

**A MANAGEMENT STRATEGY FOR DEALING WITH HIV/AIDS AT
SCHOOLS**

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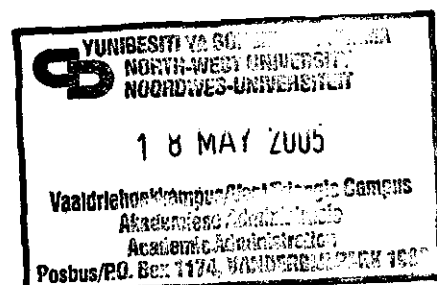
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Abstract

This study investigated the nature of a management strategy for the HIV/AIDS pandemic at schools, the effects of HIV/AIDS on the school system, and, on the basis of both the literature review and the empirical research, suggested a management strategy for dealing with the HIV/AIDS pandemic at schools. The literature review reveals that HIV/AIDS has the potential to affect schools through impacting on learners, educators, curriculum content, the school organization, control and planning of teaching and learning, and human, material, and financial resources for education. It also emerges from the literature review that the HIV/AIDS pandemic does not only affect learners and educators, but also attacks teaching and learning systems, and eventually impacts on the education system of the country. Demand for education drops, many educators become ill and die, and ultimately the tragedy caused by the loss of friends, family and educators grows.

The literature review therefore highlights the necessity for schools to develop a management strategy to deal with the HIV/AIDS pandemic concertedly. This may not be a recipe for success, but without it, a school is much more likely to fail to function effectively and at the same time to lose educator human resources. A sound management strategy can serve as a framework for decisions and for securing support and approval of funds to help and support learners and educators infected with and affected by the HIV/AIDS pandemic. It can also provide a basis for more detailed planning to deal with the potential areas of the HIV/AIDS impact on learners, educators and the school systems in general.

A satisfactory management strategy is realistic and allows school principals and their heads of departments to think strategically and act operationally. The management strategy of a school is guided by the principles that learners and educators with HIV/AIDS should be involved in all prevention, intervention and care strategies at school.

The empirical research reveals the respondents' perceptions of fundamental issues such as the main reason for the mortality and absenteeism rate among educators at their respective schools, as well as the experience of their duties.

This study recommends, on the basis of both the literature review and the empirical research, a management strategy that provides a strategic and operational framework for the prevention of the HIV/AIDS pandemic, guiding all stakeholders of the school, in HIV/AIDS prevention and in caring for and supporting victims effectively.

OPSOMMING

Hierdie studie het die aard van 'n bestuurstrategie vir die MIV/VIGS – pandemie op skole nagevors, asook die uitwerking van MIV/VIGS op die skoolsisteem en, op grond van die literatuursoorsig en die empiriese navorsing, 'n bestuurstrategie voorgestel vir die hantering van die MIV/VIGS – pandemie op skole.

Die literatuursoorsig onthul dat MIV/VIGS die potensiaal het om skole aan te tas deur in te werk op leerders, opvoeders, kurrikulum-inhoud, die skoolorganisasie, kontrole en beplanning van onderrig en leer, en menslike, materiële en finansiële bronne vir opvoeding. Dit blyk ook uit die literatuursoorsig dat die MIV/VIGS – pandemie nie slegs berders en opvoeders beïnvloed nie, maar ook onderrig- en leer – sisteme, en uiteindelik inwerk op die opvoeding – sisteem van die land. Aanvraag na opvoeding daal, baie opvoeders word siek en sterf, en uiteindelik vermeerder die tragedie veroorsaak deur die verlies aan vriende, familie en opvoeders.

Die literatuursoorsig beklemtoon dus die noodsaaklikheid vir skole om 'n bestuurstrategie te ontwikkel om die MIV/VIGS – pandemie omvattend te hanteer. Dit is dalk nie 'n suksesresep nie, maar daarsonder sal 'n skool meer geneig wees om in gebreke te bly om effektief te funksioneer en terselfdertyd opvoedersbronne te verloor. 'n Gesonde bestuurstrategie kan dien as 'n raamwerk vir besluite en vir die werwing van ondersteuning en die toewysing van fondse om leerders en opvoeders wat geïnfecteer is met en geaffekteer is deur die MIV/VIGS – pandemie te help en te ondersteun. Dit kan ook 'n grondslag voorsien vir meer gedetailleerde beplanning om die potensiele impak-areas van MIV/VIGS op leerders, opvoeders en die skoolsisteme oor die algemeen te hanteer.

'n Bevredeigende bestuurstrategie is realisties en stel skoolhoofde en hul departmentshoofde in staat om strategies te dink en operasioneel op te tree. Die bestuurstrategie van 'n skool word gelei deur die beginsels dat leeders en

opvoeders met MIV/VIGS betrokke behoort te wees in alle voorkonings-, bemiddelende en versorguigstrategiëe op skool.

Die empiriese navorsing onthul die respondente se persepsies van fundamentele sake soos die hoofrede vir die sterfte – en afwesigheidskoers onder opvoeders op hul onderskeie skole, asook hul beleving van hul pligte.

Hierdie studie beveel, op grond van die literatuuroorsig en die empiriese navorsing, 'n bestuurstrategie aan wat 'n strategiese en operasionele raamwerk vir die voorkoming van MIV/VIGS sal voorsien, om alle belanghebbendes van die skool te lei in MIV/VIGS – voorkoming en in die effektiewe versorging en ondersteuning van slagoffers.

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Chapter 1

Orientation

1.1 Introduction

Both national and international research reveals that in most parts of the world the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) have become the most common diagnosis among learners and educators (Tucker, Wenzel, Elliot, Hambarsoomian & Golinelli, 2003:415; World Health Organization, 2003:7). Many schools in South Africa are likely to see a huge increase in the prevalence of infection and the manifestation of this pandemic among learners and educators over the next few years. This increase in prevalence is caused by a number of factors, *inter alia*, the learners' temptation to explore their sexual identities and often not only experiment with sex, but also with drugs, which leads them to fornication and promiscuous sexual behaviour. Learners' sexual behaviour tends to be impulsive and is greatly influenced by peer pressure. This leads to their being sexually active at a very tender age to ignorance and illiteracy concerning how HIV is contracted (Brewer, 2003:144; Wallman, 2000:189).

Literature has also revealed that educators' absenteeism due to illnesses caused by HIV/AIDS has affected learning and teaching. When an educator falls ill, the class may be taken on by another educator, may be combined with another class or left untaught. But even when there is a sufficient supply of educators to replace losses, there can be a significant impact on the learners because some of the replacement educators are not the same as the ones who are ill or have died. They cannot teach or do the work as well as the ones infected by HIV/AIDS (Cross, 2001:133; Luzinda, Senabulya & Musiitwa, 2000:140).

As most researchers have pointed out, HIV/AIDS wreak havoc on the psychological health and mental functions of learners and educators such as memory, concentration, and creativity (Donahue, 2000:78; Goyer & Gow, 2000:102). Behavioural efficiency and effectiveness, interpersonal

relationships and personal productivity are also limited (Green, 2003:152; Desmond, Michael & Gow, 2000:39). Because of the physical and psychological demands involved in coping with this dreadful disease, it is not surprising that physicians and psychologists have suggested that experiencing HIV/AIDS will have a negative effect on an infected learner and educator in his/her general functioning at school (Kelly, 2000:43; Ayele, Dorigo-Zetsma & Pollakis, 2003:373). Learners and educators infected and affected by HIV/AIDS cannot function effectively and this impacts on effective learning and teaching and as such, the whole learning and teaching system is disrupted, and eventually the whole school cannot function and develop efficiently.

Some insight into what this apocalyptic scenario means for the functioning of the school system can be gleaned from an examination of the potential multiple effects of HIV/AIDS on education, such as:

- decline in school enrolment as a result of the death of learners;
- the quality of education suffering because of educator absenteeism and deaths;
- erratic performance of duties by educators;
- education budgets are depleted through double payment of educators, as sick educators have to be replaced while on fully paid sick leave; and
- the emotional and physical stress and pains that HIV infected and AIDS suffering learners and educators go through which impact on their effective learning and teaching abilities (Barnett & Whiteside, 2002:105).

All these variables have a devastating impact on the general effective functioning of the school system.

Research has revealed that learners and educators infected with HIV and suffering from AIDS face discrimination because of their HIV positive status.

The foregoing paragraphs indicate a necessity for a management strategy in order to deal with the HIV/AIDS pandemic concertedly. This may not be a

recipe for success, but without it, a school is much more likely to fail to function effectively and at the same time to lose educator human resources. A sound management strategy can:

- serve as a framework for decisions and for securing support and approval of funds to help and support learners and educators infected with and affected by the HIV/AIDS pandemic;
- provide a basis for more detailed planning to deal with the potential areas of HIV/AIDS impact on learners, educators and the school systems in general;
- explain the HIV/AIDS vision and mission statement to learners, educators, parents and communities in order to inform, motivate and involve them in the struggle against this deadly pandemic;
- assist benchmarking and performing and monitoring of the school in dealing with the HIV/AIDS pandemic; and
- stimulate organizational change and become a building block in the next HIV/AIDS plan (Dean & Moalusi, 2002:22; Groenewald, 2000:46; Pretorius, 2002:6).

A satisfactory management strategy is realistic and allows school principals and their heads of departments to think strategically and act operationally. The management strategy of the school is guided by the principles that:

- learners and educators with HIV/AIDS should be involved in all prevention, intervention and care strategies at school;
- learners and educators with HIV/AIDS, their partners, families and friends should not suffer because of discrimination;
- the vulnerable position of women at school should be addressed, to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection;
- confidentiality and informed consent of learners and educators with regard to HIV testing and test results should be protected;

- education, counselling and health care should be sensitive to the culture, language and social circumstances of all learners and educators at all times;
- all intervention and care strategies should be subject to critical evaluation and assessment;
- the school should work with all sectors of government and other stakeholders in their communities in the fight against HIV/AIDS;
- an ecosystemic, constructivist and holistic approach to education and care should be developed and sustained;
- capacity building should be emphasized to accelerate HIV/AIDS prevention and control measures; and
- the prevention and control of sexually transmitted diseases' (STDs) are central elements in the response to HIV/AIDS (Alemayehu, 2003:23; Department of Social Development, 2000:147; Bentwich, Weisman, Borkow, Beyers & Beyers, 2002:485).

Unlike an operational strategy (which is of a shorter term, tactical, focused, implementable and measurable), a management strategy is visionary, conceptual and directional (Amogne & Abubaker, 2002:397; Grobler, 2003:22). An example of the management strategy for combating HIV/AIDS pandemic in schools includes strategic issues such as where, when, duration, budget, who performs certain duties, and how the goals are to be achieved. An operational strategy includes operational issues such as tasks, deadlines, funding, and so and has to do with the final preparations of implementations (Dudgeon, Phillips, Bopp & Hand, 2004:81; Cordes, Moll, Kuecherer & Marcus, 2004:582). The primary goals for the management strategy are to reduce the number of new HIV infections (especially among learners and educators), and reduce the impact of HIV/AIDS on individuals, families and communities (Howse, 2000:678; Smart, 2000:13).

Yigemeru, Girmachew and Wudie (2002:172) have highlighted the following general strategies, which are crucial in developing an effective management strategy:

- an effective and culturally appropriate information, education and communications (IEC) strategy;
- increased access and acceptability to Voluntary HIV Counselling and Testing;
- improved STD management, treatment of opportunistic infections and increased condom use to reduce STD and HIV transmission; and
- improved care and treatment of HIV positive persons and persons living with AIDS, to promote a better quality of life and limit the need for hospital care.

Sutton (2001:75) and Hancock (2001:275) postulate that the management strategy should be structured according to prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance. In addition, learners are broadly targeted as a priority population group, especially for prevention efforts.

1.2 Statement of the problem

A school with a high number of learners, educators and non-teaching staff members infected and affected by HIV and AIDS cannot function efficiently and effectively since learners infected and affected with HIV and AIDS cannot cope with learning and cannot perform their learning tasks to the fullest of their abilities while infected and affected educators cannot teach effectively because they are often ill and absent from school, and this has an effect on the efficient and effective management of the school.

Little empirical research has been undertaken on the need for an educational management strategy for dealing with the HIV/AIDS pandemic at schools. It is, therefore, of the essence to conduct such a research in South Africa, which is said to be among the top nations, which are being ravaged by the HIV/AIDS pandemic (Colvin, 2000:335; Stillwaggon, 2000:3). Statistics estimate that there are 250 new infections in South Africa every day, which includes learners and educators (World Health Organization, 2003:178). Research estimates that the infection rate among educators is 12% of the general

population (Department of Health, 2003:159). Projections suggest that around one in seven educators was infected with HIV by the end of last year and there is also an increasing occurrence of illness and deaths among younger staff (Kidane, Banteyena & Nyblade, 2003:38) with educator losses averaging 1, 5% biennially. Many schools report a high rate of absenteeism of educators due to illness as a major and increasing problem (Badcock-Walters, 2000:137; Coombe, 2000:36).

This research therefore endeavours to investigate the extent of the effects of HIV/AIDS at schools and, on the basis of literature review findings and empirical research, to make suggestions for a management strategy, which schools could adopt in order to deal with the HIV/AIDS pandemic. It answers the following questions:

- What is the nature of the management strategy for the HIV/AIDS pandemic in schools?
- What is the effect of the HIV/AIDS pandemic on the school system?
- What management strategy can be effective in dealing with the HIV/AIDS pandemic at schools?

1.3 Aims of the study

The aims of this research are to:

- determine the nature of the management strategy for the HIV/AIDS pandemic in schools;
- determine the effects of the HIV/AIDS on the school system; and
- suggest a management strategy for dealing with HIV/AIDS pandemic at schools.

1.4 Methods of research

Literature review and empirical research methods were used in this investigation.

1.4.1 Literature Review

Primary sources that were consulted include current international and national journals, papers presented at professional meetings, dissertations by graduate students' reports written by school and university researchers, and both South African Acts 27 and 84 of 1996, which provide information on how far research on HIV/AIDS at schools and their effects on teaching, learning and management of schools have progressed. South African Acts were consulted for governmental and departmental policy theoretical frameworks. Books on HIV/AIDS serve as secondary sources.

1.4.2 Empirical Research

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

The research was conducted as follows:

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

1.4.2.1 Measuring instrument

An unstandardized questionnaire which was designed by the North-West University's School of Educational Sciences (Vaal Triangle Campus) was used to determine:

- the nature of the management strategy for the HIV/AIDS pandemic in schools;
- the effects of the HIV/AIDS on the school system; and
- suggest a management strategy for dealing with HIV/AIDS pandemic at schools.

This questionnaire was used because a standardized questionnaire relevant to the study in question could not be found. Only internationally developed questionnaires were available and were not appropriate for the problem statement of this research.

1.4.2.2 Target population

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

1.4.2.3 Accessible population

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

1.4.2.4 Sample

A randomly selected sample (N= 400) of managers and educators of schools at 30 schools in the Vaal Triangle was drawn. These managers and educators were supplied with the questionnaires on a management strategy for dealing with the HIV/AIDS pandemic at schools.

1.4.2.5 Statistical techniques

The data obtained from the target population were analysed, using the SPSS programme of the Statistical Consultation Services of North-West University.

1.5 Programme of study

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

In Chapter 2 a management strategy for dealing with the HIV/AIDS pandemic at schools is discussed.

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

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

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

1.6 Conclusion

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

In Chapter 2 the management strategy for dealing with the HIV/AIDS pandemic at schools is discussed by means of a literature survey.

Chapter 2

A management strategy for dealing with the HIV/AIDS pandemic at schools

2.1 Introduction

School management teams are often so pre-occupied with teaching and learning issues that they lose sight of their strategic role in dealing with the threats and challenges posed by the HIV/AIDS pandemic at their schools. This leaves learners (the age group which is particularly exposed to experimenting with sex) and staff vulnerable to HIV infection and consequent discrimination.

It is this reason that has lead researchers such as Barnett, Whiteside and Desmond (2000:189), Dennis (2000:34) and Arndt and Lewis (2000:77) to advocate that schools need to put in place management strategies that will, among other things, promote awareness about HIV/AIDS in order to prevent infection, address discrimination, encourage voluntary counselling and testing, and integrate HIV/AIDS issues into the curriculum. Such health-promoting management and leadership endeavours need to ensure that school policies protect both learners and staff.

This chapter provides a literature review of the impact of the HIV/AIDS pandemic on school systems, the management strategy, and the management strategy for dealing with HIV/AIDS. Before the management strategy for dealing with HIV/AIDS is discussed, pertinent concepts which are used in this chapter are first exposed.

2.2 Definition of concepts

The following concepts, which are applied throughout this research, are defined in order to provide both the scientific use of the concepts and the context in which they are applied in this research:

2.2.1 HIV

The acronym HIV stands for human immunodeficiency virus. This virus is human because it causes diseases only in people; immunodeficient because the immune system, which normally protects the body against viruses and diseases, becomes weak; and viral because, like all viruses, HIV is a small organism that affects living things and uses them to multiply itself (Kumaranayake & Watts, 2000:91).

This definition means that once the human immunodeficiency virus gets into a person's body, it slowly breaks down the immune system (McNeil & Donald, 2002:13; Delnessa & Nduba, 2003:60).

HIV is, therefore, a very small and microscopic germ or organism (virus) with which people become infected. It cannot be seen with the naked eye, but only under a microscope. HIV survives and multiplies only in body fluids such as sperm, vaginal fluids, blood and breast milk (Fitaw & Worku, 2003:382; Goliber, 2000:71; Kamuzora, 2000:9). People become infected only through contact with infected body fluids. HIV attacks the immune system, which is the body's natural ability to fight illness and its defence against infection, and reduces the body's resistance to all kinds of illness, including flu, diarrhea, pneumonia, tuberculosis and certain cancers. HIV can make the body so weak that it cannot fight sickness anymore, and cannot heal itself. In the process this deadly human immunodeficiency virus slowly gets stronger and stronger. When the human immunodeficiency virus has weakened the person's immune system, he/she starts to get sick more often (Kaplan, Hu, Holmes, Jafee, Masur & Decock, 2000:6). In the human blood stream, the human immunodeficiency virus is attracted to white blood cells, known as T4 helper lymphocytes, which are among the most important in the working of the body's immune system because of their effect in causing various different cells to become active in fighting infections, including the cells that produce anti-bodies (Wolday, Flener & Zeru, 2003:151; Walker & Gilbert, 2002:75).

From the foregoing paragraphs, it is apparent that HIV causes damage in the following ways: it enters T4 helper cells and uses the cells' own reproductive

material to reproduce itself. Eventually numerous copies of the virus break out of the cells, killing them. Then they find other T4 cells to invade, and the process starts again (Hughes-Gibbs, 2000:21; Anderson, Ebrahim & Sansom, 2004:165). It then causes uninfected T4 helper cells to clump around infected T4 cells, thus immobilizing them. T4 types of cells dependent on T4 helper cells cease to function properly as the T4 helper cells become depleted. Some cells, other than T4 helper cells, may be directly attacked by the virus or by the damaged immune system itself (Wolday, Girma, Hailu, Sanders & Fontanet, 2003:45).

This destruction of the immune system means that infectious organisms can invade the body largely unchallenged, and multiply to cause serious opportunistic diseases like weight loss, dry cough, recurring fever or profuse night sweats, profound and unexplained fatigue, swollen lymph glands in the armpits, groin, or neck; diarrhoea that lasts for more than a week; white spots or unusual blemishes on the tongue, in the mouth or in the throat; red, brown, pink, or purplish blotches on or under the skin or inside the mouth, nose, or eyelids; memory loss, depression and other neurological disorders; tuberculosis, pneumonia, gastro-enteritis, meningitis and cancer which affect both the physical and psychological wellness of people infected with HIV/AIDS (Eisenman, Cunningham, Zierler, Nakazono & Shapiro, 2003:125; Kibret, 2003:39). It is during this process that full-blown acquired immune - deficiency syndrome (AIDS) begins.

2.2.2 AIDS

AIDS is an acronym standing for Acquired Immune Deficiency Syndrome. It is assumed that this disease is acquired because it is not inherited. It is caused by a virus, which enters the body from the outside (MacPhail, Campbell, Williams & Van Dam, 2000:113; Bentwich, 2003:6; Hill & Fardiman, 2003:105; Crewe, 2000:12). Immunity refers to the body's natural inherent ability to defend itself against infection and disease. Deficiency refers to the fact that the body's immune system has been weakened so that it can no longer defend itself against passing infections. Syndrome is a medical term which

refers to a set or collection of specific signs and symptoms that occur together and that are characteristic of a particular pathological condition. Aids is not a specific illness but a collection of many different conditions that manifest in the body (or specific parts of the body) because of the human immunodeficiency virus which has so weakened the body's immune system that it can no longer fight the pathogen (or disease – causing agent) that invades the body. It is a syndrome of opportunistic diseases, infections and certain cancers, all of which have the ability to kill the infected person in the final stages of the disease (Demissie, Getahun & Lindtjorn, 2003:455; Kwatubana, 2004:3). The AIDS virus infects the body by entering the blood stream. It then attacks the immune system and gradually destroys it. Infection with the virus develops in the following three stages of which AIDS is the last:

- In Stage1 a person is infected, but feels healthy. At this point s/he has not yet developed AIDS. S/he looks and feels well and usually does not know that the virus is in his body. However, from the moment of infection he can pass on the virus to others. During this stage the virus begins to attack the immune system by entering and destroying a specialized white blood cell called the T4 lymphocyte.
- In stage 2 the person becomes sick. After about five years, the number of T4 cells has usually decreased dramatically and the immune system becomes so weak that the body can no longer effectively defend itself. Major symptoms and opportunistic diseases begin to appear as the immune system continues to deteriorate. At this point, the cell count becomes very low while the viral load becomes very high. The person feels tired and becomes sick more often than before. He may develop the following symptoms: constant unexplained fevers that last more than a month, night sweats, tiredness, skin infections such as rashes, boils and abscesses, diarrhea, significant and unexplained weight loss, thrush in the mouth, genital sores that do not heal, generalized lymphadenopathy, abdominal discomfort, headaches and persistent cough. During this stage, these illnesses can usually be effectively treated and controlled and a person can still lead a full and active life

(Rosen, Simon, Thea & Vincent, 2000:300; Weinstock, Berman & Cates, 2004:6).

- In Stage 3, it becomes serious and the person is ill. At this stage the T4 cells have been destroyed and a person's immune system shows signs of serious damage. The body can no longer fight off infections and cancers. A person now experiences one or more of the following illness problems: pneumonia, tuberculosis, kaposi's sarcoma, prolonged diarrhea, excessive weight loss, infection of the brain; he/she becomes weaker and weaker and eventually dies (Wilkinson & Dore, 2000:276; Barnett & Whiteside, 2000:66). According to Govender, McIntyre, Grimwood and Maartens (2000:352) symptoms of HIV infection in children are failure to cope with the demands of general life, weight loss, prolonged fever, recurrent oral thrash, chronic diarrhea and gastroenteritis, tuberculosis, recurrent bacterial infections (causing upper respiratory tract infections, otitis media or ear infections, pneumonia, urinary tract infections and meningitis), lymphoid intestinal pneumonitis (characterized by a continuous cough and mild wheezing), anaemia, pallor, nose bleeds, persistent generalized lymphadenopathy (swelling of the lymph nodes in the neck, armpit and groin), delays in attaining developmental milestones or the loss of those already attained, and complicated chicken pox or measles. The time lapse between infection and the onset of full-blown AIDS is usually much shorter in children than it is in adults (Klepp, Fuglesang, Flisher, Leshabari, Lie & Mapanga, 2000:38).
- In stage 4, full-blown AIDS and death result. Typically, a person not receiving treatment will die within a year and a half of reaching this stage (Human Rights Watch, 2001:489).

2.2.3 Strategy

Strategy is defined as a long-term plan, a vision for the future, a fundamental framework through which an organization can assert its continuity, while at the same time adapting to a changing environment; basic directional decisions,

such as purposes and missions (Boal, 2000:515; Kirt & Waschkuhn, 2001:101).

A strategy consists of the important actions necessary to realize these directions and answers the following questions:

- What should the organization be doing?
- What are the ends (goals) the organization seeks to achieve and how should it achieve them (Sheared & Kakabadse, 2002:129; Robinson, 1998:152)?

Campbell and Alexander (1998:42) argue that strategy is about being different. It means deliberately choosing a different set of activities to deliver a unique mix of values. Steinhilsson and Soderholm (2002:69) also argue that strategy is about competitive position, about differentiating the school in the eyes of the parents, about adding value through a mix of activities different from those used by other school organizations. For Bratton and Gold (2003:55), a strategy is a combination of the ends (goals) for which the school is striving and the means (policies) by which it is seeking to get there. Strategy also refers to the means by which policy is effected, thus strategy becomes the art of distributing and applying means to fulfil the ends of policy (Dollar & Kraay, 2001:53; Nowlan, 2000:987).

