disagreed. It is also notable that of the respondents, a sizeable number (15.8%) did not respond to this question.

The implication of this response is that workloads do increase on individual educators, but not to a large extent, as indicated by the majority. This could be interpreted to mean that schools do not have a problem of educators who are continuously absent due to illness. This is a significant finding and seems to confirm earlier findings about respondents' not being aware of educators who are HIV positive or have AIDS. However, the number of respondents who agree that they often have to assign more work to educators as a result of other educators who are continuously absent due to illness, is also significant and could allude to respondents' unease in disclosing this kind of information and consequently their careful responses. This consequential work overload should have implications for school management in terms of effects on educators and learners (cf. 2.4.1; 2.4.2 & 2.4.3).

Question 5.1

This question sought to verify, as a follow-up on the previous question, how often educators are assigned to do more work. Table 4.12 illustrates responses to this question.

Table 4.12 Data on how often educators are assigned more work as a result of continuous illness of other educators

Responses	Frequency	Percentage
Always	14	5.1
Often	23	8.3
Sometimes	61	22.4
Never	7	2.5
N/A	141	51.8
Null response	26	9.9
Total	272	100

Data collected indicate that a significant number of respondents (51.8%) indicated the answer as not applicable, in line with the “no” and “null” responses to the previous question. Just over a fifth of the respondents (22.4%) indicated that additional work was sometimes assigned, 8.3% indicated that this happened often, 2.5% indicated that this never happened, while 9.9% did not respond to the question.

It is clear from this data that respondents do not largely have a burden of assigning more work to other educators as a result of continuously ill educators. This implies that schools generally do not have absenteeism as a result of educators’ continued illness. It is, however, significant that a sizeable number of respondents (22.4%) indicated that this sometimes happened at their schools, which implies that such problems do happen in some schools. At such schools, this situation could be frustrating as school management teams would struggle with operational planning exercises (cf. 2.4.1) due to uncertainty and not knowing when educators would be sick or absent, especially if their HIV/AIDS status are not known. This could also mean that at some schools, sick educators continue to work for fear of being talked about as being infected (2.4.2).

Question 6

The purpose of this question was to find out to what extent educators who have disclosed their HIV/AIDS status are offered moral support by their colleagues. Data in this regard are portrayed in Table 4.13.

Table 4.13 Data on the extent to which educators who have disclosed their HIV/AIDS status are offered moral support by their colleagues

Responses	Frequency	Percentage
Always	15	5.5
Often	5	1.8
Sometimes	6	2.2
Never	4	1.5
N/A	239	87.9
Null response	3	1.1
Total	272	100

It is interesting to find out that few respondents (5.5%) indicated that educators were always supportive towards their sick colleagues, with 1.8% indicating often, 2.2% indicating sometimes and 1.5% indicating never. The majority of respondents (87.9%) indicated this question as not applicable in their cases, which implies that they do not have educators who are HIV positive or have AIDS or are continuously ill due to HIV/AIDS-related illnesses. This is consistent with responses to earlier questions (cf. responses to questions 1, 3, 4 and 5).

Question 7

This question sought to find out if substitutes were always appointed for educators who are often absent. Data in this regard are presented in Table 4.14.

Table 4.14 reveals that very few respondents (9.5%) indicated that there substitutes were always appointed for educators who were regularly absent; with 5.6% indicating that it happened often and 31.6% indicating that this happened sometimes. However, most respondents (40.1%) indicated that substitutes were never appointed for educators who were regularly absent.

Table 4.14 Data on whether substitutes are always appointed for educators who are often absent

Responses	Frequency	Percentage
Always	26	9.5
Often	15	5.6
Sometimes	86	31.6
Never	109	40.1
Null response	36	13.2
Total	272	100

The data seems to suggest that substitutes are generally not appointed for educators who are regularly absent. This could relate to educators who are regularly absent as a result of illness in general and not necessarily due to AIDS-related illnesses. This reasoning is motivated by responses to previous questions which seem to suggest that schools do not have major problems regarding educators whose illnesses are related to HIV/AIDS (cf. questions 1, 3, 4, 5, & 6).

This seems inconsistent with an earlier finding (question 5), where respondents largely indicated not having to assign more work to educators as a result of the continuous illness of other educators. This is indicative of the difficulty emanating from HIV/AIDS-related issues. More precisely, it is indicative of the effects of non-disclosure of HIV/AIDS status by educators, which leads to the reluctance of respondents to divulge information relating to educators who are HIV/AIDS affected. This could be due to fear of

contravening legislative stipulations or fear of stigmatising both affected educators and their schools.

However, these responses indicate a serious management implication in that when substitutes are not appointed for regularly absent educators, workloads of other educators, timetabling and work scheduling would be affected (2.5.1).

The conclusion that can be drawn from these data is that, it would always be difficult for school management teams to plan for school projects due to educators' low morale and motivation, absenteeism and long illnesses that impact negatively on teaching and learning (2.4.1). The impression created is that there is never stability in terms of greater numbers of educators who are not substituted. This implies that contact sessions for learners are sacrificed as a result of long leave periods that are never prepared for or pre-empted as a consequence of non-disclosure by infected as well as affected educators, mainly because school management would not be able to plan for possible absenteeism and possible substitutions.

Question 8

This question endeavoured to find out if educators often had to cope with additional work as a result of educators who are often absent. Data regarding this are portrayed in Table 4.15.

Data from 4.15 show that most respondents (49.0%) indicated that educators had to cope with additional work as a result of other educators who were often absent, while 12.1% and 9.1% indicated that this happened always and often respectively. Taken together, these responses suggest a high incidence of educators having to take on additional work as a result of educators who are often absent.

While this does not specifically refer to absence due to illness, it does suggest a discrepancy with earlier responses about additional workload having to be assigned, as well as with the non-appointment of substitutes for educators who are regularly absent. In both cases responses were largely negative, indicating no major problems.

However, this response indicates that there might be problems regarding educator absenteeism and in the context of the subject of the questionnaire, it may be assumed that there are more problems related to HIV/AIDS than is revealed by responses to the questions in the questionnaire.

Table 4.15 Data on whether educators often have to cope with additional work as a result of other educators who are often absent

Responses	Frequency	Percentage
Always	33	12.1
Often	25	9.1
Sometimes	133	49.0
Never	59	21.7
Null response	22	8.1
Total	272	100

A number of reasons can be attributed to this. The major reason may be related to the HIV/AIDS stigma and fear concerning disclosure of status thereof. Because of perceptions about this disease, it is clear that respondents generally do not have knowledge about the HIV/AIDS status of their educators and schools, hence the inconsistencies in their responses. This is clearly a major cause and effect of non-disclosure of the HIV/AIDS status by educators.

However, a significant number of respondents (21.7%) indicated that educators never had to cope with additional work as a result of other educators who are often absent. This could mean there are no educators who are often absent or when educators are often absent, their work is left undone until they come back. Either way, this spells significant management implications. Low educator morale and motivation can result from, among others, stress and trauma related to having to take on extra work-related duties to cover for their sick colleagues (cf. 2.4.2).

