A Success Case Method evaluation of the effectiveness of the implementation of the HIV and AIDS management at schools in the Tshwane South District

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To whom it may concern

This letter serves to confirm that the thesis entitled "A success case method evaluation of the effectiveness of the implementation of the HIV and AIDS management at schools in the Tshwane South District" by Mr N.A. Mbada (ID number: 7208256166085) has been language edited by CTrans. This means that the thesis has been edited for spelling, grammar, syntax and formatting. However, the onus rests on Mr Mbada to work through the changes proposed by CTrans, and to either accept or reject them.

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is my own work, that all the resources used or quoted have been indicated and acknowledged by means of complete references[1], and that this thesis has not been previously submitted by me for a degree at any other university.

Ndavheleseni Albert Mbada

[1] Some sources, such as internet web pages, do not have page numbers and, though acknowledged, most sources are derived from official documents of the United Nations and its affiliated organisations and thus are mostly in the form of direct quotations.

DEDICATION

I dedicate this thesis to my mother, Florah Mutshinya Mudau, whose support in my entire life is immeasurable, and to my beautiful and only one wife, Takalani, and our children, Hanihani (2003), Haya (2006) and Hana-Mukundi (2010). Lastly, I dedicate it to my sister, Egeant Mbada, and my only young brother, Khathutshelo, who passed on at an early age.

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ABSTRACT

The intention of this study was to evaluate the effectiveness of the implementation of the HIV and AIDS management at schools in the Tshwane South District. The rationale was based on the gap in research regarding evaluation of the implementation of intervention programmes at schools, especially the management and leadership intervention strategies. The Foundation for Professional Development (FPD), a South African Medical Association self-funding education provider in the health sector, had conducted a training intervention with the members of the School Management Teams (SMT) of the Tshwane South District schools. The application of the skills, knowledge and attitudes gained through this training was the main focus for evaluation. For that reason, the Success Case Method (SCM), an innovative programme evaluation design, was used. The first phase of the SCM involved using a short questionnaire to identify appropriate participants for the second phase, which involved in-depth telephone interviews as directed by the SCM. The second phase also involved probing, understanding and documenting the successes, thus allowing an evaluation of the findings.

The findings of the study indicate that some SMTs are actually implementing the skills, knowledge and attitudes gained in the FPD training with success, albeit with differing levels of effectiveness. It was also found that there are unsuccessful SMTs that are not implementing or are unable to implement their learning from the FPD training. There were various reasons for both the successes and non-successes. These included matters pertaining to conflicting directions, policy guidelines, commitment, empathy and attitude of the SMTs in understanding circumstances related to people living with and affected by HIV and AIDS, teamwork, reporting systems, the duration of the training workshop and pace of learning of SMTs members, marketing collaterals, workforce availability and availability or lack of time for implementing the HIV and AIDS programme.

The recommendations include the provision of follow-up and material support to schools, including the formation of HIV and AIDS management forums and networks. Recommendations are also made to the FPD for enhancing and sustaining the training and implementation. Further recommendations are proffered to the Department of Education regarding activities for directed and needs-based support for schools.

The study contributes to the practice of HIV and AIDS management in that it produced an evaluation report on the implementation of HIV and AIDS management at schools. This should be useful to practitioners at school, community and departmental levels regarding the status of HIV and AIDS management at schools. The study also contributes to the theory of intervention programmes using the Success Case Method in education, which is a novel, user-friendly and easy-to-use method of evaluation.

Key terms: HIV and AIDS management; HIV and AIDS in education; HIV and AIDS legislative framework; evaluation research; Success Case Method, UNAIDS terminology on HIV and AIDS.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AU	African Union
AWA	AIDS Watch Africa
DACs	District AIDS Councils
ESS	Education Support System
FPD	Foundation for Professional Development
GDE	Gauteng Department of Education
HIV	Human Immuno-deficiency Virus
HoD	Head of Department
HRD	Human Resources Development
ICPD	International Conference of Population and Development
IEC	Information, Education and Communication
ILO/AIDS	ILO Programme on HIV/AIDS and world of work
IPDs	Internationally Displaced People
LO	Life Orientation
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MTCT	Mother-to-Child Transmission
NACOSA	National AIDS Coordinating Committee of South Africa
NAS	Need Additional Support
NEPA	National Education Policy Act
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organisations
ORID	Other Related Infectious Diseases
PAC	Provincial AIDS Council

PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
REG	Regional Economic Commission
SANAC	South African National AIDS Council
SCM	Success Case Method
SGB	School Governing Body
SMTs	School Management Teams
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
UNIFEM	United Nations Fund for Women
US/USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

NOTES ON PERTINENT ASPECTS OF THE THESIS

1) The thesis follows the Success Case Method for the evaluation of intervention programmes.

2) The terminology on HIV and AIDS is based on the latest UNAIDS' guidelines in **UNAIDS** Terminology Guidelines (January 2011) available at (http://allafrica.com/download/resource/main/main/idatcs/00021002:90458421432f2d83e2ddf5a89f058c58.pdf), except where direct quotations are use, e.g. HIV/AIDS instead of the recommended HIV and AIDS.

3) The literature review uses numerous official documents and literature from the United Nations and the World Health Organization and associated organisations. Consequently, the terminology used regarding HIV and AIDS is that recommended by the World Health Organization.

4) The term SMT(s) is used to refer to members of School Management Teams, who in most instances comprise the school principal, the deputy principal and the heads of departments.

5) Where reference is made to the District Office or District, this specifically refers to the Tshwane South District Office of the Gauteng Department of Education; and where district office is used, it refers to district offices in general and not specifically to the Tshwane South District.

6) Where page numbers of the sources cited are not used, this is because these are not specified in the sources themselves, such as on the websites of some organisations.

7) Punctuation marks at the end of bulleted sentences are formatted in line with the language editor's advice.

8) The reference technique and the list of references are written according to the NWU Referencing guide (2012) available at www.nwu.ac.za.

9) Where tables are used without sources, these are self-developed as guided in the Success Case Method.

CHAPTER 1
GENERAL ORIENTATION

1.1 INTRODUCTION

The year 2011 was said to mark 30 years since the discovery of the Acquired Immune Deficiency Syndrome (AIDS), and there is evidence that lives are still being lost due to the disease (UNAIDS, 2011:1). For instance, it was reported that an estimated 5.7 million people were living with Human Immuno-deficiency Virus (HIV) and AIDS in South Africa in 2009, more than in any other country in the world (Avert.org [s.a.]). This confirms the status of South Africa as the worst affected country.

The education sector also feels the impact of this pandemic. According to Bennell (2005:1), the prevalence of HIV among educators is projected to increase from 12.5% in 2000 to 30% by 2015 and annual mortality rates are projected to increase eightfold from 0.5% to 4.0% during the same period. Young people also remain at the centre of the HIV and AIDS epidemic in terms of infection, vulnerability, impact and potential for infection, which indicates that schools are being severely threatened by the HIV and AIDS epidemic. Shaeffer (1994:12) confirms this and points out two such threats, namely that children infected at birth do not live to enrol at school and that the process of teaching and learning itself becomes more complicated and more difficult due to the presence of HIV in classrooms and schools.

Gachuhi (1999:3) is of the opinion that the bulk of AIDS cases are among young people of school-going age. Sekopane (2004:1) cites McFarland and Williams who maintain that the school-age population is very much at risk of either acquiring the infection or being affected by it, due to this population's high rates of sexual activity, lack of knowledge and high rate of unsafe behaviour. On the side of educators, Sekopane (2004:1) further cites Shaeffer who asserts that the supply of education is also being hampered by the declining productivity of educators due to frequent absenteeism because of illness, caring for an ill family member or funeral attendance, which, in turn, leads to a severe decline in

learner-educator ratios and reduced teaching due to the slow or non-replacement of educators who have died from HIV or AIDS-related illnesses. Burger (2008:7) contends that the emotional stress of educators and learners is also high through increased incidents of HIV and death due to AIDS among colleagues and relatives. It can, therefore, be concluded that HIV and AIDS have become a serious barrier to teaching and learning.

Considering how HIV and AIDS impact on the smooth running of teaching and learning at schools, the Department of Education has been obliged to come up with strategies to manage the situation and turn what is seen as a high-risk environment into an effective instrument to combat ignorance and motivate sustainable behaviour change (Badcock-Walters, 2001:12). One of the strategies is the establishment of partnerships for generating, collecting and disseminating HIV and AIDS relevant knowledge, wisdom, understanding and practice as part of HIV and AIDS management at schools. In this regard, Rayners (2007:2) maintains that HIV and AIDS management at schools is a complex and challenging context for which school managers need to undertake specific leadership roles. UNICEF, UNAIDS and WHO (2002) state that leadership in the HIV and AIDS context can be regarded as:

- making sure that the school community is equipped with facts about HIV and AIDS and how to prevent it and has access to the services, skills and support needed to develop safe behaviour from the start and to spread the message
- having the courage to meet the sexual and reproductive health needs of the school community by creating an environment in which HIV and AIDS is not discussed in secrecy and shame, but openly and with compassion
- creating a culture of zero tolerance for sexual abuse, exploitation and any form of violence against children and adolescents.

Schenker and Nyirenda (2002:6) point out that reversing the course of the HIV and AIDS epidemic should be a goal for the education sector through enacting

creative responses such as educator empowerment in the form of training. To this end, Stephen (2009:1) states:

> *In the fight against HIV/AIDS the Department of Education has put in place various programmes in schools, of which SMT training in HIV/AIDS management is one, to ensure that quality education is not compromised as a result of the negative impact of the HIV pandemic. The gap or challenge is that to date, there is no clear guideline on how training on the management of HIV/AIDS in schools should be conducted.*

School Management Teams (SMTs) are facing a complicated task of managing HIV and AIDS in their respective schools. Citing the Education Labour Relations Council, Wood and Webb (2008:112) acknowledge the existence of this problem by outlining how HIV and AIDS are severely impacting on the education system in South Africa and have become central in many issues of quality at schools, and stating that school principals are expected to consider not only the prevention of HIV infection, but also the other far-reaching impacts that HIV and AIDS will have on learners, staff and on the general learning environment at their schools. This is because, in heavily infected countries, the individuals most likely to be HIV-free are those in the 5–14 age group, that is those who are normally at primary school, which is where the hope for the future lies (Kelly, cited by Vergnani, Chopra & Johnson, 2001:1).

The challenge faced in providing formal education is to work with these disease-free children to enable them to remain so while managing the effects of the disease on those already infected and affected. Therefore schools have an important role to play in reducing the risk and vulnerabilities associated with HIV and AIDS (UNAIDS, 2008:1). To reach this goal, educators and other education personnel should be well prepared and supported to address HIV and AIDS through in-service and pre-service training. According to Vergnani *et al.* (2001:2), this approach is clearly endorsed by the National Education Policy Act (NEPA) on HIV and AIDS (Department of Education, 1999), which states that a continuing HIV and AIDS education programme must be implemented at all

schools and institutions for all learners, students, educators, and other staff members.

Although there are numerous studies on the effects of HIV and AIDS on education, there is little evidence of intervention programmes aimed at empowering SMTs to deal with the effects of HIV and AIDS. I also did not find evidence of studies evaluating the effectiveness of intervention programmes involving SMTs. Nonetheless, numerous interventions have been initiated in line within the NEPA directive, which include life skills programmes at schools and curriculum changes to include HIV and AIDS-related foci, as well as interventions from community-based and non-governmental organisations (NGOs) (Department of Education, 1999). One such initiative was undertaken by the Foundation for Professional Development (FPD), a South African Medical Association self-funding education provider in the health sector, which conducted a two-day training programme on the management of HIV and AIDS at schools for all public primary and secondary SMTs in the Tshwane South District in 2010.

This training programme aimed to provide SMTs with skills, knowledge and attitudes to deal with the epidemic appropriately, enable school managers to better manage the effects of HIV and AIDS on their staff and learners through developing a holistic HIV programme for each school and providing a resource toolkit that includes district maps and directorates of local NGOs, government programmes and companies that support schools, educators and learners affected by HIV and AIDS (FPD, 2010a:2). The FPD therefore initiated one of the most important management interventions towards mitigating the effects of the HIV and AIDS epidemic at the operational level of education by empowering and capacitating SMTs to deal with the effects of this epidemic.

1.2 PURPOSE STATEMENT AND RESEARCH OBJECTIVES

The intent of this predominantly qualitative evaluation study was to evaluate the effectiveness of the implementation of HIV and AIDS management at schools in

the Tshwane South District. This was translated into research objectives intended to:

- expose the reality of HIV and AIDS
- determine what HIV and AIDS management entails
- investigate how effective the HIV and AIDS management programme is at schools in the Tshwane South District using the Success Case Method
- derive lessons from the successes and/or non-successes in the implementation of the HIV and AIDS management programme at schools in the Tshwane South District
- recommend how lessons from the FPD programme can be used to further enhance the implementation of HIV and AIDS management at schools.

The main aim of this study, then, was to evaluate the effectiveness of the implementation of the HIV and AIDS management at schools in the Tshwane South District by using the Success Case Method (SCM). This study addressed this aim within a particular conceptual-theoretical framework.

1.3 CONCEPTUAL-THEORETICAL FRAMEWORK

According to Okaro, Eze and Ohagwu (2010:441), three basic elements are required in the management of HIV and AIDS, namely knowledge, skills and attitude. *Knowledge* about the disease in terms of how it is acquired, how it impacts on infected and affected people, how it spreads and how it can be prevented and 'cured' is of paramount importance in dealing with its effects. *Skills* relating to the treatment of infected and affected people and in dealing with environments where the disease prevails are important in, for instance, preventing further infection, dealing with issues of the stigma attached to people living with or affected by HIV and AIDS, and creating conditions in line with human rights. *Attitudes* towards the disease itself and people living with and

affected by HIV and AIDS are crucial elements in managing its effects and are critical for creating conditions amenable to a culture of human rights and non-discrimination against HIV-positive and affected people. Therefore any intervention programme should aim to equip people with proper knowledge, appropriate skills and proper attitudes towards HIV and AIDS and its effects. This is, especially in such environments as workplaces and schools in order to change their current knowledge levels, skills and attitudes about the disease.

Lewin's Three-Step Theory of Change (Kritsonis, 2005:1) underpins the approach to this evaluation study which seeks to examine what effect the FPD had in changing SMTs' knowledge, skills and attitudes towards the management of HIV and AIDS at schools. The aim was, therefore, to determine how successful this learning was for the SMTs. According to this theory, change takes behaviour to be a dynamic balance of forces working in opposing directions. The driving forces facilitate change as they push employees in a desired direction, while the restraining forces hinder change because they push employees in an opposite direction. This theory seems to have a critical meaning for this study with its proposition that the driving forces of planned change or outcomes of the intervention can be shifted (Kritsonis, 2005:2). In this regard, Kritsonis (2005:2) reasons that successful learning performance can be achieved by:

- increasing driving forces that direct behaviour away from the existing situation
- moving the target system to a new level of equilibrium
- sustaining good performances or practices.

The Three-Step Theory of Change propounds that change will occur when the combined strength of the driving forces is greater than the combined strength of the restraining set of forces. With regard to the FPD-initiated intervention, the assumption in this study is that the programme provided driving forces for changing the behaviour of SMTs by moving them to a new level of knowledge, skills and attitudes about HIV and AIDS and its management. It is assumed that

these SMTs, equipped with new levels of knowledge, skills and attitudes towards the management of HIV and AIDS, went out to schools with a willingness to perform and the determination to implement the knowledge and skills gained through the FPD training and, as such, have implemented the management programme with a new set of attitudes towards the disease and its management at schools.

It is within this framework that this study intends to evaluate the effectiveness of HIV and AIDS management at schools in the Tshwane South District. This evaluation was conducted by following a methodology appropriate to evaluation research.

1.4 OVERVIEW OF THE RESEARCH DESIGN AND METHODOLOGY

As espoused by Rossi, Lipsey and Freeman (2004:2) and McMillan and Schumacher (2001:528), evaluation research entails the use of social research methods to investigate systematically the effectiveness of a social intervention programme in ways that are adapted to organisational environments and are designed to inform social action to improve social conditions. This study, as mentioned earlier, intended to evaluate the effectiveness of HIV and AIDS management by SMTs and focused on the implementation of the knowledge, skills and attitudes gained during the FPD HIV and AIDS management training programme. As such, it was guided by a research paradigm related to qualitative research.

The study is grounded on the interpretivist paradigm and thus sought to discover SMTs' experiences regarding their implementation of HIV and AIDS management at schools. Consequently, the study was a qualitative evaluation of the implementation of HIV and AIDS management at schools in the Tshwane South District. For that reason the Success Case Method was used.

The Success Case Method evaluation, designed by Brinkerhoff (Brinkerhoff, 2005; Brinkerhoff & Dressler, 2003) is a two-phase method. It firstly uses a short quantitative survey questionnaire to identify a small group of exceptionally successful cases. This is then followed up with a purposeful selection of

(i) a core sample of successful case 'buckets' for in-depth interviews to probe the performance context factors that enabled them to achieve the greatest possible results, and (ii) a core sample of non-successful cases to identify and understand the performance system and other obstacles that kept such cases from using their learning successfully. The whole Success Case Method evaluation process intended to explore critical dimensions of the success and/or non-success of SMTs in the implementation of HIV and AIDS management at schools.

1.5 ASSUMPTIONS

Since no evidence has been found of a previous evaluation of current HIV and AIDS management at schools, this study was initiated on a number of assumptions, namely:

- The FPD training programme for SMTs provided them with appropriate knowledge, skills and attitudes to manage HIV and AIDS at schools.
- The FPD training programme inspired change in SMTs; this became a driving force for behavioural change to a willingness and competence to sustain new HIV and AIDS management practices actively.
- Evaluation of the 'new' HIV and AIDS management practices at schools is essential in order to derive lessons from both success and non-success case buckets in terms of what is and what is not good practice.
- The Success Case Method is an inexpensive, appropriate and effective qualitative evaluation method for social practice.

Based on the assumptions of this study, its significance could thus be contextually projected.

1.6 SIGNIFICANCE OF THE STUDY

The significance of the study is located in its potential to contribute to theory and practice. Firstly, the use of the Success Case Method was deemed a

contribution to theory in that it is a relatively new and novel approach to qualitative evaluation of social practice in educational management. The Success Case Method constitutes a novel, easy, inexpensive and yet effective method with significant advantages for qualitative evaluation research in educational management. Brinkerhoff (2002:viii) epitomises the value of the Success Case Method thus:

> *The Success Case Method is a fresh in-between alternative that has reasonable rigor and accuracy but is relatively cheap and quick, and produces credible evidence about what is working and what is not in a way people … find believable, compelling, and useful.*

Secondly, the study was deemed to be a contribution to practice in so far as it evaluated current HIV and AIDS management at schools, thus discovering what works and needs enhancement, and what does not work and needs to be addressed.

1.7 CHALLENGES OF THE STUDY

The challenges of the study included the local nature of its demarcation; this means that it may not be possible to generalise the findings to other schools in other districts, but the recommendations arising from the study may be useful to other Districts in and outside Gauteng province. This is typical of evaluation case examples and thus does not detract from the value of the insights gained. Therefore the lessons derived from the study will be of functional significance to schools in terms of HIV and AIDS management, especially as they were derived through a scientific process.

Because questionnaires seeking to identify cases for the interviews were personally administered, no challenges were foreseen as follow-up and retrieval was done in person. Challenges regarding attendance or non-attendance at interviews were dealt with by purposeful substitution of participants with those who had been identified and were on the list of desirable cases. However, this was not predetermined or enacted as a pre-emptive measure and was determined by the dynamism of the study process.

1.8 DEMARCATION OF THE STUDY

The study was demarcated to the Tshwane South District of the Gauteng Department of Education, which consists of 126 primary schools and 55 secondary schools. This demarcation was deemed appropriate because it is in this district that the FPD training programme was conducted and all the District's schools were represented in the training.

Only participants who indicated willingness to participate were selected as per the directives of the Success Case Method's selection of success and non-success case buckets.

1.9 LAYOUT OF THE STUDY

This study is divided into six chapters. Chapter 1 is introductory and deals with the conceptual and theoretical orientation and a methodological overview. It presents the purpose of the study and its rationale, the theoretical orientation, an overview of the research design and methodology, the assumptions and the practical significance, as well as the study's contribution, challenges and layout.

Chapters 2 and 3 present the reality of HIV and AIDS, especially since the study took place many years after the HIV and AIDS epidemic became a global concern, and discuss the nature of HIV and AIDS management at schools.

Chapter 4 consists of a detailed discussion of the research design and methodology.

Chapter 5 presents the data analysis and interpretation, encompassing the data used to identify high- and low-success cases for the qualitative evaluation, and data pertaining to the evaluation of HIV and AIDS management at the Tshwane South District schools.

Finally, Chapter 6 presents the summary, conclusions and recommendations of the study. Lessons derived from the evaluation of HIV and AIDS management by school managers in the Tshwane South District and the use of the Success

Case Method as a qualitative research evaluation method are outlined and recommendations are made.

1.10 CHAPTER SUMMARY

This chapter has dealt with the study's general orientation. The introduction presented the background to and rationale of the study. This was followed by the purpose statement, which located the study within a focused trajectory that encompassed the conceptual-theoretical framework on which the study was grounded, and an overview of the research design. The latter expounded on the paradigm of the study, and introduced the Success Case Method (SCM) as the evaluation method to be used in the study, also linking the SCM to the main assumptions of the study and its practical significance. The possible challenges, study demarcation and the study layout have been given as well.

The next two chapters address the research objectives, focusing on the reality of HIV and AIDS and the nature of HIV and AIDS management at schools.

CHAPTER 2
THE REALITY AND IMPLICATIONS OF THE HIV AND AIDS EPIDEMIC

2.1 INTRODUCTION

The management of the HIV and AIDS epidemic at schools is crucial in mitigating its adverse effects. To this end, a school is regarded as a social system consisting of various stakeholders, made up of, but not limited to, educators, learners, parents, the community and its various structures and the support systems which include the Department of Education and all its functionaries. Clearly, the HIV and AIDS epidemic has an effect on schools, just as it has an effect on society at large. This chapter focuses on the reality of the HIV and AIDS epidemic and its implications for society. This is crucial in order to create a context for understanding HIV and AIDS management in the context of the school as a social system that is influenced by and which influences these structures.

2.2 THE REALITY OF HIV AND AIDS

The prevalence and effects of HIV and AIDS are contemporarily and generally accepted as real and are a concern worldwide. Whereas in the past decades this epidemic was viewed sceptically in many parts of the world, many societies seem to have accepted that it is real, that it is decimating societies and communities, and that it has to be accorded priority status among the needs pressing for attention. Consequently, governments across the globe have initiated strategies and various programmes to deal with the epidemic at various levels of their societies. This is evidenced by large-scale research programmes aimed at discovering scientific and medical remedies, programmes aimed at stopping the spread of the disease, programmes aimed at providing medical and sustenance support for people living with HIV, and various other legislative considerations intended to combat its effects. Just how real the HIV epidemic is, is demonstrated by its prevalence, the measures taken to mitigate it, and its

effects since it became identifiable and known from its evolution to the present day.

2.2.1 HIV prevalence

The reality of HIV and AIDS, its prevalence and effects are now discussed in their global, African, sub-Saharan African and South African contexts.

2.2.1.1 HIV globally

US Global Health Policy (2010:1) reports the following since the first cases of HIV and AIDS were reported in 1981:

- More than 33 million people are currently living with HIV.
- Almost all people living with HIV (97%) reside in low- and middle-income countries, particularly in sub-Saharan Africa.
- Most people living with HIV or who are at risk for HIV do not have access to prevention, care and treatment, and there is still no cure.
- HIV affects primarily those in their most productive years – about half of new infections are among those under the age of 25.
- HIV not only affects the health of individuals, it impacts households, communities and the development and economic growth of nations. Many of the countries hardest hit by HIV also suffer from other infectious diseases, food insecurity and other serious problems.

The seriousness of the epidemic, while impacting on all regions of the world, does indeed seem to be more prevalent in low- and middle-income countries. Table 2.1 illustrates the global HIV and AIDS prevalence per region.

Table 2.1 Global HIV prevalence per region

Region	Total no. (%) living with HIV at the end of 2009	No. of people newly infected in 2009	Adult prevalence rate (15–49), 2009
Global total	**33.3 million (100%)**	**2.6 million**	**0.8%**
Sub-Saharan Africa	22.5 million (68%)	1.8 million	5.0%
South/South-East Asia	4.1 million (12%)	270 000	0.3%
North America	1.5 million (5%)	70 000	0.5%
Eastern Europe/ Central Asia	1.4 million (4%)	130 000	0.8%
Central/South America	1.4 million (4%)	92 000	0.5%
Western/ Central Europe	820 000 (2%)	31 000	0.2%
East Asia	770 000 (2%)	82 000	0.1%
Middle East/ North Africa	460 000 (1%)	75 000	0.2%
Caribbean	240 000 (0.7%)	17 000	1.0%
Oceania	57 000 (0.2%)	4 500	0.3%

Source: US Global Health Policy, 2010:1

These statistics clearly indicate the severity of HIV prevalence across the globe. Notably, sub-Saharan Africa leads with 22.5 million people living with HIV and a concomitant prevalence of 5% of adults, which indicates just how serious the HIV and AIDS epidemic is in this region. It is also noteworthy that Asian regions, including Eastern Europe, have the next highest prevalence at 16% of the global rate. North and South America also constitute a sizeable part of global prevalence at 9% of the global rate.

According to UNAIDS (2010a:22), trends in the number of people living with HIV indicate the following:

- The estimated number of children living with HIV increased to 2.5 million (1.7 million–3.4 million) in 2009.

- The proportion of women living with HIV has remained stable, at slightly less than 52% of the global total.

- Despite the decrease in new HIV infections, sub-Saharan Africa still bears an inordinate share of the global HIV burden and the total number of people living with HIV continues to rise. To this end, in 2009, that number reached 68% of the global total.

A disconcerting fact revealed in the global statistics is the scale of HIV prevalence in the sub-Saharan region of Africa, despite there being indications that the number of new HIV infections is decreasing and/or stabilising. UNAIDS (2010a:22) points out that the estimated 1.3 million (1.1 million–1.5 million) people who died of AIDS-related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of 1.8 million (1.6 million–2.0 million) deaths attributable to the epidemic.

US Global Health Policy (2010:1) adds the following details, among others, regarding the prevalence of HIV globally:

- Most new infections are transmitted heterosexually.

- Although HIV testing capacity has increased over time, enabling more people to learn their HIV status, the majority of people with HIV are still unaware they are infected.

- HIV has led to a resurgence of tuberculosis (TB), particularly in Africa, and TB is a leading cause of death for people with HIV worldwide.

- Women represent slightly more than half of all people living with HIV worldwide and 60% in sub-Saharan Africa, which is more than double that of their male counterparts.

- Young people aged between 15 and 24 years account for 41% of new HIV infections among those aged 15 and over.

- Globally, there were 2.5 million children living with HIV in 2009, 370 000 new infections among children and 260 000 AIDS deaths.

In addition to the details stated above, there are approximately 16.6 million children orphaned by AIDS, mostly living in sub-Saharan Africa (US Global Health Policy, 2010:1), which is disconcerting considering the effect this is likely to have on education in the region. Regarding the global prevalence of HIV, UNAIDS and WHO (2009a:8) point out that:

- AIDS continues to be a major global health priority.
- There is geographic variation between and within countries and regions.
- The epidemic is evolving.
- There is evidence of successes in HIV prevention.
- Improved access to treatment is having an impact.
- There is increased evidence of risk of exposure to HIV among key populations.

The foregoing exposition indicates that although significant strides have been made in measures taken to mitigate the prevalence of HIV, equally there is evidence that the responses to the HIV epidemic are far from over, even more so when the prevalence of the epidemic in Africa is analysed.

2.2.1.2 HIV and AIDS in Africa

The seriousness of HIV prevalence in Africa can be understood within the context of regional prevalence, categorised into the Middle and North African and sub-Saharan African regions as indicated by statistics reported by UNAIDS and WHO (2009a:11). According to this report (2009a:11), there was a prevalence of 310 000 people living with HIV in the Middle and North Africa region and there were 35 000 newly-infected adults and children in 2008. While comparatively low, the HIV prevalence in these regions also seems very serious. For instance, UNAIDS and WHO (2009a:71) indicate that in Egypt, 6.4% of the key male population and 14.8% of key female population at higher risk were HIV-positive in 2006, with exceptions to the low prevalence being

evident in Djibouti and southern Sudan, where the HIV prevalence among pregnant women exceeded 1%.

UNAIDS and WHO (2009a:72) further state that in settings where overall HIV prevalence is low, discrete populations are often heavily affected by the epidemic, which is typically concentrated among injecting drug users, men who have sex with other men and among sex workers and their clients, including in risky areas such as prisons as well as in cases involving unsafe blood transfusions and mother-to-child transmissions (MTCT).

It is, of course, a well-documented fact that the sub-Saharan region of Africa is, and continues to be, the worst affected in terms of HIV prevalence as detailed in the next section.

2.2.1.3 HIV and AIDS in sub-Saharan Africa

The sub-Saharan Africa region comprises countries that include Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

As pointed out above, although the HIV and AIDS epidemic affects the whole of Africa, its prevalence seems more intense in sub-Saharan Africa. UNAIDS and WHO (2009a:11) indicate a prevalence of 22.4 million among both adults and children in sub-Saharan Africa. This is a very high prevalence and there is a strong possibility of negative impacts on the region's population. For instance, the prevalence trends seem almost similar in most countries bordering each other. This can be seen in an analysis of the prevalence among the sub-Saharan countries in Table 2.2.

Table 2.2 HIV and AIDS prevalence in sub-Saharan Africa (2009)

Country	People living with HIV and AIDS	Women with HIV and AIDS	Children with HIV and AIDS
Angola	200 000	110 000	22 000
Benin	60 000	32 000	5 400
Botswana	320 000	170 000	16 000
Burkina Faso	110 000	56 000	17 000
Burundi	180 000	90 000	28 000
Cameroon	610 000	320 000	54 000
Central African Republic	130 000	67 000	17 000
Chad	210 000	110 000	23 000
Comoros	<500	<100	...
Congo	77 000	40 000	7 900
Côte d'Ivoire	450 000	220,000	63 000
Dem. Republic of Congo	(430 000–560 000)	(220 000–300 000)	(33 000–86 000)
Equatorial Guinea	20 000	11 000	1 600
Eritrea	25 000	13 000	3 100
Gabon	46 000	25 000	3 200
Gambia	18 000	9 700	...
Ghana	260 000	140 000	27 000
Guinea	79 000	41 000	9 000
Guinea-Bissau	22 000	12 000	2 100
Kenya	1 500 000	760 000	180 000
Lesotho	290 000	160 000	28 000
Liberia	37 000	19 000	6 100
Madagascar	24 000	7 300	...
Malawi	920 000	470 000	120 000
Mali	76 000	40 000	...
Mauritania	14 000	4 000	...
Mauritius	8 800	2 500	...
Mozambique	1 400 000	760 000	130 000
Namibia	180 000	95 000	16 000
Niger	61 000	28 000	...
Nigeria	3 300 000	1 700 000	360 000
Rwanda	170 000	88 000	22 000
Senegal	59 000	32 000	...
Sierra Leone	49 000	28 000	2 900
South Africa	5 600 000	3 300 000	330 000
Swaziland	180 000	100 000	14 000
Togo	120 000	67 000	11 000
Uganda	1 200 000	610 000	150 000
United Rep. Of Tanzania	1 400 000	730 000	160 000
Zambia	980 000	490 000	120 000
Zimbabwe	1 200 000	620 000	150 000
Total sub-Saharan Africa	**22 500 000**	**12 100 000**	**2 300 000**

Source: Avert.org, 2011a

There are some noteworthy points about the HIV and AIDS epidemic in the sub-Saharan region from Table 2.2 above, namely:

- Nine of the countries, except Nigeria and Uganda, are all neighbours who share borders, and possibly cultures.
- Of the 41 countries listed, 7 have incidences of 1 million and more. In this regard, it is notable that South Africa rates highest with 5 600 000 people living with HIV, followed by Nigeria with 3 300 000 people.
- The people most affected seem to be women. For instance, of the 5 600 000 people affected in South Africa, the majority, 3 300 000, are women, while Swaziland, with 180 000 people affected, has 100 000 affected women.
- Malawi, a relatively small and poor country, has a striking prevalence of 920 000 people living with HIV.
- It is also noteworthy that children who are affected make up a sizeable number (2.3 million) of people living with HIV.

It should also be noted that of the sub-Saharan countries, some countries have a higher HIV and AIDS prevalence than others. Table 2.3 illustrates this trend.

Table 2.3 Sub-Saharan countries with the highest prevalence of HIV

Rank	Country	Prevalence among adults, 2007 (%)	Total population
1	Swaziland	26.1	1 123 913
2	Botswana	23.9	1 990 876
3	Lesotho	23.2	2 130 819
4	South Africa	18.1	49 052 489
5	Namibia	15.3	2 108 665
6	Zimbabwe	15.3	11 392 629
7	Zambia	15.2	11 862 740
8	Mozambique	12.5	21 669 278
9	Malawi	11.9	14 268 711

Adapted from Global Health Council (2011)

From Table 2.3 it can be seen that countries such as Namibia, Zimbabwe, Zambia, Mozambique and Malawi have high HIV prevalence rates when considered in relation to their total populations. It is, however, also notable that South Africa, while ranking fourth, has a very high prevalence rate at 18.1%, despite its large population. This has serious implications for South Africa's ability to mitigate the effects of HIV and AIDS, especially in the provision of education.

The implications of these statistics are enormous for mitigating the causes and spread of HIV and are dire for the socio-economic status of people in these countries. The implications are even more significant for the management of HIV and AIDS at schools, especially considering their collective impact on school resources and on people involved in school education.

2.2.1.4 HIV and AIDS in South Africa

With an estimated 5.6 million people living with HIV, South Africa is the country with the highest HIV prevalence in the world (UNAIDS, [s.a.]a:3). Table 2.4 gives data pertaining to HIV prevalence in South Africa from 2001 to 2009.

Table 2.4 HIV prevalence estimates from 2001–2009 in South Africa

Year	Population 15–49 years		Percentage of the total population	Total number of people with HIV (in millions)
	Percentage of women	Percentage of the population aged 15–49		
2001	18.5	15.63	9.3	4.19
2002	18.9	15.6	9.6	4.35
2003	19.1	15.6	9.6	4.35
2004	19.3	16.1	9.9	4.61
2005	19.4	16.2	10.0	4.72
2006	19.4	16.4	10.1	4.83
2007	19.5	16.5	10.2	4.94
2008	19.5	16.7	10.4	5.06
2009	19.7	17.0	10.6	5.21

Source: Statistics South Africa: 2009 (mid-year release)

From an analysis of the statistics in Table 2.4 it is clear that South Africa has experienced a steady increase in HIV prevalence since 2001. The increase in prevalence among the entire population in 2009 to 10.6% and a total number of 5.21 million South Africans living with HIV is quite significant. It is also noteworthy, as depicted in Table 2.4 above, that a sizeable percentage of HIV prevalence is among the age group of 15–49 years. This group will include school-going youth, who are in all probability in the final stages of secondary school education, as well as those who are in tertiary education stages and those who are supposed to be economically active. Strikingly, as mentioned by Avert.org (2011b): “the overall prevalence of HIV is highest among women of 25 to 29 years of age, with one in every three women being HIV positive and prevalence among males being highest within the 30 to 34 age group, where approximately one quarter of all men were HIV positive in 2008”.

Another important observation on the prevalence of HIV in South Africa, according to USAID (2011:1), is that while the number of people living with HIV and AIDS has stabilised in recent years, South Africa continues to face a

generalised hyper-epidemic due to the high HIV prevalence. To this end, USAID (2011:1) observes that South Africa is one of the few countries:

> *… where maternal and child mortality has increased since the 1990s, and AIDS is the largest cause of maternal mortality. It accounts for an estimated 42.5 percent of maternal deaths, according to the World Health Organization (WHO), and for 35 percent of deaths in children under 5. While South Africa is home to only 0.7 percent of the world's population, it accounts for 28 percent of the world's HIV and tuberculosis (TB) co-infections and 33 percent of the co-infection in sub-Saharan Africa.*

- **The status of HIV and AIDS evolution in South Africa**

The HIV and AIDS epidemic has undergone a cycle of evolution whereby, according to Nicolay (2008:2), South Africa is experiencing a mature epidemic, in which new infections and deaths are more or less at the same level. The total numbers of HIV-positive people remain constant, with total new HIV incidences and AIDS deaths converging to a level of between 400 000 and 500 000 per annum. This is an indication that, as alluded to in UNAIDS (2010a:8), HIV is generally stabilising or showing signs of decline. This is portrayed in Figure 2.1, which illustrates projected new HIV incidences and AIDS deaths per province in the country.

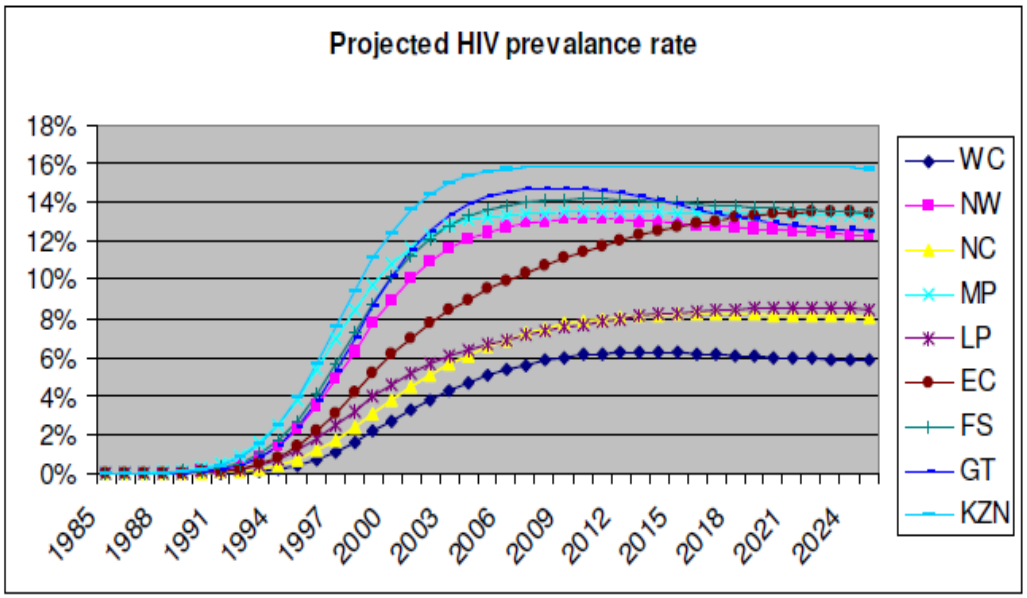


Figure 2.1 Projected new prevalence rate for South Africa (Nicolay, 2008)

What is notable from this figure is that while, encouragingly, there are trends indicating a decline, the projected percentages are in the region of 14% in some provinces and 6% in others. Translated into real numbers, at an estimated population of 45 million to 50.4 million in 2010 (USAID, 2011:1), about 7.056 million people at the most and 3.024 million at the least are estimated to be HIV-positive. These figures indicate, in real terms, unacceptably high HIV prevalence, which confirms South Africa as a country "with the highest number of infections in the world" and "as one of the countries most severely affected by the AIDS epidemic" (USAID, 2011:1).

The following observations about the prevalence of HIV and AIDS in South Africa are pertinent to the reality of the epidemic:

- **Prevalence according to provinces**

Based on the results of the study on prevalence (Avert.org, 2009), HIV and AIDS prevalence varies among the provinces of South Africa, as illustrated in Table 2.5.

Table 2.5 HIV prevalence (%) by province, 2002, 2006 & 2008

Province	2002	2005	2008
KwaZulu-Natal	11.7	16.5	15.8
Mpumalanga	14.1	15.2	15.4
Free State	14.9	12.6	12.6
North West	10.3	10.9	11.3
Gauteng	14.7	10.8	10.3
Eastern Cape	6.6	8.9	9.0
Limpopo	9.8	8.0	8.8
Northern Cape	8.4	5.4	5.9
Western Cape	10.7	1.9	3.8
National	11.4	10.8	10.9

Source: Avert.org, 2009

Table 2.5 indicates an increasing trend in four provinces over the three years, in line with the national trends as alluded to earlier. It is, however, noted that some provinces experienced declining trends in one year and marginal increases in another over the same period. For example, the Free State and Limpopo had initial declines in 2005 and marginal increases in 2008. However and in general, Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbelle, Van Zyl, Parker, Zungu, Pezi and the SABSSM III Implementation Team (2009:32) state that the 2008 HIV prevalence was lowest in the Western Cape, followed by the Northern Cape, Limpopo and the Eastern Cape, with the highest HIV prevalence remaining in KwaZulu-Natal and Mpumalanga, followed by the Free State, the North West and Gauteng provinces which fell in between these two groups.

As can be seen from the prevalence outlined above, HIV prevalence varies between provinces. This variance is indeterminate and is therefore not indicative of specific trends per province. The likelihood is that the prevalence of HIV in a particular province reflects the national trends and generally indicates, as pointed out earlier, a stabilisation of the epidemic or, as it were, its maturity.

It might, however, be pointed out that the prevalence of HIV seems high in highly populated provinces.

- ***Prevalence according to age and gender***

The prevalence of HIV by age indicates the reality of HIV and AIDS and enables an understanding of future projections and the impacts of the epidemic on society at large, as well as on different service delivery nodes, including the education sector. Figure 2.2 depicts estimated HIV prevalence rates among South Africans by age from 2002 to 2008.

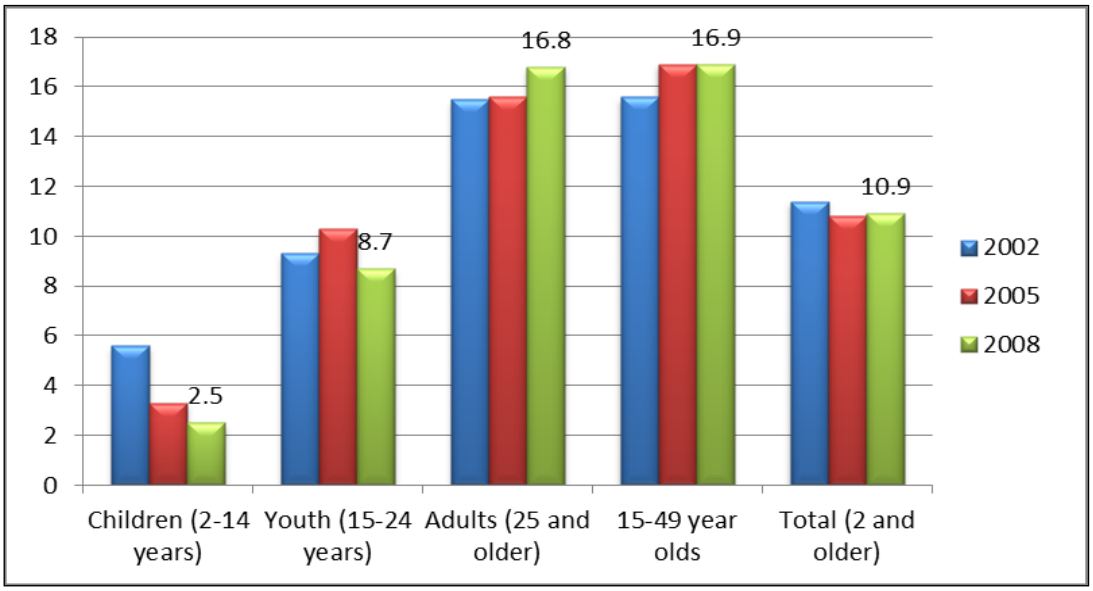


Figure 2.2 Estimated HIV prevalence (%) among South Africans by age 2002–2008 (Avert.org, 2010)

The estimates in Figure 2.2 indicate that the prevalence of HIV among South Africans is highest among the group aged from 15 to 49. It can also be noted that there is an estimated 16.8% prevalence among adults 25 years and older. Notably, as remarked on elsewhere in this text, this is the age at which people are most likely to be economically active and/or in the final years of tertiary education and starting on their careers. It can also be seen that there is an estimated 8.7% prevalence among the youth between 15 and 24 years, which indicates serious challenges and implications for the education sector as this is the population cohort most likely to be at school or higher education institutions

and requiring care and support. This also implies the need for a rigorous HIV and AIDS management system.