Elford, Bolding and Sherr (2004:151) argue that strategy emerges over time, as intentions collide with and accommodate a changing reality. Thus, one might start with a perspective and conclude that it calls for a certain position, which is to be achieved by way of a carefully crafted plan, with the eventual outcome and strategy reflected in a pattern evident in decisions and actions over time. This pattern in decisions and actions defines what Mintzberg (1998:421) called "realized or emergent strategy".

Hey (2003:53) asserts that strategy is the pattern of decisions in a school that determines and reveals its objectives, purposes and goals; produces the principal policies and plans for achieving those goals; and defines the range of activities the school is to pursue, the kind of economic and human

organization it is or intends to be, and the nature of the economic and non-economic contribution it intends to make to its shareholders, that is: educators, learners and communities. In short, a strategy is a term that refers to a complex web of thoughts, ideas, insights, experiences, goals, expertise, memories, perceptions, and expectations that provide general guidance for specific actions in pursuit of particular ends. Therefore, strategy is a course the school charts, the journey the school imagines and, at the same time, it is the course the school steers, and the trip the school actually makes. Even when schools are embarking on a voyage of discovery, with no particular destination in mind, the voyage has a purpose, an outcome, an end to be kept in view (Lorangr, 1998:18). Strategy, therefore, cannot exist without the goals that the school is striving for.

Strategy has the following multiple aspects:

2.2.3.1 Strategy as a form of statement of goals, purpose and intent

Education, upliftment of self-respect and accommodation of moral value standards of learners and educators should be the purpose of the future. The underlying purpose being to create a healthy teaching and conducive learning environment where learners and educators are less threatened by the HIV/AIDS pandemic. The role of strategy is to determine, clarify and refine purpose. This may require creating new visions of the future to inspire the school to greater efforts or wider scope (Osborn, 2000:37).

2.2.3.2 Strategy as a high level plan

The HIV/AIDS pandemic can influence different contexts in ways that it has acquired which schools cannot always anticipate. Achieving the best strategy is important in doing a contextual analysis to understand the reality and define what the needs and priorities are. The strategy defines such means in broad and general terms. As detail is added and it answers the questions: who, when, where, how, and with what, the strategy develops into a plan or perhaps a set of plans with varying scope and focus. It is impossible to draw a hard distinction between a strategy and a plan. In general, strategies tend to

be at a higher level and to take an overall view; while plans tend to be more detailed, more quantified, and more specific about times and responsibilities. However, some details may be so essential to the strategy that they become 'strategic' (Bottery, 2000:6).

Therefore, as a high level plan, strategy entails

2.2.3.3 Strategy as the means of beating the competition

Many ideas about strategy derive from analogies of war and games. One aim of strategy is to win and this means beating the enemy or winning the competition in a game which may be won or lost (Smit & Cronje, 2001:68). As the HIV/AIDS virus attacks human beings, they, in turn, must fight to overpower this deadly disease and to win the battle against it. Schools' strategies are therefore required to keep ahead of the tough competition among business organizations to beat the pandemic. They may also have strategies (or stratagems) for out-manoeuvring particular competitors at particular times for particular kinds of positive results (Cluster, 2001:1; UNAIDS, 2000:79).

2.2.3.4 Strategy as an element of management

School managers are expected to know and understand that a strategy is part of management and setting strategy is one of the responsibilities of managers. For school managers to think and act strategically, they need to evaluate the effects of their actions on educators and the response of educators on their actions. No school manager can lead a school if he/she does not agree with its strategy. However, school managers should agree on a set strategy agreed upon by other stakeholders such as educators, parents and learners (in the case of secondary schools) about dealing with the HIV/AIDS pandemic in schools. Conversely, schools which have no proper management or are inadequately managed have difficulty defining clear strategies even if they continue to function in their day-to-day activities. When managers change, strategies tend to change. Conversely, if the strategy needs to change, it may be necessary to appoint a new manager. A change of

managers may be both a symbol that a change in strategy has occurred and an opportunity to appoint an individual with a management style appropriate to the new strategy. Other managers possess characteristics that are more appropriate for the long, slow building of a school over many years (Goldman, 2002:431; Beer, 2000:18).

2.2 3.5 Strategy as positioning for the future

As the HIV/AIDS pandemic is being felt in our schools, it is necessary that a strategy be seen as preparation for the uncertainty of the future of learners, educators and schools. It is therefore necessary to position schools for the future so as to be prepared for this uncertainty. One way to achieve this is to make schools more adaptable (Aharoni, 2000:89).

2.2 3.6 Strategy as building capability

Some educators may show certain capabilities which may be seen as improving the chances of future success of schools in the fight against HIV/AIDS and a strategy may lay a firm foundation on which these capabilities are to be built. The capabilities of educators may be exceptional or even unique. The essence of any school is partly defined by the unique set of skills and knowledge of its educators and teams. Strategic building of capabilities can exploit this uniqueness. For example, this may involve maintaining a lead in specific technical skills or investing to sustain a general ability to react fast to unexpected circumstances (Danspeckgruber, 2002:190).

2.2 3.7 Strategy as a fit between capabilities and opportunities

One of the aims of a management strategy for dealing with HIV/AIDS pandemic should be to create an impressive and inviting learning and teaching atmosphere without fear of discrimination for learners and educators already affected and infected. Another is opportunities for the development of learning programmes that will be of use when learners are unable to attend school because of the intense sickness. The success results from a good match between the capabilities of the school and the opportunities that should

serve the needs of both infected and affected learners and educators. One aspect of strategy is to improve the fit between capabilities and the opportunities available and thereby to make learning more accommodative, conducive and fruitful (Kirt & Waschkuhn, 2001:101).

2.2 3.8 Strategy as the result of deep involvement with the school

This aspect contrasts with the idea of strategy as detached thinking about the school. Mintzberg (1998:423) coined the term “crafting strategy” and uses the analogy of a potter throwing a pot on a wheel. While the potter will have had an original intention for the design of the pot, the final shape of the pot depends also on the interaction of the potter’s hands with the clay as it rotates on the wheel. Schools need to be particularly good at allowing their strategies to emerge from the deep involvement of school managers with the school rather than from doing abstract exercises in strategy formulation (Michaluk, 2002: 301).

2.2.3.9 Strategy as a pattern of behaviour resulting from embedded culture

Every school has its own culture, determined by the community in which it is situated. This culture is easy to observe, but hard to change. The strategies that a school is able to adopt are partly determined by this culture. Those within the school see the outside world through their own conditioned perspective and this influences everything they do and permeates their strategy even though they may be unaware of this. In addition, since cultures are hard to imitate, culture may sometimes be a source of competitive advantage (Nwagwu, 1997:87).

2.2 3.10 Strategy as an emerging pattern of successful behaviour

Few strategies are implemented in their entirety in the form in which they were formulated. Similarly, the reasons for success when analysed retrospectively may be different from what was expected in advance. Part of strategy may therefore be in recognizing the patterns that seem to have led to success,

even if these patterns arose by chance rather than as a result of planned actions.

These multiple aspects of strategy are separable, but not usually contradictory.

2.2.4 Vision

According to Jimenez and Sawada (1998:210), a vision relates to some futuristic ideal, to some notion of how things could/should be, and can reflect an aspired state of being for an individual, a school, or a society. It indicates what the school as an organization exists to achieve and what it is willing and not willing to do to achieve it and it provides a sense of direction and purpose which inspires people and puts meaning into their lives (Thomson & Strickland III, 1999:95). Secor (2003:13) states that a vision serves as a unifying focal point of effort and acts as a catalyst for team spirit.

Cornelissen (1999:14) views determining a school's vision as a process of developing a long-term direction, which involves gathering a broad range of data and looking for patterns, relationships and linkages that help to explain things. The process produces or creates a vision and strategies that describe activities, technology and corporate culture futuristically and articulates a feasible way of achieving this future. Noble (1999:19) believes that this ability to influence educators to make decisions that enhance the school voluntarily is the most important part of a management strategy.

2.3 The extent of HIV/AIDS in South Africa

The Department of Health's study conducted among antenatal sexually active women (DoH, 2003:159), estimates that 4.7 million people were living with HIV in South Africa in 2003. Based on extrapolation of the results of this 2003 survey, the Department of Health estimates that 5.6 million South Africans were HIV positive by the end of 2003. These high prevalence rates show what a significant problem HIV/AIDS is in South Africa, with enormous social, economic and development implications. The rates also indicate the future

burden of HIV- associated diseases and the difficulties faced by the health system in coping with the provision of adequate care and support. The Nelson Mandela study of HIV/AIDS (2002:42) suggests that a survey which looks only at the prevalence of HIV/AIDS among sexually active women will have difficulty in drawing conclusions about their prevalence among other sections of the population. The Nelson Mandela survey is a 'household' study looking at a proportional cross-section of society. A total of 14450 people were selected, of whom 4001 were children, 3720 youths and 6729 adults. Of these, 93.6% responded, and 65.4% of those who responded agreed to give a specimen for a HIV test.

The tables below show the estimated HIV prevalence per Province and per age Group. The HIV prevalence is the percentage of people tested in each group who were found to be infected with HIV. The tables only display the average percentage of the minimum and maximum rates for HIV prevalence. The confidence interval is outlined in the original study (UNAIDS, 2003:212).

2.3.1 Estimated HIV prevalence 1999-2003 per province among antenatal clinic attendees

In 2003, the province that recorded the highest HIV rate among antenatal attendees was KwaZulu-Natal, which had a rate of 37.5%, an increase of 4% since 2001. The next highest HIV levels were found in Mpumalanga (32.6), and Free State (30.1)

2.3.2 Estimated average percentage of HIV prevalence 1999-2002 per age among antenatal clinic attendees

Table 2.1 Halperin and Epstein (2004:364)

Age group	2000 Prevalence %	2001 Prevalence %	2002 Prevalence %	2003 Prevalence %
< 20	16.1	15.4	14.8	15.8
20-24	29.1	28.4	29.1	30.3
25-29	30.6	31.4	34.5	35.4
30-34	23.3	25.6	29.5	30.9
35-39	15.8	19.3	19.8	23.4
40+	11	9.8	17.2	15.8

An estimated 34.5% of women aged 25 - 29 were infected with HIV, making this the age group with the highest prevalence rate. 29.5% of women aged 30 - 34 were estimated to be infected and 29.1% of women aged 20 - 24 years were estimated to be infected. The rest of the age groups had lower prevalence rates. There were increases in the HIV prevalence in the 25 - 29 and 30 - 34 years age groups, which were statistically significant, and the increase in the 40+ year's age group was statistically very significant. The prevalence rates in the <20 years age group suggests a continued stabilization, which is encouraging.

The figures below show the HIV prevalence estimates produced by the Nelson Mandela study.

Table 2.2 World Health Organization (2004:224)

Sex and Race	Number surveyed	HIV+ (%)
Male	3772	9.5
Female	4656	12.8
African	5056	12.9
White	701	6.2
Coloured	1775	6.1
Indian	896	1.6
Total	8428	11.4

The following table shows the HIV prevalence (%) and numbers of people tested, per province.

Table 2.3 Department of Health (2003:159)

Sex and Race	Number surveyed	HIV+ (%)
Kwazulu-Natal	1579	11.7
Mpumalanga	550	14.1
Gauteng	1272	14.7
Free State	540	14.9
North West	626	10.3
East Cape	1221	6.6
Limpopo	679	9.8
Northern Cape	694	8.4
Western Cape	1267	10.7
Total	8428	11.4

The results in this study suggest that the Free State and Gauteng provinces have the highest levels of HIV infection.

The next table shows the estimated HIV prevalence data per age group. The prevalence among girls and boys aged 2 -14 years was estimated to be 5.2% and 5.9% respectively. Due to the relatively small sample numbers, the statistic for girls should be interpreted with caution. The prevalence among male and female youths aged 15-24 years was estimated to be 6.1% and 12.0% respectively. The prevalence among people aged 25 years and above was estimated to be 14.4% for males and 16.2% for females.

Various reasons for the higher estimated prevalence of HIV among females have been suggested. One reason may be that the low social and economic status of women affects their ability to control their sexual lives. Another reason may be that women are biologically more susceptible to HIV infection than men.

Table 2.4 Department of Health (2003:161)

Sex and Race	Number surveyed	HIV+ (%)
Children (2-14 yrs)	2348	5.6
Youths (15-24 yrs)	2099	9.3
Adults (=> 25 yrs)	3981	15.5
Total	8428	11.4

Overall, the study found HIV prevalence in the South African population to be 11.4%.

The first study shows an estimated HIV prevalence rate of 27.9% at the end of 2003 among sexually active women aged 15 - 49 years, while the second shows an estimated HIV prevalence rate of 11.4% across the general population. This is a country where one in four pregnant women is HIV+. In spite of the great difference between these two averages, what is clear is that there is an exceptionally high HIV prevalence in South Africa, and tremendous challenges remain in the fields of HIV education, prevention and care (World Wide AIDS Statistics, 2003:91 World Wide Aids Statistics, 2003: [web] <http://www.aver.org/aidssouthafrica.htm>).

2.4 The impact of HIV/AIDS on school systems

Various national and international researchers have also noted that HIV/AIDS has the potential to affect schools through impacting on learners, educators, curriculum content, the school organization, control and planning of teaching and learning, and human, material, and financial resources for education (Bell, Devarajan & Gersbach, 2003:2; Donahue, Kabbucho & Osinde, 2000:12).

The HIV/AIDS pandemic does not only affect learners and educators, but also attacks teaching and learning systems, and eventually impacts on the education system of the country. Demand for education drops, many educators become ill and die, and ultimately the hurt caused by the loss of

friends, family and educators grows (Bond, Macquarrie, Hallom & Nyblade, 2003:287; Goudge & Govender, 2000:109).

Various researchers have noted that HIV/AIDS has a significant impact on the attendance of both learners and educators, and learner school enrolment and schools may have to respond to a greater demand for second-chance education by learners returning to school after absence from the system, or for more flexible learning opportunities for those who are ill (Haile, 2000:690; Baylies, 2002:351). On the other hand, these demands may be offset by fewer births and more deaths of under-fives, and the fact that families will have less disposable income for school fees, voluntary funds, transport costs and uniforms.

AIDS Weekly (2000:12) reports that HIV/AIDS kills educators faster than they are trained. Kelly (2004:139), who was commissioned by the South African National Education Department to research teaching and learning needs, estimated that 30 000 new educators would be needed each year to compensate for the decline in teacher numbers because of HIV/AIDS in future. Kelly (2004:139) recommended that 2% to 3% of matriculants who choose teaching as a profession need to increase to 15% (Kelly, 2004:139). The work of educators who are HIV positive and have to be absent from school is, according to Foster (2000:4), disrupted by periods of illness. Most educators have to take on additional teaching and other work-related duties in order to cover for sick colleagues. The quality of teaching is compromised and stigmatization of infected educators is a deeply rooted response (<http://www.info.gov.za/speeches/2004/04081113151002.htm>).

As a result, there is reduced teaching and learning time, and continuity and school budgets are affected through "double payment" of off-duty educators due to paid sick leave and their replacements, training of additional educators, reduced availability of school funds, as well as reduced public funds for the system with AIDS-related allocations to the health sector; educators, as well as learners, suffer emotional stress through being affected by the incidence of HIV/AIDS among relatives and colleagues; the standing of educators in the

community is devalued through community views of educators' contributing to spreading the disease; school facilities are seen as a risk–environment for sexual relations between learners, and between learners and educators; management, administration and financial control of the school system are likely to deteriorate through loss of human resources; and HIV/AIDS-induced changes in the demography will lead to a reduced growth in the number of new learners (Bezabih, 2003:42; Mdladla, Marsland, Van Zyl & Drimie, 2003:5; Desmond, 2000:92).

Wang, Burstein and Cohen (2002:737) and Gupta (2001:11) reveal that the pandemic is also widening the gap between boys and girls in the school system. When parents fall ill, the daughter is the first child to be taken out of school to look after sick parents and siblings. More girls than boys catch the virus too. Children are kept out of school if they are needed at home to care for sick family members or to work in the fields; and some children drop out of school if their families cannot afford school fees, due to reduced household income as a result of an HIV/AIDS death (Dorkenoo, 2001:2).

Berhane (2003:1) and Kalipeni (2000:965) believe that HIV/AIDS is still in a relatively early stage of its history, and the possibility of HIV infection becoming more widespread is high. This statement has implications for school development, since both educators and learners are becoming victims of this fatal pandemic on a daily basis. Being victims of this dreadful disease can be attributed to:

- ignorance of how the virus is contracted;
- denial, in the sense that some learners and educators in the townships believe in myths that HIV/AIDS is a white man's disease so they cannot be infected;
- gender issues, as the preventative campaigns have been narrowly focused on the use of condoms and partner reduction, in so doing not acknowledging the economic and social realities facing women and girls; and

- the power dynamics that exist within relationships where men still subject women to mutually uncongenial sex (Diop, Trudelle, Champagne & Beaudry, 2000:80).

As a solution to the foregoing exposition of the impacts of the HIV/AIDS pandemic on schools, Bollinger and Stover (1999:14) suggest that schools need to integrate sexual health and HIV/AIDS education into the curriculum at all educational levels, ensuring that every school:

- is adequately equipped with the relevant life skills, and that adequate learning takes place in the fourth 'R' of the other three 'Rs' (reading, writing, arithmetic) that is, "relationships" with oneself and with others;
- manifests an improved human rights profile, in terms of its own procedures and actions and in terms of the curriculum;
- extends its mission beyond the strictly academic to include more attention to counselling and care for learners, educators and parents; and
- promotes care and compassion for people with HIV/AIDS.

Schools also need to adopt a strategic approach where the HIV/AIDS crisis is placed at the centre of a whole school development plan. The school management teams and school governing bodies should agree on proven methods of combating HIV/AIDS, preventative strategies should be implemented, community mobilization should be reinforced, as this can address the economic, political, social and cultural factors that render learners and educators vulnerable (Bourne, 2000:3). In addition, access to comprehensive care and treatment should not be regarded as luxury, but as a necessity where schools work hand in hand with the neighbouring health centres, governmental and non-governmental organizations that are dealing with HIV/AIDS within the communities and also ensure the use of precautionary measures within the school such as giving all learners, educators, sport coaches and other staff appropriate information and training on HIV transmission and the application of universal precautions in preventing this pandemic from being transmitted through contact with blood other than

during sexual contacts (Karim, 2000:288; Raviola, 2002:55). Learners, especially those in pre-primary and primary schools, must be trained never to touch blood or wounds of other children. Age appropriate education about HIV/AIDS, including knowledge, skills and attitudes, must be included in the curriculum (Kitheka, 2000:24; Department of Education, 2003:17).

The school management teams together with the school governing bodies should also consider whether condoms need to be made accessible within the school; and they should also take appropriate measures to protect the school community against medically recognized significant health risks in the context of HIV/AIDS, such as highly communicable diseases, uncontrollable bleeding, and sexual or aggressive behaviour (Hecht, 2000:34; Department of Health, 2000:415; Government Gazette No. 20372).

Clinton (2003:1800) and Wallis (2004:18) highlight that the school, as a major social institution, cannot afford to ignore the increasing complexity of the AIDS pandemic or underestimate its impact on teaching and learning which has manifested in the form of learners infected with HIV/AIDS:

- not wanting to attend school because of the stigma and scorn they experience at school;
- experiencing psychological trauma and shock after being diagnosed HIV positive, which make it difficult for them to concentrate on their school work, including participating effectively in class activities;
- experiencing a decline in their school performance because of their continuous absence from school due to illness, low-self esteem, depression and disability to participate fully in the social and academic life of the school; and
- experiencing the deterioration of their educators' attitudes towards their work where educators appear unconfident and unmotivated to their learning efforts (Colvin, Gouws, Kleinschmidt & Dlamini, 2000:117).

Kumar (2000:137) states that the loss of large numbers of educators in a developing country like South Africa is a serious blow to the nation's future

development of human resources. Unless the trend is reversed, a future generation of young South Africans faces the prospect of a lower quality education because of the quality and quantity of educators who are weakened and dying of HIV/AIDS, of affected learners who cannot attend school because they have to attend to their parents and siblings who are infected with AIDS, and of reduced job prospects because affected learners have not gained the necessary knowledge at school due to recurring absenteeism and chronic illness.

Susser and Stein (2000:1042) and Kongsin and Watts (2000:36) posit that as the AIDS pandemic progresses, there will be fewer adults of normal parenting age to care for the children they leave behind. The burden of care falls increasingly on other children or on the growing proportion of elderly people.

Schools also need to deal with the plight of learners affected by HIV/AIDS, such as orphans, who cannot afford to pay school fees and have no money for school uniforms and are largely impeded in doing their school work (Hooper- Box, 2002:89; Halperin, 2001:12). In this regard, Simms, Rowson and Peattie (2001:41) and Piwoz and Preble (2000:141) found in their research that the following variables affect the learner orphans in doing their schoolwork:

- poverty, that is, going to school on empty stomachs;
- no one to see to it that they wear school uniforms and are clean;
- no parental support in supervising their work at home; and
- intense anxiety.

Because of the above variables, these learners:

- suffer from lack of concentration in class;
- perform poorly scholastically;
- do not participate in class discussions because of mental fatigue and stress debilitation;
- have a very low self-esteem;
- lack motivation and self-regulation;
- develop learning and behavioural difficulties;

- have their quality of learning compromised;
- experience low morale ;
- drop out of school, or attend school infrequently, in order to nurse parents or to engage in income-generating or domestic activities, replacing deceased family members; and
- are unable to afford education.

Therefore, to investigate the impact of HIV/AIDS in schools, it is imperative for schools to have a management strategy for dealing with this pandemic.

2.5 Management strategy

While management is the ability to influence a group towards the achievement of goals, Collins, Lowe and Arnett (2000:18) argue that a management strategy is the management's ability to anticipate, envisage, maintain flexibility, think strategically and work with others to initiate changes that will create a viable future for the school.

Schwartzbeck's (2002:116) assertions on a management strategy explicitly include the concept of voluntary decision-making, and focus on the present as well as the future. David (1999:164) and Squelsh (2000:308) strongly believe that the most important part of a management strategy is influencing school management teams to make decisions that enhance the school voluntarily through the implementation of policies adopted by the school as foundations for learning and teaching. A management strategy is thus concerned with ensuring the future of the school through the development and management of educators, learners and parents, ensuring that collectively they are capable of participating in ways that help achieve the school's future and embrace the curriculum needs of the school.

A management strategy is described by Olson (2000:53) as an extremely complex and multifunctional form of management, which requires the ability to accommodate and integrate both external and internal conditions, and to manage and engage in complex information processing by being in constant

consultation with the district offices so as to be on par with developments in areas of learning and educator development so that educators can transfer the new knowledge through facilitation to the learners. The capacity to learn, the capacity to change and managerial wisdom are thus the essence of a management strategy. The following key effective elements of a management strategy have been identified (French & Bell, 1999:61; Gwatkin, 2000:47):

2.5.1 Determining the school's purpose and vision

A management strategy becomes, therefore, a process by which a school determines its long-run direction and performance by ensuring that careful formulation of the school's objectives and goals, effective and efficient implementation of the learning programmes, and continuous evaluation of strategy by means of individual or group assessment and performance of results take place (Gerber, Nel & Van Dyk, 1998:148). It integrates various school functions and processes (that are typically strategic in nature) into a cohesive, broader strategy. The boundaries between these various functions and processes are conceptual only, and it is through their interaction and interdependence that each is able to contribute to the school's improvements. It links the various other functions and strategic processes together in a dynamic and interactive manner that is responsive to the school's changing environment (Hussey, 1999:134).

2.5.2 Exploiting and maintaining core competencies

Core competencies are the resources and capabilities that give a school a competitive advantage over its rivals (Mosia, 2003:64). Typically, core competencies relate to the functional skills of the school, such as producing good results, managing its finances in an appropriate manner, marketing, research and development. They allow schools to produce and deliver products that have unique benefits and value for parents (Caset & Clem, 2001:81).

In exploiting and maintaining core competencies, the strategic managers identify, gather and distribute resources to influence the school's processes for the achievement of set goals.

They compare alternative resource utilizations and allocations, and select that alternative which is most energy-effective towards accomplishing a product (Kent, Crotts & Azziz, 2001:221). Strategic managers align and distribute the available resources according to strategic school needs and in ways that will improve and profit the school's performance (Ireland & Hitt, 1999:43). They also promote the sharing of resources across committee units in the school to create a competitive advantage (Hagen, Hassen & Amin, 1998:39).

In the 21st century, an ability to develop and exploit core competencies will be linked even more positively and significantly with the school's success. Escaith and Inoue (2001:3) are of the opinion that the most effective core competencies are based on intangible resources, which are less visible to other participants because they relate to employees' knowledge and skills, for example: marketing, promotion, research and development.

The school's core competencies are only nurtured effectively through the sharing of knowledge or intellectual capital that is unique to a particular school. However, core competencies cannot be emphasized and exploited effectively in a school without appropriate human capital (Girmachew & Yigemeru, 2003:77).

