

CHAPTER TWO

THE PREVALENCE OF HIV/AIDS IN SOUTH AFRICAN SCHOOLS AND THE IMPACT OF THE DISEASE ON SCHOOL MANAGEMENT AND SELF-ACTUALIZATION

2.1 INTRODUCTION

As mentioned in chapter one according to Cangemi (1984:105) the ultimate aim of education and therefore educational management, school organization and educational provision, should be the self-actualization of the role player's innate potential. Disruption in schooling, the spread of HIV/AIDS, sexual abuse of children inside and outside schools, gender inequality, dysfunctional families and the spread of drug abuse in South Africa's schools do not bode well for this aim.

Media headlines constantly refer to the rampant spread of HIV/AIDS in South African schools. In an article titled "*AIDS will shatter education system in South Africa*" Pela (2001:1), reports that as many as 16% of teachers in most provinces and up to 20% in Kwa Zulu-Natal are HIV-positive. The report states that 8% of principals and heads of department were infected with HIV at the end of 2000, a statistic that could have devastating implications for school management. According to Pela (2001:1), the impact of the epidemic has shaken the entire education system in South Africa. Not only is South Africa faced with a loss of teaching professionals, but it also faces declining enrolment rates and delayed registration of learners from households, affected by the AIDS crisis. Moreover, a study commissioned by the South African Government shows that AIDS and HIV infection have made a dramatic impact on the education system (Barrow 2001:1).

The quality of education and skills development is threatened by the epidemic, leading to failure of students at the tertiary level. Pela (2001:1) reports that affected students are less likely to be able to repay study loans, which in turn could have serious financial spin-offs for educational institutions, further hampering the provision of quality education and management. A study conducted on behalf of the Department of Education reveals that one in four undergraduates and one in eight post-graduate students were HIV positive in 2000 (Pela 2001:1,2). This means that one in

four teachers in training and one in eight teachers who are improving their qualifications could be infected with HIV/AIDS.

Bartlett (2002:1) highlights the extent of the problem further, stating that, while education ranks as their top priority, South African teenage learners rate HIV/AIDS as their biggest concern. Bartlett reports in 'Love Life', that a large number of teenage learners (33%) cite HIV/AIDS as their greatest fear, and that 51% of the teenage learners were sexually active, with a staggering 29% between the ages of 12-17. Moreover, 53% of the sexually active learners engaged in risky sexual behaviour most believing that, although they were very concerned about HIV/AIDS, their chances of contracting the virus were minimal (Bartlett 2002:1). This finding has been confirmed in recent reports, citing that in spite of a high level of awareness, risky sexual behaviour remains a problem (James *et al.* 2004:264-269).

In 1999 experts warned that an estimated one in eight of the countries' sexually active population, i.e. those over 14 years of age, was infected. This experts warned, *"would worsen the projected shortage of teachers, affect their ability to teach, increase infection rates among pupils, change enrolment patterns and generally disrupt schooling because of erratic attendance rates as teachers and pupils take time to care for family members with AIDS"* (Pretorius 1999:1).

2.1.1 WHAT IS AIDS?

In order to understand fully what the impact of HIV/AIDS could be on schooling in South Africa, it is necessary to have a brief look at what AIDS is, i.e. what causes AIDS, and how it is spread. AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus, which is officially known as HIV, the abbreviation for the Human Immunodeficiency Virus. The word "acquired" sets AIDS apart from similar genetic conditions, as it is caused by an external factor the virus, which is not hereditary (American Lung Association 2002:1).

The virus is found in the blood of infected individuals. The diagnosis of AIDS depends on the blood test results of these individuals together with evidence of associated symptoms of illness. Evidence of infection with the virus may also be found in people who seem healthy. These people are then called HIV positive. Although new antiviral drugs are able to control the infection, most people who are HIV positive will eventually develop full-

blown AIDS. This process may develop over a number of years, and in this period a person who is HIV-infected, but appears healthy can pass the virus on to other people. The AIDS virus is transmitted via body fluids, thus mostly via by sexual intercourse or by contact with infected blood.

It is important that individuals know if they are infected, for the following two important reasons:

- The knowledge will prevent the spread of HIV, by enabling infected persons to take precautions against passing the virus on to others (responsible sexual behaviour).
- The knowledge will also encourage individuals to take special precautions to protect their own health to stem the effects of the disease.