Despite these estimates, there are promising trends in the HIV prevalence in South Africa. Shisana *et al*. (2009:31) found that HIV prevalence among people aged 2^+ years stabilised between 2002 and 2008 at 11%. Furthermore, the following changes, though mixed, were identified among the various groups:

- In children aged 2 to 14 years, the prevalence decreased by 3.1% from 2002 to 2008.
- Among young people aged 15 to 24, a decline in HIV prevalence was only observed from 2005 to 2008.
- In adults aged 24^+ years, the prevalence increased by 1.3% from 2002 to 2008.

The reality of HIV in South Africa is more pronounced when age and gender for the year 2008 statistics are specifically scrutinised. Such data are presented in Table 2.6.

Table 2.6 HIV statistics: Estimated HIV prevalence among South Africans, by age and gender (2008)

Age	Male prevalence %	Female prevalence %
2–14	3.0	2.0
15–19	2.5	6.7
20–24	5.1	21.1
25–29	15.7	32.7
30–34	25.8	29.1
35–39	18.5	24.8
40–44	19.2	16.3
45–49	6.4	14.1
50–54	10.4	10.2
55–59	6.2	7.7
60+	3.5	1.8
Total	12.79	18.3

Adapted from Avert.org, 2010

The most remarkable feature from the data in Table 2.6 is how the prevalence varies from one age group to another and how it affects more females than males. With the prevalence reaching about 6.7% in girls aged 15 to 19 compared with 2.5% of boys of the same age, it seems that girls are more vulnerable than boys. The data above also shows that prevalence rates begin to decrease in the mid- to late 40s. It is not clear why this should be and if it is of any significance, considering that in the age group between 50 and 54, there seems to be an increase for males from 6.4% to 10.4%, and a decrease for females from 14.1% to 10.2%.

The prevalence rate in men is alarming between the ages of 25 and 29, and between 30 and 34. It can be concluded, taking the variations into account, that females are much more exposed to the risk of HIV infection or more vulnerable than men in most age categories. Clearly the overall variance, females leading by 5.6%, shows how women constitute a higher percentage of people living with HIV than men. In this regard, Scott and Harrison (2009:11) assert:

> *... The prevalence of HIV in women rises earlier and higher than that of men, equalising only in people in their mid-thirties and older.*

It is also remarkable that HIV prevalence is highest among women of 25 years and older and among men 30 years and older, as found in the national HIV household surveys conducted in South Africa in 2002, 2005 and 2008 by Rehle, Hallet, Shisana, Pillay-Van Wyk, Zuma, Carrara and Jooste (2009:5). These figures are strong indicators of an urgent need for intervention programmes to be directed to women and girls, while not neglecting men. Such programmes should also address cross-generational sexual activity since the figures denote greater possibilities of young women or girls contracting HIV from men above their age group. This also implies that school-going girls are at high risk of being infected by the disease. The low prevalence rate in the age group between 2 and 14 years gives hope for having an HIV-free generation in their future, especially with the advent of early mitigation interventions and strategies.

The reality and seriousness of the HIV and AIDS epidemic is even more evident in the measures taken to mitigate it and its effects.

2.2.2 Measures taken to mitigate HIV and AIDS

Measures taken to mitigate the HIV and AIDS epidemic range from those taken at global levels to those taken at national and local levels. To gain insight into the management of HIV and AIDS, especially in educational institutions and at schools, it is important to gain an understanding of the measures taken at various levels which, for the purposes of this study, are the global, African, sub-Saharan region and South African levels.

2.2.2.1 Mitigating HIV and AIDS globally

The United Nations, through the Joint UN Programme on HIV and AIDS (UNAIDS), together with numerous other organisations, including governments and NGOs, has taken the lead in the fight against HIV and AIDS worldwide. This initiative has brought forth various declarations and programmes aimed at mitigating the effects of HIV and AIDS, as well as soliciting strong commitment from various countries across the globe. Mohiddin and Jonston (2006:2) assert:

> *... mitigation strategies exist to control, treat, and prevent HIV and are technologies (including institutional organisations) that a state needs to adopt in order to achieve mitigation.*

These mitigation strategies are accompanied by intended outcomes and objectives aimed at scaling-up responses to HIV and its impacts. On that note, the following strategies and campaigns, among others, are noteworthy:

- **The Millennium Development Goals**

In 2000, the United Nations General Assembly adopted Resolution 55/2 detailing the United Nations Millennium Declaration, which defined targets for “international cooperation, inspiring development efforts” to improve “the lives of hundreds of millions of people around the world” (United Nations, 2010:3). In the Declaration, the UN pledged itself to eight so-called Millennium Development Goals (MDGs) to be achieved by 2015. According to the UN General Secretary, Mr Ban Ki-moon (United Nations, 2010:3), the MDGs:

> *… represent human needs and basic rights that every individual around the world should be able to enjoy, including freedom from extreme poverty and hunger; quality education, productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality.*

In essence, according to WHO (2011) and United Nations (2010), "… the goals aimed to eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV and AIDS, malaria and other diseases, ensure environmental sustainability and develop a global partnership for development". Of interest to fighting HIV and AIDS is MDG 6 which aims specifically to combat HIV and AIDS, malaria and other diseases (United Nations, 2010:40) and sets targets aimed at "halting HIV/AIDS by 2015 and reversing its spread" and, secondly, to achieve, by 2010, "universal access to treatment for HIV/AIDS for the infected" (UNAIDS, 2010b:2). Furthermore, indicators have been set over the years since 2000 to measure progress in terms of achieving MDG 6.

In evaluating the impact of and progress on the implementation of the MGDs, it is clear that although there are numerous challenges around the world, some significant successes have been achieved. In this regard, UNAIDS (2010b:2) observes that new HIV infections are falling, more than 5 million people are having HIV treatment, HIV prevention works, virtual elimination of MTCT is possible by 2015, laws are challenging the AIDS response and investing for AIDS is a shared responsibility.

- **The Global Strategy Framework**

The Global Strategy Framework (UNAIDS, 2001), established in 2001, provides a common strategic approach to achieving these global targets and encourages the many actors engaged in the response to:

- formulate additional goals at national and local levels to bring the AIDS epidemic under control and to support communities and countries in order to reduce risk and vulnerability to infection
- save lives and alleviate human suffering
- lessen the epidemic's overall impact on development and be guided by four fundamental principles, namely
    - It is the role of national governments, working with civil society, to provide the leadership, means and co-ordination for national and international efforts to respond to country and community needs.
    - In communities around the world, support for the active engagement of people living with and affected by HIV and AIDS is central to the response.
    - Gender inequalities fuelling the epidemic must be explicitly addressed.
    - Prevention methods, life-saving treatments and the results of scientific breakthroughs need to be equitably and affordably available to all.

The main thrust of the Global Strategy Framework is therefore to focus on measures aimed at combating HIV by (i) decreasing the risk of infection so as to slow the epidemic, (ii) focusing on behaviours where there is a risk of HIV infection, (iii) decreasing vulnerability in order to decrease the risk of infection and the impact of the epidemic, and, in doing so, (iv) prolonging the productive lives of individuals living with HIV and AIDS (UNAIDS, 2001:8).

The Global Strategy Framework thus translates into "an expanded response to the epidemic ... addresses both what places individuals at risk and why they are at risk" (UNAIDS, 2001:8).

- **Political Declarations of Commitment on HIV and AIDS**

On the 25th to the 27th June 2001, the United Nations General Assembly Special Session came up with a political declaration, called the *Declaration of Commitment to HIV/AIDS* which recognised the need for global action in responding to HIV and AIDS and its aftermaths (United Nations, 2001:1). The required global action, in the words of the then UN Secretary-General, Mr Kofi Annan:

> *… signals the emergence of a response to this deadly disease – by governments, multilateral organizations, the private sector and civil society – that could soon match the scale of the epidemic.*

The Declaration of Commitment on HIV/AIDS sets a broad agenda of five targets to be met, namely to ensure that people everywhere – particularly the young – know what to do to avoid infection; to stop perhaps the most tragic of all forms of HIV transmission – from mother to child; to provide treatment to all those infected; to redouble the search for a vaccine, as well as a cure; and to care for all whose lives have been devastated by AIDS, particularly the more than 13 million orphans (United Nations, 2001:1; Gruskin &, Tarantola 2008:124).

In 2006, the UN issued another declaration, *The Political Declaration of Commitment on HIV/AIDS: five years later*, which aimed to review and provide an update on progress in the global AIDS response since the 2001 Special Session, and to identify critical challenges that must be addressed through urgent recommendations to strengthen efforts at the global, regional and country levels. At that stage, the heads of states and governments and their representatives, in the comprehensive review of the progress achieved in realising the targets set out in 2001, acknowledged (UN General Assembly, 2006:1):

> *AIDS has inflicted immense suffering on countries and communities throughout the world; and that more than 65 million people have been infected with HIV, more than 25 million people have died of AIDS, 15 million children have been*

orphaned by AIDS and millions more made vulnerable, and 40 million people are currently living with HIV, more than 95 percent of whom live in developing countries.

Consequent to that acknowledgement, the following commitments, among others, were made (UN General Assembly, 2006:3):

- A commitment to implement fully the Declaration of Commitment on HIV/AIDS, entitled “Global Crisis – Global Action”, adopted by the General Assembly at its 26th Special Session in 2001 and to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV and AIDS, malaria and other major diseases. This included the agreements dealing with HIV and AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development (ICPD).

- An undertaking to reinforce, adopt and implement, where needed, national plans and strategies, supported by international cooperation and partnership, to increase the capacity of human resources for health to meet the urgent need for the training and retention of a broad range of health workers, including community-based health workers; improve training and management and working conditions, including treatment for health workers; and effectively govern the recruitment, retention and deployment of new and existing health workers to mount a more effective HIV and AIDS response.

- A request to the Secretary-General of the United Nations, with the support of the Joint United Nations Programme on HIV/AIDS, to include in his annual report to the General Assembly on the status of implementation of the Declaration of Commitment on HIV/AIDS, in accordance with General Assembly Resolution S-26/2 of 27 June 2001,

the progress achieved in realizing the commitments set out in the present Declaration.

- A decision to undertake comprehensive reviews in 2008 and 2011, within the annual reviews of the General Assembly, of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS, entitled "Global Crisis – Global Action", adopted by the General Assembly at its 26th Special Session, and the present Declaration.

The 2006 declaration was followed by the 2011 Political Declaration on HIV/AIDS which strove to "up-scale efforts to eliminate HIV/AIDS through reviewing and noting the progresses of the 2001 and 2006 declarations" (UN General Assembly, 2011). In this Declaration, the heads of state and government representatives conceded:

> *Despite substantial progress over the three decades since AIDS was first reported, the HIV epidemic remains an unprecedented human catastrophe inflicting immense suffering on countries, communities and families throughout the world …*

To this end, UN General Assembly (2011:7) notes that "more than 30 million people have died from AIDS, with another estimated 33 million people living with HIV; more than 16 million children have been orphaned because of AIDS; over 7 000 new HIV infections occur every day, mostly among people in low- and middle-income countries; and [that] less than half of the people living with HIV are believed to be aware of their infection".

The Declaration thus underscored priorities to intensify the fight against HIV and AIDS, expressed as:

> … *commitment to end the epidemic with renewed political will and strong, accountable leadership and to work in meaningful partnership with all stakeholders at all levels to implement bold and decisive actions … , taking into account the diverse situations and circumstances in different countries and regions throughout the world*".

- **The universal access campaign/plan, 2006–2010**

The universal access campaign was a response to the progress of the political declarations, which, although there had been a number of significant achievements, were less than ideal or successful. Thus in 2005, the United Nations Member States agreed to work towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010 (WHO, 2006:5). The 'universal access' concept, besides being aligned to HIV prevention, treatment and care, includes the element of the protection of human rights, such as non-discrimination against those living with HIV. According to Gruskin and Tarantola (2008:124), the universal access plan is a rights-based approach to address the challenges of HIV and AIDS. In this regard, Gruskin and Tarantola (2008:123) assert that countries that failed in their early response to HIV, such as China, Russia and South Africa, were characterised by persistent discrimination and denial of access to participation of affected communities, which aggravated the risk of acquiring HIV infection. For this reason, the universal access plan advocates the protection of human rights as a vessel to transport its mission, that is, coming as close as possible to HIV prevention, treatment and care (OHCHR & UNAIDS, 2007:3).

According to Gruskin and Tarantola (2008: 123), the universal access plan advocates three principal components, namely

- examining the legal and policy environment in which programmes take place and systematically integrating core human rights principles into policy and programmatic responses at local, national and international levels, for example non-discrimination, participation and core components of the right to health, including availability, accessibility, acceptability and quality of services delivered
- ensuring that the most vulnerable populations are reached with the services they need
- ensuring transparency and accountability for how policies and programmes are carried out.

It can be deduced that these components describe a strategy for the protection of human rights through policies and legal frameworks.

To achieve the universal access goal, five strategic directions were to be implemented by the health sector (WHO, UNAIDS & UNICEF, 2007: 5; OHCHR & UNAIDS, 2007:1), namely (i) enabling people to know their HIV status through confidential testing and counselling; (ii) maximising the health sector's contribution in areas of HIV prevention, such as MTCT of HIV, sexual transmission (especially among young people and high-risk populations), transmission through injecting drug use, transmission in health care settings, care of people living with HIV and AIDS and adopting new technologies; (iii) accelerating the scale-up of HIV and AIDS treatment and care; (iv) strengthening and expanding health systems; and (v) investing in strategic information to guide a more effective response.

By the end of 2010, it was observed that progress had been attained in numerous countries due to the universal access plan. Among others, 15 countries, including Botswana, Guyana and South Africa, were able to provide more than 80% of HIV-positive pregnant women in need with the services and medicines to prevent mother-to-child HIV transmission; 14 countries, including Brazil, Namibia and Ukraine, were providing HIV treatment to more than 80% of the HIV-positive children in need; and eight countries, including Cambodia, Cuba and Rwanda, had achieved access to antiretroviral therapy (ART) for adults.

Furthermore, Avert.org (2011b) reports that from 2006 to 2010 an extra 3 million people in low- and middle-income countries were put on treatment for HIV. The provision of ART to needy people contributed to the fall of AIDS-related deaths worldwide from the peak of 2.2 million recorded in 2005 to an estimated 1.8 million in 2010 (WHO, UNAIDS & UNICEF, 2011: 170). In sub-Saharan Africa, close to 1 million more people started on ART, the number increasing from 2.95 million at the end of 2008 to 3.91 million at the end of 2009, covering 37% of those in need (WHO, 2010). Therefore the universal access plan significantly improved the delivery of health services to those in need.

Although the targets of the universal access plan had not been met completely by 2010, there were indications of the possibility of such attainments. Table 2.7, which is an extract from the Key Indicators for the HIV epidemic from 2002 to 2010, shows those indications.

Table 2.7 Key Indicators for the HIV epidemic, 2006–2010

	2006	2007	2008	2009	2010
Number of people living with HIV (in millions)	31.4 [29.6–33.0]	31.8 [29.9–33.3]	32.3 [30.4–33.8]	32.9 [31.0–34.4]	34.0 [31.6-35.2]–
Number of people newly infected with HIV (in millions)	2.8 [2.6–2.9]	2.7 [2.5–2.9]	2.7 [2.5–2.9]	2.7 [2.5–2.9]	2.7 [2.4–2.9]
Number of people dying from AIDS-related causes (in millions)	2.2 [2.1–2.4]	2.1 [2.0–2.3]	2.0 [1.9–2.2]	1.9 [1.7–2.1]	1.8 [1.6–1.9]
% of pregnant women tested for HIV	13%	15%	21%	26%	35%
Number of facilities providing antiretroviral therapy	-	7700	12 400	18 600	22 400
Number of people receiving antiretroviral therapy	2 034 000	2 970 000	4 053 000	5 255 000	6 650 000
Number of children receiving antiretroviral therapy	125 700	196 700	275 400	354 600	456 000
Coverage of antiretroviral medicines for preventing mother-to-child transmission (%)	23%	33%	43%	48%	48%

[a] In low- and middle-income countries

[b] The coverage data include the provision of single-dose nevirapine which is no longer recommended by WHO.

[c] These data do not include the single-dose nevirapine regimen which is no longer recommended by WHO. They should not be compared with the previous years. When including single-dose nevirapine, the coverage in 2010 is 59%.

Source: WHO, UNAIDS & UNICEF (2011)

An important observation from Table 2.7 is that there seems to be an increase in the number of people living with HIV. For example, in 2006 there were 31.4 million people living with HIV as compared with 34.0 million by the end of

2010. This should be understood in the context of the effects of more treatment and more effective treatment, which prolongs life and reduces AIDS-related deaths. Therefore, instead of people dying from AIDS-related diseases, the treatment offered prolongs their lives, which translates to high HIV prevalence. Therefore, the more people accessing ART, the higher the HIV prevalence, which is a reiteration of the fact that HIV incidences have stabilised even in regions such as sub-Saharan Africa. This means that there is no decline or increase in new incidences. Despite this, challenges in the prevention and treatment of HIV and AIDS still remain. For example, an estimated 2.7 million people were reportedly newly infected with HIV in 2010, including 390 000 children, bringing the total number of people living with HIV to 34 million (WHO, UNAIDS, UNICEF, 2011:171). This prompted even more action as can be seen in the next campaign discussed below.

- **Getting to Zero Campaign, 2011–2015**

The Getting to Zero Campaign is a UNAIDS strategy, adopted in December 2010, aimed at advancing the global responses towards the achievement of the set targets for the universal access to HIV prevention, treatment, care and support, and at halting and reversing the spread of HIV and contributing towards the achievement of the MDGs by 2015 (UNAIDS, 2010c:5). This strategy mirrors the UNAIDS vision of what is to be implemented at country level and encompasses three components, namely *Zero new infections*, *Zero AIDS-related deaths* and *Zero discrimination* (UNAIDS, 2010c:7).

With this strategy in place, countries continue to scale up their actions and implementation strategies, with UNAIDS having an enhanced supportive role to play. As outlined in the UNAIDS 2012–2015 unified budget and accountability framework, UNAIDS in supporting countries and regions to achieve the Getting to Zero vision plays the roles of (i) generating, analysing and promoting the use of strategic information to guide evidence-based policies and resources allocation; (ii) working with countries and donors to ensure that resources for AIDS responses are invested in the most effective and efficient way;

(iii) advocating for human and gender rights; and (iv) driving the AIDS response at global, regional and country level (UNAIDS, 2010c:6).

Therefore the targets of the Getting to Zero Campaign are, according to Avert.org (2011b), the reduction of new infections by 50% among young people (15–24 years), the reduction of TB-related mortality by 50%, the elimination of new infections in children, and the reduction AIDS-related mortality. These targets were agreed upon as a way of intensifying the progress achieved in the 2001 Declaration of Commitment on HIV and AIDS and the 2006 Political Declaration on HIV and AIDS (UN General Assembly, 2011:1). The Getting to Zero Campaign shows recommitment to the objectives of the universal access plan as is demonstrated by the strategic directions with goals and objectives that serve as guidelines to breaking the trajectory of HIV and AIDS and to pursuing the Getting to Zero vision by 2015, as summarised in Table 2.8 (UNAIDS, 2010c:21, 31–42).

Table 2.8 Strategic directions towards 'Getting to Zero' by 2015

Strategic direction	Goals for 2015	Objectives
Revolutionise HIV prevention	Sexual transmission reduced by half, including among young people, men who have sex with men and transmission in the context of sex work Vertical transmission of HIV eliminated and AIDS-related deaths reduced by half All new HIV infections prevented among people who use drugs	To generate political commitment to address how and why people are getting infected To mobilise communities to effectively demand transformative social and legal change To direct resources to epidemic 'hot spots' through the right interventions
Catalyse the next phase of treatment, care and support	Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment TB deaths among people living with HIV reduced by half People living with HIV and households affected by HIV addressed in all national social protection strategies and have access to essential care and support	To ensure that people living with HIV can access effective treatment when they need it To strengthen national and community systems to deliver treatment, care and support To significantly scale up access to care, support and social protection by people living with and affected by HIV
Advance human rights and gender equality for HIV response	Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions HIV-specific needs of women and girls addressed by at least half of all national HIV responses Zero tolerance for gender-based violence	To support countries in protecting human rights in the context of HIV and to create protective social and legal environments that enable access to HIV programmes To advance countries' capacity to reduce stigma and discrimination and to realise equitable service provision for those most affected by HIV To ensure that national HIV strategies address the needs and rights of women and girls in the context of HIV

Source: UNAIDS, 2010c:21

These strategic directions guide countries in responding to HIV and AIDS so that they move faster, better and smarter towards Zero new infections, Zero AIDS-related deaths and Zero discrimination. The Getting to Zero concepts have been adopted as the theme for the 2011 to 2015 World AIDS Days (Ecumenical Advocacy Alliance, 2011).

2.2.2.2 Mitigating HIV and AIDS in Africa

Despite the indisputable truth that HIV has infected more people in Africa than on any other continent, Africa is scaling up its response by applying measures intended to halt the rate of HIV infection, provide care, treatment and support and reduce the impact of HIV and AIDS. In 1999, the International Partnership against AIDS in Africa was formed with the intention of mobilising a broader, intensified response to the epidemic by encouraging African countries to create a high-level coordinating body for treatment and planning efforts (Rosen, 2001). These intervention strategies include forums, declarations, continental strategic plenary meetings and the development of frameworks of action.

A significant mitigation initiative is Africa's adoption in 1994 of a 20-year programme of action. According to Ekanem (2006:13), the measures to deal with the impact of HIV and AIDS will include: increasing behavioural surveillance to track progression of the epidemic and the impact of interventions; increasing HIV and AIDS awareness in diverse communities; using various HIV prevention efforts, particularly for youth aged from 15 to 24; expanding Voluntary Counselling and Testing (VCT) services throughout regions; condom distribution; provision of services to prevent mother-to-child transmission; making community care and support programmes available for orphans and vulnerable children; providing care and support for HIV-positive people; and intensifying partnerships and mobilising resources within and outside the African region.

Specific strategies have also been developed to deal with the HIV and AIDS epidemic. The following are among such intervention strategies in Africa.

- **The Abuja Declaration and Framework of Action on HIV/AIDS 2001**

The Abuja Declaration and Framework of Action on HIV/AIDS, as stated by the Ndinga-Muvumba, Scanlon and Murithi (2005:15), was developed in Abuja, Nigeria, where African leaders committed themselves to fighting HIV and AIDS, tuberculosis and other infectious diseases. The summit was attended by the heads of states and governments of eight African countries, namely Botswana, Ethiopia, Kenya, Mali, Nigeria, Rwanda, South Africa and Uganda (Africa-union.org, 2006a:2).They signed a declaration to implement measures in 12 priority areas that play an integral part in mitigating HIV and AIDS. These include, according to African-Union.org (2006a:2): leadership at national, regional and continental levels to mobilise society as a whole to fight HIV and AIDS, TB and Other Related Infectious Diseases (ORID); resource mobilisation; protection of human rights; addressing poverty, health and development; strengthening health systems; improvement of information, education and communication; access to treatment, care and support; access to affordable drugs and technologies; and research and development on HIV and AIDS, TB and ORID, including vaccines, traditional medicines and indigenous knowledge.

The signing of the Declaration ensured that all African leaders have common objectives to achieve in addressing the impact of HIV and AIDS. Observations show that this declaration of commitments has made progress five years after it was signed. For example, Ndinga-Muvumba *et al*. (2005) observe that some countries have formed National AIDS Councils, developed their own National Strategic Frameworks and Plans and have accessed funds from donors such as the Multi-Country AIDS programme and the Global AIDS fund to respond to HIV and AIDS. In addition, African leaders are now strong public advocates for action against AIDS in their countries (African-Union.org, 2006b:1) and there are established Ministries of HIV and AIDS in some countries, namely in countries such as Cote d'Ivoire and Rwanda (African-Union.org, 2006b: 11).

To ensure that the programmes of the Abuja Declaration and Framework of Action on HIV/AIDS were implemented, it was necessary to monitor progress and the relevance of the outcomes and impact of the strategy. For that reason,

the AIDS Watch Africa (AWA) strategic framework was developed in 2001. This aimed to co-ordinate, survey and accelerate the implementation of pledges to respond to HIV and AIDS, create a platform for HIV and AIDS advocacy, co-ordinate the efforts of African leaders and mobilise resources to achieve these objectives (Ndinga-Muvumba *et al*., 2005:9).

The AWA intended that achievements on responses to HIV and AIDS would be regularly tracked and countries' levels of response would be used for development, thus leading to sharing practices, especially factors favouring and impeding the implementation of the strategies set aside for the mitigation of HIV and AIDS.

Despite these efforts, HIV continues to infect people. For example, although the Abuja Declaration was signed in 2001, the number of people living with HIV increased from 23 million in 2000 to 25.8 million in 2005 (African-Union.org, 2006:3) which suggested that even more work on HIV mitigation was required.

- **The Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, 2003**

The African heads of states met in Maputo, Mozambique, to review the plan of action declared in Abuja in 2001, and the recurring spread of HIV and AIDS and Malaria (African-Union.org, 2006a:1). At this summit, African countries, together with WHO, decided to accelerate the mitigation strategies by declaring 2006 the year for accelerating HIV prevention, and UNAIDS, UNESCO, UNIFEM, UNFPA, UNICEF were called in to support countries in the region to accelerate HIV prevention (African-Union, 2006b:10). This was an acknowledgement of the many challenges posed by the HIV epidemic, of the need to strengthen efforts aimed at HIV mitigation and of the need for an all-out assault on the diseases in a way that exhibited solidarity and joint efforts.

- **The Gaborone Declaration on Universal Access to Prevention, Treatment, Care and Support, 2005**

The Gaborone Declaration on Universal Access to Prevention, Treatment, Care and Support was about the delivery systems of integrated AIDS, TB and malaria health care services to all who need them with no or limited costs (African-Union.org, 2006a:10). The aim of the Declaration was to work towards achieving universal access to prevention, treatment and care by 2015, and according to African-Union.org (2005:2), it targeted the "promotion of a pro-poor health care system through strengthening of primary health care; scaling up of the treatment of AIDS, tuberculosis and malaria through proven effective drug combinations; distribution of free insecticide-treated bed-nets to pregnant women and all under-5 children in malaria-endemic zones and the use of indoor residual spraying where applicable; strengthening health systems to promote universal access by implementing the Abuja Recommendation of allocating at least 15% of the national budget to health; and preparation and implementation of costed human resources for health development plans".

- **The Abuja Plan of Action, 2006**

The Abuja Plan of Action, 2006, was an outcome of a summit on HIV and AIDS impact mitigation held by the leaders of African states in Nigeria from 2 to 4 May 2006 so as to strengthen their plans of action by reviewing the 2000 and 2001 Abuja Declaration and Plan of Action. The summit intensified the pressure for accelerated action towards universal access to HIV and AIDS prevention, treatment and care and to tuberculosis and malaria services by a united Africa by 2010. The following resolutions, among others, were taken (African-Union.org, 2006b):

- Recognising the commitment made by the 2005 World Summit on the review of the Millennium Development Goals to fully implement the Declaration of Commitment on HIV/AIDS and developing a comprehensive package of HIV prevention, treatment, care and support

with the aim of coming as close to possible to achieving universal access to treatment by 2011, for all who need it.

- Recalling the request made by African heads of state made at the January 2006 Khartoum African Union Assembly for an African Common Position be to prepared as Africa's contribution to the UN General Assembly Special Session on AIDS held in May/June 2006.

- Recognising that HIV and AIDS is also a cross-border issue and that there is need for coordination and sharing of experiences in the responses, and the need to strengthen the Regional Economic Commission (REG).

- Recognising the increase in the number of people living with HIV despite all the actions taken by the African Member States, and other stakeholders.

The reviews suggested that a comprehensive action plan needed to be developed in response to the goals of the 2001 Declaration of Commitment. African countries therefore adopted *guiding principles* which were to form the proximal outcome of the Declaration (African-Union.org, 2006b:5). These guiding principles included: building on existing international and continental frameworks, such as the NEPAD programme; fostering and strengthening community, national, regional and continental leadership and strong political commitment that builds on and strengthens existing African institutions at all levels, including civil society institutions; integrating the control of HIV and AIDS with broader efforts to combat poverty and food insecurity and fostering development, whilst recognising the urgency and exceptionality of the HIV and AIDS response; respecting human rights, particularly the rights of women and children, with regard to the fight against stigma and discrimination and to advancing equity; putting people at the centre of the HIV and AIDS response, especially vulnerable people; and adopting a gender-centred approach in order to address the needs of women and girls (African-Union.org, 2006b:5). This also meant: a greater focus on HIV prevention, care and support of children and

young people; ensuring mutual accountability (political, moral and programmatic) at every level of the response; maintaining an unwavering commitment to deliver a comprehensive package of services for prevention, treatment, care and support for people infected and affected by HIV and AIDS, including nutrition and linkages with reproductive health; ensuring that no good plan go unfunded; and reinforcing and strengthening the central role of strategic partnerships among countries, and within countries, between governments and civil society, especially with regard to people living with HIV, faith-based organisations, women, young people and the private sector, all of which require effective coordination (African-Union.org, 2006a:5).

Furthermore, the guiding principles, according to African-Union.org (2006a:5) included recognising the need to build long-term infrastructure and systems as well strengthening capacity-building at all levels; using the resources available for an exceptional response to HIV and AIDS; considering access to essential medicines and other basic commodities as human rights and ensuring that these are available and accessible to all; giving special consideration to people and countries affected by conflicts, including Internally Displaced People (IDPs) and refugees; and urging for sustained and increased funding and capacity for AIDS vaccine research and development in Africa, in order to contribute to the control and eventual elimination of the AIDS epidemic.

The implication of these guiding principles was that all African countries were committed to implementing the aforementioned outcomes in order to strengthen the objectives set during the 2001 Abuja Declaration on HIV and AIDS. Failure to achieve these objectives would suggest that certain African countries, or even all of them, would have not applied their strategies in accordance with the terms of the HIV action guidelines. Furthermore, this meant that countries that successfully implemented the guidelines would show progress in mitigating the impact of HIV and AIDS. To concretise the expected outcomes of the Abuja Plan of Action, 2006, measurable outputs were formulated as indicators for success in the implementation of the guiding principles on HIV and AIDS mitigation in Africa. These were as follows (African-Union.org, 2006a:5):

- The reduction of HIV prevalence in young people between 15 and 24 years, by at least 25% in all African countries
- The protection and support by 2010 of 5 million children orphaned by AIDS and ensuring that 80% of orphans and vulnerable children have access to basic services
- Ensuring that at least 80% of pregnant women have access to Prevention of Mother to Child Transmission (PMTCT) and treatment for HIV-positive women and children
- Ensuring that at least 80% of those in need, particularly children, have access to HIV and AIDS treatment, especially antiretroviral therapy, as well as care and support.

African leaders were therefore charged with the responsibility and role of creating enabling environments for their countries to perform within the set standards and framework of reference.

- **The African Union HIV Workplace Policy, 2011**

On 2 December 2001, the African Union (AU) Commission, informed by the International Labour Organisation (ILO) Code of Practice on HIV and AIDS and the ILO World of Work, and in recognition of the principles of human rights and workers' rights, launched the African Union HIV Workplace Policy in Addis Ababa, Ethiopia (African-Union.org, 2011). The policy was aimed at ensuring that human rights and, in particular, workers' rights in the workplace are entrenched. The specific objectives of the policy, according to African-Union.org (2011), include: the protection of the human rights of personnel who are living with or affected by HIV and AIDS; dealing with HIV and AIDS as a workplace issue, treated like any other serious illness, in the context of occupational safety and health in the workplace; ensuring consistency in managing HIV and AIDS within the workplace; reducing the risk of HIV infection for personnel and their dependants; mitigating the socio-economic and individual impact of HIV and AIDS; reducing AIDS-related morbidity and mortality through appropriate and

up-to-date treatment, care and support for personnel and their dependants; and providing the foundation for a comprehensive HIV and AIDS workplace programme.

This initiative was an indication of intention of the AU and its member states, through an intra-regional approach, to respond to the HIV epidemic. While HIV and AIDS remain a daunting challenge for Africa, there have indeed been some achievements. Certain African countries, such as Uganda, are making enormous progress in the response to combating HIV and AIDS. As a result of the above measures, there is general evidence that the incidence of HIV in the sub-Saharan Africa region declined by more than 25% between 2001 and 2009 (UNAIDS, 2011:7). In particular, South Africa witnessed a drop of one-third in HIV prevalence between 2001 and 2009 from 2.4% to 1.5% (WHO, UNAIDS & UNICEF, 2011: 24).

2.2.2.3 Mitigating HIV and AIDS in sub-Saharan Africa

Although HIV prevalence in sub-Saharan Africa is the highest in the world, the region does not seem to have given up on working on and accelerating strategies to manage HIV and its ramifications. This is because of, among others, the strong level of governments' commitment to presenting a positive response to HIV and AIDS since its diagnosis in the region. In 2004, the sub-Saharan governments reported, during the Regional Ministerial Review Conference, that they had successfully implemented a range of measures and strategies to curb HIV and its impacts (Ekanem, 2006:13). The review then indicated that:

- Behavioural surveillance had been increasing to supplement epidemiological surveillance in tracking progression of the epidemic and the impact of interventions.
- There was increased HIV and AIDS awareness in diverse communities.
- Diverse HIV prevention efforts were in place, particularly for the youth aged 15–24.

- Voluntary Counselling and Testing (VCT) services had expanded throughout the region.
- Condoms were readily available.
- Services for preventing mother-to-child transmission (PMTCT) were being provided and had been made available at pilot sites in urban areas.
- Community care and support programmes for orphans and vulnerable children were being developed, particularly in the southern and eastern sub-regions.
- Care and support for People Living With HIV and AIDS (PLWHA) had been increasing with considerable expansion in home care services, primarily through NGOs and faith-based organisations.
- There was growing resource mobilisation within and from outside the region.

These intervention strategies are rooted in what USAID (2012:6) regards as indicators of strong commitment at government level to mitigate HIV prevalence and its effects, namely provision of leadership, drafting and implementing of HIV and AIDS policies, and allocating funds for HIV and AIDS programmes. For example, countries in various sub-regions have national plans on HIV and AIDS or HIV and AIDS policies and sets of laws guiding their response to the epidemic (USAID, 2012:6). Table 2.10 gives an example of some intervention strategies on HIV and AIDS in one sub-Saharan country (Angola).

Table 2.9 Example of Angola's HIV and AIDS mitigation strategies

Country	Year	Initiative	Aim	Achievements
Angola	2001	VCT programme	To improve HIV monitoring	HIV prevalence between young people aged 15–24 declined to 1.7% at the end of 2009 as compared with 2.6% in 2006
	2002	National Commission to fight the HIV and AIDS and Major Epidemic	To coordinate the responses to HIV at national level	
	2005	The National Institute to Fight HIV and AIDS	To improve coordinating government and civil society's response to HIV and intensify prevention, care and treatment	
	2006	National Strategic Plan	To guide the response to HIV and AIDS in 2007–2010	

Adapted from UNAIDS, [s.a.]b

The information depicted in Table 2.9 show the strides made by one sub-Saharan country with a gradual intensification of the management of HIV and AIDS. Other sub-Saharan countries have also succeeded to various extents in decreasing or stabilising the incidence of HIV. Furthermore, the report shows that the sub-Saharan countries had generally expanded ART to 45% of HIV-positive pregnant women in 2008, as compared with 9% in 2004 (UNAIDS & WHO, 2009b:2), which suggests a decrease in MTCT and AIDS-related deaths. Clearly, ART does reduce the incidence of AIDS-related deaths with, for example, 460 000 (30%) fewer people having died from AIDS-related causes in 2010 than in 2004 when access to ART was low. In addition, there has been an improvement in HIV prevention in the region. The 2011 report on progress towards universal access to ART confirms this (WHO, UNAIDS, UNICEF, 2011:13):

> *... An estimated 1.9 million [1 7000 000–2 100 00] people became infected in 2010. This was 16% fewer than the estimated 2.2 million [2 100 000–2 400 000]*

> *people newly infected with HIV in 2001 and 26% fewer than the annual number of people infected in 1997 (when the overall incidence in sub-Saharan Africa peaked).*

It is also notable that the collective strategies embarked upon in the sub-Saharan region have resulted in a decline in the number of children becoming infected with HIV and those dying from AIDS-related causes. In this regard, WHO *et al.* (2011:25) report:

> *The estimated 350 000 [300 000–410 000] children who were newly infected with HIV in 2010 in sub-Saharan Africa were 30% fewer than the 500 000 [450 000–570000] who acquired HIV infection in 2001. Fewer children are dying from AIDS-related causes, from an estimated 320 000 [280 000–360 000] in 2005 to 230 000 [200 000–260 000] in 2010.*

This means that, in the context of this study, there is an increase in the demand for education on the issue in sub-Saharan Africa due to the lower mortality rate of children coupled with fewer children becoming infected. Besides that achievement, equipping educators with skills and knowledge on HIV and AIDS brings other benefits to the Ministry of Education, creating an enabling environment for schools to function to their optimal level. In Kenya, as an example, HIV and AIDS have been mainstreamed into schools' national curricula, and since 2000 educators in primary and secondary schools have been trained on how to infuse HIV and AIDS messages when teaching (CfBT, 2006).

It can therefore be concluded that sub-Saharan Africa is keen to reverse the daunting effects of HIV and AIDS – hence the strategies are being implemented with promising results.

2.2.2.4 Mitigating HIV AND AIDS in South Africa

South Africa signed the United Nations Declaration of Commitment on HIV/AIDS in 2001 and the Political Declaration on HIV/AIDS in 2006 as a way to push the global MGD 6 on HIV and AIDS. Consequently, numerous initiatives have been put in place since then in the quest to mitigate the impact of HIV and

AIDS. While initially there were numerous challenges, especially of a political nature, to the HIV and AIDS phenomenon, South Africa came up with one of the most comprehensive HIV and AIDS programmes, which informed a broad framework of mitigation strategies. These programmes essentially address the drivers and determinants of HIV while taking four key priority areas into account, namely prevention, treatment, care and support, human and legal rights and monitoring, research and surveillance. Mitigation strategies in South Africa are therefore tailored to all three levels of government, *viz*. national, provincial and local level.

- **National strategies**

At national level, various initiatives have been developed on the national multi-sectoral level to curb the HIV and AIDS challenges facing the country, including the following:

- **National Strategic Plan, 2000–2005**

  This five-year *National Strategic Plan*, developed in 1999, served as a national strategic framework to outpace the challenges brought about by HIV and AIDS. This initiative flowed from the 1992 National AIDS Coordinating Committee of South Africa (NACOSA), the 1994–1995 National AIDS Plan for South Africa and the 1997 White Paper for the Transformation of the Health System in South Africa. This strategic framework obliges all government departments, organisations and stakeholders to use it as a basis to develop their own strategic and operational plans (Republic of South Africa, 2000a:5). The framework was developed to mitigate the high HIV infection rate which had increased significantly from 2000 to 2005 globally (Republic of South, 2000a:1). Thus the Plan's primary objectives were geared towards reducing the number of new HIV infections (especially among the youth) and reducing the impact of HIV and AIDS on individuals, families and communities, which, it might be asserted, resonates with the objectives

of MDG6 and the global quest for Zero new infections, Zero AIDS-related deaths and Zero discrimination (UNAIDS, 2010c:7).

To meet the goals of this intervention, an *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment* was developed in 2003 to further support the implementation of the 2000–2005 National Strategic Plan, and among others, to ascertain how many people were non-infected, but with great support also to those living with HIV and AIDS (Republic of South Africa, 2003:4). The Operational Plan also enhances efforts in the areas of prophylaxis and the treatment of opportunistic infections, and of improved nutrition and lifestyle choices. It lends weight to the South Africa National AIDS Council (SANAC) programme which seeks to effectively and efficiently implement the strategic framework and contribute to South Africa's commitment to universal access in terms of treatment, prevention, care and support.

The National Strategic Plan, 2000–2005 also addresses (Republic of South Africa, 2000a:16): effective and culturally appropriate information; an information, education and communication (IEC) strategy; increasing access to and the acceptability of voluntary HIV testing and counselling; improving the management of sexually transmitted diseases (STD) and promoting increased condom use to reduce STDs and HIV transmission; and improving the care and treatment of HIV-positive people and people living with AIDS to promote a better quality of life and limit the need for hospital care. However, going by the statistics indicating prevalence and incidences of HIV (see Table 2.4), it is clear that the key targets of the country in mitigating HIV and AIDS were not completely achieved and for that reason, and after a review of the 2000–2005 Strategic Plan, the *2007–2011 HIV and AIDS and Sexually Transmitted Infections (STIs) National Strategic Plan* came into existence.

- **The HIV and AIDS and Sexually Transmitted Infections Strategic Plan 2007–2011**

  This initiative built on the 2000–2005 National Strategic Plan. Not very different from the preceding plan, the *National Strategic Plan 2007–2011* aimed to reduce the number of new infections (especially among young people in the 15–24 age group and reduce the impact of HIV and AIDS on individuals, families, communities and society. The key priority areas remained the same as in the prior strategic plan, as depicted in Figure 2.3.