2.5.3 Developing human capital

Human capital refers to the knowledge and skills of the school's entire workforce. People in the organization (school) are a critical resource on which many core competencies can be built and through which competitive advantages can be exploited successfully. In today's economy, people have become the factor that will make or a break school, and they need to feel that they can make a difference (Green, Caporaso & Risse, 2000:73).

According to Ludlow (2000:27), educators cannot contribute to the aims and aspirations of a school if they do not know what to do, and they cannot help if they do not know how to do so. Strategic school managers therefore continuously develop the capacity of their employees by providing an environment conducive to learning. Strategic school managers motivate individuals to grow, expose them to learning opportunities, and provide needed support. They encourage employees to inquire about and analyze decisions, set personal goals that improve a school's performance, and develop new competencies and skills (Daresh, 2001:93).

Strategic school managers involve educators in establishing key priorities; then they transfer the power and authority to learners to make a difference at the school. Thus educators are empowered not only to voice their opinion, but also to use their authority to make decisions that matter. They help educators to get a sense of confidence and autonomy in performing their tasks, as they encourage them to fulfil their potential (Doyle, 2002:27).

Deal and Peterson (1999:119) are of the opinion that a good approach to developing human capital is through training and development programmes. They explain that these programmes can help build skills and facilitate communication among educators by providing a common language, building educator networks and constructing a common vision for the school. In addition to this, Rosen and Jonathan (2002:61) highlight the importance of integrating an educator well-being programme when developing human capital. They believe that developing human capital is the building up or nurturing of individual educators in order to bring out the best in them and to help them reach their highest potential, and this includes educator well-being.

2.5.4 Establishing strategic controls

Strategic controls are the formal information-based procedures that strategic leaders and managers use to frame, maintain and alter patterns of the school's activities. Bottery (2000:6) argues that controls influence and guide work in ways necessary to achieve performance objectives. The effective use of strategic controls by school managers is frequently integrated with

appropriate autonomy for the sub-units so that they can gain competitive advantage in their respective schools (Guaglinone, 1998:119; Sisli 2000:73).

According to Collins, Lowe and Arnett (2000:18), strategic managers seek to develop and use a balanced set of strategic and financial controls. Strategic managers use strategic controls to focus on positive long-term results, while pursuing simultaneously the requirements to execute corporate actions in a financially prudent and appropriate manner. Campbell and Alexander (1998:42) emphasize that the school system must support the selected strategy and produce behaviour with the attributes of both flexibility to adapt to the external environment and congruence to carry out the school's strategy.

2.5.5 Skills-based education

2.5.5.1 Teaching life skills as a strategy to manage the HIV/AIDS pandemic in schools

In addition to giving accurate information and knowledge, and dispelling fears and misconceptions about HIV/AIDS, the school management teams should ensure the provision of HIV/AIDS education curricula which empower infected learners with problem-solving skills, decision-making skills, communication, refusal and negotiating skills, as well as skills that help them avoid alcohol and drugs (Assan & Wigglesworth, 2001:93; Smith-Fawzi, 2003:62).

Specific skills, such as conflict management and the ability to refuse sex successfully need greater attention and inclusion in the school curriculum. Developing self-sufficiency may help infected and affected learners and educators to become motivated and to act in responsible, accountable and healthier ways. Educational and behavioural research has shown that having learners participate in role-playing activities that demonstrate healthy ways of living can help them sustain this behaviour throughout their lives, and that often their behaviour is re-inforced by observing the positive and negative consequences of others' actions (Dorrington, 2000:121). Co-operative group work in class adds to the learners' understanding of the norms, beliefs, convictions, philosophy of life, life-world and values of others. Peers have the

power to influence and help maintain positive behaviour. When learners work with their peers in appropriate settings, they can often guide one another toward healthier, more positive behaviour, such as abstaining from or delaying sexual intercourse, using condoms, and saying no to alcohol and drugs (Flisher, 2000a: 109; Schuler, 2000:7).

The effectiveness of skills-based education for HIV/AIDS prevention is tied to the following three factors:

- addressing the developmental (physical, emotional and cognitive) stages that learners pass through and the skills they need as they move toward adulthood;
- participatory and interactive academic methods; and
- use of culturally relevant and gender-sensitive learning activities within a safe and open environment (Chabala, 2000:171; Shutte, 2000:30).

For changes in behaviour to occur, learners first need to have sufficient knowledge and develop attitudes derived from that knowledge, so that they can move in a direction that leads them to positive and healthy decisions throughout their lives (Fourie & Schonteich, 2001:29; World Bank, 2000:63).

At school, school management teams should promote skills-based education targeting:

- Life skills (negotiation, assertiveness, refusal, communication);
- Cognitive skills (problem- solving, critical thinking, decision- making);
- Coping skills (stress management, increasing internal locus of control); and
- Practical skills (using a condom).

2.5.5.2 Monitoring and evaluation of life skills education

Questions dealing with the evaluation of school-based HIV/AIDS prevention programmes have only recently been taken into serious consideration. In past years, these questions were either not asked or were considered less

important in the mission to tackle a dramatic world pandemic (Beresford, 2002:2; Williams, Gilgen, Campbell, Taljaard & Macphail, 2000:203). Today we understand better the need to include monitoring and evaluation as an integral part of the planning of any educational HIV/AIDS intervention. The management teams providing education about HIV/AIDS prevention at schools should perform monitoring and evaluating tasks that will enable them to measure the success of HIV/AIDS instruction in the classroom. School management teams can also monitor progress either in individual classes or in the entire school. This information is valuable in determining the effectiveness of the current curriculum and in planning for better methods of action for the future (Alabana & Guinness, 2000:2).

Summary or outcome evaluation is difficult in any programme aimed at behavioural changes. It takes many years to determine the success of health education programmes; furthermore, it is almost impossible to control the variables in the situation that may make it difficult to evaluate the level of success. Current research, however, indicates that not only are evaluation and monitoring achievable goals, but they should also be a regular part of the development of any intervention aimed at protecting learners from contracting HIV (Kelly & Parker, 2000:89; Danesi, 2003:27).

Management teams can estimate their success rate with HIV/AIDS education in the classroom by developing and administering pre-tests and post-tests that compare the behaviour, skills, attitudes and knowledge of the same learner before and after the programme (James, 2001:88; Hailom, Kidanu & Nyblade, 2003:31). Documenting the changes that occurred in these areas within the classes that received instruction on HIV/AIDS prevention can help to determine which programmes are more effective and should be used in future. This kind of appraisal helps to ensure that educators and schools know that the curricula they offer to learners are delivered in the most effective, appropriate, up-to-date and politically correct manner possible, while, at the same time, respecting community values in the educational contents. This

appraisal process could check the following points about a given curriculum (Parker & Mundawarara, 2000:114).

- The effectiveness of the curriculum in addressing the specific needs of the learners;
- The comprehensiveness and quality of the curriculum's components (instructional principles, functional knowledge, societal attitudes, involvement of parents and guardians, skills and duration);
- The degree of reliability between the curriculum and its application in the classroom; and
- The impact of the curriculum on learner's knowledge, attitudes and behaviour.

2.5.6 Emphasizing ethical practices

According to Glenn (2001:81) effective strategic managers emphasize ethical practices within their schools and seek to infuse them through the corporate culture. Corporate culture refers to the core values shared by all or most of educators. It consists of a complex set of ideologies, symbols and values that influence the way the school conducts its activities. It defines a normative order that serves as a source of consistent behaviour within the school (Charles, 1999:156).

These ethical practices serve as moral filter through which potential courses of action are evaluated. Strategic managers thus use trust, honesty and integrity as the foundations for their decisions, mobilizing educators through adherence to shared values. They are clear about their operating values and communicate these values to others for shared understanding (Russell, 2000:77; Le Roux, 2000:51).

It is clear from the above literature findings that a management strategy is strategic behaviour which involves cognitive, emotional and territorial interplay of school management teams within their departments when the agenda relates to strategic issues.

2.6 The role of a management strategy in dealing with HIV/AIDS

It is proper and acceptable that a school must have its own management strategy, which is an overall plan for accomplishing the schools' mission in a changing environment where HIV/AIDS has mercilessly taken its toll on learners, educators and parents. The strategy addresses the school's statutory mission and historical role, which is to carry out the expectations of its key stakeholders, namely, learners, educators and parents.

Management strategies articulate the key issues that must be successfully addressed by the school as an agency and identify the priorities and required resources for proposed actions (Flisher, 2000c: 124; Poku, 2002:112).

In the environment that is threatened by the prevalence of the HIV/AIDS pandemic, a management strategy is designed to guide the school's response as a whole to HIV/AIDS, thereby building a community that confronts HIV/AIDS with exceptional skill, teamwork and compassion. The management strategy forms the rules and guidelines by which the vision, mission, objectives, values, goals and programmes of the school with regard to HIV/AIDS are reflected. They can cover the school as a whole, including such matters as infusing the HIV/AIDS pandemic in the school curriculum, introducing health promotion programmes at the school, encouraging testing for HIV/AIDS, infusion of human rights values in the curriculum which guarantee the rights of learners and educators infected with HIV/AIDS or they can relate to primary matters in key functional areas (Booyesen, 2000:104; Jennings, 2000:119).

The school management strategies for safeguarding schools should be underpinned by cultural values and principles of the communities they serve and which are in line with the Constitution of South Africa (Drysdale, 2000:213).

2.6.1 Guiding the school's response on the HIV/AIDS pandemic

The basic requirements for the school management teams in guiding the school's response on the HIV/AIDS pandemic include commitment among key people, and allocation of human and financial resources.

First, guiding is best approached as a learning process. It is not a one-off event, because, even if a school successfully establishes attention to HIV/AIDS, it would still need to engage in on-going activities such as training new staff. Moreover, schools need to be alert to changes in, for example, the availability and cost of antiretroviral treatments, patterns of HIV infection within the community, and trends in the impacts of AIDS on educators, learners and community members (Ainsworth & Teokul, 2000:55).

Furthermore, the process involves experimentation, reflection and learning; schools will inevitably make mistakes, and must learn from them if practice is to improve.

Second the process of guiding should involve educators as active participants. The initiatives, which aim to support staff, will be effective only if the staff, which is in effect 'project beneficiaries', have helped to shape their design and delivery. Consultation on controversial issues such as the absenteeism rate of the infected educators and learners, and sensitive issues such as confidentiality, is likely to be particularly important if workplace policies are to be accepted and used by educators. Staff also need to be actively engaged in activities relating to HIV/AIDS programmes, because success requires changes in the hearts and minds of educators; in particular, it is crucial to develop a shared understanding and vision among educators about what guiding means and what they are trying to achieve through it (Kongsin, Sirinirund, Jiamton, Boonthum & Watts, 2000:135). Guiding cannot happen by simply telling staff what it is and instructing them to do it.

Third guiding must involve people who are affected by HIV and AIDS. Guiding is not an academic exercise, but one, which responds to the experiences of individuals, households, and communities affected by AIDS. If schools are to

understand the implications of HIV and AIDS for their work, then as part of the process their staff need to learn directly from women, men, and children affected by the pandemic (Meeson, 2000:24).

If schools are to make their programme work more relevant to the changes brought about by HIV and AIDS, then they need to involve affected people in devising, implementing, and monitoring suitable adaptations to that work. Involving people who are openly HIV-positive is a tried and tested strategy for challenging social stigma, and may, among other benefits, help schools to promote the idea of positive living to their staff (Ducket, 2000:153).

Fourth people who are guiding need to attend to gender-related issues throughout the process. Gender and AIDS are always connected, such that attention to gender issues is integral to all the elements of both internal and external guiding of HIV/AIDS (Pattersen, 2000:14).

Fifth schools need to learn from, and link with, others. It makes sense, for schools to share with other agencies their training curricula, research on HIV statistics or employment law, and lessons learned, in order to reduce duplication of effort and so make the process more effective (Bekele, 2003:14).

Learning can be accelerated if agencies share with each other their experiences of what seems to work and what does not.

Connected to this is the possible need for specialist help: for example, assistance with training, professional advice about employment law, help in predicting future impacts, or advice about the feasibility of particular modifications to programme work (Ganesan, 2000:87).

Sixth guiding is aimed at making changes as appropriate, both internally and externally. However, these changes should be practical and plausible modifications to existing approaches, perhaps involving new initiatives within

a programme, rather than a complete revolution in the way in which the agency operates (Cohen, 2002:16).

Lastly, it is critical to attend to practice and to monitor progress actively. Policies can set out excellent ideas, but they may then be ignored or misapplied. On-going monitoring of the application of the policies, and their effects, provides the opportunity to modify and improve both policies and practice. In the same way, planned activities and changes need to be monitored, assessed, and revised as necessary, as do methods to institutionalize attention to HIV and AIDS (Binswanger, 2000:2173).

2.6.2The establishment of a Health Advisory Committee

Organizations such as schools are expected to establish a Health Advisory Committee (HAC), which is a sub-committee of the school that deals in depth with HIV/AIDS and is founded on Act No. 27 of 1996, (South Africa, 1996a) becomes crucial. Section 13.1 (Act No. 27 of 1996) states that this committee is a committee of the school that advises on health issues. The structure and approach of the committee is a major asset in mitigating the impact of HIV/AIDS on educators, learners and on teaching and learning. Its membership includes members of the school management team, staff, parents, learners, health professionals such as psychologists, nurses, a doctor, business people, a religious leader, a traditional healer (where necessary) and a prominent member of the society (an organizational leader or a councillor). Someone with health knowledge chairs the committee.

The objectives of the HAC are to raise awareness of the impact of HIV/AIDS on education (educators, learners and parents) promote health and safety at school, and help reduce the spread and transmission of HIV.

The duties of the HAC as spelt out in the National Policy for HIV/AIDS (RSA, 1996a) are to promote and develop an institutional plan from time to time, advise the school management on all health matters including HIV/AIDS and

report back to the school management on the information given to learners and members of the community.

The school management should delegate health-related tasks with their attendant responsibilities to the HAC. However, in the final instance it is the responsibility of the school management to create an enabling environment for both learners and educators to perform well at school, as stated in section 20 (Act 27 of 1996). This means that if the HAC has responsibilities and authority, with which it is entrusted, the school management (which delegates) remains primarily responsible and accountable for all activities, as well as their execution.

In terms of the South African Schools Act (RSA, 1996b) Section 20(1) (m), the management of a school has to discharge functions as determined by the Minister of Education or the Member of the Executive Committee. The functions of the management of a school could therefore include the adoption of an HIV/AIDS policy for a specific school, provided that the policy does not infringe upon the norms and minimum standards of the National Policy determined by the Minister of Education.

From the above statement, it is clear that there is a need for the development of school level policies that will reflect the needs, ethos and values of the school and its community within the framework of the National Policy. School managers should develop these policies beforehand to adopt a "wait and see" approach (DoH, 2001:71). There are no foolproof ways for school managers to avoid controversy, but if it is anticipated and planned for, controversy can be managed.

The school has the responsibility to be a centre of information and support on HIV/AIDS in the community it serves. Major role players from the broader community (for example, religious leaders, traditional leaders and local health workers) should be invited to participate in developing the school's policy (Marks & Louis, 1999:707).

2.6.3 Designing and adopting HIV/AIDS policies

The school policy should be reviewed as new scientific information on HIV/AIDS becomes available, including advice from the national or provincial health or education authorities.

Infected and affected learners should be supported. This includes understanding their absenteeism, lack of concentration and confidentiality; the policy should challenge prejudice, stigma and related bullying across the school; provide positive learning opportunities that are relevant to all, including those at greater risk of infection or already living with the virus (either themselves or their families); and ensure links with community health and support services (Cohen, Farley, Taylor, Martin & Schuster, 2002:110).

An HIV/AIDS school level policy should be formulated and adopted to strengthen schools' prevention efforts and to provide guidance on school operations. The HIV/AIDS school policies should demonstrate commitment to the principles and practices of the school, and provide authoritative backbone to efforts preventing HIV/AIDS (National Development Plan, 1996:3). HIV/AIDS school level policies should cover admission of learners to school, school attendance, universal precautionary measures, and education on general health and safe lifestyles, of which sexuality education is to form part.

The present National Policy on HIV/AIDS has been developed in a joint consultative process that includes the Department of Education, the Commission and the Project Committee. The Project Committee is of the view that Nkosi Johnson's experience (whereby the latter was barred from attending school after being diagnosed with HIV) suggests that a precisely directed and clearly targeted policy would create legal certainty and help prevent injustice to learners with HIV. It thus provisionally recommends the adoption of a national policy on HIV/AIDS in schools that will constitute a set of basic principles from which the management of schools may not deviate.

Swarns (2000:98) reflects the critical and inevitable relationship between theory and practice, that is, policy design and implementation, and advises

that the school managers should not focus only on designing the policies while ignoring the implementation. Crocker and Harris (2002:47) suggest a combination of good ideas with good implementation decision and support systems.

2.6.4 Dissemination of information on HIV/AIDS

Because the managers of schools and educators are well educated, they can grasp the facts about HIV/AIDS and help spread correct information about the disease and its effects. Since almost every child in the country attends school, educators have a unique opportunity to influence children's ideas about sex and relationships, even before these start, a great opportunity to discuss the disease, and help the young to protect themselves from becoming infected, getting sick and dying. By so doing educators can play a central role in changing the course of the HIV pandemic. From the time they first start school, learners need to have information about HIV/AIDS presented to them in a way that is appropriate to their age, in the context of life skills education. Learning programmes are being developed for life skills education for all ages, and training is being provided to enable educators to do this (Borkow & Bentwich, 2000:1368).

In a classroom situation educators have an obligation to:

- keep insisting that learners take the necessary precautions and know that any one of us may contract HIV;
- give learners proper information about sex, about the risks associated with sexual activity, how they can protect themselves, then they are more likely to decide for themselves to delay the start of sexual activity. If they have knowledge, and have discussed these questions openly and without fear, they are more likely to practice sex safely when they do begin a sexual relationship;
- teach learners to respect themselves, to respect their peers, to show special understanding for the rights of girls and women, and to join together in human solidarity to save themselves and each other;

- let learners hold group discussions about dangers of being sexually active at an early age when they do not yet have that assertiveness to say no to sex, how to provide support to other learners who are already infected and help to spread the message to others.
- Provide life skills education where learners are informed of what to do when they feel lonely, angry, frustrated, sad, and insecure (Tembo, 2000:17; Eaton & Flisher, 2000:97).

Dissemination of information to immediate communities need educators to be in frequent touch with parents, and can therefore spread the message about HIV/AIDS deeply into the community, take the initiative by working together to resist the pandemic and deal with its consequences effectively. They could also harness the energies of all sectors of the society to fight the epidemic and prevent it from destroying schools. Use of HIV/AIDS awareness campaigns, distribution of pamphlets, drama, talk shows and use of the media can do this.

Educators can help create an environment in the workplace where people can speak openly about their HIV status, attack ignorance, without fear of prejudice or discrimination. They can find creative ways to support their ill colleagues and learners, and make the school a centre of hope and care in the community (Bonnel, 2000:91). They should equip everyone to play his/her part in the struggle against HIV and secure a shining future for this and the next generation and setting an example of responsible sexual behaviour that should prevent them from becoming infected and infecting others, by being careful and sensible of their actions and encourage learners to abstain from sex until the right time. In so doing, they will protect their families, colleagues, learners and themselves (Gouws & Williams, 2000:274).

2.6.5 Establishing support for infected and affected learners

For a school to be effective in the fight against HIV/AIDS it needs to take in the plight of infected and affected educators and learners' needs and

aspirations into consideration. To implement its strategies efficiently the school has to support those already infected and affected by the pandemic.

This can be done through support groups that:

- help each other to deal and survive with the truth, horror, pain and deep sorrow;
- consist of a community which shares their aspirations, sorrows and cares about their well-being together;
- where help in the form of finance, care giving and other means come from all directions;
- share among others their personal experiences, work related issues and their relationships with immediate family members, will also give another person hope;
- provide a supportive, trusting environment where members can explore interpersonal issues;
- introduce themes that include coping with HIV disease, health status, intimacy issues, death and dying, and the challenges of "coming out";
- learn new skills and how to develop coping strategies and living a healthy life; and
- exchange information and experiences which will encourage and promote confidence and awareness (Meeson, 2000:21; De Waal & Whiteside, 2003:109).

Another process by which schools can establish support is through counselling. It is essential that educators provide psychosocial support for children who are in HIV/AIDS-related trauma. Failure to help them will provoke 'second generation' difficulties including alcohol and drug abuse, violent behaviour, suicidal tendencies, unwanted pregnancies and STD/HIV infections. Schools play a significant role in the socialisation process which may have fractured at home (Ainsworth, 2003:13).

2.6.5.1 Peer educator and counselling program

Globally peer education and counselling is one of the most widely used strategies to address the HIV/AIDS pandemic.

Peer education and counselling involves training and supporting members of a given group to effect change among members of the same group. They effect changes in knowledge, attitudes, beliefs, and behaviours at the individual level and group level (Brewer, 2003:144).

In the light of this exposition, the management strategy must reflect the following elements:

- **The vision**

The first step is to develop a realistic vision for the school, which categorically states what the school would like to see happening in its concerted efforts and endeavours in dealing with HIV/AIDS at school. This should be presented as a pen picture of the school in three or more years' time in terms of its likely physical appearance, size and activities. The vision statement of the school regarding HIV/AIDS should answer the question: "If people from Mars visited the school, what would they see or sense regarding health promotion at this school? " The school should consider the health of learners and educators; as well as the school's learning and teaching processes which are affected by HIV/AIDS (Geiser & Berman, 2000:42).

The vision should state the school's obligation to provide a safe and healthy learning and teaching environment and to assure fair, non-discriminatory treatment of all learners and educators, irrespective of their health status. Therefore the vision statement of the school should be that individuals with HIV/AIDS will be treated with the same compassion and consideration given to any other person with a health problem. No learner or educator will be discriminated against at the school as a result of having or being at risk of acquiring HIV/AIDS (Henscher, 2000:51).

- **Mission**

The mission indicates the purposes of the school in dealing with HIV/AIDS, for example, to design a toxic-free, healthy teaching and learning climate and environment; to develop healthy learners who are taught by healthy educators; to infuse human rights values, including those of learners and educators infected and affected by HIV/AIDS, in the school's curriculum; and to design awareness programmes on HIV/AIDS for learners, educators and parents (Shell, 2000:21).

A statement along these lines indicates what the school's mission is concerning HIV/AIDS and other related diseases, such as creating an enabling and just environment for those infected and affected by HIV/AIDS by integrating an ethical, legal and human rights dimension into the national response to HIV/AIDS; facilitating education and conscientization of society; and advocating for reforms and policy formulation. In so doing, the school is striving to promote transparency, destigmatization and respect for humanity (Siegel & Schrimshaw, 2000:1543).

As a public institution of learning and teaching, the school is destined to avail its services to every learner and offer employment to every educator who has the potential to contribute to the development of the school, irrespective of his/her health status, with the view to: ensuring continued respect for humanity; developing self-sufficiency, build self-esteem, sense of pride and dignity for him/herself and others; upholding a positive self-worth as enshrined in the Bill of Rights; empowering and instilling a sense of belonging in both affected and infected educators and learners; promoting total respect, unity and support for those already affected and infected; promoting and conducting communication programmes; upholding the morals and values of our learners through organized talk shows; working hand in glove with the nearby clinics to ensure that counselling sessions are held for those in need of them; and ensuring that community representatives are brought on board and given the right tools to service others (Bateman, 2001:13).

- **Objectives**

Another key element is to state the school's objectives explicitly in terms of the results it needs and wants to achieve in the medium and long term with regard to HIV/AIDS. Presumably the objectives would indicate a necessity to slow down the rate of new infections, help infected learners and educators to cope, and support those among them who have been bereaved by HIV/AIDS. Objectives should also relate to the expectations and requirements of all major stakeholders for example, learners, parents and educators, including the non-teaching staff and they should reflect the underlying reasons for managing a healthy and toxic-free school environment and climate. These objectives could cover school enrolment, good results, antiretroviral medicine provision, budgets, and the involvement of health agencies (Day, Harris, Hadfield, Tolley & Beresford, 2000:204).

These objectives embrace the school's capacity to develop and communicate messages for scaling-up the desired behaviour change and putting in place HIV/AIDS-sensitive procedures and practices with regard to admissions, recruitment of educators, health care for HIV/AIDS-affected learners and staff at the school, collaboration with the neighbouring community, sensitization of the school's community, voluntary counselling; promotion of safer sexual life, and developing a working relationship between the school and the neighbouring community, utilizing the existing frameworks of government and non-governmental organizations (Mc Evoy & Welker, 2000:39; Tawfik & Kinoti, 2001:30).

Short-term objectives should be to have: constant interaction between the school and parents (especially of infected and affected learners) about their children's progress and processes retarding it, a potential to work with the management of the school and to help both infected and affected learners achieve their dreams through active participation in all school activities (Denolf, 2000:51).