Question 9

This question sought to find out if there were educators who were regularly absent due to illness. These data are depicted in Table 4.16.

Table 4.16 Data on educators who are regularly absent due to illness

Responses	Frequency	Percentage
Always	31	11.4
Often	39	14.3
Sometimes	158	58.1
Never	36	13.2
Null response	8	3.0
Total	272	100

According to data in Table 4.16, 11.4%, 14.3% and 58.1% of the respondents respectively indicated that educators were regularly absent due to illness. These responses collectively indicate 84.8% of respondents citing the prevalence of educator absence due to illness. Of the respondents, only 13.2% indicated that this was never the case, while 3% did not respond to this question. These responses are a clear confirmation of comments on earlier findings about the effects of non-disclosure of HIV/AIDS status by educators (cf. questions 5, 7 and 8). While not specifically indicating illness due to HIV/AIDS, respondents could have felt comfortable in revealing information in this case, since the question does not seem to associate the reason for educator absenteeism directly with HIV/AIDS.

All the same, responses to this question indicate the effect of non-disclosure of the HIV/AIDS status by educators, that is, the difficulty of relating educator absenteeism to HIV/AIDS, as well as the difficulty of talking openly about the disease. The consequence of this is that educators affected by AIDS-related illnesses will be frequently absent and when they are at work, many will find it difficult to be effective classroom educators (2.4.2). This means that no

effective teaching and learning will take place and this will bring about poor results at schools with learners being the ones suffering mostly.

Question 10

The purpose of this question was to find out the reasons mostly cited for educators' absenteeism from school. Data in this regard are portrayed in Table 4.17.

Table 4.17 Data on reasons mostly cited for educators' absence from school

Responses	Frequency	Percentage
Illness of self	165	60.7
Illness of others (family members)	49	18.0
Funerals	24	8.8
Work related	20	7.4
Null response	14	5.1
Total	272	100

It is interesting to find out that data from Table 4.17 indicate that the majority of respondents (61.02%) indicated educators who cited illness of self as a reason for absence from school. Other respondents (18.0%; 8.8% and 7.4%) indicated reasons cited as illness of others, funerals and work-related respectively. Although not specifically referring to HIV/AIDS-related diseases, these responses highlight how serious the incidence of absence from school as a result of illness, is at schools. It can be deduced that HIV/AIDS-related illnesses could be playing a major role in these statistics. This is because HIV/AIDS is not a notifiable disease and, as such, there is no obligation for disclosure of status thereof. This indicates, the effects of non-disclosure of the HIV/AIDS status by educators. Clearly, this massive indication of absenteeism as a result of illness, confirms the need for disclosure of people's HIV/AIDS status.

A careful scrutiny of these responses also suggests inconsistencies noted earlier in principals' responses to the prevalence of HIV/AIDS and its effects at schools. Clearly, there is not adequate information about the status of educators, due to non-disclosure or to the level of stigma attached to HIV/AIDS being so immense that it is not easy to freely talk about its effects at schools.

Question 10

This question sought to find out if the HIV/AIDS pandemic affects the school's teaching and learning processes. Data in this regard are depicted in Table 4.18.

Table 4.18 Data on whether the HIV/AID pandemic affects the school's teaching and learning processes

Responses	Frequency	Percentage
Yes	46	17.0
Unsure	113	41.5
No	105	38.6
Null response	8	2.9
Total	272	100

From data in Table 4.18, it can be seen that the majority of respondents (41.5%) indicated that the school's teaching and learning processes were not affected by the HIV/AIDS pandemic, while 38.6% indicated not being sure if they did. Of the respondents, only 17.0% indicated that the HIV/AIDS pandemic affected the teaching and learning processes.

These responses raise a number of issues. Firstly, it is possible that the scale of the disease is so low that teaching and learning are not affected. This would confirm earlier findings regarding the prevalence of HIV/AIDS-infected educators (cf. questions 1, 3, 4 and 5). Secondly, it is possible that due to the nature of the HIV/AIDS disease and the issues attached to it (cf. 2.3),

principals do not have ways of dealing with its effects and thus are unable to assess whether it affects the teaching and learning processes or not. It is only when there is a management strategy for mitigating its causes and effects that principals can be able to conduct assessment exercises that will yield information for them to act on (2.5).

Question 12

This question intended to find out as a follow up on the previous one, the extent to which the HIV/AIDS pandemic has affected teaching and learning processes question.

From Table 4.19, it can be seen that respondents differ slightly in their responses, as data reflect that 6.3% of respondents indicated that teaching and learning processes were affected, 4.0% indicated often affected and 6.6% indicated sometimes affected. The majority of the respondents (80.1%) indicated that the pandemic never affected teaching and learning processes.

Table 4.19 Data on the extent to which the HIV/AIDS pandemic affects the school teaching and learning processes

Responses	Frequency	Percentage
Always	17	6.3
Often	11	4.0
Sometimes	18	6.6
Never	218	80.1
Null response	8	3.0
Total	272	100

These responses confirm findings on the previous question and seem to evoke the same issues raised above. Clearly, without disclosure of their HIV/AIDS status, it would be impossible for school principals to assess the extent to which it affects the school's teaching and learning processes. It

could also be that educators in general have become used to current conditions at schools to the extent of not realizing anything wrong.

Question 13

The purpose of this question was to find out if respondents find themselves having to attend to the needs of learners who are affected and infected with HIV/AIDS.

According to Table 4.20, an equal number of respondents (34.6%) indicated sometimes or never having to attend to learners affected and infected with HIV/AIDS. A significant number (15.4%) indicated that they always had to, while 8% indicated often having to. These responses indicate that the knowledge of infected and affected learners is very low. This could be because of the non-disclosure of the HIV/AIDS status. It is understandable that this would be so in light of the fact that learners do not have role models of disclosure, since educators themselves do not disclose their status. Clearly, teaching and learning processes would be affected as well, especially since infected and affected learners would suffer from all types of HIV/AIDS-related traumas in silence (cf. 2.4.3).

Table 4.20 Data on having to attend to the needs of learners affected and infected with HIV/AIDS

Responses	Frequency	Percentage
Yes	42	15.4
Probably	22	8.0
Unsure	94	34.6
No	94	34.6
Null response	20	7.4
Total	272	100

Question 14

Questions 14.1 to 14.6 sought to find out if there were learners who performed poorly as a result of the effects of HIV/AIDS. Data in this regard are portrayed in Tables 4.21 to 4.26.

Table 4.21 indicates responses to whether there are learners who perform poorly due to being HIV/AIDS-infected and affected.

From Table 4.21, it can be seen that most respondents (44.1%) were unsure, just over a fifth (22.8%) responded affirmatively, while 16.2 indicated that it was probable that there were learners who performed poorly due to being infected and affected by HIV/AIDS.