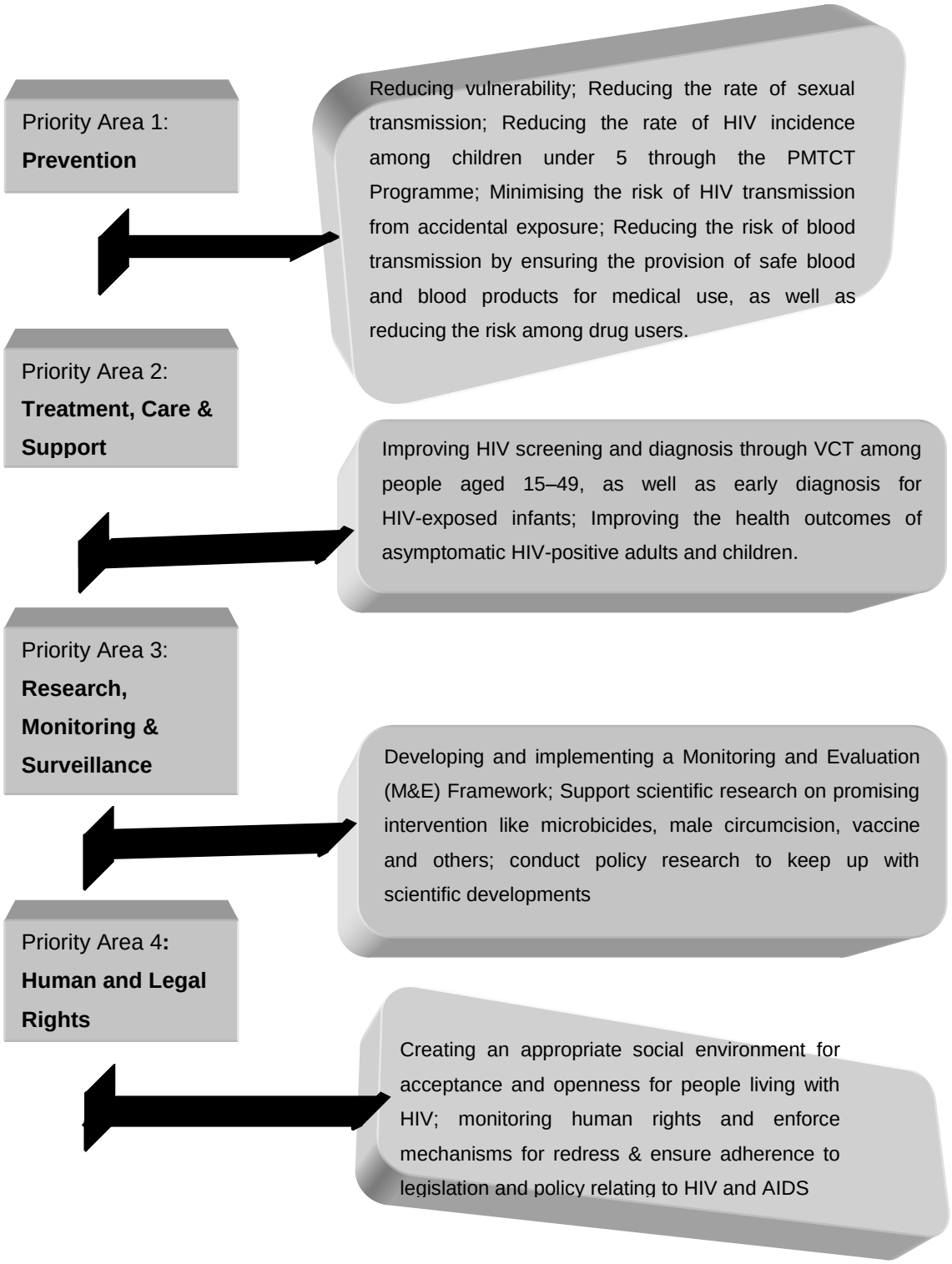


Figure 2.3 Key priority areas for reducing HIV incidences and effects

Source: Department of Health, 2006

In pursuit of achieving these priority areas, the national government has also developed mitigation policies since the early stage of the identification of HIV and AIDS in the country. These policies are: the Medium Term Strategic Framework, which is the guiding document of the South African Government for the period 2009-2014; the Ministerial Negotiated Service Delivery Agreements, which reflect the agreement between National Ministries and the Presidency on key deliverables; the TB Strategic Plan; the National HIV & AIDS and TB Management Policy; the AIDS Effectiveness Framework for Health; the Department of Basic Education HIV & AIDS Integrated Strategy 2011–2015; and the Policy Framework for Orphans and Other Children made vulnerable by HIV and AIDS (The Government of the Republic of South Africa & The Government of the United States of America, 2010:8). These policies help the country to address the four key priority areas without violating the rights of those living with and affected by HIV and AIDS, and also give rules governed by the constitution of the country to be followed in mitigation strategies. For example, the South African Government has set a budget for HIV and AIDS programmes, such as the provision of ARVs to people with a CD4 count of 350 and less for HIV-positive pregnant women. For HIV-infected infants, ARVs are issued regardless of the CD4 count as compared with the early days when ARVs were only given to infected people with CD4 counts of 250 and less (Plus News/IRIN, 2010:2).

- **Partnership Framework in Support of South Africa's National HIV & AIDS and TB Response 2012/13–2016/17**

As one of the paramount strategies, South Africa has established a partnership with the government of the USA for a period of five years with the intention of improving the South African National HIV and AIDS response (The Government of the Republic of South Africa and The Government of the United States of America, 2010:8). The prime objectives of this partnership are to prevent new HIV and TB infection,

increase life expectancy and improve the quality of life for people living with HIV and those affected by HIV and TB, and strengthen the effectiveness of the HIV and TB response system. Meeting these objectives would translate to South Africa having demonstrated efforts and commitment to finding the solution to the HIV and AIDS epidemic in a collaborative approach. This involves the partnership with the US President's Emergency Plan for AIDS Relief (PEPFAR) in mitigating strategies for HIV and AIDS. This commitment is also evident in provincial responses to the effects of the HIV and AIDS epidemic. Provincial responses are, in other words, informed by the national frameworks and thus provinces are obliged to frame their strategies in line with the overall national initiatives.

- **Provincial strategies**

The effects of HIV and AIDS are felt in all provinces of South Africa. For this reason, provinces also develop strategies to combat HIV and AIDS. As a mandate from the national government of South Africa, provinces implement the National Strategic Plan to prevent infection and to manage HIV and AIDS and TB. As an initiative, all provinces have formed a Provincial AIDS Council (PAC) tasked with coordinating the provincial multi-sectoral approach with a particular focus on districts, local governments and communities. The respective provinces have their own provincial strategic plans that assist in responding to HIV and AIDS. For example, among the nine provincial initiatives, three are:

- *KwaZulu-Natal,* which has developed a provincial four-year plan that serves as a mitigation strategy, namely the HIV and AIDS Strategy for the Province of KwaZulu-Natal 2006–2010. It is noteworthy, however, that, to date, with the Strategic Plan in place, the province has remained more highly affected by the prevalence of HIV and AIDS than any other province in the country since 2005 (see Table 2.4).

- *Gauteng,* which has also developed its own strategic plan to halt the progress of HIV and AIDS and to mitigate their impacts, and also to

alleviate the new infection rate. This is embodied in the Gauteng AIDS Strategic Plan for 2009–2014. A multi-sectoral AIDS unit has been developed to coordinate the responses to HIV and AIDS. This initiative, as reported by Tomlinson (2006:28), is a collaborative effort of all government sectors, business and civil societies in Gauteng with the aim of reducing new infection in the general public, youth and babies, increasing productive life for people living with HIV and AIDS, ensuring normal lives for children and families affected by HIV and AIDS, and reducing the impact of AIDS on socio-economic development.

- The *Eastern Cape Province*, which also has a strategy developed in 2006 by the Eastern Cape Provincial Government and the Eastern Cape AIDS Council. The strategy seeks to guide the implementation of HIV and AIDS programmes at a multi-sectoral level to halt and prevent the spread of HIV by 2014 (Eastern Cape Provincial Government, 2006:5).

- **Local government initiatives**

Local governments' response to HIV and AIDS is the determining factor for the successful or unsuccessful mitigation of the HIV epidemic at provincial and national level due to its level of operation. Local governments and their respective municipalities are the level of government closest to the people – the context of this study – who are infected and affected. These structures are charged with the coordination and promotion of social and economic development, which makes it highly relevant for them to respond effectively to the HIV epidemic and its effects. For this reason, local governments align their strategies to the national HIV and AIDS strategic plans in order to address their needs or priority areas.

As stated by the Education and Training Unit (2007), in many parts of South Africa municipalities have set up Local AIDS Councils that develop strategies and action plans to deal with HIV and AIDS in their respective areas. As an example, in the Eastern Cape Province, District AIDS Councils (DACs) that lead, plan, coordinate and monitor HIV and AIDS responses in the districts have

been established (Eastern Cape Provincial Government, 2006:32). According to Kelly and Van Donk (2009), responses to HIV and AIDS at a local level is promoted through civil societies, that is NGOs, faith-based organisations, trade unions, indigenous groups, charitable organisations, community groups and foundations. This collaboration creates enabling settings for behavioural change, especially among the youth. To this end, municipalities have developed working systems that address the HIV challenges of their own people. This was done by conducting situational analyses within their environments to find gaps and challenges promoting the spread of the virus.

Local governments also serve as a tool in helping poor families, especially those affected by HIV and AIDS. For example, in South Africa local governments provide free housing and services and the consumption of services to a certain level to low-income households as a strategy used for prevention and care (Tomlinson, 2006:18–19). In short, local governments respond to HIV and AIDS effectively by forming partnerships with internal and external stakeholders. Thus, existing local structures work with the local governments in addressing the challenging realities of HIV and AIDS.

2.3 IMPLICATIONS OF THE HIV AND AIDS REALITY FOR EDUCATION

> *AIDS is turning back the clock on development. In too many countries the gains in life expectancy won are being wiped out. In too many countries more teachers are dying each week than can be trained. We will mainstream AIDS in all World Bank work* (World Bank, 2002:xv).

The statement above, made at the United Nation's Security Council in January 2000 by James D. Wolfensohn, the President of the World Bank Group, conveys the seriousness and the reality of the HIV epidemic and indicates very clearly the epidemic's effect on society at large and, in particular, on education. Indeed, as it was then, the statement still resonates in relation to the current education scenario, 12 years later. Education, while profoundly and adversely affected by the HIV epidemic, ironically ranks among the most effective and cost-effective means of HIV prevention (World Bank, 2002:xv). For this reason,

prioritising the education system in the fight against HIV is crucial. The World Bank (2002:xvi) points out the reasons as follows:

- *It* (education) *has been proven to provide protection against HIV infection* because *a* general basic education can equip children and the youth with the means to make healthy decisions concerning their own lives, bring about long-term healthy behaviours, and give people the opportunity for economic independence and hope.

- *It is among the most powerful tools for reducing girls' vulnerability* because girls' education can slow and reverse the spread of HIV by contributing to female economic independence, delayed marriage, family planning and work outside the home.

- *It offers a ready-made infrastructure for delivering HIV and AIDS prevention efforts* to large numbers of the uninfected population, namely schoolchildren, as well as the youth in general, who in many countries are the age group most at risk.

- *It is highly cost-effective as a prevention mechanism* because the school system brings together learners, educators, parents and the community, and preventing AIDS through education avoids the major AIDS-related costs of health care and additional education supply.

The reasons cited above indicate the important and pivotal role education can play in mitigating the HIV epidemic. This, however, reveals as well that HIV and AIDS can also have a devastating impact on education. Reports variously show HIV and AIDS accounting for approximately 77% of educator absenteeism in countries with high HIV prevalence (UNESCO, 2008:1). This high rate of educator absenteeism suggests that learners are often left unattended or that School Management Teams have to devise *ad hoc* teaching structures until such educators are back at school, which entails, among others, overloading other staff members.

The HIV epidemic seems to have had an effect on educator numbers, with attrition leading to shortages of educators. For example, it was estimated that in Zambia, HIV and AIDS would have reduced the number of educators from 59 500 to 50 000 in 2010 (UNESCO, 2008:1). Just how disastrous the effect of HIV and AIDS on educators is, is demonstrated by the HIV and AIDS-related incidents as depicted below.

Box 2.1 HIV and AIDS and educator supply: Evidence from Africa

- In the Central African Republic 85% of teachers died before they were due to retire.
- In Zambia 1 300 teachers died in the first 10 months of 1998, compared with 680 teachers in 1996.
- In Kenya teacher deaths rose from 450 in 1995 to 1 500 in 1999 (reported by the Teaching Service Commission), while in one of Kenya's eight provinces 20 to 30 teachers die each month from AIDS.
- HIV-positive teachers are estimated at more than 30% in parts of Malawi and Uganda, 20% in Zambia and 12% in South Africa.

Source: World Bank, 2002:12

The prevalence of HIV is also high among learners. Citing UNAIDS (2010), WHO (2009), and Herat, Gamer, Chetty and Samuels (2011:5) indicate that approximately 5.4 million young people are reported to have been living with HIV worldwide in 2010, and new infections of about 45% occurred among those 15–24 years of age in the same year. Therefore HIV and AIDS seem to have dire effects on education, which include the impact on the demand for education services, on the supply of education services and on the quality and management of education services.

2.3.1 The impact of HIV and AIDS on the demand for education services

The effects HIV and AIDS have on school learners and/or children compromise the demand for education in South Africa and the rest of the world. Hill-Carr, Katabaro, Katahoire and Oulai (2002:41) state:

> *As a result of HIV/AIDS, relatively fewer children are being born because of the early death of one or both parents. Some of them are born HIV^{+} and most die before reaching school age*.

Furthermore, Louw, Edwards and Orr (2001:1) state that more and more learners are affected either because they themselves have HIV and AIDS (infected) or a family member or friend has HIV and AIDS (affected). To be infected in this context means a child is HIV-positive and to be affected means a child is HIV-negative but has family members who are HIV-positive. In this case, where children become infected with or affected by HIV and AIDS, the entire pattern of the demand for education changes. Coombe (2002:9–11) highlights the three key areas affecting this change in the demand for education, namely *the declining size of learner populations*, *the demand for education*, and *more complex learner cohorts*.

2.3.1.1 The declining size of learner populations

The changing size of learner populations in the context of the effects of HIV and AIDS can best be illustrated in terms of learners affected and infected by the disease.

- **Affected children**

As the number of adults and parents infected by and living with HIV and those living with AIDS increases, it follows that the number of children affected also increases. This number logically includes children whose parents have died of HIV-related diseases. United Nations Non-Governmental Liaison Service Roundup (2003:2) reported in 2003 that, globally, more than 14 million children under the age of 15 had lost one or both parents to AIDS-related deaths. Clearly this figure may have risen substantially since then. Risley and Drake

(2007) indicate, for instance, that in Cambodia, Lao PDR, Myanmar, Vietnam and Thailand, approximately 674 300 children were found to have lost their parents to AIDS-related deaths in 2007 and 721 200 children were estimated to loose parents to AIDS-related deaths by the end of 2015. According to Bennell, Hyde and Swainson (2002:49), it is estimated that there were 8.2 million “AIDS orphans” in sub-Saharan Africa in 1999, which was 3.6% of the population under 15.

The implications of children affected by HIV and AIDS for the size of learner populations are the decreases in school enrolments and attendance. In this regard, Richter (2003:11) points out:

> *In households affected by HIV/AIDS, the school attendance of children drops off because their labour is required for subsistence activities and, in the face of reduced income and increased expenditure, the money earmarked for school expenses is used for basic necessities, medication and health services ... .*

Furthermore, according to UNESCO (2005:2), learner population sizes decrease because of causes such as children being pulled out of school to look after their sick parents or family members, children dropping school to earn money, especially when the breadwinner gets sick or dies, and children lacking motivation to go to school due to their stressful family environment or due to (fear of) teasing or bullying by classmates.

The decline in the learner population may also arise from the effects that HIV and AIDS have on parents or adults within families or communities. Coombe (2002:9) points out that factors decreasing the size of the learner population include: rising deaths among parents or adults of reproductive age, resulting in fewer children enrolling for and attending school; most parents or adults having AIDS avoiding pregnancy or bearing children, resulting in fewer children enrolling for school; and parents or family members pulling children out of school due to feelings of shame when the child is infected or they themselves are in need of someone to look after them.

Coombe (2002:8) further makes the point that "in general, children at risk or orphaned by AIDS, and those in HIV-affected homes, are likely to be withdrawn from schooling and higher education and that children who have been orphaned are more likely to be denied education". It can be concluded that this situation will have an impact on the provision of education services in terms of long- and short-term planning, which might have to take cognisance of the variances in learner population sizes. This can also make educational needs forecasting and resource provisioning challenging, as well as have a negative effect on future planning for education continuity in terms of different school grades, phases and education bands.

- **Infected children**

Living with HIV or having AIDS is a traumatising experience that can provide an almost insurmountable hurdle to child development in totality, especially when the rights of the infected child are denied. Conway (2005:1) supports this notion and quotes an HIV-positive young person speaking at the Children's Rights and HIV conference in June 2004:

> *At school I found it difficult knowing that I have HIV and that I couldn't talk to anyone ... Talking to a teacher about your situation was too risky; you hear about young people who have told one teacher in confidence and soon every teacher in the school knew about it. Because of this lack of good judgement, confidentiality and trust, many young people like me have to live a life based on secrets due to the fact that we are in a situation that is surrounded by ignorance and prejudice.*

When conditions like this arise, in which children do not feel accommodated by their school environments due to their HIV-positive status, they become demotivated to go to school, which causes a decline in learner population sizes. Hill Car *et al*. (2002:31) and Moila (2004:18) postulate that learner populations also decrease because children pull out of school when they get ill due to the effects of HIV on the body and because of the stigma and discrimination suffered due to their HIV status. They attend school irregularly because they need time off to see a doctor for treatment or medication and eventually some

die due to AIDS-related illnesses. Furthermore, Coombe (2002:8) argues that where “HIV prevalence is high, rising deaths among adults of reproductive age and declining fertility rates result in fewer children being born and thus, combined with increased mortality among children infected around the time of birth, most of whom die before they are five years old, there are fewer potential learners than there would have been without AIDS”.

2.3.1.2 Demand for education

According to Risley and Drake (2007:6), the socio-economic impacts of HIV and AIDS include increases in household poverty that result in financial barriers to education as manifested in the inability to pay fees and to purchase uniforms, school materials and books. Therefore the seriousness of the HIV epidemic has unbearable effects on the demand for education by children or learners. In the midst of HIV and AIDS, it becomes very difficult for children to attend school, thus leaving classrooms with fewer children or empty.

To show the seriousness of the effects of HIV and AIDS on the demand for education, UNICEF (2012) points out that as children get infected with HIV and some die due to AIDS-related causes, there is a decrease in “basic education, vocational and adult education and tertiary education enrolment rates and [that] drop-outs increase and consequently, access to education is limited or denied to many young people. This is due to additional HIV and AIDS-related demands that include 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”. In addition, UNICEF (2012) argues that a high percentage of drop-outs will likely be orphans, street children and working youth with very limited resources and few clear incentives for entering the education system.

The arguments raised above clearly indicate that the impact of HIV and AIDS on education gives rise to a decline in the demand for education. Another consequence of this could be the obsolescence of existing educational facilities due to decreasing enrolments and lower demand for education, which in all

probability will result in skewed location of educational resources as some areas become more affected than others, including the migration of people to areas thought of as having more resources for access to treatment, care and support for people infected and affected by HIV and AIDS.

2.3.1.3 More complex learner cohorts

The education sector cannot in any way ignore the daunting effects of HIV and AIDS on school learners because, as Coombe (2002:10) asserts, they are the primary clientele for education services. While only some learners are directly infected by HIV, Coombe (2002:10) makes the point that many learners are affected by HIV and AIDS in the sense that some of them have had one or both parents die due to AIDS-related causes and some have parents living with HIV, which conditions counter their progress at school. To this end, Coombe (2002:11) remarks:

> *... Such learners are often at physical disadvantage for nutritional and economic reasons. Their attendance and performance decline and they are likely to suffer HIV-related discrimination. Their attendance at school becomes increasingly random, and they must learn under a cloud of trauma and loss. When teachers suffer for the same reasons, and are unable to respond to the needs of children in distress, decline in motivation, morale and performance on both sides is inevitable.*

The conditions outlined above may even cause inconsistency in the flow of the age cohort in school grades. In this regard, Sprietsma (2006:3) points out, for example, that children should enter Grade One if they have reached a certain age before the start of the school. However, as a consequence of conditions pertaining to infected and affected children, some may be delayed in terms of starting their primary education together with their age cohorts.

2.3.2 The impact of HIV and AIDS on the supply of education services

Education services entail all resources required for the delivery of education at schools including, among others, human resources, financial and technical resources and physical resources. The effects the epidemic has on education

create particular difficulties problem in delivering education services at schools, thus depriving children of the right to learn.

According to Pennap, Chaanda and Ezirike (2011:165), the effects and implications of HIV and AIDS for education can be noticed when, in sum, the numbers of educators dying from AIDS surpass the number of newly produced or trained educators to supply education. Pennap *et al.* (2011:165) argue that the high rate of educator deaths due to HIV and AIDS-related illnesses has disrupting effects on the supply of education. They point out that, for example, the World Bank projected that in Tanzania by 2010 and 2020, 14 460 and 20 200 educators, respectively, would have died from AIDS and 45 000 educators were needed to make up for those who had died or had resigned because of the stigma attached to HIV and AIDS.

Clarke (2008:176) points out that in South Africa reports show that the impact of HIV has created a situation in which the demand for educators is likely to be much greater than the supply, and 30 000 new educators have to be trained each year to overcome educator attrition due to HIV and AIDS. These assertions imply that the prevalence and impact of HIV and AIDS in the education sector result in shortages of qualified educators. The worst part is that there are in any event fewer newly trained educators entering the teaching profession. Hill-Carr *et al.* (2002:40) postulate that the declining pattern in the education supply can also be noticed by falls in the number of trained educators, falls in the provision of teaching-learning material and insufficient school buildings.

Tragically, educators also become infected with HIV. Hill-Carr *et al.* (2002:41) argue that educators, " … like many others, are not spared by HIV and AIDS so that, even if facilities continue to be available, there may be a lack of teachers and other personnel to provide teaching services". Furthermore, Makuka and Kalikiti, as cited by Hill-Carr *et al.* (2002:47), point out that AIDS cases among educators result in them frequently being absent, their attitude to work deteriorating and their becoming unable to perform well.

Educators being infected and affected by HIV and AIDS also accounts for a high rate of absenteeism among them. Furthermore, they can still be at school and not be productive as a result of distress or illness caused by HIV and AIDS. For example, in the research carried out by Castro, Duthilleul and Caillods (2007:16) it was concluded that educators' absences do not merely imply physical absence from the classroom, but also refer to educators who leave early and do not teach for the prescribed duration of their classes, educators who are physically present in the school but who do not go to class, and educators who attend classes but do not deliver.

The implication of the above discussion is that education supply severely decreases when educators fail to perform their duties, especially the delivery of quality education services, by leaving children untaught or by absconding due to the effects that HIV and AIDS have on them. Simply put and in line with what Hill-Carr *et al.* (2002:47) point out, the results of lower education supply translate into educators:

- being absent from school because of ill health emanating from HIV infection
- staying out of school to attend the funerals of family members, colleagues or friends who have died of AIDS
- not going to work but rather spending time looking after a family member who is ill or hospitalised
- disappearing due to the stigma attached to their HIV-positive status
- dying an AIDS-related death
- not being willing to work in areas believed to have high HIV prevalence
- suffering from stress due to their HIV-positive status, making them unproductive at school.

Therefore the education of children is blocked and hampered by conditions emanating from the existence of HIV and AIDS or what Pennap *et al.* (2011:165) call “AIDS-related sickness episodes” in the education sector.

2.3.3 The impact of HIV and AIDS on the quality and management of education services

The main impacts that HIV and AIDS have on education are the reduced quality of education resulting from loss of trained and experienced educators, increased management difficulties at schools and the movement of educators (FPD, 2010a:82).

- **Loss of trained and experienced educators**

The loss of trained, qualified educators in the teaching profession poses enormous challenges regarding the supply of quality education at schools. Kakonge (2001:4) remarks that in 2001 in Malawi and Zambia, 30% of the qualified educators were already infected with HIV. Such a situation can put the delivery of quality education at stake due to the effects associated with HIV and AIDS, such as the death of an experienced educator, and can force schools to resort to hiring unqualified educators. Coombe (2002:13) asserts that as educators die, schools tend to rely on less-qualified educators, and young educators with less experience and knowledge of the subject matter which they have been appointed to teach. Furthermore, a study done in 2004 found 4 000 educators to have died of AIDS-related complications in South Africa resulting in educator shortages at schools (Louw, Shisana, Peltzer & Zungu, 2009).

- **Increased management difficulties at schools**

The preponderance of HIV and AIDS in the education sector has devastating impacts that generate disruptions in the management of educators, making it difficult for them to perform their roles, and also in the overall organisation of schools. Prew states (2004:2-3):

> *The planning of staff works at various levels becomes difficult. The school faces irregular absenteeism of staff. This is impossible to plan and can leave classes*

untaught with potential safety and discipline issues. This can be compounded by death of staff and the disruption in teaching that this causes. It takes months to replace a member of staff which implies reorganisation of lessons and oversize classes.

In addition, Mabona (2010:1) highlights the following as conditions caused by HIV and AIDS that result in difficulties in managing schools.

- *Educators booked off sick because of HIV-related illnesses*: When an educator is on sick leave, usually the school operates at an *ad hoc* level leading to restructuring of the learning areas or subject allocation, which means that the subjects of the absent educator are shared among other educators. This creates difficulties in rendering proper and efficient management of teaching and learners' performance since the subjects of ill educators are mostly shared among educators who have their own subject allocation and who might have low interest in the new added subjects. This can also lead to learners getting frustrated by different teaching styles they experience.

- *Educators retiring or taking too long or short leave when the disease takes its toll:* It becomes difficult to manage a school where educators are in and out of school due to recurring periods of long or short leave or retirement. This creates low performance on the part of the educator who is affected since she or he cannot complete the syllabus and learning programmes.

- *School managers constantly dealing with educator absenteeism and underperformance resulting from educators' HIV-related illnesses*: As educators take days off work due to the effects of HIV and AIDS on them, the SMTs find it difficult to run the school effectively because they spend time trying to sort out the aftermaths of absenteeism by educators than on managing educators' and learners' work. In some instances where absenteeism is high due to HIV and AIDS, SMTs or school principals become overloaded with performing classroom activities, such as teaching, rather than their intended managerial duties.

- *Healthy educators forced to deal with large workloads because of backlogs caused by their ill counterparts' absenteeism*: At schools where educators are overloaded with learning areas, staff meetings are compromised due to lack of time and the tiredness of the overloaded educators.

- *Learners depressed because they have a parent who is dying due to AIDS at home:* The effects that HIV and AIDS have on learners cause them to refrain from attending and doing school work optimally, making it difficult for the effective management of a school. For example, if learners are not in a position to do their school work, such as developing their portfolios of evidence for internal or external moderation, it reflects back on the school managers and thus they can be referred to as 'NAS' (Need Additional Support). In some cases, which make school management difficulties worse, such as when the school task team compiles the summative evaluation, educators even go the extra mile to take the portfolio task or activity to the home of the learner if that learner is sick but able to write from home or hospital.

The problems listed above show that HIV and AIDS pose severe challenges to SMTs, as vessels carrying schools in the right direction, making it difficult for them to manage their schools in the midst.

- **The movements of educators**

The impact of the epidemic on the delivery of quality education services results in educators moving from one area to another. FPD (2010b:84) asserts that educators move from rural to urban areas when first diagnosed with HIV in order to obtain access to better health care. Also, when their AIDS reaches the terminal phase they move back to the rural areas to die with their families. This means that their quality services are withdrawn from their original schools, temporarily or permanently, and moved to another school or other sectors, thus leaving imbalances in the supply of education services.

Bennell *et al*. (2002:90) makes the point that “HIV and AIDS would lead to large increases in staff transfers because sick staff would want to be posted near hospitals and other health facilities where they could access proper treatment and in the case of sick single educators, many would want to be looked after by their parents or other friends and relatives. In addition, educators will themselves be called upon to look after sick dependants and other relatives in their home areas, which will further complicate the deployment of teaching staff, especially in less attractive rural and remote areas”.

2.4 CONCLUDING REMARKS

Although the HIV and AIDS epidemic has reached a stage of so-called ‘stabilisation’ in South Africa, it is also clear that this is mainly due to the enactment of mitigation strategies, especially the treatment, care and support strategies. Indeed, the provision of ARTs to people living with HIV has gone a long way towards reducing AIDS-related deaths. This also bears testimony to the world’s response to the epidemic. However, it is also clear that new infections continue, and disconcertingly among the most active members of society – women of 25 years and older and men 30 years and older. This prevalence has numerous implications for the state and, in particular, for the education system as discussed in detail elsewhere in this chapter. Most important is that there is yet no cure for HIV and AIDS and, as such, HIV will continue to be a feature of society.

Schools are severely affected by the HIV and AIDS epidemic, particularly with regard to management. Although the National Policy addresses critical elements of HIV and AIDS management at schools, the implementation of such measures is equally critical. For this reason, it is important to explore ways of evaluating the implementation of the provisions of the National Policy on HIV and AIDS at schools. Furthermore, it is important that the impact of the implementation of the policy be evaluated continuously so as judge what works in practice.

2.5 CHAPTER SUMMARY

This chapter expounded on the reality and implications of the HIV and AIDS epidemic, starting from a global perspective down to the South African national, provincial and local perspectives. HIV and AIDS mitigation strategies, regarding their development, aims, achievements and shortfalls, at various levels were also discussed. Lastly, the implications of HIV and AIDS for the education sector were described in terms of the demand for education services, the supply of education services and the quality and management of education services.

To evaluate the effectiveness of the implementation of HIV and AIDS management at schools currently, it is imperative to understand the nature of such management. This is dealt with in Chapter 3.

CHAPTER 3
THE NATURE OF HIV AND AIDS MANAGEMENT AT SCHOOL LEVEL

3.1 INTRODUCTION

This chapter outlines the nature of HIV and AIDS management at schools. This is done firstly by exploring the pertinent parameters of HIV and AIDS management in the workplace and at school level, and secondly the FPD's training programme on the management of HIV and AIDS.

3.2 RATIONALE

South Africa's first response to the HIV and AIDS epidemic in the education sector was in 1998 with the development of the *National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions* and its gazetting in 1999. This policy instituted the HIV and AIDS Life Skills Education Programme funded by National Treasury as a primary intervention, which focused on the prevention of HIV and AIDS among learners through knowledge and skills building, mainly through the Life Orientation (LO) Learning Area, which was subsequently infused into other Learning Areas (Department of Basic Education, 2010:2).

However, the Department of Basic Education (2010:2) acknowledged that just over ten years later, South Africa is in a state of crisis regarding HIV and AIDS, and consequently the new Department has embarked on a process to develop and adopt a comprehensive approach to realising the HIV and AIDS national strategic plan at schools, through the development of a new integrated strategy on HIV and AIDS. The new strategy starts from the premise that schooling is a protective factor, and thus advocates schooling as a vehicle for HIV prevention, which is considered as being the turn-around strategy in the fight against the HIV epidemic (Department of Basic Education, 2010:8). The rationale behind

this move, as cited by Department of Basic Education (2010:10) is aptly expressed by Giese, Meintjes and Monson (2005) who argue that:

- schools are relatively accessible and they often provide a physical infrastructure in communities where other crucial infrastructure is absent
- schools represent an existing network of many components, including school staff, learners, their caregivers, school governing bodies and the broader school community, with each component being a potentially valuable resource for care and support
- the way schools are currently clustered creates opportunities for further collaboration and provides educators and middle management with more support
- the school environment is an inclusive environment, which focuses on children and is committed to children's development and with a reach to approximately 11 809 355 children, including those most affected and most at risk of HIV infection – the school is an environment where all kinds of vulnerabilities are exposed and it therefore has the potential to combat the stigma associated with HIV and AIDS.

Against this background, the Department of Basic Education has aligned its strategy to the National Strategic Plan (see Section 2.2.3.4) to achieve the following objectives:

- To support South Africa's HIV prevention strategy by increasing sexual and reproductive knowledge, skills and appropriate decision-making among learners, educators, school support staff and officials;
- To mitigate the impact of HIV by providing a caring, supportive and enabling environment for learners, educators, school support staff and officials in all South African schools and in the country's education departments;

- To transparently monitor and evaluate all goals, objectives and outcomes in line with government's monitoring and evaluation (M&E) framework and to research all components of this strategy

- To ensure the provision of a safe, rights-based environment at schools and in the country's education departments, including zero tolerance of discrimination, stigma and any form of sexual harassment/abuse.

While this is a strategic framework emanating from the Department, it remains crucial that its implementation should be effective at school level. To this end, the framework informs the new direction with regard to HIV and AIDS management at schools. However, the National Education Policy Act No. 27 of 1996 remains the basic information driver for the management of HIV and AIDS at schools, and the understanding of its context in terms of the school is essential.

3.3 CONTEXTUAL EXPOSITION OF HIV AND AIDS MANAGEMENT AT SCHOOL

The school is a complex organisation in terms of the composition of its population. For the purposes of this study, the school comprises the immediate population and the larger community surrounding it. The immediate school community is made up of the school staff, parents or guardians and learners, while the larger community is composed of learners' extended families, learners' neighbours, orphans, business concerns, service organisations such as government departments, NGOs and community-based organisations (CBOs).

The complexity of the school population is a result, firstly, of the interrelationship between and among the immediate and larger communities in terms of the effects and influence of the HIV and AIDS epidemic on these communities and the fact that mitigation and management strategies aimed at the school cannot be divorced from those aimed at the larger communities. Based on these circumstances, the focus of HIV and AIDS management at school will be contextualised according to the school's immediate community, while the

interrelatedness of the entire school community, which includes the larger community, will be recognised and taken into account.

Secondly, the complexity of the school concerns its role as a workplace and a space that provides a service to consumers. This implies a functional space with the school staff as a labour force governed by a particular legislative framework and a service space for learning, with learners as consumers of its service who are also governed by a particular legislative framework. Unlike business and industry, whose main thrust in HIV and AIDS management can be confined to the immediate workforce, the school's HIV and AIDS management cannot be approached separately for staff and for learners in specific terms. This boils down to the fact that HIV and AIDS management at school cannot be separated into approaches for producers and consumers, but has to be an all-embracing approach. The context of HIV and AIDS management at school is therefore a space for creating an enabling environment for the implementation of management strategies for both staff and learners in a holistic manner.

In light of the school's contextual environment, the legislative framework relevant to such a space is considered in the next section.

3.4 HIV AND AIDS MANAGEMENT: THE LEGISLATIVE FRAMEWORK

Governments have various roles to play in preventing and controlling HIV and AIDS in various sectors and levels of operation such as schools. One of their roles is to protect the rights of people living with and affected by HIV and AIDS. According to Amnesty International [s.a.], violating the rights of people living with and affected by HIV and AIDS fuels the HIV epidemic by increasing people's vulnerability to infection.

The National Association of People Living with HIV and AIDS (NAPWHA) (2005) gives reasons why human rights are fundamental in responding to HIV and AIDS and as being *ethical*, – "…because all human beings have a right to health, to life and all other human rights", *legal,* "… to implement the International Declaration of Human Rights and many other international and national laws and guidelines on human rights" and *pragmatic* – "because it is

beyond doubt that a human rights-based response", which empowers the "whole community to avoid infection, and which treats those with HIV with respect and inclusion and aims to properly manage their health, is significantly more effective in reducing the spread of HIV than a response of silence, discrimination and exclusion". It is for this reason that various pieces of legislation enacted place much emphasis on the protection of human rights. In the context of this study, the Constitution of the Republic of South Africa (1996a) informs all other laws, and this is expressed in Chapter 2, which details the Bill of Rights.

In terms of the Bill of Rights, the following stipulations inform every citizen's rights and are, in particular, related to the rights of people living with and affected by HIV and AIDS:

3.4.1 Human dignity

According to section 10, everyone has the right to have their dignity respected and protected. This implies, as emphasised by Barrett-Grant, Fine, Heywood and Strode (2003:83), that a person or institution such as a hospital or company may not insult or damage any person's self-respect, by their work or actions. Furthermore, as stated by the International HIV/AIDS Alliance (2011), the protection and promotion of human dignity entails the guiding principle of all actions in addressing and supporting people living with and affected by HIV and AIDS. In an environment where human dignity is safeguarded, people living with and affected by HIV and AIDS are supported and protected from all forms of discrimination. To this end, UNESCO and UNAIDS [s.a.] mentions two benefits of protecting and promoting human dignity in the context of HIV and AIDS:

- The message of how to avoid infection is accessed by most people and they are encouraged and supported not to indulge in risky behaviours
- PLWH are supported and protected against unfair discrimination and they are linked to care, treatment and support.

The protection of human dignity plays a significant role in alleviating HIV and AIDS denial, and fears and myths associated with HIV infections, thus building positive esteem, especially for those living with or affected by HIV and AIDS. In this regard, Harvey [s.a.] asserts:

> *The principle of human dignity in community is anchored in the basic human need that must be satisfied to attain true happiness, namely, the need of every person for society, since it is only in community that his dignity is recognised and supported. Moreover, this satisfaction is required by the human person's dignity itself. Human dignity in community sums up the true global value of human life. Thus all ethical decisions … must aim at human dignity, that is, the maximum integrated satisfaction of the innate and cultural needs of every person including his or her biological, psychological, ethical and spiritual needs as a member the world and the national communities.*

3.4.2 Freedom and security of the person

Section 12(2) stipulates that "everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction; to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent".

This right, as stated by Barrett-Grant *et al.* (2003), implies firstly that people living with HIV can take their own decisions about medical treatment and pregnancy without, for example, being forced to take HIV tests, and secondly, it implies that people cannot be treated in a cruel or degrading way by any person due to their HIV-positive status. Health24.com (2012) asserts that people living with HIV and AIDS are protected by the right of freedom of movement and they may not be segregated, isolated or quarantined in prisons, schools, hospitals or elsewhere merely because of their HIV-positive status.

3.4.3 Privacy

Section 14 makes provision for the right to privacy for everyone, which includes the right not to have their person or home searched; their property searched; their possessions seized; and the privacy of their communities infringed.

This right implies that PLWHA have the right to keep information regarding their HIV status to themselves and no one, including an employer or hospital, can forcefully require anyone to take HIV tests or to obtain a copy of his/her medical records without consent. In the case that an employer knows an employee's HIV-positive status, that employer is bound to maintain strict confidentiality regarding the matter to avoid unjust discrimination. Alabama Disabilities Advocacy Program [s.a.] mentions that virtually every complaint of AIDS discrimination begins with unnecessary disclosure of HIV or AIDS information which, according to UNAIDS (2003:2) is a breach of the right to privacy.

3.4.4 Freedom of expression

In terms of section 16 (1), everyone has the right to freedom of expression, which includes, among other things, freedom to receive or give out information or ideas. This right has far-reaching implications for people living with and affected by HIV and AIDS. Firstly, information on how HIV can be prevented is made available to everyone who needs it, including PLWHA. This includes training on HIV and AIDS prevention and treatment as well as access to updated information about HIV and AIDS prevention (Free Word Centre, 2011). Secondly, as people obtain the required information on HIV and AIDS, it becomes easier for them to make better decisions that affect their sexuality and reproductive and maternal health (Free Word Centre, 2011). Thirdly, people living with and affected by HIV and AIDS are free to give information about, for example, HIV and AIDS (South African AIDS Vaccine Initiative and South African Medical Research Council, [s.a.]: 11).

3.4.5 Freedom of association

According to section 18, everyone has the right to freedom of association. For PLWHA, this right implies that they can join organisations of their choice such as trade unions and political organisations (South African AIDS Vaccine Initiative and South African Medical Research Council, [s.a.]: 11). This also implies that their HIV-positive status cannot be used as a justification to separate them from other people or exclude them from any institution.

3.4.6 Freedom of movement and residence

Section 21 guarantees the right of movement and residence to everyone, and includes the right to freedom of movement, the right to leave the Republic of South Africa and the right to enter, to remain in and to reside anywhere in the Republic of South Africa. This right has certain implications for people living with and affected by HIV and AIDS, which range from free movement to citizenship. As asserted by South African AIDS Vaccine Initiative and South African Medical Research Council [s.a]: 11), PLWHA are free to move around and in and out of the country and they cannot be forced to live in a separate place.

3.4.7 Freedom of trade, occupation and profession

According to section 22, all citizens have the right to choose their trade, occupation or profession freely. The existence of this section gives people, including PLWHA as well as those who are affected by HIV and AIDS, a platform to choose the kind of work they want to do, regardless of their HIV-positive status, and they can therefore not be discriminated against or shunned at work.

3.4.8 Labour relations

Section 23(1) states that everyone has the right to fair labour practices (Republic of South Africa, 1996b). The right to fair labour practices prohibits actions that constitute unfair discrimination at work. Such actions range from dismissing an employee to denying an employee promotion because of his or her HIV-positive status

3.4.9 Environment

The right to a safe environment, which is guaranteed by section 24 (a), protects everyone from working environments that are harmful to their health or wellbeing. This right implies that people living with HIV and AIDS are also entitled to a healthy environment even if in custody or hospitalised in order to prevent HIV transmission or to assist them to gain access to ART.

3.4.10 Housing

Section 26 (1) states that everyone has the right to have access to adequate housing. To PLWHA, this implies that they may not be refused a home loan or a housing subsidy due to their HIV-positive status. Furthermore, as mentioned by Barrett-Grant *et al.* (2003), it is unlawful to evict people from a house or a flat because of their HIV-positive status.

3.4.11 Health care, food, water and social security

In terms of section 27 (1) everyone has the right to have access to:

(a) Health care services, including reproductive health care;

(b) Sufficient food and water; and

(c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

This right implies that people living with HIV and AIDS may not be refused emergency medical treatment and that a hospital cannot refuse to treat a person living with HIV or who has AIDS. Needless to say, these rights extend to PLWHA being cared for in terms of the provision of food and water and social security in terms of, for instance, government grants.

3.4.12 Education

Section 29(1)(a) states that everyone has the right to basic education, including adult basic education. This section protects people's right to access to education, even if they are living with and affected by HIV and AIDS. As stated by Barrett-Grant *et al.* (2003), as well as South African AIDS Vaccine Initiative and South African Medical Research Council ([s.a.]: 11), a school cannot refuse to educate individuals or their children because they are living with HIV or have AIDS. This means that people living with HIV and AIDS can also be educated like any other people, thus creating an enabling environment for a fair chance for them to live a normal life regardless of their HIV-positive status.

3.4.13 Access to information

According to section 32(1)(b), everyone has the right to have access to any information that is held by another person and that is required for the exercise or protection of any rights. This implies that people living with HIV and AIDS cannot be denied access to any information which they need in order to safeguard their rights. In this regard, Barrett-Grant *et al.* (2003), as well as the South African AIDS Vaccine Initiative and South African Medical Research Council [s.a.]: 12), assert that if people feel that they are being discriminated against because of policy, they can demand to see that policy, and then challenge it in court.

3.4.14 Just administration action

In terms of section 33(2), anyone whose rights have been adversely affected by administrative action has the right to be given written reasons. This right implies that PLWHA have the right to be given valid reasons if they feel that they have been negatively affected by administrative actions, whether at school, the workplace or any other place in which they find themselves.

In conclusion, the South African Government has adopted the legally compliant approach in addressing HIV and AIDS that binds all people, institutions or sectors to adhere to human rights standards of the country as articulated in the Constitution of South Africa. As alluded to by GEM Diamonds [s.a.], this approach, which of course does not infringe on constitutional and individual rights, helps in dealing with PLWHA. Furthermore, as stated in the Ministry of Education, Youth and Culture (2001:2), it offers timely and focused responses to the social concerns and the management of incidences of HIV and AIDS.

It is therefore, as stated above, the duty of all departments, government sectors, CBOs and NGOs and all other sectors and parties concerned to adhere to a legally compliant approach in managing HIV and AIDS. This duty can be carried out by (South African AIDS Vaccine Initiative & South African Medical Research Council, [s.a.]: 3):

(a) Respecting human rights: This means that people's rights cannot be taken away and nor can they be stopped from using or enjoying their rights. PLWHA should therefore not be unfairly discriminated against.

(b) Protecting human rights: This means that action should be taken against those who violate the rights of people living with and/or are affected by HIV and AIDS.

(c) Promoting human rights: This duty can be fulfilled only if PLWHA are made aware of their rights and how they can enjoy them.

(d) *Fulfilling human rights:* This means that reasonable legislative and judicial steps are essential to make it possible for PLWHA to enjoy and use their rights.

3.5 LEGISLATION REGARDING HIV AND AIDS MANAGEMENT IN THE WORKPLACE

The Bill of Rights has the regulatory powers to manage HIV and AIDS, especially in the workplace where infringements and violations of human rights can be prominent and give rise to undesirable actions, such as unfair treatment and discrimination. For this reason, the current legislative framework in South Africa makes it *a prerequisite* to manage HIV and AIDS in the workplace effectively. To this end, workplace laws or policies have been developed to protect the rights of employees and employers. The following are examples of such workplace laws.