Patients who die from full-blown AIDS normally succumb to an opportunistic disease, because they are immune-suppressed. People who are immune-suppressed do not have normal resistance to disease and are therefore more susceptible to infection. One example of an opportunistic disease often associated with AIDS is PCP or Pneumocystis carinii pneumonia, a rare form of pneumonia that seldom affects healthy individuals.

While some opportunistic diseases such as PCP cannot easily be passed on from one person to another, others such as TB are highly contagious, and if untreated can spread through susceptible communities, thereby compounding the effects of AIDS (American Lung Association 2002:1-4). The effect of HIV/AIDS can be seen in the escalating number of TB cases in South Africa. Dr Riana Louw the Gauteng Health Department medical advisor responsible for TB control stated in 2003 that the rising numbers of HIV infection is complicating the fight against TB: *“We are losing the fight against TB. The other problem is that we do not know the exact figures of TB patients who are HIV positive because we do not test all people,”* Louw said (in Makgalemele 2003:6). The chief executive officer of the South African National Tuberculosis Association confirmed Louw’s statements, saying that between 50-60% of all TB patients in 2003 were also HIV positive (Makgalemele 2003:6).

Photograph 2:



This *Beeld* (2002:3) placard underscores the plight of HIV/AIDS victims in South Africa

2.1.1.1 HIV STRUCTURE

Figure 2 shows the structure of the HIV. The outer shell of the virus is called the viral envelope. Embedded in the viral envelope are a complex structures each consisting of an outer protruding glycoprotein cap and a stem. Within the viral envelope is the HIV protein matrix, and within this is the viral core, consisting of another viral protein, the core antigen. The major elements contained within the viral core are two single strands of HIV RNA; a protein nucleocapsid; and three enzyme proteins; reverse transcriptase, protease and integrase (Avert 2002b:1)

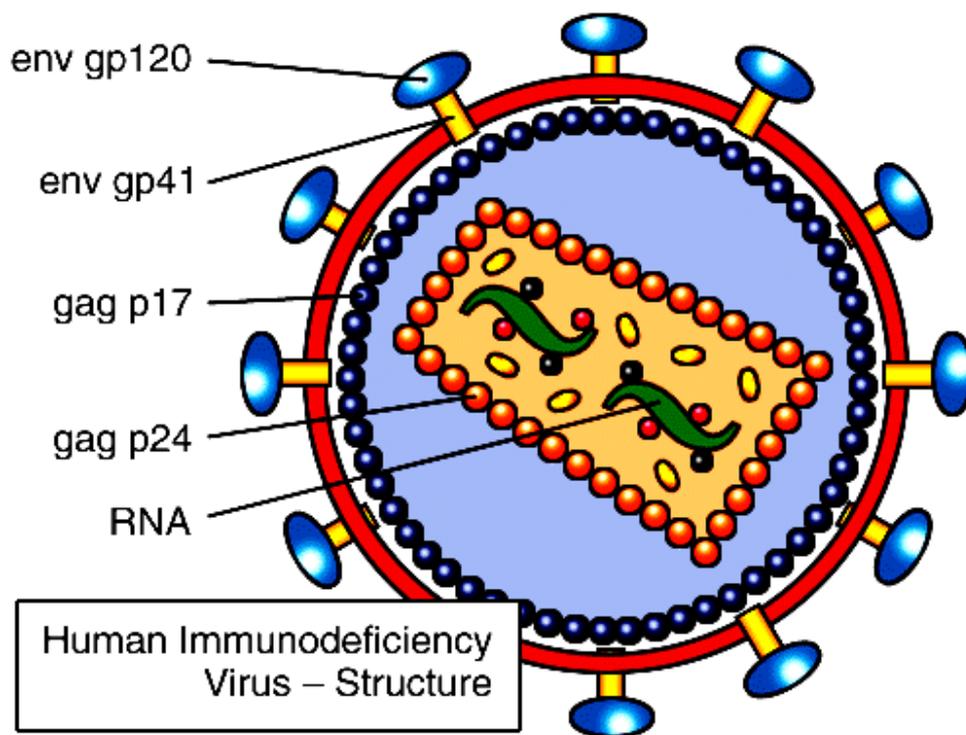


Figure 2: the structure of an HI virus (Avert 2002b:1)

2.1.1.2 HIV REPLICATION

Figure 3 depicts a cell replicating the HIV virus. HIV belongs to a class of viruses called *retroviruses*, which have genes composed of ribonucleic acid (RNA) molecules. Retroviruses, like all viruses, can only replicate within a living host cell because they contain only RNA and no DNA. Infection begins when an HIV particle encounters a T-Helper cell (a type of white blood cell) with a surface molecule called CD4. The virus particle uses a glycoprotein to attach itself to the cell membrane and then enters the cell. Within the cell the virus particle releases its RNA, and the enzyme reverse transcriptase then converts the viral RNA to DNA. This new HIV DNA then moves into the cell nucleus where with the help of the enzyme integrase it is then inserted into the host cell's DNA. Once it is in the cell the HIV DNA is called a provirus. The HIV provirus is then replicated by the host cell, which can then release new infectious virus particles (Avert 2002b:1,2).

