

**AN INCLUSIVE APPROACH TO DEALING WITH  
HIV/AIDS AT SCHOOLS**

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**A dissertation submitted in fulfilment of the  
requirements for the degree**

**MAGISTER EDUCATIONIS**

**in**

**TEACHING AND LEARNING PERSPECTIVES**

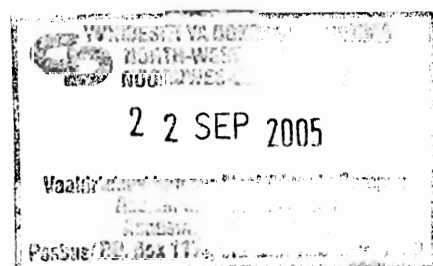
**NORTH-WEST UNIVERSITY**

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**Vanderbijlpark**

**2005**



## ACKNOWLEDGEMENTS

The author wishes to thank the omniscient, omnipotent and omnipresent God for providing her with both the physical and psychological fortitude to finish this work. I also thank God for the following people whose interest and supervision made the presentation of this dissertation possible:

- ❖ Dr. NJL Mazibuko for his expert advice, patience and constant encouragement throughout the duration of this study.
- ❖ Siphokazi Kwatubana for support, encouragement and patience in typing my work.
- ❖ Mrs Denis Kocks for language editing the document.
- ❖ My husband, Dithakong, for his incessant and unconditional support during the course of this study. May God bless him.
- ❖ The Ferdinand Postma library staff for their friendly and excellent service.
- ❖ My sons, Eyase and Kebone, and my daughter Qiniso for their understanding and support when they had to do without their motherly care and love.

## SUMMARY

The aims of this research were to determine the effects of HIV/AIDS on school systems; and to, on the basis of the findings of both the literature study and the empirical research, make a suggestion for an inclusive approach to dealing with the HIV/AIDS epidemic at schools.

The literature review revealed that a school with a high number of learners and educators infected and affected by HIV/AIDS cannot function efficiently and effectively, since learners infected and affected by HIV/AIDS cannot cope with learning and cannot perform their learning tasks to the fullest of their abilities, while infected and affected educators cannot teach effectively because they are often ill and absent from school, and this has an effect on the efficient and effective development of the school.

The literature review, also, revealed that HIV/AIDS can have an enormous impact on the learning and teaching situation in most HIV/AIDS-affected schools, but at the same time, inclusive school systems can also have an enormous impact on HIV/AIDS prevention, care and support, especially when supported by inclusive health-promoting educational strategies and collaborative support from other social and educational sectors such as non-governmental organizations dealing with HIV/AIDS and health, Departments of Social Welfare and Health, and so on.

In the absence of appropriate effective inclusive measures, the school system in a community that is seriously HIV-infected is also in danger of being weakened and disrupted. It falls prey to a myriad of opportunistic problems like the high rate of absenteeism, deaths of educators and learners, demotivation, low morale, *etcetera*, which lead, in turn, to a number of reactive changes and adaptations.

The empirical investigation revealed that the majority of respondents who filled in the questionnaire regard illness as the main reason for mortality among educators at their schools. The investigation of the extent of

feelings/attitudes experienced by respondents who have to carry a heavy teaching workload because of educators who are absent due to illness revealed that the majority of educators:

- are frustrated, stressed, depressed and not motivated any more to do their work;
- are less interested in their school work and other school-related activities;
- are not coping with their teaching work;
- have developed a negative attitude towards their work;
- are experiencing low morale; and
- are feeling like resigning from their teaching job.

The empirical investigation also revealed that the majority of respondents who participated in this research regarded sickness of self as the main reason for educator absenteeism at their schools.

These results of the empirical results led to the researcher making some recommendations which schools can adopt in order to create inclusive learning and teaching settings where teachers who are always at schools are not unfairly overloaded by the teaching work-loads of those educators who have to be absent from work because of being sick.

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# CHAPTER ONE

## ORIENTATION

### 1.1 INTRODUCTION AND STATEMENT OF THE PROBLEM

Human immunodeficiency virus (HIV) and Acquired immune deficiency Syndrome (AIDS) can have an enormous impact on school systems of most HIV/AIDS affected schools, but at the same time, inclusive school systems can also have an enormous impact on HIV/AIDS prevention, care and support (Arguelles, Hughes & Schumm, 2000:50; Muthukrishna & Schoeman, 2000:886), especially when supported by inclusive health-promoting educational and psychological strategies and collaborative support from other social and educational sectors such as non-governmental organizations dealing with HIV/AIDS and health, Departments of Social Welfare and Health and so on (Soul Buddyz, 2003: 15).

Badcock-Walters, Desmond and Dan (2003:2) propound that HIV/AIDS has had an impact on school systems primarily by affecting the:

- demand for education;
- supply and quality of education; and
- management of education systems.

According to Debswana (2004:12), since the epidemic began, more or less 3.8 million children have already been infected with HIV, and over two-thirds have died. As the HIV/AIDS incidence increases, most affected school communities are beginning to witness:

- a decrease in the overall demand for education in terms of basic education enrolment rates;
- an increase in dropping-out of schools by learners and access being limited or denied to many children due to additional HIV/AIDS-related demands such as coping with personal illness, caring for family

members, trauma related to illness and death in the family, discrimination and stigma, reduced family income and income-generating needs, and/or declining financial support from parents (Hepburn, 2002; Beresford, 2002:3; Tembon, Drake, Shirlaw, Connolly, Lee, Patrikios, Kaleeba, Mannathoko, Gillepsie & Bundy, 2003:44). A high percentage of these drop-outs are orphans, street children and working youth with very limited resources and few clear incentives for entering the school system. For marginalised learners such as girls, orphans, street children, the out-of-school youth and working youth, the impact of HIV/AIDS is exacerbated (Schneider & Stein, 2002:55);

- reversed achievements in gender equality that the new system of education in South Africa has been striving for at schools. Girls tend to bear a greater burden in terms of care-taking responsibilities, in addition to domestic chores and tradition favouring education towards boys, especially in black communities (Dean & Moalusi, 2002:2; Leach, 2002:23). Moreover, infection rates among girls as young as 13 have risen, thereby reducing their likelihood of benefiting from, or completing, their basic education. Pessimism about the value of education can emerge where public confidence in the quality of education is low and the strain of poverty favours income-generating skills over schooling, especially as HIV/AIDS adds to the economic burden of families providing for orphans from other relatives, or of child-headed households (Cohen, 2002a:14); and
- greater inconsistency in the supply of quality educational services where educators are in poor health, caring for others, or not well trained. Irregular educator attendances and the depletion of educators trained in directly HIV/AIDS matters have been a source of great aggravation to already struggling education systems (Crepaz & Marks, 2002:240; Bennell, Hyde & Swainson, 2002:26). Where trained educators are in short supply, the quality of education decreases in terms of both teaching processes and content. The epidemic has highlighted inadequacies in the curricula, which are not designed in content or delivery to address the many sensitive issues surrounding HIV/AIDS.

Consequently, the introduction of essential life skills critical for learners to handle HIV risk contexts has often been inhibited, and in some cases prohibited (Bundy, 2003:5; Cavet, 2000:154). Where HIV/AIDS has appeared in curricula, it has tended to be inadequately addressed with an over-emphasis on information and a marked under-emphasis on attitudes, values, and skills, particularly those related to human sexuality and social norms, including gender issues (Gillespie, Birdthistle, Jones, Bundy, Hoffman, Pigozzi, Draxler, Whitman, Fouilhoux & Drake, 2003:81).

Generally, HIV/AIDS has not been factored into educational planning in schools (Lawrence, 2002:23). In some cases, existing school policies and educational practices reinforce discrimination and stigmatization of learners and staff infected and affected by HIV/AIDS, neglect human rights and personal safety of learners infected and affected by HIV/AIDS, and fail to improve school organizational climate in order to accommodate working and learning conditions of unhealthy educators and learners infected with HIV/AIDS. In some cases, human resource management policies and practices undermine the health or welfare of staff, especially those related to recruitment, training and compensation, which overlook factors such as the need to be close to family or medical services (Hamilton, 2002:22; Clinton, 2003:1801). Such factors indicate exclusive approaches to accommodating learners and educators who attend schools having been infected and affected by HIV/AIDS.

The foregoing paragraphs highlight the seriousness of the effects of the HIV/AIDS epidemic on the human resources of learners and educators, and the effective functioning of the school systems. Since HIV/AIDS is a health problem because of its effect on the human psycho-somatic-spiritual beings of learners and staff and has implications for regard of their human dignity, it is imperative that schools develop inclusive health promoting educational approaches for effectively dealing with the incidence and the impact of the spread of HIV/AIDS. For proactive planning purposes, schools need to ascertain, in particular, the consequences of the curriculum, the expected

enrolment and drop-out rates and the continual absence of educators and learners infected with HIV/AIDS (Boler, 2003:4; Brown, 2002:56).

Inclusive health promoting educational approaches to HIV/AIDS can work with learners and educators living with both the virus and the syndrome of this disease, especially where they are re-inforced and supported by the collaboration of all social and educational sectors such as medical doctors, traditional healers, social workers, nurses, ministers of religion and so on (Anderson & Scharflander, 2002:74; Braaten & Quinn, 2000:16; South Africa, Act No. 27 of 1996). Ebersohn and Eloff (2002:125) assert that well implemented inclusive health promoting educational programmes cannot only delay the start of sexual activity, but also reduce the number of sexual partners among promiscuous learners and educators (even among those traditional Blacks who believe in polygamy) and raise contraceptive use among children and adolescents who become sexually active.

Mendel (2002:54) and (Kelly, 2002:5) have commented that the development of HIV/AIDS-specific inclusive health promoting educational approaches at schools has been disappointing, due to:

- a lack of comprehensive and inclusive skills-based education linking knowledge, attitudes, values and psycho-social skills;
- a lack of educator training and ongoing support on HIV/AIDS programmes;
- inadequate school policy and structures to support consistent and high quality coverage;
- schools' inability to mobilise communities, non-governmental organizations (NGOs), medical doctors, traditional healers, social workers, nurses, ministers of religion, and others, in the fight against this dreadful epidemic.

Meyer (2003:76) emphasizes a great need for all schools in South Africa to develop and design organizational climates that are inclusive and health promoting in order to concertedly deal with the impact of HIV/AIDS on school systems. According to various researchers, an inclusive health-promoting educational approach to the HIV/AIDS epidemic needs to, among other:

- provide guidelines on managing HIV/AIDS at school (Meyer, 2003:76);
- recognize and honour the legal rights of learners, educators and parents, including those who are HIV positive or have AIDS (Meyer, 2003:76);
- minimize, as far as possible, the spread of the HIV/AIDS disease and the impacts thereof within the school and all stakeholders (learners, educators and parents) (Carr-Hill & Peart, 2003:10);
- encourage the use of counselling and other support services by those learners and educators who are affected, so as to improve their overall health status (Dickinson, 2003:66);
- approach learners and educators infected with HIV/AIDS compassionately, ensure protection against unfair discrimination against them (Meyer, 2003:76);
- provide training and sensitization to educators, where appropriate, on how to deal with learners and colleagues who are HIV positive or have AIDS in a humane and appropriate manner (Dean & Moalusi, 2002:28);
- develop and implement HIV/AIDS policies after communication and, where appropriate, after consultation with learners, educators, parents and communities (Meyer, 2003:76); and
- ensure that learners and educators with HIV/AIDS have the same rights and obligations as other learners and educators (Chatier, 2002:56)

An inclusive health promoting educational approach to HIV/AIDS calls for school policies to outline a strategic plan for implementation, including responsibility delegation, implementation, monitoring and assessment (South African Act No 27 of 1996). The school should develop an HIV/AIDS policy and programme framework to be used by all operations to manage HIV/AIDS at the schools, including:

- prevention;
- non-discrimination;
- confidentiality and disclosure;
- learning and teaching performance management;
- stakeholder consultation; and
- education and awareness.

The school specific HIV/AIDS policy should be infused into the school's strategic plan, that is, a process to assess internal and external situations from which key issues on the virus and syndrome can be focused on (Department of Health, 2000b:32).

This research is premised on the assumption that a school with a high number of learners and educators infected and affected by HIV/AIDS cannot function efficiently and effectively since learners infected and affected with HIV/AIDS cannot emotionally, metacognitively and behaviourally cope with learning and consequently cannot perform their learning tasks to the fullest of their latent abilities, while infected and affected educators cannot teach effectively because they are often ill and absent from school, and this has an effect on the efficient and effective management of the school. Such learners and educators can also be subjected to tremendous discrimination in the form of stigmatization and labeling which can affect them both cognitively, emotionally and spiritually.

Little empirical research, if any, has been undertaken on the need for an inclusive health promoting educational approach to dealing with the HIV/AIDS epidemic at South African schools. It is, therefore, of the essence to conduct such research in South Africa, a country, which is said to be among the top nations, which are being ravaged by the HIV/AIDS epidemic (Joseph, 2002:14). Statistics estimate that there are 250 new infections in South Africa every day, which includes learners and educators (Pretorius, 2002:9). Research estimates that the infection rate among educators is more or less 12% of the general population (Munusamy, 2002:24). Projections suggest that around one in seven educators were infected with HIV by the end of 2003. There is also an increasing occurrence of illness and deaths among younger educators and learners (Kelly, 2002:10), with educator losses averaging 1, 5% biennially. Many schools report a high rate of absenteeism of educators due to illness as a major and increasing problem of the HIV/AIDS epidemic (Whisson, 2002:1; Keeton, 2002:31).

This research therefore endeavours to:

- investigate the extent of the effects of HIV/AIDS at schools, with particular reference to the schools in the Vaal Triangle area of the Gauteng Province; and on the basis of the findings of both literature review and empirical research;
- make suggestions for an inclusive educational approach to the HIV/AIDS epidemic which schools could adopt in order to deal with this epidemic.

This research, therefore, answers the following questions:

- What is the effect of HIV/AIDS on school systems?
- Which inclusive health promoting educational approaches could be effective in dealing with the HIV/AIDS epidemic at schools?

School systems in this research refers to learners, educators, teaching and learning situation, and critical prerequisites educators have to comply with for effective teaching and learning. These factors are regarded in this research as the most important organs which form the key functioning of a school.

## **1.2 AIMS OF THE STUDY**

The aims of this research were to:

- determine the effects of HIV/AIDS on school systems; and, on the basis of the findings of both the literature study and the empirical research,
- make a suggestion of an inclusive approach to dealing with the HIV/AIDS epidemic at schools.

## **1.3 METHODS OF RESEARCH**

A literature review and empirical research methods were used in this investigation.

### **1.3.1 Literature Review**

Current international and national journals, papers presented at professional meetings, dissertations by graduate learners, and reports written by school researchers, university researchers, White Paper 6 of the Department of Education on inclusive education in South Africa, and both South African Acts

27 and 84 of 1996 (which provide information on human rights and how far research on HIV/AIDS at schools, its effects on teaching, learning and the management of schools has progressed) were consulted and serve as primary sources. South African Acts were consulted from governmental and departmental policy theoretical and legal frameworks. Books on HIV/AIDS serve as secondary sources.

### **1.3.2 Empirical Research**

In addition to the literature study, data were collected by means of a questionnaire. These data were analysed and interpreted.

The research was conducted as follows:

The authorities of district 7 and 8 in Vereeniging and Vanderbijlpark were respectively requested permission to conduct this research in a sample of both primary and secondary schools under their jurisdiction. The researcher personally visited these schools to deliver and collect the questionnaires.

#### **1.3.2.1 Measuring instrument**

An unstandardized questionnaire which was developed and designed by the Teaching and Learning section of the School of Educational Sciences of the North-West University (Vaal-Triangle Faculty) was used to determine the extent of the effects of HIV/AIDS on learners, educators and the teaching and learning situation. It was also necessary to investigate what the prerequisites for an effective teaching and learning situation are. This questionnaire has not been validated, but the researcher deemed it necessary to use it because of its value in investigating the effects of HIV/AIDS on teaching and learning practices. The results of this empirical research were triangulated with those of the literature review to make suggestions for an inclusive educational approach to the HIV/AIDS epidemic at schools. The researcher therefore endeavours to determine:

- 
- What is the effect of the HIV/AIDS epidemic on school systems?

- On the basis of literature review (see chapters 1 and 2) and empirical research results (see chapter 4), which inclusive health promoting educational approaches could be effective in dealing with the HIV/AIDS epidemic at schools?

The questionnaire developed by the section mentioned above was used because a standardized and validated questionnaire relevant to the study in question could not be found. Only internationally developed questionnaires were available and they were not appropriate for the context and problem statement of this research. The results of the questionnaire were crucial in helping the researcher reach the last aim of this study, which is to suggest an inclusive educational approach to dealing with the HIV/AIDS epidemic at schools.

#### **1.3.2.2 Target population**

All members of school management teams (principals, deputy principals, heads of department) and educators (educators on post level one) of public schools in the townships and farm schools of the Gauteng Province were initially considered the target population.

#### **1.3.2.3 Accessible population**

Because of the large number of public schools in the Gauteng Province, which would have taken long to visit with huge financial implications, it was decided to limit the target population to the township and farm schools in the Vaal Triangle area of the Gauteng Province.

#### **1.3.2.4 Sample**

A randomly selected sample (N= 400) of school management teams, comprising of Heads of Departments, Deputy Principals and Principals, and educators of schools at 30 schools in the Vaal Triangle was drawn. These school management teams and educators were supplied with the questionnaires on the effects of HIV/AIDS on learners, educators and the teaching and learning situation, and prerequisites for effective teaching and learning.

### **1.3.2.5 Statistical techniques**

To determine empirically the effects of HIV/AIDS on learners, educators and the teaching and learning situation, as well as the prerequisites for effective teaching and learning at schools in the Vaal Triangle, the data obtained from the target population were analysed, using the SPSS programme of the Statistical Consultation Services of North-West University (Vaal Triangle Faculty).

## **1.4 PROGRAMME OF STUDY**

Chapter 1 is primarily an orientation chapter, preparing the reader for the subsequent chapters.

In Chapter 2, an inclusive educational approach to dealing with the HIV/AIDS epidemic in schools is discussed.

In Chapter 3 the empirical design is motivated. The purpose of the research, method of research, the choice of the target group and the development of the questionnaire are discussed.

In Chapter 4, the research results are statistically analysed and interpreted.

The concluding Chapter 5 provides a summary of findings from the literature study, as well as the empirical design. Recommendations for further research and for practical implementation are also presented.

## **1.5 CONCLUSION**

In Chapter 1 the orientation of the research, in the form of the statement of the problem, the aims of the research, the methods of research and the programme of research were discussed.

Chapter 2 presents literature review on HIV/AIDS and inclusive health promoting educational approach to dealing with the HIV/AIDS epidemic at schools.

## **CHAPTER TWO**

### **LITERATURE REVIEW ON INCLUSIVE APPROACH TO THE HIV/AIDS EPIDEMIC**

#### **2.1 INTRODUCTION**

This chapter presents literature review on the theories of HIV/AIDS epidemic and inclusive health promoting educational approach to the HIV/AIDS epidemic. Concepts related to this research are also clarified.

#### **2.2 DEFINITION OF CONCEPTS**

It is necessary to define concepts such as HIV/AIDS, immune system, syndrome and inclusion because of their primary use in this research. This section, therefore, provides the definition of concepts which form the core of this research and highlights the effects of HIV/AIDS on general health.