3.5.1 The Employment Equity Act, No. 55 of 1998 (EEA)

Chapter 2 section 6(1) of the EEA (Republic of South Africa, 2004:7) states that "no person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth". Furthermore, in terms of section 7(2) of the Act, testing of an employee to determine that

employee's HIV status is prohibited unless such testing is declared justifiable by the Labour Court in terms of section 50(4) of the Act.

The Act directs that employees living with and affected by HIV and AIDS may not be unfairly discriminated against, for example, they cannot, on the basis of their HIV-positive status, be denied promotion which they are due, denied access to training and development, nor be subjected to unfair distribution of employee benefits (Barrett-Grant *et al*., 2003:162). The Act also protects applicants from being refused employment on the basis of their HIV status – infected or affected, unless it is, according to Barrett-Grant *et al*. (2003:161), an inherent or essential requirement of that job. Nevertheless, the employer cannot refuse employment unless the Labour Court has granted permission and the employee has consented.

3.5.2 The Labour Relations Act, No. 66 of 1995

The Labour Relations Act aims at regulating the relationships between employees, trade unions and employers. For example, section 187(1)(f) of the Act states that an employee may not be dismissed from work if the dismissal is not based on an inherent requirement of the particular job (Republic of South Africa, 1995). This section means that employees, as pointed out by Labour Protect (2011) and Barrett-Grant *et al*. (2003:160), cannot be dismissed from work or taken off certain work simply because of their HIV status. The Act guarantees fair labour practices as well as prevention of unfair dismissal of employees, including employees living with HIV and AIDS.

3.5.3 Occupational Health and Safety Act, No. 85 of 1993

In terms of section 8(1) of this Act, "every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees" (Republic of South Africa, 1993a). This safety law binds all employers to ensuring that HIV incidences brought about by work-related circumstances are relatively low or entirely absent by providing a hazard-free working environment. The Act also provides that employees living with HIV should be able to work freely with employees who are

HIV-negative, and that all employees should be informed by the employer of workplace conditions that may propagate the spread of HIV. This is highlighted by Barrett-Grant *et al*. (2003:164) as follows:

> *Work-related accidents often happen where there is unsafe machinery, or where employees are not properly trained about how to use machinery. If an accident happens and blood is split, there is a very small risk of HIV transmission. This could only happen if blood passed directly from an infected person to another.*

3.5.4 Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993

The Compensation for Occupational Injuries and Diseases Act gives every employee "the right to apply for compensation if injured in the course and scope of their employment. This would include compensation for HIV infection if it can be shown that the employee was infected in the course and scope of their employment" (Department of Public Service and Administration, 2002:21). To this end, Chapter 4, section 22(1) of this Act states that "*if an employee meets with an accident resulting in his/her disablement or death, such employee or the dependents of such employee shall, subject to the provisions of this Act, be entitled to the benefits provided for and prescribed in this Act*" (Republic of South Africa, 1993b). The implication of this Act in the management of HIV and AIDS in the workplace is that if an employee is infected with HIV as a result of occupational activities or incidents, such employee is entitled to benefits or compensation which he or she can apply for. To this end, Labour Protect (2011) asserts:

> *An employee who is infected with HIV as a result of an occupational exposure to infected blood or bodily fluids may apply for benefits …*

3.5.5 Basic Conditions of Employment Act (BCEA), No. 75 of 1997

According to section 22(2) of this Act as amended by the Basic Condition of Employment Amendment Act (BCEAA), No. 11 of 2002, every employee has the right to sick leave (Department of Labour, 2002). This includes the

entitlement of an employee, during every sick leave cycle, to an amount of paid sick leave equal to the number of days an employee would normally work during a period of six weeks. This implies that employees living with HIV have a right to claim days of sick leave following minimum working standards which outline the number of sick leave days an employee may take.

3.5.6 Medical Schemes Act, No. 131 of 1998

In terms of section 24(2)(e) “the medical scheme does not and will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health” (Republic of South Africa, 1998a). This Act gives all employees a right to enjoy the minimum medical schemes benefits regardless of their HIV-positive status. With regard to the management of HIV and AIDS in the workplace, this Act provides that the medical scheme must offer the basic benefits to employees living with HIV. Such benefits, as highlighted by Barrett-Grant *et al.* (2003:167), include treatment of all opportunistic infections for HIV or AIDS. In short, the Act protects employees from being denied medical scheme subsidy cover on the basis of their HIV-positive status.

In conclusion, the pieces of legislation described above are essential in regulating occupational practices to avoid HIV incidences and to support those employees living with and affected by HIV and AIDS by fair labour practices outlined by the Constitution of the Republic of South Africa, which gives all employees the right to be treated fairly at work. Furthermore, the Constitution, through the equality clause in section 9, entitles everyone to equality before the law, equal protection, benefit of law and freedom from unfair discrimination together with the protection of an individual’s human dignity as stated in section 10, and other fundamental rights in terms of section 7. In order to explain specific strategies for managing HIV and AIDS in a particular workplace environment, the next section discusses legislation affecting schools as opposed to general workplaces.

3.6 LEGISLATION INFORMING HIV AND AIDS MANAGEMENT AT SCHOOLS

The management of HIV and AIDS at schools, unlike at other workplaces, involves strategies aimed at both the staff as the labour force and other immediate stakeholders as clients of the school (see opening remarks in Section 3.2 above). Legislation informs the management of HIV and AIDS at schools by virtue of its regulatory powers. Such legislation includes the National Education Policy Act, No. 27 of 1996, the South African Schools Act, No. 84 of 1996 and the Employment of Educators Act, No. 76 of 1998.

3.6.1 The National Education Policy Act (NEPA), No.27 of 1996

This Act, as contemplated in section 4, protects and guarantees the rights of every person (Republic of South Africa, 1996c). These include the right in terms of section 4(a)(i)(ii) of this Act "to be protected against unfair discrimination within or by an education department or education institution on any ground and to the basic education and equal access to education institutions". With regard to the management of HIV and AIDS at schools, the Act provides that learners in the General Education and Training (GET) band and students in the Further Education and Training (FET) band living with HIV and AIDS have to lead as full a life as possible and may therefore not be refused the right to receive education to the maximum of their ability regardless of their HIV-positive status. This means that schools, as well as any other public education institutions, are bound by policy to allow learners regardless of their health or HIV-positive status to learn according to their ability and to enrol at any school of their choice.

The NEPA further provides for the establishment of Health Advisory Committees (HACs) at schools as sub-committees of school governing bodies. According to section 13 of the Act, the main objective of the HAC is to advise the school governing body on all health matters, including HIV and AIDS, to be responsible for developing and promoting a school plan of implementation on HIV and AIDS, to review the plan from time to time, and to report back and update the school governing body on the latest developments. Furthermore, as

a sub-committee of the school governing body, the Health Advisory Committee must ensure that there is a school policy on HIV and AIDS.

ILO Programme on HIV/AIDS and world of work (ILOAIDS, 2003) states that the school policy must be developed to ensure a consistent and equitable approach to the prevention of HIV and AIDS among learners, educators and their families, and to the management of the consequences of HIV and AIDS, including the care of learners and educators living with HIV and AIDS. The approach should be in compliance with existing laws regarding HIV and AIDS, and where necessary, existing laws on discrimination, working conditions, and safety and health must be inserted. For this reason, Health Advisory Committees should be composed of stakeholders who include prominent members of society, e.g. politicians, health workers, religious leaders, traditional leaders, business people, educators and learner representatives.

3.6.2 The South African Schools Act (SASA), No. 84 of 1996

This Act states that, in accordance with Chapter 2, section 5 (1), a public school must admit learners and serve their educational requirements without unfair discrimination in any way (Republic of South Africa, 1996d). This provision requires schools to admit all learners regardless of their HIV-positive status. Furthermore, in terms of Chapter 2, section 5(2) of the Act, the governing body of a public school may not conduct any tests for purposes of admission of learners to schools, or direct or authorise the principal of the school or any other person to do such tests. This means that a school may not conduct HIV testing as a condition for admission of a learner to a public school. This gives all who seek admission to a school, be they children living with HIV or not, a fair chance to be registered and learn. In short, learners living with HIV or who have AIDS cannot be denied admission to public schools and they cannot be removed from schools on the basis of their HIV-positive status. To this end, Chapter 2 section 5(b) provides *that* "any other person who, without just cause, prevents a learner who is subject to compulsory attendance from attending a school, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months".

An important provision emanating from section 20(1)(a) of the Schools Act is the directive for the promotion of the "best interests of the school". This entails ensuring that the school is in a position to deliver quality education. This can only happen in a school environment that is supportive of educators, learners and parents. Such an environment can only prevail where human dignity and rights are respected. By implication, this means respecting the provisions of the Constitution regarding non-discrimination on any grounds, which includes respecting the dignity and rights of people living with HIV and AIDS. Furthermore, as a directive of the NEPA, there should be non-discrimination and equality with regard to learners, students and educators regardless of their HIV and AIDS status, no HIV and AIDS testing for purposes of admission of learners to a school and students to an institution or the appointment of educators, and no restrictions on attendance by educators and learners on account of their HIV status. A safe school and institution environment should be a prerequisite for educators and learners, and there should be measures aimed at the prevention of HIV transmission during play and sport, as well as measures aimed at education on HIV and AIDS. Most importantly, the NEPA states in sections 2.5 and 2.6, in line with the respect for human dignity and rights, that:

> *Compulsory disclosure of a learner's, student's or educator's HIV/AIDS status to school or institution authorities is not advocated as this would serve no meaningful purpose. In case of disclosure, educators should be prepared to handle such disclosures and be given support to handle confidentiality issues.*
>
> *Learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practised against them.*

3.6.3 The Employment of Educators Act, No. 76 of 1998 (E of EA)

This Act deals with educators' service conditions, and among others, pronounces on prohibited conduct. This includes conduct that may promote the

spread of HIV, such as educators' intimate relationships with learners. For example, Jones (2001) reports that a girl learner was diagnosed as HIV-positive after contracting it from one of her educators as a result of an educator-learner sexual relationship. The Act therefore forbids educators from indulging in such acts.

Section 17(c) of the Education Laws Amendment Act, No. 31 of 2007 (Republic of South Africa, 2000b) shows how educators found to be engaging in or to have engaged in 'HIV-spreading acts' with specific reference to sexual relationships with learners are to be dealt with. Such steps include the provision for the dismissal of an educator who has been found guilty of engaging in sexual relationships with a learner of a school where he or she is employed, with or without the consent of the learner (Republic of South Africa, 2000c; Republic of South Africa, 1998b). Furthermore, section 23(1)(c) of the South African Council of Educators Act No. 31 of 2000 (Republic of South Africa, 2000c) provides for the removal of the name of an educator found guilty of a breach of the code of professional ethics. This includes such unlawful acts as those mentioned in the case of the E of EA. The SACE Act deals decisively with such misconduct by making sure that such educators will never be employed by any education department in the country, and their names will be struck off the teacher's roll.

3.6.4 The National Policy on HIV/AIDS for Learners and Educators in Public Schools and Educators in Further Education and Training Institutions

The National Policy on HIV/AIDS for Learners and Educators in Public Schools and Educators in Further Education and Training Institutions[2] was developed for South African schools to be implemented in the management of HIV and AIDS (Department of Education, 1999). In essence, the National Policy on HIV and AIDS was aimed at "increasing learner knowledge on HIV and AIDS through

[2] Hereafter referred to as the National Policy on HIV and AIDS.

schools and specifically, through the curriculum, reducing discrimination against those affected and infected by HIV and AIDS and introducing universal precautions for the safety of learners and educators at schools" (Department of Basic Education, 2010:32). To this end, the National Policy on HIV and AIDS provides for "non-discrimination and equality with regard to learners, students and educators with HIV and AIDS, HIV and AIDS testing and the admission of learners to a school and students to an institution, or the appointment of educators, attendance at schools and institutions by learners or students with HIV and AIDS, disclosure of HIV and AIDS-related information and confidentiality, a safe school and institution environment, prevention of HIV transmission during play and sport, education on HIV and AIDS duties and responsibilities of learners, students, educators and parents, refusal to study with or teach a learner or student with HIV and AIDS, or to work with or be taught by an educator with HIV and AIDS, school and institutional implementation plans and Health Advisory Committees".

Furthermore, section 12.1 directs schools to develop and adopt their own implementation plan on HIV and AIDS to give operational effect to the policy. In this regard, the National Policy on HIV/AIDS prescribes the following principles on HIV and AIDS at schools:

- The Constitutional rights of all learners and educators must be protected equally;
- There should be no compulsory disclosure of HIV and AIDS status (applicable to learners and educators);
- 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; they must be 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; and
- If and when learners with HIV or AIDS become incapacitated through illness, the school should make work available to them for study at home and should support continued learning where possible, or provide older learners with distance education.

The Policy further sets parameters within which HIV and AIDS management should be located. Most importantly, the establishment of Health Advisory Committees at school is of paramount importance as this is the structure that will be responsible for policy formulation and implementation at school level.

The foregoing discussion has revealed legislation concerning HIV and AIDS issues in the workplace. It is important to note the unique and complex nature of the school as a dual service institution that doubles as a workplace and a site of education service delivery. HIV and AIDS management at schools should therefore be understood in this context – a context that informs the nature of its management. There can therefore be no one-size-fits-all approach to HIV and AIDS management. For this reason, the nature of HIV and AIDS management is exposed from the recognition of the legislative imperatives as highlighted above. In this sense, HIV and AIDS management at schools requires an understanding of the elements pertaining to it.

3.7 THE ELEMENTS OF HIV AND AIDS MANAGEMENT AT SCHOOLS

The management of HIV and AIDS at schools flows from the National Education Policy Act and the new Department of Education Strategic Framework as discussed in the foregoing sections. To this end, the management of HIV and AIDS at schools comprises three fundamentals, namely policy formulation, HIV and AIDS programmes and their implementation, and educator training and development. These elements work interdependently and therefore can never be divorced from each other.

3.7.1 Policy formulation

A school HIV and AIDS policy is a statement of values, beliefs and commitments regarding the management of learners and educators living with HIV and other HIV and AIDS-related situations, with their rights and obligations laid out (FPD, 2010a:143).

The management of HIV and AIDS at schools is a huge task that requires committed and dedicated efforts and robust initiatives. For this reason, schools are required, in terms of section 13.1 of the National HIV and AIDS Policy Act, to establish their own HACs. A school HAC is (Department of Health, 2010:6) an advisory group composed of school, health and community representatives who act collectively to advise the school district on aspects of a coordinated school health approach. Therefore the HAC should (Department of Education, 1999):

- be set up by the governing body or council and should consist of educators and other staff, representatives of parents of learners at the school or students at the institution, representatives of the learners or students, and representatives from the medical or health care professions;
- elect its own chairperson who should preferably be a person with knowledge in the field of heath care;
- advise the governing body or council on all health matters, including HIV and AIDS;
- be responsible for developing and promoting a school or institution plan of implementation on HIV and AIDS and review the plan from time to time, especially as new scientific knowledge about HIV and AIDS becomes available; and
- be consulted on the provisions relating to the prevention of HIV transmission in the code of conduct.

Basically, the policy formulation process comprises a series of steps, which generally and ultimately encompass (Barrett-Grant *et al*. 2002:51; THETA Tourism, Hospitality & Sport Education and Training, 2003:18) the following:

- Creating an HIV and AIDS committee to identify a senior person to lead the process; developing the terms of reference for a Policy Task Team and nominating representatives for the Policy Task Team. At school this would be the Health Advisory Committee;

- Developing the committee's capacity by providing training on relevant HIV and AIDS facts, on the impact of HIV and AIDS in the workplace/school, and on the terms of reference, and reviewing past policy;

- Gathering information about the school, the HIV and AIDS situation, the concerns/issues related to HIV and AIDS, other workplace HIV and AIDS policies and research on HIV and AIDS;

- Reaching consensus on the type of policy, the goals of the policy, the guiding principles and elements of the policy, as well as identifying any areas where expertise is required (legal and medical status);

- Formulating the policy by developing a draft policy (with technical inputs where required), establishing a consultation process, revising and finalising the policy; and identifying indicators for monitoring the policy implementation;

- Negotiating policy by considering issues to be included in it, defining objectives to be achieved through the development of a policy, gathering information to support policy positions taken, developing a strategy and reaching agreement; and

- Developing an implementation strategy to launch and popularise the policy, adopting and launching the policy formally, conducting public relations activities around the policy and conducting research to identify and address any barriers to ownership and implementation.

The steps involved in policy formulation for HIV and AIDS management cover all the aspects intended to make the identification and implementation of HIV and AIDS management programmes effective.

3.7.2 School HIV and AIDS management programmes and their implementation

A school HIV and AIDS programme, according to Tshepang Teachers Treatment as cited by Mbada (2010:3), is a plan of action which schools implement in order to address the issues of HIV and AIDS on learners. School HIV and AIDS programmes, as Schenker and Nyirenda (2002:10) point out, focus on the specific student population of each school, while maintaining close links with their parents and the community at large.

For the successful design of school HIV and AIDS programmes, especially when developing a school HIV and AIDS policy and action plan in response to HIV and AIDS, certain critical priorities, which form the pillar of HIV and AIDS management at schools, deserve mention (Department of Education, 2003:10):

3.7.2.1 Preventing the spread of HIV

Prevention of HIV and AIDS is the most important thing that most sectors such as schools are aiming for. School, a place where young people meet in large numbers almost every day, has a mandate to develop and implement plans to stop the spread of HIV and AIDS among school children and their educators. On that note, the Department of Education has proposed measures that schools can adopt to prevent the spread of HIV and AIDS among learners and educators. Such measures include (Republic of South Africa, 2003:23-24):

- Provision of basic knowledge about HIV and AIDS;
- Encouraging HIV counselling and testing among educator and learners;
- Developing a peer education programme;
- Providing life-skills training in order to promote healthy lifestyles among learners;

- Forming partnerships with other stakeholders with a clear memorandum of understanding in addressing HIV and AIDS challenges.

The measures listed above form a critical basis for HIV and AIDS management at schools. This is precisely what the FPD training sought to deliver in its training programme.

3.7.2.2 Providing care and support for learners affected by HIV and AIDS

Since there are many learners who are vulnerable, infected and affected by HIV and AIDS, schools take certain steps to give care and support, which can range from, as pointed out by the Department of Education (2003:49-52), spiritual and emotional support for traumatised learners, material support for affected learners, as well as academic support for ill learners. Johnson ([s.a.]: 179) suggests:

- Identifying children in need by doing a school survey
- Drawing up a combined list from all the class surveys
- Arranging a household visit to collect more information
- Deciding which school children need the most help
- Prioritising actions to help children stay in school.

The care and support of learners affected by HIV and AIDS are also critical dimensions of HIV and AIDS management at schools, especially in light of the fact that many learners and educators are already living with HIV.

3.7.2.3 Providing care and support for educators affected by HIV and AIDS

The huge tasks facing schools are to keep educators affected by HIV and AIDS productive, and providing them with physical, medical, emotional and social support and care (Department of Education, 2003:66). This also involves turning schools into working place environments which are free from stigma and discrimination, and promoting educators' meaningful involvement in education

sector responses (The Carribean Community, UNESCO and World Bank, 2006:5). In an attempt to provide care and support for educators living with HIV and AIDS and those affected, school HIV and AIDS programmes should be able to (Department of Education, 2003:68–69; Johnson [s.a.]:188–190):

- Reinforce educators' efforts by recognising and rewarding those who provide care and support for learners and colleagues.
- Provide educators with accurate knowledge of HIV and AIDS and counselling skills to enable them to provide care and support to learners and colleagues living with HIV and AIDS or affected by it.
- Make sure that educators have someone to talk to such as a doctor, psychologist, spiritual leader or counsellor so as to relieve stress.
- Encourage educators living with HIV and AIDS to manage their own stress levels by using techniques such as getting enough sleep, exercising, not abusing alcohol, not smoking and eating healthy food.
- Encourage educators to create an Educator Support Team (EST) which is a caring and a safe school environment on its own.

Schools' HIV and AIDS programmes require particular approaches to achieve the intended results. The approaches could include identification of the actions the schools need to take in order to mitigate HIV and AIDS (Department of Education, 2003:38). It is imperative for schools to design 'do-able' steps or activities, to assign a responsible person and also to impose time frames in which to accomplish the identified actions. For the HIV and AIDS programme to produce the projected outcomes, schools are expected to have the financial and physical resources. It is therefore also important to develop partnership with other external stakeholders who can support the programme so that it runs effectively as planned. It is clear therefore that school HIV and AIDS programmes need to be monitored in order to check whether the HIV and AIDS activities are being carried out according to plan.

School HIV and AIDS programmes, which are integrated in the life skills education programme, have a fundamental role in the development of the child's understanding of preventive measures. The programmes also suggest certain standards in addressing HIV and AIDS. In essence, a school HIV and AIDS programme should, according to Department of Education (1999:14-15), meet such standards as the provision of information on HIV and AIDS and develop the life skills necessary for the prevention of HIV transmission. It should also inculcate basic first-aid principles from an early age, including how to deal with bleeding using the necessary safety precautions; emphasise the role of drug abuse, sexual abuse, violence and sexually transmitted diseases in the transmission of HIV; empower learners to deal with the situation; encourage learners to make use of health care, counselling and support services offered by community service organisations; teach learners how to behave towards a person with HIV and AIDS; raise awareness of prejudices and stereotypes concerning HIV and AIDS; cultivate an enabling environment and a culture of non-discrimination towards a person with HIV and AIDS; and provide information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse, the use of condoms, being faithful to one partner, medical treatment for sexually transmitted diseases and tuberculosis, and avoiding traumatic contact with blood.

3.7.3 Educator training and development

The training of educators in HIV and AIDS is an important action for schools to effectively manage and prevent HIV and AIDS. It also assists educators to feel comfortable when addressing their learners and colleagues on HIV and AIDS matters. For example, in their research (Duflo, Dupas, Kremer & Sinei, [s.a.]) found that:

> *Training teachers on how to implement the national HIV/AIDS curriculum greatly increased the likelihood that teachers teach about HIV in the classroom. Two years after the training, students whose teachers had been trained had greater knowledge about the disease and also reported more tolerant attitudes towards those with AIDS …*

The training of educators in HIV and AIDS is done firstly by way of pre-service training and secondly in-service training. The Department of Education emphasises (1999:6) that:

> *Appropriate course content should be available for pre-service and in-service training of educators to cope with HIV and AIDS in schools.*

For the purpose of this study, educator training and development is discussed in terms on in-service training which, according to UNESCO (2011:13), is defined as the training of practising educators as part of a process of professional development or for the purpose of updating their curriculum knowledge, improving their pedagogical skills and/or implementing a new programme at institutional level. In this study then, in-service educator training is defined as the training of practising educators in HIV and AIDS for the effective management of HIV and AIDS at schools. UNESCO (2011:13) further states the advantages of in-service HIV and AIDS training as speed and impact; scale, which implies short programmes on HIV and AIDS reaching large numbers of educators; flexibility and innovation, which relates to the availability of different modalities providing a range of teaching and learning technologies and methodologies; cost-effectiveness, responsiveness and flexibility, which implies that it is not dependent on lengthy or cumbersome policy change, nor is it tied to an institutional timetable; and evaluation and accreditation systems. In-service training can therefore be delivered by a range of providers, including special NGOs and the private sector.

With these kinds of training practice in place, educators are able to carry out their role in responding to HIV and AIDS at schools. Thus schools become centres of HIV and AIDS knowledge, and impart skills and values to the communities they serve. Educational International (2007:3) reports that the training of educators provides them with the knowledge and skills to protect themselves, their colleagues and students against HIV infection, and to help other adults prevent infection and related discrimination. They will be able to advocate for effective HIV prevention and education programmes for learners

and adults at schools, and help young people acquire the skills they need to prevent HIV infection and related discrimination.

It is imperative to expose the training programme of the Foundation for Professional Development so as to contextualise its content with regard to the contextual, legislative and management framework of HIV and AIDS at schools as exposed in the foregoing sections.

3.8 THE FOUNDATION FOR PROFESSIONAL DEVELOPMENT (FPD) FOR HIV AND AIDS MANAGEMENT AT SCHOOLS

3.8.1 Background

The FPD was established in October 1997 by the South African Medical Association. Its aim was to build a better society by equipping professionals and managers with the skills to deliver a service to the public that is affordable, evidence-based and congruent with international practices (FPD, 2010b). The FPD has been registered as a private institute of higher education with the Department of Education since 2002, and is an accredited service provider for continuous development by the Medical and Dental Professional Board of the Health Professions Councils of South Africa (HPCSA) (Brink, 2010:5). There are myriads of activities that the FPD is engaged in as a response to HIV and AIDS. Among others, Brink (2010:6) mentions the following:

- The US President's Emergency Plan for AIDS Relief (PEPFAR Fellowship Programme): The Programme responds to the growing need for the rapid expansion and development of human resource capacity in HIV and AIDS care and treatment programmes within the South African health care environment. The Programme has placed 52 Master's students to date.

- *Positive Life Project:* This is a donor-funded project that works in partnership with government to support HIV and AIDS as well as TB services, and supports more than 60 000 people on anti-retroviral

therapy (ART), and more than 120 000 people have been reached with counselling and testing programmes.

- *That's It*: This project, in collaboration with the Medical Research Council (MRC), expands the delivery of ART to TB patients in South African and promotes TB screening in HIV-positive patients, using lessons learnt from the best practice models developed by other MRC partners.

- *Fund raising:* A total of R1.5 billion has been raised for HIV and AIDS initiatives since its establishment.

The FPD developed a training programme for schools, which presented a strategy to assist schools in managing HIV and AIDS.

3.8.2 Overview of the FPD training programme

The FPD training programme is an intervention strategy established with the goal of capacitating school managers to respond to the effects of HIV and AIDS so as to bring about worthwhile changes in the school community as a whole. This programme was motivated by the need to give correct and basic knowledge of HIV and AIDS and to lessen its impact at schools. To achieve this goal, the FPD embarked on HIV and AIDS training solely for school managers, namely principals, deputy principals and heads of departments (Brink, 2010:1). With the implementation of the knowledge and skills acquired during the training, schools managers were expected, as an anticipated outcome of the FPD training, to give support and care to educators and learners affected and/or infected by HIV. Furthermore, school managers were expected to develop school-based programmes to address the HIV and AIDS challenges such that all parties involved in the provision of quality teaching and learning at school level are involved in a positive way in responding to the epidemic.

3.8.3 Aims of the FPD training programme

The purpose of the FPD training programme was to equip the SMTs with the knowledge of HIV and AIDS needed in the development and implementation of

an effective programme that addresses the challenges brought about by HIV and AIDS to schools in general, and to learners and educators in particular. As seen from its impact model (FPD, 2010a:3), the FPD training tried to reduce the impact, incidence and prevalence of HIV at schools by creating a conducive working and learning environment characterised by the constant provision of information about HIV and AIDS for staff and learners, more open discussions about HIV and AIDS, regular HIV Counselling and Testing (HCT), integration with support services that provide access to HCT, and care, treatment and support for educators and learners living with and affected by HIV and AIDS. The FPD training was based on the FPD's mission to ensure the availability of skilled professionals and managers who would be able to deliver a service to the public that is affordable, evidence-based and congruent with international best practice.

3.8.4 Outline of the FPD training programme

Unlike the majority of past HIV and AIDS programmes at schools, which focused on curriculum and content support for life orientation educators, awareness and information about HIV for youth and peer educators programmes (Miedema, [s.a.]), the FPD's training programme aimed at better managing the effects of HIV and AIDS at both primary and secondary level. For this reason, school managers in the Tshwane South District received training in managing HIV and AIDS at schools from May 2010 to August 2010 in a workshop format.

So as not to disrupt teaching and learning at schools, training was conducted on Saturdays and Sundays. This was done in groups of 16, which was made up of 48 participants per training session. The training required three participants from each school. These were the principal or deputy principal from the public primary or secondary school, the head of department and an educator assigned to employee/learner wellness responsibilities at schools. Since not all schools had deputy principals due to low learner enrolment, educators in charge of the health of employees and learners' wellness were admitted to the training. The

training was held at the Tshwane South District office and at the Burgers Park Hotel in Pretoria.

All the participants received a training manual containing case studies and best practices from the business and education sectors on the implementation of an HIV workplace programme, a resource kit that included a map and directory of the relevant HIV and AIDS support organisations, government HIV testing and treatment sites operating in the Tshwane South District, information and edutainment material about HIV and AIDS, stories from those affected by HIV and AIDS as well as strategies for managing HIV and AIDS, and posters and communication tools that included information about HIV and AIDS and messages to encourage HIV testing. These were intended to be used at school level.

The training was conducted by clinical psychologist, Mr K D Joubert, and was characterised by group discussions, video clips, role plays and question-and-answer sessions. For example, the participants were grouped according to their schools, and were tasked with identifying the effects of HIV and AIDS on their schools and designing an HIV school programme to mitigate the effects. A video clip of the life cycle of HIV was shown to explain the anatomy and the epidemiological processes of HIV. The participants shared their experiences of trying to mitigate HIV and AIDS in their schools in their respective capacities or portfolios.

To demonstrate understanding of the FPD training concepts, participants had to pass an assignment which became a portfolio of evidence on the implementation of the HIV programme at each school. The participants were requested to send their assessment answer sheet (Appendix A**)** to an assessor for marking three to six months after the training. For the participants to receive the compliance certificate, a pass mark of 70% was required. If the participants failed to complete the course within six months, they had to re-register at their own cost (FPD, 2010c:5). The certificate awarded on completion of the FPD training programme is regarded as being on the National Qualification Framework (NQF) level, which means that the participants would have attained

the competencies which would qualify them to (South African Qualification Authority, [s.a.]:5):

- Demonstrate and apply knowledge of HIV and AIDS management at schools.
- Demonstrate an understanding of different forms of knowledge, school of thoughts and forms of explanation within the management of HIV and AIDS at schools.
- Demonstrate an ability to evaluate, select and apply appropriate methods, procedures or techniques in managing HIV and AIDS at school.
- Identify, analyse and solve problems relating to HIV and AIDS at schools in unfamiliar contexts.
- Apply ethics and professional practices in responding to the effects of HIV and AIDS at schools.
- Evaluate different sources of information regarding HIV and AIDS in order to assist learners and educators with relevant and up-to-date information on HIV and its effects.
- Present and communicate sensitive information regarding HIV and AIDS in an appropriate manner.
- Work effectively in a team or group, and take responsibility for his or her actions and decisions and the actions of others in responding to HIV and AIDS at schools.

The participants were also assisted to get their tasks correct. In this regard, Brink (2010:4) reports that a facilitated feedback session of 2–3 hours was held three months after the training, in order to support and guide participants in the implementation of the HIV and AIDS programme at their schools.

3.8.5 Delivery of the FPD training

The FPD training on the management of HIV and AIDS consisted of nine modules (FPD, 2010a: 5–7).

- Module 1: *The HIV and AIDS epidemic*

  This module aimed to equip the SMTs to understand the reality of HIV and AIDS. The training focused on basic facts about HIV and AIDS. This was done by teaching the origin of HIV, its transmission, prevention and lifecycle.

- Module 2: *The impact of the HIV and AIDS epidemic*

  The purpose of this module was to outline challenges, such as the impact on society, economic growth, school or workplace caused by HIV and AIDS. It alerted the SMTs to the need for caring for and supporting learners and educators or colleagues living with or affected HIV and AIDS (FPD, 2010a:45). This module equipped the SMTs with the skills to identify possible signs of a learner or a colleague being affected by HIV to enable them to give support and address the impact on schools and on society at large.

- Module 3: *Impact of HIV and AIDS on the Education sector*

  This module was aimed at equipping the participants with the ability to determine how learners and the education sector as a whole are affected by HIV and AIDS. This is done by first conducting an HIV and AIDS prevalence survey at their schools and then by assessing the level of impact of HIV and AIDS at their schools, and lastly by designing strategies that will help SMTs to respond to the effects.

- Module 4: *The legal and ethical aspects of HIV and AIDS*

  This module taught the participants about the relationship between human rights and HIV and AIDS at schools. The understanding of this relationship prepared them to deal with the challenges that teachers and

learners living with or affected by HIV and AIDS are faced with at schools. The challenges range from discrimination, denial and stigma to absconding. Furthermore, this module prepared the SMTs to develop creative approaches to a safe school environment with regard to HIV, HIV testing, confidentiality and disclosure. The SMTs also learned how to protect confidentiality, how disclosure can be encouraged and how to address incapacity due to HIV-related illness (FPD, 2010a:150).

- Module 5: *School response to the HIV and AIDS epidemic*

  This module prepared the SMTs to respond to HIV and AIDS by developing HIV and AIDS school programmes following the top-down approach, whereby all school managers and employee representatives are included in planning initiatives. Such programmes involve stakeholders, research, policy implementation, leadership development, awareness prevention programmes, support for educators living with learners vulnerable to HIV, treatment, literacy, managing absenteeism and community outreach (FPD, 2010a:157–159),

- Module 6: *School HIV and AIDS strategy*

  The purpose of this training module was to equip the SMTs with strategies for developing and implementing a school HIV and AIDS action plan. The module covered strategies for identifying possible programmes that schools intended to implement, garnering support from educators and all internal and external stakeholders, designing roles and responsibilities of the parties in charge of stakeholders, and accessing resources required for the effective implementation of the action plan (FPD, 2010a:113).

- Module 7: *School HIV and AIDS policy*

  This module was intended to give the SMTs an understanding of the importance of HIV and AIDS policies at schools and to outline the

essential components or priority areas that constitute a school HIV and AIDS policy.

- Module 8: *School HIV and AIDS programme*

  The aim of this module was to equip the SMTs with the skills to design a school HIV and AIDS programme. This was done by identifying different HIV programmes and seeing how each category contributes to HIV prevention and care in a school setting.

- Module 9: *School HIV and AIDS monitoring and evaluation*

  The purpose of this training module was to capacitate the SMTs with strategies that will help them to determine whether their school HIV and AIDS programmes are working and/or whether they are yielding the intended results that meet the set objective or goal.

Each module had its learning outcomes, and it is assumed that what the school managers learned from the FPD training programme should be evident in their performance at their respective schools. This means that the knowledge and skills they acquired during the intervention had to be practically demonstrated at the schools. Table 3.1 illustrates the knowledge, skills, attitudes and values as major projected learning outcomes of the FPD training.

Table 3.1 Skills, knowledge, attitudes and values covered in the FDP training

Knowledge	Skills	Values and attitudes
• The truth about HIV and AIDS • How testing is done • The types of HIV tests currently available • The truth about negative or positive HIV status • The importance of the immune system • The national and school HIV and AIDS policy • Treatment that is currently available • Transmission of HIV and AIDS • Prevention of transmission of HIV and AIDS • Sources of care and support in local communities • Sources of support for the OVCs • Information for those caring for and living with people infected by HIV and AIDS • The causes and effects of prejudice and discrimination against those living with HIV and AIDS • Sources of financial support and where to access them • Rights and responsibilities • Effects of HIV and AIDS on families • Communication • Anger	• Caring and supporting • Advocating for HIV counselling and testing • Communication • Identifying where schools lack accurate information • Explaining the policy provision implications • Planning short-, medium- and long-term goals • Coping with HIV and AIDS • Caring for and supporting those with HIV and AIDS • Support for children orphaned by AIDS • Accessing grants and financial aid • Problem solving • Facilitating and participating in meetings • Guidance and coaching • Expressing thoughts and feelings • Anger management • Self-awareness • Goal setting	• Empathy • Collaboration • Respect • Helpfulness • Importance of caring for those infected with and affected by HIV and AIDS • Overcoming discrimination and prejudice against those in need of support and care • Awareness of the rights and feelings of others • Respect for people's choice of living with HIV and AIDS • Appreciation of the value of support services for those close to someone with HIV and AIDS • Recognising the importance of making responsible decisions • Non-discriminatory attitudes • Considerations • Optimism • Support • Responsibility

Source: GDE-GIED (2004:10, 56 &106).

3.9 CONCLUSION

This chapter underscored various levels of HIV and AIDS management. Intervention strategies were described in accordance with the terms of the

Constitution of the Republic of South Africa. The first level that this chapter covered was *the school as a place of work*. Intervention strategies pertinent to working categories were discussed to familiarise the reader with working force intervention strategies and how the realities of HIV and AIDS, which were discussed in Chapter 2, could be dealt with, with the aid of legislation. The second level, which sets out intervention strategies suitable for HIV and AIDS management, was *the school as a learning site*. For these levels to produce the intended performance, it was shown that a collaborative approach with the aid of various regulations is essential in managing HIV and AIDS at schools. To show the significance of partnership in managing HIV and AIDS, the FPD programme on managing HIV and AIDS at schools was detailed, which is at the core of this study.

The management of HIV and AIDS at schools currently has nothing to do with the development of resources or materials to assist educators or learners in understanding ethics and moral values required in dealing with the HIV epidemic. To date, as seen in this chapter, sufficient resources are available and offered free to schools. Some resources are, on the one hand, in the form of laws that enforce schools to react in a way that may halt the spread of HIV and ensure unconditional support for educators and learners living with and affected by HIV and AIDS. On the other hand, information through training and development has also been made available to school management teams. Therefore in view of such resourced school environments, the question is: are schools taking further steps to apply and implement the knowledge and skills they have acquired regarding the management of HIV and AIDS in an effective way? This study seeks to find the answer to this question.

The following chapter details the research methodology and design.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter details the operational steps that the researcher followed to obtain meaningful outcomes of the study. First, the research processes are outlined, thereafter the Success Case Method (SCM) of evaluation is discussed. The SCM is defined and a description is given of how it works. The five overall steps of the SCM are explained in relation to the FPD's HIV and AIDS school management training.

4.2 RESEARCH PROCESS

The research process of this study involved the following operational phases:

- A literature review was done to justify the study of HIV and AIDS management at schools. The reality and implications of HIV and AIDS globally, in Africa, in the sub-Saharan region and, most importantly, nationally in South Africa, were investigated, as were mitigation measures. The literature review was also focused on HIV and AIDS management at schools, after which its effectiveness was evaluated.
- The FPD training programme as an intervention measure at schools in the Tshwane South District was used as a basis for the evaluation of the effectiveness of HIV and AIDS management implemented at schools.
- The literature review, from which the evaluation process was 'dimensionalised', culminated in the empirical study, which consisted of data collection for the evaluation in terms of a two-phase SCM of evaluation.
- The entire process was written up in the research report.

The research method is discussed in terms of the application of the SCM.

4.3 THE SUCCESS CASE METHOD

The aim of this study, as mention earlier, was to evaluate the effectiveness of HIV and AIDS management, and focused on the implementation of knowledge, skills and attitudes gained during the FPD's HIV and AIDS management training programme. For this purpose, the research method involved the use of the Success Case Method described in the following sections.

4.3.1 Description of the Success Case Method

The Success Case Method of evaluation was developed by Robert O. Brinkerhoff, Professor of Education at Western Michigan University and Principal Consultant to the Advantage Performance Group. He has been actively involved in Human Resource Development (HRD) evaluation, research and practice for several decades, is the author of 10 books on HRD and is a well-known HRD international speaker and consultant (Brinkerhoff, 2002:219). The Success Case Method, according to Brinkerhoff (2005:90) is a process for evaluating the business effect of training and responds to the question of whether a training intervention is or is not working. It investigates how training can be improved and produces concrete evidence of the effect of training (or the lack of it) in ways that senior managers and others find highly believable and compelling. The Success Case Method relates verifiable incidents of trainees who actually applied their learning in specific behaviours that can be convincingly shown to lead to worthwhile results for the organisation (Brinkerhoff, 2005:90; Beets, 2007:36; Mbada, 2010:20).

Various authors have attested to the effectiveness of the SCM as an evaluation method. Millman, Alemdar and Harris (2009:5) contend that the SCM is a simple process that combines analysis of outstanding groups with case study and storytelling. Foxon (2007:1) regards the SCM as a research-based approach to training evaluation and other interventions, which allows one to make a fast, practical assessment of organisational impact and business gains. Furthermore, Advantage Performance/Learning Alliance (2005) describes the SCM as an innovative approach to training evaluation that helps organisations

to convert learning consistently, quickly and effectively into improved performance.

From the above definitions it is evident that the Success Case Method is an evaluation tool that focuses more on the application of the training objectives or one that measures an intervention programme in an organisation in order to improve performance. In this regard, Coryn, Schroeter and Hanssen (2009:80) comment:

> [the] *SCM is conducted with the intent of assessing how well an organizational intervention is working … by focusing on extreme groups and identifying the contextual factors that differentiate successful from unsuccessful adopters of the new initiatives.*

The SCM employs a simple two-part process. In the first phase, through a brief survey, a few trainees who have been most successful in using their learning to achieve valuable results are identified. A few of the least-successful trainees are also identified, who, for one reason or another, have been unable to apply their learning in useful ways (Brinkerhoff, 2006:305). In the second phase of the inquiry, interviews are conducted with samples of the highly successful and the unsuccessful trainees to identify success cases. The actual nature of success is documented – the first part of the interview is aimed at screening and determining whether the person being interviewed represents a true and verifiable success. The second part goes on to probe, understand and document the successes and non-successes, thus providing stories of use and results (Brinkerhoff, 2005:91).

According to Brinkerhoff (2002:4), storytelling is at the heart of the SCM. In this regard, he states:

> *SCM combines the ancient craft of storytelling with more current evaluation approaches of naturalistic inquiry and case study. It employs simple survey methods allowing extrapolation of estimates of breadth of training transfer and effect. It also employs the social inquiry process of key informants and borrows approaches from journalism and judicial inquiry. In a way, we are journalists looking for a few dramatic and 'newsworthy' stories of success and non-*

success. Once found, we seek corroborating evidence and documentation to be sure that the success story is defensible and thus reportable – that is, corroborated by evidence that makes claims of effect and value believable beyond any reasonable doubt.

The SCM therefore "helps to learn what worked, what did not, what worthwhile results have been achieved, and most importantly, what can be done to get better results from future efforts" (Brinkerhoff, 2006:305). Furthermore, and more specifically, according to Brinkerhoff (2006:305), the SCM produces answers to the following important questions:

- How many employees are using training successfully to achieve worthwhile results? How many are not?
- What is the business value of the successful applications of training?
- What is the unrealised value of the training? That is, what value has been ''left on the table'' due to non-usage of the training?
- What is the organisation doing that facilitates performance improvement from learning that needs to be maintained and strengthened?
- What is the organisation doing, or not doing, that is impeding performance improvement from learning that needs to change?

Answers to these questions project the usefulness of the SCM. According to Brinkerhoff (2006:59), the key purposes of the SCM include the following:

- Documenting the nature and extent of impact to ensure that a training programme or an intervention programme is achieving its intended results;
- Estimating the Return on Investment (ROI) of a programme;
- Creating examples of success for use in marketing a programme or otherwise convincing others of its value;

- Documenting the action early adopters take to apply and get results from their training to guide and motivate later participants;
- Refining and improving a programme based on the experience of those who have actually participated in it;
- Assessing what a programme is actually achieving to decide whether or not to continue it;
- Documenting the actual impact of the programme to allay (or confirm!) the concerns of sceptics;
- Assessing the impact of a pilot programme before making a decision to engage in large implementation efforts;
- Developing awareness of the contextual factors that support, or inhibit, successful applications of a programme or innovation; and
- Helping to make a business case for line managers to take a more active role in supporting, for example through coaching and feedback, the way in which their employees apply training to achieve the impact.

It can be concluded from these pronouncements that the SCM is a truly credible and reliable evaluation method. This is the basis for its use in this study.