Table 4.21 Data on learners who perform poorly due to being infected and affected by HIV/AIDS

Responses	Frequency	Percentage
Yes	62	22.8
Probably	44	16.2
Unsure	120	44.1
No	39	14.3
Null response	7	2.6
Total	272	100

Table 4.22 indicates data for learners who perform poorly due to being frequently absent. From this Table, it can be seen that most respondents (46.7%) agreed, less than a fifth (15.4%) indicated that it was probable, 24.6% indicated that they were unsure, and just less than a tenth (9.6%) indicated "no" to the question.

Table 4.22 Data on learners who perform poorly due to being frequently absent

Responses	Frequency	Percentage
Yes	127	46.7
Probably	42	15.4
Unsure	67	24.6
No	26	9.6
Null response	10	3.7
Total	272	100

Table 4.23 indicates data on learners who perform poorly due to being orphaned. From these data, it can be seen that many respondents (47.4%) agreed that there are learners who perform poorly due to being orphans, with 18.9% indicating that it was probable, and 22.4% being unsure, while, 6.9% responded negatively to the question.

Table 4.23 Data on learners who perform poorly due to being orphaned

Responses	Frequency	Percentage
Yes	129	47.4
Probably	51	18.9
Unsure	61	22.4
No	19	6.9
Null response	12	4.4
Total	272	100

Table 4.24 depicts data on learners who perform poorly due to having to take care of siblings because parents had died. Data from Table 4.24 reveal that 34.6% of respondents confirmed that there were learners taking care of siblings because parents had died, with 15.8% indicating it was probable that there were such cases, 29.4% being unsure and 16.5% indicating “no”.

Table 4.24 Data on learners who perform poorly due to having to take care of siblings because parents have died

Responses	Frequency	Percentage
Yes	94	34.6
Probably	43	15.8
Unsure	80	29.4
No	45	16.5
Null response	10	3.7
Total	272	100

Table 4.25 illustrates data on learners who perform poorly due to suffering from malnutrition. Data provided in Table 4.25 indicate that 37.9% of respondents agreed that there were learners who performed poorly due to suffering from malnutrition, 29.9% indicated that it was probable, 26.1% indicated being unsure, while 12.5% certainly disagreed.

Table 4.25 Data on learners who perform poorly due to suffering from malnutrition

Responses	Frequency	Percentage
Yes	103	37.9
Probably	57	20.9
Unsure	71	26.1
No	34	12.5
Null response	7	2.6
Total	272	100

Table 4.26 indicates data on learners who perform poorly due to being ill frequently. Table 4.26 indicates that 38.9% of respondents acknowledged that there were learners who performed poorly due to being ill frequently, 21.7% indicated that it was probable, 24.3% were unsure and 12.1% disagreed.

Table 4.26 Data on learners who perform poorly due to being ill frequently

Responses	Frequency	Percentage
Yes	106	38.9
Probably	59	21.7
Unsure	66	24.3
No	33	12.1
Null response	8	3.0
Total	272	100

Data collected from this battery of questions about learners' poor performance because of various effects of HIV/AIDS indicate that there are indeed learners who are affected by these effects. Although not directly stating that these learners were infected and affected, it can be inferred from the data, that HIV/AIDS does have a measure of effect on learners. This, however, contrasts with an earlier finding that respondents did not find that they had to attend to the needs of learners who are affected and infected with HIV/AIDS. This could be due to the effects of non-disclosure and could be indicative of the fact that while attending to various needs of learners, it is not known that these are a result of being infected and affected by HIV/AIDS.

4.4 IMPLICATIONS FOR SCHOOL MANAGEMENT IN MITIGATING THE CAUSES AND EFFECTS OF NON-DISCLOSURE OF THE HIV/AIDS STATUS BY EDUCATORS

Management implications in mitigating the causes and effects of non-disclosure of the HIV/AIDS status by educators involve such measures as the content of life skills programmes, aligning school programmes with the National Policy on HIV/AIDS, including prevention, awareness, care and support of people infected and affected by HIV/AIDS, school policies, reduction of vulnerability and risk, human rights, a management strategy for mitigating causes and effects of HIV/AIDS (cf. 2.5.1, 2.5.2 & 2.5.3).

Question 15

The purpose of this question was to find out if life skills programmes sensitised learners against immature sex indulgence. Table 4.27 reveals that more than half of the respondents (51.8%) agreed that life skill programmes sensitised learners against immature sex indulgence, 12.5% indicated that it was probable, 18.8% were unsure, with 11.4% disagreeing. Clearly from this data, life skill programmes do address learners' needs for knowledge regarding immature sexual indulgence. It is however, worrisome that 18.8% of the respondents indicated being unsure of this and 11.4% indicated that life skills programmes did not address this. The last group could be respondent principal who are not attached to actual classroom teaching and learning activities and are thus ignorant of what the school curricula actually contain.

Table 4.27 Data on whether life skills programmes sensitise learners against immature sex indulgence

Responses	Frequency	Percentage
Yes	141	51.8
Probably	34	12.5
Unsure	51	18.8
No	31	11.4
Null response	15	5.5
Total	272	100

Question 16

Question fifteen intended to inquire whether staff members know the National Policy on HIV/AIDS. Table 4.28 portrays data in this regard.

Table 4.28 Data on whether staff members know the National Policy on HIV/AIDS

Responses	Frequency	Percentage
Yes	143	52.6
Probably	45	16.5
Unsure	64	23.5
No	17	6.3
Null response	3	1.1
Total	272	100

Data in Table 4.28 show that the majority of respondents (52.6%) acknowledged that staff members knew the National Policy on HIV/AIDS, with 16.5% indicating that it was probable that staff members knew the policy, 23.5% being unsure, while 6.3% disagreed. The indication is that most educators are conversant with the contents of the National Policy on HIV/AIDS, which can be utilised as a starting point at schools for laying the foundation to encourage disclosure of HIV/AIDS status (cf. 2.5.1). However, it is disconcerting to note such responses as “probably”, “unsure” and “no”, especially in the face of the devastation this pandemic causes in society.

Question 17

This question intended finding out if schools had established Health Advisory Committees as prescribed by the National Education Policy Act on HIV/AIDS. Data in this regard are shown in Table 4.29.

Table 4.29 Data on whether school have established Health Advisory Committees

Responses	Frequency	Percentage
Yes	100	36.8
Probably	18	6.6
Unsure	30	11.0
No	112	41.2
Null response	12	4.4
Total	272	100

From data in Table 4.29 it can be seen that most respondents (36.8%) confirmed having established HACs at their schools, with 6.6% indicating that it was probable, 11.0% being unsure and the majority (41.1%) indicating there were no such committees at their schools. These data show clearly that the provisions of the Nation Education Policy Act on HIV/AIDS are not implemented at most schools (cf. 2.5.1). It is also worrying that respondent principals gave such responses as “probably” and “unsure” – implying that they do not know what is happening at their schools or leave such functions to others without monitoring them. Most disconcerting is the “no” response from the majority of respondents.

Question 18

This question purported to find out if there were HIV/AIDS awareness programmes at the schools. Table 4.30 depicts data in this regard.