##### **2.2.1 HIV/AIDS**

HIV is an acronym for human immunodeficiency virus while AIDS is an acronym for acquired immune deficiency syndrome. HIV is a very small germ or organism which infects people through contact with infected body fluids. It cannot be seen through the naked eye, but only under an electron microscope. It only survives and multiplies in body fluids such as sperms, vaginal fluids, breast milk, blood and saliva. HIV attacks the immune system and reduces the resistance of the body to all kinds of illness, including influenza, diarrhoea, pneumonia, TB and certain cancers. It eventually makes the body so weak that it cannot fight sicknesses and causes death between five and ten years after becoming infected, but some HIV-infected people live longer if they receive the right antiretroviral therapy and medication (Emini & Koff, 2004: 1913). This means that it attacks the immune system that protects the body from opportunistic infections and illnesses, which affect the physical and psychological wellness of learners and educators infected with HIV/AIDS, such as:

- weight loss, dry cough, recurring fever or profuse night sweats, profound and unexplained fatigue, swollen lymph glands in the armpits, groin, or neck;
- diarrhoea that lasts for more than a week;
- white spots or unusual blemishes on the tongue, in the mouth or in the throat;
- red, brown, pink or purplish blotches on or under the skin or inside the mouth, nose or eyelids;
- memory loss, depression and other neurological disorders; and
- tuberculosis, pneumonia, gastro-enteritis, meningitis and cancer (Clements, Abdool-Karim & Chang, 2004: 2824; Beyrer, 2003).

HIV, therefore, damages the ability of the body to protect itself from these opportunistic infections and illnesses. The body loses its ability to fight infections after the immune system has been weakened and devastated by this death-causing virus (Cohen, 2002b). After many years the devastation and damages are serious and the person contracts serious illnesses, which develop to a syndrome known as AIDS, which is the final stage of infection with HIV, and this is what causes the person to die (Gillespie *et. al.*, 2003:81).

### **2.2.2 Immune system**

This is the body's defence against infection. The immune system is a flexible and highly specific defense mechanism that kills micro-organisms and the cells they infect, destroys malignant cells and removes the debris. It distinguishes such threats from normal tissue by recognizing antigens (substances that induce the production of anti-bodies called immuno-globulin when introduced into the body (Garber & Feinberg, 2003:136; Evian, 2004:10).

### **2.2.3 Syndrome**

The concept "syndrome" means that several symptoms occur at the same time. It is used to emphasize that people with AIDS have many signs and symptoms, because they suffer the effects of the pandemic's associated opportunistic diseases, such as weight loss, dry cough, recurring fever or

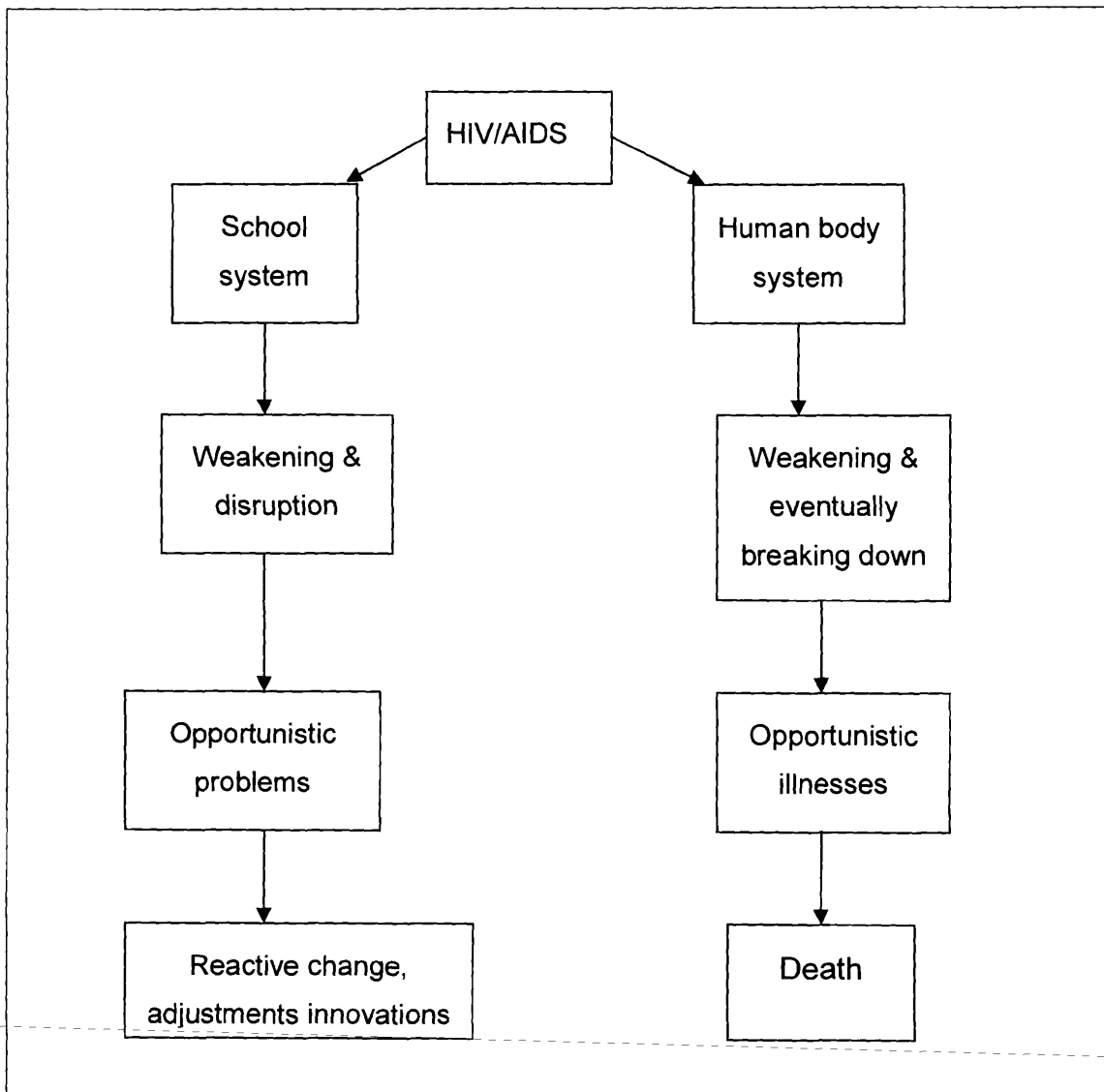
profuse night sweats, profound and unexplained fatigue, swollen lymph glands in the armpits, groin, or neck; diarrhoea that lasts for more than a week; white spots or unusual blemishes on the tongue, in the mouth or in the throat; red, brown, pink or purplish blotches on or under the skin or inside the mouth, nose or eyelids; memory loss, depression and other neurological disorders; tuberculosis, pneumonia, gastro-enteritis, meningitis and cancer affect both the physical and psychological wellness of learners and educators infected with HIV/AIDS (Kelly, 2002:12; Idemyor, 2003:423; Johnston, 2002:421).

The definitions provided in the above paragraphs imply that when a person is infected with the human immunodeficiency virus, the immune system of the human body weakens and eventually breaks down (see figure 2.1 below). This leaves the infected individual a prey to the hazards of a multitude of opportunistic infections and illnesses (see paragraph 2.1.1 above). In the absence of the costly anti-retroviral therapy that can slow the progression of HIV infection, the infected individual will eventually succumb to the serious cluster of illnesses like tuberculosis, cancer, measles, poliomyelitis, pneumonia and others that define AIDS (Beyrer, 2003; Keeton, 2002:16; Lawrence, 2002:3). This means that the course of HIV/AIDS in a human body system starts when HIV enters the system through sex or any other mode of infection (see paragraph 2.1.1). The weakening of the body and the breaking down of the immune system follows this. Opportunistic illnesses then follow and eventually the person dies (Clements, Abdool-Karim & Chang, 2004: 2823; Department of health, 2001b; Kelly, 2002:12; Bradshaw, Johnson, Schneider, Bourne & Dorrington, 2002:15).

In a similar way, in the absence of inclusive health promoting measures at schools, the system of a school that has learners and educators who are seriously infected with HIV/AIDS is also in danger of being weakened and disrupted (Cohen, 2002:15; Le Roux, 2001:100; Department of education, 1999:2). It falls prey to a myriad of opportunistic problems which have an impact on the efficient and effective educational management like the high rate of absenteeism, deaths of educators and learners, de-motivation, low

morale, *etcetera*, which lead in turn to a number of re-active changes and adaptations. The course of HIV/AIDS within the school system starts when learners and educators develop AIDS with its opportunistic diseases and they become both physically and psychologically weak, which is followed by the weakening and disruption of the school system and opportunistic problems for the school system follow (De Coito, 2001:2; Department of health, 2000a: 5; LoveLife, 2000). This course of HIV/AIDS at schools can be diagrammatically represented as follows:

**Figure 2.1: Course of HIV/AIDS in both the body and school systems**



In such a scenario, schools are obliged to deal with the potential areas of impact on learners, educators and the school systems, and to design inclusive

and effective responses (Dean & Moalusi, 2002: 24; Kelly, 2002:11; O'Connor, 2001:34). Some interventions may be designed in reaction to circumstances that have actually been experienced (Garber & Feinberg, 2003:134; Parker & Mundawarara, 2002:4; Eaton & Flisher, 2000:1913). However, dealing with the HIV/AIDS situation at schools requires being proactive, anticipating what might possibly happen, forestalling undesirable situations, and managing the impact with the following two strategic objectives in mind (Garber, Silvestri & Feinberg, 2004:399; Leclerc-Madlala, 2002:5):

- enabling the school system to pursue and attain its essential objectives; and
- using the school's potential to slow down the rate of new infections, help infected learners and educators to cope, and support those among them who have been bereaved by HIV/AIDS.

### **2.3 THE IMPACT OF HIV/AIDS ON SCHOOL SYSTEMS**

HIV/AIDS affects schools through impacting on:

- the physical and psychological well-being and wellness of learners and educators;
- curriculum content, as it must accommodate other learning areas that are to deal with AIDS in schools, like Life-Orientation and Life-Skills, and it also includes sex education;
- the organization, management and planning of teaching and learning; and
- human, material and financial resources for education (Keeton, 2002:35; Mendel, 2002:5; Joseph, 2002:14; Heard, 2001).

The impact of the HIV/AIDS epidemic at schools manifests itself in the following manner:

#### **2.3.1 The school has to take care of orphans**

Hoopet-Box (2002:5) believes that the problem of orphans at schools is not static as it grows every day and schools are obliged to keep a record of its orphans. Having a record or a register of orphans at a school helps to check if there is an increase in number and is convenient for the purpose of

sponsorship and adoption (Idemyor, 2003:422; Hepburn, 2002:34). Orphans are often identified by:

- the state of their uniform that is usually torn;
- not playing freely because they always think about their plight and the conditions they live in; and
- not being open or not participating in class as they do not always have time to learn or do homework, and in some instances they are not supervised or even cared for where they live (Bundy, 2003:14; Ames, 2001:1).

These learners may attend school infrequently, being kept out of school if they are needed at home to care for sick family members or the grannies they live with, or they may have to engage in income-generating or domestic activities, replacing deceased family members (Soul Buddyz, 2003:2). Fewer of these learners are able to afford education. It is easy for orphans to drop out of school, especially if they do not have a strong support system at home, or if the foster parents cannot afford school fees, due to reduced household income as a result of HIV/AIDS deaths of parents or guardians (Bradshaw, *et.al.*, 2002:15). There is, also, a problem of AIDS orphans who are often rejected by their schools because they cannot pay school fees and do not have money for uniforms (Bateman, 2002b:10). Tembon *et. al.* (2003:15) highlight the fact that learner orphans are affected by the following factors in doing their schoolwork:

- poverty, that is, going to school on empty stomachs;
- no one to supervise their work at home; and
- intense stress, depression and anxiety.

According to Pfeiffer (2002:10) and Mohlala (2002:5), these learners, because of the social plight they find themselves in:

- find it difficult to concentrate in class because of their affected psychological well-being;
- perform poorly scholastically because of their affected cognitive well-being;

- do not participate in class discussions because of being always withdrawn and thinking about their problems which at times are linked to discrimination;
- have a very low self-esteem;
- lack motivation; and
- eventually develop learning difficulties.

### **2.3.2 Attendance and enrolment of learners and educators infected and affected by HIV/AIDS are irregular**

Ebersohn and Eloff (2002:125) reveal that HIV/AIDS has a significant impact on school attendance of both learners and educators, and leads to a greater demand for more flexible learning and teaching opportunities for learners and educators who are ill.

The effects of HIV/AIDS on educators and learners do not only destroy the human resources of both schools and the economy of the country, but also attack school systems. Most researchers believe that HIV/AIDS kills educators faster than they can be trained (Keeton, 2002:15) and they have concluded that 30 000 new educators would be needed each year to compensate for the decline in educator numbers because of HIV/AIDS. There is, therefore, a need that the 2% to 3% of matriculants who choose teaching as a profession in South Africa must increase to 15% in order to meet the demands of the future (Munusamy, 2002:4). The work of educators who are HIV-infected is disrupted by periods of illness. As a result, healthy educators have to take on additional teaching loads and other work-related duties in order to cover for sick colleagues. The quality and effectiveness of teaching are compromised because of the impact on motivation and capacity of educators and learners alike (Brown, 2002:3).

The loss of large numbers of educators in a developing country like South Africa is a serious blow to the nation's future development of schools and quality education because of the fact that:

- the supply of educators is diminished due to mortality;

- productivity of educators declines due to frequent educator absenteeism because of illness;
- learner and educator ratios worsen because educator replacement procedures have to be adapted, especially for educators still in service, but who only perform duties erratically (Dickinson, 2003:11). As a result, there is reduced teaching time and continuity;
- educational budgets are affected through double payment of “off-duty” educators and their substitutes (Mendel, 2002:65);
- the standing of educators in the community is devalued when through the community views educators as contributing to the spreading of the disease (Frank & Seghal, 2004: 13);
- educational facilities are seen as a risky environment for sexual relations between learners and educators; and
- management, administration and financial control of school systems are likely to deteriorate through loss of human resources (Lisk & Cohen, 2004:20) .

On the basis of this paragraph it is necessary that schools develop and design inclusive health promoting approaches to HIV/AIDS epidemic in order to accommodate learners and educators who are already sick because of HIV/AIDS and to protect those who are not yet infected.

The next section defines the concept inclusion and provides literature review on inclusive health-promoting approaches which schools could adopt in order to deal with the HIV/AIDS epidemic.

## **2.4 LITERATURE REVIEW ON INCLUSIVE APPROACH TO THE HIV/AIDS EPIDEMIC**

### **2.4.1 Inclusion**

Inclusion has been defined by various authors as follows:

- Webster's New Unabridged Universal Dictionary (1994) defines inclusion as "the act of including," that is, "to contain, embrace, or comprise, as a whole does parts."
- Belanger (2000:250) defines inclusion as "...a value that supports the right of all children regardless of their diverse abilities to participate actively in natural settings in their community.
- Allen and Schwartz (2001:4) state that inclusion is not a set of strategies or a placement issue. Inclusion is about belonging to a community, that is, a group of friends, a school community, or a neighbourhood.
- Engelbrecht and Snyman (1999:96) and Sands, Kozleski and French (2000:5) see inclusion as changing the attitudes and practices of individuals, organisations and associations, towards the exclusion of children who are perceived as 'different' because of such factors as their impairment, ethnic background, language and poverty, so that they can fully and equally participate in and contribute to the life of their community and culture. An inclusive society is one in which difference is respected and valued, and where discrimination and prejudice is actively combated in policies and practices.

All these authors highlight that inclusion is about recognizing and respecting the differences among all learners and building on similarities. Inclusive approach is seen as supporting all learners and the system as a whole so that the full range of learning needs can be met. The focus is on teaching and learning factors, with the emphasis on the development of good teaching strategies that will be of benefit to all learners. It focuses on overcoming barriers in the school system that prevent it from meeting the full range of learning needs and the focus is on the adaptation of and support systems available in the classroom (Department of Education, 2001; Becker, Roberts & Dumas, 2000:57; Bruder, 2000:223; Clough & Corbett, 2000:44).

Choate (2000:12) and Bloin and Peterson (2000:15) postulate that inclusion is a philosophy of acceptance, belonging and community, and also means that general education classes are structured to meet the needs of all the learners in the class. This is accomplished through educational strategies designed for a diverse learner population and collaboration between educators so that

specially designed teaching and supplementary aids and services are provided to all learners as needed for effective learning (Buchan, 2000:70; Staub, Spaulding, Peck, Gallucci & Schwartz, 1996:314).

These definitions, also, indicate that inclusion is a term which expresses commitment of schools to educate each child to the maximum extent appropriate and in the classroom he/she would otherwise attend. It involves bringing the support services to the child (rather than moving the child to the services) and requires only that the child will benefit from being in the class (rather than having to keep up with the other learners) (Kidd, 2001:23; Levy, 2001:41; Scruggs & Mastropieri, 1996:74; Stainback & Stainback, 1996:23).

Full inclusion means that all learners, regardless of handicapping conditions or severity thereof, will be in a regular classroom/programme full time. All educational services must be taken to the child in that setting (Arguelles, Hughes & Schumm, 2000:50).

On the basis of the above definitions of inclusion, inclusive education is, in this research, defined as a system of creating access to a process of education appropriate to the needs of all children. It is enshrined in the South African Bill of Rights, which protects all children from discrimination. This calls for schools, centres of learning and educational systems to be open to all learners, and advocates a process of identifying any barriers within and around the school that hinder learning, and reducing or removing them (Levy, 2001:20; Sands, Kozleski & French, 2000:5; Engelbrecht & Snyman, 1999:57). Inclusiveness, as used in this research, mean that the needs, abilities and aspirations of learners and educators infected and affected by HIV/AIDS are recognised, understood and met within a socially constructivist, ecosystemic and supportive environment, which encourages them to achieve their goals and to make real and measurable progress.

-----What, therefore, is highlighted in the above definitions is that inclusion is about the effective education of all children, in the case of this research, irrespective of their health conditions or status. It is about accommodating children with and without learning special educational needs at the same schools and all of them feel emotionally, mentally and spiritually part of the

school system. Learners infected and affected by HIV/AIDS are, in this research, regarded as learners with learning special educational needs. Even educators infected and affected by this epidemic do have special employment and labour needs such as special time to consult doctors, psychologists and so on during school hours, not to be overloaded with teaching work when they are beginning to feel weak, special services such as counselling *etcetera* (Gibson, Swartz & Sandenbergh, 2002:54).

#### **2.4.2 The influence of inclusion at schools**

From the definitions of inclusion provided in paragraph 2.4.1 above, it is clear that inclusion at schools is used to relate to educational and social values, as well as to the sense of individual and human worth of all learners, educators and parents, including communities where schools are situated (Fisher, 2001:21; Clark, Dyson, Milward & Robson, 1999:157). It addresses questions such as:

- Do schools value all learners, educators and parents equally?
- Is anyone more or less valuable?
- Are there some learners, educators and parents for whom "inclusion" is inappropriate? (O'Donoghue & Chalmers, 2000: 889)

The most important factor in dealing with HIV/AIDS is the development of a culture of inclusiveness within school organizations. Changes leading to an overall inclusiveness approach can take place if school policies and practices are developed by all school stakeholders such as parents, staff, learners and communities in order to promote an inclusive and shared vision and a common sense of purpose within their organization (Bedini, 2000:68; Cook, Tessier & Klein, 2000:16).