However, this method has its own disadvantages in its usefulness and validity. Brinkerhoff (2002:24–25; 2006:50) states that the disadvantages include the following:

- It is a biased method as it rests on the assumption that it is very helpful to look for the most successful (and often the least successful) users of a new innovation;
- The whole success of the programme is based on few cases;
- It is not concerned with ‘average’, namely typical or statistically mean performances, as all the action is at the extreme successful and non-successful ends of the spectrum;

- It cannot be used to track usage trends and patterns over time; and
- It does not allow researchers to gather opinions from all participants about a programme regarding its usefulness, strengths, and so forth.

The SCM therefore has limitations, mainly because, as Brinkerhoff (2003:24) acknowledges:

> *The SC Method is not a comprehensive and 'one fix' sort of approach. Rather it is a … useful tool that change leaders and others can use to help them get the information they need to more effectively guide change initiatives.*

However, apart from the usefulness of the SCM as noted, Brinkerhoff (2003:24) also points out that although the SCM reports on only a small number of successful cases, it is very useful to learn from success stories (as well as from particularly unsuccessful cases), and that the success stories themselves are very objective and rigorously supported by confirmable evidence.

4.3.2 Rationale for using the SCM

The SCM was chosen for two main reasons. First, the SCM process would assist in determining what is working and what is not working in the implementation of the FPD programme by the Tshwane South District SMTs. In this regard, the SCM addresses two issues relating to the implementation of learning from training, which according to Dowdall, DeJong and Austin ([s.a.]:1) are: *accountability and efforts,* which deal with what the organisation is doing in relation to what was expected, and *effectiveness and efficiency* issues, which seek to find out what the effects of the intervention are on an organisation.

In the context of this study, the former issues relate to what SMTs at the Tshwane South District schools are doing regarding the expected outcomes of the implementation of knowledge, skills and attitudes gained from the FPD training in HIV and AIDS management. The latter issues relate to determining the effects of the training intervention of the SMTs on HIV and AIDS management in the Tshwane South District schools. The SCM addresses these issues. Brinkerhoff (2002:viii) asserts that the SCM enables useful and accurate

information to be gathered about an initiative, especially with reference to results that are being achieved, what is working, what is not working, and how it can be improved.

Secondly, the SCM enables the identification of contextual factors behind the performances of SMTs in meeting the FPD training objectives on the management of HIV and AIDS at schools. The SCM in this study is therefore also based on its ability to pinpoint additional factors that play a role in the success of training or a new initiative (Brinkerhoff, 2006:13). In support of this statement, Foxon (2007:1) found that the SCM adds value by uncovering systemic factors that contribute to success as well as reasons for a neutral or negative outcome of the intervention. This implies that the positive impact of the FPD's school HIV and AIDS management programme operates with what Brinkerhoff (2006:37) considers as a healthy, aligned and integrated set of performance system factors. These factors have a variety of beneficial uses that can aid other programme users. Brinkerhoff (2002:12) suggests that such benefits include additional programme users having to raise their success so that they come close to the very highest levels of success being achieved by most of the programme users.

The SCM therefore offers a pragmatic orientation to the investigation in this study. Pragmatism allows the researcher to choose an investigative approach that "arises from actions, situations and consequences rather than antecedent conditions as in post positivism" (Creswell, 2009:10). Creswell (2009:10) further argues that a pragmatic approach is concerned with applications – what works and solutions to problems. Researchers using this approach therefore emphasise the research problem and/or questions, and choose all the approaches or methods available to understand the problem. In this sense, the SCM provides an evaluation method that is pragmatic in that it allows the use of multiple methods in pursuit of solutions to the research problems. It furthermore reduces the burden of extensive, "straight-jacketed and often tiresome justifications for the use of specific designs and methods". Rather, as propounded by Creswell (2009:11):

> *... pragmatism opens the door to multiple methods, different worldviews, and different assumptions, as well as different forms of data collection and analysis.*

Furthermore, the SCM, through the interview phase, allows a phenomenological strategy to be used for data collection. The phenomenological strategy enables one to understand and interpret the meaning that people assign to their everyday lives, which in essence implies a description that the experiences of a phenomenon, topic or concept has for various individuals (Fouché, 2002:273). According to Fouché (2002:273), the phenomenological strategy uses mainly naturalistic methods of study, analysing the conversations and interactions that researchers have with subjects, which include interviews for data collection. The phenomenological data collection strategy was apt for this study because I sought to evaluate the meanings and insights that SMT members in the Tshwane South District assign to the effectiveness of their implementation of HIV and AIDS management at schools in terms of the capacity building they derived from the FPD's HIV and AIDS management programme. The SCM achieves this by basically utilising interviews with high success and low success cases as a means of data collection. To this end, the SCM 'digs deep' into participants' experiences to discover the exact nature and extent of their success and/or non-success by using interviews (Brinkerhoff & Dressler, 2003:13). Brinkerhoff and Dressler (2003:13) point out: "More specifically, the evaluator seeks to discover exactly what they used, when they used it, how, when, etc., what results they accomplished, how valuable the results are and what environmental factors enabled (or disabled) their application and results".

Finally, the SCM provides a data collection procedure to assess how a training initiative or intervention is working in practice (Brinkerhoff, 2006:17). This is in line with the intention of this study, which is to evaluate the effectiveness of HIV and AIDS management at schools in the Tshwane South District. The SCM further specifically identifies organisational factors which facilitate or impede the successful implementation of a training intervention, which is also in line with this study in that the SCM evaluation provides an indication of factors at schools

in the Tshwane South District regarding the different contexts within which the training intervention is implemented. Finally, the SCM evaluation assists in pinpointing examples of what can come out of a programme that is functional in terms of success cases or dysfunctional in the case of non-success cases.

Because it is a relatively new evaluation method, the SCM is fully discussed in the next section.

4.3.3 How the SCM works

The SCM has a two-part structure that basically defines its process of evaluating training or intervention. The first part comprises snap survey spectrum that seeks to identify success cases (the high performers) – those participants who are most successful in applying the knowledge gained during the training or meeting the objectives of a programme intervention by demonstrating tangible results – and least or non-success cases (low performers) (Brinkerhoff, 2002:16). This process of categorising performances is done through the use of a questionnaire. Brinkerhoff points out that the first structure of the SCM provides the additional advantage of extrapolating results to obtain quantitative estimates of the proportions of participants who report using, or not using, some new method or innovation (Brinkerhoff, 2002:16; Brinkerhoff, 2005:91).

Secondly, the spectrum of performances through which participants were identified as high or low performers is validated by interviewing them in order to gather verifiable and documentable evidence so that success can be ‘proven’ (Brinkerhoff, 2002:16). To achieve the proven results, interviews follow the success story-telling approach – participants tell stories that, in line with the interview questions, reflect what they did to achieve success or not, and also explain the factors behind their success or non-success (Brinkerhoff, 2005:91).

The application of the SCM in any study requires an understanding of how it works, including various aspects of the model. Figure 4.1 shows a schematic representation of the SCM evaluation model.

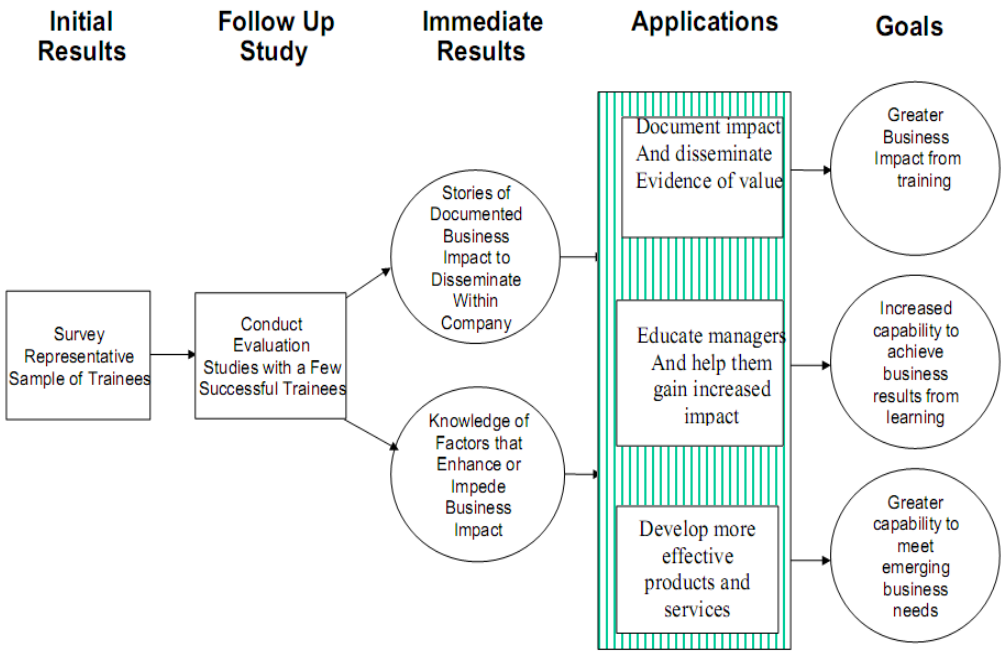


Figure 4.1 The SCM evaluation model (Brinkerhoff & Dressler, 2003)

The SCM model as depicted in Figure 4.1 illustrates the link between the training, data collection, outcomes and goals of the training or intervention. As the figure shows, the SCM first determines the results of the training or intervention implementation. The results of this survey are used for the evaluation of successful participants of the training or intervention. This is accompanied by documenting the business or organisational impact of the intervention as well as factors that enhance and/or impede the impact of the training or intervention. This then leads to the documenting of the impact with evidence of value, education, enhancement and increased impact, and to the development of more effective products and services. This whole process links to organisational goals via greater impact from training, increased capability to achieve business or organisational results from learning, and a greater capability to meet emerging organisational needs.

The SCM has the ability to answer questions that determine the meaningfulness and value of a new initiative or an intervention programme in an organisation. To this end, and most importantly, Brinkerhoff (2002:7) asserts that these are questions that help the researcher to discover and illustrate ways in which a

new initiative or programme is being used or whether anything is happening as a result of such a programme. Further, as a benefit, the SCM can indicate proportions of people in respect of their organisational units who have successfully achieved the expected results by applying learning. All this ensures that estimates of return-on-investment can be made, as well as decisions about how much value a programme is realistically capable of adding over and above its current level of impact (Brinkerhoff, 2002:7). In this regard, questions of pivotal importance in the SCM model include the following (Brinkerhoff, 2002:6):

- What is really happening?
- What results, if any, is the programme helping to achieve?
- What is the value of the results?
- How can the initiative be improved?

4.3.4 The Success Case Method as applied in the evaluation of HIV and AIDS management at schools in the Tshwane South District

In the context of this study, the SCM evaluation of HIV and AIDS management at schools in the Tshwane South District is represented in Figure 4.1 by the first three stages, namely initial results, follow-up study and immediate results. These stages are expressed in the five chronological steps making up the SCM illustrated in Figure 4.2.

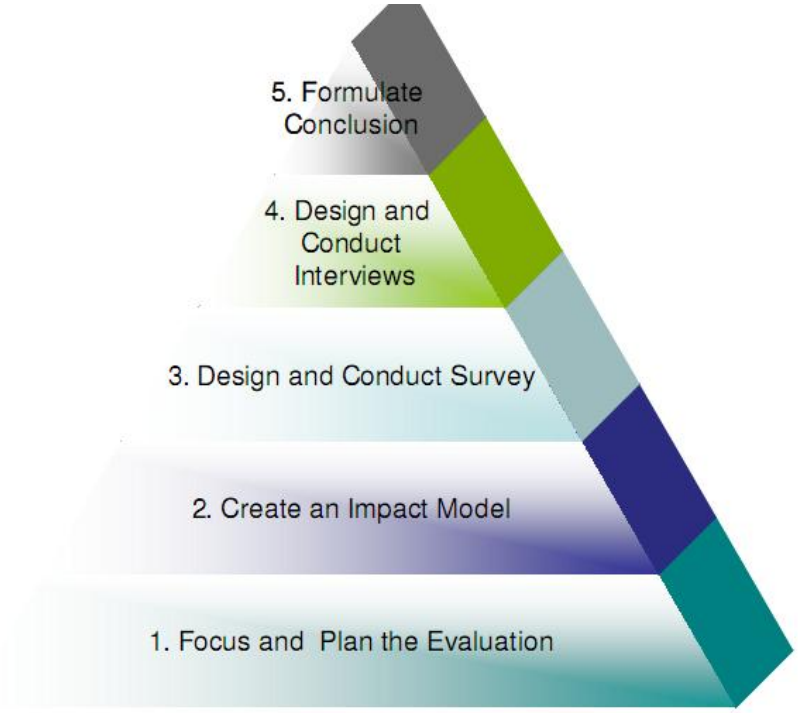


Figure 4.2 The five steps of a Success Case Method (adapted from Brinkerhoff, 2003)

The five SCM steps unfold in the following manner:

Step 1: Focus and plan the evaluation

This step essentially describes the design of the study and aims at clarifying and planning the evaluation. According to Brinkerhoff (2006:57; 2002:30), there are seven key areas in which the SCM design decisions must be made, namely (1) clarifying and defining the purpose of the study; (2) meeting with key stakeholders and discussing the study; (3) specifying the programme or initiative on which the study will focus; (4) defining the population of participants to be studied and identifying any needed sampling parameters; (5) establishing time frames for the study; (6) determining resources available and needed for the study; and (7) finalising the success case strategy. These key areas were followed in the design for this study and culminated in the overall SCM evaluation strategy or design. Some of the areas are presented in the following sections.

- *The purpose of the SCM study*

This was clarified, defined and outlined in the purpose statement of this study as the evaluation of the effectiveness of the implementation of HIV and AIDS management at schools in the Tshwane South District (see Section 1.2). This was premised on the FPD training intervention provided to SMTs in the district and, based on the skills, knowledge and attitudes they had gained during the training, was implemented at schools (see Section 3.7).

- *Key stakeholders*

Key stakeholders in this study were limited to the FPD and the Tshwane South District's Education Support Systems (ESS) unit, the Human Resource Development (HRD) unit and the School Management Teams. This was based on the scope and purpose of the study, which included it being conducted in part as my doctoral thesis. Discussions were held with the FPD, the HRD and the ESS on their desire to assess the impact of the training, and to determine its usefulness, strengths and challenges for the purpose of improvement and/or large-scale roll-out to other districts. All these stakeholders were engaged before the study was carried out to give it substance and rigor by finding out what they would want to know and how the results of the evaluation would assist them. Therefore the study was tailored to uncover data on these aspects, and this justified the use of the SCM as an evaluation method.

Table 4.1 shows how this identification was done for this study. As the evaluator, I considered what would be required to conduct an effective study that would provide the information that people needed and expected (Brinkerhoff, 2002:29; 2006:30; Brinkerhoff & Dressler, 2003).

Table 4.1 Key stakeholders and their interests in the FPD training programme

Who will use the evaluation?	What do they want to know?	How will they use the information?
The Foundation for Professional Development (FPD)	Is the school HIV and AIDS management programme meeting the clients' needs? Are SMTs applying the FPD learning outcome? Has the programme produced results?	To decide whether the programme is useful or not. To decide on gaps that need to be filled in executing the training.
The Tshwane South District: Education Support System and the Human Resource Development units	Is the programme serving any purpose? Are there schools that are implementing the FPD HIV and AIDS programme? Is there any challenge faced during the implementation?	To decide whether to proceed with sourcing information on HIV and AIDS from NGOs. To decide whether to participate in other programmes offered by FPD. To decide on improvement plans in managing HIV and AIDS at schools
Tshwane South District School Management Teams	Is my school implementing the FPD learning effectively?	To decide on effective implementation strategies. To modify the programme activities with which the school is engaged.

- *The intervention programme*

The intervention initiative was specified and described as the FPD training as detailed in Section 3.7 of this thesis.

- *The population of participants to be studied and sampling parameters*

According to Brinkerhoff (2006:60), this area involves the identification of the research population, the setting of specific criteria for its inclusion in the study and its demographic factors, such as job roles, geographic location and the time that has elapsed since training was conducted. This area also includes the description of sub-populations where applicable.

In this study, the population is fairly homogeneous in the form of SMTs. There are 126 primary schools and 55 secondary schools in the district. With the FPD requirement of three participants from each school, it was projected that 460[3] SMT members would have attended the training. The actual participants in, and the sampling parameters of this study are defined in a later part of this section.

- *The time frames for the study*

This area entails determining how soon after the training the evaluation must be conducted, and establishing a schedule for the study (Brinkerhoff, 2006:65). Regarding the former, Brinkerhoff (2002:60) recommends that the SCM be applied no later than a year after a training intervention has been conducted in order to protect the reliability and integrity of the data. Permission from the GDE and the Tshwane South District to conduct this study was granted in July 2011, which suited the recommended duration. However, this period had to be extended to January 2012 in order to comply with the research protocols of the university and, most importantly, to

[3] This figure includes principals, deputy principals and heads of departments and excludes educators who also attended the training, because the focus of the study is on SMTs whose responsibility is to ensure the implementation of any school improvement and development programmes.

ensure the availability of a large enough research population Cognisance was taken of the longer than one year period after training, and consequently rigorous ethical and data reliability and validity measures were implemented during data collection.

The schedule for the study was based on expectations of possible difficulties regarding questionnaire retrieval and the length of time it would take to conduct the interviews (Brinkerhoff, 2002:62). Challenges in this regard were in fact encountered, especially but not limited to the availability of participants, transcribing of the interview recordings, and lack of money to purchase air time for telephone interviews. However, the bursary from North-West University contributed in relieving the financial burdens, such as the appointment of a person to transcribe the interviews to speed up the very exhausting transcription processes. To recruit participants, the researcher made follow-up calls to find out whether they were ready to be interviewed, and these efforts helped since most of the people (SMTs) who had indicated that they had no time agreed to be interviewed at the second attempt, and others at the third attempt.

- *The final SCM strategy*

This area involves the overall evaluation strategy, which is discussed in this chapter. It includes a description of the research design in terms of all the operational activities carried out during the evaluation process and culminates in the final SCM report.

After this first step, an impact model representing the second SDM step was created.

Step 2: Create an impact model

This is an SCM study-driven initiative that comes immediately after the description of the study design and its aim(s). Brinkerhoff (2002:75) defines the impact model as a carefully articulated and concise ‘forecast’ of what the most successful performance might be expected to look like if the programme being studied is accomplishing what its stakeholders hope it should. In the case of this

study, the FPD programme was intended to be used for the attainment of the following objectives (FPD, 2010a):

- To develop the HIV and AIDS school programme
- To develop a school HIV and AIDS action plan
- To develop and communicate the school HIV and AIDS policy to all concerned stakeholders
- To link the school HIV and AIDS programme to the community strategies
- To commit to the implementation of the FPD training at school
- To impart knowledge of, and the skills to address HIV and AIDS to other staff members and learners
- To conduct an HIV and AIDS prevalence survey at school.

Brinkerhoff (2006:72) further defines the impact model as a tool that is used to capture the impact of the training. To this end, the model is represented as a grid and in this study it has features as depicted in Table 4.2.

Table 4.2 illustrates how carefully the FPD training was planned. It shows exactly what the SMTs were expected to do at their schools after their training regarding how successful implementation should look. The first column depicts the key systematic abilities expected of the SMTs. The second column shows how these systemic capabilities were to be put into action by the SMTs so as to produce the training results shown in column three. The last column shows the overall goals to which the training was to contribute. Therefore Table 4.2 shows how each SMT member was intended to use the FPD training to manage HIV and AIDS their schools.

The impact model shown in Table 4.2 was designed by the researcher in consultation with the stakeholders of this study. According to Brinkerhoff (2006:60), a stakeholder is a person or group that holds some ‘stake’ in the study, which includes those who commissioned or will use the results of the SCM study, such as trainers or programme owners, or even managers of the participants. As indicated earlier (see Table 4.1), in this study the stakeholders

are the FPD, the Tshwane South District and the SMTs within the Tshwane South District.

Table 4.2 The HIV and AIDS training Impact Model for the FPD

Key system capabilities	Critical application	Key results	Goals
Understanding the basic facts about HIV and AIDS	Develop the HIV and AIDS school programme	Appropriate strategies to manage the impact of HIV and AIDS on orphaned and vulnerable learners	Improved management of the effects of HIV for educators and learners
Ability to implement a holistic HIV programme at school	Develop a school HIV and AIDS action plan Develop and communicate the school HIV and AIDS policy to all stakeholders concerned	Greater awareness of and interest in HIV Counselling and Testing (HCT)	Improved access to HIV testing and treatment and information on care/support
Ability to interpret the 'circle of service' map surrounding the school district	Link the school HIV and AIDS programme to the community strategies	Increased and appropriate open discussions about HIV in the school	Improved link with existing DoE and union HIV programmes to create a holistic approach
	Commit to the implementation of the training at school	Effective collaboration with support services that provides access to HCT, care, treatment and support	Reduced risk of HIV at school for both educators and learners
	Disseminate knowledge and skills in addressing HIV and AIDS issues to other staff and learners	The attitude shift among learners towards making informed choices about health and sexual behaviour (including living positively)	Increased integration with all support organisations and other departments within the Tshwane South District
	Conduct an HIV and AIDS prevalence survey at school		

Step 3: Design and conduct a survey

This third step was conducted to identify those SMTs who applied what they had learned at the FPD training with greatest impact or success, and those SMTs who did not apply the learning, or those who tried to apply the learning but made no worthwhile impact. A survey was done to find the answers to these questions. This was therefore the quantitative data collection phase of the SCM. To this end, a *quantitative technique was used to collect data* in order to sort, without error, data pertaining to those SMTs who were most successful and those who were least successful for the purpose of interviews. A questionnaire to survey SMTs was designed for this purpose. A survey is defined as a non-experiential way of collecting data from a pre-determined population either by a designed tool such as a questionnaire to gain credible and valid answers to the research questions (Kelley, Clark, Brown & Sitzia, 2003:1). The entire process of designing and conducting the survey followed six basic steps which, according to Brinkerhoff (2006:85), are essential for designing and implementing an SCM study.

- ***Basic step 1 Determining the survey population***

  This step seeks to determine and delineate the population to be used in the study. As pointed out above, Brinkerhoff (2006:60) views this as involving the identification of the research population, setting specific criteria for its inclusion in the study, and the population's demographic factors, such as the job roles, the geographic location and the time span that has elapsed since training was conducted. In this regard, Pearman (2009) suggests that when identifying the survey population, one thing to keep in mind is where to find this population and how to access them.

  In this study, the population constituted all the SMT members who completed the FPD training on the management of HIV and AIDS at schools in the Tshwane South District in 2010. These SMT members constituted the participants in the study, and were from public primary and secondary schools in the Tshwane South District. Both categories of participants were treated in the same way by using a one-shot survey

format since the FPD training was tailored to produce the same impact regardless of the school level of operation of each participant. A one-shot quantitative survey (refer to Appendix B) was therefore carried out to identify success and non-success cases. Dyer (2006:50) points out that one-shot surveys produce data that are collected from a single sample drawn from the population of interest.

In this study, the population was fairly homogeneous and consisted of SMTs. There are 126 primary schools and 55 secondary schools in the district. With the FPD requirement of three participants from each school, it was projected that 460 SMT members would attend the training. However, I found that only 80 SMT members had successfully completed the training intervention. On the question of how many participants should be surveyed, Brinkerhoff (2002:125) suggests a cut-off point of forty to fifty participants for the SCM evaluation. He reasons that "… there is little to be gained from drawing samples for the survey when conducting a success case inquiry", because SC surveys are typically very brief and take respondents less than three minutes or so to complete (Brinkerhoff, 2006:89). For this reason, it was decided to survey all 80 participants. At this stage it is important to restate the intent of this single-purpose survey. According to Brinkerhoff (2002:103), this survey has the function of simply identifying the most and least successful participants in a programme from among all the participants.

To give the participants enough time to effectively apply their learning from the FPD training, the survey was carried 13 months after the training. This time frame, according to Brinkerhoff (2006:88), is sufficient for one to effectively apply training and does not allow the survey to extend too far back in time. For this reason, and considering other job profiles of the SMTs, twelve months after the training was regarded as adequate for them to have applied their learning

experiences. The authenticity of their experiences would be based on their stories as is inherent in the SCM.

- ***Basic step 2 Planning the survey access, distribution, and returning processes***

  This step details the route taken to distribute, administer and retrieve the quantitative survey tool to the research participants. Before distributing the survey tool to individual respondents, a request to conduct the survey was made first to the Gauteng Department of Education Head Office (see Appendix C) and then to the Tshwane South District Offices (see Appendix D). The survey tool and all covering letters were distributed in hard-copy format since most of the schools and the respondents did not have Internet access, so the survey tool could not be sent electronically. This also applied to the collection of the survey tool. In order to increase the return rates, the researcher collected the survey tool personally from the respondents two days after it had been distributed.

  In order to solicit participation, the survey tool was accompanied by a consent form (see Appendix E) which also served as a covering letter. This introduced the researcher and the research study leader, described the purpose of the survey, indicated the time needed to complete the questionnaire and guaranteed confidentiality. I appended an original signature in ink in order to personalise the consent form. I then sent the covering letter to the school principals and School Governing Bodies (SGBs) of the potential respondents detailing the purpose of the study and how the results would be used (see Appendix F). Apart from the consent form, I submitted the letters of permission signed by the Director of Tshwane South District (see Appendix G) and the Chief Education Specialist Research Coordinator from the Gauteng Department of Education's Head Office (see Appendix H). Appendices G and H served as consent from the schools' gatekeepers to conduct the research. This also informed the participants that there would be no

risk from their participation in the survey. However, the respondents were free to decide whether to participate in the survey or not as shown in Appendix C.

- ***Basic step 3 Determining the nature and scope of data the researcher must gather***

  For purposes of this study, the data required as propounded by the SCM is firstly the quantitative determination of both success and non-success cases. For this reason, the data required was single-purpose in nature. Brinkerhoff (2006:91) describes this as data gathered only to distinguish between the high-success and low-success trainees from the rest of the research population. The result of the survey should therefore be able to give quantitative estimates of the extent of the FPD training impact at schools within the Tshwane South District, and to enable conclusions to be made regarding its effectiveness.

- ***Basic step 4 Constructing the survey items–using the impact model as reference***

  The survey tool, as depicted in Annexure B, comprises four items that seek (Brinkerhoff, 2006:31) to gauge the breadth or extent of learning application in order to determine the numbers of SMTs who represent success and non-successful cases. In short, the survey items were constructed to show the extent to which the SMTs applied the FPD training outcomes indicated in Table 4.2, and the extent to which the application brought positive results.

- ***Basic step 5 Identifying a scoring scheme***

  The researcher had to design a system to sort through the questionnaires in order to determine the success and low success cases. The system was designed to meet the requirements of what Brinkerhoff (2006:96) regards as a *scoring scheme*. He states: “In this step you determine how you would score the returned instruments and

how you would determine what sorts of responses constitute success or lack of it".

The scoring scheme designed is depicted in Table 4.3. According to the scheme, a successful SMT is the one that made choice (a) for any learning application in items 1, 2, 3, 4; 6 and 7 of the survey questionnaire *(*see Appendix B*)* and choice (a) or (b) in item 5. The non-success SMTs are those with no (a) choice in items 1, 2, 3, 4, 6 and 7, but response choice (b), (c) or (d) in the same item, and choice (c) or (d) in item 5. Respondents who gave contradictory responses were contacted telephonically to get more information with regard to their responses in an effort to place them either in the success or non-success category.

Table 4.3 Response and of scoring the survey for items 1, 2, 3, 6 and 7 in the questionnaire

Response	**Score allocated**
a) Yes, with clear positive results.	3
b) Yes, but have had no clear results yet.	2
c) Not yet, but I expect to do this.	1
d) I don't have any intention of doing this.	1

The scoring scheme indicates that the success category in the application of the FPD training should have achieved the programme's intended outcomes. The choice of (a) in each item means that the respondent obtained a score of 3, which is the highest score in the scheme. Any other choice in each item means that the respondent falls with the non-success category. Item 4 indicates the extent to which the SMT in a particular school had buy-in to the implementation of the FPD training. This item reflects to what extent the participants managed to

involve other colleagues in the same managerial position in his or her school. The score was allocated according to their level of commitment in the implementation of the FPD training, and Table 4.4 shows the scoring scheme of this item.

Table 4.4 Response and scoring for item 4 of the questionnaire

Response	**Score allocated**
The SMT is interested in the programme and is fully committed to its implementation	3
The SMT fully understands the importance of the FPD intervention, but has not fully committed to its implementation	2
I think the SMT is somewhat committed to the implementation of the FPD intervention	1
The SMT has not committed at all to the implementation	1

As stated in the preceding paragraph, responses (a) and (b) of item 4 are separated by a thin line. The choice of (b) implies that the respondent had involved other SMTs in the implementation of the programme, but they had not yet fully committed to the programme implementation. In this regard, response (b) cannot be given the same score as response (a) in item 4, and this implies that choice (b), (c) or (d) signifies non-success while choice (a) in the same item signifies the high-success category. A score of (1) was allocated for responses (c) and (d), which fall within the non-success category.

- ***Basic step 6 Distribution and follow-up on a survey***

  In this step, the researcher prepares for the distribution of questionnaires by, among other things, getting permission from the stakeholders relevant to the study, and thereafter distributing the questionnaire (Brinkerhoff, 2006:98). These requirements were fulfilled as outlined in step 2 above. The questionnaires were personally collected from each respondent a day after the delivery at their schools. This process was preceded by phone calls to the participants to notify them about the distribution. A list of names with cellphone contact numbers of the SMTs who attended the FPD training was used for this purpose.

  The letter of permission from the GDE Head Office and the Tshwane South District Office, together with the consent form and the letter to the school principals were part of the distribution. The questionnaire was distributed as hard copies to 80 SMTs who had successfully completed the FPD training. It took 10 days to distribute the questionnaires. Follow-up was done to remind the respondents about the completion of the questionnaires and the collection of the questionnaire in the early hours of the day (between 8:00–9:00).

  Due to the personal distribution, administration and retrieval of the completed questionnaires, the return rate of the questionnaires was 100%. However, of the retrieved questionnaires, not all were usable for analysis purposes as illustrated in Figure 4.3.

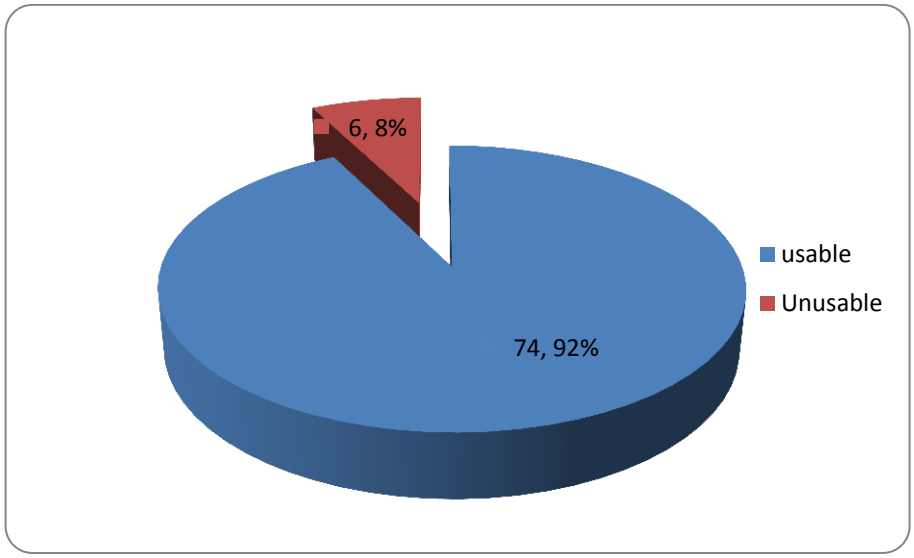


Figure 4.3 Status of retrieved questionnaires

As illustrated in Figure 4.3, of the 80 questionnaires, 74 (92.5%) were usable and thus accepted for analysis, and 6 (7.5%) were not and were thus rejected. Of the usable questionnaires, it was found that 38 (51%) were completed by female SMTs while 36 (49%) were completed by male SMTs. Figure 4.4 presents this analysis.

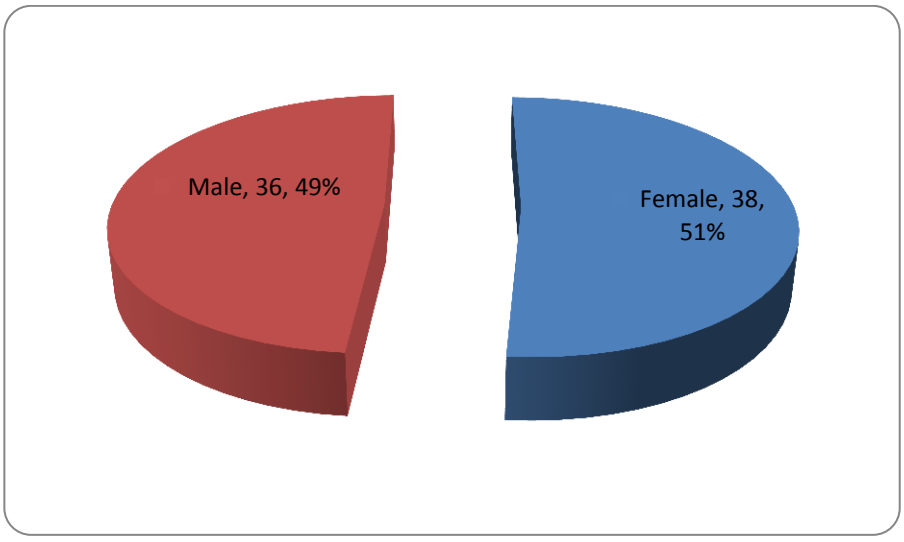


Figure 4.4 Analysis of survey data according to gender

This figure indicates that the numbers of female and male SMTs who participated in this study were marginally different. This narrow margin of two indicates an equal split of particpants in terms of gender.

Furthermore, the demographic analysis of the questionnaires showed that 71.6% (n = 53) of the SMTs were from primary schools while 28.4% (n = 21) were from secondary schools.

Brinkerhoff (2006:104) directs researchers in the SCM survey to sort scores into categories that define varying levels of success or applications that led to different sorts of impacts. To this end, I sorted and loaded the questionnaires into two categories, namely successful participants and non-successful participants. Fifty-one (69%) participants reported that they had effectively implemented the learning outcomes of the FPD training. Thus this group was considered to fall within the successful category. Conversely, 23 (31%) participants indicated that they had not implemented the FPD learning outcomes and as a result, they fall into the non-success category. Figure 4.5 shows the rates in the success and non-success categories.

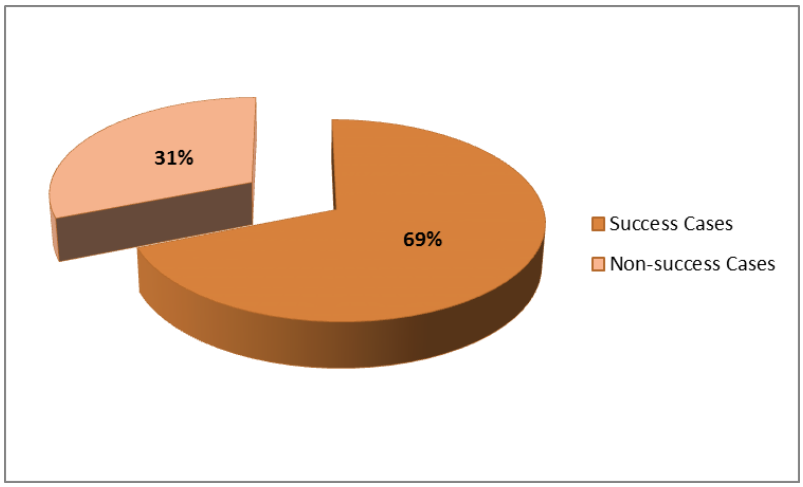


Figure 4.5 Success and non-success cases

Since a quantitative survey in the SCM study seeks to identify the respondents with whom follow-up interviews could be conducted (Brinkerhoff, 2006:101) to validate the assumptions or performance claims, the participants from the success and non-success categories were identified by comparing performances with the set cut-off score,

and not by the mathematical reduction or central tendency measures as is the case with the typical quantitative survey.

After identifying the success and non-success cases, participants were selected for in-depth interviews to determine the impact of training and therefore the effectiveness of the management of HIV and AIDS at schools. In this regard, Brinkerhoff (2003:135) asserts: "… the approach you use to identify interview candidate is determined by the overall purpose of the study".

In this study the successful category comprised 51 participants. Therefore a simple random sampling of 29% (15 of the 51) of the success cases was considered sufficient to represent performance that is reliable, valid and unbiased through an interview, which is a proportion recommended by Brinkerhoff (2006:105). Random sampling is a selection of subjects from a population in such a way that every member of the population has an equal chance of being selected (McMillan and Schumacher, 2001:599). In this study, all the participants in the high success category had an equal chance of being selected for interviews. The chances were greater for those who supplied their contact (cellphone) numbers and indicated their interest and willingness to be interviewed. The same procedure of simple random sampling was used to select 26% (6 of 23) of the non-success participants.

All the potential interview candidates were informed by telephone of their performance results from the survey, and appointments were made with them, which laid the ground for the next SCM step.

Step 4: Design and conduct a success case interview

This step, according to Brinkerhoff (2002:38), produces the most and richest information for the SCM study. In this study, as mentioned in the preceding paragraphs, the researcher sought to gather data about the effectiveness of the implementation of the FPD HIV and AIDS programme by defining, from their stories, participants' perceptions, opinions and feelings about their application of

the programme. To uncover such information, interviews were conducted with the sampled success and non-success population as discussed above. Brinkerhoff (2002:38) states that interviews must be conducted with the aim of capturing and documenting various and personal ways in which a programme has been or is being implemented in an organisation. In this study, telephonic interviews were used as recommended by Brinkerhoff (2005:96). The telephone interview is regarded as an accepted and well-studied approach that produces rich, detailed, vivid and high-quality results (Novick, 2007:2). Furthermore, telephone interviews could be used because of the easy access of participants to high-technology equipment available today. A digital voice recorder was used to record the telephone conversations with the interviewees. This was done, as recommended by Morgan (2012:1), by turning on the cellphone speaker and placing the digital recorder's microphone beside the phone before the calls were made.

Individual telephone interviews were conducted with 15 SMTs considered to be success cases and 6 SMTs who were found to be within the non-success category. In order to ensure the highest reliability of the study results, the interviews were conducted by the researcher alone as suggested by Brinkerhoff (2006:121). This eliminates the burden of identifying and training of interviewers (Boyce & Neale, 2006:6). An advantage of this approach is that I had already gained experience of conducting interviews from my Master's dissertation, where I also used the SCM.

Each interview was allocated 90 minutes for preparing, completing the call, taking notes and thoroughly reviewing the interview (Brinkerhoff, 2006:121). Specifically, the length of the actual interview was 35 minutes for the success cases and 10 minutes for the non-success cases, which is a time frame recommended for an SCM study (Brinkerhoff, 2006:121).

An interview protocol was developed for conducting the interviews. Interview protocols (Boyce & Neale, 2006:4) are rules that guide the administering of the interviews. The interview protocol developed contained three components of a success case study, which, according to Brinkerhoff (2002:38), are firstly the

overall questions the study aims to answer, and which essentially describe what the study intends to explore (see Section 1.2). The second component was five success case interview buckets and two non-success case interview buckets with core questions for each bucket (see Appendix I and Appendix J**)**. The third component was additional probes which were located beneath each core question. Furthermore, the interview protocol developed for both success and non-success cases used what Brinkerhoff (2006:120) refers to as the elements of success and non-success interviews, which are:

- opening
- probing and documentation
- identification of support factors (for success cases[4]) or identification of hindering factors (for non-success cases[5])
- final exploration and resolution of causal issues (for the success case interview[6])
- identification of follow-up needs
- closing.

These elements are designed so that the interview flows easily from the beginning. According to Brinkerhoff (2003:38), this is done to ensure that all aspects related to the core questions, with the intention of filling the buckets with correct information, have been explored. To achieve this, I developed and asked the respondents semi-structured, open-ended questions to clarify the core questions. When conducting the interviews, Brinkerhoff (2002:141) suggests, it is useful to imagine the process as a "bucket filling" process. For the success case interviews, the interviewees were asked core questions as

[4] Success performers indicate environmental factors that helped to apply the learning.
[5] Non-success performers indicate factors that contributed to their inability to apply the learning.
[6] Success performers should be asked whether the results they achieved were/are due to the training impact.

illustrated in Figure 4.6 so that they could expound on the subject so that each bucket could, as it were, be filled with scientific answers.

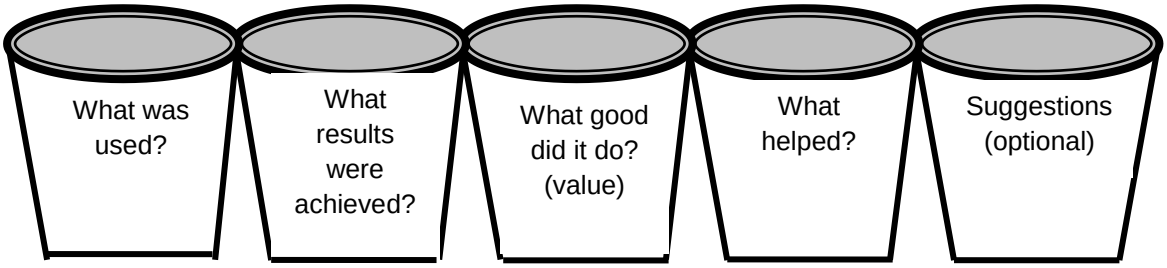


Figure 4.6 Success case interview buckets (Adapted from Brinkerhoff, 2003:142)

The success case interviews were conducted first. As illustrated in Figure 4.6 above, the success case interviews consisted of five core questions. In responding to these questions, the participants were required to give answers that could, as it were, stand up in court by, for example, providing evidence of the success claim for the researcher to judge whether they really belong to the success pool or not. To elicit this information, additional probes located beneath each core question were used to probe deeper and gather, from the stories, evidence of success.

A similar process was used with the non-success case interviews. Similarly, the interview buckets consisted of core questions, two in this case as illustrated in Figure 4.7.

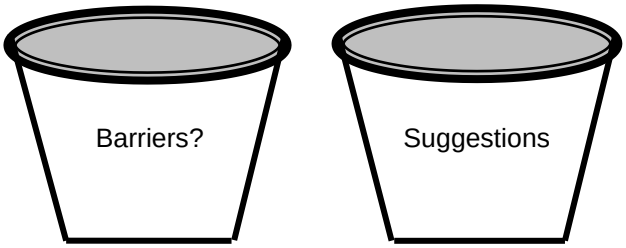


Figure 4.7 Non-success case interview buckets (adapted from Brinkerhoff, 2003)

The two core questions sought to determine, through the narration of stories, barriers to the implementation of the FPD's HIV and AIDS management

programme at the participants' schools. The participants who belonged to the non-success category had to justify their performance by filling the buckets with information that revealed impeding factors against the successful implementation of HIV and AIDS management at their schools, as well as providing suggestions on what could be done to ensure or improve the implementations of the HIV and AIDS management programme at their schools.

The interviews were very useful as they provided information through story-telling as recommended by Brinkerhoff (2006:171).

Finally, the last stage of the interview was to document the true success stories. In this regard Brinkerhoff (2006:126) states:

> *… the interview process ends with formalising and documenting the Success Cases you decide to include in you final report. This may be all of the Success Cases you find, or it may be only a selected few that best illustrate and 'tell the story' of the innovation you are studying …*

This phase therefore culminated in the documentation of the success and non-success stories (see Chapter 5). All the documented key findings were communicated to the key stakeholders namely, the FPD, the Tshwane South District ESS unit and the SMTs interviewed. A detailed description of such information is given in Chapter 5.