Table 4.30 Data on whether there are HIV/AIDS awareness programmes at schools

Responses	Frequency	Percentage
Yes	200	73.5
Probably	21	7.7
Unsure	21	7.7
No	26	9.6
Null response	4	1.5
Total	272	100

Interesting enough, data in Table 4.30 reveal that almost three quarters of the respondents (73.5%) indicated having HIV/AIDS awareness programmes at their schools, with 7.7% indicating probably, 7.7% indicating being unsure and 9.6% indicating no.

The indication is that the majority of schools have HIV/AIDS awareness programmes, which means that school communities are conscientised around HIV/AIDS. However, a significant number of respondents indicated “probably”, “unsure” and “no”, which is a cause for concern. It is even more worrisome when it is considered that school principals responded this way. However, the fact that they indicate this candidly is a positive sign for future attempts to address HIV/AIDS-related problems.

Question 19

The set of questions from 19.1 to 19.3 sought to find out if there were programmes that address prevention of the spread of HIV/AIDS, awareness of how HIV/AIDS is spread, and care and support for learners and educators who are infected and affected by HIV/AIDS.

Table 4.31 indicates responses regarding programmes that address prevention of the spread of HIV/AIDS. Data in Table 4.31 reflects great numbers of respondents (68.4%) confirming the presence of programmes that

address prevention of the spread of HIV/AIDS. However, 6.9% indicated that it was probable, 8.8% were unsure and 13.2% indicated that there were no such programmes. The latter responses project a disturbing situation at schools. It could be that respondent principals do not see these programmes as being important and thus delegate them without following up to ensure that they are implemented.

Table 4.31 Data on programmes to address prevention of the spread of HIV/AIDS

Responses	Frequency	Percentage
Yes	186	68.4
Probably	19	7.0
Unsure	24	8.8
No	36	13.2
Null response	7	2.6
Total	272	100

Data in Table 4.32 reveal that about three quarters of respondents (74.3%) agree that there are programmes that address awareness of how HIV/AIDS is spread, 8.8% indicated that this was probable, 7.4% indicated being unsure and 7.7% indicated no. This implies that more educators and learners are by now acquainted with HIV/AIDS programmes that address awareness of how HIV/AIDS is spread.

According to the data collected, most schools have programmes in place to this effect (cf. 2.5.2). However, considering all the data collected, it is clear that not all schools have such programmes, which means that there are still school communities faced with high risks of HIV/AIDS.

Table 4.32 Data on programmes that address awareness of how HIV/AIDS is spread

Responses	Frequency	Percentage
Yes	202	74.3
Probably	24	8.8
Unsure	20	7.4
No	21	7.7
Null response	5	1.8
Total	272	100

Table 4.33 shows that 40.8% confirmed that there were programmes for care and support of people infected and affected at school level, (11.8%) indicated that this was probable, 22.4% were unsure and 21.7% disagreed.

Table 4.33 Data on programmes that address care and support for learners and educators who are infected and affected by HIV/AIDS

Responses	Frequency	Percentage
Yes	111	40.8
Probably	32	11.8
Unsure	61	22.4
No	59	21.7
Null response	9	3.3
Total	272	100

Question 20

This question sought to inquire how regular HIV/AIDS awareness advocacy campaigns were held at school.

Data from Table 4.34 reveals that only 8.1% of respondents indicated that programmes are always held regularly, 32.4% indicated they were held

sometimes, 45.6% indicated that they were held once a year and 10.6% indicated that they were never held. It does seem that schools seem to take HIV/AIDS awareness advocacy campaigns as a priority, albeit not at a regular rate. The majority of respondents indicated once a year, which could relate to annual programmes sponsored by the department.

This is a worrying situation in that schools stand a better chance to mitigate the effects of HIV/AIDS in communities. Regularly held awareness campaigns would be a sure way to ensure that the message of awareness and prevention of the HIV/AIDS pandemic is driven home. School principals should be the key drivers of these campaigns, especially since management implications reside in their functional domains.

Table 4.34 Data on how regularly HIV/AIDS awareness advocacy campaigns are held

Responses	Frequency	Percentage
Always	22	8.1
Sometimes	88	32.4
Once a year	124	45.6
Never	29	10.6
Null response	9	3.3
Total	272	100

Question 21

This question intended to find out if there were school policies on HIV/AIDS. Table 4.35 depicts data in this regard.

The majority of respondents (69.9%) indicated that schools had policies on HIV/AIDS. Only 6.2% of the respondents indicated that this was probable, 13.6% indicated being unsure, while 8.1% indicated that there were no policies. This data indicate that schools, though having school policies, do not

implement them. This reasoning is prompted by earlier findings regarding, for instance, awareness programmes (cf. question 18). It is possible that school policies were drafted as a requirement from the department and as such did not enjoy the involvement of stakeholders in their drafting.

Table 4.35 Data on whether there were school policies on HIV/AIDS

Responses	Frequency	Percentage
Yes	190	69.9
Probably	17	6.2
Unsure	37	13.6
No	22	8.1
Null response	6	2.2
Total	272	100

Question 22

The purpose of this question was to find out if there were programmes that ensured the reduction of vulnerability and risk, like abstinence, use of condoms and having one partner. Table 4.36 depicts data in this regard.

Table 4.36 Data on programmes that ensure the reduction of vulnerability and risk reduction

Responses	Frequency	Percentage
Yes	111	40.8
Unsure	79	29.0
No	66	24.3
Null response	16	5.9
Total	272	100

From data in Table 4.36, 40.8% of the respondents agreed that there were such programmes, while 29.0% were unsure, with 24.3% indicating that there

were no such programmes and 5.9% of respondents did not respond. The implication of these findings is that the majority of respondents need good quality prevention programmes as they result in the adoption of positive behaviours (cf. 2.5.2). It is, however, clear that for the majority of schools, there are no programmes in place for the reduction of vulnerability and risk, which is a serious cause for concern.

Question 23

This question sought to inquire if schools promoted the culture of human rights. The data pertaining to this question are presented in Table 4.37.

Data from Table 4.37 shows that the majority of respondents (73.2%) indicated that their schools promoted the culture of human rights, while 9.6% indicated that this was probable, 10.3% indicated being unsure and 5.5% indicated that their school did not. These responses are positive in promoting school cultures that seek to promote human rights, among other things, respect for the dignity of others. It is this kind of school culture that encourages disclosure of people's HIV/AIDS status. However, it is a worrisome fact that responses such as probably, unsure, no and even null responses were proffered.

Table 4.37 Data on the whether schools promote the culture of human rights

Responses	Frequency	Percentage
Yes	199	73.2
Probably	26	9.6
Unsure	28	10.3
No	15	5.5
Null response	4	1.4
Total	272	100

Question 24

This question aimed at finding out if the school curriculum included HIV/AIDS education. Data in this regard are portrayed in Table 4.38.