The key characteristics of an inclusive school organization are that it:

- puts the learners, parents and educators at the centre of its policies and practices (Beninghof, 2000:55);

- recognises and supports diversity by striving to meet the widest possible range of needs;
- seeks to achieve the best "match" between provision and the needs of the individual (Arosen, 2000:79; Ireland & Webb, 2002:34);
- supports staff in implementing an inclusiveness approach through ongoing training and development;
- helps staff to adapt teaching styles to match the learning styles of the individual;
- offers high quality effective identification of learning and support needs;
- develops positive relationships with the young person and family, for example, by sharing information (Buchan, 2000:71);
- develops positive working relationships with other agencies, for example, by sharing information with other agencies and organizations, in line with agreed protocols; and
- fosters an atmosphere in which educators and learners can thrive and progress (Cook, *et.al.*, 2000:34). These should be core activities and fully reflected in day-to-day management of schools.

The literature findings provided above have revealed that at the centre of inclusion is the belief that all learners belong in the regular school, and that effective schools are those which can meet the needs of all the learners, educators and parents regardless of what those needs may be.

One of the greatest challenges faced by schools today is the way in which they can meet the needs of all learners and educators infected and affected by HIV/AIDS in an equitable, efficient, effective and appropriate manner. With the inclusion policy of the South African government, as propounded by White Paper 6 (Department of Education, 2001), now underpinning all inclusive educational practices at schools, it is imperative that schools approach the HIV/AIDS epidemic on the basis of both White Paper 6 and South African Act Number 27 of 1996 in an inclusive manner so that learners and educators, irrespective of their health status can feel comfortable and accepted at their schools without being discriminated against and stigmatized. Inclusiveness becomes the single and unifying principle at the core of health promotion

(Colwell & Thompson, 2000:205) and concerted efforts by schools in dealing with the HIV/AIDS epidemic in this regard.

Both the South African White Paper 6 and Act Number 27 of 1996 on inclusive education and national policy on HIV/AIDS respectively provide a constitutional imperative for all learners, whatever their health circumstances are, to have access to adequate and appropriate learning provision within a learning environment matching their needs, abilities and aspirations. The inclusive approach is essential for an effective programme in dealing with the HIV/AIDS epidemic at schools as it:

- encompasses the personal development of both learners and educators, as well as more formal skills of dealing with stigma and discrimination of learners infected and affected by HIV/AIDS;
- provides appropriate life orientations (Clinton, 2003:1801).

It is therefore important that inclusiveness should also underpin the policies and practices of all schools.

The key to inclusiveness at schools is that the learning and teaching environment should match the learner and educator's needs, abilities and aspirations, irrespective of their health circumstances (O'Donoghue & Chalmers, 2000:990). An inclusive approach does not, therefore, remove the option of a separate learning environment where it is offered in response to the needs of the individual, but a separate learning environment is not justified on the grounds that it fits better with the institutional infrastructure or organizational practices (Rogers, 1993:1). An inclusive approach also avoids the location of the difficulty in the learner and educator, and focuses instead on the capacity of the educational institution to understand and respond to the individual learner and educator's requirements (Kidd, 2001:33; Staub, Schwartz, Gallucci & Peck, 1994:194).

The response to the special requirements and needs of the learners and educators infected and affected by HIV/AIDS calls for all schools to adopt inclusive education policies. All learners, educators and parents are equally entitled to the public protection and benefit of the Constitution, the Bill of

Rights, human rights legislation, White Paper 6 and other laws and policies, irrespective of health disability, colour, creed, faith, ideology, lifestyle, religion or values. Such protection enables all learners, educators and parents to fulfil their particular purpose in life, within the framework of equitable legislation that respects all and discriminates against none. Such a constitutional inclusive approach acknowledges differences (Barker, Wang & Walberg, 1995:125). This principled approach recognizes that all learners, educators and parents must be given the public space and social room to be who they think they want to be, without being discriminated against on the basis of, in the case of HIV/AIDS learners and educators, their health status.

The emphasis placed by various United Nations Policies on equality and non-discrimination can be seen as responsible for the international thinking on “inclusion”. The trend now is for school systems to move from exclusive schooling towards inclusive schooling which encapsulates diversity as the new norm because of :

- the learner population which is clearly continuing to become less and less homogeneous (Braaten & Quinn, 2000:15);
- collaborative teaching arrangements where educators’ working together does not only create more energy around problem-solving and effective strategies, but also models people skills for learners (Choate, 2000:13; Block, 2000:32);
- flexible school structures which provide physical arrangements that are adaptable to a variety of learner needs as well as teaching approaches and scheduling approaches reflecting a similar flexibility; and
- performance-based and alternative assessments where there are many ways to demonstrate learning, and learner performance expectations are as individualized as their teaching (O’Donoghue & Chalmers, 2000:891).

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International trends and practices have had a profound impact on education in South Africa and have necessitated a move away from the unequal discriminatory provision of special needs of the apartheid era (Muthukrishna & Schoeman, 2000: 319). In addition to the International guidelines, the

Constitution of the Republic of South Africa, Act 108 of 1996 provides a binding framework for legislation in Education. This has resulted in the intended inclusion of learners with special education needs in mainstream schools becoming a priority on the agenda of the National Department of Education. The long term goal of the Ministry of Education is to establish gradually an inclusive education and training system according to which learners who experience mild to moderate disabilities can be accommodated in mainstream schools, while special schools will be upgraded so that they can provide a high quality service for learners with severe and multiple disabilities, as well as act as resource schools for mainstream schools (Department of Education, 2001:12; Arguelles et.al., 2000:50).

When talks about inclusion first began, the general public, including educators and parents, expressed anxiety and concerns (Department of Education, 2001:7). Research has shown that these feelings, at least on the part of the educators, are not peculiar to South Africa. In the USA, studies have revealed that general education educators are not supportive of "full inclusion" and educators who have not been participating in inclusive programmes have expressed very strong negative feelings about inclusion, feeling that decision-makers were out of touch with classroom realities (Avramidis, et.al.,2000: 194). Later, research showed that, as educators get more involved in inclusive education, their attitudes also change (Lipsky & Gartner, 1996:762).

Research has indicated that educators often face a number of challenges pertaining to the inclusion of LSEN in the mainstream schools. These include feeling unprepared to teach LSEN; lacking the skills in teaming and collaboration, which is imperative in inclusive classrooms (Daane, Berne-Smith & Latham, 2000:336; Avramidis *et al.*, 2000:199; Clark *et al.*, 1999:171). Daane et. al. (2000:333) found that educators who had been involved in inclusive education for two years did not support the view that LSEN could benefit in the general education classroom; that inclusive education increased the teaching load of the educator and that it created classroom management problems. They also had problems in adapting the curriculum to meet the needs of LSEN. Many educators reported academic and behaviour problems

and pupils with emotional and behaviour problems were indicated as causing more concern and stress to the educators (Byra & Jenkins, 2000: 26; Clark, 2000:56). Even while expressing a number of challenges, educators with active experience of inclusion had significantly more positive attitudes towards inclusion than those randomly selected.

The literature is unanimous about the importance of the educator for successful inclusion initiatives. Engelbrecht, Green, Naicker & Engelbrecht, (1999:36) believe that educators' beliefs, attitudes and feelings with regard to what is happening in the classroom is of crucial importance, while Fishbaugh & Gum, (1994: 45) maintain that mainstream educators should be receptive to the principles and demands of inclusion for it to be effective. A number of studies have been conducted regarding educators' responses to inclusive education. However, what is absent from the research on inclusion is an acknowledgement of the socially constructed nature of inclusive education, and that educators' feelings, attitudes and sense of challenge will be simultaneously constructed and restricted by discourses available to them regarding inclusion (Rogers, 1993:1).

The foundation of inclusive education is social constructivism and ecosystems. Inclusion cannot be created simply by the diktat of school administrations; instead, the educators in inclusive schools have to construct the meaning of inclusion for themselves as part of an overall cultural transformation of their schools (Clark, *et.al.*, 1999:161). The social constructivist perspective acknowledges that realities are socially constructed and constituted through language, and that all reality arises through social interaction over time. In other words, that people construct their realities as they live them and that there are no essential truths (Freedman & Combs 1996:45).

The cornerstone of inclusive education is the parallel between ecological communities (that is, ecosystems) and learning communities (that is, schools). To understand the theory of ecosystems and apply them to human communities, schools need to learn the principles of ecology, the "language of nature." They need to become ecologically literate. Once they really

understand and implement the principles of ecology, which are interdependence, diversity, partnership, energy flow, flexibility, cycles, co-evolution, and sustainability, they become inclusive communities. In schools and other learning communities, these principles of ecology become principles of education (Steffe & Gale, 1995:41; Brice & Miller, 2000:240). The link between ecological communities and human communities exists because both are living systems, and this is where systems-thinking comes in. The parallel between ecosystems and human communities is not just a metaphor. It is a real connection, because both are living systems. The principles of ecology are the patterns of life. To understand these patterns, to understand living systems, there is a need for a new way of thinking at schools. The fundamental change in schools' way of thinking must be a shift of emphasis from the parts to the whole (Von Glasersfeld, 1995:4; Beninghof, 2000:23).

The foregoing paragraphs therefore highlight the foundation of inclusive education as the philosophy and belief that all learners in a school, regardless of their strengths or weaknesses in any area, become part of the school community and that educators work in inclusive school communities with people of different races, religions, aspirations, disabilities. In the same vein, learners of all ages should learn and grow in environments that resemble the environments that they will eventually work in. When effective inclusion is in place, the learner who needs the inclusion does not feel excluded (Bruder, 2000:223). The learner is included in the feeling of belonging among other learners, educators and support staff. Inclusive education acknowledges that all children can learn; acknowledges and respects differences in children: age, gender, ethnicity, language, disability, HIV and TB status, *etcetera*; enables education structures, systems and methodologies to meet the needs of all children; is part of a wider strategy to promote an inclusive society; is a dynamic process which is constantly evolving; need not be restricted by large class sizes or a shortage of material resources (Block, 2000:40; Hunt, Farron-Davis, Beckstead, Curtis & Goetz, 1994:247).

In this regard, White Paper 6 sees inclusive education and training as:

- acknowledging that all children and youth can learn and that they all need support;
- accepting and respecting the fact that all learners are different in some way and have different learning needs which are equally valued and an ordinary part of our human experience;
- enabling education structures, systems and learning methodologies to meet the needs of all learners;
- acknowledging and respecting of differences in learners, whether due to age, gender, ethnicity, language, class, disability or HIV/AIDS status;
- broader than formal schooling, acknowledging that learning also occurs in the home and community, and within formal and informal modes and structures;
- concerned with changing attitudes, behaviour, teaching methodologies, curricular and the environment, to meet the needs of all learners;
- maximizing the participation of all learners in the culture and the curricula of educational institutions, uncovering and minimizing barriers to learning; and
- empowering learners by developing their individual strengths and enabling them to participate critically in the process of learning (Department of education, 2001:5; Clark, 2000:60; Werts, et.al., 1996:11).

This means that in inclusive educational settings all learners in a school's attendance area are full members of that school community and each learner participates equitably in the opportunities and responsibilities of the general education environment (Choate, 2000:55; Salisbury & Chambers, 1994:215).

The educators involved in inclusion efforts understand that classrooms are becoming more and more diverse and that the educator's job is to arrange teaching that benefits all learners, even though the various learners may derive different benefits (Rogers, 1993:4; Schnorr, 1990: 233). Past assumptions about special education and general education as separate

systems are giving way to a challenge to work together (Moore, 1996:43). Inclusive education views schools as inclusive and they should always look for ways to educate that will benefit all learners.

The philosophy of inclusion hinges on helping learners and educators become better members of a community by creating new visions for communities and for schools (Lipsky & Gartner, 1996: 782). This means that inclusion is about membership and belonging to a community. That is why inclusive curricula will always include strong parental involvement, learners making choices and a lot of hands-on and heads-on involvement.

Inclusion is a key while learners are still at school. According to Stainback and Stainback (1996:54), inclusive educators are aware that when learners will have left the public school, they will be living and working with a diverse population of people. So they have to be accepted after they are out of school as much as when they are at school. Inclusion therefore involves all kinds of practices that are ultimately practices of good teaching. What good educators do is to think thoughtfully about learners and develop ways to reach all of them. Ultimately good teaching is a relationship between two people; educators get good results because they enter into that relationship. Inclusion is providing more options for learners as ways to learn. It is structuring schools as communities where all learners can learn (Butler-Hayes, 1995:32; Villa & Thousand, 1995:23).

But there is no recipe for becoming an inclusive educator or an inclusive school. It is not a mechanized format (Belanger, 2000:240). This implies less whole-class, educator-directed teaching, for example, lecturing; less learner passivity: sitting, listening, receiving and absorbing information; less prizing and rewarding of silence in the classroom; less classroom time devoted to fill-in-the-blank worksheets, dittos, workbooks and other "seatwork"; less learner time spent reading textbooks and basal readers; less attempts by educators to "cover" thinly large amounts of material in every subject area; less rote memorization of facts and details; less stress on the competition and grades at school; less tracking or levelling learners into "ability groups"; less use of pull-out special programmes; and less use of and reliance on standardized

tests (Clough & Corbett, 2000:12; Beloin & Peterson, 2000:18; Staub *et al.*, 1996:197; Phillips *et al.*, 1990:185). The emphasis is on more experiential, inductive, hands-on learning; more active learning in the classroom, with all the attendant noise and movement of learners doing, talking and collaborating; more emphasis on higher-order thinking; learning a field's key concepts and principles; more deep study of a smaller number of topics, so that learners internalize the field's way of inquiry; more time devoted to reading whole, original, real books and nonfiction materials; more responsibility transferred to learners for their work: goal-setting, record-keeping, monitoring, evaluation; more choice for learners; for example, picking their own books, writing topics, team partners, research projects; more enacting and modelling of the principles of democracy at school; more attention to affective needs and the varying cognitive styles of individual learners; more cooperative, collaborative activity; developing the classroom as an interdependent community; more heterogeneously grouped classrooms where individual needs are met through inherently individualized activities, not through segregation of bodies; more delivery of special help to learners in regular classrooms; more varied and cooperative roles for educators, parents and administrators; and more reliance upon educators' descriptive evaluation of learner growth, including qualitative/anecdotal observation (Colwell & Thompson, 2000: 210; Becker, *et al.*, 2000:71; Engelbrecht *et al.*, 1999:12; Yell & Shriner, 1996:111).

Competent inclusive educators have the ability to solve problems, to be able to assess informally the skills a learner needs (rather than relying solely on standardized curricula); take advantage of learners' individual interests and use their internal motivation for developing needed skills; set high but alternative expectations that are suitable for the learners, this means developing alternative assessments; set appropriate expectations for each learner, regardless of the learner's capabilities (Clough & Corbett, 2000:36). If educators can do this, it allows all learners to be included in a class and school; determines how to modify assignments for learners and how to design classroom activities with so many levels that all learners have a part (Beloin & Peterson, 2000:20). This teaching skill can apply not just at the elementary or

secondary level, but at the college level as well. It will mean more activity-based teaching, rather than seat-based teaching, learning how to value all kinds of skills that learners bring to a class, not just the academic skills. In doing this, educators will make it explicit that in their classrooms they value all skills (even if that is not a clear value of the whole school), providing daily success for all learners (Colwell & Thompson, 2000:220). Educators have to work to counteract the message all learners get when certain learners are continually taken out of class for special work. Other competencies that will help general education educators in an inclusive environment include a realization that every learner in the class is the educator's responsibility. Educators need to find out how to work with each learner (rather than assuming that someone else will tell them how to educate a learner), knowing a variety of teaching strategies and how to use them effectively. This includes the ability to adapt materials and rewrite objectives for a learner's needs; working as a team with parents and special education educators to learn what skills a learner needs and to provide the best teaching approach; and viewing each learner in the class as an opportunity to become a better educator, rather than a problem to be coped with or have someone else fix (Yell & Shriner, 1996:113; Byra & Jenkins, 2000:26).

Inclusive education maximizes the individual growth of each learner and builds a sense of community in an educational setting. Learners with special needs are afforded a sense of belonging to the diverse human family. Such education provides a diverse stimulating environment in which to grow and learn; evolves in feelings of being a member of a diverse community; enables development of friendships; provides opportunities to develop neighbourhood friends; enhances self-respect; provides affirmations of individuality; provides peer models; provides opportunities to be educated with same-age peers (Villa & Thousand, 1995:57; Bedini, 2000:55).

Villa *et. al.* (1996:36) assert that general education:

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- provides opportunities to experience the diversity of society on a small scale in a classroom;

- develops an appreciation that everyone has unique and beautiful characteristics and abilities;
- develops respect for others with diverse characteristics;
- develops sensitivity toward others' limitations;
- develops feelings of empowerment and the ability to make a difference;
- increases abilities to help and teach all classmates;
- develops empathetic skills;
- provides opportunities to put their feet vicariously in another learner's shoes; and
- enhances appreciation for the diversity of the human family(Cavet, 2000:155).

General education also

- helps educators appreciate the diversity of the human family;
- helps educators recognize that all learners have strengths (Chapman, 2000:14);
- creates an awareness of the importance of direct individualized teaching;
- increases ways of creatively addressing challenges;
- teaches collaborative problem-solving skills (Cawley, 2000:40);
- develops teamwork skills;
- acquires different ways of perceiving challenges as a result of being on a multi-disciplinary team;
- enhances accountability skills; and
- combats monotony (Werts *et al.*, 1996:15; Bricker, 2000:14).

Society promotes the civil rights of all individuals; supports the social value of equality; teaches socialization and collaborative skills; builds supportiveness and interdependence; maximizes social peace; and provides learners with a miniature model of the democratic process (Hilton & Liberty, 1992:168).

Inclusive education means that educators work with learners in a context that is suitable to a diverse population of learners. It also means the educator may need alternative expectations and goals for learners (Coulehan, Friedlander & Heatherington, 1998:33).

Inclusive education operates from the assumption that almost all learners should start in a general classroom, and then, depending on their needs, move into more restrictive environments. Research shows that inclusive education helps the development of all learners in different ways (Lipsky & Gartner, 1996:780). Learners with specific challenges make gains in cognitive and social development and physical motor skills. They do well when the general environment is adjusted to meet their needs. Learners with more typical development gain higher levels of tolerance for people with differences. They learn to make the most of whoever they are playing with. When we exclude people, it ultimately costs more than the original effort to include them (Muthukrishna & Schoeman, 2000:334).

From the foregoing paragraphs, it can be deduced that the concept of inclusiveness goes beyond the immediate provision of education and training (Hunt, Staub, Alwelli & Goetz, 1994:291). It is also a guiding principle for schools in offering the learners, educators and parents a rewarding and fulfilling learning experience. Schools can do this with the outside agencies like social workers, psychologists, *etcetera*. Without a common, shared understanding and belief in the idea of inclusiveness, the transitions from one provider to another. (which for some learners, educators and parents can be multiple transitions) may be ineffective and undermine previous achievements. To achieve smooth transition and progression it is necessary for all the agencies and organizations to play their part (Beninghof, 2000:23). This will mean joint and tactical work by agencies at national level, strategic level and operational level and, perhaps more important, "joined up thinking".