Long-term objectives should be to encourage those who are affected and infected to stick to a healthy diet and take regular medication at the specified

times, to make available and maintain vegetable gardens for those who cannot afford to buy vegetables; and to form groups and possibly a radio station where they can air their views and help those who are still in denial.

- **The values**

The next element to address is values, which are the roots for the promotion of good morals and self-respect in human beings. Positively managing values can set an example in the daily operation of the school and its conduct or in relationships dealing with HIV/AIDS in society at large, learners, educators, parents, non-teaching staff, the local community and other stakeholders (Shisana & Simbayi, 2002:101).

These values comprise no learner, educator or non-teaching staff member being discriminated against because of his/her HIV status, disclosure being treated with confidentiality and respect, a person's dignity being maintained despite age or status, a school endeavouring not to isolate anyone because of his/her HIV status, assisting, encouraging and giving advice when needed or asked for and offering services and undivided attention to those who are desperate and in need of comfort (Department of Education, 2000:179).

- **The goals**

The primary goals of a school management strategy should be the reduction of new HIV infections among learners and educators and the reduction of the impact of HIV/AIDS on learners, educators and the schooling system (DoH, 2001:91). Guided by the above goals the management of schools should first and foremost embark on strategic planning, create safe and healthy schools and develop HIV/AIDS policy.

The goals, are specific interim or ultimate time - based measurements to be achieved by implementing strategies in pursuit of the school's objectives, for example, to have learners and educators who are aware and well-informed of the dangers of HIV/AIDS and who are aware of how to prevent this pandemic, and, also, have learners and educators infected with and affected by this

pandemic who can effectively and productively cope with the physiological and social ravages of this disease in three years time. Goals should be quantifiable, consistent, realistic and achievable. They can relate to finances and efficiency (Blasé & Blasé, 2001:18; Braveman 2002:17).

Goals are developed to create an environment in which children and adults with HIV or AIDS can live free from discrimination create adequate information centres where greater awareness and communication about HIV/AIDS will be addressed educate people, especially the young about the dangers of HIV transmission through unsafe sexual practices and about the need to take preventive measures make sure that sex education, which is absent in most schools is correctly implemented by educators through life skills interventions on the part of the government to address the pandemic and behavioural change on the part of the individual (Williams & Dye, 2003:102).

Goals targeted for decreasing the pandemic from the United Nations General Assembly and Education for all are; expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children; ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory primary education of good quality; ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes; achieving a 50 per cent improvement in levels of adult literacy by education, especially for the most vulnerable and disadvantaged children; and eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality especially in literacy, numeracy and essential life skills, and improving all aspects of the quality of education and ensuring excellence of all so that recognized and measurable learning outcomes are achieved (UNAIDS, 2000:79).

Agreed upon targets include: reducing HIV infection among 15-24-year-olds by 25 per cent in the most affected countries by 2005 and, globally, by 2010; developing by 2003, and implementing by 2005, national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS; ensuring that by 2005 at least 90 per cent, and by 2010 at least 95 percent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; and having in place strategies by 2003, to address vulnerability to HIV infection, including under-development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys (AIDS Analysis Africa, 2001:4).

The attainment of many of these goals is dependent upon the full participation of all school stakeholders such as learners, educators and parents in efforts to counter HIV/AIDS and its impact on the effective management of schools (UNAIDS, 2002:450).

- **The programmes**

The final elements are the programmes, which will serve as bridges and set out the implementation plans for the key strategies of a positive fight against the HIV/AIDS pandemic at schools (Brent, 1998:81). These should cover resources, objectives, time-scales, deadlines, budgets and performance targets.

Programmes should:

- increase the incidence rate of people who are uninfected by promoting safe sex;
- assume interventions to reduce mortality in respect of treatment of sexually transmitted diseases;
- promote mother-to-child transmission prevention;

- encourage behavioural changes such as reduction in the number of partners and increase in condom usage;
- develop a support programme for infected and affected educators and learners in their respective communities;
- sustain the involvement of People Living With Aids (PLWA) in order to strengthen the HIV/AIDS programmes;
- establish community outreach programmes with national and provincial AIDS service organizations; and
- link communities with relevant support systems and assist communities to develop coping measures that will help them maintain a stable community and workforce in the era of HIV/AIDS (Flisher, 2000b:97; Cullinan, 2002:3).

2.7 The key components of the management strategy for dealing with HIV/AIDS

Bader (2000:68) has postulated the following key components of the management strategy framework:

2.7.1 *Committed and informed leadership*

The school management team should be knowledgeable *and* committed, convinced that the HIV/AIDS situation is grave, and recognize that teaching and learning structures are being steadily undermined. In the context of HIV/AIDS, curriculum and educational transformation must extend further to the development of the knowledge, attitudes, values and life-skills needed for making and acting on the most appropriate and positive health-related decisions. This latter is critically important in equipping individuals for their personal combat against HIV/AIDS, but does not address other needs that arise in an AIDS-ravaged society. The school curriculum should encompass measures to reduce the individual risk of being infected with HIV/AIDS, as well as to reduce societal vulnerability to HIV/AIDS. Managerial commitment and leadership, participatory planning and intersectoral partnerships are essential to a successful response, all of which need to be founded in a rights-based approach (Chiganze, Decosas & Chikore, 2000:87).

2.7.2 Collective dedication

Broad-based multidisciplinary management partnerships are established with other government sectors, non-governmental organizations, faith groups, community groups and the private sector. In partnership with other bodies, schools have an important role to play in reducing the risks and vulnerability associated with the pandemic. Among the actions that should be prioritized are:

- efforts to ensure that educators are well prepared and supported in their teaching on HIV/AIDS, through pre-service and in-service education and training;
- preparation and distribution of scientifically accurate, good-quality teaching and learning materials on HIV/AIDS, communication and life skills;
- promotion of life skills and peer education for learners and young people, and among parents and educators themselves;
- elimination of stigma and discrimination, with a view to respecting human rights and encouraging greater openness concerning the pandemic;
- support for school health programmes that combine school health policies, a safe and secure school environment for both educators and learners, skills-based health education and school health services that explicitly address HIV/AIDS; and
- promotion of policies and practices that favour access, gender equity, school attendance and effective learning (Israel, 2003:102; Agyarko & Kowal, 2000:118). It is therefore imperative that the school management work in partnership with the whole school community, including educators, learners, parents, non-teaching staff and caregivers, to ensure a safe environment, a positive ethos, a stimulating curriculum, pastoral support and effective links to community health and support services (Otaala, 2000:63).

2.7.3 ***Policy and regulatory framework***

A framework of common understanding about the nature of the pandemic and its potential impact on teaching and learning is developed, as are guidelines, regulations and codes of conduct which interpret policy for educators and school governing body members responsible for implementing it. The school management teams should endeavour to create safe and healthy schools. To create a safer environment for learners and educators, the school management team should set up a Health Advisory Committee, design programmes to combat the disease, develop HIV/AIDS policies (Act No. 27 of 1996), and draft and adopt a code of conduct for the learners (Act No 4 of 1996 section 8).

A healthy school is one in which all learners can develop and grow safely with confidence (Karim & Karim, 1999:82). Learners can learn and develop only when they feel safe and are actually safe. Safe and healthy school environments would be the ones that are drug-free, rape-free and free of bullies where learners and educators learn and teach without risk of being infected or affected.

- *Strategic and operational planning:* Strategic principles are elaborated which are commonly held and understood, and which underpin realistic and realizable operational plans.
- *Effective management:* School management teams should be committed to not just *react* to the HIV/AIDS crisis, but also to *anticipate* its consequences and be effectively proactive in harnessing resources to counteract it.
- *Appropriate capacity:* Procedures and structures should be set in place for ensuring implementation of HIV/AIDS-dictated activities, building capacity at all levels of the system, and providing for personnel replacement and training.
- *Research and monitoring:* A research agenda should be developed, along with research principles, priorities and resources for collecting, storing and

sharing information, and a set of benchmarks and crisis indicators – alarm bells indicating trouble – which can be monitored over time.

- *Streamlined funding:* Adequate budgetary provision should be made for substitute educators in cases where educators are absent from school because of HIV/AIDS (Chalsworth, 2001:279).

2.8 Conclusion

This chapter discussed a management strategy for dealing with HIV/AIDS. The next chapter discusses the empirical design of this study.

Chapter 3

Empirical research design

3.1 Introduction

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

- determine the nature of the management strategy for the HIV/AIDS pandemic in schools;
- determine the effects of the HIV/AIDS pandemic on the school system; and
- suggest a management strategy for dealing with HIV/AIDS pandemic at schools

The study investigates the perceptions of educators, principals, deputy principals and heads of department on the impact of HIV/AIDS on educators, learners and the teaching and learning situation. The responses of the participants are used to make suggestions for a management strategy (see chapter 5) which schools can adopt in dealing with the HIV/AIDS pandemic at their schools.

3.2 Method of research

This research was conducted by means of a literature study and empirical research.

3.2.1 Literature study

Primary sources that were consulted include current international and national journals, papers presented at professional meetings, dissertations by

graduate students' reports written by school and university researchers, and both South African Acts 27 and 84 of 1996, which provide information on how far research on HIV/AIDS at schools and their effects on teaching, learning and management of schools have progressed. Acts were consulted for governmental and departmental policy theoretical frameworks. Books on HIV/AIDS serve as secondary sources.

3.2.2 Empirical research

The empirical investigation, both qualitative and quantitative in nature, was conducted to gather information about the effects of HIV/AIDS on educators, learners and the teaching and learning situation. Personal visits were made to primary and secondary schools in the townships and farm school areas where questionnaires were distributed to educators (educators serving and appointed on post level one of the schools' organizational hierarchical structure of educational management) and school management teams comprised of Heads of Departments (educators serving and appointed on post level 2), Deputy Principals (educators serving and appointed on post level 3) and Principals (educators appointed on either post level 4 or depending on the enrolment of the school). Questionnaires were handed to educators, heads of departments and deputy principals through the school principals with the request that the questionnaires had to be filled in within three days and the researcher would come back to the school on the fourth day to collect them.

This method of distributing questionnaires to the educators via the school principals created problems for the researcher because not all questionnaires were returned. Only 363 out of 400 were returned. The table below indicates the numbers distributed to educators and school management teams, those that were returned and those that were not returned.

TABLE 3.1 Feedback of the population group

No. of schools 30	Number of questionnaires distributed				
		Educators	Managers	Total	Percentage
	No. distributed	305	95	400	100
	No. returned	292	71	363	90.8
	No. lost or misplaced	13	24	37	9,2

3.3 Description of the population

All educators and school management teams falling under the jurisdiction and control of the Gauteng Department of Education were considered as the study population. The Gauteng Department of Education in the Vaal Triangle area has 2 040 educators serving in school management teams in public schools, and this figure is calculated at an average figure of 5 school management team members per school. Seeing that the carrying out of the study could be delayed if all of them were to participate in this study and this could have heavy financial implications for the researcher, the researcher and the supervisor took these two factors into consideration in deciding on the 400 participants who had to take part in this study. The researcher and the supervisor also decided to limit the study population to educators and school management teams in the Vaal Triangle area of the Gauteng Province.

3.4 Method of random sampling

Samples like cluster and random sampling were considered for use in this investigation. After careful consideration of the advantages and disadvantages of each of these methods, random sampling was decided on, to ensure that the sample is representative of the population. A list of all public schools from Vereeniging and Vanderbijlpark districts was obtained and

schools for investigation were randomly selected from the list. The respondents consisted of educators and school management teams from 30 randomly selected public schools in both districts of the Vaal Triangle area of Gauteng Province.

3.5 Random sample size

A total of educators (N=400), which consisted of school management teams (N=80), and educators (N=320) from 30 public schools, participated in the survey. This sample ranged from farm school areas to township school areas, consisting of primary, secondary and combined schools.

3.6 Covering letter

In a covering letter to the principals of 24 primary schools, 5 secondary schools, and 1 private school, the purpose of the questionnaire was described. Stressing the confidentiality of information, an appeal was made to the respondents to respond openly and sincerely (see Appendix A).

3.7 Procedure

With the permission of the school principals, the researcher distributed copies of the questionnaire to principals for distribution to their educators, HODs and Deputy Principals. Written guidelines were provided on the questionnaire to ensure, as far as possible, standardized administration and to secure participants' guarantee of confidentiality.

Educators and school management teams were given three days to complete the questionnaires, which were to be collected by the researcher on the fourth day. All data were collected during September 2003.

3.8 The composition of the questionnaire (closed and open-ended questions)

Although several measuring instruments have been devised to obtain self-reports of educators and school management teams on their perceptions of the impact of HIV/AIDS on educators, learners and the teaching and learning situation (see tables 4.9; 4.10; 4.11), as far as it could be ascertained, only overseas measuring instruments have been designed to determine the perceptions of educators in countries whose social and educational situations are different. As a result of a peculiar situation in South African society and schools, especially in Black townships where learners, parents and educators maintain different culturally founded stereotypes and misconceptions of HIV/AIDS (Crawler, 2004:39), not a single one of these instruments was suitable and appropriate for use in the investigation in question. It was then decided to construct a distinctive HIV/AIDS questionnaire which could be used to measure perceptions of educators and school management teams about the impact of HIV and AIDS on educators, learners and the school systems within their schools and cultural context.

Based on the information gathered through a literature review, a questionnaire was designed. The questionnaire comprised 90 questions divided into five sections, namely: a section for biographic information (questions 1-7, see appendix A), a section of questions to determine the impact of HIV/AIDS on educators (questions 8-18, see appendix A), a section of questions to determine the impact of HIV/AIDS on learners (questions 19-38, see appendix A), a section of questions to determine the impact of HIV/AIDS on the teaching and learning situation (questions 39-68, see appendix A) and finally a section to determine perceptions on the existing measures to curb the negative effect of HIV/AIDS on teaching and learning (questions 69-90, see appendix A). Five of the questions in the questionnaire were open-ended and gave educators the opportunity to give their personal input (questions 18, 19.12, 43.8, 46.8 and 51). In total, 400 questionnaires were distributed.

3.9 Feedback of the research population group on the questionnaire

Feedback from the 30-targeted schools was as follows:

3.9.1 Number of respondents per school category

Table 3.2

Type of schools		
Schools	Frequency	Percentage
Primary	24	80
Secondary	5	19.6
Private	1	0.4

Table 3.3

Number of educators		
Educators	Frequency	Percentage
Primary	295	84.5
Secondary	53	15
Private	3	0.5

Table 3.4

Location	Frequency	Percentage
Rural	40	11.5
Urban	309	88.5

Schools from the township areas participated more than schools in the farm areas. This was due to the fact that there are more schools in the urban areas than in the rural areas. It was impossible to have a 100% retrieval of questionnaires, as most of them were left at the mercy of the principals of participating schools to deliver to educators and no follow-ups were made concerning the ones not retrieved. Thirteen (13) were incomplete because

educators claimed that the questionnaire was too long making it difficult for them to concentrate on the questions.

3.10 Statistical techniques

Data was processed using the SPSS programme in consultation with the Statistical Consultation Services of North-West University in which the computer programme performed the TEST procedure of the SPSS System for Windows Release (SPSS-Institute, 2000; Steyn, 1990).

3.11 Conclusion

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

Chapter 4

Data analysis and interpretation

4.1 Introduction

The purpose of the empirical survey of this research was to determine by means of a questionnaire:

- determine the nature of a management strategy for the HIV/AIDS pandemic at schools;
- determine the effects of the HIV/AIDS pandemic on the school system; and
- suggest a management strategy for dealing with HIV/AIDS pandemic at schools

The summary of the data collected by means of empirical research is analysed and interpreted in this chapter. The percentages of demographic particulars are reported and t-tests were conducted to compare the perceptions of educators and school management teams with regard to the effects of HIV/AIDS on educators, learners, teaching and learning situation (which in this research are referred to as school systems) and to find out if schools comply with certain categories of critical prerequisites for effective teaching and learning. These critical prerequisites are necessary for the suggestion of an effective strategy for managing school systems against HIV/AIDS.

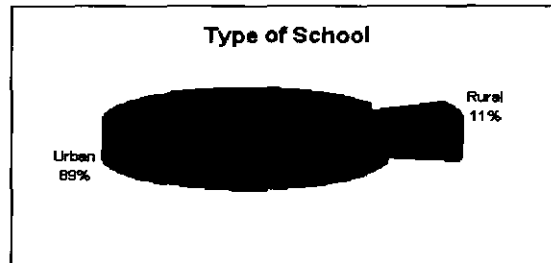
4.2 Data on the demographic information

Data concerning the demographic information of respondents is presented in Tables 4.1 to 4.7. These data are analysed and interpreted.

4.2.1 The distribution of the number of educators who participated in this research according to school types (N=349)

Table 4.1

Variable	N
Farm	40
Township	309



4.2.1.1 Analysis

89% of respondents who participated in this research are from township schools, and 11% are from farm schools.

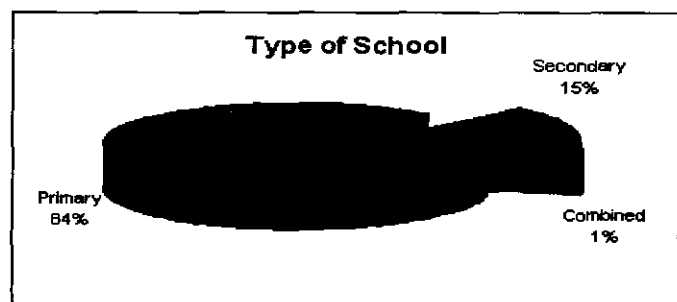
4.2.1.2 Interpretation

It can be deduced from the data collected in figure 4.1 that the majority of schools in the Vaal Triangle are in township areas and a few in farm areas. This could be attributed to the fact that there is a great exodus of learners with their parents to the townships because of the current urbanization of the South African communities and the prospects of finding jobs in the highly industrialized Vaal Triangle towns which are situated near the townships.

4.2.2 The distribution of the number of educators who participated in this research according to levels of schools in which they teach (N=351)

Table 4.2

Variable	N
Primary	295
Secondary	53
Combined	3



4.2.2.1 Analysis

84% of the respondents who participated in this study are from primary schools, while 15% are from secondary schools and 1% from schools, which combined both primary and secondary school levels.

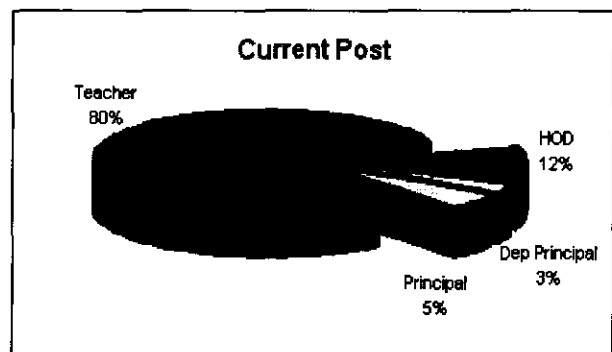
4.2.2.2 Interpretation

It can be deduced from the data collected in figure 4.2 that the majority of schools in the Vaal Triangle are primary schools, followed by secondary schools, with only a few combined schools.

4.2.3 The distribution of the number of educators who participated in this research according to their current posts (N = 363)

Table 4.3

Variable	N
Educator	292
HOD	43
Deputy Principal	10
Principal	18



4.2.3.1 Analysis

80% of respondents who participated in this research are educators, 12% are HODs, 3% are deputy principals, and 5% are principals.

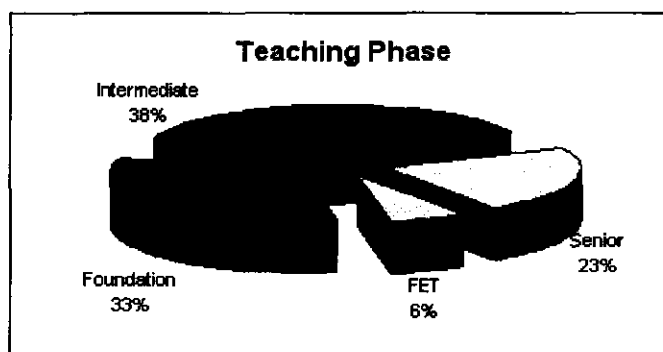
4.2.3.2 Interpretation

It can be deduced from the data collected in figure 4.3 that educators are in the majority, followed by HODs, then Deputy Principals and lastly Principals.

4.2.4 The distribution of educators according to the phases in which they are teaching (N=366)

Table 4.4

Variable	N
Foundation	121
Intermediate	137
Senior	85
FET	23



4.2.4.1 Analysis

38% of respondents who participated in this research teach in the intermediate phase, while 33% are in the foundation phase, followed by 23% in the senior phase, and 6% in the further education and training phase.

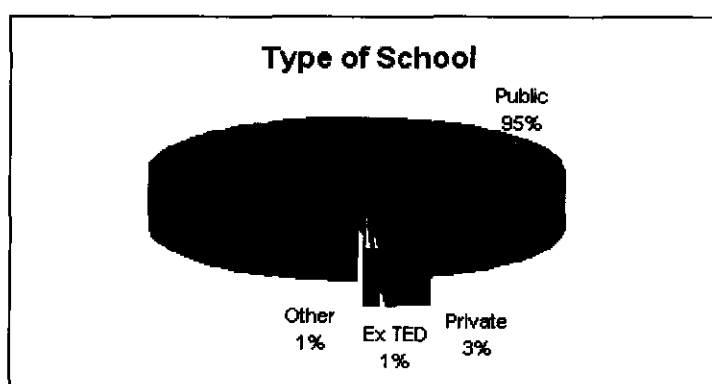
4.2.4.2 Interpretation

It can be deduced from the data collected in figure 4.4 that the majority of educators teach in the intermediate phase, followed by those in the foundation phase, others teach in the senior phase and lastly those that teach in further education and training phase.

4.2.5 The distribution of educators who participated in this research according to government's classification of schools (N=361)

Table 4.5

Variable	N
Public	345
Private	12
Ex TED	2
Other	2



4.2.5.1 Analysis

95% of respondents who participated in this research are from township schools, 3% from private schools, 1% from historically white schools and 1% from other schools.

4.2.5.2 Interpretation

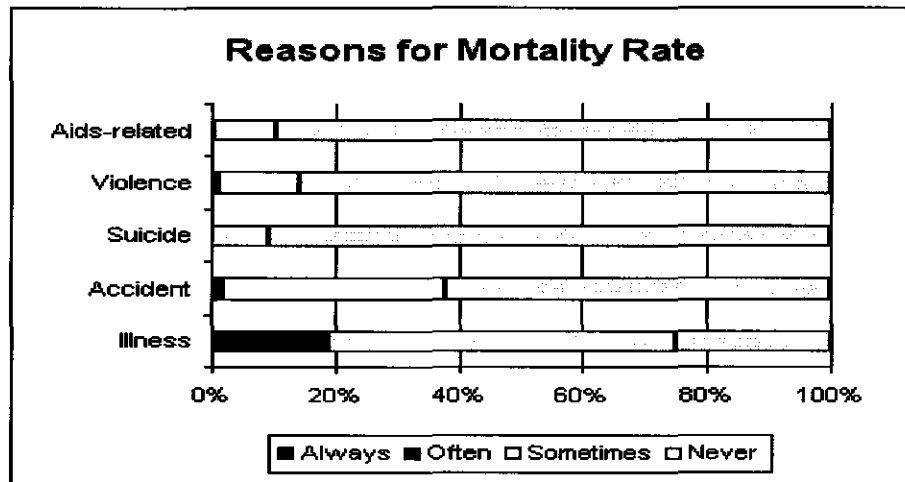
It can be deduced from the data collected in figure 4.5 that the majority of educators are from township schools, followed by private schools. It is a reality in South Africa that townships are highly populated because of the majority of poor people who stay there.

4.2.6 Reasons given for the mortality rate among educators

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

Table 4.6

Variable	Always		Often		Sometimes		Never	
	Frequency	%	Frequency	%	Frequency	%	frequency	%
Illness	18	5	48	14	194	56	88	25
Accident	0	0	7	2	121	36	211	62
Suicide	0	0	0	0	32	9	317	91
Violence	2	1	2	1	44	13	288	85
Aids-related	0	0	1	0	35	10	306	90



4.2.6.1 Analysis

75% of the respondents indicated that illness was the main reason for the mortality rate among educators at their respective schools.