According to Table 4.38, the majority of respondents (65.1%) agreed that the school curriculum included HIV/AIDS education, 10.7% indicated that it was probable and 10.7% were not sure, while 11% indicated that the curriculum did not. Clearly, the majority of respondents agreed that the curriculum does address HIV/AIDS issues, which indicates that most schools have managed to integrate life-skills programmes in the curriculum (cf. 2.5), as prescribed by The National Education Policy Act on HIV/AIDS (cf. 2.5.1). However, it is disturbing that some respondents indicated that this was probable or they were not sure. This gives the impression that they are not aware of what their school curricula contained in regard to HIV/AIDS. This is strange since these are principals, who should be instructional leaders in their schools. It might be that they are not involved in actual classroom teaching and learning processes.

Table 4.38 Data on whether the school curriculum includes HIV/AIDS education

Responses	Frequency	Percentage
Yes	177	65.1
Probably	29	10.7
Unsure	29	10.7
No	30	11.0
Null response	7	2.5
Total	272	100

Question 25

The purpose of this question was to find out if there was a management strategy for mitigating causes and effects of HIV/AIDS. Data in this regard are depicted in Table 4.39.

Table 4.39 shows that a relatively small number of respondents (29.8%) affirmed having a management strategy for mitigating causes and effects of HIV/AIDS in their schools, with 13.2% indicating that this was probable, with 27.6% being unsure and 25.4% responding in the negative.

The responses to this question perhaps address the inconsistencies found in earlier findings. That is, lack of management strategies at schools to mitigate the causes and effects of non-disclosure of HIV/AIDS status by people in general, and in this case, educators, is probably the main reason why issues around HIV/AIDS are not dealt with openly and confidently. There are no measures to direct activities at schools around HIV/AIDS. That is perhaps the reason why some responses suggest lack of knowledge about the disease or discomfort in divulging data pertaining to it.

This implies that there is a need for school management to work towards the standards set by the school visions (cf. 2.5) in trying to deal effectively with the effects of HIV/AIDS and ensuring that management strategies for mitigating the causes and effects of HIV/AIDS are implemented.

Table 4.39 Data on whether there is a management strategy for mitigating causes and effects of HIV/AIDS

Responses	Frequency	Percentage
Yes	81	29.8
Probably	36	13.2
Unsure	75	27.6
No	69	25.4
Null response	11	4.0
Total	272	100

Question 26

The purpose of this question was to find out if the school management strategy encourages disclosure of HIV/AIDS status by educators. Data in this regard are depicted in Table 4.40.

Table 4.40 indicates that the level of disclosure at schools is very low and as a result, only 26.1% of the respondents agreed that the management strategy encouraged educators to disclose their status; the majority (38.9%) responded negatively to the questions, 9.6% and 23.9% indicated respectively that it was probable and that they were unsure. These responses confirm that there are no management strategies as found in the previous question.

Table 4.40 Data on whether the school management strategy encourages disclosure of HIV/AIDS status by educators

Responses	Frequency	Percentage
Yes	71	26.1
Probably	26	9.6
Unsure	65	23.9
No	106	38.9
Null response	4	1.5
Total	272	100

Question 27

This question intended to find out whether the effects of HIV/AIDS are assessed at school. Data in this regard are presented in Table 4.41.

Table 4.41 Data on whether the effects of HIV/AIDS are assessed

Responses	Frequency	Percentage
Yes	35	12.9
Probably	30	11.0
Unsure	72	26.5
No	129	47.4
Null response	6	2.2
Total	272	100

Information in Table 4.41 reflects a relatively small number of respondents (12.9%) who confirmed that the effects of HIV/AIDS were assessed at their schools, with 11% indicating that they probably were, 26.5% being unsure and 47.4% indicating that they were not assessed. Table 4.42 indicate follow-up data regarding how many time a year the effects of HIV/AIDS were assessed.

Table 4.42 Data on how many times the effects of HIV/AIDS are assessed

Responses	Frequency	Percentage
Once	26	9.6
Twice	18	6.6
Every month	13	4.8
Never	57	20.9
Null response	158	58.1
Total	272	100

From Table 4.42 it can be seen that the majority of respondents (58.1% & 20.9%) did not respond and respectively indicated that the effects of HIV/AIDS were never assessed. Only 9.6%, 6.6% and 4.8% of the respondents indicated that the effects of HIV/AIDS were assessed once, twice and every month respectively.

These responses suggest that there are many schools that do not engage in assessing the effects of HIV/AIDS. The reason could be that they find it difficult to conduct assessments due to the fact that they may not know what to do, whom to consult or which instrument to use in order to quantify and understand the results of assessment, especially because of the silence about HIV/AIDS status.

Question 29

This question aimed to find out if there were AIDS awareness programmes that involved parents and the community. Data in this regard are presented in Table 4.43.

Table 4.43 shows that 35.3% of the respondents indicated having AIDS awareness programmes that involved parents and the community, 9.9% indicated that it was probable that these were there, 17.3% were unsure and 36.4% indicated that there were no such programmes.

Table 4.43 Data on whether there were AIDS awareness programmes that involve parents and the community

Responses	Frequency	Percentage
Yes	96	35.3
Probably	27	9.9
Unsure	47	17.3
No	99	36.4
Null response	3	1.1
Total	272	100

The respondents who responded to this question with “unsure” and “no” make up about half of the responses (17.3% & 36.4%), which implies that many schools do not involve parents or extend awareness activities to school communities. The most worrisome issue relates to responses that denote “probably”. These responses seem to suggest that respondents do not know what is going on and do not considers issues under scrutiny as being of

priority. This indicates the importance of concerted efforts in the fight against the causes and effects of HIV/AIDS.

Question 30

The purpose of this question was to find out if funds allocated for HIV/AIDS activities were properly utilised. Data in this regard are depicted in Table 4.44.

Table 4.44 Data on whether funds allocated for HIV/AIDS activities are properly used

Responses	Frequency	Percentage
Yes	135	49.6
Unsure	78	28.7
No	54	19.9
Null response	5	1.8
Total	272	100

Almost half the respondents (49.6%) indicated that funds allocated for HIV/AIDS activities were properly utilised. Almost a fifth of the respondents (19.9%) indicated that funds for this purpose were not properly used, while 28.7% were unsure. These responses indicate that there are funds allocated for HIV/AIDS activities. It is also clear that some respondents do not know how these funds are utilised or whether they are properly utilised. In the light of the seriousness of the HIV/AIDS disease, this is disturbing and is indicative of poor strategies for mitigating causes and effects of HIV/AIDS.

This implies a need for school communities to be fully involved in HIV/AIDS activities so as to ensure that there is full participation and support of all stakeholders, thus creating a friendly atmosphere to encourage disclosure.

4.5 SUMMARY

This chapter presented the empirical research findings and gave an analysis and interpretation thereof. Data collected from investigations revealed

shortcomings regarding the disclosure of HIV/AIDS by educators infected and affected by the disease. The next chapter presents the summary, findings and recommendations pertaining to the study.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the summary of this study. The summary focuses on aspects highlighted in the study in terms of research findings regarding aims stated in chapter 1, namely findings with regard to the literature study on the causes and effects of non-disclosure of HIV/AIDS status (chapter 2) and the actual causes and effects of educators' non-disclosure of their HIV/AIDS status and the implications for school management (chapter 4). Finally recommendations based on the research findings will be presented.