### 2.4.3 Inclusive approaches to the HIV/AIDS epidemic

At the heart of the inclusive approaches to HIV/AIDS is the belief that understanding stakeholder needs, that is, the needs of learners and educators and their environment and incorporating them into school strategy and sustainable value creation activities are central to the achievement of sustainable growth and competitiveness of the school (Belanger, 2000:231; Bricker, 2000:14; Cluster, 2001:5). In this regard, the World Health Organization (WHO) (2002:12) has suggested that HIV/Aids epidemic can be addressed at schools if HIV/AIDS education programmes can:

- be infused in the school curriculum to influence children's ideas about sex and relationships even before HIV/AIDS start;
- deal with sexuality in education with emphasis to HIV/AIDS and
- respond to the country's increasing number of AIDS orphans who are still of school-going age and learners experiencing physical and psychological distress because of being infected or affected by HIV/AIDS.

The introduction of life skills education to all school-going youth was identified by Sunter (1996:4) as one of the five key strategies of Department of Health's HIV/AIDS and STD Directorate. Brown (2002:2) has identified youth as a critical decisive crucial group for education and support with regard to HIV/AIDS, and has recommended that the task of taking HIV/AIDS and sexuality education to the youth should be the primary responsibility of any education department.

The South African Department of Health (2000a:5) and the South African Act No. 27 of 1996 (the National policy on HIV/AIDS for schools) prescribe that with the increasing numbers of learners and educators becoming infected with HIV/AIDS, it is of vital importance for all schools to have an HIV/AIDS policy. According to this Department, the schools' HIV/AIDS policies should include, among others, guidelines to:

- non-discrimination on grounds of a person's HIV status;
- admission policy;
- HIV testing;

- prevention of HIV transmission;
- management of HIV/AIDS; and
- an HIV/AIDS education programme.

The South African Act No. 27 of 1996 specifies the right of children to basic education. According to this Act, a child cannot be excluded from any school because of his/her HIV/AIDS status. A child should have access to information that will help develop his/her physical and emotional well-being. The Act, also, states that children have a right to be educated about sexuality and HIV/AIDS. All children therefore, according to this Act, have a right to sexuality education. This Act builds on the childcare Act (South African Act No. 74, 1983) which protects the rights of children, including their medical treatment. The childcare Act promulgates that, at the age of 14, a child can legally consent to an HIV test and he/she has the right to keep the results private. The constitution provides that all children have the right to health. Children thus have the right to protect and control their reproductive health. The South African Government Gazette (1999) no. 20372 specifies that:

- The constitutional rights of all learners and educators must be protected equally.
  - There should be no compulsory disclosure of HIV/AIDS status.
  - The testing of learners as a prerequisite for attendance at an institution, or of an educator as a prerequisite of service, is prohibited.
  - No HIV positive learner or educator may be discriminated against, but treated in a just, humane and life-affirming way.
  - No learner may be denied admission to or continued attendance at an institution because of his or her actual or perceived HIV status.
  - No educator may be denied appointment to a post because of his or her actual or perceived HIV status.
- 
- Learners and educators who are HIV positive should lead as full a life as possible.

- Infection control measures must be universally applied to ensure safe institution environment.
- Learners must receive education about HIV/AIDS and abstinence in the context of life skills education as part of the integrated curriculum (South African Act No. 27, 1996; Clinton, 2003:1805).

The foregoing paragraphs highlight that the concept of inclusiveness has a central place in dealing with the HIV/AIDS epidemic at schools. An inclusiveness approach to HIV/AIDS, through effective identification:

- recognises and acknowledges the distinct and diverse needs and abilities of learners and educators infected or affected by HIV/AIDS, and builds on the idea of value; and
- values HIV/AIDS learners and educators as whole persons, and does not focus solely, or even primarily, on their health problems and difficulties. The idea of value is integral to the policies and practices of the school.

An effective identification procedure, which values the individual and leads to an individual profile and action plan, is the key to providing a high value learning and teaching experience (Phillips, *et.al.*, 1990: 186; Cohen, 2002a:16).

Since "labelling" of people with HIV/AIDS perpetuates stigmatisation and creates barriers to participation, it is necessary that schools develop an effective identification process which identifies all the learning and support needs, and the skills and abilities of learners and educators infected and affected by HIV/AIDS (Cullinan, 2002:67; Banful, 2003:12). This denotes that an inclusive approach recognises the diversity of need. It does not exclude a separate learning environment if that is the best way of delivering an appropriate and relevant learning experience for an individual. Within a culture of inclusiveness, this should be a positive, not a negative, development, provided that learners and educators with HIV/AIDS are fully involved in a process of identification and action planning which is designed to take full account of their needs, abilities and aspirations (Cohen, 2002b:24; Crepaz &

Marks, 2002:140). In promoting the value of a separate learning environment, if appropriate, within an over-arching culture of inclusiveness, this research is not arguing against the benefits of integration where learners learn alongside their peers with support from special equipment or a personal carer, if required. The fundamental principle remains always that the provision must be the best and most appropriate to meet the identified needs of the learner infected with HIV/AIDS (Evian, 2004:135; Hoopet-Box, 2002:8).

Research has shown that educators and learners infected with HIV/AIDS who are at risk of exclusion from learning, employment and ultimately society, experience a range of different transitions and pathways to exclusion. HIV/AIDS-infected learners and educators often experience multiple transitions or "scheme hopping" (Salisbury & Chambers, 1994:215). The characteristics of infected and affected learners who "drop out" or reject the system represent a continuum of needs. This potential for unstable or unproductive transitions has led to the view that an inclusiveness approach requires a continuum of learning opportunities. This means that there should be no single starting point and no single exit route. There should be a continuum of learning and teaching opportunities, which gives flexible provision when HIV/AIDS infected and affected learners and educators most need it (Lisk & Cohen, 2004; 56; Meyer, 2003:21; Anderson & Scharlander, 2002:75).

Carr-Hill and Peart (2003:43) note that the other key element of a continuum of learning and teaching opportunities is that there must be clear routes for progression. Many educators and learners infected and affected by HIV/AIDS have experience of education and learning that offers a worthwhile learning and teaching experience, but does not seem to lead on to an appropriate next stage. It is important that the HIV/AIDS-infected and affected learners and educators have access to well-informed and timely information and guidance when they are approaching another transition. The school should be able to offer some guidance, but should also have close links with other health sectors (Kelly, 2002:13).

There is also a clear link to be made with the identification process. An effective identification process will include regular monitoring of an HIV/AIDS infected and affected persons' progress and a review of their goals (Chartier, 2003:10). An inclusiveness approach would require that schools use the outcomes of the identification process as a valuable source of information about the range and scope of learning and teaching opportunities, which should be available within their area. There is also an economic argument for ensuring that the resources already devoted to improving an HIV/AIDS-infected and affected person's skills and capabilities are not wasted through lack of further appropriate opportunities (Bennell *et al.*, 2002:54; Cohen, 2003:8).

#### **2.4.4 The role of health promotion in dealing with HIV/AIDS at schools**

Schools need a health promotion strategy to deal with HIV/AIDS epidemic. Health promotion can be an effective framework for an inclusive approach to dealing with HIV/AIDS. Since HIV/AIDS affects the psychosomatic-spiritual being of humans and thereby affect their health, it is necessary that an inclusive approach to this epidemic should adopt a health-promoting framework (Beresford, 2002:11; Schuler, 2000:1). An inclusive approach to HIV/AIDS promotes the health-promoting school's framework as a way of supporting a comprehensive and holistic approach to achieving educational and health outcomes. The health-promoting school's framework is also referred to as a whole school approach (Joseph, 2002:15; Shutte, 2000:32).

A health-promoting school aims to create an environment that is safe, stimulating and satisfying. It complements classroom-based learning experiences and provides a relevant sexual health education available to learners, educators and parents (Hepburn, 2002:136; Whisson, 2002).

The South African Department of Health (2001a:15) defines health education as any planned combination of learning experiences designed to predispose, enable and reinforce voluntary behaviour conducive to health in individuals, while health promotion is broader and involves any planned combination of educational, political, regulatory and organizational supports for actions and

conditions of living conducive to the health of individuals, groups or communities (Pretorius, 2002:17; Williams, 2000:33). Thus, in the case of HIV/AIDS, health education cannot fulfil completely its promise, nor should it be expected to, if co-ordinated actions related to health promotion, which include education and environmental supports, are not in place. The South African Department of Health (2001b:9) further explains that environmental supports encompass not only social, political, economical, organizational and regulatory circumstances related to human behaviour, but also all political actions related to health.

At times, however, health education and health promotion have been used interchangeably in the developing world (Parker & Mundawarara, 2002:34). The concept of health education is more limited than that of health promotion because it only addresses individual behavioural changes. Although social change is part of the health promotion conceptualization, in practice health promotion has historically concentrated more on individual behavioural changes (Department of Health, 1999:15). Nevertheless, this does not mean that health education cannot be linked to health promotion. In fact, Clinton (2003:1809) and Evian (2004: 17) argue that health education should move to health promotion in order to tackle both the individual and the social levels. Still, the concept of health promotion schools implies that schools should promote strategies targeted to reduce disease and promote health by allied changes in both the individual and social levels. According to Cohen (2003:56), this means that the schools' traditional focus, which was either health behavioural change or health maintenance, now also encompasses advocacy, empowerment and support.

Educational interventions emphasize that the transmission of HIV/AIDS is associated with actions such as sexual intercourse, blood transfusions, the injection and use of other skin-piercing instruments, organ and semen donation, peri-natal transmission, and with the delivery of vaccines (Whisson, 2002:19; Rugamela & Akoulouze, 2003:10). However, less stressed in educational interventions are the non-behavioral problems affecting the transmission of the disease (Pfeiffer, 2002:4). These stem from:

- an economic base (no money to buy condoms and health care, no efficient blood screening);
- occupation (prostitution, blood donation to get money); and
- environmental isolation (lack of family support and lack of access to school and/or work) (Van Aard, 2002:22).

These non-behavioural problems are exactly the issues health promotion should address.

It is often assumed that health education can protect health status if people learn to avoid the behaviours leading to the spread of HIV infection (Fuphe, 2002:16). However, people need to have sufficient material and symbolic resources to avoid the health compromising behaviours (Schneider & Stein, 2002:33). Material resources refer to:

- condoms in the case of sexual intercourse;
- disinfected piercing instruments in the use of drugs or other activities;
- decontaminated blood in blood products and transfusions;
- decontaminated organs and semen, use of drugs to prevent vertical transmission and health-related complications; and
- better access to vaccines (Munusamy, 2002:33).

Symbolic resources refer to access to information as well as the understanding of cultural values and norms. In other words, symbolic resources provide a shared cultural understanding of current events, affectivity, social norms and social ties. People and institutions provide these resources (Soul Buddyz, 2003:21). The three main institutions (family, school and work) can generate both material and symbolic resources to prevent and treat health problems. These institutions can act in alliance with each other, in the way that health clinics and neighbourhood associations do to promote health (Kelly, 2002:10).

In a country like South Africa where citizens are divided between rich and poor people, this epidemic has increased rapidly among the majority of the poor. As the link between HIV/AIDS and poverty is reported increasingly, the lack of both material and symbolic resources is crucial. The fact that the epidemic is growing among the poor can be seen in extreme cases such as South Africa where one fifth of its population is already infected (Department of Health, 2000b:1) and it is considered epidemic. Gwatkin and Deveshwar-Bahl (2002:14) says: "It is inevitable that AIDS claims the largest number of people from this majority of the poor, mainly because they have no access to resources-whether material or symbolic: they cannot afford medicine, education or information to help them cope with the disease. It is also apparent that these poor conditions undermine average survival after diagnoses. In the last decade, Brazil embraced the political strategy to distribute freely drugs for HIV/AIDS patients to help their survival (Jewkens, Levin, Mbananga & Swinson, 2002:131). Before this policy, the average survival after diagnosis was reported to be only 5.1 months, less than half as long as the average in countries such as the United States, Spain, Italy, Australia, and England" (Boler, 2003:12).

Yet many people are either abandoned entirely, or helped only by institutions that are ill-prepared to cope with the problem. The lack of health education can be crucial. In fact, the HIV/AIDS scientific advances that should increase the compliance to the drug usage are not always known (Lisk & Cohen, 2004:36).

It is important to note that not all material and symbolic resources available in any society are conducive to enhancing the health of individuals and groups. An extreme example is one related to adolescents' symbolic resources. (Barnett & Schueller, 2002:35), studying 103 Brazilian adolescents, states that their reports indicate that they engage in high-risk sexual activity not only for money, but also as a rite of passage for men (homosexual or bisexual experimentation and sexual intercourse), as birth control for women (anal intercourse) and for both sexes, as a means to get affection.

Moreover, it is possible that material resources are available, but symbolic resources may enter into competition with them. Avoiding pregnancy is one of these situations where girls may resort to the symbolic role of becoming a mother. In a fascinating study, Van Aard (2002:56) explains that it is primarily through motherhood that HIV-infected poor Brazilian girls can hold on to their status as women and to their social identity threatened by the disease. Of course, these girls' choice to have the child despite infection could be seen as part of their right to lead a gratifying life (Rickert, 2002:13; Gwatkin & Deveshwar-Bahl, 2002:34).

Considering all the complexities imposed by HIV/AIDS and by society at large, health education must provide people with a multitude of symbolic resources so that they can decide how to avoid infection and improve their health status (Joseph, 2002:15). Health promotion programmes should be inclusive, providing as many material and symbolic resources as possible for people to choose from. Perhaps then this comprehensive approach, designed to go beyond the individual level, is capable of addressing the social problems that contribute to the spread of HIV/AIDS, such as the causal relationship between poverty, ignorance and infection (Anderson & Scharlander, 2002:76).

Health-promoting schools ensure that learners acquire age- and context-appropriate knowledge and skills so that they can behave in ways that will protect them from infection (Pfeiffer, 2002:22). Educators need more skills to deal with HIV/AIDS and should be trained to give guidance on HIV/AIDS. The focus of this guidance is to build social and emotional health, including sexuality.

Sexuality is an integral part of the personality of everyone: man, woman and child. It is a basic need and aspect of being human that cannot be separated from other aspects of life (Ebersohn & Eloff, 2002:144). It influences thoughts, feelings, actions and interactions and thereby our mental and physical health. Since health is a fundamental human right, so must sexual health be a basic human right (Mohlala, 2002:9; Chartier, 2002:23).

Sexual health is the integration of the physical, emotional, intellectual and sexual aspects of sexual beings, in ways that are positively enriching and that enhance personality, communication and love. It involves a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic (Bateman, 2002a:6). It involves freedom from shame, fear, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relations, and freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive function (Crepaz & Marks, 2002:140).

It is important that school-based policies, guidelines and programmes also support and guide learners to make positive choices about their relationships and sexual health. Discrimination in terms of gender and homophobia are also key issues for schools to address (Hurting, Pande, Baral, Newell, Porter & Bam, 2002:79). Such guidance and support have been found to increase adolescents' confidence and ability to make informed decisions: delay the onset of sexual activity; decrease the frequency of sexual intercourse; increase the use of contraceptives in those adolescents who have decided to be sexually active; prevent teenage pregnancy and sexually transmissible infections among young people; and provide additional opportunities for learners to learn about and discuss relationships and sexual health issues outside their homes (Kelly, 2002:10; Mohlala, 2002:6).

In planning curricula, health-promoting schools need to be inclusive of all groups of learners, irrespective of the educational setting, by providing them with a wide range of knowledge, skills and values (Department of education, 1999:12). This means recognizing the different starting points, learning rates and previous learning experiences of learners. The curriculum needs to be mindful of cultural differences, valuing and including the understanding and knowledge of all groups, including those infected and affected by HIV/AIDS. Schools need to be aware of and understand that:

- there are many cultural sensitivities surrounding sexuality issues; and

- in some cultures, young males of a certain age are considered to be men after certain cultural activities and the responsibilities that go with that change (Parker & Mundawarara, 2002:323).

This curriculum provides opportunities for learners to increase their understanding and appreciation of supportive environments, equity and diversity. It includes activities linked to the curriculum framework that encourages learners to:

- understand that sexual health is a significant health concern for young people and the broader community;
- accept that diversity of sexual orientation exists within the community; and
- challenge heterosexist attitudes that marginalize gay and lesbian groups, as well as leading to physical and emotional harassment of some young people (Leach, 2002:99; Lawrence, 2002:66).

The curriculum framework sets out what all learners should know, understand, value and be able to do as a result of the programmes they undertake at school. The broad outcomes from the curriculum framework form the basis for the educators to decide the purpose, content and procedure for lessons; develop a progress map for the ongoing monitoring of learner progress; and undertake regular, periodic monitoring and reporting of learner progress towards achieving the outcomes (England, 1996:7; Schneider & Stein, 2002: 34).

The learning activities in a curriculum that can grow and develop healthy relationships provide learners with opportunities to develop knowledge, understanding, skills and values related to health (Cohen, 2002a: 22). In this way, educators help learners in the early childhood years to establish a strong foundation in concepts related to developing healthy relationships throughout their lives. Information should be provided about the meaning of the term “sexual”, including correct terminology for body parts and human growth from birth to present age. Recognizing that people are uniquely different both physical and emotionally is an important concept for young children to explore

(Bundy, 2003:46). The differing structures of families are an equally important concept. Opportunities to discuss changes, which may occur within the family, such as the arrival of a new baby, separation or divorce, should also be included (Gwatkin & Deveshwar-Bahl, 2002:65). Friends and friendship development are important concepts to be discussed in the context of self-knowledge. Learning to keep safe and to reduce risks to their health is also important for young children. Children need to know about the safe disposal of needles, syringes and safety procedures if they are bleeding or if they find a person who is bleeding (Leclerc-Madlala, 2002:9; Kelly, 2002:87).

Health promotion focuses on reducing and eliminating discrimination. (Rickert, 2002:45) and (Hamilton, 2002:3) recognize the need for school policies to avoid discriminating against learners and educators with HIV/AIDS. But there are other noninfectious diseases and social differences that continue to generate discrimination. The need for policies to reduce and eliminate discrimination against HIV-infected people is the responsibility of all institutions (South African Act No. 27 of 1996). Without social solidarity and tolerance, the challenges of this epidemic will continue even if a cure is found because the challenges do not lie only with HIV/AIDS-related problems, but with the way societies are organized in discriminating, hierarchical models. An effort in this direction is the remarkable work by Barnett and Schueller (2002:56) in the Brazilian Northeast who has been investing in social networks of learners and educators to disseminate values of tolerance, the recognition of human rights and the need to build a culture that values individual rights and respects individual history.

#### **2.4.5 The role of educators in developing inclusive health-promoting approaches at schools**

Some challenges with regard to the HIV/AIDS epidemic are left for all educators to build societies based on health promotion approaches (Boler, 2003:23). The initial recommendations for educators relate to building and providing more symbolic resources.

- Firstly, educators should study and discuss with the population the symbolic contents related to HIV/AIDS and to the experience of death. This means addressing the psychological factors of people dealing directly or indirectly with family members who died or will die. Thus, a task can be for educators to try to teach hope to children who have experienced the death of their parents from AIDS (UNAIDS, 2002:45).
- Secondly, educators can encourage and give practical advice to parents who will die of AIDS and leave their children as orphans (with or without the infection). Educators should also study and address other symbolic issues related to the identification and explanation of cultural issues and problems. This may mean examining the specific ways in which individuals and institutions deal with a health problem, comparing hegemonic health models with popular health models (Bateman, 2002a:67; Gwatkin & Deveshwar-Bahl, 2002:19).
- Thirdly, educators can contribute by studying and discussing social patterns that do not apply only to the HIV/AIDS epidemic (Leclerc-Madlala, 2002:10).