4.2.6.2 Interpretation

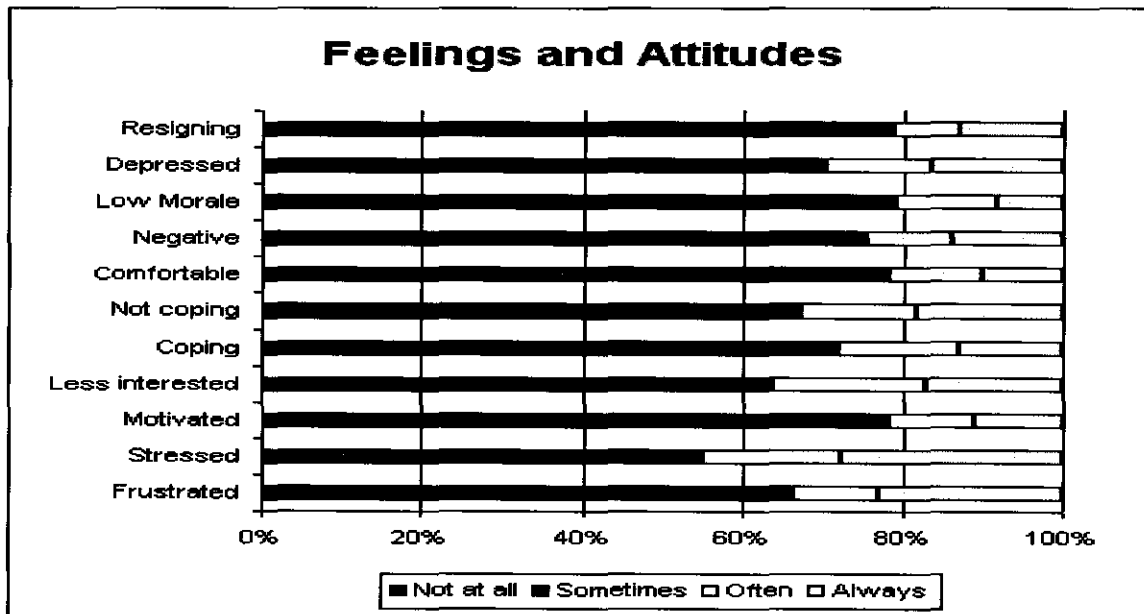
This suggests that the main cause of educator mortality rate at schools which formed the sample of this study is illness.

4.2.7 The extent of feelings/attitudes experienced by educators and school management teams who have to carry a heavy workload

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

Table 4.7

Variable	Not at all	%	Sometimes	%	Often	%	Always	%
Frustrated	30	9	175	57	33	11	71	23
Stressed	34	10	139	44	55	18	87	28
Motivated	133	43	107	35	33	11	34	11
Decreased interest	69	23	126	41	59	19	52	17
Coping	81	26	141	46	46	15	40	13
Not coping	63	21	138	46	43	14	55	19
Comfortable	123	40	116	38	36	12	31	10
Negative	79	26	149	49	32	11	42	14
Low morale	68	22	172	57	38	13	25	8
Depressed	64	20	153	50	41	13	51	17
Resigning	110	36	129	43	25	8	39	13



4.2.7.1 Analysis

- 91% of the respondents reported that they are frustrated to a certain extent, while 9% of the respondents reported that they are not at all frustrated.
- 90% of the respondents reported that they are stressed, to a certain extent while 10% of the respondents reported that they are not at all stressed.
- 57% of the respondents reported that they are motivated to a certain extent, while 43% of the respondents reported that they are not at all motivated.
- 77% of the respondents reported that they have a decreased interest to a certain extent, while 23% of the respondents reported that they do not have a decreased interest at all.
- 74% of the respondents reported that they are coping to a certain extent, while 26% of the respondents reported that they are not coping at all.
- 79% of the respondents reported that they are not coping to a certain extent, while 21% of the respondents reported that they are not coping at all.
- 60% of the respondents reported that they are comfortable to a certain extent, while 40% of the respondents reported that they are not at all comfortable.
- 74% of the respondents reported that they are negative to a certain extent, while 26% of the respondents reported that they are not at all negative.
- 78% of the respondents reported that they experience low morale to a certain extent, while 22% of the respondents did not experience any low morale at all.
- 80% of the respondents reported that they are depressed, while 20% of them said that they are not at all depressed.
- 64% of the respondents reported that they felt like resigning, while 36% of them said that they did not feel like resigning at all.

4.2.7.2 Interpretation

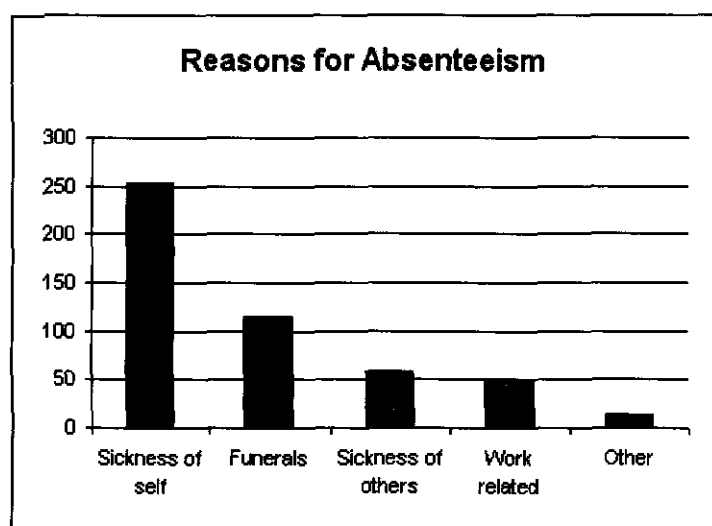
These revelations of such a significant majority of educators and school management team members who are frustrated; stressed; have a decreased interest in their work; negative about their work; experience low morale; depressed; and feel like resigning is a great cause of concern for this research. These could be symptoms of being emotionally drained and burned out for respondents who participated in this study. A management strategy for dealing with these repercussions of HIV/AIDS pandemic should include the implementation of a Wellness Programme for staff at schools.

It is interesting to note that in spite of manifesting symptoms of emotional debilitation and burnout the respondents still report to be motivated, coping and comfortable. This could be attributed to the fact that educators and school management team members still feel that teaching is a calling and therefore they have to tenaciously hold to the professional values of their teaching calling.

4.2.8 Reasons for educator absenteeism in participating schools

Table 4.8

Sickness of self	254	52%
Funerals	114	23%
Sickness of others	59	12%
Work –related	48	10%
Other	13	3%



4.2.8.1 Analysis

52% of the respondents who participated in this research reported "Sickness of self" as the main reason for absenteeism among educators, 23% reported funeral attendance, while 12% reported sickness of others; work-related reasons accounted for 10%, while 3% was for other reasons.

4.2.8.2 Interpretation

The fact that most of the educator absenteeism is due to sickness of self clearly indicates that there is a problem concerning both the physical and psychological wellness of educators and school management team members at schools. The rate of funeral attendance is another cause for concern, while sickness of others is also a big problem for this research. It should be noted that educators could still find it difficult to notify their managers of the nature and extent of their diseases, especially HIV/AIDS and other sexually transmitted infections because of the stigma and discrimination that always go with these ailments. An effective management strategy for such a state of affairs would include the promotion of human rights at all schools through infusing them in all school intra-and extra-curricular activities and implement effective Wellness Programmes for staff.

4.3 An analysis of differences in the perceptions of educators and school management teams with regard to the effects of HIV/AIDS on school systems

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

was computed to determine the effect sizes of the significant differences. This was done for differences in responses between educators and school management teams.

4.3.1 The t-test

The t-test is used to determine whether two means differ significantly from each other or whether two sets of scores differ significantly at a selected probability level (Fraenkel & Wallen, 1990:185; Vockel & Asher, 1995:321). The t-test was used in this study in order to determine if there are any significant differences between the perceptions of respondents (educators and school management teams) with regard to the effects of HIV/AIDS on educators, learners, and the teaching and learning situation and certain categories of critical prerequisites for effective teaching and learning. The t-test was also used for its reliability to produce accurate probability statements.

4.3.2 The p-value

The probability value (p-value) indicates whether there are statistically significant differences between two means of a sample (Vockel & Asher, 1995:326).

In this study:

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

(educators and school management teams) with regard to the effects of HIV/AIDS on educators, learners, and the teaching and learning situation and certain categories of critical prerequisites for effective teaching and learning (Vockel & Asher, 1995:326).

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

4.3.3 The d-value (effect size)

The effect size assesses the magnitude of a difference between two means, that is: it takes into account the size of the difference between means, regardless of whether it is statistically significant (Fraenkel & Wallen, 1990:189). In this regard, Vockel and Asher (1995:330) assert that the effect size determines if the difference is enough to recommend changes in the educational practice. Gall, Borg and Gall (1996:196) caution however, that though the effect size is helpful in judging the practical significance of a research result, it is by no means an absolute index of practical significance. It is therefore an aid to interpretation, albeit an important one.

Therefore, in this study the effect size is computed in order to determine whether the observed differences in perceptions derived from the t-test can be interpreted to be of practical significance or use. This is done for differences in responses between educators and school management teams. It was obtained by using the following formula (Fraenkel & Wallen, 1990:185; Vockel & Asher, 1995:334):

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

where,

$$\begin{aligned}\bar{x}_1 &= \text{the mean of principals/deputy principals/HODs} \\ \bar{x}_2 &= \text{the mean of educators}\end{aligned}$$

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

d = effect size

The interpretation of the effect size was done on the basis of the following guidelines proffered by Vockel and Asher (1995:337):

$d = 0, 2$ (small effect)

$d = 0, 5$ (medium effect)

$d = 0, 8$ (large effect)

According to Fraenkel and Wallen (1990:187) effect sizes of 0, 5 or more should be treated as important. However, Vockel and Asher (1995:338) postulate that such effect sizes could depend on the reader's frame of reference, that is, he may consider them either too small or too large, which projects the arbitrariness of quantitative operational definitions to qualitative adjectives. It was therefore decided in this study to interpret effect sizes above 0, 8 to be important. This was because it was realised that all respondents are operating in school systems where the HIV/AIDS pandemic is still not a notifiable disease and, at times, it is still a taboo to discuss any items related to this pandemic.

Therefore, they would all require developing a management strategy to deal with all the stereotypes and taboos on this pandemic. On the strength of that frame of reference, only significant differences of a large enough effect size, $d = 0,8$, would be considered to be of practical significance (Fraenkel & Wallen 1990:187).

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

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

4.3.4 The effects of HIV/AIDS on educators

Table 4.9

Item description	Mean	SD	Mean	SD	T	P	D
	Educators		SMT				
Educators who are HIV positive	3.55	0.69	3.60	0.62	-0.52	0.60	
Educators who retired or died	0.09	0.29	0.00	0.00	1.25	0.22	
	0.09	0.29	0.06	0.24	0.41	0.68	
	0.11	0.31	0.06	0.24	0.59	0.56	
	0.19	0.43	0.00	0.00	1.71	0.09	
	0.07	0.26	0.00	0.00	1.14	0.26	
	0.11	0.37	0.00	0.00	1.21	0.23	
Educators possibly affected	1.2	1.38	0.40	0.55	1.26	0.22	
	1.46	1.95	0.40	0.55	1.20	0.24	
Absenteeism rate of educators	1.94	2.99	1.30	0.75	1.17	0.24	
	2.73	4.27	2.20	1.85	0.66	0.51	
Problems experienced in taking over for an absent colleague	2.77	0.94	2.81	0.88	-0.38	0.71	
Appointment of	3.33	0.98	3.31	1.01	0.15	0.88	

substitute educators							
Coping with one educator's workload	1.81	0.45	1.78	0.42	0.40	0.69	
Shortage of staff members	2.71	1.06	2.57	1.23	0.58	0.56	
Frequent absence of staff members	2.79	0.81	2.93	0.66	-0.86	0.39	
Staff members not replaced	2.70	0.96	2.70	0.99	-0.01	0.99	
Absence due to personal illness	2.38	0.75	2.59	0.95	-1.25	0.21	

4.4 The comparison between educators and school management teams' perceptions of the effects of HIV/AIDS on educators

4.4.1 Analysis

The p-values of Table 4.9.2 indicate that there were no significant differences in the perceptions of educators and school management teams with regard to the effects of HIV/AIDS on educators.

4.4.2 Interpretation

The reason for this result could be the fact that educators in township schools do not yet feel free to discuss their HIV/AIDS status with their colleagues because of the stigma that is always attached to the person suffering from this pandemic. Table 4.6.2 revealed that the majority of educators in the schools and school management teams who participated in this research stipulated illness as the reason for the mortality rate among educators at their schools. It would be interesting to investigate the real nature of these illnesses to see if these illnesses are not related to opportunistic diseases as highlighted in chapters 1 and 2 of this research (see paragraphs 1.1 & 2.2.1)

4.5 The effects of HIV/AIDS on learners

Table 4.10

Item description	Mean	SD	Mean	SD	T	P	d
	Educators		SMT				
Awareness of learners who are HIV positive	3.24	1.06	3.17	1.09	0.47	0.64	
Number of learners affected	5.46	6.70	2.09	2.80	1.62	0.11	
	5.66	8.43	2.83	4.22	1.13	0.26	
Percentage of orphaned children who repeated grades	2.03	1.37	1.83	1.46	0.91	0.36	
Percentage of learners affected by interrupted schooling	1.92	1.27	1.68	1.19	1.17	0.24	
Percentage of learners who dropped out of school due to incomplete families-	1.78	1.24	1.59	1.19	0.99	0.32	
Learners involved in sexual harassment by educators	1.93	0.29	1.94	0.24	-0.25	0.80	
Relationships between learners and educators	1.98	0.30	1.97	0.17	0.13	0.90	
Percentage of learners suffering from poor nutrition	3.66	1.93	3.55	2.00	0.41	0.69	
Percentage of learners unable to pay school fees	3.82	1.96	3.66	1.93	0.60	0.55	
Reasons for learner absence	2.37	2.08	2.63	2.12	-0.91	0.36	
Absenteeism rate of learners on a weekly basis	18.30	30.30	28.77	47.60	-1.89	0.06	
Both parents alive	4.14	1.53	4.66	1.65	-2.06	0.04	0.28
Paternal orphan	2.94	1.52	2.75	1.67	0.77	0.44	
Maternal orphan	2.61	1.98	2.65	1.45	-0.18	0.86	
Double orphan	2.20	1.70	1.98	1.82	0.78	0.44	
Learners living with guardians	3.10	1.06	2.94	1.10	0.68	0.50	

Learners who are HIV positive	1.50	1.46	1.39	1.31	0.47	0.64	
Learners living with HIV positive family members	2.13	1.47	1.91	1.29	0.81	0.42	
Learners whose parents have died of HIV/AIDS	2.30	0.52	1.83	0.50	1.74	0.08	

4.5.1 Analysis

The results of table C reveal a significant statistical difference between the perceptions of educators and school management teams with regard to absenteeism rates of learners on a weekly basis ($t=-249$, $p<0.01$, $d<0.30$) and the life of both parents ($t=-2,06$, $p<0.04$, $d<0.28$). Statistically, both these differences between the perceptions of educators and school management teams imply a small effect in practice.

4.5.2 Interpretation

This result is attributable to the fact that educators have daily access to learners' information on absenteeism and the life of both parents because of the registers they have to control for their classes, while school management teams only work on summaries provided by educators.

4.6 The effects of HIV/AIDS on teaching and learning

Table 4.11

Item description	Mean	SD	Mean	SD	T	P	D
	Educators		SMT				
Does HIV/AIDS have a detrimental effect on teaching and learning?	1.47	0.50	1.47	0.50	0.00	1.00	
Is the academic	1.55	1.03	1.43	0.94	1.78	0.08	

progress satisfactory?							
Classes too big	2.09	0.92	2.47	0.82	-2.07	0.04	0.37
Impossible to pay attention to individual learners	2.05	0.77	2.22	0.63	1.01	0.31	
Learners are frequently absent	2.74	0.99	2.65	1.07	0.65	0.52	
Educator workload too heavy	2.01	0.93	2.67	0.90	-3.62	0.00	0.62
Learners not motivated	2.74	0.79	2.71	0.60	0.17	0.86	
Frequent absence of educators due to family responsibilities	3.04	0.82	3.10	0.81	-0.50	0.62	
Frequent absence of educators due to personal illness	2.72	0.80	2.67	0.74	0.38	0.71	
Lack of motivation	2.39	0.80	2.31	0.86	0.73	0.47	
Lack of social interactions	2.39	0.72	2.29	0.64	0.94	0.35	
Hyperactivity	2.37	0.71	2.27	0.64	1.01	0.31	
Passivity	2.39	0.67	2.28	0.69	1.07	0.28	
Nervousness	2.25	0.91	2.17	0.89	0.90	0.37	
Poor discipline	2.42	0.71	2.61	0.65	-1.54	0.12	
Absenteeism	2.40	0.65	2.37	0.72	0.23	0.81	
Tiredness	2.22	0.82	2.14	0.76	0.94	0.35	
Lack of motivation	2.30	0.74	2.39	0.70	-0.86	0.39	
Lack of concentration	2.57	0.88	2.31	0.79	2.56	0.01	0.35
Memory loss	2.34	0.72	2.15	0.69	1.58	0.11	
Poor attention span	2.50	0.84	2.34	0.76	1.59	0.11	

Decreased interest in school	2.47	0.81	2.06	0.70	3.63	0.00	0.49
Personal illness	2.56	0.81	2.41	0.78	1.43	0.15	0.32
Illness of family members	2.57	0.87	2.31	0.82	2.37	0.02	0.30
Loss of family members	2.88	0.92	2.61	0.89	2.25	0.02	0.42
Too many responsibilities at home	2.75	0.89	2.37	0.80	3.02	0.00	0.32
Poor academic performance	2.81	0.81	2.52	0.85	2.36	0.02	0.12
Rejection by peers	2.23	0.74	2.12	0.68	0.94	0.35	
School-related problems	2.30	0.92	2.25	0.84	0.43	0.66	
Diarrhoea	3.28	0.92	3.28	0.84	0.06	0.96	
Pneumonia	3.25	0.92	3.22	0.94	0.27	0.79	
Tuberculosis	3.24	1.06	3.11	1.00	0.99	0.32	
Severe weight loss	3.04	0.64	3.09	0.51	-0.35	0.73	

4.6.1 Analysis

The results of table 4.9.3 reveal a significant statistical difference between the perceptions of educators and school management teams with regard to classes which are too big ($t=-2.07$, $p<0.04$, $d<0.4$); educator workload too heavy ($t=-3.62$, $p<0.00$, $d<0.6$); lack of concentration ($t=2.56$, $p<0.01$, $d<0.4$); decreased interest in school and school activities ($t=-3.63$, $p<0.00$, $d<0.5$); illness of family members ($t=2.37$, $p<0.02$, $d<0.3$); loss of family members ($t=2.25$, $p<0.02$, $d<0.3$); too many responsibilities at home ($t=3.02$, $p<0.00$, $d<0.4$); poor academic performance ($t=2.36$, 0.02 , $d<0.3$). Statistically, the differences between the perceptions of educators and school management teams with regard to classes which are too big, lack of concentration, illness of family members, loss of family members, too many responsibilities at home

and poor academic performance imply a small significant effect in practice; whereas decreased interest in school and school activities, and educator workload which is too heavy imply a medium significant effect in practice.

4.6.2 Interpretation

These results indicate that the perceptions of educators and school management teams with regard to classes which are too big, manifestations of lack of concentration among learners, manifestations of illness of family members, loss of family members, too many responsibilities at home, poor academic performance among learners, educator workload which is too heavy, and decreased interest in school and school activities are different. This could be attributable to the fact that educators spend a lot of time with their learners in classrooms and their experiences of what happens in the classroom may be different. Educators are likely to experience more burnout and job satisfaction because of their daily exposure to learner experiences of depression and stress.

4.7 Pre-requisites for effective teaching and learning

Table 4.12

Item description	Mean	SD	Mean	SD	T	P	D
	Educators		SMT				
Educators are well prepared	3.40	0.64	3.26	0.51	1.60	0.11	
Educators present interesting learning activities	3.21	0.64	3.20	0.51	0.06	0.95	
Educators have well organized classrooms	3.14	0.72	3.02	0.70	1.29	0.20	
There is a constant flow of learning	3.17	0.70	3.09	0.65	0.83	0.41	
On-going interaction between	3.30	0.71	3.27	0.60	0.34	0.73	

learners and educators							
Educators correct tests	3.45	0.63	3.30	0.61	1.67	0.10	
Tests are handed back in good time	3.20	0.72	3.06	0.66	1.36	0.18	
Educators check learners homework	3.27	0.72	3.11	0.70	1.57	0.12	
Educators provide assistance with personal problems	3.07	0.73	3.05	0.65	0.26	0.80	
Educators provide assistance with educational problems	3.21	0.71	3.06	0.75	1.47	0.14	
Educators involve learners actively in learning	3.42	0.70	3.18	0.58	2.47	0.01	0.33
Educators reinforce learning	3.33	0.71	3.17	0.65	1.66	0.10	
Educators pay individual attention	2.98	0.83	2.92	0.74	0.46	0.65	
Educators control disciplinary problems effectively	3.21	0.79	2.98	0.67	2.14	0.03	0.29
Educators make sure that learners pay attention during lesson presentation	3.39	0.67	3.09	0.61	3.29	0.00	0.45
Educators are dependable	2.89	0.99	2.98	0.68	-0.70	0.49	
Educators are role models in good ethics, attitudes and values	3.30	0.71	3.25	0.72	0.50	0.62	
Educators are punctual and regular in attendance	3.08	0.69	3.02	0.57	0.75	0.46	
Educators are sexually involved with learners	1.25	0.66	1.21	0.60	0.47	0.64	
Are learners of different grades combined into one classroom?	1.96	0.20	1.93	0.26	1.17	0.24	
Is the curriculum flexible to deal with learners who cannot	1.59	0.49	1.68	0.47	-1.35	0.18	

attend school or whose schooling is interrupted?							
Are classes left untaught?	1.87	0.33	1.91	0.29	-0.90	0.37	
Is there a sufficient educator supply?	1.35	0.48	1.33	0.48	0.26	0.79	
Are posts filled in good time?	1.37	0.48	1.29	0.46	1.22	0.22	
Are staff development programmes in place for educators who have to cope with heavy workloads?	1.49	0.50	1.54	0.50	-0.66	0.51	
Does the curriculum teach learners how to handle the emotional changes during puberty and adolescence?	1.23	0.42	1.13	0.34	1.67	0.97	
Is the curriculum focusing on promoting abstinence from sexual activities?	1.24	0.43	1.10	0.31	2.50	0.01	0.32
Does the curriculum focus on promoting a delay in taking part in sexual activities?	1.16	0.37	1.16	0.37	-0.08	0.94	
Are topics on HIV/AIDS infused into subjects?	1.03	0.18	1.03	0.17	0.14	0.89	
Are these topics well taught?	1.14	0.34	1.10	0.31	0.71	0.48	
Is there an in-depth coverage of HIV/AIDS topics?	1.28	0.45	1.25	0.44	0.49	0.63	
Planning of extra-curricular activities planned to address HIV/AIDS	1.34	0.47	1.16	0.37	2.78	0.01	0.37
Are school-based activities arranged to address HIV/AIDS?	1.20	0.40	1.15	0.36	0.96	0.34	
Are intensive pre-service and /or in-service training	1.31	0.47	1.24	0.43	1.18	0.24	

programmes implemented?							
Are educators confident to teach HIV/AIDS topics?	1.20	0.40	1.21	0.41	-0.20	0.84	
Are strict measures in place to deal with staff involved in sexual harassment of learners?	1.28	0.45	1.11	0.32	2.83	0.00	0.38
Are strict measures in place to deal with love relationships between learners and staff members?	1.27	0.44	1.16	0.37	1.72	0.09	
Are there strict measures for educators who are frequently absent?	1.19	0.39	1.22	0.42	-0.50	0.62	
Is your school offering feeding scheme?	1.12	0.33	1.15	0.36	-0.68	0.50	
Are you of the opinion that it is the school's task to deal with the causes and effect of HIV/AIDS?	1.19	0.40	1.20	0.40	-0.06	0.96	
Are you of the opinion that we give too much attention to HIV/AIDS in our schools?	1.51	0.50	1.48	0.50	0.52	0.60	

4.7.1 Analysis

The results of table E reveal a significant statistical difference between the perceptions of educators and school management teams with regard to educators involving learners actively in learning ($t=2.47$, $p<0.01$, $d<0.3$); educators controlling disciplinary problems effectively ($t=2.14$, $p<0.03$, $d<0.3$); educators making sure that learners pay attention during lesson presentation ($t=3.29$, $p<0.00$, $d<0.5$); the curriculum focusing on promoting abstinence from sexual activities ($t=2.50$, $p<0.01$, $d<0.3$); planning extra-curricular activities to

address HIV/AIDS ($t=2.78$, $p<0.01$, $d<0.4$) and dealing with staff involved in sexual harassment of learners ($t=2.83$, $p<0.00$, $d<0.4$).

Statistically, the differences between the perceptions of educators and school management teams with regard to educators involving learners actively in learning, educators controlling disciplinary problems effectively, the curriculum focusing on promoting abstinence from sexual activities, planning extra-curricular activities to address HIV/AIDS, and dealing with staff involved in sexual harassment of learners, imply a small significant effect in practice; whereas educators making sure that learners pay attention during lesson presentation implies a medium significant effect in practice.