5.2 SUMMARY

Chapter 1 outlined the rationale of this study. The study focused on the causes and effects of educators' non-disclosure of their HIV/AIDS status and the management implications in the mitigation thereof. HIV/AIDS affects school communities in many ways, as is evident in the reported infection rates among educators (1.2). The entire education system is faced with on-going major challenges of supporting both infected and affected individuals, to deal with regular absenteeism, low morale and productivity due to illnesses related to HIV/AIDS, particularly at school level.

Chapter 2 outlines the causes and effects of non-disclosure of the HIV/AIDS by educators. The HIV/AIDS pandemic affects school communities through its effects on the lives of people infected and affected by the disease. These effects affect the performance of individuals and that of the school in its attempt to deliver effective education. The main barrier to effective school management is the non-disclosure of HIV/AIDS status by people affected and infected (2.1).

Various reasons are cited as main causes of non-disclosure of the HIV/AIDS status. Among other things, these relate to denial, (2.3.1), lay and culturally

determined beliefs (2.3.2), religion (2.3.3), fear of stigmatization (2.3.4) and fear of discrimination (2.4.5).

Implications for school management in mitigating the causes and effects of non-disclosure of the HIV/AIDS status by educators highlighted the importance of legislation (2.5). In mitigating the causes and effects of non-disclosure of HIV/AIDS status, legislation such as the National Education Policy Act, the South African Schools Act and the Employment Equity Act were highlighted (2.5.1).

Measures for school management to mitigate the causes and effects of non-disclosure of HIV/AIDS status involve prevention of the HIV infection, reducing the risks of infection and reducing vulnerability to infection (2.5.2)

In mitigating the causes and effects of non-disclosure of HIV/ADS status, school management needs to establish a strategy that determines where the school is with regard to disclosure, where it wants to be and how it will get there (2.5.3). It is important to note that this is a comprehensive strategy that involves stakeholders and seeks to ensure that measures taken to mitigate the causes and effects of non-disclosure take into consideration all relevant legislation, especially the implementation stage of the strategy.

Chapter 3 presented the study's research design. The research method presented the empirical study and outlined the research instrument and its construction, population and sampling procedures, response rates and the procedures followed in administering the research instrument.

Chapter 4 presented data analysis and interpretation. This was done by analyzing responses to each question, using frequency counts and percentages as presented through tables.

5.3 FINDINGS FROM RESEARCH

5.3.1 Findings on research aim 1: The causes and effects of the non-disclosure of the HIV/AIDS status by educators

The following findings were made with regard to the causes of non-disclosure of the HIV/AIDS status by educators:

- Denial, which is manifested as a coping style through the use of distractions, blocking techniques and non-acceptance of the HIV status' diagnosis and its consequences (2.3.1);
- Lay and culturally determined beliefs, which involve how people interpret messages and information about HIV/AIDS and how it is transmitted. Beliefs in this regard include interpreting the disease in terms of cultural taboos, obligations and sorcery. These include encouraging more than one sexual partner, polygamy and use of traditional medicines. Some beliefs propound the divination of the causes of HIV/AIDS, which promote such beliefs as HIV/AIDS being caused by witches, sorcerers, ancestors and non-mystical factors (2.3.2);
- Religion, which in most instances, subscribes the spread of the HIV/AIDS disease to God's anger and punishment and thus blames victims for their own illness. Religion also subscribes the causes of HIV/AIDS to promiscuity and thus increases the stigma attached to the disease (2.3.3);
- Fear of stigmatization, which comes as a result of associations of the disease with negative lifestyles like promiscuity, homosexuality and is manifested in social isolation and ridicule, negative judgements, blame levelled at people living with HIV/AIDS and even attacks and murder of people who disclose their HIV status (2.3.4);
- Fear of discrimination, which occurs in the workplace because of the unequal power between employer and employee and manifests in terms of employment preferences and work allocation, as well as discrimination as a result of sexual preferences, e.g. discrimination against gay people or

sex workers. At schools, though not overt, most teaching staff is concerned about working with HIV-infected people and, as a result, many infected and ill educators continue to work for fear of being talked about as infected.

The following findings were made with regard to the effects of non-disclosure of the HIV/AIDS status by educators:

- The effects of HIV/AIDS and the consequent non-disclosure of the status thereof are manifested in effects on the school system, educators and learners and the following manifestations were found (2.4.1, 2.4.2 & 2.4.3):
 - Educator absenteeism and eventual deaths disrupting the provision of education;
 - Educator absenteeism due to the need to care for relatives and to attend funerals of dead relatives, colleagues and people close to them;
 - Low educator morale and motivation as a result of, *inter alia*, trauma of dealing with the loss of colleagues and learners and increased workloads as a result of absenteeism, illness and weakness of their colleagues;
 - Learner enrolments declining as learners drop out to care for their sick parents, siblings and relatives;
 - Increase in orphans and an increase in child-headed families;
 - Traumatized learners as a result of being affected or infected;
 - Shortage of resources as a result of reduced enrolments and effects on school fees; and
 - The need for continuous redeployment of staff to temporary vacancies created by absenteeism and illness of colleagues.

Implications for school management in mitigating the causes and effects of non-disclosure of the HIV/AIDS status by educators were found to necessitate a school management strategy to deal with the HIV/AIDS pandemic at schools (2.5). The following findings were pertinent to this:

- the following legislation exists to address policies on HIV/AIDS at schools (2.5.1);
 - *The National Education Policy Act No. 27 of 1996*, which deals with non-discrimination and equality, HIV/AIDS testing, admission of learners and appointment of educators, disclosure of HIV/AIDS-related information and confidentiality, a safe school environment, education on HIV/AIDS, duties and responsibilities of educators and learners, refusal to study and work with people with HIV/AIDS and establishment of Health Advisory Committees;
 - *The South African Schools Act No. 84 of 1996*, which provides for safe school environments and the abidance by all the laws and regulations pertaining to fair and non-discriminatory practices towards people with HIV/AIDS, including learners and educators;
 - *The Employment Equity Act No. 55 of 1998*, which stipulates that there should be no unfair discriminatory practices against employees on the basis of their HIV status, and prohibits medical testing of employees to determine their HIV status.

Measures to mitigate the causes of non-disclosure of the HIV/AIDS status revealed the following as necessary at schools (2.5.2):

- Prevention of HIV infection, which necessitates developing policies addressing HIV/AIDS education, providing HIV/AIDS-related knowledge and skills to all people, especially those at risk, linking with relevant health services and supporting activities that reduce overall vulnerability to HIV/AIDS;

- Reducing the risk of infection, which emphasises good quality prevention education programmes that will result in the adoption of positive behaviours;
- Reducing vulnerability to infection, which includes such issues as addressing poverty, lack of good schooling, gender roles and expectations, violence and conflict and inadequate health and social services; and
- A management strategy for mitigating the causes and effects of non-disclosure of the HIV/AIDS status by educators implying a school strategy for dealing with HIV/AIDS and its causes and effects at schools. This strategy addresses where the school is, where it wants to be and how it gets there. This entails a comprehensive school situational analysis, planning to address the causes and effects of non-disclosure (including using available legislation) and implementing the strategy (2.5.3.2).