Educators can provide effective leadership in the development of inclusive programmes, provided that they have training and experience in collaborative consultation, behavioural and academic intervention design, curriculum adaptation, modification of learning environments, programme evaluation, peer-mediated learning, facilitating friendships and other issues critical to effective inclusive programmes (Pretorius, 2002:98). Such expertise gives them a unique position to assist schools in assessing learner needs, re-allocating existing resources and restructuring service delivery systems to meet the educational and physical and psychological well-being and wellness needs of all learners and educators (Dean & Moalusi, 2002:25). Educators competent in the philosophy and principles of inclusion can foster the development of inclusive schools by:

- gathering and providing information regarding the strengths and needs of individual learners;

- providing meaningful support and consultation to educators and other school governing bodies implementing inclusive programmes (Crepaz & Marks, 2002:140);
- distributing articles and research to fellow educators and district committees responsible for educational restructuring;
- leading or serving as members of groups that are evaluating or restructuring education programmes (Carr-Hill & Peart, 2003:32);
- planning and conducting staff development programmes that support inclusion;
- offering training and support to educators, learners and families (Chartier, 2003:56);
- developing new resources through grant writing and collaboration with other community agencies, and other activities;
- providing information on needed changes to legislators and state and federal policy-makers; and
- collecting and analysing programme evaluation and outcomes-based research (Whisson, 2002:55).

They should inculcate self-management skills where learners are placed in situations in which they can observe, develop and explore self-management skills as individuals in class and friendship groups. They should practice decision-making, goal-setting and planning skills to maintain their personal safety through play and interaction with peers, siblings and school community members (Meyer, 2003:10; Tembon *et al.*, 2003:45). The basic steps of decision-making when confronted with a situation such as finding a person who is bleeding or finding a needle and syringe should be learned and practised. Opportunities should also be provided for the children to explain to friends and educators or family members, the basic strategies, which can be used to cope with unsafe situations or unhappy feelings such as harassment or bullying or changes in life situation (Ebersohn & Eloff, 2002:123).

Educators should also develop interpersonal skills pertaining to learners who get opportunities and support to learn and value the interpersonal skills required to communicate and cooperate with peers and others in play, games, school and social situations (Dickinson, 2003:6). Such opportunities will enable children to speak positively about themselves, as well as openly express their feelings about topics such as ways in which love and affection should be provided (Kelly, 2002:26). Children need to practise the effective use of the telephone in blood spill and other emergency situations. Assertive verbal and non-verbal messages should be practised to cope with situations in which they feel uncomfortable (Debswana, 2004:13).

Children should also have the opportunity to learn about their place in their family and social group and how they can use their communication and cooperation skills to strengthen and maintain their relationships with family members, peers and the school community (Leach, 2002:100). At this phase of development, they begin to understand how these relationships change and how to use their interpersonal and self-management skills to cope with them (Jewkens, Levin, Mbananga & Swinson, 2002:319).

It is also necessary that educators develop healthy attitudes and values among learners where learners identify and demonstrate attitudes and values that contribute to the prevention of ill health and recognize personal responsibility for their health (Bateman, 2002b:76). Such efforts enable learners to value and demonstrate a commitment to the benefits of collaboration (England, 1996:6); to explore friendships, valuing skills to promote health and rewarding relationships with peers, family and the wider community; to demonstrate this by being inclusive and just in their interpersonal relationships in the classroom, peer, friendship and team situations (Cook *et al.*, 2000:25); to value the concept of personal excellence, understanding the need to cope with change to attain their goals and to enjoy a healthy rewarding life; and to acknowledge the value of safety procedures if they find a person who is bleeding (Cohen, 2002b:24).

## **2.5 CONCLUSION**

This chapter presented the literature review findings of both HIV/AIDS and the inclusive approach to HIV/AIDS. The next chapter presents the empirical design of this research.

## **CHAPTER THREE**

### **EMPIRICAL RESEARCH DESIGN**

#### **3.1 INTRODUCTION**

This chapter presents the research methods used in this study. It includes an overview and justification of the questionnaire administered for the collection of the empirical data for this research. The use of a questionnaire is taken as the most appropriate and practical technique in reaching the aims of this research, which are to:

- determine the effects of HIV/AIDS on school systems; and, on the basis of the findings of both the literature study and the empirical research,
- make a suggestion of an inclusive approach to dealing with the HIV/AIDS epidemic at schools.

The study investigates the perceptions of educators and school management teams (principals, deputy principals and heads of department) on the impact of HIV/AIDS on the human resources of schools, which are educators and learners; and the school system, which in this research refers to the learning and teaching situation. The responses of the participants together with the findings of the literature research (see chapter 2) are used to make suggestions for an inclusive health promoting educational approach (see Chapter 5), which schools can adopt in dealing with the HIV/AIDS epidemic at their schools.

#### **3.2 DESCRIPTION OF THE POPULATION**

All educators and school management teams falling under the jurisdiction and control of the Gauteng Department of Education were considered as the study population. The Gauteng Department of Education has 2 040 educators serving in school management teams in public schools, and this figure is calculated at an average rate of 3 school management team members per

school. As the completion of the study could be delayed if all of them were to participate in the study and this could have heavy financial implications for the researcher, the researcher and the supervisor used these two factors in deciding on 400 participants who would take part in this study. The researcher and the supervisor also decided to limit the study population to educators and school management teams in the Vaal Triangle area of the Gauteng Province

### **3.3 METHOD OF RANDOM SAMPLING**

Samples like cluster and random sampling were considered for use in this investigation. After careful consideration of the advantages and disadvantages of each of these methods, random sampling was selected, to ensure that the sample would be representative of the population. A list of all public schools from Vereeniging and Vanderbijlpark districts was obtained and schools for investigation were randomly selected from the list. The respondents consisted of educators and school management teams from 30 randomly selected public schools in both districts in the Vaal Triangle area of Gauteng Province.

### **3.4 RANDOM SAMPLE SIZE**

A total of (n=400) educators, comprising of (n=120) school management teams and (n=280) educators from 30 public schools participated in the survey. This sample ranged from farm school areas to township school areas consisting of primary, secondary and combined schools.

### **3.5 PROCEDURE**

The researcher personally visited primary and secondary schools in the townships and farm school areas where questionnaires were distributed to educators, Heads of Departments (educators serving and appointed on post level 2), Deputy Principals (educators serving and appointed on post level 3) and Principals (educators appointed on either post level 3 or 4, depending on the enrolment of the school). Questionnaires were given to educators, heads of departments and deputy principals through the school principals with the

request that the questionnaires had to be filled in within four days and the researcher would come back to the school on the fifth day to collect them.

This method of distributing questionnaires to the educators via the school principals created problems for the researcher because not all questionnaires were returned. Only 207 (51, 75%) out of 400 (100%) were returned.

The questionnaires had a covering letter which described the purpose of the research and conveyed uniform instructions to all the participants. Stressing the confidentiality of information, an appeal was made to the respondents to respond openly and sincerely (see Appendix A). Written guidelines (see Appendix A) on the covering letter ensured, as far as possible, uniform and standardized administration and secured participants' guarantee of confidentiality.

All data were collected during September 2003.

### **3.6 THE CHOICE OF A MEASURING INSTRUMENT**

Although several measuring instruments have been devised to obtain self-reports of educators and school management teams on their perceptions of the impact of HIV/AIDS on educators, learners and the school systems, there have been, as far as could be ascertained, only overseas measuring instruments designed to determine the perceptions of educators in countries whose social and educational situations are different from those of South Africa. As a result of a peculiar situation in the South African society and schools, especially in Black townships where learners, parents and educators have different culturally founded stereotypes and misconceptions on HIV/AIDS (Brown, 2002: 22), not a single one of these instruments was suitable and appropriate for use in the investigation in question. The researcher then decided to use a questionnaire which was developed by the Teaching and Learning section of the North-West University (Vaal Triangle Faculty) to measure perceptions of educators and school management teams of the impact of HIV/AIDS on educators, learners and the school systems within their schools and cultural context. This questionnaire was chosen because of its appropriateness in measuring the effectiveness of the teaching

and learning situation and its investigation of the impact of HIV/AIDS on the teaching and learning situation (see appendix A).

This questionnaire comprises of 90 questions divided into five sections, namely: a section for biographic information (questions 1-7, see appendix A), a section of questions to determine the impact of HIV/AIDS on educators (questions 8-18, see appendix A), a section of questions to determine the impact of HIV/AIDS on learners (questions 19-38, see appendix A), a section of questions to determine the impact of HIV/AIDS on the teaching and learning situation (questions 39-68, see appendix A) and finally a section to determine perceptions on the existing measures to curb the negative effect of HIV/AIDS on teaching and learning (questions 69-90, see appendix A). Five of the questions in the questionnaire were open-ended and gave educators the opportunity to give their personal input (questions 16, 17.12, 41.7, 44.8 and 49). In total, 400 questionnaires were distributed, though only 207 (51, 75%) returned.

It was impossible to have a 100% retrieval of questionnaires, as most of them were left at the mercy of the principals of participating schools to deliver to educators and they did not follow up the ones not retrieved. Thirteen (13) were incomplete because educators claimed that the questionnaire was too long and made it difficult for them to concentrate on the questions.

### **3.7 STATISTICAL TECHNIQUES**

Data was processed, using the SPSS programme in consultation with the Statistical Consultation Services of North-West University (Vaal Triangle Faculty) in which the computer programme performed the TEST procedure of the SPSS System for Windows Release.

### **3.8 CONCLUSION**

--- In this chapter the research design process was discussed. The next chapter provides the analysis and interpretation of data collected during the empirical research.

## CHAPTER FOUR

### ANALYSIS AND INTERPRETATION OF RESULTS

#### 4.1 INTRODUCTION

The aim of the empirical study of this research was to primarily determine by means of an unstandardized and unvalidated questionnaire the effects of HIV/AIDS on school systems. The results of the questionnaire were used together with the findings of literature to make a suggestion of an inclusive approach to dealing with the HIV/AIDS epidemic at schools (see paragraphs 1.2 and 3.1 above).

The empirical study investigated the perceptions of educators and school management teams (principals, deputy principals and heads of department) on the impact of HIV/AIDS on the school system. The school system in this research refers to:

- educators and learners whose psycho-physical human resources are significant for effective teaching and learning at schools;
- curriculum. The delivery of curriculum is key to the development of learners and the effectiveness of teaching and learning situation.

The responses of the participants together with the findings of the literature review (see chapter 2) were used to make suggestions for an inclusive health promoting educational approach (see Chapter 5), which schools can adopt in dealing with the HIV/AIDS epidemic at their schools.

The summary of the data collected during empirical research is analysed and interpreted in this chapter. The percentages of demographic particulars (see paragraph 4.2 below) were reported and t-tests were conducted to compare the perceptions of educators and school management teams with regard to the effects of HIV/AIDS on educators, learners, and the delivery of the school

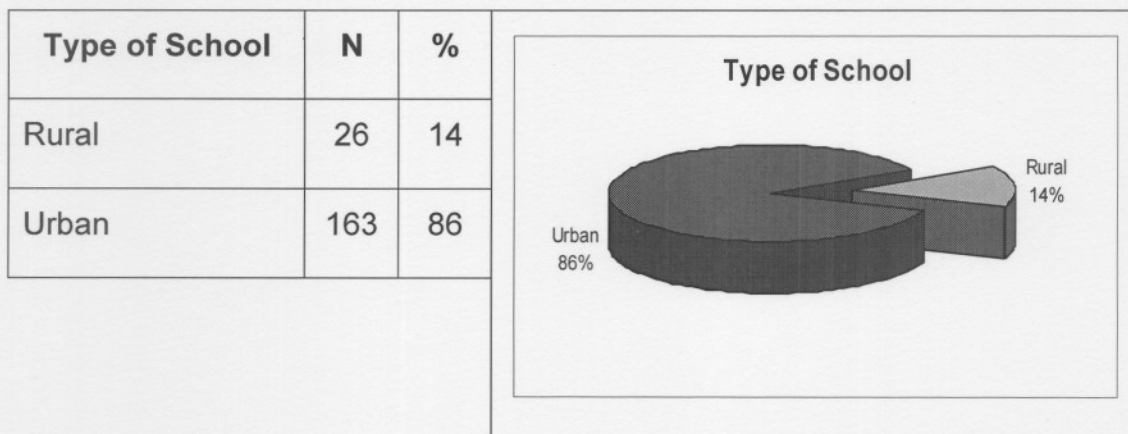
curriculum. It was also necessary to investigate if schools comply with certain categories of critical prerequisites for effective teaching and learning.

#### 4.2 DATA ON THE DEMOGRAPHIC INFORMATION PROVIDED BY THE RESPONDENTS

Analyses and interpretations of the data concerning the demographic information provided by the respondents is presented in paragraphs 4.2.1 to 4.2.5.

##### 4.2.1 The demographic distribution of the number of respondents who participated in this research according to school types (N=189)

Table 4.1



##### 4.2.1.1 Analysis

- 86 % of the respondents who participated in this research are from township schools; while
- 14 % are from farm schools.

##### 4.2.1.2 Interpretation

The majority of the schools in the Vaal Triangle area are in the townships. This is due to the fact that urbanization and the prospects of better jobs for parents are causing parents and their children to leave farms and stay in the townships which are nearer the highly industrialized Vereeniging, Vanderbijlpark and Sasolburg towns.

**4.2.2 The demographic distribution of the number of respondents who participated in this research according to levels of schools at which they teach (N=189)**

**Table 4.2**

Type of School	N	%
Primary	173	91.
Secondary	11	6
Combined	5	3

**Type of School**

Type of School	N	%
Primary	173	91%
Secondary	11	6%
Combined	5	3%

**4.2.2.1 Analysis**

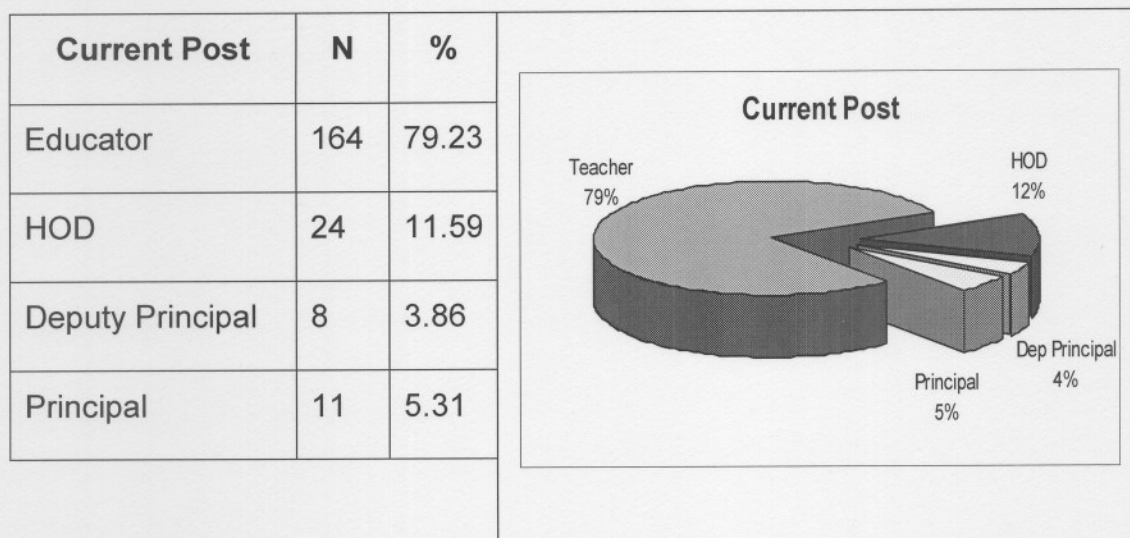
- 91% of the respondents who participated in this study are from primary schools;
- 6% are from secondary schools; and
- 3% are from combined schools.

**4.2.2.2 Interpretation**

The majority of the schools in the Vaal Triangle are primary schools.

**4.2.3 The demographic distribution of the number of educators who participated in this research according to their current posts (N=207)**

**Table 4.3**



**4.2.3.1 Analysis**

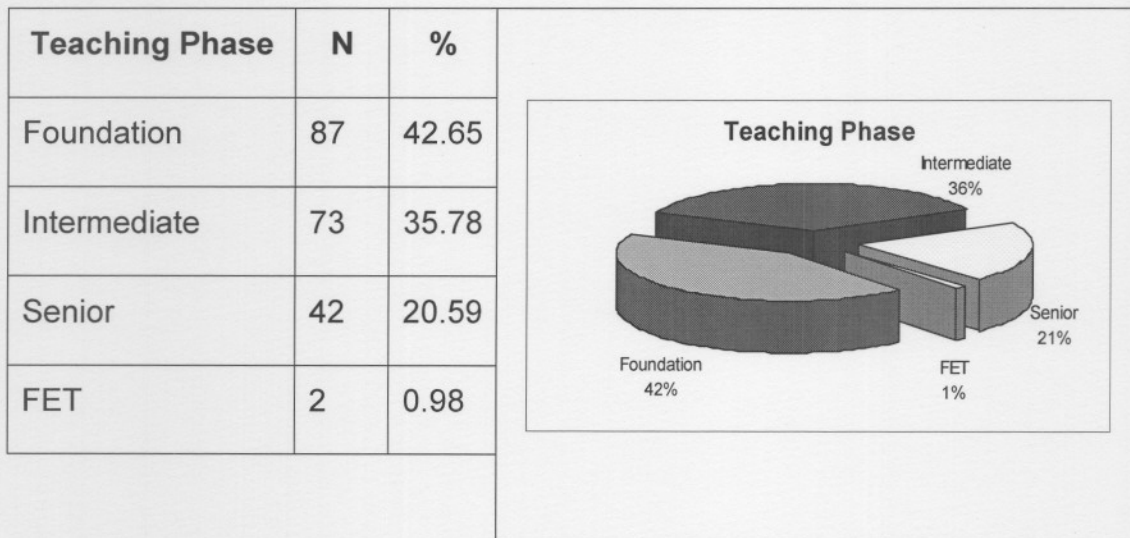
- 79% of the respondents who participated in this study are educators on post level one;
- 12% are Heads of Departments;
- 4% are deputy principals; and
- 5% are principals.

**4.2.3.2 Interpretation**

It is a given fact that educators will always be in the majority at all schools as compared to heads of departments, deputy principals and principals. This is caused by the fact that heads of departments, deputy principals and principals are occupying promotional posts which are not as many as the operational posts occupied by educators on post level one.