Step 5: Formulate conclusions and recommendation

Conclusions and recommendations are designed to summarise and bring together the main areas covered in the study, which might be called 'looking back'. They are followed by final comment(s) or judgement(s) based on the significance of the findings, as well as making recommendations and speculating on future work (Academic Phrasebank, 2010). For the SCM study, Brinkerhoff (2003:32) points out that this step requires the researcher to determine key findings or 'facts' about the results of the study and to draw meaningful conclusions and recommendations that will help to improve the impact of the training. Therefore I have drawn conclusions to this study (see Chapter 6) according to the major SCM conclusion framework in determining

whether the SMTs had implemented the FPD training outcomes at their schools.

4.4 ETHICAL STANDARDS

Although alluded to in part in sections above, it is necessary to detail ethical standards followed in the conduct of data collection. Ethical issues taken into consideration included my own biases, values and personal background emanating from such issues as social, cultural, historical, socio-economic status, for example, the socio-cultural background where HIV and AIDS is generally viewed as a disease emanating from immoral conduct and where people infected and affected by the disease are stigmatised, especially where I might perceive responses as indicative of such perceptions.

To ensure that these issues do not taint the research results, I ensured that all measures to ensure validity and reliability of the findings were adhered to. Probing non-invasive questions were used to validate responses indicating preferable or positive implementation effects. Furthermore, to deal with social, cultural, historical and socio-economic perceptions about the HIV and AIDS disease, these were explained clearly even before interviews were conducted. I also ensured that in conducting interviews, all participants were willing and were assured of all ethical measures attendant to their right of participation and or refusal and withdrawal from the interview process. Because HIV and AIDS-related issues involve sensitive areas, I ensured that participants were fully aware of the confidential nature of certain information, which was also “claused” in the consent form.

Consent to conduct the study was sought and obtained from the Gauteng Department of Education (GDE) Head Office. As is required by the department, a full research application protocol as outlined in the GDE website was followed. This was followed by the necessary protocol applicable in obtaining consent from schools’ immediate authorities, including the District Manager, school governing bodies and principals for gaining entry and access to schools and participants respectively.

An outline of the nature of this study, the contribution that the individual participant would make to the research, and the nature and extent of their involvement was provided to each participant as well as assurance that participants and their schools would only be identified by pseudonyms in the report. Throughout the research process, confidentiality of the subjects was given paramount importance. Participants were requested to sign the consent forms before being involved in this study. The consent forms detailed their level of involvement, how and why they were selected, their right to participate or refuse to, withdraw at any stage if they so wished and refusing to answer questions they were not comfortable with. For purposes of ethical clearance, an application through the formal and prescribed protocol was made to the North-West University Ethics Committee,

Since this study intended to evaluate the implementation of the HIV and AIDS management at schools and did not involve dealing with people infected or affected by the disease, no personal risks to participants were envisaged. Therefore there was no need for any form of debriefing.

4.5 CHAPTER SUMMARY

The processes used for the evaluation set a critical value on the research and acquainted the reader with the systematic designs and logical components that align core elements of the study to produce authentic findings. In this chapter a detailed description of the methodology adopted in the present study was presented to evaluate the effectiveness of the implementation of HIV and AIDS management at schools in the Tshwane South District. The Success Case Method was discussed by looking at its rationale, how it is used, and the data collection method and analysis. The Success Case Method was discussed within the context of the implementation of the HIV and AIDS management programme at schools, and provides conclusions about the success and non-success cases, comprising both quantitative and qualitative outcomes. The next chapter present the findings and results of the study.

CHAPTER 5
DATA ANALYSIS AND INTERPRETATION OF RESULTS

5.1 INTRODUCTION

The aim of this chapter is to analyse the data collected and to interpret such data with the intention of answering the research questions of this study. First the *quantitative data* from the survey instruments will be discussed to provide a descriptive statistical analysis of the learning application of the Foundation for Professional Development (FPD) training by School Management Teams (SMTs) within the Tshwane South District, with reference to the management of HIV and AIDS at schools. Secondly, the results of the most fundamental part of the Success Case Method (SCM) will be reported, namely the *qualitative data* obtained through interviews with the research participants. In reporting the data gathered, the anonymity of the respondents is treated with the strictest confidentiality, thus pseudonyms are used in the report to refer to participants and, in so doing, to ensure that no part of the report reveals their identities.

5.2 QUANTITATIVE DATA: THE BASIS OF PARTICIPANT SELECTION FOR THE SECOND PHASE OF THE SCM

To determine the success and non-success cases as outlined in the previous chapter, a frequency analysis of the telephone responses was carried out to obtain the frequencies of scores for each questionnaire item. These provided a frequency distribution, which Brinkerhoff (2006:107) regards as the most fundamental type of quantitative analysis in the vast majority of SCM studies. Tables 5.1 summarises the simple frequency distribution and percentages of participants' responses to each questionnaire item on the application of the FPD training to develop an HIV and AIDS management programme at schools.

Table 5.1 Overview of responses on the application of the FPD training to develop an HIV and AIDS management programme at schools

Questionnaire items	Application possibilities and frequency distributions							
	I have tried this with clear positive results		***I have tried this but had no clear results yet***		***I have not yet tried this, but am expected to do so***		***I do not have any intention to do this yet***	
	f	**%**	**F**	**%**	**f**	**%**	**f**	**%**
I have applied the FPD training to develop an HIV and AIDS management programme	**52**	70.3	**10**	13.5	**12**	16.2	**0**	0
I have developed the school's action plan for HIV and AIDS management	**54**	72.9	**6**	8.0	**14**	18.9	**0**	0
I have developed a programme that links the school to the community in the fight against HIV and AIDS	**52**	70.3	**12**	16.2	**10**	13.5	**0**	0
I have used the FPD training to impart knowledge and skills on HIV and AIDS management to other staff members and learners at my school	**53**	71.6	**7**	9.4	**14**	18.9	**0**	0
I have used the training to do an HIV and AIDS prevalence survey at my school	**58**	78.3	**10**	13.5	**6**	8.1	**0**	0

The summary in Table 5.1 indicates how the decision to select success and non-success cases for the second phase of the SCM was arrived at. In terms of the frequency analysis, two distinct patterns were distinguishable. Firstly, the majority of SMT members (70.3%) reported having applied the FPD training with clear positive results. A breakdown of responses on items in this category indicates that most SMT members had:

- developed their school's action plan for HIV and AIDS management (72.9%)
- developed a programme that links the school to the community in the fight against HIV and AIDS (70.3%)
- used the FPD training to impart knowledge and skills on HIV and AIDS management to other staff members and learners at their school (71.6%)
- used the training to conduct an HIV and AIDS prevalence survey at their school (78.3%).

Secondly, a significant number indicated having "Not yet tried this, but am expected to do so", as evidenced by the percentage frequencies on the items listed above which ranged between 8.1% and 18.9%. Although these are not very large percentages, they are a cause for concern, mainly because these are mostly above the 10% mark. However, as is characteristic of the SCM, these would be part of the non-success category and in-depth interviews would shed light on the reasons for this. Such responses would also be combined with those of SMTs who had tried to apply the FPD training and had not attained clear results yet.

A summative analysis of the SMTs' responses to questionnaire items indicated a positive overall effect of the FPD training. This is evidenced by the percentage responses on all items, which ranged between 70% and 78%. In this regard, 70.3% (n=52) of the respondents indicated that they had achieved a positive result by applying the FPD training's critical learning outcomes to

develop an HIV and AIDS management programme in their schools and 78.3% (n=58) had conducted an HIV prevalence survey at their schools.

Although the survey results showed 23 non-success cases, there were parts in which some SMTs from this group claimed to have achieved positive results, as seen in the following examples:

- Firstly, the frequency distribution of 70.3% (n=52) means that one SMT member from the non-success cases claimed to have developed an HIV and AIDS management programme at his or her school with clear positive results.

- Secondly, the frequency distribution of 78.3% (n=58) means that seven SMTs from the non-success cases claimed to have conducted an HIV prevalence survey at their schools.

The data in Table 5.1 indicate a general willingness among all SMTs to apply the FPD training to develop an HIV and AIDS programme at their schools, as evidenced by the fact that of the 74 respondents, none indicated “not having any intention to do this yet”. This willingness is also reflected in the responses to the item designed to determine the commitment of SMTs from schools that were represented at the training, as illustrated in Table 5.2.

Table 5.2 Overview of responses regarding the feelings of the trainees with regard to their entire SMTs' overall commitments to the implementation of the FPD training

Application possibility	Frequency	Percentage
The SMT is interested and is fully committed to the implementation of it	**51**	68.9%
The SMT fully understands the importance of the FPD intervention, but has not fully committed to the implementation of it	**15**	20.2%
I think the SMT is somewhat committed to the implementation of it	**7**	9.4%
The SMT has not committed at all to the implementation	**1**	1.5%
Total	**74**	100%

According to the responses in Table 5.2, there was only one group, the success case candidates, that seemed to have instilled confidence in the reliability and dependability of the FPD training in all of their schools' SMT members – hence the level of interest in and commitment to its application and to trying to manage HIV and AIDS at their schools. This group constituted 68.9% (n=51) of the participants. However, 15 of the respondents indicated that although all the members of their SMT understood the importance of the FPD HIV and AIDS management programme at schools, they showed lack of commitment to applying the training outcomes. In addition, seven of the respondents reported their SMTs to be only somewhat committed to the implementation of the FPD training. This suggests that although the FPD programme on the management of HIV and AIDS had commenced at some schools with the expected enthusiasm by SMTs, it had not been followed through. Taken together with the one respondent who indicated that that there had been no commitment on the part of his or her SMT to implementing the FPD training at his or her school, it can be concluded that a significant 23 of the respondents had not garnered enough commitment from their SMTs in implementing the FPD training. These respondents, then, constituted the non-success case candidates on this survey

item and formed part of the overall non-success cases earmarked for in-depth interviews in the second phase of the SCM evaluation.

These success and non-success claims were tested for authenticity and were either rejected or accepted as valid based on the findings or primary data obtained during the interview with each respondent. Findings to this effect constitute the qualitative data and the second and final phase of the SCM evaluation.

5.3 QUALITATIVE DATA ANALYIS

This section presents the findings from in-depth telephone interviews with the research participants as the second phase of the SCM, which will elucidate the degree to which claims of success in the implementation of the HIV and AIDS management programme at school were supported. Brinkerhoff (2006:126) draws attention to the fact that in the SCM qualitative data analysis can be presented either by documenting all of the true success cases found or by selecting a few that best illustrate and 'tell the story' of the innovation being studied. As pointed out elsewhere in this text (Section 4.3.4), only 15 of the 51 success cases were selected for in-depth interviews and documentation in this study. Verifiable evidence from six of the 23 non-success participants also added to the overall findings of this study.

The findings of this study were obtained by managing all the relevant processes involved – from recording interviews, transcription and grouping of textual data as starting points for the inductive analysis (McMillan & Schumacher, 2006:364). Key themes with sub-headings were identified in the textual data derived from the interviews. To support the identified key themes, the 'giving voice' approach was used in analysing the interview transcripts. This means that the interviewees' own words or direct quotations were used, as well as paraphrasing, to achieve empathetic understanding of the meaning that the experiences described might hold for the person(s) concerned (Dyer, 2006:137).

Although Brinkerhoff (2003:32) details the procedure for drawing conclusions based on data collected through interviews, I applied qualitative inductive data analysis techniques, within predetermined categories (McMillan & Schumacher, 2006:369), which were based mainly on the questions outlined in Step 4 of the SCM (see Section 4.3.4 and Figures 4.6 and 4.7). For ease of reading, these are repeated here:

- What was used?
- What results were achieved?
- What good did it do?
- What helped?
- What suggestions can help improve the programme?

These were the success cases and for the non-success cases, the questions guiding the analysis were:

- What were the barriers to the implementation?
- What suggestions can help improve the programme?

This involved the identification of themes or categories, through reading and re-reading of the interview transcripts with the aim of rendering the comprehensive documented contents unequivocal in order to generate “a conceptually rich, intense and contextually grounded account” (Pidgeon, as cited by Dryer, 2006:138).

Based on the analysis conducted, the interview data yielded six categories and accompanying themes as presented in Table 5.3.

Table 5.3 Categories presenting the key areas of the FPD training application

CATEGORIES	THEMES
Application of the FPD training	• Advocacy • Re-emphasising the integration of HIV and AIDS in the curriculum
Results achieved by implementing the FPD learning outcomes	• Establishment of HIV and AIDS committees • Action plan on HIV and AIDS • HIV and AIDS policy development • Development of HIV and AIDS programmes • Personal development
Impact of the FPD training	• Destigmatisation • Reduced discrimination • Increased care and support • Increased HIV testing
Helping factors	• Passion for HIV and AIDS management course • Positive community • Internal support
Hindering factors	• Understaffing • Lack of resources • Lack of implementation strategy • Workload too large • Lack of support from other SMT members • Lack of support from the district • Reluctant educators • Location of the school learners • Time
Suggestions	• More training • Programme monitoring • Resources must be made available • External support • Internal support • Support from the district • Collaborative efforts

5.3.1 Success case stories

5.3.1.1 Theme 1: What was used?

This category corresponds to the first question relating to what was used. It was found that *advocacy, information dissemination, establishment of HIV and AIDS management committees* and *re-emphasising the integration of HIV and AIDS into the curricula* were the key activities used. Thus the success of the implementation of the FPD training was really a function of the approaches used subsequent to the training. These approaches proved to have integrated all the processes involved to attain the proximal outcomes of the training and to generate effective on-the-job performance with regard to the management of HIV and AIDS. Nevertheless, the degree of the application differed among schools. *Advocacy* and *information dissemination* were evidently applied through meetings involving the community and staff members as outlined below.

- **Advocacy**

Almost all the success case performers gave feedback from the FPD training through staff meetings with their colleagues. This became the baseline and became an effective advocacy strategy undertaken in the initial and early phases of the implementation of HIV and AIDS management at schools. Most heads of departments reported that they had given feedback first to their entire SMTs before disseminating it to staff members, while principals reportedly used staff meetings for giving such feedback and for advocating for HIV awareness and management. For example, Mr Height, a school principal, reported that giving feedback during the staff meeting was the only and best strategy to apply after the training. He stated:

> *Ja, we all came back to the school and introduced that to the staff during* (the) *staff meeting. This was the best way of engaging educators so that they could understand the importance of the programme and how it should be implemented. That was our starting point ...*

Another participant, Ms Get-Down, mentioned that meeting first with other SMTs was a helpful strategy to get their buy-in. She acknowledged:

> *First of all, I started by requesting a meeting with all the School Management Team members, through the Principal of course, so that I could give information during our SMT's morning briefing. By so doing, all the SMTs, including the Principal, would understand the programme much better, so much so that when all other teachers were to be involved, as SMTs we would be at the same par and* [be] *able to push the programme forward.*

It is also noteworthy that at schools the meetings included members of the School Governing Body (SGB), especially because their role would be critical in the development and approval of the HIV and AIDS management policy, including the establishment of HIV and AIDS committees or Health Advisory Committees as directed by the NEPA (see Section 3.5.1). Mrs 45's story related specifically to the need to involve the SGB for her to apply the FPD training with success. She commented in this regard:

> *What I did after the training, I got back to school, and then I organised a short meeting with the teachers where I gave feedback shortly after the training. And then from there, I organised the meeting with the SGB where I disseminated information and requested permission from them to hold some activities related to HIV.*

Participants also indicated organising community meetings and information dissemination through existing community structures and programmes, including dissemination through pamphlets. This type of involvement supports the claim of having developed, with clear positive results, programmes that link the school to the community in responding to HIV and AIDS. The fact that, for instance, PLWH were roped in and were willing to be part of the activities related to HIV and AIDS management attests to the successes recounted by the success case participants. This involvement of the community was aptly described as follows by one participant, Ms Smile:

> *... we also look for partners who will be helping us. The NGOs and we looked for Social Workers who would come to our schools whenever we wanted them. And then we have the NGO, the Future Family NGO ...* [and] *we have the nurse who comes to our schools whenever we ask her.*

Further, as stated by Mrs Dear, this type of involvement was not limited to direct meetings with people only:

> *... and even pamphlets, I went as far as the Department of Health to consult. I went and got, eh, eh some pamphlets, some books, and I even have some here which I keep to give to the learners to give to their parents.*

The involvement of PLWH as part of the community was also used to good effect and was found to play a major role in yielding the intended results of the FPD training. For one, it demonstrated the reality of HIV and AIDS in communities, which also helped in terms of destigmatisation, reducing discrimination based on HIV status and encouraging voluntary counselling and testing. At least, learners, educators and community members could, while learning to see that the disease is real, also see that living with HIV was not necessarily a curse or a death sentence as previously and generally believed. The following comment from Ms Table 60 demonstrates this:

> *What I can say is that usually we, during HIV awareness days, do call the parents, we call the Department of Health, we call people who are infected, people who are affected. You know, we try the best ... And then those people would explain their sickness to them and they encourage people to go and test, you see ...*

In addition, it was noteworthy that non-professional staff members were also involved in activities relating to the programme. Their involvement was found to be of assistance in achieving the learning outcomes of the FPD training and in implementing HIV and AIDS management at schools. All success cases confirmed having engaged all staff members at their schools, albeit to varying

degrees among schools. Mr Best actually laid emphasis on this involvement and stated:

> *... there is a need to actually involve other people that I work with in this matter. The groundsman has been elected to be part of the HIV and AIDS committee. Everyone can now at least see that HIV is an issue for all of us*.

Mrs Reality emphasised the building of a common vision by involving everyone in the management of HIV and AIDS. She stated:

> *... every time we meet to discuss and assess progress of the HIV and AIDS programme in this school, we call the clerk, the cleaner and one of the security personnel to join us. They are part of us. And by so, we are able to have a common vision with regard to, to, eh, this thing* [sic], *the management of the disease …*

In the same way, Mr Standing commented:

> *If we don't involve these people, people such as the principal's secretary and all these others, the cleaners and gatekeepers, we wouldn't have managed to reach this far. They present good ideas that might sound stupid, but they are important. In my school, it is the admin clerk and the life orientation educator who are pushing this programme, and we getting outstanding results.*

In addition, Mrs 45 commented:

> *After the workshop nê, we workshopped other staff members to give them that opportunity. So, everyone came up with his or her problem in the classroom and whatever he or she experienced concerning the death disease* [sic]. *So we planned together which activities we can do …*

To this end, the success case performers were found not to have ignored any of the aspects emphasised during the training. For example, when asked about the part of the training which they had used most to manage HIV and AIDS at

their schools, all 15 SMTs shared similar sentiments on the integration of aspects presented in the training modules. Mrs Fly best articulated these sentiments when she stated:

> *... for me, all modules were very, I mean, very important. No way would one manage HIV without referring to all of them. I still believe that all the aspects were important and easy to apply, especially after having undergone the assessment part of it.*

- **Re-emphasising integration of HIV and AIDS into the curricula**

The integration of HIV and AIDS into school curricula is an issue that has always been part of the campaigns relating to HIV and AIDS and is addressed in the NEPA (see Section 3.5.4). However, training for educators to enable them to do it is pivotal to its success. With regard to the success case participants, it was found that they actually re-emphasised the need to integrate the HIV and AIDS topic into all curricula at schools. It was found that successful participants take the HIV and AIDS topic not as a stand-alone entity in making the goals of the FPD training achievable. They had been made to realise the importance of putting more emphasis on the integration of HIV and AIDS into school curricula. Therefore Learning Areas, especially Life Orientation (LO), were used as entry points to disseminate basic knowledge of HIV and AIDS. It was found that the success case performers actually took the lead in the integration of this basic knowledge into their classes. In this regard, Mr Debit noted that in order to apply the FPD learning, it was imperative to have HIV and AIDS activities through LO. He indicated:

> *… we allow our learners to use communication media such as posters, and they also do presentation and drama on HIV and AIDS for marks. But the drama is mostly used in Grade 6 and Grade 7 learners. You know, and it becomes very interesting when they explain what their posters are all about to the entire students, especially during morning assemblies on Fridays. We do give the Life Orientation educators to let their kids to exhibit their work. For the drama, is very much edutainment.*

Furthermore, the SMTs managed to apply the FPD learning outcomes by putting more emphasis on the integration of HIV and AIDS into school curricula. This was done, among others, by inviting professional nurses to address learners about certain modules that speak to HIV and sexual health, as well as to productivity. However, the information given was in accordance with the age and grade of learners. Mrs 45 stated:

> *… and this year, what we did, we invited, eh, the community nurse to come at the school and be part of programme because we are busy educating our learners about HIV and how to accommodate people living with HIV. The nurse addressed the learners. In fact, they started with learners in Grade 2, Grade 3, Grade 4 until Grade 7.*

Various ways of dealing with HIV and AIDS topics in all grades were used. Participants largely stressed that educators were required to be factual, honest and realistic about the subject. For example, in the senior phase, learners were given group work activities on HIV and AIDS, such as classroom discussions, as part of their portfolio assessment tasks. As the activities were meant for their portfolios, they were all obliged to participate to get marks. While this served assessment purposes, it afforded learners the opportunity to grasp the reality and implications of the HIV and AIDS epidemic (see Chapter 2). In this regard Mr Height commented on their approach:

> *What we did is that our Grade 8 and Grade 9 were treated differently from the FET learners. We gave them topics to write on or discuss in group work whereby they would discuss and report to other groups. Topics such as: How, eh, eh, does teenage pregnancy and HIV affect a child's life at school and life at home? How do I live with somebody who is HIV-positive? Topics such as: How to prevent myself from getting HIV.*
>
> (In my case) *I have a class of 50 learners and I divided them into groups of five. I gave each group different topics and they must report. One would be a scriber, one would report and others would make inputs and assist to answer questions from other groups. I would be there to rectify*

and recommend good things regarding HIV and AIDS. So their feedback was assessed and each group received marks, and those marks appeared in their portfolio files. Through these discussions, we were able to close gaps that might condone things such as discrimination and unsafe learning milieu and encourage a safe and caring environment where learners can learn and teachers teach regardless of their HIV-positive status. This was a good entry point for having us as school managers to get everyone at school to see HIV as a virus that can be prevented and managed.

To show the constant emphasis in teaching and learning about HIV and AIDS at schools at the FET level, Ms Table 60 stated:

… we combine all the Grade 12 classes, and our HIV programme coordinator, who is our LO educator, to address the learners on HIV and AIDS and how it is affecting us. We avoid having different educators teaching the same thing. It is good to have the LO educator to have such kind of an assembly. Same applies to Grade 10 and 11. To show the importance of the HIV and AIDS concept in our different learning areas, there would be questions on HIV and AIDS which learners should answer during tests, especially in learning areas such Life Sciences, Geography, Life Orientation, Economic and Management Sciences. This kind of strategy is working because learners and teachers are able to discuss HIV and AIDS with no prejudice.

It was clear from the success performers' accounts that re-emphasising the integration of HIV and AIDS topics into the curricula assisted them in achieving some notable outcomes. It is significant that this reportedly assisted in making HIV and AIDS discussion easy, especially since the learners' developmental ages were accommodated. But most notable is the fact that this extended beyond the classroom into assembly addresses by professionals other than educators, like nurses, whose experiential and anecdotal information and knowledge would make the reality of HIV and AIDS accessible equally to young minds and adults.

5.3.1.2 Theme 2: What was achieved?

A number of successful achievements in the process of managing HIV and AIDS at schools were reported. It was found that all success cases managed to get useful and meaningful results due to the implementation of the FPD programme on the management of HIV and AIDS at schools. To be precise, five major positive results were achieved:

- **Establishment of HIV and AIDS committees**

All 15 success case SMTs were found to have established HIV and AIDS Committees at their schools as a result of the FPD training. This initiative is in line with the National Policy on HIV and AIDS (see Section 3.5.1), which requires schools to have a body that will coordinate HIV and AIDS programmes. However, the constitutions of such committees were found to differ from school to school although the objective remained the same, namely to take charge of HIV and AIDS programme initiatives or activities. In this regard, Mr Debit pointed out that at his school the committee comprises two Life Orientation educators, one parent from the SGB and one head of department. The committees had different compositions. For instance, Mr Lager said:

> *… we have me as the coordinator; we have a nurse who comes to our school whenever we ask her. And then we also have the principal and the HoD in the committee. For the Foundation phase and the Intermediate phase, we also have a teacher who liaises with the coordinator and the principal.*

It was notable that the success case performers attempted to make sure that their school committees included other stakeholders, which means that success case performers realised the importance of integrating and bringing many hands together to produce effective responses to HIV and AIDS. For example, from the comment above by Mr Lager, it is clear that besides social aspects, SMTs realised the need for schools to focus on other aspects of HIV and AIDS, such as therapeutic intervention for PLWH, hence the involvement of health professionals such as a nurse. An important aspect of HIV and AIDS

management committees is the fact that they drive activities pertaining to HIV and AIDS management, from the drawing up of policies to the planning for activities attendant on the entire management process.

- **Action plan on HIV and AIDS**

Due to the application of the FPD learning outcomes, the success case performers, together with their school HIV and AIDS management committees, were able to design their school action plans which then enabled them to plan HIV and AIDS programme activities in responding to the epidemic. Over and above this, it was found that though the training helped in carrying out the task of action plan development, there was also a need to bring in experienced people so as to have reliable plans of action. As a result, most of success case performers confirmed that their schools had a clear picture of what actions to take, who would carry out such actions, when the action would take place, and what resources would be needed in carrying out such an actions. This was evident in comments such as:

> … *what we did, we checked around as a committee, and I think it was last year sometime. We had a guy from an NGO. I can't remember his name. But the other committee members know who he is. We, we went with him through, and I think, it was three sections*. *We were meeting to develop an HIV and AIDS action plan, and we developed one* – Mrs Longhair.

When asked how the action plan was helping her to manage HIV and AIDS at her school, Ms Smile responded:

> *… I think it helped us in a way that we always look into issues concerning HIV, and try to improvise where we can … .We identified, you know, some issues or let me say challenges that need to be addressed and, you know, we are able to prioritise them and have plan-based actions.*

The following story by Mrs 45 also illustrates this achievement:

> *... we were for the first time able to come up with a short programme, because it was for the first time we had to put in some few activities that we would manage to achieve over the year. So what we did was to put down those activities in the form of, like eh, an action plan with activities, with who will be responsible for what, and when are we supposed to achieve what. So the activities that we targeted was like eh, the candlelight, the World HIV/AIDS day. But besides that, we also thought of checking out in the school whether we have learners who are victims* [sic] *of HIV. Fortunately, we were able to identify a few of them, of which we were thinking of trying to assist. Eh, so far, we, in the action plan, agreed that these learners are going to be assisted, their households would be visited and we would check out how the situation is, and then we would try to assist from there.*

Mr Best also commented:

> *... now, everybody, including learners, is aware of what is taking place at the school with regard to HIV activities. And I feel delighted about that, and all is attributed to the training that we attended*.

Mrs 45 mentioned how the action plan was developed:

> *... so we sat together and then we put our heads together and tried to agree on exactly what is it that we can do. Something we can be able to achieve. Something that is small enough for us to achieve. So I think with their commitment* [referring to the HIV and AIDS Committee]*, and the collaboration we were able to develop what we have so far*.

It was pleasant to find that SMTs were able, by developing action plans, to design HIV and AIDS programmes that helped them to manage the epidemic effectively including, for example, providing care and support to people living with and/or affected by HIV and AIDS. As pointed out earlier (see Section 3.6.2.3), by achieving this result, that is, developing school action plans, SMTs demonstrated the ability to develop realistic, specific, measurable, achievable, realistic and time-bound objectives in managing HIV and AIDS.

- **Development of an HIV and AIDS policy**

All 15 success case SMTs were able to have their schools develop and/or make improvements in their school HIV and AIDS policies, with some schools being able to meet the required standards (see Section 3.5.4) and, most important, emphasise the implementation of the programme. It was also notable that in almost all success cases the school policy development was done with the involvement of recognised structures such as a school HIV and AIDS committee. The policy development was reportedly a cooperative initiative which was then communicated to learners and educators, and also recognised conducts and practices to manage effective responses to HIV and AIDS, as well as health promotion activities at the schools, as highlighted elsewhere in this text (see Section 3.6.1). Mr Tall's comment gives pertinent expression to these findings:

> ... *when we came back from the training, we sat with the established committee, we had to review the, eh, HIV and AIDS policy. And we thought of, hmm, most of the things that are in there are not important. So we decided to make it more lively so that it becomes suitable for us. We wanted to contextualise it so that we could be able to live by it.*

Mr Tall further commented that, as a committee, they found it important to explore and state clauses that entail what they needed to acquire, like first aid kits, surgical gloves at the school, and to make sure that each classroom had a bucket of clean drinking water and a basin of water for learners to wash their hands in. These committee deliberations included discussion about keeping toilets clean and giving talks occasionally at prayer assemblies in the mornings to encourage the learners to wash their hands after using the toilets, not to touch blood, no to discriminate against other people and so forth.

The majority of the success case performers seemed to have demonstrated the capacity to communicate their policies to learners, educators and parents, which of course was one of the skills with which the FPD training had equipped them (see Table 3.1). They made the policy documents available to everyone,

in hard copy or electronically, and they also went so far as to make the policies available in languages other than English, especially at schools where English is not the first language of learners. Mrs Fly commented in this regard:

> *We tried to put that* (HIV and AIDS policy) *electronically, we typed it and then we printed a copy. We then distributed copies to the teachers. Some of the parents were struggling to read policies, so we requested one of the committee members to translate it to the mother tongue. The policy is also available in the principal's office and also in the file of the HIV and AIDS committee. Initially, we had a policy but never communicated to others. So this training brought improvement indeed*.

Notwithstanding the fact that the policies were now accessible, the SMTs did not seem to have had time to explain the implications of the policy provisions to learners, educators and parents. Not even a single success performer proved to have done that. One of the skills that the FPD training provided was to equip SMTs with *the ability* to provide and explain the policy to the recipients (see Table 3.1). This shortcoming could also result in stakeholders having copies of the policy but not having a clear comprehension of the contents.

Other SMTs indicated that they had realised the importance of an HIV and AIDS policy at their schools and the weight it carries in managing HIV and AIDS. Some also commented that they had had 'dormant' HIV and AIDS policies before. Due to the FPD training, they had managed to assess and evaluate the existing policies to make them define ways in which they could respond with clear positive results to challenges emanating from HIV and AIDS. Most of them still mentioned the involvement of other relevant stakeholders in developing the policies. Seemingly, policies were previously formulated without adequate knowledge of policy development and, as a result, they were not usable or effective. For example, Ms Get-Down stated that having reviewed their HIV and AIDS policy: "the programme is running and all relevant stakeholders are involved and supportive because they are now part of the policy. We adjusted it together, and it's no longer a one-person thing".

The general impression regarding the development of HIV and AIDS policies is that all success case performers had their policies even before the FPD training. However, these policies had not been evaluated as far as their efficacy and effectiveness in responding to HIV and AIDS is concerned. For example, one of the SMTs members mentioned that:

> *The policy was there but it was in the office, it was not up to standard. And again, not all of us knew that there was a policy for HIV and AIDS in our school … but now everybody is aware and we are achieving good results since it is a binding and guiding document. We know as a school what to do …*

Therefore the effectiveness of the policy can be attributed to the FPD training as the majority of the SMTs demonstrated their understanding of policy development and its application after the training. Furthermore, a point of concern could be raised with the Tshwane South District about what it was that the schools did not do that resulted in ineffective HIV and AIDS policies at schools before the FPD intervention programme?

- **Development of the school HIV and AIDS programmes**

All 15 success case interviewees mentioned that the FPD training equipped them with useful mechanisms that enabled them to develop school plans and systems for the successful management of HIV and AIDS at their schools. Evidently, it was the development of their own HIV and AIDS programme that made the schools supportive and caring, and made them advocate environments in which all learners and educators, regardless of their HIV status, could be treated without prejudice. For example, when asked how the programme was being established, Mr Tall said:

> ... *we have been able to design a programme in such a way that it communicates, eh, HIV and AIDS prevention, care and support as well as messages that promote behaviour change to our people. Everybody is now aware of that*.

This kind of proclamation emphasises how the SMTs, through the FPD training, had managed to develop HIV and AIDS programmes that respond to key challenges for their schools (see Section 2.3). It can again be noted that they were very strategic in making the programmes pertinent to their own circumstances, taking into account factors that constitute requirements for an effective programme for HIV and AIDS management at school (see Section 6.3.2).

Though the programmes are said to be running, little was said about services to other staff members rather than learners. For example, Mr Height indicated that their focus was on learners at the time the interviews were conducted. He further mentioned that "services at moment were learner-based", which view Mrs Longhair concurred with.

- **Personal development**

The findings further reveal that besides enhancing schools' ability to manage HIV and AIDS effectively, STMs who attended the FPD training experienced personal growth and development in terms of attitudinal change and skills and knowledge acquisition, which signifies that the training was, as pointed out by Kritsonis (2005:2), a driving force for change in a desired direction (see Section 1.3). Ms Table-60's story best illustrates this point and captures almost all success case SMTs' sentiments:

> *As an individual, I am really very much thankful for this training because it was in a way, a, a, a wake-up call for me. And at the same time, it was an awareness kind of training, because there were so many things that were uprooted and some we came across in our day-to-day life. But we did not mind. We thought it is part of life. But since I came back from the training I feel, as a person, very much concerned about whatever is happening, especially with our learners. If something is happening or if I see some kind of a behaviour, I become interested and want to know more, you know, of what could be the reason behind such behaviour.*

And I am able to assist skilfully because I am now knowledgeable and empowered.

One of the respondents, Mr Central, also remarked: "... the training was very good. It improved my knowledge on HIV issues. I now know what to do for the programme to run".

5.3.1.3 Theme 3: What was the result or impact?

All 15 success case SMTs were able to justify their claim of success as they reported to have achieved important and positive results due to their application of the FPD learning outcomes. These results can be grouped under the headings of destigmatisation, reduced discrimination, increased care and support, and increased HIV testing.

- **Destigmatisation**

In the context of this study, the concept of HIV and AIDS destigmatisation signifies the school's ability to reduce prejudice and discrediting attributes towards SMTs, educators, learners and other staff members living with and/or affected by HIV and AIDS, with the intention of creating a conducive teaching and learning environment. Therefore, it is encouraging to find that schools have started to devise responses that promote destigmatisation due to the FPD training. This kind of achievement is important because of the impact it has on teaching and learning environments such as schools.

It was found that the FPD training had positively reduced the stigma attached to HIV and AIDS at schools through promoting anti-rejection or anti-exclusion behaviours. For example, learners' attitudes towards people infected and affected by HIV seem to have changed to a noticeable degree. To illustrate this impact, Ms Get-Down commented:

... Ja, you know what, one thing that I have observed nê, possible the learners, they used to tease each other. They know of the neighbours who also got the disease. So, you will hear some of the learners coming to us and say 'this one said my mother is dead because of this and this

and this, all these things nê'. But nowadays, that issue is reduced. They don't dwell much on them. They tease each other but not with issues of HIV.

It was also found that due to the application of the FPD training, schools had experienced such a reduction in the stigma attached to HIV and AIDS that PLWHA could even visit schools to give motivational talks about HIV and AIDS issues, such as prevention, treatment and care. About 73.3% (11 of 15) of the SMTs involved PLWHA to talk about HIV and AIDS topics at their schools, thus, as mentioned by University of California San Francisco (UCSF) (2006:1), reducing the negative attitude towards HIV and AIDS. In this regard, Mr Best responded:

You know what, the guy who came to our school talked about HIV and AIDS to all of us without fear. Educators and learners were not aware that he was living with the virus. But, he was so open and told us that he has been living with HIV for more than 13 years. His address helped my educators and learners to understand that HIV is not a death sentence.

In addition, half of the respondents voiced their opinion that learners became the vehicle of change through drama and poetry whereby they were educated on HIV and AIDS with the aim of, among other intentions, promoting destigmatisation. The best illustration of this is the comment made by Ms Get-Down:

Basically, the use of drama helped a lot. Our learners started to understand that if a person is living with HIV, he or she is still a person. And he or she can do anything that can be done by any other person. What is required is only protection so that others may not be infected. Even poetry, there is this learner who will, mostly on Fridays at the assembly, recite for us. And I'm telling you, if you are living with HIV or you have a family member who is HIV-positive, you will understand that you are not an outcast.

This kind of impact signifies the SMTs' understanding of the need first to deal with issues fuelled by misinformation and misunderstanding which, as a result, can intensify psychological problems of both educators and learners.

- **Reduced discrimination**

It was also found that the FPD training had led to positive change in terms of discrimination against PLWH. All 15 success case SMTs confirmed that they had witnessed a decrease in discrimination since the implementation of an HIV and AIDS management programme at their schools. This decrease ranged from allowing those learners living with HIV to access education like any other learner, to the appointment of people living with HIV. In this regard, Mr Height proclaimed:

> *We were able to get some people to come to school as members of the community to actually, eh, disclose their HIV-positive status to the learners and teachers. And we now look at them as people like us. We even appointed somebody last year to help us in the feeding scheme and with the cleaning of the school. So, to show that we are not seeing them as a threat to ourselves since they are still human beings. And I think that was one thing which makes us feel that the training made strides.*

Mrs Reality also commented:

> *... like myself, I had no, I had no knowledge of how to manage it at school you know. Now I am aware about the confidentialities* [sic]*. Some teachers used to discriminate at other schools. But we must not discriminate, but we must just assist the learners. We didn't learn to be biased ... so that the child or the teacher can feel as part of the school*.

- **Increased care and support**

The success case respondents indicated that the FPD training led to an increase in their care and support for those living with and/or affected by HIV and AIDS. Most of them have provided nutritional, material and emotional support, like providing food, clothing and paying home visits. It was found that

the support and care were not limited to educators only, but that the business sector and other community members were involved as well. In this regard, Ms Get-Down illustrates:

> *As a school, we are now able to support and to look after those who are infected and affected. There are few learners that we were able to establish that are victims of HIV and AIDS. We have a list of these learners and then we know their places of their household, where they are situated. We also sit down with them individually and privately to support them emotionally. ... We realised that they are running short of some, eh, necessities for school, like, school uniform, eh, shoes, you know, winter clothing and so on. So what we did was to go around businesses in our vicinity where we were asking for donations. We managed to get some, eh, eh, winter clothes, we were able to get some, eh, eh, shoes. And we also organised a donation box in the school where we encouraged learners who are having extra clothing, extra uniform, they can just throw in the box. And members of the committee will, eh, look around and see those who are in need and call them to give them those clothes ... The other thing, we have already started to, to plan to have a vegetable garden at school. Actually, it was there, but it was not functional. So, we are intensifying that project for a vegetable garden so that those who can't afford food at home, we can support with vegetables.*

- **Increased HIV testing**

One of the most advocated activities regarding mitigating the effects of HIV and AIDS is the notion of Voluntary Counselling and Testing (VCT) (see Section 2.2.3.4).

The qualitative findings of this study show that the implementation of the HIV and AIDS management programme had a positive impact on the rate of HIV tests among teachers. For example, Mrs Longhair mentioned:

We had an HIV testing at our school last year. They tested all our teachers and also the neighbour teachers came to our school and the nearby school teachers, the teachers from nearby school also come to us, and I was running that too.

It was also found that more than half of the respondents encouraged educators to know their status. In that regard, HIV testing units were called to conduct HIV tests at schools, especially during events such as Candlelight Memorial Day and World AIDS day. Although HIV testing is confidential, school managers were given the statistics for the number of educators who had themselves tested for reporting purposes. It was found that a high number of educators were taking HIV tests.

It can be averred from the above exposition that HIV and AIDS management at schools as a whole underwent significant implementation changes after FPD training and, as such, commendable results were displayed for both the schools and the people involved at the schools. It is, however, recognised that the impacts achieved were certainly not without challenges. Notwithstanding these challenges, participating SMTs seem to have had strategies for helping them to succeed.

5.3.1.4 Theme 4: What helped?

The findings from the interviews reveal *three sources of success* which have been significant for the implementation of the FPD HIV and AIDS programme at schools.

- **A passion for the HIV and AIDS management course**

A common feature noticeable among participating SMTs seems to be the passion they had for dealing with HIV- and AIDS-related issues, especially in the light of their effects on schools, educators, learners, parents and communities. This passion signifies their willingness to acquire up-to-date knowledge and skills to prevent HIV incidence and to show care and support to PLWHA and those affected by HIV and AIDS. In this regard, the World Food

Programme (2006:6) posits that HIV and AIDS management training courses empower individuals to behave as sensitive, knowledgeable and effective leaders and managers in personal relationships on the job, at home and in communities. Clearly, the SMTs who attended the FPD course on HIV and AIDS management developed this passion and eagerness to acquire the knowledge and skills to communicate the correct information that would shape attitudes and beliefs with regard to HIV and AIDS. At the same time, it solidified their own passion for implementation of the programme at schools. In this regard 90% of the SMTs indicated that it is the passion they have for HIV and AIDS matters that enabled them to implement the HIV and AIDS programme successfully.

For example, Mr Standing stated:

> *... you know what, I have a passion to talk about HIV. I read a lot to know more about it. I like to see my people living free from it. I need to support those who are HIV-positive. I push the agenda of HIV prevention. Everywhere I go, I talk about HIV. You visit me, eh, in my office, I will touch* [on] *the topic. I think my interest in this issue also assisted us as a school to be where we are today.*

Furthermore, over half of the respondents indicated that their success was a product of their ability to speak out without fear and doubt about HIV and AIDS in a non-offensive way, thus informing people about the realities of HIV and AIDS without incentives or instructions from senior managers. They made it clear that their ignited passion helped them to push their schools to achieve the intended results of the training. The following quotation represents this:

> *... I think, personally as a person, I am very outspoken when it comes to HIV and AIDS issues. Secondly, I am not afraid to can still speak* [about] *things even if they are not comfortable, as long as at the end of the day* [it] *is to the benefit of all of us. I read* [about] *HIV and AIDS aspects a lot, whatever information that I get, whether from magazines, newspapers, radio, everything. I am a person who shares, always comes back and*

shares with my colleagues. ... Mmm, I told myself that I am here as an educator and I am not here for my own benefit. I let my learners and colleagues benefit out of me... – Ms Table 60.

It is clear that the implementation of the HIV and AIDS programmes at schools requires internal strength, such as a passion for it to be effectively implemented. Clearly, their passion for dealing with the effects of HIV and AIDS made SMTs eager to acquire knowledge and skills for this purpose and to implement HIV and AIDS management at their schools.

- **A positive community**

In scaling up and sustaining HIV and AIDS responsive measures at schools, the role of communities cannot be overemphasised. This is because there is just a thin layer that separates schools and communities from each other. In fact, a school fundamentally mirrors its larger community. Therefore, the involvement of the community in processes relating to how HIV and AIDS should be managed at school advances such programme implementation at schools.

The involvement of communities in managing HIV and AIDS seems to have helped SMTs' achievement of successful results. In these cases the community was supportive and considerate with regard to addressing the HIV and AIDS challenges facing schools. All 15 success cases indicated that the support given by their communities helped them to achieve compelling results. To this end, Mrs Reality commented:

I think it is the support from the parents that made us to achieve these good results. After I attended the FPD training, a meeting was called for parents to come and get the feedback so that we could plan for the programme together. Although not all of them did come, the majority came. And what is important is that they supported the idea, made inputs on activities to be included the programme.

Expressing similar sentiments, Ms Table 60 stated that the success of their HIV and AIDS management programme was also helped by "bringing other

stakeholders on board". She opined that she found people at school initially not completely comfortable with her as a colleague. However, they became more open and accessible when people from outside the school were involved. In this regard she mentioned people from the District Office and people from community-based institutions. This seems to have worked and she decided then that she would encourage other staff members to attend any other training workshop so as to "also expose them to empower them to have that kind of knowledge and information so that we can [have] a stronger team as a staff". This clearly implies that staff involvement in the initial stages of training generated trust and induced teamwork.