5.3.2 Findings on the research aim 2: the empirical investigation

5.3.2.1 Findings on the causes and effects of educators' non-disclosure of their HIV/AIDS status

The analysis of findings regarding causes and effects of non-disclosure of the HIV/AIDS status by educators revealed that, largely, the rate of disclosure by educators is very low (4.3), although data regarding this was found to yield inconsistencies. This was understood as resulting from the nature of HIV/AIDS and perceptions thereof as highlighted in the literature study. The following findings were made:

- Principal largely do not know the HIV/AIDS status of educators at schools, which implies a high level of non-disclosure.
- Disclosure of the HIV/AIDS status, though very low, is done mainly through educators' own willingness and is done confidentially.

- Principals mostly do not know the causes of death or resignations of educators. Only a small percentage knows about educators who died due to illnesses related to HIV/AIDS.
- Most principals do not know how educators disclose their HIV status.
- Principals reportedly do not find that they have to assign more work to other educators as a result of educators who are continuously ill.
- It is not possible to ascertain whether HIV/AIDS affected and infected educators are supported by their colleagues. This is possibly due to fear of disclosure by affected and infected educators.
- Substitutes are not mostly not appointed for educators who are regularly absent because of illness.
- Educators often have to cope with additional work as a result of educators who are often absent.
- There seems to be a high incidence of educators who are regularly absent due to their own illness. This does not specifically relate to illness due to HIV/AIDS or even HIV/AIDS-related diseases.
- The HIV/AIDS pandemic does not seem to affect schools' teaching and learning processes.
- Principals do not find that they have to attend to the needs of HIV/AIDS affected and infected learners.
- There seems to be incidences of learners who perform poorly due to being frequently absent from school, being orphaned, having to take care of siblings because parents have died, suffering from malnutrition and being frequently ill.

These findings highlight a number of issues, *inter alia*:

- HIV/AIDS is still regarded as a taboo subject.

- Disclosure of HIV status is very low.
- Data collected through questionnaires, despite assurances of anonymity, does not reveal the actual situation at schools. There seems to be a reluctance to divulge information as seen in the numerous inconsistencies in data provided (4.7).

5.3.2.2 Findings on the implications for school management in mitigating the causes and effects of non-disclosure of HIV/AIDS status

The analysis of findings regarding the implications for school management in mitigating the causes and effects of educators' non-disclosure of their HIV/AIDS status revealed the following:

- Life skills programmes sensitise against negative behaviours.
- There is generally knowledge in schools about the National Policy on HIV/AIDS.
- Schools have largely not established Health Advisory Committees as required by the National Education Policy Act.
- There are HIV/AIDS awareness programmes at schools.
- There are programmes that address how HIV/AIDS is spread and the prevention of the spread of HIV/AIDS.
- There are programmes that address care and support for learners and educators infected and affected by HIV/AIDS.
- HIV/AIDS awareness advocacy campaigns are not held regularly – they are held at least once a year.
- Schools seem to have policies on HIV/AIDS.
- There seems to be programmes that ensure the reduction of vulnerability and risk of HIV infection.
- The culture of human rights is promoted at schools.

- School curricula largely include HIV/AIDS education.
- There largely seems to be no school management strategies for mitigating the causes and effects of HIV/AIDS and where they are available, they do not seem to encourage disclosure of the HIV/AIDS status by educators.
- The effects of HIV/AIDS are not assessed at schools.
- HIV/AIDS awareness programmes do not involve parents and the community.
- Funds allocated for HIV/AIDS activities are usually utilised properly.

Due to the numerous inconsistencies found from the data collected, it is necessary to provide a brief discussion of the findings of this study.

5.4 DISCUSSION OF FINDINGS

The findings of this study create an impression that there are very few educators in schools who are HIV/AIDS infected and affected. However, the significant number of respondents who responded negatively, were unsure or who indicated “probable” in response to questions attest to the sensitivity and silence regarding disclosure of the HIV/AIDS status by educators. This could be because AIDS is not a notifiable disease, as well as the stigma attached to it. This is, consequently, a cause for the low rate of disclosure of educators’ disclosure of their HIV/AIDS status.

Despite these findings, it is clear that HIV/AIDS programmes are undertaken *ad hoc* and possibly as a requirement from the department of education. The fact that there seem to be policies on HIV/AIDS at schools, yet there are no management strategies outlining and defining said strategies, attests to this. This also leaves to question the authenticity and honesty with which some responses can be considered.

It is, however, clear that there is awareness regarding the effects of HIV/AIDS and this reflects societal awareness at large. However, it is also clear that schools do not have formalised programmes for dealing with the causes and

effects of educators' non-disclosure of their HIV/AIDS status, and consequently the whole school community.

5.5 RECOMMENDATIONS

School can encourage educators to disclose their HIV/AIDS status by creating conditions that are enabling, supportive and sensitive to the causes and effects of non-disclosure of HIV/AIDS status by people in general. The following recommendations are made in light of the literature and the empirical studies:

5.5.1 Recommendation 1

A concerted effort involving the department of education in partnership with the department of health and the department of social welfare needs to be advocated to ensure the implementation of the provisions of the National Education Policy Act on HIV/AIDS.

Motivation

Schools on their own do not seem to succeed in implementing the provisions of the Act. Furthermore, it seems as if when they do, they do this as a requirement from the Department of Education.

5.5.2 Recommendation 2

It is necessary to establish partnerships between schools and concerns like non-governmental organisations whose experience in working with people infected and affected by HIV/AIDS is immense and can be valuable.

Motivation

Principals and educators are not trained to deal with sensitive issues of the nature of HIV/AIDS. Partnerships with such concerns can add value to the attempts of principals and educators in destigmatising the HIV/AIDS disease and mitigating the causes and effects of non-disclosure.

5.5.3 Recommendation 3

School level HIV/AIDS awareness programmes need to be co-ordinated and planned meticulously. Schools can form cluster programmes or district programmes coordinated at a regular basis.

Motivation

School clustering and coordination can pool both intellectual and financial resources and avoid unnecessary duplication of programmes, especially since many schools are within cluster-possible radii.

5.5.4 Recommendation 4

Schools need to establish Health Advisory Committees as a matter of priority and begin initiatives to establish these committee through the assistance of education district office personnel in charge of, inter alia, employee assistance programmes.

Motivation

There are presently no Health Advisory Committees at most schools and departmental officials in charge of these programmes and functions have to be seen to be doing their jobs of assisting schools in facilitating such programmes.

5.5.5 Recommendation 5

Disclosure of HIV/AIDS status needs to be encouraged in all sectors of society and role models in that regard need to be established.