#### 4.2.4 The demographic distribution of respondents according to the phases in which they are teaching (N=204)

Table 4.4



##### 4.2.4.1 Analysis

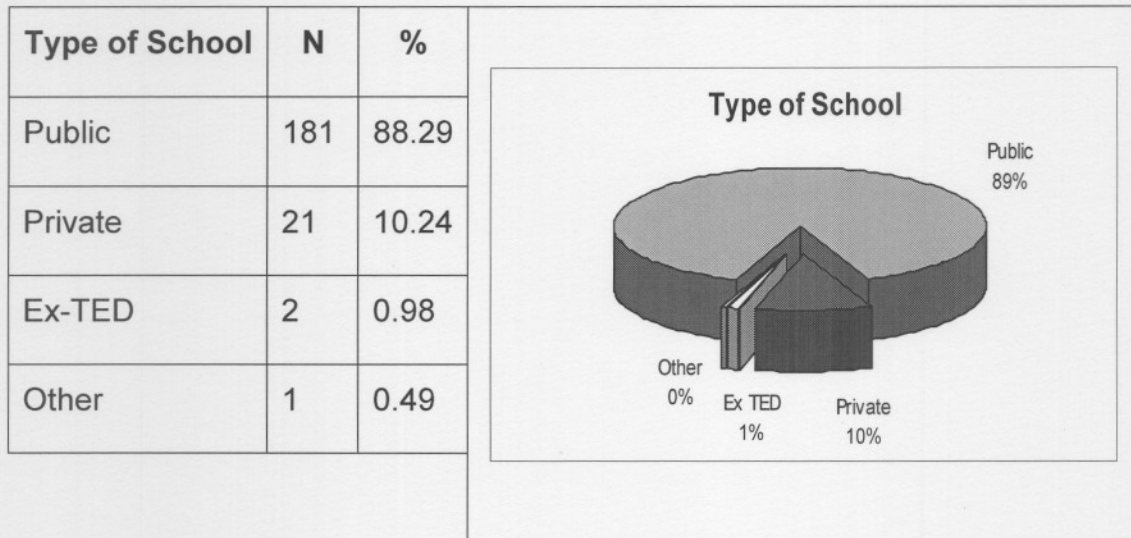
- 42% of the respondents who participated in this research are teaching at the foundation phase;
- 36% are teaching at the intermediate phase;
- 21% are teaching at the senior phase; and
- 1% are teaching at the further education and training phase.

##### 4.2.4.2 Interpretation

The foundation phase educators are in the majority in this study, which implies that there are more learners in the foundation phase than in the intermediate and senior phases at schools in the Vaal Triangle area.

**4.2.5 The demographic distribution of respondents who participated in this research according to the state classification of schools (N=205)**

**Table 4.5**



**4.2.5.1 Analysis**

- 89% of the respondents who participated in this study are public township schools;
- 10% are private schools; and
- 1% are ex-TED town schools.

**4.2.5.2 Interpretation**

Most of the schools in the Vaal Triangle area are public schools situated in the townships. It is interesting to note that private schools are in the majority, as compared to ex-TED schools which are historically white schools situated in towns. This could be caused by the fact that most of the Black parents prefer sending their children to private schools rather than sending them to historically white schools which are predominantly dominated by the Afrikaans ethos, culture and language.

### 4.3 THE EFFECTS OF HIV/AIDS ON EDUCATORS

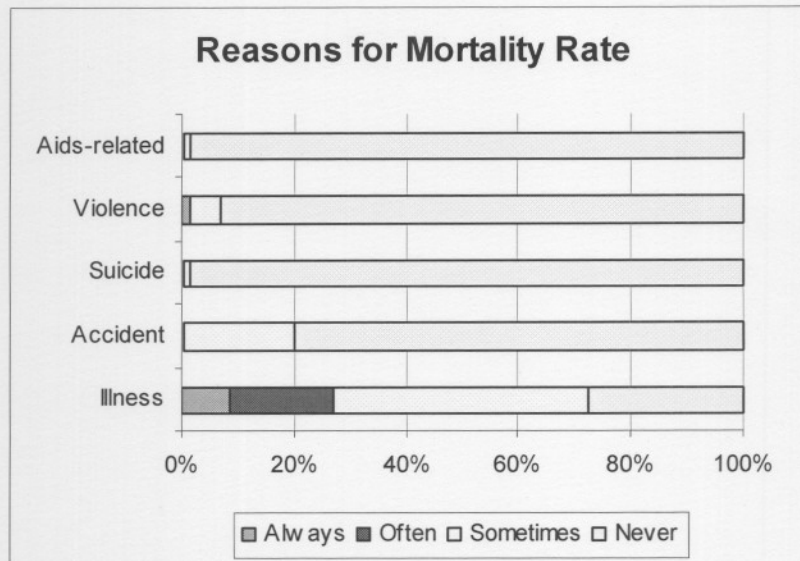
This sub-topic of the empirical research provides the primary aim of this research.

#### 4.3.1 Reasons given for the mortality rate among educators

For the purpose of interpreting this table, the researcher decided to combine the scales indicating always, often and sometimes in order to draw a conclusion that certain variables in question 12 (compare Figure 4.6 below) indicate reasons for the mortality rate among educators at the schools of the respondents.

**Table 4.6**

Reasons for Mortality Rate	Always		Often		Sometimes		Never	
	N	%	N	%	N	%	N	%
Illness	16	8.6	34	18.2	85	45.7	51	27.4
Accident	0	0	1	0.56	35	19.7	142	79.8
Suicide	0	0	1	0.53	2	1.1	184	98.4
Violence	3	1.7	0	0	9	5.2	161	93.6
Aids-related	0	0	1	0.6	2	1.1	173	98.3



#### 4.3.1.1 Analysis

- 73% of the respondents revealed that illness is the main reason for mortality among educators at their schools;
- 27% indicated that illness is not a cause of mortality at their schools;
- 20.2% of the respondents reported that accidents are the cause of mortality among educators at their schools;
- 79.8% of the respondents reported that accidents are never the cause of mortality among educators at their schools;
- 1.6% of the respondents reported that suicide is the cause of mortality among educators at their schools;
- 98.4% indicated that suicide is never the cause for mortality among educators at their schools;
- 6.9% of the respondents indicated that violence is the cause of mortality among educators at their schools, while 93.1% of the respondents indicated that violence is never the cause of mortality among educators at their schools;

- 1.7% of the respondents revealed that AIDS-related illnesses is the cause for mortality among educators at their schools; while
- 98.3% of the respondents indicated that AIDS could be the cause of mortality among educators at their schools.

#### 4.3.1.2 Interpretation

It can be deduced from the analysis of these items that illness is the main cause of mortality. It remains to be seen what these illnesses are since HIV/AIDS is not yet a notifiable disease in South Africa because of the stigma and discrimination which always go with divulging one's HIV/AIDS positive status. This could be the reason for HIV/AIDS infected educators not informing their colleagues or supervisors about their status.

#### 4.4 THE EXTENT OF FEELINGS/ATTITUDES EXPERIENCED BY EDUCATORS AND SCHOOL MANAGEMENT TEAMS WHO HAVE TO CARRY A HEAVY WORKLOAD BECAUSE OF EDUCATOR ABSENTEEISM

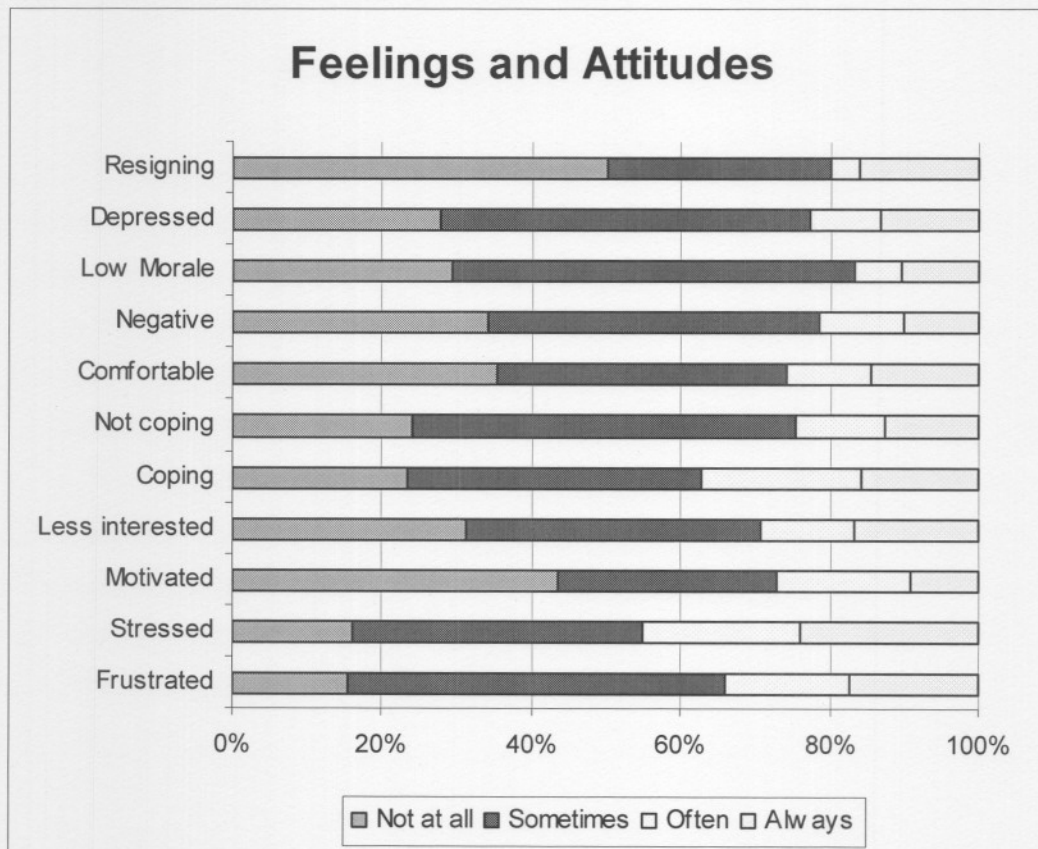
The purpose of this question was to investigate the extent of feelings/attitudes experienced by respondents who have to carry a heavy workload because of educators who are absent due to illness.

For the purpose of interpreting this table, the researcher decided to combine the scales indicating always, often and sometimes in order to draw a conclusion that certain variables in question 19 (compare Figure 4.7 below) indicate certain feelings/attitudes for having to carry more than one educator's heavy workload because of educator absenteeism.

**Table 4.7**

	Not at all		Sometimes		Often		Always	
	N	%	N	%	N	%	N	%
Feelings and Attitudes								
Frustrated	25	15.4	82	50.6	27	16.7	28	17.3
Stressed	26	16.0	63	38.9	34	21	39	24.1

Motivated	67	43.5	45	29.2	28	18.2	14	9.1
Less interested	50	31.3	63	39.4	20	12.5	27	16.9
Coping	37	23.3	63	39.6	34	21.4	25	15.7
Not coping	36	23.8	78	51.7	18	11.9	19	12.6
Comfortable	56	35.2	62	39	18	11.3	23	14.5
Negative	54	34.2	70	44.3	18	11.4	16	10.1
Low Morale	46	29.5	84	53.8	10	6.4	16	10.3
Depressed	44	27.8	78	49.4	15	9.5	21	13.4
Resigning	78	50.0	47	30.1	6	3.8	25	16.0



#### 4.4.1.1 Analysis

- 15.4% of the respondents reveal that they are not at all frustrated;
- 84.6% reveal that they are frustrated to a certain extent;

- 16% of the respondents indicate that they are not at all stressed;
- 84% of the respondents report that they are stressed to a certain extent;
- 43.5% of the respondents indicate that they are not at all motivated;
- 56.5% report that they are motivate to a certain extent;
- 31.3% of the respondents indicate that they are not at all less interested in school and school activities;
- 56.5% of the respondents reveal that they are less interested to a certain extent;
- 23.3% of the respondents indicate that they are not at all coping;
- 76.7% of the respondents reveal that they are coping to a certain extent;
- 23.8% of the respondents indicate that they are not coping at all;
- 76.2% of the respondents reveal that they are not coping to a certain extent;
- 35.2% of the respondents indicate that they are not at all comfortable;
- 64.8% reveal that they are comfortable to a certain extent;
- 34.2% of the respondents report that they are not at all negative;
- 65.8% reveal that they are negative to a certain extent;
- 29.5% of the respondents reveal that they do not at all experience low morale;
- 70.5% of the respondents report that they experience low morale to a certain extent;
- 27.8% of the respondents indicate that they are not at all depressed;
- 72.2% reveal that they are depressed to a certain extent;

- 50% of the respondents reveal that they do not at all feel like resigning; and
- 50% of them reveal that they feel like resigning to a certain extent.

#### **4.4.1.2 Interpretation**

It is a cause for concern for the researcher that a significant number of educators indicated that they are:

- frustrated to a certain extent;
- less interested in their school work;
- stressed to a certain extent;
- negative to a certain extent;
- experiencing low morale to a certain extent;
- depressed to a certain extent; and
- feeling like resigning from their jobs.

This is a clear expression of being psychologically unwell. This could be an expression of being emotionally drained and burned out because of the heavy workload that these educators have to carry for educators who are absent from work. It is interesting to note that in spite of a possibility of being emotionally drained and burned out, these educators still indicate feelings of being:

- motivated to a certain extent;
- coping to a certain extent; and
- comfortable to a certain extent.

This could explain the type of dedication and commitment that these educators have for their calling.

## 4.5 REASONS FOR EDUCATOR ABSENTEEISM IN PARTICIPATING SCHOOLS

**Table 4.8**

Reasons for Absenteeism	N	%
Sickness	137	58.1
Funerals	55	23.3
Sickness of others	22	9.3
Work-related	12	5.1
Other	10	4.2

### 4.5.1.1 Analysis

- 58.1% of the respondents who participated in this research reveal that sickness of self is the main reason for educator absence at their schools;
- 23.3% attribute absenteeism to funerals;
- 9.3% feel that absenteeism at their work is caused by sickness of others;
- 5.1% indicate work-related issues as a reason for absenteeism; and
- 4.2% is for other reasons, which respondents could not state.

### 4.5.1.2 Interpretation

The fact that the majority of respondents revealed sickness of self as the main reason for educator absence is also another indication that educators do feel sick and have to be absent from work. It again remains to be seen what the causes of their sicknesses are which could also be related to the fact that HIV/AIDS is not yet a notifiable disease in South Africa because of the stigma and discriminations that are always attached to people living with HIV/AIDS. Educators in this case could be finding it difficult to disclose the nature and extent of their ailments to their colleagues and supervisors because of being afraid to be associated with this epidemic.

## **4.6 AN ANALYSIS OF DIFFERENCES IN THE PERCEPTIONS OF EDUCATORS AND SCHOOL MANAGEMENT TEAMS WITH REGARD TO THE EFFECTS OF HIV/AIDS ON SCHOOL SYSTEMS AND ON CATEGORIES OF CRITICAL PREREQUISITES FOR EFFECTIVE TEACHING AND LEARNING**

It was necessary to analyse the differences between the perceptions of educators and school management teams with regard to the effects of HIV/AIDS on school systems and on certain categories of critical prerequisites for effective teaching and learning in order to determine if differences in perceptions between these important stakeholders in effective school management and leadership were significant or not. For this purpose, the t-test was used, and subsequently, the d-value was computed to determine the effect sizes of the significant differences. This was done for differences in responses between educators and school management teams.

### **4.6.1 The t-test**

The t-test is used to determine whether two means differ significantly from each other or whether two sets of scores differ significantly at a selected probability level (Herbert, 1990:87; Fraenkel & Wallen, 1990:185; Vockel & Asher, 1995:321). The t-test was used in this study in order to determine if there are any significant differences in the perceptions of respondents, that is, educators and school management teams, with regard to the effects of HIV/AIDS on educators and learners; school systems; and to on the basis of findings of both the literature study and the empirical research, suggest an inclusive educational approach to dealing with the HIV/AIDS epidemic at schools. The t-test was also used for its reliability to produce accurate probability statements.

### **4.6.2 The p-value**

The probability value (p-value) indicates whether there are statistically significant differences between two means of a sample (Lawson, 1992:185; Vockel & Asher, 1995:319).

In this study:

- the 0.05 (5%) significance level was selected to determine if there are any significant differences in the perceptions of respondents, that is, educators and school management teams, with regard to the effects of HIV/AIDS on educators, learners, the teaching and learning situation, and certain categories of critical prerequisites for effective teaching and learning; and
- p-values greater than 0,05 indicated no significant differences in perceptions between educators and SMT's, while p-values less than 0.05 indicated significant differences in the perceptions of respondents, that is, educators and school management teams, with regard to the effects of HIV/AIDS on educators, learners, the teaching and learning situation, and certain categories of critical prerequisites for effective teaching and learning ( Lawson, 1992:184).

All these statistical differences were determined between educators and school management teams.

#### **4.6.3 The d-value (effect size)**

The effect size assesses the magnitude of a difference between two means, that is: it takes into account the size of the difference between means regardless of whether it is statistically significant (Fraenkel & Wallen, 1990:197). In this regard Vockel and Asher (1995:357) assert that the effect size determines if the difference is enough to recommend changes in the educational practice. Lawson (1992:196) cautions, however, that though the effect size is helpful in judging the practical significance of a research result, it is by no means an absolute index of practical significance. It is therefore an aid to interpretation, albeit not an important one.

Therefore, in this study the effect size is computed in order to determine whether the observed differences derived from the t-test can be interpreted to be of practical significance or use. This is done for differences in responses between principals and deputy principals, principals and HODs and deputy

principals and HODs. It was obtained by using the following formula (Cohen, 1988:553; Fraenkel & Wallen, 1990:197; Vockel & Asher, 1995:357):

$$d = \frac{\bar{x}_1 - \bar{x}_2}{SD_{\max}}$$

$SD_{\max}$

where,

$\bar{x}_1$  = the mean of principals/deputy principals/HODs

$\bar{x}_2$  = the mean of educators

$SD_{\max}$  = the maximum standard deviation (of either of the respondents)

d = effect size

The interpretation of the effect size was done on the basis of the following guidelines proffered by Cohen (1998:26) and Vockel and Asher (1995:357):

d = 0,2 (small effect)

d = 0,5 (medium effect)

d = 0,8 (large effect)

According to Fraenkel and Wallen (1990:197), effect sizes of 0,5 or more should be treated as important. However, Cohen (1988:26) postulates that such effect sizes could depend on the reader's frame of reference, i.e. he may consider them either too small or too large, which projects the arbitrariness of quantitative operational definitions to qualitative adjectives. It was therefore decided in this study to interpret effect sizes above 0,8 to be important. This was because it was realised that all respondents are operating in school systems where the HIV/AIDS epidemic is still not notifiable diseases and, at times, it is still a taboo to discuss any items related to this epidemic.

Therefore, all schools would need to develop an inclusive approach to dealing with all the stereotypes and taboos on this epidemic. On the strength of that frame of reference, only significant differences of a large enough effect size,  $d = 0,8$ , would be considered to be of practical significance (Cohen, 1988:26).

Since the effect size indicates the practical significance of findings displaying significant differences, only those findings displaying significant differences in terms of their p-values are considered for practical significance. Therefore, d-values were only indicated in cases where  $p < 0,05$ .

The following section highlights the results of the t-test and the procedures which were used in this study in order to determine if there are any significant differences in the perceptions of respondents, that is, educators and school management teams, with regard to the effects of HIV/AIDS on educators, learners, the curriculum, and certain categories of critical prerequisites for effective teaching and learning.