4.7.2 Interpretation

These results indicate that the perceptions of educators and school management teams with regard to educators involving learners actively in learning; educators controlling disciplinary problems effectively; educators making sure that learners pay attention during lesson presentation; the curriculum focusing on promoting abstinence from sexual activities; planning extra-curricular activities to address HIV/AIDS; and dealing with staff involved in sexual harassment of learners are different. These results could be attributable to the fact that the needs of the Revised National Curriculum Statement (RNCS) expect educators to facilitate and let more work be done by learners through discovery and exploration of their abilities, thus exposing them to working in groups. This leads them to work effectively according to their capabilities and to show expertise, rather than the educator wasting their time, teaching aspects which may tend to be boring and uninteresting to the learners. Active participation of learners in their respective groups is thus observed and noise disturbances are inevitable, as the situation sometimes turns out to be chaotic and uncontrollable as learners are all engaged in proving their communication and listening skill potentials with their peers, thus impacting negatively on educators as if they cannot control disciplinary problems effectively.

Concerning the planning of extra-curricular activities to address HIV/AIDS, it is understandable that some educators still have myths and reservations about the seriousness of the pandemic and want to shy away from the reality of its existence. This can lead others to a wait- and- see period and they will plan those activities when they come into contact with infected and affected learners at their schools. Regarding strict measures being in place for staff members involved in the sexual harassment of learners, the Department of Education has clearly stated that any educator found guilty of sexual harassment of learners will be charged with misconduct and upon being found guilty of the act, will be expelled from school with immediate effect.

4.8 Conclusion

In chapter 4, responses gathered from respondents through data collection instrument were analysed and interpreted. In chapter 5 a summary, conclusions and recommendations will be made. The recommendations are based on the findings of both the literature and the empirical studies of this research.

Chapter 5

Summary, findings and recommendations

5.1 Introduction

In this chapter, a summary of the four preceding chapters is presented. Firstly, the summary of the findings from the literature review which were highlighted in chapters 1 and 2 are presented, followed by the summary of the statement of the problem, purpose and methods of research as highlighted in chapters 1 and 3, and lastly the summary of the findings of the empirical research as revealed in chapter 4. The summaries of the literature findings and empirical research chapters will enable the researcher to formulate recommendations for a management strategy which schools could adopt and adapt in their dealing with the HIV/AIDS pandemic at their respective schools.

5.2 Summary and conclusions

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

The literature review of this research revealed that HIV/AIDS wreaks havoc on learners and educators' psychological health and mental functions such as memory, concentration and creativity (see paragraph 1.1 and paragraph 2.4). Behavioural efficiency and effectiveness, interpersonal relationships and personal productivity are also limited (see paragraph 1.1 and paragraph 2.4). Because of the physical and psychological demands involved in coping with this dreadful disease, it is not surprising that physicians and psychologists have suggested that experiencing HIV/AIDS will have a negative effect on an infected learner and educator in his/her general academic and vocational functioning at school (see paragraph 1.1). Some insight into what this apocalyptic scenario means for the general functioning of the school system can be gleaned from an examination of the potential multiple effects of HIV/AIDS on education, such as:

- decline in school enrolment as a result of the death of learners;

- the quality of education suffering because of educator absenteeism and deaths;
- erratic performance of professional duties by educators;
- depleted education budgets through double payment of educators, as sick educators have to be replaced while on fully paid sick leave; and
- the emotional and physical stress and pains that HIV- infected and AIDS- suffering learners and educators go through which impact on their effective learning and teaching abilities (see paragraph 1.1 and paragraph 2.4).

All these variables have a devastating impact on the general effective functioning of the school (see paragraph 1.1 and paragraph 2.4).

The foregoing paragraphs indicate that a management strategy is a virtual necessity for schools in order to deal with the HIV/AIDS pandemic concertedly. This may not be a recipe for success, but without it, a school is much more likely to fail to develop the necessary human resources for the country and at the same time to lose educator human resources in case of HIV/AIDS infected learners and educators dying or crippled by the pandemic.

A sound management strategy:

- can serve as a framework for decisions and for securing support and approval of funds to help and support learners and educators infected with and affected by the HIV/AIDS pandemic;
- can provide a basis for more detailed planning to deal with the potential areas of HIV/AIDS impact on learners, educators and the school systems in general;
- can explain the HIV/AIDS vision and mission statement to learners, educators, parents and communities in order to inform, motivate and involve them in the struggle against this deadly pandemic;
- can assist benchmarking and performance monitoring of the school in dealing with the HIV/AIDS pandemic; and

- can stimulate organizational change and become a building block in the next HIV/AIDS plan (see paragraph 1.1 and paragraph 2.6).

A satisfactory management strategy is realistic and allows school principals, deputy principals and their heads of departments to think strategically and act operationally. The management strategy of the school is guided by the principles that:

- learners and educators with HIV/AIDS should be involved in all prevention, intervention and care strategies at school;
- learners and educators with HIV/AIDS, their partners, families and friends should not suffer because of discrimination;
- the vulnerable position of women at school should be addressed, to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection;
- confidentiality and informed consent of learners and educators with regard to HIV- testing and test results should be protected;
- education, counselling and health care should be sensitive to the culture, language and social circumstances of all learners and educators at all times;
- all intervention and care strategies should be subject to critical evaluation and assessment;
- the school should work with all sectors of government and other stakeholders in their communities in the fight against HIV/AIDS;
- an ecosystemic, constructivist and holistic approach to education and care should be developed and sustained;
- capacity building should be emphasized to accelerate HIV/AIDS prevention and control measures; and
- the prevention and control of sexually transmitted diseases (STD) are central elements in the response to HIV/AIDS (see paragraph 1.1 and paragraph 2.6).

Unlike an operational strategy (which is of a shorter term, tactical, focused, implementable and measurable), a management strategy is visionary,

conceptual and directional. A management strategy involves the process of planning to combat the HIV/AIDS pandemic such as where, when, duration, budget, who performs certain duties, how the goals are to be achieved, while the final preparations such as tasks, deadlines, funding and so on form an operational strategy (see paragraph 1.1 and paragraph 2.5). The primary goals for the management strategy are to:

- reduce the number of new HIV infections (especially among learners and educators); and
- reduce the impact of HIV/AIDS on individuals, families and communities (see paragraph 1.1 and paragraph 2.6.3).

The following general strategies, which are crucial in developing an effective management strategy, have been highlighted:

- an effective and culturally appropriate information, education and communications (IEC) strategy
- increased access and acceptability to Voluntary HIV counselling and testing
- improved STD management, treatment of opportunistic infections and increased condom use to reduce STD and HIV transmission
- improved care and treatment of HIV- positive persons and persons living with AIDS, to promote a better quality of life and limit the need for hospital care (see paragraph 1.1 and paragraph 2.6.3).

The literature review also revealed that the management strategy should be structured according to:

- prevention;
- treatment, care and support; human and legal rights; and
- monitoring, research and surveillance (see paragraph 1.1 and paragraph 2.4).

In addition, learners are broadly targeted as a priority population group, especially for prevention efforts (see paragraph 1.1 and paragraph 2.6).

5.2.2 Statement of the problem

The argument presented in this research is that a school with a high number of learners, educators and non-teaching staff members infected with and affected by HIV/AIDS cannot function efficiently and effectively, since learners infected with and affected by HIV/AIDS cannot cope with learning and cannot perform their learning tasks to the best of their latent and innate abilities, while infected and affected educators cannot teach effectively because they are often ill and absent from school, and this has an effect on the efficient and effective management of the school.

It also emerged in the literature review findings that learners and educators infected with HIV/AIDS can be psychotic (see paragraphs 1.1 and paragraph 2.4) and it is the belief of the researcher of this dissertation that a psychotic learner and educator cannot effectively learn, teach and work because of psychological obfuscation that usually accompanies psychosis.

5.2.3 Findings and conclusion from the empirical investigation

The empirical investigation on the items of the questionnaire (see appendix A) revealed that:

- the majority of the respondents perceived illness as the main reason for the mortality rate among educators (see Table 4.6, paragraph 4.2.6)
- the majority of the respondents revealed that educators and management teams are:
 - frustrated;
 - stressed;
 - less interested in their work;
 - negative about their work;
 - experiencing low morale; and
 - depressed (see Table 4.7, paragraph 4.2.7)

These emotional problems are manifestations of being emotionally drained and of burnout because of having to carry a heavy workload for an absent educator (see Table 4.9, paragraph 4.3.4). Such emotional debilitations call for a management strategy that encapsulates an effective psychological wellness programme for all staff members of the school (see Table 4.7 and paragraph 4.2.7).

- The majority of respondents reported that reasons for educator absenteeism were sickness of self (see Table 4.8 and paragraph 4.2.8). It is difficult to speculate what the cause of sickness of self is, because HIV/AIDS is not yet a notifiable disease in South Africa and the stigma and discrimination that always go with this pandemic could be the reason educators find it difficult to divulge their ailments to their colleagues and supervisors, that is, school management team members.

This research found no significant differences on the perceptions of educators and school management teams on the effects of HIV/AIDS on educators (see Table 4.9, paragraph 4.3.4).

The study revealed the following significant differences on the perceptions of educators and school management teams on the effects of HIV/AIDS on learners:

- There were significant differences between the perceptions of the educators and school management team members with regard to the absenteeism rate of learners on a weekly basis, and concerning the fact that both parents are alive (see Table 4.10, paragraph 4.5).

The study revealed the following significant differences on the perceptions of educators and school management teams on the effects of the HIV/AIDS pandemic on the teaching and learning situation:

- classes are too big;
- educator workload is too heavy;
- lack of concentration decreased interest in school;

- illness of family members;
- loss of family members;
- too many responsibilities at home; and
- poor academic performance (see Table 4.11, paragraph 4.6).

The study revealed the following significant differences on the perceptions of educators and school management teams on the prerequisites for effective teaching and learning:

- educators involve learners actively in learning;
- educators control disciplinary problems effectively;
- educators make sure that learners pay attention during lesson presentation;
- the curriculum focuses on promoting a delay in taking part in sexual activities;
- planning of extra-curricular activities to address HIV/AIDS; and
- strict measures to deal with staff involved in sexual harassment of learners (see Table 4.12, paragraph 4.7).

5.2.4 Problems and possible shortcomings of the research

The research was done on homogeneous racial groups, that is, Blacks from the townships (see Table 4.2, paragraph 4.2.2). Had it involved heterogeneous groups from all racial groups of South Africa, it would have provided an effective comparison of the perceptions of all racial groups on the effects of HIV/AIDS on school systems, especially because cultural beliefs have a bearing on sexual orientations and convictions about the origins of the HIV/AIDS pandemic (see paragraph 1.1 and paragraph 2.4).

The questionnaire was long (90 items), which could have caused the respondents to lose concentration and interest while filling in the answers. That is why some items were not responded to, which could have impacted on the reliability and validity of the study. Some items of the questionnaire could have been combined in order to prevent duplication and confusing the respondents.

Learners were also not part of the population of this research. Their perceptions and responses would have added more weight to the validity and reliability of this study.

5.2.5 Limitations of the study

The study may have suffered because of the following limitations:

5.2.6 Missing data

Due to either a lack of a clear understanding of the questionnaires, or a negative attitude towards the questionnaires, some educators and school management teams failed to complete them fully. This resulted in missing data and an inconsistency in the numbers of sample sizes for the various analyses.

5.2.7 Measuring instrument

With relation to instrumentation, it would be better if the questionnaire was standardized for all South Africans in order to determine the stereotypes and attitudes towards HIV/AIDS of all racial and cultural groups of educators and school management teams in this country.

5.3 Recommendations

Both the findings of the literature review and of the empirical research (see chapters 1, 2, and 4) highlight the necessity of a management strategy for dealing with HIV/AIDS at schools. It emerged from the literature review that the primary purpose of a management strategy for dealing with HIV/AIDS at schools should be to:

- provide a strategic and operational framework for the prevention of the HIV/AIDS pandemic (see paragraph 1.1)
- guide all stakeholders of the school (learners, educators and parents) in HIV/AIDS prevention, care and support (see paragraph 1.1);

- guide external support organizations providing support (financial and technical assistance, etcetera) for all HIV/AIDS-related activities at schools (see paragraph 2.6.5);
- provide a mechanism for the mobilisation and allocation of resources (see paragraph 2.5.2); and
- provide guidelines for monitoring and co-ordinating activities for preventing the spread of HIV/AIDS, and caring for learners and educators living with HIV/AIDS (see paragraph 2.5.5.2).

Since HIV/AIDS is a health problem (see paragraphs 1.1; 2.2.1; 2.2.2; 2.4) and a human rights problem (see paragraphs 2.4; 2.6), it goes without saying that any management strategy for dealing with HIV/AIDS at schools should be founded on, among other things, World Health Organization (WHO) Guidelines on HIV-Infection and AIDS; Constitution of RSA 108 of 1996, especially the Bill of Rights; White Paper on Transformation of Health Services 667/1999; Statement to the National Assembly: DR M. E. Tshabalala-Msimang, Minister of Health, on HIV/AIDS and Related Issues, 2004; South African National Policy on HIV/AIDS (Act No. 27 of 1996); HIV/AIDS Strategic Plan for SA 2000-2005, Department of Health.

On the basis of both the findings of the literature review and the empirical research, a management strategy for dealing with HIV/AIDS at schools should be informed by the following health promotion and human rights based principles:

5.3.1 Confidentiality, respect, sensitivity and kindness in dealing with

HIV/AIDS matters

- Information regarding the HIV status of an educator and learner must not be divulged to others (officials, other educators, learners or relatives) without the consent of the learner or educator concerned. This information must be kept confidential at all times.

- The principle of "need to know basis" or "shared confidentiality" should be applied only to those who need to know in order to render appropriate health, social, psychological, religious and custodial (security) care of HIV positive learners and educators.

5.3.2 Promotion and encouragement of voluntary HIV- testing

- The compulsory testing of learners and educators to determine the presence of HIV-status is considered as an unnecessary or ineffective endeavour with no treatment basis, unethical and is therefore forbidden.
- Testing learners and educators for HIV-antibodies must only be carried out, upon request of the learner or educator, by recommendation of a registered nurse or by written order of the attending medical officer/practitioner.
- In all cases where voluntary testing is requested, the learner or educator must consent to the test in writing, and be subjected to adequate pre- and post-test counselling.
- An HIV test carried out without informed consent shall be considered to be an unlawful infringement of the learner/educator or the child's bodily integrity and invasion of privacy.
- If a learner is to be HIV tested, the parent or legal guardian should give informed written consent.
- For the mentally ill or handicapped learners or educators, the spouse, parent or the appointed curator *ad litem* should give consent for testing.
- The counsellor must ensure that the patient understands the reasons for testing, the nature of the test, the meaning of the positive and negative test results, implications of the results both negative and positive, and follow-up plans.
- In the event of anonymous HIV epidemiological surveys, written informed consent must be obtained from all participants.

- Voluntary testing of learners and educators should be encouraged, services should be accessible and incentives should be provided to those who come out for testing.
- All HIV positive tests must be confirmed.
- Counselling must be conducted by a professional trained in counselling.

5.3.3 Non-segregation of learners and staff living with HIV/AIDS from learners and staff not living with HIV/AIDS

- Learners and educators who are HIV positive should not be separated from others.
- Learners and educators living with HIV/AIDS must be treated the same way as the general public where every person is to be considered potentially HIV positive.
- Medical segregation (isolation) will be practised only when indicated by the person's medical conditions, for example by active TB, incontinence, persistent bleeding, sores and other infections to prevent the spread of infection to other learners and educators.
- Should medical isolation (segregation) be carried out, it should be done without any reference to whether the learner or educator is or is not infected with HIV.
- HIV positive learners and educators should have equal access to all intra- and extra-curricular activities of the school. They should also participate in all other educational and school programmes without discrimination.

5.3.4 Availability of pre and post testing counselling services for learners and staff

Schools should be seen as an ideal environment for preventive programmes with learner and educator populations.

- Information about HIV must be given to learners on admission to school, on a continuous basis and during teaching and learning situations regarding HIV/AIDS and STDs.
- The information should include: HIV/AIDS-what it is, cause, risk behaviours, spread within school environment, signs and symptoms, stages, complications, prevention, safer sex, STDs, etcetera.
- Female learners and educators should be informed about mother-to-child contamination during pregnancy, birth and breast-feeding.
- Female learners and educators should also be informed about the available reproductive health care services such as TOP (termination of pregnancy).
- Health education should be given to all categories of personnel, that is, to both teaching and non-teaching staff.
- A variety of strategies such as pamphlets, lectures, discussions, audiovisuals, debates, workshops, dramas, role-plays, etcetera should be employed in preventive programmes.
- Learners and educators should be trained in life skills to enable them to take responsible decisions regarding their health and lives.
- HIV/AIDS programmes should be culture, language, literacy, gender and age specific.
- Educators in all phases of the school should participate in HIV/AIDS organization, as they are in daily contact with learners.
- The World AIDS Day and all other national and international Commemorations such as Women's Day, Youth Day, Human Rights Day, etcetera, should be commemorated in such a way that the target groups or people are sensitized about HIV/AIDS. These celebrations should be used as opportunities to promote awareness about the pandemic.

5.3.5 Universal precautions

- All body fluids such as blood, urine, vomits, semen, sputum, saliva, ^efaces, pus, tears, mucus and others should be treated as potentially infectious as they may contain the HIV-Virus.
- Universal precautions should aim at the prevention of contamination with not only the HIV infection, but also with other blood-borne diseases such as Hepatitis B and C, etcetera.
- Open wounds, sores, bruises and other skin lesions should be considered potentially infectious.
- When handling these fluids and lesions, protection should be ensured through the use of gloves.
- Soiled linen should also be considered as dangerous and therefore gloves should be worn and the linen must be disinfected prior to laundering, in the case of boarding schools.
- Protection should be ensured when performing messy procedures on learners and educators.
- Care should be taken to ensure that all school laboratory equipment, instruments and toilets are kept clean, including baths, showers and toilets.
- All learners, parents and staff should have information about the universal precautions and a copy of the guidelines should be displayed on notice boards and school surroundings.

5.3.6 Availability of condoms

- Condoms should be accessible to learners and educators who need them, including the information regarding their use.
- Condom dispensers should be secured at accessible areas at all schools.
- The Health Advisory Committee should keep a record of the number of condoms dispensed, for monitoring purposes.

- The availability of condoms should be seen as an integral part of the HIV/AIDS intervention strategy.

5.3.7 Management of Sexually Transmitted Diseases (STDs)

- Learners and educators should be encouraged to seek medical care for early treatment of STDs.
- Provision of proper treatment and health education, including monitoring, is essential for the effective management of STDs.

5.3.8 Non-consensual (coercive) sex among learners and staff

- Both learners and educators must be sensitized about the dangers of unprotected sex, violation of others' human rights and the criminalization of any non-consensual (coercive) sex or rape.
- All rapes must be reported and the victim must receive medical intervention. Vulnerable female learners and educators must be empowered to protect themselves from rapes and abuse by fellow learners and educators.

5.3.9 Management of HIV/AIDS and opportunistic diseases

- Care and support should be provided to every learner especially those infected and affected, their families and relatives.
- The management of opportunistic diseases and infections should be in accordance with the guidelines of the Department of Health.
- There must be effective management of the physical, emotional, social and spiritual needs and problems of learners and educators living with HIV to reduce the stress level and retard progression into full-blown AIDS.

5.3.10 Partnership

Both the School Management Teams and the School Governing Bodies should counteract the undesirable effects of the pandemic within the general

population; lobby for a more equitable and just distribution of resources in schools; obtain guidelines on infection control from specific centres in the country which deal with HIV/AIDS, ensure that amongst their membership there are those who have or are prepared to receive the necessary training, education and support so as to maintain high standards of service to people living with HIV/AIDS. The School Governing Bodies should exchange, knowledge, share experiences, learn from others and encourage other role players to participate in these endeavours.

- External role players such as Non Governmental Organizations (NGOs), churches, business sectors, tertiary institutions, unions, professional organizations, people living with HIV/AIDS and individuals should be encouraged to render their services at schools.
- Cooperation with relevant organizations and individuals, especially those with expertise in HIV prevention, counselling, training, support and home care should be encouraged to render services to learners and educators.
- Learners and educators should participate in HIV/AIDS programmes as peer educators and support system for fellow learners and educators.
- All categories of personnel-nurses, social workers, psychologists, educators, religious officers, employee assistant practitioners and custodial staff should participate actively in HIV/AIDS programmes.
- Caregivers such as nurses, volunteers and others should receive care and support, with the understanding that caring for those who have HIV/AIDS is stressful.
- School staff should also participate in community HIV/AIDS and other programmes/activities.
- Each school must have NGO HIV/AIDS programmes/activities and identify other community structures to assist in HIV/AIDS programmes.

5.3.11 Capacity building

- Each school should have one or more HIV/AIDS focal person/s who will be actively involved in coordinating programmes. These persons

need not necessarily be nurses. However, they must be trained and have sufficient knowledge about HIV/AIDS.

- Each school should have trained counsellors.
- Educators and non-teaching staff should be trained in HIV/AIDS.
- Each school must have an HIV/AIDS plan which is being strictly implemented and monitored and evaluated for impact.
- Each school must identify and ensure that resources (human, fiscal and logistical) are available to support HIV/AIDS programmes.
- Each school must have learner and staff peer educators, and the selection criteria for such a task could include:
 - respect by colleagues and learners
 - respect by fellow learners
 - ability to communicate
 - interest in health or HIV/AIDS matters
 - sense of maturity.

5.3.12 Promotion of the rights of learners and personnel to protection

- The observance of human rights is critical for the protection of the vulnerable.
- Both the learners and personnel at all schools should be trained in Human Rights.
- All sexual assaults to learners and educators must be reported and recorded and criminal action taken against the perpetrators.
- Learners should be empowered to be able to protect themselves and fellow learners.
- Learners and educators have the right to privacy, bodily autonomy, integrity and safety and these and other rights should be protected.
- The deliberate spread of HIV infection by learners and educators to fellow learners and educators should be regarded as a serious crime against which action should be taken.

5.3.13 Contact tracing

- Measures should be taken at each school to trace contact of HIV, STDs and Hepatitis B and C infections.
- Contacts should not only be limited to sexual contacts, but also include sharing of shaving appliances and others where there is a possibility of coming into contact with the blood of another person.

5.4 Conclusion

This study explored a management strategy for dealing with the HIV/AIDS pandemic at schools by means of a literature review and empirical research. Valuable findings were highlighted. It is hoped that it will make a valuable contribution in developing inclusive health promoting school policies and procedures which respect the human dignity and rights of learners living with HIV/AIDS.

BIBLIOGRAPHY

AHARONI, Y. 2000. Globalization and the Small Open Economy in Almor, T. and Hashai, N. eds *FDI, International trade and the economics of peacemaking*, Tel Aviv: College of Management p 89.

AGYARKO, R. & KOWAL, P. 2000. Older people, children and the HIV/AIDS Nexus. 13th Paper presented at the International AIDS Conference in Durban. 9-14 July. Geneva: WHO p 118.

AIDS Analysis Africa. 2001. Analyzing the impact of the AIDS epidemic on organizations, business and the economy. World Bank. Vol. 11(4) Dec. /Jan. [web:] [<http://www.aidsinfo.co.za>]. (Date of access 31 April 2001) p 4.

AIDS Weekly. 2000. The impact of HIV/AIDS on the Education System.12.

AINSWORTH, M. & TEOKUL, W. 2000. Breaking the silence: setting realistic priorities for AIDS control in less developed countries. *Lancet*, 356: p55-60.

AINSWORTH M. 2003. AIDS and public policy: the lessons and challenges of "success" in Thailand. *Health Policy*, 2003, 64: p13—37.

ALABAN, A. and GUINNESS, L. 2000. Socio-economic impacts of HIV/AIDS in Africa UNAIDS. Geneva: UNAIDS. (PowerPoint presentation) p2.

ALEMAYEHU, H.G. 2003. Faith-based HIV/AIDS prevention and support in Ethiopia's third largest city. Abstracts of the International Conference on AIDS and STI's in Africa Nairobi: Abstract WedPs6365521 p23.

AMOGNE, W., & ABUBAKER, A. 2002. Multifocal vertebral tuberculosis with the involvement of the ribs: case report. *Ethiopian medical journal*, 40: p397-405.

ANDERSON, J.E., EBRAHIM, S.H. & SANSOM, S. 2004. Women's knowledge about treatment to prevent mother-to-child HIV transmission. *Obstetric gynecology*, 103:p165-168.

ARNDT, C. and LEWIS, J.D. 2000. The macro implications of HIV/AIDS in South Africa: a preliminary assessment The World Bank, presented to IAEN Conference, Jul. Houghton: Trade & Industrial Policy Secretariat p 77.

ASSAN, S. & WIGGLESWORTH, A. 2001. The quality of STI services in Namaqualand. Liverpool School of Hygiene and Tropical Medicine p93.

AYELE W, DORIGO-ZETSMA W, POLLAKIS G. 2003. Preliminary investigation of using dried blood spots on filter paper as a method of collecting samples for evaluating viral load in HIV-1 infected Ethiopians (abstract). *Ethiopian medical journal*, 41: p373-4.