Similarly, Mr Debit mentioned that "we had the 'out-of-school youth' who made the programme run well. It was good to work with them because they engage with learners with ease". He made the point that these youth from the community found it easy to talk to learners because they "spoke the same language and they understand each other more than us talking to them".

Therefore, it can be stated that the community's reaction towards the management of HIV and AIDS at school helped with the effectiveness of the implementation of the programme at school. This included the involvement of people living with and affected by HIV and AIDS, whose anecdotal information brought home the reality of the disease.

- **Internal support**

Findings from the interviews show that all 15 success case SMTs were able to implement the HIV and AIDS management programme more effectively due to the support shown by other school managers and educators, which was a manifestation of teamwork. For example, when asked about key factors that led to such a successful performance, Mr Central commented:

> *Mmm, I'm trying to think. ... Teamwork is always ... actually our school eh, is not very bad in terms of teamwork. Even before we could bring the concept of HIV activities in the schools, it was there. Generally, they are committed and they are able to play teamwork in a group. We have been*

working as a team, not a one-man show. When I raised the concept, everybody supported the programme. And to tell you the truth, that worked to my advantage. And [it] *is the culture of our school. They are supportive.*

Mr Lager stated that leadership support made his work easy. When asked how teamwork helped him in his achievement, he commented that their management team was open. Consequently, he asserted: “If you come up with something that they see is important for our school, eh, they welcome that decision and support it so that it becomes a reality”. He remarked that he had explained that he had received training on the management of HIV and AIDS and wanted to implement it. The response was that that was a good idea and his colleagues committed themselves to being involved. This, he emphatically opined, helped a great deal in producing success in so far as achieving the proximal outcomes of the training was concerned and, most importantly, initiated the process of having a coordinated and well-planned HIV and AIDS management programme at his school.

It is therefore clear that SMTs would not have achieved successful results if it had not been for their ability to take advantage of the internal forces at schools, such as working with other school managers and educators as teams, which actually intensified the programme and made it implementable. This was also combined with the nature and reality of HIV and AIDS, especially at schools and in communities, and the fact that most educators had been affected in one way or another by the epidemic – at their schools, in their communities and even in their own home environments. Therefore it can be averred that internal forces helped to drive the programme and that such support became a strong catalyst for success.

5.3.2 Non-success case stories

5.3.2.1 Theme 5: Hindering factors

Participating SMTs mentioned numerous challenges which they saw as hindering factors to the successful implementation of HIV and AIDS

management at schools. Although the success case SMTs also mentioned challenges, in line with the SCM protocol, the non-success cases are also reported here. Indeed these SMTs, unlike the success cases, revealed numerous hindering factors as highly instrumental in their non-successes. Analysis of the data from the interviews with the non-success case participants revealed the following eight hindering factors:

- **Understaffing at schools and a large workload**

All six non-success SMTs attributed their poor performance to understaffing at their schools. Although this was a common factor even among the success case SMTs, it was found to have particularly hampered the implementation of HIV and AIDS management at the non-success SMTs' schools. For example, when Ms Glass was asked why she couldn't achieve the proximal outcomes of the FPD training, she commented:

> *To be honest with you, actually there are few people who are involved. We are actually two, and it is because there are few teachers in my school. I think the situation is impacting negatively on us, our school is very small but the number of learning areas is more. And we have to cater for all the learning areas. So it is actually impossible for us to go an extra mile.*

All six non-success SMTs also indicated that large workloads led to their failure to implement the HIV and AIDS programme at their schools. Ms Postpone's comment best captured the sentiments expressed in this regard. She stated:

> *... We are overloaded with work. So the HIV thing* [sic] *becomes less considered as it's actually not our core task*.

Mr Morning asserted that: " … there is no way that an educator can perform well in managing HIV when that educator is overloaded with so many learning areas to teach", while Ms Glass opined that their workload was such that "the teachers are so confused that they couldn't get involved the way they are supposed to when it comes to HIV management at school".

It is clear that these SMT members found the heavy teaching workload a hindering factor. They stressed that their commitment was to teaching and learning, which is their core function. Their workloads left them with little motivation and/or ability, not only to initiate the implementation of HIV and AIDS management, but also to require and expect other educators to become involved in the implementation of the programme. This does, however, beg the question as to the effectiveness of teaching and learning at these schools in the light of the effects of HIV and AIDS on the teaching and learning processes (see Chapter 3).

- **Lack of resources**

Findings from the interviews with the non-success performers also indicated that lack of resources could have played a part. Three of the six non-success SMTs stated that lack of financial resources was a contributing factor. They found it difficult to organise events such as HIV and AIDS campaigns at their schools because they needed money to buy food for the participants, especially people from outside. In this regard, Mrs Round stated:

> *... as a school we struggle because of finance issues. And coming to raising funds becomes a problem to us. Because we wanted to invite a community to come and be part of us with drum majorette, HIV and so forth, according to the way we have planned it. You know, when you invite people and you don't give them food, then they don't attend your functions again. I have tried to organise one event, the Candlelight event, but parents did not come, and those few who came, complained that we invited them but we did not give them food.*

The other three non-success SMTs, Mr Morning, Mr Midday and Ms Postpone, expressed a similar sentiment to justify their performances. They attributed their non-performance to the lack of physical resources such as office equipment, including stationery, to facilitate correspondence with parents or any other external party interested in the schools' activities. Ms Postpone actually stated:

The fact that our school does not have a photocopying machine, is, eh, created a problem for us and therefore we couldn't function as we were supposed to. Certain things we cannot do. Like if we want to invite the parents to develop together a programme of action for HIV, it's difficult. So, that contributed a lot, is difficult to function normally under those conditions.

- **Poor understanding and lack of implementation strategy**

Findings from the six non-success SMTs show that two of them did not, even after the training, apply their learning because they did not know how to design HIV programme activities in their schools. In this regard Mrs Round stated that, "we partly understand it" and Mr Midday remarked:

We only had an informal meeting after the training about it but we never made follow up after. But so far, we don't have anything, we still have the basic HIV things and we actually don't know where to start. That is why we did not have good results.

Further, but surprisingly and contrary to what the majority of the training participants said, Mrs Take-time said the training did not equip them enough to be able to implement it at their schools. She opined: "I have not gathered enough knowledge from the training". This can be attributed in part, to the short duration of the training and the fact that the training itself comprised 9 modules. This could have impacted negatively on the level of understanding of SMT members.

- **Lack of support from other SMT members**

Lack of support from other SMT members was found to be one of the hindering factors in the management of HIV and AIDS at most of the schools. Although some participants had the desire to implement the programme, others did not. Of the six non-success SMTs, three found this to have impacted negatively on their application of the learning from the FPD training. Mr Morning commented:

The main issue is lack of support from other SMT members. We discussed these issues immediately after the training, but nothing was done so far. You bring the issue on the table, and if your boss is not showing commitment for the task to be carried, then [there] *is a problem. I also sit and relax. I cannot do everything on my own without the go-ahead from us as managers. It should be a collaborative effort. If ever I do it alone, and something goes wrong, they will start pointing fingers.*

- **Lack of support from the District Office**

It was found that non-success SMTs have not been able to implement the HIV and AIDS programme effectively at their schools due to lack of support from the District Office. All six non-success SMTs stated that the fact that the District did not support them in carrying out their task as outlined during the training meant that they did not take the implementation part of it very seriously. Mr Midday aptly expressed this reservation:

Mmm, ... lack of follow-up session, because since we have gone to the training, maybe from the District side, there is nobody who came in order to can find out whether the information that I got has been cascaded and implemented. That is a contributing factor because the Department doesn't come to follow up. That made me to have no courage to continue.

- **Reluctant educators**

The non-success SMTs' responses also indicated that other staff members' reluctance had led to poor or unsuccessful performance in the management of HIV and AIDS at schools. It was mentioned that there were staff members who were not committed and not willing to be involved in the programme. This shows lack of passion and dedication from other staff members when it comes to HIV and AIDS management at schools. This was evident in Mrs Round's comment that:

Most of the educators they don't … they ignore the programme ... and if you want to talk with them about HIV, they ignore you a lot. The staff here at school ignore this HIV course. For example, there is another course now on HIV. When I tell them about the course, all of them said no, the school is closed, they are going to Limpopo, they are going to Rustenburg, they are going where-where. If they don't like that, you cannot have this programme in place at all because they ignore you or the programme.

The matter raised concerning "going elsewhere or away" seems to have to do with educators being reluctant to attend workshops or even work over weekends and or during school holidays, which is a serious matter of concern expressed in many instances.

- **Location of the school learners**

One non-success SMT maintained that the location of learners in squatter camps was a hindrance that led to the inability to achieve the goals of the FPD training on HIV and AIDS management. In this regard, Mrs Round remarked:

Oh, most of the learners we cannot reach their homes to see if they are getting enough food or not. Most of the areas that the learners are coming from are squatter camps [sic]*. And then there is no proper address. Sometime when you think you will go after school, you don't have enough time to go there because is most of them stay far. So, is actually difficult to reach their homes. That is also a reason why we did not do well in this school.*

- **Lack of time**

All six non-success SMTs indicated that lack of time has led to their failure to apply the learning. For instance, when one respondent was asked why she did not implement the acquired skills from the FPD training, she stated:

The main problem is time. There are too many things to do and we are always under pressure. And the district officials they come now and then

to monitor whether teaching and learning is happening. So we try to push. Every time you are left behind and your mind is tired, ... things of that nature. – Mrs Morning.

Clearly, non-success cases attributed their poor performance in the application of the FPD training to the abovementioned factors. Although many might argue about the credibility of these factors, from the point of view of the non-success cases they remain real and need to be attended to in order to enhance the rate of successful application.

5.3.3 Theme 6: Suggestions for improvement

This section details the success and non-success SMTs' recommendations on how they can further improve the management of HIV and AIDS, based on the FPD training outcomes of course, in their respective schools.

- **More training required**

Almost all 21 respondents expressed the need for more training on HIV and AIDS management at schools. They stated that continuous training would give them a clear picture of what to do at school, especially when supporting learners and other staff members living with or affected by HIV and AIDS. They indicated that although the FPD training had been executed efficiently by the training facilitator, not all educators had received such training since training was limited to a maximum of three people per school. In this regard, the following quotation is significant:

Eh, I don't know what I can add there because the gentleman [referring to the training facilitator] *was so resourceful* (giggling) ... *the gentleman was having all sorts of information. I can call them teaching aids. I really don't know what I can add there. Maybe just to repeat: to get other people on board, maybe it can help us to get other schools also involved. That's what I am thinking* – Mr Best.

Mrs Take-time suggested that HIV training should be done continuously, but that timing would be very important. She recommended that more workshops

should be conducted, " … maybe twice a month". She opined that Saturdays could be inconvenient for most educators. She, however, pointed out that more workshops should be conducted "So that everyone can be acquainted with these HIV things [sic]".

Another respondent further suggested that training of the educators should be school-based. She stated:

> *I think if maybe that FPD, they send somebody to come here in our school. That day you workshop all the staff ... . Maybe after training them, they will understand the challenges of HIV and AIDS. Because those learners, we have them* [referring to learners who are infected and/or affected].

- **Continuous programme monitoring**

Nine participants stated that monitoring of the HIV and AIDS management programme was a step that should be taken to bring improvement and changes regarding HIV and AIDS management at schools. They pointed out that this type of intervention would keep the school awake and make it commence or continue to have an effective programme. Monitoring could also identify and fill any gaps that were hindering, for example, the application of the FPD learning. Mr Lager called for "a plan to monitor it" – referring to the HIV and AIDS management programme at school. In addition, Mr Central articulated:

> *... After I come from the workshop* [sic], *there should be a gauge from the District side to check how far one is* [sic]. *Therefore it will push me and it will even push their entire school management team to know when the District is coming to check the progress and performances* [sic].

- **Resources must be made available**

In order to have an effective school HIV and AIDS programme, six respondents suggested that schools should be equipped with resources such as promotional materials. For example, when Ms Table 60 was asked to suggest anything that could help to improve her performance regarding the implementation of the HIV

and AIDS programme, she recommended that "... if we have pamphlets, HIV brochures, if you can tell me the source where I can get brochures ...".

- **External support**

All 21 respondents suggested that the involvement of stakeholders or the community was of the utmost importance in the delivery of HIV and AIDS-related services at schools. Such involvement would mean, as they said, an influx of resources to enable schools to function optimally in carrying out HIV and AIDS programme activities. Mrs 45 opined:

> *The community and these other organisations working with HIV should be involved. Maybe by doing activities in the school, maybe HIV/AIDS, we celebrate it and invite other stakeholders. You* [referring to the interviewer] *as, as, I don't know whether you are still working at the Department or what …* [I told her that I work at the university]. *Ja, then we can organise something which is big when big institutions support us.*

- **Internal support**

Almost all respondents suggested that if the HIV and AIDS programme could receive support from all educators, it could produce clear positive results as per the FPD's recommendations. About 80% of the SMTs indicated that educators should be the backbone of the programme since they spend most of their time with the learners, and that they should support the learners to understand and cope with HIV and AIDS. In this regard, Ms Smile commented:

> *They must not be shy to talk about HIV and AIDS issues. They must also talk to learners about the existence of HIV and how it's transmitted, and also how it can be prevented. Teachers must also inform learners on how they can give support and care to those who are living with HIV and those who are affected.*

More than half of the SMTs saw the need for other educators, other than SMTs only, to be involved in running the programme. In their view, this could be done by drawing up a work schedule for HIV and AIDS programme activities to

facilitate implementation. The best illustration of this view was expressed by Mr Morning who stated:

> *The SMT should encourage and motivate other teachers to push the programme, and cut-off dates should be set. If there is no cut-off date, there is nothing that will happen.*

- **Support from the district**

All 21 respondents indicated that there is a need for the District officials to visit schools to discuss the HIV and AIDS programme. Discussions of this kind could be helpful if undertaken not only with the SMTs, but with all educators, including the learners. In this regard, Mr Standing remarked:

> *The District should come to our school maybe during morning assemblies to explain the purpose of this* [referring to the HIV and AIDS programme at school] *to the learners. And I think it will carry weight if they can also talk to all teachers, not just the SMT or a person who is coordinating.*

The sentiments expressed above are significant in that the monitoring and support roles of the departmental officials are critical to the success of HIV and AIDS management at schools. This is basically because the FPD, as an external structure, does not have jurisdiction or authority over schools and, as such, does not have enforcement authority.

- **Collaborative efforts**

Lastly, all respondents suggested that introducing collaborative efforts could be another measure to take in order to implement the HIV and AIDS management programme at schools with success. Some mentioned that although they had HIV and AIDS committees, everyone should take full responsibility in managing HIV and AIDS at schools. One respondent stated that through collaboration, schools could learn from one another and share information and strategies. For example, when Ms Glass was asked how she could improve her performance, she stated:

The other thing that can work is bringing schools together. Like neighbouring schools, if we start by, for example, pairing ourselves with other schools and then try to, to, to share information and especially on how each school is doing to manage HIV, we can learn from one another and improve performance.

Scrutiny of the suggestions made for improvement reveals the interest, commitment and perception of the potential for success in implementing HIV and AIDS management at schools. Indeed, it is clear that the need for this is deeply felt by participants and that, although the current implementation of HIV and AIDS management at schools can be improved, much has been done as evidenced by the participating SMTs.

5.4 CHAPTER SUMMARY

This chapter presented an analysis and interpretation of the survey and the interview results. It was clear that the possibilities for applying the FPD training were not consistent throughout. Therefore it was imperative to follow up on those application variations so that leading factors could be identified. For example, the conditions surrounding the success cases and non-success cases were discussed. Based on the findings of this study, the researcher drew conclusions and recommendations with regard to the implementation of HIV and AIDS programme at schools within the Tshwane South District. Such conclusions and recommendations are presented in Chapter 6.

CHAPTER 6
CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

As mentioned in Chapter 1, this study set out to determine the effectiveness of the implementation of the FPD's HIV and AIDS management programme at schools in the Tshwane South District. Chapters 2 and 3 detailed the literature review on the reality and implications of HIV and AIDS and the nature of HIV and AIDS management at schools respectively to address the objectives listed at the beginning of this study. The Success Case Method (SCM), as presented in Chapter 4, was used to determine what was and was not working with regard to the implementation of the FPD's HIV and AIDS programme at schools. The empirical findings of this study were presented in Chapter 5.

This chapter presents useful and compelling conclusions of this study. The conclusions were drawn using the SCM as opposed to conventional methods. First the report was structured within Brinkerhoff's recommended conclusions framework or model. Next, seven types of conclusions were drawn from the evaluation of the HIV and AIDS management programme implementation following Brinkerhoff's (2006:134) eight major types of SCM conclusions framework.

6.2 CONCLUSION TYPES RELEVANT TO THE SCM EVALUATION OF THE IMPLEMENTATION OF HIV AND AIDS MANAGEMENT AT SCHOOLS IN THE TSHWANE SOUTH DISTRICT

The conclusions drawn from the evaluation of the implementation of HIV and AIDS management basically address this study's fourth research objective, namely to formulate conclusions derived from lessons from the success and non-success cases in the implementation of the HIV and AIDS management programme. To this end, the data analysis presented in the previous chapter was philosophically relevant to Brinkerhoff's conclusions types, which determined whether the School Management Teams (SMTs) who attended the

Foundation for Professional Development's (FPD) training intervention were able to implement their learning at schools, which gave answers regarding the full impact of the application of learning acquired during the training (Brinkerhoff, 2006:133). Although most of these conclusion types are based on the interview findings, the SCM allows other types of conclusions to be centred on survey results. Therefore conclusion types two, three and four were drawn from either the survey or a combination of the survey and the interview results (Brinkerhoff, 2006:137–145).

6.2.1 Conclusion type one: What impact was achieved?

This type of conclusion seeks to provide substantial information regarding the results which the training initiative generates on the job (Brinkerhoff, 2006:134). Evidence from the data analysis suggests that the FPD training intervention was largely useful and enhanced, to a significant degree, the management of HIV and AIDS in the Tshwane South District. This is based on the success of the FPD training in bringing about change in the participating SMTs' knowledge, skills and attitudes towards the HIV and AIDS epidemic and their subsequent application and behavioural change at their schools.

The most notable impact of the training relates to the *improvement of SMTs' knowledge of HIV and AIDS and its reality.* This was testimony to the assertion of the three-step theory (Section 1.3) that change occurs when the combined strength of driving forces is greater than the combined strength of the restraining set of forces. In the case of the SMTs who participated in this study, it is concluded that the FPD, through its training intervention, provided the driving forces for changing the behaviour of the SMTs by moving them to new levels of knowledge, skills and attitudes about HIV and AIDS and its management. In this regard, the following were evident:

- The participants reported that they had improved their knowledge of the reality of HIV and AIDS and how it can be managed at schools. It was also evident that the participating SMTs had benefited from the

acquisition of skills required for the management of HIV and AIDS at schools. In fact, the SMTs in the success category managed to:

- Establish critical organisational structures and liaisons for the management of HIV and AIDS at their schools. Firstly, they were able to organise the establishment of HIV and AIDS management committees. A remarkable feature of the committees is their inclusive nature, as they were not only composed of professional staff but of non-professional staff as well, which included ground and administrative staff. This is a significant feature as it is critical for facilitating the establishment of "strategies for identifying possible programmes that schools intended to implement, garnering support from educators and all internal and external stakeholders, designing roles and responsibilities of the parties in charge of stakeholders, and accessing resources required for the effective implementation of the action plan" (Section 3.7.6).

- Liaise with a variety of stakeholders in school committees. This opened up avenues for SMTs at schools to establish and increase their information banks about sourcing partners and aids for managing HIV and AIDS at their schools. It is clear that prior to the training, the SMTs had either no knowledge or scanty knowledge about sources of information and/or resources for HIV and AIDS management at school. It was just after the FPD training that the SMTs felt empowered to find out about and engage other interested parties, such as the Department of Health, NGOs and clinics, in managing HIV and AIDS at schools (Section 5.3.1.1). This included sourcing resources such pamphlets and books on HIV and AIDS advocacy (Section 5.3.1.1). This meant that such committees would not only deal with the social aspects of the epidemic, but other issues such as "therapeutic intervention for PLWH." This was accomplished with the involvement of health professionals such as professional nurses and NGOs on the committees (Section 5.3.1.2).

- Develop and refine customised and relevant comprehensive HIV and AIDS policies at their schools. Indeed, some SMTs indicated that "they had dormant HIV and AIDS policies before" and had managed to assess and evaluate existing policies to make them define ways in which they could respond with clear positive results to challenges emanating from HIV and AIDS. These policies formed the framework for schools' action plans to prevent the further transmission of HIV and to provide care and support to people living with and/or affected by HIV and AIDS (Section 5.3.1.2). As these policies were customised for their schools, the implication was that the schools had consequently developed responsive strategies to promote effective prevention and care within the context of the public education system (Ministry of Education, Youth and Culture, 2004:9). To this end it was clear that the policies had been developed to focus on measures to address the effects of HIV and AIDS, such as stigma, absenteeism and discrimination in order to establish and enhance healthy teaching and learning environments (Sections 1.3, 3.6.2 and 5.3.1.3). Some schools had the skills to communicate with parents of the learners, develop a school HIV and AIDS committee and make the policies available in languages that people understand (Section 5.3.1.2).

- Develop action plans for the management of HIV and AIDS at schools. The action plans enabled them to develop programme activities in response to the epidemic. The schools were able to put in place focused measures to address the effects of HIV and AIDS so as to establish and enhance a healthy teaching and learning environment. In developing measures in the form of programme activities, they needed to enlist the aid of experienced people, which culminated in the schools gaining a clear picture of what actions to take, who would carry out such actions, when the actions would be carried out, and what resources would be needed for such actions. Other features of note were the customisation of action plans to cater for the schools' needs, the timing of programmes, clear starting

points, a focus on issues pertaining to HIV and AIDS, and being able to identify learners living with or affected by HIV for purposes of implementing measures for prevention, care and support.

- Increase liaison and integration with other organisations and departments in response to the effects of HIV and AIDS. For the purposes of this study, integration is defined as establishing avenues that allows other interested organisations, bodies, structures and sister departments to have a say from the plenary to the execution phase of the school's HIV and AIDS management programme, with the intention of developing preventive, supportive and protective activities (Section 5.3.1.4).

- Link with existing DoE's HIV programmes to create a holistic approach to HIV and AIDS management. The knowledge and skills acquired during the FPD training led to the reinforcement of the connection between school activities and the Department of Basic Education's HIV and AIDS programme. Most of the successful SMTs indicated that the training helped them to realise the importance of calling in district officials to talk to their learners and educators about HIV and AIDS. Therefore the FPD intervention process improved the link between the schools' and the Department's approaches in addressing HIV and AIDS challenges.

- Scale up awareness of personal practices that can alleviate exposure to HIV infection. For instance, the use of universal precautions was indicated by many to be a strategy which they could put in place to minimise the risk of infection (DeWalt, Callahan, Hawk, Broucksou & Hink, 2010:2). This included practices to protect educators and learners from exposure to blood and other body fluids (Section 5.3.1.2).

- Develop other methods that would address universal precautions to manage HIV and AIDS at schools. This included customised and

age-relevant methods such as drama, debate, posters and HIV and AIDS awareness campaigns. These methods also promote awareness of drug and alcohol abuse and sexual intercourse as risk behaviours, which could also tarnish the quality of the universal awareness campaign.

- Initiate measures aimed at improving access to HIV testing and treatment and information on care and support. The training equipped the SMTs with the skills, abilities, and most importantly, the information on how to manage HIV and AIDS, and also on where to access voluntary HIV counselling and testing. For example, one participant mentioned that HIV testing was organised at her school and educators from her school and neighbouring schools were tested. This means that the FPD training enabled them to organise and establish measures for accessing critical elements of HIV and AIDS management, which included making schools accessible sites for counselling and testing (Section 3.7.6). In this regard, some SMTs used their learning to assist PLWHA to access treatment.

The impacts discussed above pertain mostly to measures that improved the management of the effects of HIV and AIDS on educators and learners. Regarding measures taken after the FPD training and testimonials from participating SMTs, it can be concluded that there was indeed considerable improvement in the management of HIV and AIDS at the schools.

The FPD training seems to have had a notable impact on participating SMTs themselves. It is noteworthy that a number of success performers indicated levels of improvement in terms of lessened stigmatisation of, and discrimination against PLWHA, increased care and support, and HIV testing. While these achievements required the approach to and implementation of HIV and AIDS management at schools, significant impacts of the FPD training on participant SMTs themselves were discernible, such as the following:

- A *change of attitude towards HIV and AIDS as well as towards PLWHA*. In this regard, it was clear that most SMTs seemed to have had a 'wake-up call', especially in terms of the role they could and had to play in management at schools. They appreciated the reality and effects of the epidemic on their schools and communities, which entailed understanding the multifaceted approach in addressing HIV and AIDS. This included the realisation of the importance of drugs and alcohol abuse, peer pressure and sexual intercourse as risk behaviours which they addressed through participatory methods. It can thus be concluded that the SMTs experienced personal growth and development in terms of attitudinal change, skills and knowledge acquisition. They seem to have inculcated the values at their schools as evidenced by their perceptions of reduced stigmatisation and discrimination usually associated with HIV and AIDS.

It must, however, be stated that attitudinal changes are not easy to accomplish and take time to take root. It was noticed that the use of deprecating and offensive words referring to HIV and AIDS inadvertently persisted, in for example, the use of such language as "... this thing ..."; the "death disease" and "victims of HIV" (Sections 5.3.1.1 and 5.3.1.2). This, it must be mentioned, is an area that needs to be worked on to completely eradicate the stigma associated with HIV and AIDS.

- *Acquisition of good communication skills*, which proved to be essential in managing HIV and AIDS at schools. This is evident in the report-back meetings and the consequent support of the programme at many schools. This implies that good, language-specific and age-appropriate communication relevant to HIV and AIDS was used.

- *Acquisition and development of leadership skills* as evidenced in organisational abilities at school levels. Participating SMTs were able to organise programmes and involve stakeholders in such programmes, which indicates evidence of leadership qualities.

- The staff meeting approach used by the SMTs indicated good and *improved intrapersonal skills* on the part of the participating SMTs and staff members. The fact that the schools had policies that had not been implemented and were revived and refined to suit their circumstances, including involvement of stakeholders and especially non-professional school staff such as ground staff, indicates the improved level of interpersonal skills. This could only have been derived from the confidence instilled by the FPD training that the SMTs underwent.

- The FPD training, it can be asserted, also assisted in sharpening the *reporting skills* of the participating SMTs, as is evident from the success of report-back meetings and the resultant involvement of staff at the schools.

- The FPD training also seems to have strengthened their *analytical and innovation skills* with regard to making sound decisions on the proper management of HIV and AIDS. This was noted in the SMTs' responses to 'filling' the *what was achieved* bucket (Section 5.3.1.2), especially when they mentioned the drawing up of an effective school action plan and developing and/or reviewing the school HIV and AIDS policy as part of achievements due to the FPD training.

- The training also improved the SMTs' *information-gathering skills*, which is also useful in the management of HIV and AIDS, as information gathering keeps one up to date with most current knowledge to guide decisions on behaviour change (Goodell & Cohen-Osher, [s.a.]: 3).

The foregoing discussion indicates that, while not optimal, the FPD training did produce positive outcomes, and much was achieved by the success category of participating SMTs. Just how much was achieved is highlighted by the extent of the successes.

6.2.2 Conclusion type two: How widespread is success?

According to Brinkerhoff (2006:137), the basis of this sort of conclusion is the survey data in conjunction with the interview data. In this regard, conclusions were made on how widespread the success was of the implementation of HIV and AIDS programmes at schools.

The first conclusion is that the FPD training assisted 48 SMTs (55–13%) to achieve significant results with regard to the implementation of HIV and AIDS management programme at schools in the Tshwane South District. This figure constitutes 60% of the 80 SMTs who attended the FPD training. This conclusion is based on the following:

> Of all the questionnaires that were sent to 80 SMTs who attended the FPD training, 74 were usable for the study. The survey analysis showed that 69% of the SMTs claimed to have used the FPD training to produce valuable outcomes, and 31% of the SMTs claimed worthless results. In this regard, 15 success cases, which were randomly selected, were interviewed and 87% of the SMTs were found to be *true positives*. This means that their claims for success were found to be valid during the interview. Thus there was no need to sample another 15 SMTs via interviews because 87% is sufficiently convincing that the remaining SMTs would still produce the same responses. However, two of the total of 15 SMTs (13%) were found to be *false positives*. By the mere fact that there were false positive results, the researcher could not conclude that the 69% of the original population of 80 SMTs who received the FPD training signified true success. Therefore I had to condense the success cases by 13% in order to accommodate the false positive results when drawing conclusions on the scope of the impact of the FPD training.

The second conclusion drawn is that eight participants were found to be false negatives based on the following:

> Eighty SMTs attended the FPD training as mentioned in the earlier chapters of this study. Although surveys were sent to all of them, only 74

responses were usable. The survey analysis shows that 23 SMTs did not produce success results at the time the survey was conducted. As a result, to validate the survey results, interviews were conducted with randomly selected participants comprising six SMTs. Interview results showed that of the six respondents, four reported *true negative performances*. In contrast, the interview findings show that two SMTs had *false negative results*. Therefore 33% of 23 was rounded to 8.

It can therefore be concluded that 56 SMTs implemented the FPD training outcome to accomplish successful results that helped them to manage HIV and AIDS effectively. This is because the eight SMTs which were found to be false negatives were added to the SMTs who were found to be true positives. Thus 24 SMTs did not produce worthwhile results.

6.2.3 Conclusion type three: Did the training work better in some parts of the organisation or with some types of participants than others?

According to Brinkerhoff (2006:141), this type of conclusion is a simple analysis which can be based on survey results alone, or can be enriched by with interviews. In this regard, the quantitative results showed that the application of the FPD training varied in terms of gender as presented in Table 6.1.

Table 6.1 Cross-tabulation of responses to the application survey items for males and females

Application possibilities	Yes, with clear positive results		Yes, but have had no clear results yet		Not yet, but I expect to do this		I don't have any intention of doing this	
	Gender							
	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE
I have applied the FPD training to develop the HIV and AIDS management programme in my school	51.4% (n=38)	18.9% (n=14)	0% (n=0)	13.5% (n=10)	0% (n=0)	16.2% (n=12)	0% (n=0)	0% (n=0)
I have developed the school's action plan for HIV and AIDS management at my school	44.6% (n=33)	28.4% (n=21)	2.7% (n=2)	5.4% (n=4)	4.0% (n=3)	14.9% (n=11)	% (n=0)	0% (n=0)
I have developed a programme and communicated my school's HIV and AIDS policy to all relevant stakeholders	42.9% (n=33)	28.4% (n=21)	4.% (n=3)	12.2% (n=9)	5.4% (n=4)	8.1% (n=6)	0% (n=0)	0% (n=0)
I have developed a programme that links the school to the community in the fight against HIV and AIDS	40.5% (n=30)	31.1% (n=23)	2.7% (n=2)	6.8% (n=5)	8.1% (n=6)	10.8% (n=8)	0% (n=0)	0% (n=0)
I have used the FPD training to impart knowledge and skills of HIV and AIDS management to other staff members and learners at my school	41.9% (n=31)	27.0% (n=20)	6.8% (n=5)	13.5% (n=10)	2.7% (n=2)	6.8% (n=5)	0% (n=0)	1.3% (n=1)
I have used the training to do an HIV and AIDS prevalence survey at my school	48.6% (n=36)	29.7% (n=22)	1.35% (n=1)	12.2% (n=9)	1.35% (n=1)	6.8% (n=5)	0% (n=0)	0% (n=0)

As Table 6.1 illustrates, the FPD training produced worthwhile results for both male and female participants. However, data from the survey suggests that the training worked better with female SMTs. For example, female SMTs scored the highest application rate of 51.4% with a minimum score of 40.5%. Conversely, male SMTs' highest application rate scored 31.1% with a minimum score of 18.9%. This could relate to female SMT members being in the majority at primary schools that at secondary schools.

The relevance of these findings is further confirmed by the interview findings. For example, of all the 21 randomly selected interviewees (from the success and non-success categories), 47.6% female SMTs proved to have implemented their learning with clear positive results, while only five male SMTs proved to have achieved worthwhile results.

Furthermore, regardless of the fact that the majority of the trainees were STMs from primary schools rather than secondary schools (Section 4.2.4, *Step 6*), the findings showed that the FPD training worked better for SMTs from primary schools than for those from secondary schools. Table 6.2 demonstrates this variation in terms of application possibilities of the FPD training.

Table 6.2 Cross-tabulation of responses to the application survey items for primary and secondary school SMTs

Application possibilities	Yes, with clear positive results		Yes, but have had no clear results yet		Not yet, but I expect to do this		I don't have any intention of doing this	
	SCHOOL CATEGORIES							
	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary
I have applied the FPD training to develop the HIV and AIDS management programme in my school	75.5% (n=40)	57.1% (n=12)	13.2% (n=7)	14.3% (n=3)	11.3% (n=6)	28.6% (n=6)	0% (n=0)	0% (n=0)
I have developed the school's action plan for HIV and AIDS management at my school	79.2% (n=42)	57.1% (n=12)	5.7% (n=3)	14.3% (n=3)	15.1% (n=8)	28.6% (n=6)	0% (n=0)	0% (n=0)
I have developed a programme and communicated my school's HIV and AIDS policy to all relevant stakeholders	83% (n=44)	38.1% (n=8)	11.3% (n=6)	28.6% (n=6)	5.7% (n=3)	33.3% (n=7)	0% (n=0)	0% (n=0)
I have developed a programme that links the school to the community in the fight against HIV and AIDS	81.1% (n=43)	47.6% (n=10)	11.3% (n=6)	4.8% (n=1)	7.5% (n=4)	47.6% (n=10)	0% (n=0)	0% (n=0)
I have used the FPD training to impart knowledge and skills about HIV and AIDS management to other staff members and learners at my school	77.3% (n=41)	47.6% (n=10)	15.1% (n=8)	33.3% (n=7)	7.5% (n=4)	14.3% (n=3)	0% (n=0)	4.8% (n=1)
I have used the training to do an HIV and AIDS prevalence survey at my school	100% (n=53)	28.8% (n=5)	0% (n=0)	47.6% (n=10)	0% (n=0)	28.6% (n=6)	0% (n=0)	0% (n=0)

Table 6.2 indicates that the FPD training worked better at primary schools than at secondary schools. For example, all 53 SMTs from primary schools conducted the prevalence survey with clear positive results, while only five from secondary schools did so. Furthermore, this table shows that there were SMTs from secondary schools that, even after the training, had no intention of applying the FPD training – 4.8% of the 21 SMTs indicated that they did not have plans to impart knowledge and skills of HIV and AIDS management to other staff members and learners at their schools. The reason for the differences between primary and secondary schools could be located in the nature of the school programmes for primary and secondary schools. For instance, primary school educators would have more contact and personal experiences with learners than secondary school educators, where numbers are high and contact with learners is usually limited to teaching periods, Furthermore, secondary school learners may not be to forthcoming on issues they regard as personal and laden with stigmatisation.

Added to that, the interview results indicated that the FPD training worked much better with SMTs who had successfully completed the assignment (Section 3.7.4) which was given during the training than those who failed to do the assignment.

6.2.4 Conclusion type four: Were some parts of the training more successfully applied than others?

This conclusion was derived, as recommended by Brinkerhoff (2006:143), from a combination of both survey and interview results. Firstly, the survey data formed the basis of this conclusion. Although the FPD training was applied successfully at most schools, the survey results showed that certain parts of the training were more successfully applied than others, although with narrow marginal application variations. This is evident from the fact that there was inconsistency in the frequency distribution of scores on the training application possibilities (see Table 5.1). Notably, the application of HIV and AIDS prevalence surveys at schools was widespread, with a frequency distribution score of 78.3%. There was no great difference in the application of survey items

2, 3 and 5. It was further found that the development of HIV and AIDS management programmes was equally applied, with the development of the schools' HIV and AIDS policies being communicated to all relevant stakeholders.

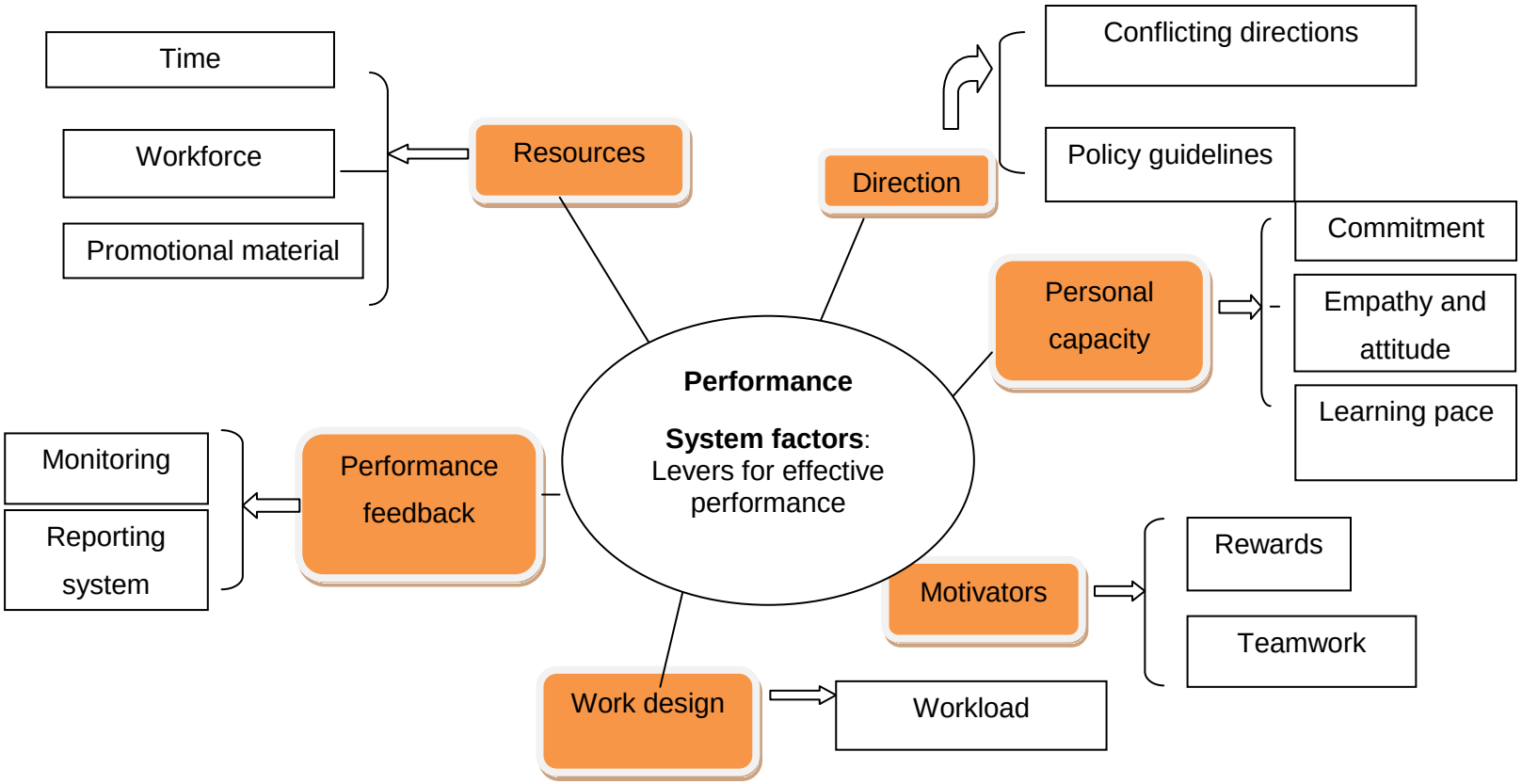
Secondly, findings from the interviews confirmed that the level of application of the FPD training varied from school to school and from one SMT to another. Although the results were not similar in terms of application and time at different schools, the SMTs demonstrated that they were applying the FPD training. Most importantly, regardless of whether any positive outcomes were seen or not, the most important thing is that they were "doing something" after the training. The participating SMTs' stories (Section 5.3.1) show that the FPD training was helpful to such an extent that they were able to put in place HIV and AIDS response measures. Examples include the creation of HIV and AIDS awareness among educators and learners by disseminating knowledge of the epidemiology of HIV and AIDS, and by empowering them with skills relating to the care and support of PLWH and those who are affected. Some stories signified the importance of the training, such as those relating how SMTs became involved with external agencies. This also applies to matters pertaining to their own development as people in terms of the implementation of their learning and their acquisition of critical management and leadership skills. All these stories demonstrate the effect which the FPD training had on the participating SMTs and their schools.

6.2.5 Conclusion type five: Systemic factors associated with success and lack of success

It was found from the interviews that there were systemic factors behind the implementation of HIV and AIDS programmes at the schools in the Tshwane South District. These factors influenced the success or non-success application results. Brinkerhoff (2006:146) draws attention to the fact that the identification of performance systemic factors is essential in identifying factors that have an influence on on-the-job performances after the training. On that basis, the analytic framework, which Brinkerhoff (as cited in Brown, 2008:1) regards as

seven factors for an effective performance model was developed. Figure 6.1 illustrates the performance systems factors.

Figure 6.1 Performance system factors associated with success or lack of success



As can be seen from Figure 6.1, it was found that various factors helped while others prevented the delivery of high-quality results. The following is a coherent description of systematic performance factors:

- *Conflicting directions:* This factor had a barrier effect in achieving the FPD's learning objectives. The SMTs were expected to schedule HIV and AIDS programme activities after hours. Unfortunately, such activities could not be carried out mostly because the SMTs were expected to attend school management meetings or workshops with district officials at the very same time.

- *Policy guidelines:* The availability of the National Policy on HIV and AIDS for Learners and Educators at Schools helped many of the SMTs to achieve the intended results of the FPD training – the contents of the policy actually supported the FPD strategies and techniques in responding to the challenges brought about by HIV and AIDS at schools.

- *Commitment:* Commitment or the lack of commitment was found to have played a major role in the success and non-success results. First, it can be concluded that success results were achieved due to the commitment of the SMTs in continuing to 'go beyond the call of duty' and engage in extra-role behaviours (Coetzee, 2005:5.7). In contrast, those SMTs who did not show commitment to the implementation of the programme consequently did not design and implement strategies to achieve the FPD training objectives.

- *Empathy and attitude:* This factor helped some of the SMTs to achieve the intended training results. The SMTs' understanding of the circumstances, as well as their positive attitude towards people living with and/or affected by HIV and AIDS, resulted in their achieving high-quality results in the management of HIV and AIDS at their schools.

- *Reward:* The SMTs who received the FPD certificate after completing the two-day course and passing the assignment produced better results than those who did not receive certificates. This translates to the fact that certification had a positive role in the SMTs' successfully applying the FPD learning outcomes. The SMTs also felt rewarded by rendering a much-

needed service, and were gratified by the positive outcomes regardless of how seemingly small they were. This can be regarded as intrinsic motivational rewards, which provide further impetus for continuing the implementation of HIV and AIDS management.

- *Teamwork:* Some SMTs achieved good results because of the teamwork at their schools. However, some schools did not achieve the expected results because of the lack of teamwork among staff members.

- *Workload:* Some SMTs did not produce good results due to the heavy administrative, managerial and teaching workload.

- *Reporting system:* Certain SMTs were unable to produce clear positive results because there was no reporting system for their application of the FPD training.