#### 4.6.4 The effects of HIV/AIDS on educators

**Table 4.9**

Item description	Mean	SD	Mean	SD	t	P	d
Educators who are HIV positive	3.57	0.69	3.60	0.63	-0.22	0.82	
Educators who died	0.36	0.82	0.00	0.00	0.87	0.39	
	0.07	0.27	0.00	0.00	0.55	0.59	
	0.07	0.27	0.00	0.00	0.55	0.59	
	0.10	0.32	0.00	0.00	0.57	0.51	
	0.15	0.60	0.00	0.00	0.54	0.59	
	0.25	0.51	0.00	0.00	1.09	0.28	
Illness	2.96	0.87	2.76	0.98	1.22	0.22	
Accident	3.77	0.44	3.86	0.36	-1.06	0.29	
Suicide	3.99	0.12	3.95	0.33	1.20	0.23	

Violence/Homicide	3.87	0.50	3.97	0.17	-1.14	0.26	
Aids-related illness	3.97	0.21	4.00	0.00	-0.82	0.41	
Suicide	3.99	1.12	4.00	0.00	-0.71	0.48	
Educators possibly affected	0.60	2.72	0.00	0.00	0.74	0.47	
	1.31	2.72	0.00	0.00	0.66	0.52	
Absenteeism rate of educators	1.56	1.32	1.13	1.13	0.89	0.38	
	2.20	1.69	2.29	1.97	-0.13	0.90	
Problems experienced for an absent colleague	2.90	1.07	2.79	1.17	0.57	0.57	
Appointment of substitute educators	3.43	0.84	3.44	0.88	-0.01	1.00	
Coping with one educator's workload	1.85	0.36	1.69	0.46	2.15	0.03	0.33
Shortage of staff members	2.86	1.22	2.46	1.13	1.04	0.30	
Frequent absence of staff members	2.95	0.70	2.55	0.93	1.60	0.12	
Staff members not replaced	3.00	0.97	2.40	1.17	1.68	0.10	
Absence due to personal illness	2.46	0.78	1.83	0.83	2.43	0.02	0.75
Frustrated	2.27	0.88	2.57	1.10	-1.59	0.11	
Stressed	2.45	0.10	2.70	1.15	-1.19	0.24	
Motivated	2.01	1.01	1.73	0.99	1.34	0.18	
Decreased interest in school	2.02	0.99	2.33	1.09	-1.50	0.14	
Coping with the situation	2.41	1.01	1.97	0.89	2.22	0.03	
Not coping with the	2.07	0.88	2.17	1.00	-0.55	0.58	

situation							
Comfortable	1.16	1.03	1.70	0.95	2.20	0.03	0.44
Negative	1.85	0.82	2.30	1.12	-2.48	0.01	0.40
Low morale	1.83	0.78	2.38	1.05	-3.14	0.00	0.52
Depressed	1.98	0.90	2.25	1.00	-1.43	0.15	
Feel like resigning	1.76	1.00	2.00	1.22	-1.10	0.27	
Reasons for absenteeism	1.50	1.08	1.28	0.99	1.03	0.31	

#### 4.6.4.1 Analysis

The p-values of Figure 4.9 reveal that there are statistically significant differences in perceptions between educators and SMTs with regard to:

- absence due to personal illness ( $p < 0.02$ ,  $d < 0.75$ );
- experiencing low morale ( $p < 0.00$ ,  $d < 0.52$ );
- not being comfortable ( $p < 0.03$ ,  $d < 0.44$ );
- negativity towards school work ( $p < 0.01$ ,  $d < 0.40$ ); and
- coping with one educator's workload ( $p < 0.03$ ,  $d < 0.33$ ).

#### 4.6.4.2 Interpretation

This could be attributed to the fact that educators on post level one are the most overloaded lot when it comes to the burden of carrying the subject load of educators who have to be absent because of being sick probably because of HIV/AIDS. This could be the reason for them experiencing low morale, not being comfortable with the load of work they are carrying, developing negative attitude towards their school work and finding it difficult to cope with the absent educators' workload.

#### 4.6.5 The effects of HIV/AIDS on learners

**Table 4.10**

Item description	Mean	SD	Mean	SD	t	p	d
Awareness of learners who are HIV positive	3.28	0.99	3.36	0.99	-0.45	0.66	
Number of learners affected	1.57	1.40	1.00	0.00	0.39	0.70	
	1.00	0.63	1.00	0.00	-0.00	1.00	
%of orphaned children who repeated grades	1.76	1.24	1.94	1.39	-0.53	0.60	
% of learners affected by interrupted schooling	1.71	1.08	1.93	1.39	-0.71	0.48	
% of learners who dropped out of school due to incomplete families	1.45	0.97	1.29	0.77	0.62	0.54	
Learners involved in sexual harassment by educators	1.92	0.36	1.94	0.23	-0.47	0.64	
Relationships between learners and educators	2.04	0.42	1.97	0.17	0.96	0.34	
% of learners suffering from poor nutrition	3.88	1.94	4.57	1.73	-1.75	0.08	
% of learners unable to pay school fees	4.41	1.89	4.19	1.69	0.57	0.57	
Reasons for learner absence	2.71	2.26	2.10	1.92	1.33	0.18	
Absenteeism rate of learners on a weekly basis	30.17	51.0 3	9.94	14.7 6	1.61	0.11	
	20.66	27.0 1	10.53	13.3 7	1.41	0.16	
Learners' status at home		1.76		1.83			0.28
Both parents alive	4.22	1.10	4.23	1.84	-0.03	0.98	

Paternal orphan	2.61	1.57	2.33	1.53	0.70	0.48	
Maternal orphan	2.60	1.31	1.83	0.92	2.36	0.02	0.58
Double orphan	2.40	1.60	2.27	1.61	0.33	0.74	
Learners living with guardians	3.08	1.98	3.35	1.67	-0.60	0.55	
Learners who are HIV positive	1.38	0.95	1.90	1.29	-1.47	0.15	
Learners living with HIV positive family members	2.44	1.77	2.79	1.97	-0.65	0.52	
Learners whose parents have died of HIV/AIDS	2.56	1.84	2.69	1.85	-0.24	0.81	

#### 4.6.5.1 Analysis

The p-values of Figure 4.10 reveal that there are statistically significant differences in perceptions between educators and SMT's with regard to:

- maternal orphans ( $p < 0.02$ ,  $d < 0.58$ ); and
- learners' status at home ( $p <$ ,  $d < 0.28$ ).

Both these results have a medium effect and small effect respectively.

#### 4.6.5.2 Interpretation

This could be attributed to the fact that educators on post level one are the ones who have to deal with orphans and are aware of learners' status at home because of their daily contacts with learners on daily basis.

#### 4.6.6 The effects of HIV/AIDS on teaching and learning

**Table 4.11**

Item description	Mean	SD	Mean	SD	T	P	d
Does HIV/AIDS have a detrimental effect on teaching and learning?	1.53	0.50	1.50	0.51	0.35	1.72	
Is the academic progress satisfactory?	1.42	0.50	1.61	0.50	-1.70	0.09	
Reasons for not being satisfied							
Classes too big	2.25	0.98	2.67	1.01	-1.85	0.07	
Impossible to pay attention to individual learners	2.09	1.01	2.25	0.90	-0.71	0.47	
Learners are frequently absent	2.64	0.83	2.88	0.90	-1.23	0.22	
Educator workload too heavy	2.10	1.04	2.58	1.18	-1.98	0.05	
Learners not motivated	2.90	0.95	2.88	1.17	0.09	0.93	
Frequent absence of educators due to family responsibilities	3.14	0.82	3.03	0.77	0.58	0.56	
Frequent absence of educators due to personal illness	2.62	0.82	2.70	0.87	-0.46	0.65	
Other							
The extent of stress reactions noticeable among learners							
Lack of motivation	2.35	0.76	2.63	0.89	-1.81	0.07	
Lack of social interactions	2.26	0.77	2.32	1.14	-0.38	0.70	
Hyperactivity	2.38	0.68	2.45	0.78	-0.46	0.64	

Passivity	2.35	0.73	2.35	0.72	0.05	0.96	
Nervousness	2.21	0.67	2.48	0.87	-1.91	0.06	
Poor discipline	2.45	0.81	2.97	0.95	-3.10	0.00	0.54
Absenteeism	2.36	0.65	2.35	0.71	0.02	0.99	
The extent of the following manifestations of depression noticeable							
Tiredness	2.18	0.62	2.22	0.71	-0.30	0.77	
Lack of motivation	2.29	0.76	2.64	0.90	-2.28	0.02	0.39
Lack of concentration	2.47	0.72	2.76	0.89	-2.05	0.04	0.33
Memory loss	2.22	0.86	2.38	0.83	-0.93	0.36	
Poor attention span	2.54	0.72	2.65	0.81	-1.39	0.17	
Decreased interest at school	2.29	0.78	2.30	0.92	-0.08	0.94	
Reasons for the manifestation of stress and depression among learners							
Personal illness	2.23	0.73	2.48	0.85	-1.74	0.08	
Illness of family members	2.24	0.76	2.34	0.87	-0.66	0.51	
Loss of family members	2.73	0.91	2.81	0.97	-0.48	0.63	
Too many responsibilities at home	2.49	0.08	2.21	0.96	1.24	0.22	
Poor academic performance	2.56	0.90	2.77	0.99	-1.15	0.25	
Rejection by peers	2.09	0.82	2.97	0.90	0.71	0.48	
School-related problems	2.16	0.82	2.16	0.81	0.04	0.10	
Other							
Diarrhea	3.62	0.65	3.45	0.63	1.29	0.20	
Pneumonia	3.50	0.69	3.43	0.50	0.52	0.61	

Tuberculosis	3.45	1.71	3.36	0.56	0.68	0.50	
Severe weight loss	3.13	0.11	3.17	0.85	-0.20	0.84	
Other							

#### 4.6.6.1 Analysis

The p-values of Figure 4.11 reveal that there are statistically significant differences in perceptions between educators and SMT's with regard to:

- poor discipline ( $p < 0.00$ ,  $d < 0.54$ );
- lack of motivation ( $p < 0.02$ ,  $d < 0.39$ ); and
- lack of concentration ( $p < 0.04$ ,  $d < 0.33$ ).

These results have a medium effect and small effect respectively.

#### 4.6.6.2 Interpretation

This could be attributed to the fact that educators and school management teams can possibly have different perspectives on discipline and motivation, and even concentration because SMTs are daily dealing with the problems of discipline among educators and learners respectively. It is possible that educators may easily lose concentration because of the emotional problems they mentioned in Table 4.7 above.

#### 4.6.7 Pre-requisites for effective teaching and learning

**Table 4.12**

Item description	Mean	SD	Mean	SD	T	P	d
Educators are well prepared.	3.39	0.59	3.26	0.69	1.10	0.27	
Educators present interesting learning activities.	3.31	0.63	3.22	0.53	0.86	0.39	
Educators have well organised classrooms.	3.16	0.75	2.87	0.84	2.11	0.04	0.35
There is a constant flow of	3.26	0.67	3.05	0.66	1.66	0.10	

learning.							
On-going interaction between learners and educators.	3.32	0.79	3.19	0.62	0.90	0.37	
Educators correct tests.	3.46	0.64	3.42	0.64	0.32	0.75	
Tests are handed back tumerously.	3.16	0.74	3.08	0.81	0.54	0.59	
Educators check learners homework.	3.21	0.77	3.17	0.77	0.33	0.74	
Educators provide assistance with personal problems.	3.26	0.72	3.11	0.67	1.12	0.26	
Educators provide assistance with educational problems.	3.35	0.69	3.11	0.82	1.81	0.07	
Educators involve learners actively in learning.	3.47	0.62	3.41	0.60	0.52	0.60	
Educators reinforce learning.	3.38	0.68	3.45	0.60	-0.59	0.56	
Educators pay individual attention.	2.16	0.80	3.03	0.73	0.90	0.37	
Educators control disciplinary problems effectively.	3.27	0.77	3.18	0.77	0.56	0.52	
Educators make sure that learners pay attention during lesson presentation.	3.39	0.66	3.30	0.66	0.79	0.43	
Educators are dependable.	3.00	0.92	3.14	0.91	-0.82	0.41	
Educators are role models in good ethics, attitudes and values.	3.39	0.67	3.47	0.65	-0.72	0.47	
Educators are punctual and regular in attendance.	3.21	0.59	3.18	0.69	0.23	0.82	
Educators are sexually involved with learners.	1.37	0.90	1.16	0.60	1.33	0.18	

Are learners of different grades combined into one classroom?	1.95	0.21	1.95	0.23	10.12	0.91	
Is the curriculum flexible to deal with learners who cannot attend school or whose schooling is interrupted?	1.56	0.50	1.67	0.48	-1.60	0.11	
Are classes left untaught?	1.93	0.24	1.86	0.35	1.52	0.13	
Is there a sufficient educator supply?	1.34	0.47	1.33	0.48	0.03	0.98	
Are posts timorously filled?	1.33	0.47	1.29	0.46	0.35	0.73	
Are staff development programmes in place for educators who have to cope with heavy workloads?	1.42	0.50	1.59	0.50	-1.80	0.07	
Does the curriculum teach learners how to handle the emotional changes during puberty and adolescence?	1.25	0.43	1.20	0.41	0.59	0.55	
Is the curriculum focusing on promoting abstinence from sexual activities?	1.22	0.41	1.20	0.41	0.20	0.84	
Does the curriculum focus on promoting a delay in taking part in sexual activities?	1.22	0.42	1.18	0.39	0.56	0.58	
Are topics on HIV/AIDS infused into carrier subjects?	1.12	0.33	1.03	0.17	0.63	0.10	
Are these topics well taught?	1.17	0.37	1.12	0.33	0.70	0.48	
Is there an in-depth coverage of HIV/AIDS topics?	1.33	0.47	1.30	0.47	0.27	0.79	
Are extra-curricular activities planned to address HIV/AIDS?	1.24	0.43	1.15	0.36	1.05	0.30	

Are school-based activities arranged to address HIV/AIDS?	1.28	0.45	1.26	0.44	0.22	0.83	
Are intensive pre-service and /or in-service training programmes implemented?	1.26	0.44	1.16	0.37	1.13	0.26	
Are educators confident to teach HIV/AIDS topics?	1.15	0.34	1.16	0.37	-0.17	0.87	
Are strict measures in place to deal with staff?	1.30	0.46	1.23	0.43	0.69	0.49	
Are strict measures in place to deal with love relationships between learners and staff members?	1.24	0.43	1.24	0.44	0.01	0.99	
Are there strict measures for educators who are frequently absent?	1.20	0.40	1.28	0.46	-1.06	0.29	
Is your school offering a feeding scheme?	1.04	0.18	1.00	0.00	1.14	0.26	
Are you of the opinion that it is the school's task to deal with the causes and effect of HIV/AIDS?	1.14	0.34	1.23	0.43	-1.36	0.18	
Are you of the opinion that we give too much attention to HIV/AIDS at our schools	1.57	0.50	1.51	0.51	0.58	0.56	

#### 4.6.7.1 Analysis

The p-values of Figure reveal that there are statistically significant differences in perceptions between educators and SMT's with regard to:

- educators having very well organised classrooms ( $p < 0.04$ ,  $d < 0.35$ ).

This difference is of small effect.

#### **4.6.7.2 Interpretation**

This could be caused by the fact that educators may have a different perspective from that of SMTs with regard to organized classrooms because of the fact that SMTs are not always involved in classroom organization matters. They are the people who have to carry the classroom organization duties of educators who are absent from work because of being sick, probably because of HIV/AIDS.

#### **4.7 CONCLUSION**

This chapter analysed and interpreted data collected during empirical research. The percentages of demographic particulars were reported and t-tests were conducted to compare the perceptions of educators and school management teams with regard to the effects of HIV/AIDS on school systems.

In chapter 5, a summary of the chapters 1, 2, 3, and 4 is presented, namely:

- the statement of the problem;
- the aim and methods of research; and
- the literature review and the empirical research findings.

This summary is presented in order to enable the researcher to make recommendations, on the basis of the statement of the problem which is presented in chapter 1 (see paragraph 1.1) and the findings of both the literature review and empirical research (see chapters 2 and 4), for an inclusive health promoting approach to dealing with HIV/AIDS at schools (see paragraph 5.3 below).

## **CHAPTER FIVE**

### **SUMMARY, FINDINGS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

This chapter presents a summary of the chapters 1, 2, 3, and 4, namely:

- the statement of the problem;
- the aim and methods of research; and
- the literature review and the empirical research findings.

This summary is presented in order to enable the researcher to make recommendations, on the basis of the statement of the problem which is presented in chapter 1 (see paragraph 1.1); aims and methods of research which are presented in detail in chapter 3 (see paragraphs 3.2 to 3.7), and the findings of both the literature review and empirical research (see chapters 2 and 4), for an inclusive health promoting approach to dealing with HIV/AIDS at schools (see paragraph 5.3 below).

#### **5.2 SUMMARY AND CONCLUSIONS**

##### **5.2.1 Findings and conclusions from the literature study (see chapters 1 and 2)**

In the literature study it was found that HIV attacks the immune system and reduces the resistance of the body to all kinds of illness, including influenza, diarrhoea, pneumonia, tuberculosis and certain cancers. It eventually makes the body so weak that it cannot fight sicknesses and causes death between five and ten years after becoming infected, but some HIV-infected people live longer if they receive the right psychotherapy and medication (see paragraph 2.2.1);

The literature review also highlighted that a school with a high number of learners and educators infected and affected by HIV/AIDS cannot function

efficiently and effectively, since learners infected and affected by HIV/AIDS cannot cope with learning and cannot perform their learning tasks to the fullest of their abilities, while infected and affected educators cannot teach effectively because they are often ill and absent from school, and this has an effect on the efficient and effective management of the school (see paragraph 1.1).

HIV/AIDS can have an enormous impact on the learning and teaching situation in most HIV/AIDS-affected schools, but at the same time, inclusive school systems can also have an enormous impact on HIV/AIDS prevention, care and support, especially when supported by inclusive health-promoting educational strategies and collaborative support from other social and educational sectors such as non-governmental organizations dealing with HIV/AIDS and health, Departments of Social Welfare and Health, and so on (see paragraph 1.1).

In the absence of appropriate effective inclusive measures, the school system in a community that is seriously HIV-infected is also in danger of being weakened and disrupted. It falls prey to a myriad of opportunistic problems like the high rate of absenteeism, deaths of educators and learners, demotivation, low morale, *etcetera*, which lead, in turn, to a number of reactive changes and adaptations (see paragraph 2.2.3).

The foregoing paragraphs highlight the seriousness of the effects of the HIV/AIDS epidemic on the human resources of learners and educators, and on the effective functioning of the teaching and learning situation. The development of an inclusive health promoting approach is imperative if schools are to be effective in dealing with the incidence and the impact of the spread of HIV/AIDS.

An inclusive approach to HIV/AIDS recognises and acknowledges the distinct and diverse needs and abilities of learners and educators infected and affected by HIV/AIDS (see paragraph 2.4). Learners and educators living with HIV/AIDS are in this research regarded as persons with special needs because of all the adaptations and adoptions of school policies and procedures in order to accommodate their ill-health and all the problems that

go with it. In this case, inclusion involves bringing the educational, psychological and medical support services to the child and educator (rather than moving the child and educator to the services) and requires only that the child will benefit from being in the class (rather than having to keep up with the other learners) (see paragraph 2.4.2). With the increasing numbers of learners and educators becoming infected with HIV/AIDS, it is of vital importance for all schools to have an inclusive HIV/AIDS policy (see paragraph 2.4.3).

For proactive and inclusive planning purposes, schools need to ascertain, in particular, the impact of HIV/AIDS on the curriculum, the expected enrolment and drop-out rates of learners and the continual absence of educators and learners who are infected and affected by HIV/AIDS.

### **5.2.2 Findings and conclusion from the empirical investigation**

The empirical investigation revealed the following:

- the majority of respondents see illness as the main reason for mortality among educators at their schools (see Table 4.6);
- educators are:
  - frustrated;
  - stressed;
  - not motivated;
  - less interested in school work and other school activities;
  - not coping with their work;
  - negative towards their work to a certain extent;
  - experiencing low morale to a certain extent;
  - depressed to a certain extent; and
  - feeling like resigning to a certain extent (see Table 4.7);

- the majority of respondents regarded sickness of self as the main reason for educator absenteeism at their schools ( see Table 4.8).