BADCOCK-WALTERS, P. 2000. AIDS Briefs for sectoral planners and managers: Education Sector Health Economics and HIV/AIDS Research Division (HEARD). Durban: University of Natal p137.

BADER, J. 2000. The use of community health workers will enhance the government's primary health initiative Poverty and inequality: The challenges for public health in South Africa conference. East London: Epidemiological Society of Southern Africa (ESSA) p68.

BARNETT, T. & WHITESIDE, A. 2000. Guidelines for studies of the social and economic impact of HIV/AIDS UNAIDS Geneva; UNAIDS p66.

BARNETT, T., WHITESIDE, A. & DESMOND, C. 2000. The social and economic impacts of HIV/AIDS in poor countries: review of studies and lessons. Geneva: UNAIDS p189.

BARNETT, T. & WHITESIDE, A. 2002. *AIDS in the Twenty-First Century: disease and globalization*. New York Palgrave Macmillan p 105.

BATEMAN, C. 2001. Can KwaZulu-Natal hospitals cope with the HIV/AIDS human tide? *South Africa medical journal*, 92:1, Jan. p13.

BAYLIES, C. 2002. *HIV/AIDS and Older Women in Zambia: concern for self, worry over daughters, towers of strength*. Third World Quarterly, 23(2): p351-375.

BEER, M. 2000. The silent killer of strategy implementation and learning. *Sloan Management Review*, p18-37 Summer.

BEKELE MG. 2003. Factors associated with unmet need for family planning in Amhara Region Ethiopia Addis Ababa University. (Thesis – M P H) p 14

BELL, C., DEVARAJAN, S., GERSBACH, H. 2003. *The long-run economic costs of AIDS: theory and an application to South Africa*. Washington, DC, World Bank, [web:](http://www1.worldbank.org/hiv_aids/docs/BeDeGe_BP_total2.pdf, (Date of access Sept.15 2003) p 12.

BENTWICH Z 2003. Eradication of helminthes infections will have a major impact on pathogenesis of AIDS in developing countries and on success of protective HIV vaccines. Abstracts of the International AIDS Society Conference on HIV Pathogenesis and Treatment Paris: International AIDS society p 6.

BENTWICH, Z. WEISMAN, Z. BORKOW, G. BEYERS, N., & BEYERS, A.D. 2002. Can eradication of helminthes infections change the face of AIDS and tuberculosis? *Immunology today*; 20: p485-487.

BERESFORD, B. 2002. A lost generation. *Mail/Guardian*, Oct. 4-10. p2.

BERHANE, Y. Editorial: 2003. Strengthening the fight against HIV/AIDS: lessons learned from community-based operations. *Ethiopian journal health development*, 17(Suppl.): p1.

BEZABIH T. 2003. The demographic correlates of poverty in rural Ethiopia: the case of North Shewa. Addis Ababa. University (Thesis- M P H) p 42.

BINSWANGER, H.P. 2000. Scaling up HIV/AIDS programmers to national coverage science. *Lancet*, 23:288(5474): p2173-6.

BLASÉ, J. & BLASÉ, J. 2001. Empowering teachers: what successful principals do. Thousand Oaks, CA: Corwin Press p18.

BOAL, K.B. 2000. Strategic leadership research: moving on, *Leadership Quarterly*, 11(4). p515-550.

BOLLINGER, L. & STOVER, J. 1999. The economic impact of AIDS in South Africa. The Future Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA) p14-36.

[Web:] www.policyproject.com/byTopic.cfm/HIV. (Date of access Dec. 13 2004).

BOND V, MACQUARRIE K, HALLOM B, NYBLADE L. 2003. The many manifestations of stigma: Findings from a multicountry study. Abstracts of the 13th International Conference on AIDS and STIs in Africa. Nairobi.

BONNEL, R. 2000. 'Economic Analysis of HIV/AIDS,' World Bank p 91.

BOOYSEN S. 2000. AIDS and communication strategies: entering the world of public silence and denial. Focus group research project. Durban Centre for Socio-Legal Studies, Research Unit p 104.

BORKOW G. & BENTWICH, Z. 2000. Eradication of helminthes infections may be essential for successful vaccination against HIV and tuberculosis. *Bull*, 78: p1368-1369.

BOTTERY, M. 2000. Education, policy and ethics. London. Continuum p 6.

BOURNE, D. 2000. Demographic implications for development in Southern Africa as a result of the AIDS epidemic ñ a graphical review. *Urban Health and Development Bulletin*, 3 (2):3.

BRATTON, J. & GOLD, J. 2003. Human resource management: theory & practice. 3rd ed. MacMillan Palgrave: 3rd Edition p55.

BRAVEMAN, P. 2002. Measuring health equity within countries: the challenge of limited information *MSJAMA*, 288, Oct p 17.

BRENT, B. O. 1998. Teaching in educational administration. *Newsletter of the American Educational Research Association*, 5(2): 33-4.

BREWER, D. 2003. Mounting anomalies in the epidemiology of HIV in Africa: cry the beloved paradigm. *International journal of STD and AIDS*, 14:144-147.

CAMPBELL, & ALEXANDER, M. 1998. What's wrong with strategy? *Harvard business review*, 75(6): 42-51.

CASET, J. & CLEM, D. 2001. Only the best Leadership: vol. 3. 81-90.

CHABALA, S. 2000. Social realities that hinder financial intervention in achieving poverty alleviation and sustainable development 13th International AIDS Conference. Durban p 171.

CHALSWOORTH, J. 2001. Negotiating and managing partnership in primary care. *Health and social care in the community*, 9: p279-285.

CHARLES, A.D. 1999. Hope for urban education: a study of high-performing, high-poverty, urban elementary schools. Austin: University of Texas p 156.

CHIGANZE, F., DECOSAS, J. & CHIKORE, J. 2000. *Linking the Issues: HIV, gender, human rights, and child protection*. Durban: International AIDS Conference p 87.

CLINTON, B. 2003. Turning the tide on the AIDS pandemic. *New England Journal of Medicine*, 348(18):1800 -2. May.

CLUSTER, W.H. 2001. Partnerships with the public and private sectors. *bringing powerful innovations to the front of infectious disease control*, 26(6): 1-59

COHEN, D. 2002. Human capital and the HIV epidemic in sub-Saharan Africa. Geneva: ILO, World Bank p 16.

COHEN, D.A., FARLEY, T.A., TAYLOR, S.N., MARTIN, D.H., SCHUSTER, M.A. 2002. When and where do youths have sex? The potential role of adult supervision. *Pediatrics electronic pages*, 110 (6): 1-6. Dec.

COLLINS, D.B., LOWE, JS., & ARNETT, CR. 2000. High performance leadership at the organizational level. *Developing High Performance Leadership Competency*, 6: 18-46.

COLVIN, M. 2000. Sexually transmitted infections in Southern Africa: a public health crisis. *South African journal of science*, 96(6): 335-339.

COLVIN, M., GOUWS, E., KLEINSCHMIDT, I., & DLAMINI, M. 2000. The prevalence of HIV in a South African working population 13th International Conference on AIDS. Durban p 117.

COOMBE, C. 2000. Managing the impact of HIV/AIDS on the education sector Commissioned by the UN Economic Commission for Africa (UNECA). Pretoria.36.

CORDES, C., MOLL, A., KUECHERER, C. & MARCUS, U. 2004. HIV transmission despite hiv post-exposure prophylaxis after non-occupational exposure. (Case Report). *AIDS*, 18(3): 582-584.

CORNELISSEN, R.P. 1999. An analysis of the leadership styles of principals in the Athlone region. University of the Western Cape p 14.

CRAWLER, E. 2004. Conspiracy Theories on HIV. [web:] <http://www.exampleessays.com/viewpaper/23648.html> date of access Nov.26/2004 p 39.

CREWE, M. 2000. South Africa: Touched by the vengeance of AIDS: Responses to the South African epidemic In: *South African Journal of International Affairs*, 7 (2): 12.

CROCKER, C. & HARRIS, S. 2002. Facilitating growth of administrative practitioners as mentors. *Journal of Research for educational leaders*1(2): 47-50.

CROSS, C. 2001. Sinking deeper down: HIV/AIDS as an economic shock to rural households. *Society in transition*, 32:1: 133-147.

CULLINAN, K. 2002. The nightmare draining the life out of our hospitals. *Sunday Times*: 3. Nov. 22-28.

DANESI, H. 2003. Barriers to effective refugee resettlement in special situations. Abstracts of the National HIV Conference Atlanta. (Abstract TOP-001).

DARESH, J. 2001. Leaders helping leaders: a practical guide to administrative mentoring. Thousand Oaks, CA: Cowin Press p 93.

DANSPECKGRUBER, W. 2002. (ed.) *The self-determination of peoples*, London p 190.

DAVID, F.R. 1999. *Strategic management*. Concepts. Upper Saddle River, N.J: Prentice Hall p 164.

DAY, C. HARRIS, A. HADFIELD, M. TOLLEY, H. & BERESFORD, J. 2000. Leading schools in times of change. Buckingham: Open University Press p204.

DEAL, T.E. & PETERSON, K.D. 1999. Shaping school culture: the heart of leadership. San Fransisco: Jossey-Bass p119.

DE COITO, T. 2001. The Lesedi Project – is it sustainable and replicable? Presentation at the conference of infectious diseases; Stellenbosch; Dec.

DE WAAL, A. & WHITESIDE, A. 2003. 'New Variant Famine': AIDS and Food Crisis in Southern Africa. *The Lancet*, 362: p109-112.

DEAN, N. & MOALUSI, R. 2002. AIDS the biggest killer of young women. In: *Mail & Guardian*: 3.Nov. 22-28.

DELNESSA, T. & NDUBA J. 2003. Challenges to behaviour change for youth in slum settings. Abstracts of the 13th International Conference on STDs and AIDS in Africa 2003. Nairobi p 60.

DEMISSIE, M., GETAHUN, H. & LINDTJORN, B. 2003. Community tuberculosis care through "TB clubs" in rural north Ethiopia. *Social. science. Medicine*, 56: p455-68.

DENNIS, P. 2000. Memory boxes: helping AIDS orphans to remember. *Bulletin for contextual theology in Africa*, 7:2: 34-36, Mar.

DENOLF, D. 2000. Structural obstacles for economic development in developing countries, 13th International AIDS Conference. Durban p51.

DESMOND, C. 2000. AIDS Briefs for sectoral planners and managers: Financial Sector Health Economics and HIV/AIDS Research Division (HEARD) Durban University of Natal p 92.

DESMOND, C. MICHAEL, K. & GOW, J. 2000. The hidden battle: HIV/AIDS in the household and community *South African journal of international affairs*, 7(2): p39-58.

DIOP, W., TRUELLE, M., CHAMPAGNE, P., & BEAUDRY, R. 2000. The transporter initiative: a network for community partnership in STD/AIDS management, 13th International AIDS Conference. Durban p 80.

DOLLAR, D. & KRAAY, A. 2001. "Trade, growth and poverty." Finance & Development:53 Sept.

DONAHUE, J. 2000. Community-based economic support for households affected by HIV/AIDS. (The Synergy Project Discussion Paper No 6,) HIV/AIDS Division of USAID, Washington: USAID p 78.

DONAHUE, J. KABBUCHO, K. & OSINDE, S. 2000. '*HIV/AIDS – Responding to a silent economic crisis among micro finance clients*', Micro Save Africa. (unpublished report) p 12.

DORKENOO, E. 2001. Aspects of HIV/AIDS research alliance (SAHARA). Report of Human Sciences Research Council Consultative Meeting, Pretoria, 7th August 2001. Pretoria p 2.

DORRINGTON, R. 2000. HIV/AIDS in the Western Cape: Is there still time to do something? Joint population conference: the demographic impact of HIV/AIDS in South Africa and its provinces. Port Elizabeth p 121.

DOYLE, P. 2002. Marketing management and strategy. 3rd ed. London: Prentice Hall Europe p 27.

DRYSDALE, S. 2000. AIDS Briefs for sectoral planners and managers: Health Sector Health Economics and HIV/AIDS Research Division (HEARD), Durban University of Natal p 213.

DUCKETT, M. 2000. Migrants right to health, 13th International AIDS Conference Durban p 153.

DUDGEON, W.D., PHILLIPS, K.D., BOPP, C.M. & HAND, G.A. 2004. Physiological and Psychological Effects of Exercise Interventions in HIV Disease. (Review). AIDS. 18 (2): p81-98.

EATON, E. & FLISHER, A.J. 2000. HIV/AIDS knowledge among South African youth. *Southern African journal of child and adolescent mental health*, 12: p97-124.

EISENMAN, D.P., CUNNINGHAM, W.E., ZIERLER, S., NAKAZONO, T.T., SHAPIRO, M.F., 2003. HCSUS Consortium, effect of violence on utilization of services and access to care in persons with HIV. *Journal of general internal medicine*, 18(.2,) :125-127. Feb.

ELFORD, J., BOLDING, G. & SHERR, L. 2004. Popular opinion leaders in London: a response to Kelly. *AIDS Care*: 16(2): p151-158.

ESCAITH, H. & INOUE, K. 2001. Small Economies tariff and subsidy policies in the face of trade liberalization in the Americas. *Integration and trade*, 5, (14): p3-28.

FITAW Y, WORKU A. 2003. High-risk sexual behavior of condom utilization of the Gondar College of Medical Sciences students, northwest Ethiopia (abstract). *Ethiopian medical journal*, 41: p382.

FLISHER, A.J. 2000a. Intervening through school systems. 9th International Conference on Treatment of Addictive Behaviours. Cape Town.

FLISHER, A.J. 2000b. Risk and protective factors in adolescent health. WHO/UNICEF meeting on: protective and risk factors for adolescents from different countries: what can we measure? Geneva p 97.

FLISHER, A.J. 2000c. School-based surveys. 3rd WHO/UNICEF meeting on programming for adolescent health and development: what should we measure and how? Washington DC. WHO p 124.

FOSTER, G. 2000. Children rearing children: a study of child-headed households In: The socio-demographic impact of AIDS in Africa. Based on the conference organized by the Committee on AIDS of the International Union

for the Scientific Study of Population (IUSSP), Liege, Belgium and the University of Natal, Durban, South Africa p 4.

FOURIE, P. & SCHONTEICH, M. 2001. Africa's new security threat: HIV/AIDS and human security in Southern Africa. *African Security Review*, 10:4: 29-42.

FRAENKEL, J.R. & WALLEN, N.E. 1990. How to design and evaluate research in education. New York: McGraw-Hill p 185-189.

FRENCH, W.L. & BELL, Jr., C.H. 1999. *Organizational development*. behavioral science interventions for organization improvement. Upper Saddle River, N.J. Prentice Hall p 61.

GALL, M.D., BORG, W.R. & GALL, J.P. 1996. Educational research: an introduction. New York: McGraw-Hill. p196.

GANESAN, M. 2000. Government, private sector and NGOs responses to HIV/AIDS at workplaces 13th International AIDS Conference Durban p 87.

GEISER, K.D. & BERMAN, P. 2000. Building implementation capacity for continuous improvement. Emeryville, CA: RPP International, High Performance Learning Community Project p 42.

GERBER, P.D., NEL, P.S. & VAN DYK, P.S. 1998. *Human resources management*. Halfway House: International Thomson Publishing p 148.

GIRMACHEW, M, YIGEREMU, A. 2003. Peer leadership strategy amongst the Ethiopian Armed Forces. Abstracts of the International Conference on STIs and AIDS. Nairobi. (Abstract MoPs143870.) p 77.

GLENN, R.W. 2001. Creating wealth in organizations: the role of strategic leadership. *Academy of management executive*, 1(15): 81-87.

GOLDMAN, E.F. 2002. Strategic planning in health care: a guide for board members. San Fransisco, CA: Jossey Bass p 431.

GOLIBER, T.J. 2000. Exploring the Implications of HIV/AIDS Epidemic for Demographic Question. New York: World Bank p 71.

GOUDGE, J. & GOVENDER, V. 2000. A review of experience concerning household ability to cope with resource demands of ill health and health care utilization Regional Network for Equity in Health in Southern Africa (Equine) and Training and Research Support Centre (Tarsc) Harare: Southern Africa p 109.

GOUWS, E. & WILLIAMS, B. 2000. Sciences and HIV/AIDS in South Africa: A review of the scientific literature. *South African journal of science*, 96(6): p274-276.

GOVENDER, V., MCINTYRE, D., GRIMWOOD, A. & MAARTENS, G. 2000. The costs and perceived quality of care for people living with HIV/AIDS in the Western Cape Province in South Africa. Maryland: Partnerships for Health Reform p 352.

GOYER, K.C. & GOW, J. 2000. Alternatives to current HIV/AIDS policies and practices in South African prisons in press: Health Economics and HIV/AIDS Research Division (HEARD), University of Natal: Durban p 102.

GREEN T. *AIDSLink*. [online] 81, 1 September 2003 p152. [Web:] (<http://www.globalhealth.org/publications/article.php3?id=1032>, accessed 25 September 2003).

GREEN C. M., CAPORASO J., and RISSE T. eds. 2000. Transforming Europe: Europeanization and domestic change. Ithaca p 73.

GROBLER, B. 2003. Management of the school in Context: Sandown: Heineman.

GROENEWALD, C. 2000. Northern Cape: The demographic impact of HIV/AIDS Joint Population Conference: The demographic impact of HIV/AIDS in South Africa and its provinces Port Elizabeth p 46.

GUAGLIANONE, C.L. 1998. Administrative portfolios: current uses and development by prospective and practicing administrators. Paper presented at the *American Educational Research Association* 23 Aug. San Diego p 119.

GUPTA, G.R. 2001. Gender, Sexuality, and HIV/AIDS: The what, the why, and the how. *Global Perspectives on Gender, Sexual Health, and HIV/AIDS, SIECUS Report* 29(5): 11.

GWATKIN, D. 2000: The current state of knowledge about targeting the health programmes to reach the poor. World Bank: Washington p 47.

HAGEN, A.F., HASSEN, M.T. & AMIN, S.G. 1998. Critical Strategic leadership components: an empirical investigation. *S.A.M. Advanced Management Journal*, 3(63) p 39.

HAILE, B. 2000. Affordability of home-based care for HIV/AIDS. *South African medical journal*, 90 (7): p690-1.

HAILOM, B, KIDANU, A, NYBLADE, L. 2003. People Living with HIV/AIDS accounts of stigma in the family and community: an Ethiopian study. Abstracts of the 13th International Conference on AIDS and STIs in Africa. Nairobi.: (AbstractMonPs317025).

HALPERIN, D. 2001. Is poverty the root cause of (Southern) African AIDS? *AIDS Bulletin*, 10(2): p12-14.

HALPERIN DT, EPSTEIN H. 2004. Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *Lancet*, 364:4-6. 3 July.

HANCOCK, T. 2001. People, partnerships and human progress: building community capital. *Health promotion international*, 16: p275-280.

HECHT, R. 2000. Poverty, debt and AIDS ñ Mainstreaming the epidemic and mobilizing additional resources for the response: UNAIDS into country team for West and Central Africa p 34.

HENCHER, M. 2000. Health sector impacts of HIV/AIDS. Presentation to SANAC Technical task team: treatment care and support [web:] [http://www.tac.org.za/Document/Research Papers/hensher.ppt](http://www.tac.org.za/Document/Research%20Papers/hensher.ppt). (Date of access Dec. 13 2004) p 51.

HEY, J. A .K. 2003.(ed.) *Small states in world politics: explaining foreign policy behavior* Boulder: Lynne Riennes p 53.

HILL, A, FADIMAN, D.2003. Seeds of hope: a series of documentary films about HIV/AIDS in Ethiopia. Abstracts of the 13th International Conference on AIDS and STIs in Africa Nairobi: (Abstract MonPs317025) p 105.

HOOPER-BOX, C. 2002. Aids orphans time bomb. *The Sunday Independent*, 89-97 Oct.6

HOWSE, J. 2000. The provinces at a glance: whose spending what where? (Part 3) *South African medical journal*, 90(7): p678-80.

(<http://www.info.gov.za/speeches/2004/04081113151002.htm>).

HUGHES-GIBBS, B. 2000. The care umbrellas of Kalafong ñ a continuum of holistic care and prevention for people infected affected by AIDS 13th International AIDS Conference Durban p 21.

HUMAN RIGHTS WATCH, 2001. *Scared at school: sexual violence against girls in South African schools*. New York Human Rights Watch. p 489.

HUSSEY, D. 1999. Strategic Planning. Washington: NCSL p134.

IRELAND, R.D. & HITT, M.A. 1999. Achieving and maintaining strategic competitiveness in the 21st century; the role of leadership. *Academy of management executive*, 1(31): p43-57.

ISRAEL, M. 2003. Teachers observing teachers: professional development tool for every school. Wallingford, CT: Education World p102.

JAMES, D. 2001. To take the information down to the people: life skills, HIV/AIDS peer counselors, NGOs and the state in the Durban area. AIDS in context conference Jan 7-14. Johannesburg p 88.

JENNINGS, R. 2000. Your victory is our victory, the case of "A" v South African Airways, University of the Witwatersrand Johannesburg. Aids law project, centre for applied legal studies p 119.

JIMENEZ, E. & SAWADA, Y. 1998. "Do community –managed schools work? an evaluation of El Salvador 's EDUCO program", working paper series on Impact Evaluation of Education Reforms, Paper No.8 Washington: DC. World Bank p 210.

KALIPENI, E. 2000. Africa: a comparative and vulnerability perspective. *Social science and medicine*, 50 (7-8): p965-83.

KAMUZORA, C.L. 2000. The demographic impact of HIV/AIDS in Africa Joint Population Conference: The demographic impact of HIV/AIDS in South Africa and its provinces Port Elizabeth p 9.

KARIM, S. 2000. Rising challenge of the AIDS epidemic. *South African journal of science*: p288-99. vol.5.

KARIM, Q. & KARIM, S. 1999. South Africa: host to a new and emerging HIV epidemic. *Sex transmission infection*, 75: p82-90.

KAPLAN, J.E., HU, D.J., HOLMES, K., JAFFE, H.W., MASUR, H., DECOCK, K.M. 2000. Preventing opportunistic infections in HIV-infected persons: Implications for the developing world. Washington: USAID. (Discussion paper No 4, HTS, USAID) p 6.

KELLY, J.A. 2004. Popular opinion leaders and HIV prevention peer education: resolving discrepant findings, and implications for the development of effective community programs. *AIDS Care*, 16(2): p139-150.

KELLY, K. & PARKER, W. 2000. Communities of practice: Contextual mediators of youth response to HIV/AIDS Beyond Awareness Campaign, Department of Health, South Africa. p89.

KELLY, K. & PARKER, W. 2000. Communities of practice: contextual mediators of youth response to HIV/AIDS Pretoria: Dept. of Health. beyond awareness campaign.

KELLY, K. 2000. Communicating for Action: contextual evaluation of youth response to HIV/AIDS. Pretoria: Dept. of Health. Beyond awareness campaign p 43.

KELLY, M.J.J. 2000. Adapting the education sector to the advent of HIV/AIDS 13th International AIDS Conference Durban.

KENT, T.W., CROTTIS, J.C. & AZZIZ, A. 2001. Four factors of transformational leadership behaviour. *Leadership and organizational development journal*, 5(22): 221-229.

KIBRET, M. 2003. Reproductive health knowledge, attitude and practice among high school students in Bahir Dar, Ethiopia. *Afr journal report Health*, 7(2):39-45.

KIDANE, A, BANTEYENA, H, NYBLADE, L. 2003. Stigma and related discrimination in Ethiopia: causes, consequences and coping mechanism. Miz-Hasab Research Center: Addis Ababa p 38.

KIRT, R. & WASCHKUHN, A. 2001. *Kleinstaaaten-Kontinent Europa*. Baden-Baden: ZEI p 101.

KITHEKA, J.K. 2000. Strategies to cope with the socioeconomic stress caused by HIV/AIDS (pilot testing phase) 13th International AIDS Conference Durban p 24.

KLEPP, K.I., FUGLESANG, M., FLISHER, A.J., LESHABARI, M.T., LIE, G.T., & MAPANGA, K.G. 2000. The adolescent reproductive health network: health

system and health promotion research in Eastern and South Africa. *East African medical journal*, 77: S38-S42.

KONGSIN, S. & WATTS, C. 2000. Conducting a household survey on economic impact of chronic HIV/AIDS morbidity in rural Thailand: Methodological issues International AIDS Economics Network (IAEN) Conference, Durban. p36.

KONGSIN, S., SIRINIRUND, P., JIAMTON, S., BOONTHUM, A. & WATTS, C. 2000. The economic impact of HIV/AIDS on households in rural Thailand: the analysis of household coping strategies, 13th International AIDS Conference Durban p 135.

KUMAR, M.P. 2000. Cost effectiveness of prevention of mother-to-child HIV transmission in Karalla, India international AIDS and Economics Network (IAEN) Conference Durban p 137.