Motivation

It is only when there are country-wide and vigorous campaigns to encourage disclosure that the message will get home to people. This can be promoted through the assistance of celebrities, especially those who are infected and affected by HIV/AIDS. This will also assist in demystifying the HIV/AIDS

disease and dispel the various myths surrounding the causes and effects disclosure of the disease.

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The following could be areas for further research:

- The roles of School Governing Bodies in the implementation of the management strategy for HIV/AIDS at schools.
- The role of the district education officials in the mitigation of causes and effects of HIV/AIDS in schools.

5.7 LIMITATIONS OF THE STUDY

This study was limited by the following:

- The sensitive nature of the HIV/AIDS disease made it difficult to get full disclosure of information about the conditions relating to the causes and effects of non-disclosure of the HIV/AIDS status by educators.
- Poor knowledge about the provisions of the National Education Policy on HIV/AIDS is suspected to have inhibited authentic information from respondents. As a result, it is suspected that most responses could have been motivated by social desirability rather than by honest responses.

5.8 SUMMARY

This chapter outlined the summary of the study and presented findings and recommendations.

This research set out to expose the causes and effects of non-disclosure of the HIV/AIDS status by educators. This was done by examining, through a literature study, what HIV and AIDS are, the causes and effects of non-disclosure of the HIV/AIDS status. This revealed the causes of non-disclosure in the school system, educators and learners. This also yielded information and knowledge on the implications of non-disclosure of HIV/AIDS status for school management in the mitigation thereof.

The empirical study revealed the actual situation in schools regarding causes and effects of non-disclosure of HIV/AIDS status.

This study has revealed the seriousness with which issues around HIV/AIDS need to be addressed, especially at schools.

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ANNEXURES

ANNEXURE A

Letter to principals

185 Zone 10 Ext 1

Sebokeng

1982

Dear Sir/Madam

I am currently studying for the M.Ed. degree at the North-West University: Vaal Triangle Campus. I am investigating the causes and effects of non-disclosure of the HIV/AIDS status by educators and the implications for school management.

In the light of the seriousness and the impact of this pandemic, it has become imperative to collect as much data as possible on HIV/AIDS and its impacts in school. I therefore request your assistance in my research.

Please assist me in conducting this research by completing the accompanying questionnaire. Your genuine and honest responses will be highly appreciated. **Please note that your anonymity is guaranteed and you are not required to write your name or name of school anywhere on the questionnaire.** You are further assured that this questionnaire and the information you will provide will be used only for research purposes – no part of this questionnaire will be used by anyone.

Thank you in anticipation for your co-operation.

Mrs. M.G. Kumalo-Hlahane

ANNEXURE B

Questionnaire to principals

SECTION A

Please place a cross (X) in the appropriate box

Your gender	Male	Female	
Your current post	Teacher	Head of department	Principal
The phase in which you presently teach	Foundation	Intermediate	Senior
Your school type	Primary		Secondary
Location of school	Township	Town	Farm/Rural
Number of learners in your school	0-500	501-800	800+

SECTION B: THE CAUSES AND EFFECTS OF NON-DISCLOSURE OF THE HIV/AIDS STATUS

1. Are you aware of any educators in your school who are HIV positive	Yes	No	Not sure	
2. If yes, how did you know about their status?	He/she disclosed his/her status	Suspicion	Heard rumours	Not applicable
3. Are there any educators in your school who have died or retired due to a suspected HIV/AIDS related disease?	Yes	No	Don't know	Not sure
4. Are there educators who have disclosed their HIV status?	Yes	No	Not sure	
4.1 If yes, how did they?	Publicly	Confidentially	Forced to	Not applicable

5.	Do you often have to assign more work to other educators due to continuous illness of other educators?	Yes	No
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5.1	If yes, how often?	Always	Often	Sometimes	Never	Not applicable
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5.1	To what extent are they offered moral support by their colleagues?	Always	Often	Sometimes	Never	Not applicable
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6.	Are substitutes always appointed for educators who are regularly absent?	Always	Often	Some times	Never
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7.	Do educators often have to cope with additional work as a result of educators who are often absent?	Always	Often	Some times	Never
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8.	Are there educators who are regularly absent due to illness?	Always	Often	Some times	Never
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9.	What are the reasons most cited for educators' absence from school?			
	Illness of self	Illness of others (family member(s))	Funerals	Work related

10.	Does the HIV/AIDS pandemic affect your school's teaching and learning processes?	Yes	No	Not sure
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11.	If yes, to what extent has it?	Always	Often	Sometimes	Never	Not applicable
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12.	Do you find that you have to attend to the needs of learners who are affected and infected with HIV/AIDS??	Always	Often	Sometimes	Never
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13.	Are there learners who perform poorly due to:			
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13.1	being HIV/AIDS infected and affected?	Yes	Probably	Unsure	No
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13.3	being orphaned?	Yes	Probably	Unsure	No
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13.4	having to take care of siblings because parents have died?	Yes	Probably	Unsure	No
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13.5	suffering from malnutrition?	Yes	Probably	Unsure	No
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13.6	being frequently ill?	Yes	Probably	Unsure	No
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13.6	being frequently ill?	Yes	Probably	Unsure	No
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15.	Do life skills programmes sensitise learner against immature sexual indulgence	Yes	Probably	Unsure	No
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16. Do staff members know the National Policy on HIV/AIDS?	Yes	Probably	Unsure	No
17. Does the school have a Health Advisory Committee?	Yes	Probably	Unsure	No
18. Are there HIV/AIDS awareness programmes in the school?	Yes	Probably	Unsure	No
19. Are there programmes that address:				
19.1 prevention of the spread of HIV/AIDS?	Yes	Probably	Unsure	No
19.1 prevention of the spread of HIV/AIDS?	Yes	Probably	Unsure	No
19.2 awareness of how HIV/AIDS is spread?	Yes	Probably	Unsure	No
19.3 care and support for learners and educators who are infected and affected by HIV/AIDS?	Yes	Probably	Unsure	No
20. How regular are HIV/AIDS awareness advocacy campaigns held at the school??	Yes	Probably	Unsure	No
21. Is there a school policy on HIV/AIDS?	Yes	Probably	Unsure	No
22. Are there programmes that ensure reduction of vulnerability and risk, like abstinence, use of condoms and having one partner?	Yes	Probably	Unsure	No
23. Does the school promote a culture of human rights?	Yes	Probably	Unsure	No
24. Does the school curriculum include HIV/AIDS education?	Yes	Probably	Unsure	No
25. Is there a school management strategy for mitigating causes and effects of HIV/AIDS?	Yes	Probably	Unsure	No
26. Does the school management strategy encourage disclosure of the HIV/AIDS status by educators?	Yes	Probably	Unsure	No
27. Are the effects of HIV/AIDS on the school assessed?	Yes	Probably	Unsure	No
28. If so, how many times a year?	Once	Twice	Every month	Never
29. Are there HIV/AIDS awareness programmes that involve parents and the community?	Yes	Probably	Unsure	No
30. Are funds allocated for HIV/AIDS activities properly utilised?	Yes	Probably	Unsure	No