### **5.3 RECOMMENDATIONS**

The analyses and interpretations of the results of the empirical research have led this study to reach the following recommendations which have implications for an inclusive health promoting educational approach to dealing with HIV/AIDS at schools:

- Since HIV/AIDS affects the psychological well-being of human beings (see paragraph 5.2.2 above) and is thus a health issue, it is necessary that schools develop and design wellness programmes to help educators who find themselves in a situation like the one mentioned in paragraph 5.2.2 above. The Department of Education should provide more money to schools so that substitute educators can be employed to carry the teaching load of educators who have to be absent from schools because of sicknesses. For proactive management of HIV/AIDS at schools, it is necessary that the wellness programmes should address issues of health such as HIV/AIDS, sexually transmitted diseases, family life, discrimination and stigmatization of learners and educators infected and affected by HIV/AIDS, the use of anti-retrovirals for the therapy of learners and educators who are already infected by HIV/AIDS, reproductive health, abstinence from sexual intercourse for learners, celibacy, virginity, use of condoms for those learners and educators who are promiscuous, and so on. The infusion of these issues of health in the schools' wellness programmes will help schools promote a balanced development of knowledge, attitudes, values and life skills covering healthy social behaviour associated with factors such as HIV/AIDS, family life and reproductive health among its learners and educators. Both intra and extra curricular activities of schools should incorporate mandated sex education lessons, the values of practising safe sex such as using condoms in cases of pre-marital and extra-marital sexual relationships, abstinence from sex until marriage, faithfulness to one sexual partner for life and so on. This will

help change the attitude of both learners and educators towards promiscuity and HIV/AIDS.

- Dealing effectively with the HIV/AIDS epidemic requires a strong commitment to change in the whole school community. For example, schools must find responsive and flexible ways to meet the needs of learners already affected by HIV/AIDS either directly or indirectly, for example through being orphaned and taking on wider family responsibilities. Peer support can help address the psychological burden of orphanhood and the social stigma and the sense of exclusion it may bring. Measures to reduce the financial burden for schooling, such as provision of stipends, will increase retention and completion among learners affected by their HIV/AIDS. Schools can also adopt Social Workers and psychologists to occasionally provide counselling and psychotherapy to learners and educators affected by HIV/AIDS through loss of loved ones.
- Above all, schools should not expel children on the grounds of HIV/AIDS status or because of early pregnancy or sexual orientation.
- School curricula should infuse human rights and equity issues in their HIV/AIDS policies which highlight the value and respect of human dignity. This will help learners and educators infected and affected by HIV/AIDS from being stigmatized and discriminated by their fellow school mates and colleagues. Such a curriculum should also inform and educate learners about the value of communication and accountability in sexual engagements. It should deal with the stereotypes such as men having the cultural rights to more sexual partners, more knowledge and more power in sexual matters, and using violence and sexual domination in sexual matters. Such a curriculum should also educate women on the “culture of silence” as entrenched in sexual engagements of traditional African men and women. To solve problems of cultural gender inequality, it is necessary that the curriculum promote the integration of gender dimensions into HIV/AIDS programmes at schools.

- Schools should develop and design motivating and health promoting organizational climates. Such school climates emphasize the need to humane environments for those who have HIV/AIDS and the need for educators to deliver anti-biased and caring education to learners, parents and school personnel. The school organizational climate should be humanized. Humanising the educational setting about HIV/AIDS will mean going beyond dealing with physical needs and addressing the bigotry that surrounds the disease. HIV/AIDS is more than just a biological phenomenon. These conditions are accompanied by meanings shaped by cultural, political and legal discourses, as well as by scientific discourses. These meanings take on moral significance in the context of an educator's relationship with his/her learner, the learner's parents, and the educator's co-workers. If educators are to be prepared to respond to the full human significance of HIV/AIDS, then the cultural, moral and political dimensions of the disease need to be addressed in a stress free school organizational climate.
- School management teams should have specific indicators to measure the impact of HIV/AIDS on the health of learners and educators at their schools. They should promote co-operation at various school levels such as in classrooms, curricula, school policies, regulations and rules to ensure that gender, health and HIV/AIDS are taken on board at schools. The gender focal point should not be seen as the role of schools only, but communities in the form of Non Governmental Organizations, churches, youth organizations and business sectors should partner with schools to combat the HIV/AIDS epidemic. Addressing issues holistically, for example, addressing issues of culture, sexuality, reproductive health, gender-based violence concerning HIV/AIDS and health at schools should be the joint endeavour of all the social organizations in the communities where schools are situated. Learners and educators should be encouraged to talk about their health status in an environment where they know that they won't be stigmatized and discriminated on the basis of their having notified the school management teams and their colleagues or school mates of their HIV/AIDS status.

- HIV/AIDS is not only a health problem, it is recognised at the highest political levels that HIV/AIDS is a major problem which threatens economic development, social stability and security. The epidemic has set back development gained over the past decade. All stakeholders should be included in planning, implementing and evaluating HIV/AIDS programmes. Participatory planning from learners, educators, parents and from communities should be embarked on. Schools should develop monitoring tools which link the needs and rights of learners, educators and parents with the whole planning process.

#### **5.4 CONCLUSION**

This research investigated the effects of HIV/AIDS on school systems with a view of making suggestions for an inclusive health promoting educational approach to dealing with this epidemic at schools. The literature review and empirical research methods were used in the investigation. On the basis of both the literature review and empirical research, recommendations were made in Chapter 5.

It is hoped that this research will make a contribution in the understanding and dissemination of knowledge of the epidemic and its effects on school systems. This research shall have contributed to school development if schools can be seen to be inclusive and accommodative of all children irrespective of their health status in order to effectively deal with the stigma and discrimination that always go with living with this disease in school systems that are exclusive and disregard human dignity.

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## ADDENDUM A



### HIV/AIDS Research project: Effect on the classroom

Staff members and students of the North-West University are involved with a research project on the effect of HIV/Aids on the learning and teaching situation in schools. The purpose of the research is to help schools to deal with the problem.

Please complete the attached questionnaire.

You and/or your school will at no stage be identified in the research process.

#### SECTION A: BIOGRAPHIC INFORMATION

1. Indicate whether your school is an urban or a rural school by marking your choice with an X in the appropriate block
 

Rural	Urban
-------	-------
  
2. Indicate whether your school is a primary or secondary school.
 

Primary	Secondary
---------	-----------
  
3. Indicate your current post.
 

Teacher	Head of Department	Deputy Principal	Principal
---------	--------------------	------------------	-----------
  
4. Indicate the phase in which you are presently teaching.
 

Foundation	Inter-mediate	Senior	FET
------------	---------------	--------	-----
  
5. Indicate the school in which you are currently teaching..
 

Public	Private	Ex TED Model C	Other
--------	---------	----------------	-------
  
6. Please indicate the numbers of teachers in your school
 

Male	
------	--

Female	
--------	--

7. Please indicate the numbers of learners in your school

--

**SECTION B: THE EFFECTS OF HIV/AIDS ON TEACHERS**

8. Are you currently aware of any teachers at your school who are HIV positive or who have AIDS.

Yes	Not sure	Do not know	No
-----	----------	-------------	----

9. How many teachers at your school have medically retired or died over the last three years due to a suspected AIDS-related disease?

2001

2002

2003

	Male	Female

10. How often are the following reasons indicated for the mortality rate among teachers at your school?.

10.1 Illness

Always	Often	Sometimes	Never
--------	-------	-----------	-------

10.2 Accident

Always	Often	Sometimes	Never
--------	-------	-----------	-------

10.3 Suicide

Always	Often	Sometimes	Never
--------	-------	-----------	-------

10.4 Violence/Homicide

Always	Often	Sometimes	Never
--------	-------	-----------	-------

10.5 Aids-related illnesses

Always	Often	Sometimes	Never
--------	-------	-----------	-------

10.6 Suicide

Always	Often	Sometimes	Never
--------	-------	-----------	-------

11 If your answer to question 8 was YES or

Male	
------	--

NOT SURE, please provide an indication of the number of teachers who are possibly affected by completing the table.

Female	
--------	--

- 12 Absenteeism rates of teachers on a weekly basis. Indicate the number of teachers who are absent on a weekly basis, by completing the diagram.

Male	
------	--

Female	
--------	--

- 13 Do you experience problems for having to take over the responsibilities of an absent colleague?

Always	Often	Sometimes	Never
--------	-------	-----------	-------

- 14 Are substitute teachers appointed at your school for days on which permanent teachers are absent?

Always	Often	Sometimes	Never
--------	-------	-----------	-------

15. Are you coping with more than one educator's workload?

Yes	No
-----	----

16. If your answer to question 15 was YES, indicate the importance of the following reason/s for your having to carry this workload.

Shortage of staff members.

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

Frequent absence of staff members to attend to family responsibilities.

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

Staff members are not replaced.

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

Absence of staff members due to personal illness.

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

Other  
(specify).

--

17. Indicate to what extent do you experience the following feelings/attitudes for having to carry such a heavy workload.

17.1	Frustrated	Not at all	Sometimes	Often	Always
------	------------	------------	-----------	-------	--------

17.2	Stressed	Not at all	Sometimes	Often	Always
------	----------	------------	-----------	-------	--------

17.3	Motivated	Not at all	Sometimes	Often	Always
------	-----------	------------	-----------	-------	--------

17.4	Decreased interest in school and school activities	Not at all	Sometimes	Often	Always
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17.5	Coping with the situation	Not at all	Sometimes	Often	Always
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17.6	Not coping with the situation	Not at all	Sometimes	Often	Always
------	-------------------------------	------------	-----------	-------	--------

17.7	Comfortable	Not at all	Sometimes	Often	Always
------	-------------	------------	-----------	-------	--------

17.8	Negative	Not at all	Sometimes	Often	Always
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17.9	Low morale	Not at all	Sometimes	Often	Always
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17.10	Depressed	Not at all	Sometimes	Often	Always
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17.11	Feel like resigning	Not at all	Sometimes	Often	Always
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17.12	Other (specify)				
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18. Reasons for absenteeism. Indicate the main reason for teacher absence at your school by marking with an X in the appropriate block.

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Sickness of the self	Funerals	Sickness of others (Family members)	Work related	Other
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### SECTION C: THE EFFECTS OF HIV/AIDS ON LEARNERS

19. Are you currently aware of any learners at your school who are HIV positive or who have AIDS.
- |     |          |             |    |
|-----|----------|-------------|----|
| Yes | Not sure | Do not know | No |
|-----|----------|-------------|----|

20. If your answer to question 19 was YES or NOT SURE, please provide an indication of the number of learners who are possibly affected by completing the table.
- |        |  |
|--------|--|
| Male   |  |
| Female |  |

21. Based on your experience in the last 3 years what percentage of orphaned children repeated grades. Indicate your choice by marking with an X in the appropriate block.

10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
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22. Indicate the estimated % of learners affected by interrupted schooling the past three years by completing the table below. Indicate your choice by marking with an X in the appropriate block.

10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
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23. Indicate the estimated % of learners that drop out of school the past three years due to incomplete families by completing the table below. Indicate your choice by marking with an X in the appropriate block.

10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
--------	--------	--------	--------	--------	--------	--------

24. Are you aware of learners at your school who were involved in sexual harassment cases by teachers in the past three years?
- |     |    |
|-----|----|
| Yes | No |
|-----|----|

25. Are you aware of any love relationships between learners and teachers at your school?
- |     |    |
|-----|----|
| Yes | No |
|-----|----|

26. Indicate the estimated % of learners in your school who are suffering from poor nutrition, by completing the table below.

10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
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27. Indicate the estimated % of learners who are unable to pay for school fees and school requirements.

10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
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28. Indicate the main reason for learner absence at your school by marking with an X in the appropriate block.

Sickness of the self	Funerals	Sickness of others (Family members)	Lack of clothes	Lack of school fees/school requirements	Lack of money for transport	Have to take care of responsibilities at home
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29. Absenteeism rates of learners on a weekly basis. Indicate the number of learners who are absent on a weekly basis, by completing the diagram.

Male	
Female	

30. Learner status at home. Give an indication of the estimated percentage of learners exposed to the different types of home situations by completing the table below. Indicate your choice by marking with an X in the appropriate block.

Home situation		Percentage of learners							
		10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
31.	Both parents alive	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
32.	Paternal orphan	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
33.	Maternal orphan	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
34.	Double orphan	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
35.	Learners who live with guardians	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
36.	Learners who are HIV positive	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
37.	Learners who live in households with HIV positive family members	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+
38.	Learners whose parents/guardians have died of HIV/AIDS	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80+

## SECTION D: THE EFFECTS OF HIV/AIDS ON TEACHING AND LEARNING

39. Do you think that the HIV/AIDS pandemic has a detrimental effect on teaching and learning in your school?

Yes	No
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40. Are you satisfied with the academic progress of the learners in your school?

Yes	No
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**41. If your answer to question 40 was NO, indicate the importance of the following reason/s for you not being satisfied.**

41.1 Classes are too big.

Definitely true	True	Sometimes true	Untrue
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41.2 It is not possible to pay attention to individual learners.

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

41.3 Learners are frequently absent.

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

41.4 Teacher workload is too heavy.

Definitely true	True	Sometimes true	Untrue
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41.5 Learners are not motivated

Definitely true	True	Sometimes true	Untrue
-----------------	------	----------------	--------

41.6 Frequent absence of teachers from school due to family responsibilities.

Definitely true	True	Sometimes true	Untrue
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41.7 Frequent absence of teachers due to personal illness.

Definitely true	True	Sometimes true	Untrue
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41.8 Other (specify)

**42. To what extent are the following stress reactions noticeable among your learners?.**

42.1 Lack of motivation

Not at all	Sometimes	Often	Always
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42.2 Lack of social interactions

Not at all	Sometimes	Often	Always
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42.3 Hyperactivity

Not at all	Sometimes	Often	Always
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42.4	Passivity	Not at all	Sometimes	Often	Always
42.5	Nervousness	Not at all	Sometimes	Often	Always
42.6	Poor discipline	Not at all	Sometimes	Often	Always
42.7	Absenteeism	Not at all	Sometimes	Often	Always

**43. To what extent are the following manifestations of depression noticeable among your learners?.**

43.1	Tiredness	Not at all	Sometimes	Often	Always
43.2	Lack of motivation	Not at all	Sometimes	Often	Always
43.3	Lack of concentration	Not at all	Sometimes	Often	Always
43.4	Memory loss	Not at all	Sometimes	Often	Always
43.5	Poor attention span	Not at all	Sometimes	Often	Always
43.6	Decreased interest in school and school activities	Not at all	Sometimes	Often	Always

**44. How important would you rate the following reasons for the manifestation of stress and depression among your learners?**

44.1	Personal illness	Not at all	Little	Quite	Very
44.2	Illness of family members	Not at all	Little	Quite	Very
44.3	Loss of family members	Not at all	Little	Quite	Very
44.4	Too many responsibilities at home	Not at all	Little	Quite	Very
44.5	Poor academic performance	Not at all	Little	Quite	Very
44.6	Rejection by peers	Not at all	Little	Quite	Very
44.7	School related problems	Not at all	Little	Quite	Very
44.8	Other (specify)				

**Answer the following questions with an X in the appropriate block.  
Are there learners in your school/classes who suffer from HIV-related illnesses such as:**

45.	Diarrhea?	Yes	Probably	Unsure	No
46.	Pneumonia?	Yes	Probably	Unsure	No
47.	Tuberculosis?	Yes	Probably	Unsure	No
48.	Severe weight loss?	Yes	Probably	Unsure	No
49.	Other (specify)				

This section focuses on categories of critical prerequisites teachers have to comply with for effective teaching and learning. Indicate how many of your teachers provide effective teaching. Indicate your choice by marking with an X in the appropriate block.:

50.	Teachers are well prepared.	None	A few	Most of them	All of them
51.	Teachers present interesting learning activities.	None	A few	Most of them	All of them
52.	Teachers have well organized classrooms.	None	A few	Most of them	All of them
53.	In the classrooms there is a constant flow of learning.	None	A few	Most of them	All of them
54.	There is on-going interaction between learners and teachers.	None	A few	Most of them	All of them
55.	Teachers correct tests and assignments.	None	A few	Most of them	All of them
56.	Tests and assignments are handed back timorously.	None	A few	Most of them	All of them

57.	Teachers check learners' home work.	None	A few	Most of them	All of them
58.	Teachers provide assistance with personal problems.	None	A few	Most of them	All of them
59.	Teachers provide assistance with educational problems.	None	A few	Most of them	All of them
60.	Teachers involve learners actively in learning.	None	A few	Most of them	All of them
61.	Teachers reinforce learning (motivate learners).	None	A few	Most of them	All of them
62.	Teachers pay individual attention to learners.	None	A few	Most of them	All of them
63.	Teachers control disciplinary problems in class effectively.	None	A few	Most of them	All of them
64.	Teachers make sure that learners pay attention during lesson presentations.	None	A few	Most of them	All of them
65.	Teachers are dependable.	None	A few	Most of them	All of them
66.	Teachers are role models in terms of good ethics, attitudes and values	None	A few	Most of them	All of them
67.	Teachers are punctual and regular in attendance.	None	A few	Most of them	All of them
68.	Teachers are sexually involved with learners.	None	A few	Most of them	All of them

**SECTION E: MEASURES TO CURB THE EFFECT OF HIV/AIDS ON TEACHING AND LEARNING**

**Please answer the following questions by marking an X in the appropriate block (Yes or No)**

69.	Are learners of different grades combined into one classroom?	Yes	No
70.	Is the curriculum of the school flexible to deal with learners who cannot attend school during normal school hours or whose schooling is interrupted?	Yes	No
71.	Are classes at your school left untaught/unsupervised?	Yes	No
72.	Does your school have a sufficient teacher supply?	Yes	No
73.	Are posts at your school filled timorously?	Yes	No
74.	Are staff development programmes in place for educators who have to cope with heavy workloads and/or low morale?	Yes	No
75.	Does the curriculum teach learners how to handle the emotional changes that occur during puberty and adolescence?	Yes	No
76.	Does the curriculum focus on promoting abstinence from sexual activities?	Yes	No
77.	Does the curriculum focus on promoting a delay in taking part in sexual activities?	Yes	No
78.	Are topics on HIV/AIDS infused into carrier subjects: Biology, Life Orientation and Health Education?	Yes	No
79.	Are topics of HIV/AIDS well taught?	Yes	No
80.	Is there an in-depth coverage of HIV/AIDS topics?	Yes	No
81.	Are extra-curricular activities planned to address HIV/AIDS?	Yes	No

82.	Are school-based activities eg. School health programmes, guidance and counseling arranged to address HIV/AIDS?	Yes	No
83.	Are intensive pre-service and/or in-service training programmes for HIV/AIDS implemented?	Yes	No
84.	Do teachers feel confident to teach HIV/AIDS topics?	Yes	No
85.	Are strict measures in place to deal with staff members who are involved in sexual harassment of learners?	Yes	No
86.	Are strict measures in place to deal with love relationships between learners and teachers?	Yes	No
87.	Are strict measures in place to deal with teachers who are frequently absent?	Yes	No
88.	Does your school offer a feeding scheme?	Yes	No
89.	Are you of the opinion that it is the school's task to deal with the causes and effect of HIV/Aids?	Yes	No
90.	Are you of the opinion that we give too much attention to HIV/AIDS in our schools?	Yes	No