KUMARANAYAKE, K. & WATTS, C. 2000. The costs of scaling-up HIV prevention and care interventions in sub-Saharan Africa 13th International AIDS Conference Durban p 91.

KWATUBANA, S.J. 2004. The Effectiveness of School Governing Bodies in dealing Strategically with HIV/AIDS in schools in the Vaal Triangle. Vanderbijlpark: North-West University. (Thesis- Med.) p 3.

LE ROUX, Z. 2000: Verbal sharing with author. Pretoria p 51.

LORANGR, P. 1998. Strategy Implementation: the new realities. *Long range planning*, 31(1): 18-29.

LUDLOW, P. 2000. *Liechtenstein in the New European and Global Order: Challenges and Oortunities*. Brüssel p27-29.

LUZINDA, I.N., SENABULYA, M. & MUSIITWA, R. 2000. The quality and continued care for the PWAs at their homes, a case study in Taso Entebbe, Uganda, 13th International AIDS Conference Durban p 140.

MACPHAIL, C., CAMPBELL, C., WILLIAMS, B., & VAN DAM, J. 2000. Gender and the relative risk of HIV infection amongst young men and women in a South African township, 13th International AIDS Conference Durban p 113.

MARKS, H.M. & LOUIS, K.S. 1999. Teacher empowerment and the capacity for organizational learning. *educational administration quarterly*, 35: p707-750. Supplement

MC EVOY, A. & WELKER, R. 2000. Academic achievement; conduct disorders in children; school environment. Springfield p 39.

MCNEIL, JR., DONALD, G. 2002. Global war on AIDS runs short of key weapon. *New. York. Times*, 13 Oct. 9.

MDLADLA, P., MARSLAND, N., VAN ZYL, J. & DRIMIE, S. 2003. '*Towards identifying the vulnerability of HIV/AIDS affected households to food insecurity*'. Paper presented to the United Nations Inter-Agency Coordinating and support office 911 Sept. Johannesburg p 5.

MEESON, A. 2000. Not so sweet: HIV/AIDS and South Africa's cane fields *South African labour bulletin*, 24 (5):

MEESON, A. 2000. Tackling HIV/AIDS: South African Catering & Trade Workers Union sets the example *South African labour bulletin*, 24 (3): 21

MICHALUK, G. 2002. Riding the Storm: strategic planning in turbulent markets. 301.

MINTZBERG, H. 1998. The Rise and Fall of Strategic Planning. p421.

MOSIA, M.S. 2003. *The importance of the leadership role in strategic management process*. RAU. (Unpublished doctoral dissertation) 64.

NATIONAL POLICY ACT. ACT NO. 27 OF 1996. Pretoria: Government Printers.

NOBLE, C.H. 1999. Building the Strategy Implementation Network (implementation is a vital, and often neglected, phase of strategic planning). *Business horizons*, 19-28. Nov.

NOWLAN, D. 2000. Leaders or managers: principals in the twenty-first century. Calgary, Alberta: University of Calgary p 987.

NWAGWU, C.C. 1997. "The environment of crises in the Nigerian education system", *Comparative education*, 33 (1,) 87-95.

OLSON, L. 2000. New thinking on what makes a leader. *Education week*, 1, 53-5.

OSBORN, C.E. 2000. *Statistical applications for health information management*. Gaithersburg, MD: Aspen Publishers p 37.

OTAALA, B. 2000. Living openly, HIV/AIDS, the challenge for tertiary institutions in Namibia: proceedings of a workshop. Windhoek p 63.

PARKER, W. & MUNDAWARARA, M. 2000. Living openly, HIV positive South Africans tell their stories, 4. Beyond awareness campaign, HIV/AIDS and STD Directorate, Pretoria: Department of Health p 114.

PAGE, S. 2001. *Promoting the survival of rural mothers with HIV/AIDS: development strategy for Southern Africa*. Development, 44(4): p40-46.

PATTERSEN, D. 2000. HIV/AIDS, human rights, and development. *Development bulletin*, 52: p14-17.

PIWOZ, E. & PREBLE, E. 2000. HIV/AIDS and nutrition: a review of the literature and recommendations for nutritional care and support in sub-Saharan Africa. November. United States Agency for International Development (USAID), Washington, DC: USAID, Support for Research in Africa. p141.

- POKU, N. 2002. Poverty, Debt and Africa's HIV/AIDS Crisis. *International Affairs*, 78, (3.) 112-15.
- PRETORIUS, C. 2002. AIDS pandemic killing Africa's teachers, I *Sunday Times*: 6. May 12 p 6.
- RAVIOLA, G. 2002. HIV, disease plague, demoralization, and "burnout": resident experience of the medical profession in Nairobi, Kenya. *Culture, medicine and psychiatry*, 26: p55—86.
- ROBINSON, S.P. 1998. *Organisational behavior*, 8th ed., Prentice Hall: Englewood Cliffs, NJ p 152.
- ROSEN, S., SIMON, J.L., THEA, D.M.V & VINCENT, J.R. 2000. Care and treatment to extend the working lives of HIV-positive employees: calculating the benefits to business. *South African journal of science*, 96(6): 300-334.
- ROSEN, S. & JONATHAN, S. 2002. "shifting the burden of HIV/AIDS." Boston: Center for International Health, Boston University p 61.
- RUSSEL, T. 2000. *Operations Management*. Upper-Saddle River, N.J.: Prentice Hall, 77-80.
- SCHULER, C. 2000. One woman's crusade against rape in South Africa., *The Christian Science Monitor*, Jul.7.
- SCHWARTZBECK, T.D. 2002. Choosing a model and types of models: how to find what works for your school. Washington, DC: National Clearinghouse for Comprehensive School Reform p 116.
- SECOR, L. 2003. "Mind the gap: the debate over global inequalities heats up". Boston Globe,: D1. Jan. 5 p 13.
- SHEARED, A.G. & KAKABADSE, A.P. 2002. Key roles of the leadership landscape. *Journal of managerial psychology*, 2(17): 129-144.

SHELL, R. 2000. Yangeni'nkomo endlwini: the cow enters the hut: AIDS in the poorest province of South Africa, joint population conference: The demographic impact of HIV/AIDS in South Africa and its provinces Port Elizabeth p 21.

SHISANA, O., SIMBAYI, L. 2002. Nelson Mandela/Human Sciences Research Council study of HIV prevalence, Behavioural risk and mass media. *Pretoria HSRC.p101*.

SHUTTE, S. 2000: Preparing the ground for community acceptance of AIDS orphans. *Bulletin for contextual theology in Africa*, 7:(1,): 30-33, Mar.

SIEGEL, K. & .SCHRIMSHAW, E.W. 2000. Perceiving benefits in adversity: stress-related growth in women living with HIV/AIDS. *Social science and medicine*, 51:1543-1554.

SIMMS, C., ROWSON, M. & PEATTIE, S. 2001. The bitterest pill of all: the collapse of Africa's health systems. London: save the children p 41.

SISLI, E. 2000. Empowering the victims via micro credit, 13th International AIDS Conference Durban p 73.

SMART, R. 2000. AIDS care: why and how should industry respond? *AIDS analysis Africa*, 10 (5): p13-4.

SMITH-FAWZI, M.C. 2003. Prevalence and risk factors of STDs in rural Haiti: implications for policy and programming in resource-poor settings. *International journal of STDs and AIDS*, vol.4 no.8 62-69.

SMIT, T.J. & CRONJE, G. J. de J. 2001. Management principles: a contemporary edition for Africa. Cape Town: Juta p 68.

SOUTH AFRICA GOVERNMENT GAZETTE NO 20372 (August 1999). National Policy on HIV/AIDS, for learners and educators in public schools, and case studies]; overview of the relationships between HIV/AIDS and education. Letters to ministers of Education in Africa. Paris ADEA/IIEP.

SOUTH AFRICA. DEPARTMENT OF EDUCATION 1999. National Policy on HIV/AIDS for learners and educators in public schools, and students and educators in further education and training institutions of the Department of Education. Pretoria: Government Gazette.

SOUTH AFRICA. DEPARTMENT OF EDUCATION 2000. Implementation plan for Tirisano Jan/Dec. Pretoria. : Government Printer p 179.

SOUTH AFRICA. DEPARTMENT OF EDUCATION. 2003. Gauteng schools list. Johannesburg. 17: Government Printer.

SOUTH AFRICA. DEPARTMENT OF HEALTH 2000. Draft HIV/AIDS strategic plan for children infected and affected by HIV/AIDS. Pretoria. Government Printer p 415.

SOUTH AFRICA. DEPARTMENT OF HEALTH.2001. South African national guidelines on nutrition for people living with TB, HIV/AIDS and other debilitating diseases. September. Pretoria. : Government Printer p 71-91.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 2003. National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa. Pretoria: Government Printer p 159-160.

SOUTH AFRICA. DEPARTMENT OF SOCIAL DEVELOPMENT. 2000. A draft national strategic framework for children infected and affected by HIV/AIDS. Department of Social Development: Pretoria p 147.

SOUTH AFRICAN NATIONAL POLICY ACT. ACT 27 of 1996.

SOUTH AFRICAN SCHOOLS ACT. ACT NO. 84. 1996.

SOUTH AFRICA. WESTERN CAPE DEPARTMENT OF EDUCATION. 2000. Revised business plan for HIV/AIDS life skills education, Apr.-Mar. Cape Town WCED.

SQUELSH, J.M. 2000. The right to administrative justice: the implications for school discipline. *South Africa journal of education*, 20:4: 308-313.

STATEMENT TO THE NATIONAL ASSEMBLY. 2004. Government's Changing Responses to HIV/AIDS [web:] (<http://www.info.gov.za/speeches/2004/04081113151002.htm>). (Date of access Dec. 3 2004).

STEINTHORSSON, R.S. & SODERHOLM, A. 2002. Strategic management as multi-contextual sensemaking in intermediate organizations. *Reykjavik: Univ.of Iceland* p 69.

STILLWAGGON, E. 2000. Determinants of HIV transmission in Africa and Latin America, International AIDS Economics Network (IAEN) Conference Durban p 3.

SUSSER, I & STEIN, Z. 2000. Culture, sexuality, and women's agency in the prevention of HIV/AIDS in Southern Africa. *American journal of public health* 90(7): 1042-48.

SUTTON, P., 2001. "Small states and the Commonwealth", *Commonwealth and comparative politics*, 39, (3): 75-94.

SWARNS, R. 2000. South Africa in a furore over advice about AIDS._ *The New York Times*, 98. Oct p 98.

TAWFIK, L. & KINOTI, S. 2001. The Impact of HIV/AIDS on the Health Sector in sub-Saharan Africa: the Issue of Human Resources. New York. USAID: Support for Analysis and Research in Africa Project USAID, Bureau for Africa, Office of Sustainable Development p 30.

TAYLOR, M., NAIDOO, K., JINABHAI, C.C. & BAILEY, M. 2000. Promoting community health in a rural area of KwaZulu-Natal: Linking community health workers, NGO, Department of Health, University of Natal Poverty and inequality: The challenges for public health in South Africa Conference, Epidemiological Society of Southern Africa (ESSA) East London.

TEMBO, G. 2000. An overview of the epidemiology of HIV in Africa In: HIV/AIDS in the commonwealth. Kensington Publications: London p 17.

THOMSON, J.L. & STRICKLAND III, A.J. 1999. *Strategic Management*. New York: Richard D Irwin p 95.

TUCKER, J.S., WENZEL, S.L., ELLIOT, M.N., HAMBARSOOMIAN, K. & GOLINELLI, D. 2003. Patterns correlates of HIV testing among sheltered and low-income house women in Los Angeles County. *Journal of acquired immune deficiency syndrome*, Vol. 34, No. 4, Dec. 1. p. 415-422.

UNAIDS 2000. Caring for Carers: Managing stress in those who care for people p 79.

UNAIDS. 2002. HIV/AIDS: human resources and sustainable development. [web:]
(http://www.unaids.org/whatsnew/conferences/wssd/WSSD2002UNAIDS_en.pdf. 450.

UNAIDS. 2003. *Estimating and Projecting National HIV/AIDS epidemics. The models and methodology of the UNAIDS/WHO approach to estimating and projecting national HIV/AIDS epidemics*. The UNAIDS Reference Group on Estimates, Models and Projections. Geneva p 212.

VOCKEL, E.L. & ASHER, J.W. 1995. Educational research. Englewood Cliffs, N.J.: Prentice-Hall p 321-342.

WALLIS, JM. 2004. Support Groups for People with HIV Focus, Mar, 19 (3): p18.

WALKER, L. & GILBERT, L. 2002. HIV/AIDS: South African women at risk. *African journal of AIDS research* 1(1): p75-85.

WALLMAN, S. 2000. Risk, STD, and HIV infection in Kampala. *Health, Society, and Risk* 2(2): p189-203.

WANG, L.Y. BURSTEIN, G. R. & COHEN, D.A. 2002. An economic evaluation of a school-based sexually transmitted disease screening program. *Sexually transmitted diseases*, Vol. 29 No. 12 Dec. 737-745.

WEINSTOCK, H., BERMAN, S. & CATES, Jr. W. 2004. Sexually Transmitted diseases among American youth: incidence and prevalence estimates, *perspective sexual and reproduce health*, Jan/Feb; 36(1): p6-10.

WILKINSON, D. & DORE, G. 2000. An unbridgeable gap? Comparing the HIV/AIDS epidemics in Australia and sub-Saharan Africa Australia and New Zealand *journal of public health*, 24 (3): p276-80.

WILLIAMS, B.G, DYE, C. 2003. Antiretroviral drugs for tuberculosis control in the era of HIV/AIDS. *Science* [online], 14 Aug.
[web:](http://aidsscience.org/Science/Williams_and_Dye_10_1126_science_10_86845.htm), (Date of access; 25 September 2003) p 102.

WILLIAMS, B., GILGEN, D., CAMPBELL, C., TALJAARD, D. & MACPHAIL, C. 2000. The natural history of HIV/AIDS in South Africa: biomedical and, B., GOUWS, E. & ABDOOL KARIM, S. 2000. Where are we now? Where are we going? The demographic impact of HIV/AIDS in South Africa *journal of South social survey CSIR*, Johannesburg p 203.

WOLDAY, D., FLENER, Z., ZERU, G. 2003. Persistent CCR5 and CXCR4 expression elevation despite HIV-1 genital shedding following effective treatment of sexually transmitted diseases. Abstracts of the 13th International Conference on AIDS and STIs in Africa Nairobi: WedPs747998 p 151..

WOLDAY, D., GIRMA, M., HAILU, E., HAILU, E., SANDERS, E., FONTANET, AL. 2003. Low CD4+ T-cell count and high HIV viral load precede the development of tuberculosis in a cohort of HIV-positive Ethiopians. *Ethiopian medical journal* p 45.

WORLD BANK 2000. Intensifying action against HIV/AIDS in Africa: Responding to a development crisis World Bank, Africa Region, Washington p 63.

WORLD HEALTH ORGANIZATION. 2003. Global tuberculosis control [Web:] [<http://www.who.int/gth/publications/globrep/>]. Accessed November 2004 p 178.

WORLD HEALTH ORGANIZATION. 2003. HIV-infected women and their families: psychosocial support and related issues. *ITS Occasional Paper 7*.

WORLD HEALTH ORGANIZATION. 2004. Investigating in a comprehensive health sector response to HIV/AIDS: scaling up treatment and accelerating prevention. Geneva. WHO Jul.

WORLD WIDE STATISTICS, 2003: [Web:] <http://www.avert.org/aidssouthafrica.htm> (Date accessed 21 Oct. 2004).

YIGEMERU, A., GIRMACHEW, M., WUDIE, A. 2002. Rapid assessment of the leadership strategy amongst the Ethiopian armed forces p 172.



HIV/AIDS Research project: Effect on the classroom

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

Please complete the attached questionnaire.

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

SECTION A: BIOGRAPHIC INFORMATION

1.	Indicate whether your school is an urban or a rural school by marking your choice with an X in the appropriate block	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Rural</td> <td style="width: 50%; padding: 5px;">Urban</td> </tr> </table>	Rural	Urban			
Rural	Urban						
2.	Indicate whether your school is a primary or secondary school.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Primary</td> <td style="width: 50%; padding: 5px;">Secondary</td> </tr> </table>	Primary	Secondary			
Primary	Secondary						
3.	Indicate your current post.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;">Teacher</td> <td style="width: 25%; padding: 5px;">Head of Department</td> <td style="width: 25%; padding: 5px;">Deputy Principal</td> <td style="width: 25%; padding: 5px;">Principal</td> </tr> </table>		Teacher	Head of Department	Deputy Principal	Principal
Teacher	Head of Department	Deputy Principal	Principal				
4.	Indicate the phase in which you are presently teaching.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;">Foundation</td> <td style="width: 25%; padding: 5px;">Inter-mediate</td> <td style="width: 25%; padding: 5px;">Senior</td> <td style="width: 25%; padding: 5px;">FET</td> </tr> </table>		Foundation	Inter-mediate	Senior	FET
Foundation	Inter-mediate	Senior	FET				
5.	Indicate the school in which you are currently teaching..	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;">Public</td> <td style="width: 25%; padding: 5px;">Private</td> <td style="width: 25%; padding: 5px;">Ex TED Model C</td> <td style="width: 25%; padding: 5px;">Other</td> </tr> </table>		Public	Private	Ex TED Model C	Other
Public	Private	Ex TED Model C	Other				
6.	Please indicate the numbers of teachers in your school	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Male</td> <td style="width: 50%;"></td> </tr> <tr> <td style="padding: 5px;">Female</td> <td></td> </tr> </table>		Male		Female	
Male							
Female							
7.	Please indicate the numbers of learners in your school	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="height: 20px;"></td> </tr> </table>					

SECTION B: THE EFFECTS OF HIV/AIDS ON TEACHERS

8.	Are you currently aware of any teachers at your school who are HIV positive or who have AIDS.	Yes	Not sure	Do not know	No
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9.	How many teachers at your school have medically retired or died over the last three years due to a suspected AIDS-related disease?	Male	Female
	2001		
	2002		
	2003		

10.	How often are the following reasons indicated for the mortality rate among teachers at your school?.	Always	Often	Sometimes	Never
10.1	Illness				
10.2	Accident				
10.3	Suicide				
10.4	Violence/Homicide				
10.5	Aids-related illnesses				
10.6	Suicide				

11	If your answer to question 8 was YES or NOT SURE, please provide an indication of the number of teachers who are possibly affected by completing the table.	Male	
		Female	

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

13.	Do you experience problems for having to take over the responsibilities of an absent colleague?	Always	Often	Sometimes	Never
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14.	Are substitute teachers appointed at your school for days on which permanent teachers are absent?	Always	Often	Sometimes	Never
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15.	Are you coping with more than one educator's workload?	Yes	No
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16.	If your answer to question 15 was YES, indicate the importance of the following reason/s for your having to carry this workload.	Definitely true	True	Sometimes true	Untrue
	Shortage of staff members.				
	Frequent absence of staff members to attend to family responsibilities.				

Staff members are not replaced.	Definitely true	True	Sometimes true	Untrue
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Absence of staff members due to personal illness.	Definitely true	True	Sometimes true	Untrue
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Other (specify).

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

17.1	Frustrated	Not at all	Sometimes	Often	Always
17.2	Stressed	Not at all	Sometimes	Often	Always
17.3	Motivated	Not at all	Sometimes	Often	Always
17.4	Decreased interest in school and school activities	Not at all	Sometimes	Often	Always
17.5	Coping with the situation	Not at all	Sometimes	Often	Always
17.6	Not coping with the situation	Not at all	Sometimes	Often	Always
17.7	Comfortable	Not at all	Sometimes	Often	Always
17.8	Negative	Not at all	Sometimes	Often	Always
17.9	Low morale	Not at all	Sometimes	Often	Always
17.10	Depressed	Not at all	Sometimes	Often	Always
17.11	Feel like resigning	Not at all	Sometimes	Often	Always
17.12	Other (specify)				

18. Reasons for absenteeism. Indicate the main reason for teacher absence at your school by marking with an X in the appropriate block.

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

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

Yes	Not sure	Do not know	No
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20. If your answer to question 19 was YES or NOT SURE, please provide an indication of the number of learners who are possibly affected by completing the table.

Male	
Female	

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

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

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

23. Indicate the estimated % of learners that drop out of school the past three years due to incomplete families by completing the table below. Indicate your choice by marking with an X in the appropriate block.

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

24. Are you aware of learners at your school who were involved in sexual harassment cases by teachers in the past three years?

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

Yes	No
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26. Indicate the estimated % of learners in your school who are suffering from poor nutrition, by completing the table below.

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

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

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

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

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

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

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

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

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

41.1 Classes are too big.

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

Definitely true	True	Sometimes true	Untrue
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41.3 Learners are frequently absent.

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

41.4 Teacher workload is too heavy.

Definitely true	True	Sometimes true	Untrue
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41.5 Learners are not motivated

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

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

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

Definitely true	True	Sometimes true	Untrue
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41.8 Other (specify)

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

42.1 Lack of motivation

Not at all	Sometimes	Often	Always
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42.2 Lack of social interactions

Not at all	Sometimes	Often	Always
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42.3 Hyperactivity

Not at all	Sometimes	Often	Always
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42.4 Passivity

Not at all	Sometimes	Often	Always
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42.5 Nervousness

Not at all	Sometimes	Often	Always
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42.6 Poor discipline

Not at all	Sometimes	Often	Always
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42.7 Absenteeism

Not at all	Sometimes	Often	Always
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43. To what extent are the following manifestations of depression noticeable among your learners?

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

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

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

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

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

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

50.	Teachers are well prepared.	None	A few	Most of them	All of them
51.	Teachers present interesting learning activities.	None	A few	Most of them	All of them
52.	Teachers have well organized classrooms.	None	A few	Most of them	All of them
53.	In the classrooms there is a constant flow of learning.	None	A few	Most of them	All of them
54.	There is on-going interaction between learners and teachers.	None	A few	Most of them	All of them
55.	Teachers correct tests and assignments.	None	A few	Most of them	All of them
56.	Tests and assignments are handed back timorously.	None	A few	Most of them	All of them
57.	Teachers check learners' home work.	None	A few	Most of them	All of them
58.	Teachers provide assistance with personal problems.	None	A few	Most of them	All of them
59.	Teachers provide assistance with educational problems.	None	A few	Most of them	All of them
60.	Teachers involve learners actively in learning.	None	A few	Most of them	All of them
61.	Teachers reinforce learning (motivate learners).	None	A few	Most of them	All of them
62.	Teachers pay individual attention to learners.	None	A few	Most of them	All of them
63.	Teachers control disciplinary problems in class effectively.	None	A few	Most of them	All of them
64.	Teachers make sure that learners pay attention during lesson presentations.	None	A few	Most of them	All of them
65.	Teachers are dependable.	None	A few	Most of them	All of them
66.	Teachers are role models in terms of good ethics, attitudes and values	None	A few	Most of them	All of them
67.	Teachers are punctual and regular in attendance.	None	A few	Most of them	All of them
68.	Teachers are sexually involved with learners.	None	A few	Most of them	All of them

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

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

69.	Are learners of different grades combined into one classroom?	Yes	No
70.	Is the curriculum of the school flexible to deal with learners who cannot attend school during normal school hours or whose schooling is interrupted?	Yes	No
71.	Are classes at your school left untaught/unsupervised?	Yes	No
72.	Does your school have a sufficient teacher supply?	Yes	No
73.	Are posts at your school filled timorously?	Yes	No
74.	Are staff development programmes in place for educators who have to cope with heavy workloads and/or low morale?	Yes	No
75.	Does the curriculum teach learners how to handle the emotional changes that occur during puberty and adolescence?	Yes	No
76.	Does the curriculum focus on promoting abstinence from sexual activities?	Yes	No
77.	Does the curriculum focus on promoting a delay in taking part in sexual activities?	Yes	No
78.	Are topics on HIV/AIDS infused into carrier subjects: Biology, Life Orientation and Health Education?	Yes	No
79.	Are topics of HIV/AIDS well taught?	Yes	No
80.	Is there an in-depth coverage of HIV/AIDS topics?	Yes	No
81.	Are extra-curricular activities planned to address HIV/AIDS?	Yes	No
82.	Are school-based activities e.g. School health programmes, guidance and counselling arranged to address HIV/AIDS?	Yes	No
83.	Are intensive pre-service and/or in-service training programmes for HIV/AIDS implemented?	Yes	No
84.	Do teachers feel confident to teach HIV/AIDS topics?	Yes	No
85.	Are strict measures in place to deal with staff members who are involved in sexual harassment of learners?	Yes	No
86.	Are strict measures in place to deal with love relationships between learners and teachers?	Yes	No
87.	Are strict measures in place to deal with teachers who are frequently absent?	Yes	No

88.	Does your school offer a feeding scheme?	Yes	No
89.	Are you of the opinion that it is the school's task to deal with the causes and effect of HIV/Aids?	Yes	No
90.	Are you of the opinion that we give too much attention to HIV/AIDS in our schools?	Yes	No