- *Learning pace:* Some SMTs (e.g. Mrs Take-time and Mrs Round) indicated that they could not understand the training modules very well because they were presented over just two days. More than two days would have met their learning pace (Section 5.3.1.5). It was therefore clear that those who understood and mastered the training modules within the time allocated for the training were able to implement the FPD programme with clear positive results better than those who had learning difficulties, e.g. those who were slow learners.

- *Marketing collaterals:* Most of the non-success case SMTs reported that they had been hindered in the implementation of the FPD programme with clear positive results due to a lack of marketing tools such as posters, brochures and flyers with positive HIV and AIDS messages. As a result, their programmes could not be well marketed and advocated, which led to poor implementation.

- *Workforce*: SMTs who failed to attain the FPD's proximal outcomes were shown to have been blocked by the shortage of staff at their schools.

- *Time:* Most of the SMTs who did not achieve the FPD training objectives were prevented from doing so because of lack of time for HIV and AIDS

activities since they were occupied with the academic and management part of their teaching responsibilities. Furthermore, the two-day workshop comprising 9 modules had an effect on the pace of SMTs learning and ability to implement the programme at schools. To this end, it was found that there was a need for the training to be a continuous process for SMTs.

It can be concluded when considering the above systemic factors that some were disabling while others were enabling. An encouraging result is that despite the systemic challenges, a significant number of the SMTs managed to implement an HIV and AIDS management programme at their schools. This means that despite the difficulties, an HIV and AIDS management programme can be successfully implemented with clear positive outcomes.

6.2.6 Conclusion type six: What is the value of the outcome achieved?

The results of this study together suggest that the majority of the SMTs achieved the FPD training outcomes. The FPD training provides a valuable service to schools as well as to SMTs. The value or return of the training is given in social terms, both in the short and long terms, and includes:

- effective organisational structures for HIV and AIDS management at schools
- a capacitated corps of SMTs who deal with HIV and AIDS management at schools and increased personal development
- increase in HIV and AIDS programme activities at school
- greater awareness and prevention of HIV
- increased care and support of PLWH
- improved partnerships and collaboration in the management of HIV and AIDS at schools
- an increase in the distribution of HIV and AIDS learning materials at schools
- stricter adherence to HIV and AIDS policies

- an increase in community engagement and involvement in the management of HIV and AIDS at schools.

It can therefore be concluded that the social value is the most significant effect of the FPD training outcomes achievement.

6.2.7 Conclusion type seven: What is the unrealised value of the training?

As Brinkerhoff (2002:183, 2006:149) points out, this type of conclusion involves making estimates of how much more value the programme could have achieved if all the trainees had applied the learning outcomes expected from the training. In the context of this study, this key question seeks to determine the values that the FPD training had for the schools but did not realise due to lack of successful implementation by some of the SMTs. It is therefore crucial to consider the unrealised values of the FPD training in order to increase acceptance of and commitment to the programme implementation at schools. Acceptance and commitment will turn unrealised values into actual values, and will demonstrate a comprehensive understanding of the role that SMTs have in responding to HIV and AIDS challenges at schools.

It was clear that the FPD training helped 70% of the SMTs to achieve valuable outcomes such as decreasing discrimination and stigmatisation. Because 30% of the SMTs did not apply the FPD training as intended, they could not achieve such results. However, it can be concluded that had these 30% of SMTs been given support even after the training, there could have been more than 70% of success cases.

Another aspect that needs attention is that the training was conducted over two days per group at the weekend. It may have been possible that some of the non-success cases were already tired when the training was conducted since their normal working days are from Monday to Friday. If they had received the training during the week, the learning could have been more effective and led to a higher number of SMTs achieving worthwhile outcomes. It can also be concluded that if all the schools in the Tshwane South District had participated in the programme, there would have been a higher number of success cases, because the non-success cases would have

realised the importance of the FPD training when they saw all the schools participating in the programme.

6.3 SUMMARY AND CONCLUSIONS OF THE STUDY

The study set out to evaluate the implementation of the HIV and AIDS management at schools in the Tshwane South District. The literature review revealed the reality and implications of the HIV and AIDS epidemic, which show that although many achievements have been attained, it still remains a serious threat and requires even more concerted efforts to mitigate its effects. Its impact on education and the nature of its management was shown to be a real challenge for schools and that serious and focused interventions are necessary, especially considering its effects on learners, educators and other affected people at school level.

The SCM evaluation of the effectiveness of the HIV and AIDS management at schools revealed verifiable stories from participating SMTs. On the basis of the study's assumptions (1.5), objectives (1.2) and the empirical evidence in this study, the following conclusions are made:

- The FPD training programme did provide SMTs with appropriate knowledge, skills and attitudes to manage HIV and AIDS at schools. This is evidenced by the impacts achieved in terms of SMTs' acquisition of skills for establishing organisational structures for the management of HIV and AIDS at their schools. This included the ability to liaise with stakeholders, develop and refine policies and to develop action plans for the management of HIV and AIDS, scale up awareness to alleviate exposure to HIV infection, develop other methods to address universal precautions to manage HIV and AIDS and devise measures to improve access to VCT, treatment and information on care and support.

- The FPD training programme did inspire a change in SMTs and became a driving force for behavioural change, which inspired willingness and competence to sustain HIV and AIDS management practices.

- Through the SCM evaluation of the effectiveness of the HIV and AIDS management at schools in the Tshwane South District, it can be concluded

that the management of HIV and AIDS at schools is indeed to a significant extent, effective. This is evidenced by the explanation of what was achieved (6.2.1), how widespread the success was (6.2.2), and most importantly, the value of the outcomes achieved (6.2.6).

It must, however, be pointed out that although the success case stories offered evidence of success in the implementation of the HIV and AIDS management at schools, the full impact which would determine the overall effectiveness and sustainability of the HIV and AIDS implementation goes beyond the scope of the present study and opens up a need for longitudinal research in this regard. However, on the basis of the research results in this study and the evaluation effects of the SCM, it can be concluded that at schools where there were success stories, the management of HIV and AIDS was significantly effective.

- The SCM is indeed an inexpensive, appropriate and effective qualitative evaluation method for social practice.

- The success and non-success stories provide numerous lessons in the implementation of the HIV and AIDS management at schools. These are used as the basis for recommendations of this study (see 6.3) for improving the future training interventions in general and specifically by the FPD, for the practice of HIV and AIDS management at schools and for the theory of evaluation research in education.

In light of the conclusions drawn above, it can be said that the study succeeded in evaluating the implementation of the HIV and AIDS management at schools of the participating SMTs and thus lays the basis for the study's recommendations.

6.4 RECOMMENDATIONS

The use of intervention programmes to manage HIV and AIDS at schools is one of the strategies that can help to create an HIV and AIDS-free society. Although this study attested to and documented widespread application of the FPD training at schools, improvements are still required to ensure that all schools experience the impact of the FPD intervention programme and the implementation of HIV and AIDS

management at schools equally and as intended. For that to happen, the recommendations below are made.

6.4.1 Recommendations for practice

The findings of this study point to a definite need for certain actions to be taken to help *success cases* to maintain good practices and to address gaps that were found from the *non-success cases* concerning HIV and AIDS management at schools. Action should therefore be taken on the following:

6.4.1.1 Success cases

The following recommendations are made for success case SMTs:

- **Maintenance and strengthening of partnerships**

The evidence collected shows that the positive outcomes of the application of the FPD training were due to, among others, partnership with external stakeholders. Therefore such partnerships should be maintained and strengthened in order to implement HIV and AIDS programmes continuously at schools. This could be done by, for example, extending the support to other government departments, such as the Department of Social Development, rather than just the Department of Health and NGOs, with which most of the schools reported to have established partnerships. In this regard, schools could benefit in terms of HIV and AIDS management, since the Department of Social Development also offers basic services that schools can utilise to effectively manage HIV and AIDS (Department of Social Development, 2005:7)

- **Development of HIV and AIDS management forums**

Another essential, practical implication emanating from the findings of this study is that there is a need to develop forums wherein success cases share and discuss their successes with non-success cases as well as those schools or SMTs who did not attend the training. This practice will help other non-success cases through, for example, a question-and-answer method to acquire strategies that can assist in managing HIV and AIDS at their schools. Moreover, this will allow the success cases to continuously enhance their knowledge and skills of HIV and AIDS management and its implementation.

6.4.1.2 Non-success cases

The following recommendations are made for non-success case SMTs:

- **Understaffing**

Considering Section 5.3.1.5, it is clear that understaffing made the implementation of the FPD programme at schools difficult. In this regard, staff whose sole function is to coordinate the implementation of the programme will be required. It is therefore suggested that the FPD contract HIV and AIDS programme coordinators who could, through the SMTs, manage HIV and AIDS activities at schools. These appointments can therefore be made in consultation with the Tshwane South District, SMTs and SGBs. To be cost effective, one appointee can be allocated to several schools that fall within a cluster. Furthermore, it is clear that appointing a person in charge of the programme will allow the programme to run without affecting or disrupting SMTs' and educators' core duties. SMTs would then just oversee the programme and its implementation.

- **Implementation strategy**

A better approach to address the lack of strategies to manage HIV and AIDS at schools is, among others, the development of plans for the programme. This could be done firstly at school level, where SMTs sit with their staff, including the non-professionals and learner representatives, and sharing ideas on how and what the school can do to apply the FPD training. Furthermore, and most importantly, SMTs that could not formulate effective implementation strategies will need to be retrained due to the gaps in their knowledge, skills and attitudes. There is therefore a need to re-assess or audit the levels of knowledge and skills in this regard. The FPD could be requested to develop an assessment protocol for this purpose.

Lastly, SMTs could use cluster meetings to share plans and strategies to apply the FPD training. In order to make this possible, an ad hoc committee could be formed by SMTs from schools in the same cluster to facilitate the meetings. This practice will help schools to engage in the 'learning from one another' principle.

- **Workload**

In view of the failure to design the HIV programme activities even after the training, a more ambitious approach is needed to address the matter of educator workload. It is recommended that the results of the evaluation of this study should be disseminated

to both the District Office and the FPD, with the express purpose of dealing with the staffing challenge. It might be decided, as a result of brainstorming this challenge and acknowledging the need for HIV and AIDS management at schools, that special posts should be allocated to schools or school clusters for the purpose of coordinating and driving the implementation of HIV and AIDS management. This would of course necessitate alteration and adaptation of the implementation plan and process at schools to suit a coordinated implementation plan.

6.4.2 Recommendations for an FPD training programme

The following recommendations are made to enhance the FPD training programme to realise the objective of implementing HIV and AIDS management at schools.

- **Reporting systems**

In view of the fact that there was no monitoring of the implementation of the FPD programme on HIV and AIDS management, the Tshwane South District should regularly visit schools to monitor and support the implementation of the programme. Furthermore, the line of command for HIV and AIDS management in the District should be clearly defined so that SMTs know the person whose responsibility it is to coordinate the programme in the District for the purpose of giving feedback on progress, including the challenges faced and the milestones achieved. This should include communication lines with the FPD so as to synergise activities and provide the necessary support, without duplicating functions and creating unintended conflict as a result of not having a clearly structured reporting and feedback loop.

Feedback could, for example, be in the form of monthly or quarterly reports. This could be aided by having a monitoring plan that details what to report on and when to report. However, the viability of this practice will and should depend on the District's ability to design a reporting tool or rubric that addresses the implementation of the HIV and AIDS programme in coordination with the FPD monitoring system.

- **Duration of the training**

Given that the non-success cases complained about the amount of work during the training, it is suggested that the FPD training could be structured to take into account trainees' different cognitive and learning abilities. The fact that some participants'

evaluation outcomes could not secure them a certificate of performance achievement, indicates the need for such an approach. The training could be extended to schools whose representatives could not attain satisfactory achievements in the evaluation. It would also help for the FPD to provide hands-on assistance and support to such trainees at their schools so as to boost their confidence, understanding and skills to carry out the objectives of the training programme.

- **Extension of the FPD training**

The training of SMTs in HIV and AIDS does not necessarily mean that they should go out and train other staff members and parents. However, SGBs and other staff members should be trained in managing HIV and AIDS at schools, and this should be done where necessary and possible. The extension of the training could lead to all staff members and school authorities acquiring first-hand information, and subsequently a passion and a need for an effective programme will gain a hold on them and make them to want to act and take ownership of the programme, and not just be passive observers. This type of inclusive training should be facilitated by conducting it in a school cluster or location cluster basis and also per attendee category, for instance, SGB members could be trained on dates of their own choosing.

Most importantly, the district officials who coordinate HIV and AIDS management programmes should also receive the FPD training so that the understanding of the whole processes involved in managing HIV and AIDS at schools is not vested in the SMTs alone. The training will further give the district an idea of success and/or non-success application of the training, which in essence means that the FPD programme will be valued even at the district level.

6.4.3 Recommendations for future research

This study presented areas of concern regarding the implementation of HIV and AIDS programme at schools. Further research needs to be carried out to address those areas.

6.4.3.1 Implementation of HIV and AIDS programmes in primary compared with secondary schools

The findings of this study show that the majority of SMTs from primary schools have implemented the programme compared with the number of SMTs in secondary schools who have done so. Therefore further research on this variation would be of great help in finding reasons why this occurs, and the factors behind the variation should be extrapolated. In this regard, it would be very interesting to compare the knowledge, skills and attitudes regarding HIV and AIDS between primary schools SMTs and secondary schools SMTs. Such a study might even assist in designing intervention programmes that suit primary and secondary schools respectively

6.4.3.2 Implementation of HIV and AIDS programmes by female SMTs compared with male SMTs

It was also found from this study that female SMTs implemented the HIV and AIDS programme more effectively than male SMTs. Therefore a study to determine the cause of this application difference should be conducted. Furthermore, it would be appropriate also to consider problems that can arise if more female SMTs implement the programme than male SMTs or vice versa. Problems that contribute to such a variation should also be identified and answers found. It can also be to the advantage of schools and other stakeholders if the causal relationship between gender and the effectiveness of the implementation of HIV and AIDS programmes at schools could be investigated.

6.4.3.3 Implementation of HIV and AIDS programmes according to the location of schools

As stated previously, this study did not evaluate the implementation of the HIV and AIDS programme according to the location of the schools. It would therefore enrich the findings of this study if another study of this nature (SCM study) could be conducted to determine where success lies with regard to the management of HIV and AIDS at schools. The factors contributing to success and/or lack of success could also be identified. This initiative could assist trainers to design training programmes that address the challenges or problems that face a particular area, rather than to come up with a ‘one-size-fits-all’ intervention strategy.

6.4.3.4 Evaluation of overall effectiveness of HIV and AIDS management at schools

It would be prudent to conduct longitudinal research at the success case schools so as to determine, with precision and using additional research tools, the full impact of the HIV and AIDS management at schools in terms of sustainability, changes in universal precautions, prevention, support and care, and the effects on the quality of life of PLWHA, and in particular, learners and educators at schools.

6.5 CONTRIBUTIONS OF THE STUDY

This study contributes to both theory and practice.

6.5.1 Contributions to theory: evaluation of the Success Case Method

The study presents a simple yet effective method of programme or intervention evaluation. Although there is a growing body of literature on programme evaluation, the SCM has to date received little attention. Therefore this study locates the SCM evaluation in education and provides programme evaluators and researchers with an alternative evaluation method. As stated in the text, the SCM evaluates organisational job performances in a fast and cost-effective way and provides valid and reliable results. Furthermore, the SCM can be applied anywhere by anyone interested in evaluating the application of the proximal outcomes of training. The study also provides new understanding on how to differentiate successful performers in learning application from non-successful performers. In fact, the use of the SCM in this study can be important for the Tshwane South District, the Department of Education and the FPD as it provides findings as factual accounts rather than as complex statistics which are difficult to comprehend. Finally, the use of the SCM in this study assists in gaining an understanding of, and acknowledging the need for, developing a training impact model and making it known to stakeholders or trainees in an intervention programme so that they achieve meaningful results.

6.5.2 Contribution to practice

The pragmatic findings of this study provide a range of alternatives with respect to the management of HIV and AIDS at schools, thus contributing to the practice of intervention programme implementation. To be precise, this study enhances the

understanding of the continuous need for evaluation of the implementation of the HIV and AIDS programmes. Various factors found to have a positive influence on the management of HIV and AIDS can play a crucial role in enhancing knowledge of what to consider when managing HIV and AIDS. This spectrum of knowledge therefore makes it easy for an HIV and AIDS programme to be effectively implemented at schools. In particular, it enhances understanding of a holistic approach towards HIV and AIDS management at schools.

The findings from this study can help the Tshwane South District to identify gaps and successes in HIV and AIDS management at schools in the district, which can be useful in strengthening the school- and community-based assets such as the knowledge, skills and attitudes of SMT members and community structures.

This study can also assist the FPD to know whether the application of the training outcomes has had the desired impact on the overall management of HIV and AIDS at schools. It is hoped that this will provide the FPD with the necessary impetus to assist schools by monitoring, evaluating and supporting school-based practitioners.

6.6 LIMITATIONS OF THE STUDY

The findings from this study revealed a clear picture of how SMTs in the Tshwane South District implemented the FPD programme on HIV and AIDS management at schools. However, as is usually the case with studies in social science, there are several caveats to this evaluation study (Schlechter, 2005:189).

First, the external validity of the study was confined to SMTs in the Tshwane South District who attended the FPD training on HIV and AIDS management at schools in 2010. In addition, only 74 SMTs participated in this study, which is a small proportion of the total number of SMTs in the Tshwane South District, and the findings from this study cannot be generalised beyond schools in this district. However, the SCM evaluation offered deep and useful insights into how SMTs, and by extension, schools can manage HIV and AIDS in ways that can be applicable in other school settings.

Second, the researcher experienced difficulties in gathering the quantitative data. Some of the participants completed the questionnaire on the day the researcher

wanted them. This might have led to the participants not giving accurate answers because they were rushing to complete the questionnaire and get it off their hands. Nevertheless, I also interviewed the participants to validate the collected quantitative data: two respondents were found to be false positives and another two were found to be false negatives as described in Section 6.2.2.

Third, transcribing the telephone interviews was very difficult since the telephone conversations were not always clear or very audible. This led initially to numerous data gaps. However, I enlisted at a cost a team comprising members with English as their mother tongue to transcribe the telephone interviews. I also downloaded the recordings to a laptop computer so that they could be played slowly to capture the original conversations for the transcriptions. These measures, apart from ensuring correct data capturing and transcription, also assisted in improving the reliability and validity of the data.

Lastly, it is acknowledged that this study did not compare the implementation of HIV and AIDS management as far as the location of the schools was concerned. Such comparisons could have assisted in determining the extent of implementation of HIV and AIDS management in such areas as informal settlements, townships, suburbs and town schools. This then is a further gap in the existing research.

6.7 CONCLUSIONS

This study used the SCM to evaluate the effectiveness of the FPD programme in managing HIV and AIDS programmes at schools in the Tshwane South District. It can be asserted that the study succeeded in attaining its objectives. It can also be stated that the study managed to put the SCM in the academic realm of education researchers. Finally, the study opens up scope for further research on the implementation of HIV and AIDS management on a large scale, as well as emphasising the need for programme evaluation in the Department of Education.

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APPENDICES

APPENDIX A[7]

Assessment Questionnaire

Please work through the study material and complete the attached assessment questionnaire answer sheet (Page 23).

Post or fax your answers to:

Ilana van der Merwe
Foundation for Professional Development
PO Box 75324
Lynnwood Ridge 0040
Tel: 012-816 9000
Fax: 012-807 7165

Please note:

It is recommended that you keep a copy of the completed questionnaire for your own records in case it gets lost in the postal service.

Participants, who fail to complete the course within 6 months from registration, will have to reregister for the course.

The assessment questionnaire will be sent to an assessor for marking. In order to qualify for the compliance certificate, a pass rate of 70% is required.

Your certificate will be forwarded to you by post approximately one month after receipt of your assessment questionnaire.

Should you have any questions or experience any unforeseen delays, please contact Ilana at the contact number above.

[7] Due to the length of the assessment questionnaire, only a sample of four pages is included as an appendix. The full Assessment Questionnaire can be obtained from the author.

ASSESSMENT QUESTIONNAIRE: HIV & AIDS in the Workplace

Section A

Mark the following statements as true or false:

1. **The HIV virus destroys the CD4 cells of the body's immune system.**

   a) True.
   b) False.

2. **The strength of the immune system is measured through the Viral Load and the strength of the virus is measured through the CD4 count.**

   a) True.
   b) False.

3. **Over time the Viral Load and the CD4 count usually have a reverse relationship.**

   a) True.
   b) False.

4. **During the window period the person will test HIV+ if he or she has been infected with the virus.**

   a) True.
   b) False.

5. **In Africa, HIV is transmitted mainly through the use of contaminated needles.**

   a) True.
   b) False.

6. **The total number or proportion of people identified as being infected by the HIV virus, at any given time, is known as the prevalence rate.**

   a) True.
   b) False.

ASSESSMENT QUESTIONNAIRE ANSWERSHEET

Please fax the completed answer sheet to: 012 807 7165

Name: _____ Student no: _____

Address: _____

Tel & fax no: _____ e-mail: _____

Circle the correct answers.

Section A

Question 1	a	b	Question 22	a	b
Question 2	a	b	Question 23	a	b
Question 3	a	b	Question 24	a	b
Question 4	a	b	Question 25	a	b
Question 5	a	b	Question 26	a	b
Question 6	a	b	Question 27	a	b
Question 7	a	b	Question 28	a	b
Question 8	a	b	Question 29	a	b
Question 9	a	b	Question 30	a	b
Question 10	a	b	Question 31	a	b
Question 11	a	b	Question 32	a	b
Question 12	a	b	Question 33	a	b
Question 13	a	b	Question 34	a	b
Question 14	a	b	Question 35	a	b
Question 15	a	b	Question 36	a	b
Question 16	a	b	Question 37	a	b
Question 17	a	b	Question 38	a	b
Question 18	a	b	Question 39	a	b
Question 19	a	b	Question 40	a	b
Question 20	a	b	Question 41	a	b
Question 21	a	b	Question 42	a	b

Section B

Question 43	a	b	c	d	e	Question 57	a	b	c	d	e
Question 44	a	b	c	d	e	Question 58	a	b	c	d	e
Question 45	a	b	c	d	e	Question 59	a	b	c	d	e
Question 46	a	b	c	d	e	Question 60	a	b	c	d	e
Question 47	a	b	c	d	e	Question 61	a	b	c	d	e
Question 48	a	b	c	d	e	Question 62	a	b	c	d	e
Question 48	a	b	c	d	e	Question 63	a	b	c	d	e
Question 50	a	b	c	d	e	Question 64	a	b	c	d	e
Question 51	a	b	c	d	e	Question 65	a	b	c	d	e
Question 52	a	b	c	d	e	Question 66	a	b	c	d	e
Question 53	a	b	c	d	e	Question 67	a	b	c	d	e
Question 54	a	b	c	d	e	Question 68	a	b	c	d	e
Question 55	a	b	c	d	e	Question 69	a	b	c	d	e
Question 56	a	b	c	d	e						

Section C

Question 70	a	b	c	Question 73	a	b	c
Question 71	a	b	c	Question 74	a	b	c
Question 72	a	b	c	Question 75	a	b	c

APPENDIX B: Quantitative Research Survey Tool/Questionnaire

SURVEY TOOL

Name:

_____

SECTION A: KNOWLEDGE APPLICATION

DIRECTION: Read each statement and/ or question. Carefully rate the extent to which you have implemented the Foundation for Professional Development [FPD] training on the management of HIV/AIDS at your school by circling one answer that fits you best.

1. I have applied the FPD's training to develop the HIV/AIDS management programme in my school.

   a. Yes, with clear positive results
   b. Yes, but had no clear results yet
   c. Not yet, but I expect to do this
   d. I don't have any intention to do this

2. I have developed a school action plan for HIV/AIDS management at my school

   a. Yes, with clear positive results
   b. Yes, but had no clear results yet
   c. Not yet, but I expect to this
   d. I don't have any intention to do this

1

3. I have developed and communicated my school's HIV/AIDS policy to all relevant stakeholders

   a. Yes, with clear positive results
   b. Yes, but had no clear results yet
   c. Not yet, but i expect to do this
   d. I don't have any plans to do this

4. I have developed programme that link the school to the community in the fight against HIV/AIDS

   a. Yes, with clear positive results
   b. Yes, but had no clear results
   c. Not yet, but i expect to do this
   d. I don't have any plans to do this

5. What is your feeling about your School Management Team (SMT)'s overall commitments to the FPD training implementation?

   a. The SMT is interested and is fully committed to the implementation of it
   b. The SMT fully understands the importance of the FPD intervention, but has not fully committed to the implementation of it
   c. I think the SMT somewhat is committed to the implementation of it
   d. The SMT has not committed at all to the implementation

2

6. I have used the FPD training to impart knowledge and skills on HIV/AIDS management to other staff members and learners at my school.

   a. Yes, with clear picture results
   b. Yes, but had no clear result yet
   c. Not yet, but i expect to do this
   d. I don't have any plans to do this

7. I have used the training to do an HIV/AIDS prevalence survey in my school

   a. Yes, with clear picture results
   b. Yes, but had no clear results yet
   c. Not yet, but i expect to do it
   d. I don't have any plans to do this

3

SECTION B: DEMOGRAPHIC INFORMATION

1. On which date did you receive training by FPD on the management of HIV/AIDS in school?

   _____

2. Did you receive a certificate of attendance?

   _____

3. What is your present job position?

   _____

4. How many years have you been in your current position?

   _____

5. Gender

   _____

6. Race

   _____

7. Age (*Tick*) **[20- 25]** ; **[26- 30]**; **[31-35]**; **[36-40]**; **[41-45]**; **[46-50]**; **[50 and above]**

   _____

8. In which area is your school located?

   _____

9. Name of school

   _____

10. Is you school a primary, a secondary or an LSEN? Please specify.

    _____

Upon results of this survey you might be requested to participate in a one on one in-depth interview or telephone interview or focus group interview to provide the researcher with more insights about the effectiveness of HIV/AIDS management in your school subsequent the Foundation of Professional Development [FPD] training you received on managing HIV in schools.

11. Would you like to be interviewed?

    _____

4

12. What is your preferred way to be contacted in case you are selected for an in-depth interview?

a) Phone (Kindly furnish your cell number and/or landline number

_____

b) E-mail (kindly provide your active e-mail address

_____

I appreciate your willingness to be involved in this research project.

5

APPENDIX C: Research request form framework to Gauteng Department of education Head Office

For Official Use	
Ref. No.	

GAUTENG DEPARTMENT OF EDUCATION

RESEARCH REQUEST FORM

REQUEST TO CONDUCT RESEARCH IN INSTITUTIONS AND/OR OFFICES OF THE GAUTENG DEPARTMENT OF EDUCATION

1. PARTICULARS OF THE RESEARCHER

1.1	Details of the Researcher
Surname and Initials:	Mbada N.A
First Name/s:	Ndavheleseni Albert
Title (Prof / Dr / Mr / Mrs / Ms):	Mr
Student Number (if relevant):	223769773
ID Number:	7208256166085
Gender (Male/Female):	Male

1.2	Private Contact Details
Home Address	*Postal Address (if different)*
155 Danville	*155 Danville*
Marsburg Street	*Marsburg Street*
Pretoria West	*Pretoria West*
Postal Code: 0183	*Postal Code:0183*
Tel: (012) 382 6616	
Cell: 0725090719	
Fax: ( )	
E-mail: Albert.Mbada@gmail.com	

2.5	Student and Postgraduate Enrolment Particulars (if applicable)
Name of institution where enrolled:	University of North-west [Vaal Campus]
Degree / Qualification:	Doctor of Philosophy
Faculty:	Humanities
Department:	School of Education Sciences
Name of Supervisor / Promoter:	Dr. M.I Xaba

2.6	Employer (where applicable)
Name of Organisation/School:	Tshwane University of Technology
Position in Organisation:	HIV and AIDS Programme Coordinator
Head of Organisation:	Mrs A. Sefolosha
Street Address:	Staatsartillerie Road,
	Pretoria West
Postal Code:	0001
Telephone Number (Code + Ext):	012 382 6612
Fax Number:	
E-mail:	Asefolosha@tut.ac.za

2.7	PERSAL Number (where applicable)

9	6	0	1	1	8		

3. PROPOSED RESEARCH METHOD/S

(Please indicate by placing a cross in the appropriate block whether the following modes would be adopted)

3.1 ***Questionnaire/s (If Yes, supply copies of each to be used)***

YES	X	NO	

3.2 ***Interview/s (If Yes, provide copies of each schedule)***

DECLARATION BY SUPERVISOR / PROMOTER / LECTURER	
I declare that: - 1. *The applicant is enrolled at the institution / employed by the organisation to which the undersigned is attached.* 2. *The overall research processes meet the criteria of:* • *Educational Accountability* • *Proper Research Design* • *Sensitivity towards Participants* • *Correct Content and Terminology* • *Acceptable Grammar* • *Absence of Non-essential / Superfluous items*	
Surname:	**Xaba**
First Name/s:	**Mgadla Isaac**
Institution / Organisation:	**North-West University (Vaal Triangle Campus)**
Faculty:	**Humanities**
Department:	**Educational Sciences**
Telephone:	**016 910 3068**
Fax:	
Cell:	**084 757 1197**
E-mail:	**Ike.Xaba@nwu.ac.za**
Signature:	
Date:	**09 July 2011**

N.B. This form (and all other relevant documentation where available) may be completed and forwarded electronically to Ebrahim Farista (ebrahimf@gpg.gov.za) or Nomvula Ubisi (nomvulau@gpg.gov.za). The last 2 pages of this document must however contain the original signatures of both the researcher and his/her supervisor or promoter. These pages may therefore be faxed or hand delivered. Please mark fax - For Attention: Ebrahim Farista at 011 355 0512 (fax) or hand deliver (in closed envelope) to Ebrahim Farista (Room 911) or Nomvula Ubisi (Room 910), 111 Commissioner Street, Johannesburg.

APPENDIX D: Requisition letter to Tshwane South District

155 Danville
Marsburg Avenue
Danville
Pretoria West
0183
17 July 2011

The District Manager
Tshwane South District
Gauteng Department of Education
265 Pretorius Street
President Towers Building
0001

Dear Madam

PERMISSION TO CONDUCT RESEARCH FOR DOCTORAL DEGREE

I am a post-graduate student in the faculty of Humanities in North West University (Vaal Triangle branch) conducting a Success Case Evaluation Research at schools based on the HIV and AIDS Management training conducted for your School Management Teams in 2010 by the Foundation for Professional Development (FPD). The target population for this study is all the SMTs who attended the said training from schools in your district. The study has been designed such that:

(1) SMTs will be required to complete a questionnaire
(2) Analysis of the survey tool to determine SMTs who successfully implemented and those who least or failed to implement the FPD training in their schools
(3) A sample of SMTs, from high success cases and non-success cases, will be interviewed.

Kindly find the following documents attached to this letter:

- A copy of the proposal
- A copy of the questionnaire
- A copy of the interview questionnaire and interview schedule
- A copy of the permission letter from Gauteng Department of Education Head Office

The study aims to assess and enhance the management of HIV and AIDS in the Tshwane South District Schools.

Thanking you in anticipation.

Yours Faithful

Mbada Ndavheleseni Albert
Cell: 072 509 0719 (W) 012 382 6616
Email: Albert.Mbada@gmail.com

APPENDIX E: CONSENT FORMS:

QUESTIONNAIRE

RESEARCHER: Mbada N.A.

TITLE OF RESEARCH PROJECT: A Success Case Method evaluation of the effectiveness of the implementation of the HIV and AIDS management at schools in the Tshwane South District.

PURPOSE OF THE RESEARCH is to investigate the effectiveness of the implementation of the HIV and AIDS management at schools in the Tshwane South District.

DURATION: The duration for completing the questionnaire will be approximately 10 minutes.

PROCEDURES: The questionnaire requires you to indicate your experiences relating to given statements on a five category scale, namely:

POSSIBLE RISKS: There is no risk envisaged in completing the questionnaire, to you, your school, colleagues, learners, the Tshwane South District or the Gauteng Department of Education. However, in the event of questions that may be perceived as threatening or causing discomfort, you may decline to answer such questions without providing any reason for doing so.

BENEFITS: No direct benefits or compensation will be due to any respondent to the questionnaire.

VOLUNTARY PARTICIPATION: Participation in this research is completely voluntary. You are within your right at any stage to and may, refuse to participate and or withdraw at any time.

CONFIDENTIALITY: Data in this study will be confidential. As such all data collected will, in the final research report, use (1) fictitious names; (2 identification keys, which will be known only to the researcher; and will be treated and be kept confidential until they are discarded after five year (University ethics requirement).

CONTACT: The research is conducted by Doctoral student, Mbada N.A., under the supervision of Prof. MI XABA from the School of Educational Sciences: North-West University – Vaal Triangle Campus. Prof. MI Xaba can be reached at 016 910 3068 (o/h) for questions regarding this research project.

This research has been ethically approved by the North West University Ethics Committee.

CONSENT:

I …… have read and understand the nature of my participation in this research project and agree to participate.

_____ _____

Name Signature

_____

Date

Researcher: _____

INTERVIEW

RESEARCHER: Mbada N.A.

TITLE OF RESEARCH PROJECT: An evaluation of the effectiveness of the implementation of the HIV and Aids management at schools in the Tshwane South District.

PURPOSE OF THE RESEARCH is to evaluate the effectiveness of the implementation of the HIV and Aids management at schools in the Tshwane South District.

DURATION: The duration for interviews will be approximately 60 minutes.

PROCEDURES: Interviews will be one-to-one, after school hours or at any convenient time for you.

POSSIBLE RISKS: No possible risks to you, your school, colleagues, learners, the Tshwane South District or the Gauteng Department of Education are envisaged. However, in the event of questions that may be perceived as threatening or causing discomfort, you may decline to answer such questions without providing any reason for doing so.

BENEFITS: No direct benefits or compensation will be due to any participant.

VOLUNTARY PARTICIPATION: Participation in this research is completely voluntary. You are within your right at any stage to and may, refuse to participate and or withdraw at any time.

CONFIDENTIALITY: Data in this study will be confidential. As such all data collected will be coded in terms of (1) fictitious names; (2) data collected; and (3) use of identification keys, which will be known only to the researcher.

Audio tapes being kept confidential until they are erased after five year. (University ethics requirement).

CONTACT: The research is conducted by Doctoral student, Mbada N.A., under the supervision of Prof. MI Xaba from the School of Educational Sciences: North-West University – Vaal Triangle Campus. Prof. MI Xaba can be reached at 016 910 3068 (o/h) for questions regarding this research project.

This research has been ethical approved by the North West University Ethics Committee.

CONSENT:

I …… have read and understand the nature of my participation in this research project and agree to participate.

_____

_____

Signature _____ Date:

_____

Researcher: _____

APPENDIX F: Letter to School Principals/School Governing Body

155 Danville

Marsburg Avenue

Pretoria West

0183

07 September 2011

The Principal/SGB

_____

_____

_____

Dear Sir/Madam

Conducting a research in your school (PhD level)

I, ***NDAVHELESENI ALBERT MBADA***, will be conducting a study research in public primary and secondary schools in Tshwane South District [GDE], of which your school falls within. The study seeks to evaluate the implementation of the Foundation for Professional Development [FPD]'s HIV/AIDS School management programme.

Title of the research: **School managers' perception of the effectiveness of the HIV/AIDS management at schools in the Tshwane South District: A success Case Method Study**.

The quantitative data will help the researcher identify those trainees who have been most, and least successful, and record the proportions of each category. The successful and unsuccessful trainees will be interviewed to understand, analyse and document their stories. The aim is to find out whether the FPD training is working or not. The researcher will also need to know factors that contributed to the participants' (in this case, those who attended the FPD training in 2010) results. Recommendations will be made based on the researcher's findings.

The study aims to assist school managers to effectively manage HIV and AIDS in schools.

Ethical standards in researching will be strictly adhered to. Herewith find a copy of permission letter from Gauteng Department of Education Head Office. Your assistance is always appreciated.

Thank you

_____

Mbada N.A (Researcher)

University of North West (Vaal campus)

Cell: 072 509 0719 Work Tel: 012 382 6616

APPENDIX G: Permission letter from Tshwane South District

education
Department: Education
GAUTENG PROVINCE

Reference : Policy and Planning: Partnerships
Enquiries : Sello George Ngwenya
Telephone : 012 401 6322
Fax : 012 401 6323
Fax-2-email: 0865 674 276
E-mail : Sello.Ngwenya@gauteng.gov.za
22 July 2011

Mr. N.A Mbada
155 Marsburg Street, Danville
Pretoria West
0183
012 382 6616 (T)
072 509 0719 (Mobile)

Cc: The Principal and SGB

Dear Sir

PERMISSION TO CONDUCT RESEARCH: N.A MBADA

Your research application has been approved by Head Office. The full title of your Research: **"School managers' perceptions of the effectiveness HIV/AIDS management at schools in the Tshwane South District: A success Case Method Study". You are expected to adhere strictly to the conditions given by Head Office.** You are also advised to communicate with the school principal/s and/or SGB/s regarding your research and time schedule.

Our commitment of support may be rescinded if any form of irregularity/ no compliance to the terms in this letter or any other departmental directive/ if any risk to any person/s or property or our reputation is realised, observed or reported.

Terms and conditions

1. The safety of all the learners and staff at the school must be ensured at all times.
2. All safety precautions must be taken by the researcher and the school. The Department of Education may not be held accountable for any injury or damage to property or any person/s resulting from this process. The school/s must ensure that sound measures are put in place to protect the wellness of the researcher and his/ her property.

NB Kindly submit your report including findings and recommendations to the District at least two weeks after conclusion of the research. You may be requested to participate in the Department of Education's mini-research conference to discuss your findings and recommendations with departmental officials and other researchers.

The District wishes you well.

Yours sincerely

Mrs. H.E Kekana
Director: Tshwane South District

1/1

Making education a societal priority

Office of the District Director: Tshwane South District
(Mamelodi/Eersterust/ Pretoria East/Pretoria South/Atteridgeville/Laudium)
265 Pretorius Street, Pretoria 0001
Private Bag X 27825, Sunnysie, 1322 .Tel: (012) 401 6317. Fax: (012) 401 6318
Website: www.education.gpg.gov.za

APPENDIX H: Permission Letter from GDE: Head Office

education
Department: Education
GAUTENG PROVINCE

For administrative use:
Reference no. D2012/115

GDE RESEARCH APPROVAL LETTER

Date:	13 July 2011
Name of Researcher:	Mbada N.A.
Address of Researcher:	155 Danville
	Marsburg Street
	Pretoria West
	0183
Telephone Number:	012 382 6616 / 072 509 0719
Fax Number:	None
Email address:	Albert.Mbada@gmail.com
Research Topic:	School Managers' perceptions of the effectiveness HIV/AIDS management at schools in the Tshwane South District: A success Case Method study
Number and type of schools:	ONE HUNDRED AND FIFTY SIX Primary Schools and FIFTY-FIVE Secondary Schools
District/s/HO	Tshwane South

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

1. *The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.*

Office of the Director: Knowledge Management and Research
9th Floor, 111 Commissioner Street, Johannesburg, 2001
P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506
Email: David.Makhado@gauteng.gov.za
Website: www.education.gpg.gov.za

2. *The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.*
3. *A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.*
4. *A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.*
5. *The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.*
6. *Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Director (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.*
7. *Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year.*
8. *Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.*
9. *It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.*
10. *The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.*
11. *The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.*
12. *On completion of the study the researcher must supply the Director: Knowledge Management & Research with one Hard Cover bound and an electronic copy of the research.*
13. *The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.*
14. *Should the researcher have been involved with research at a school and/or a district/head office level, the Director concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.*

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards

13 July 2011

Shadrack Phele MIRMSA
[Member of the Institute of Risk Management South Africa]
CHIEF EDUCATION SPECIALIST: RESEARCH COORDINATION

APPENDIX I: SCHEDULE FOR INTERVIEW WITH THE SUCCESS PERFORMERS (TELEPHONICAL):

1. Your responses to the questionnaire which was distributed to and completed by you show that you have successfully implemented the Foundation of Professional Development (FPD) School HIV and AIDS management programme in your school. My assumption, based on the questionnaire results, is that you have found the training very useful. Is that so?

2. Accordingly, I would like to get deeper understanding on how you made it possible to can apply the learned knowledge and skills. I would request that we schedule a time in which I conduct a telephone interview you which will take about 35 minutes.

3. The responses that you will give during the interview will be treated with confidentiality and you will also remain anonymous. Rest assured that none of the answer will be attached to or associated with your personal life.

NARROWED SUCCESS CASES INTERVIEW QUESTIONS

Opening remarks:

Let me take this opportunity to thank you for making time for me to interview you. I am currently evaluating the effectiveness of the HIV and AIDS management at schools in the Tshwane South District: A Success Case study. Be assured that confidentiality as well as anonymity is guaranteed. The interview will take almost 35minutes. Do you have any question up to so far?

1. WHAT WAS USED?

1.1. Tell me how you are applying the Foundation for Professional Development (FPD) training on the management of HIV and AIDS in your school.

1.2. What parts of the training have you used most in the management of HIV and AIDS in your school?

1.3. What part of training do you think it was not important for the management of HIV and AIDS in your school?

2. WHAT RESULTS WERE ACHIVED?

2.1. How has the FPD training made different in the management of HIV and AIDS in your school?

2.2. What has the FPD training helped you as a school to achieve in the management of HIV and AIDS in your school?

2.3. What has been changed or improved on the management of HIV and AIDS in your school?

3. WHAT GOOD DID THE PROGRAMME DO?

3.1. What did you achieve by implementing a School HIV and AIDS programme?

3.2. Why are these results important?

4. WHAT HAS HELPED?

4.1. Describe factors that helped you as an SMT members to apply the FPD training on the management of HIV and AIDS in your school successfully

5. SUGGESTIONS.

5.1. If you were to implement another FPD training of this nature, i,e., the management of HIV and AIDS at school, what help and resources would you need?

Closing remarks:

This is the end of the interview. Thank you once more for participating in this study. You are at liberty to can contact me for in case you have questions related to this study in future. My mobile number is 0725090719. Thank you!

APPENDIX J: SCHEDULE FOR INTERVIEW WITH LEAST OR NON-SUCCESS PERFORMERS (TELEPHONICAL):

1. Your responses to the questionnaire which was distributed to and completed by you show that you have least successfully implemented the Foundation of Professional Development (FPD) School HIV and AIDS management programme in your school. My assumption, based on the questionnaire results, you might have found challenges that made you not to perform to your fullest.

2. Accordingly, I would like to get deeper understanding on hindering factors towards the application. I kindly request that we schedule a time in which I can interview you, telephonic. The interview will take about 35 minutes.

3. The responses that you will give during the interview will be treated with confidentiality and you will also remain anonymous. Please rest assured that none of the answers will be attached to or associated with your personal life.

NARROWED NON-SUCCESS CASES QUESTIONS

Opening remarks:

Let me take this opportunity to thank you for making time for me to interview you. I am currently evaluating the effectiveness of the HIV and AIDS Management at schools in the Tshwane South District: A Success Case study. Be assured that confidentiality as well as anonymity is guaranteed. The interview will take almost 35 minutes, and it is based on your questionnaire scores. Do you have any question up to so far?

1. BARRIERS

1.1. How were you implementing the Foundation for Professional Development (FPD) intervention programme on the management of HIV and AIDS in your school?

1.2. What were the barriers in the implementation of the FPD training on school HIV and AIDS management?

2. SUGGESTIONS

2.1. What do you think should be done in order to get your school to implementing the FPD training on school HIV and AIDS management more successful?

Closing remarks:

This is the end of the interview. Thank you once more for participating in this study. You are at liberty to can contact me for in case you have questions related to this study in future. My mobile number is 0725090719. Thank you!