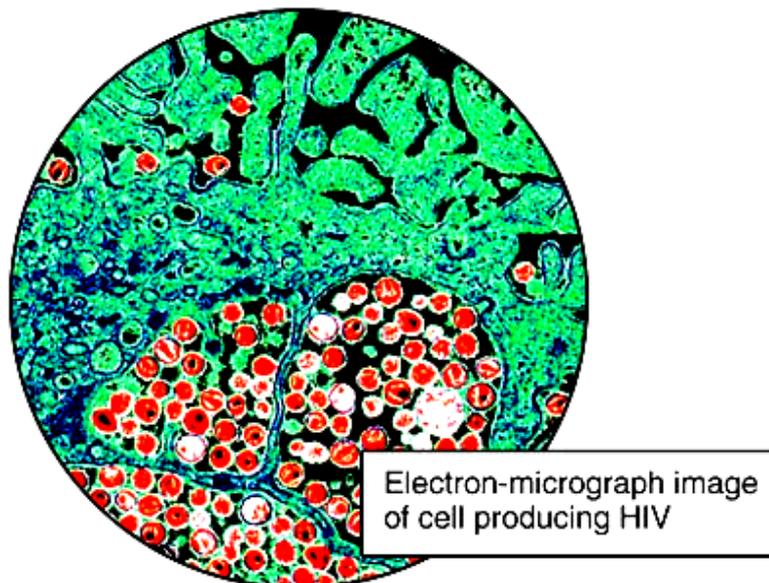


Figure 3: the reproduction of the HI virus in a human cell (Avert 2002b:1).

2.2 THE PREVALENCE OF HIV/AIDS IN SOUTH AFRICA WITH SPECIAL REFERENCE TO THE EDUCATION SYSTEM.

South Africa currently has the highest number of HIV infections in the world, according to Jordan (2002a:2-3). This alarming statistic led to an announcement by Professor William Makgoba at the 14th AIDS congress in Barcelona in July 2002 in which he argued that: *“Ten years ago we had exactly the same prevalence than Thailand. Today they’re 2.5% and we’re 25%. We have been a society in denial, refusing to take action”* (Jeter 2000:8; Jordan 2002a:3). Jordan states further that the lack of action taken to stem the spread of AIDS in South Africa has stunned the world. The message from Barcelona was clear, *“you have to do – or die”*. South Africa has to find the political will to prevent more infections and unnecessary deaths from HIV/AIDS.

The epidemic’s toll continues to rise, especially in countries already experiencing a high prevalence of infection rates. According to UNAIDS (2002:1), the number of AIDS-related deaths among young adults in South Africa is expected to peak in 2010-2015, when it is estimated that the death rate of individuals aged between 15-34 years will have increased 17-fold due to AIDS. This shocking estimate further underscores the management dilemma that is facing education in South Africa. It is evident that learners, students and teachers at all levels of school management could succumb to the disease, making planning, controlling and executing of teaching strategies very difficult. (See table 5).

The disease and the subsequent death of teachers and learners will have a severe impact on school management. Rising numbers of AIDS orphans and children affected by AIDS also present further social, psychological and management problems. Dr Anne Petersen, USAID assistant administrator for global health, said the following about the growing number of AIDS-affected children, in Lakay (2001:9); Porter (2002a:1-2) *“Countless children are living with and caring for parents who are sick and dying.”* She (Porter 2002a:1-2) concludes that the societal impact of AIDS goes beyond the impact of the orphans on society, themselves. The implications are in fact unprecedented. Peter Piot, UNAIDS director (Porter 2002a:1-2) underscores the statement made by Petersen, stating that children who raise themselves cannot develop normally, because they lack food shelter, education nurturing and healthcare, which are the very basic necessities for self-actualization Forster in UNAIDS agrees (2004a:62-63). Piot (Porter 2002a:1) summarizes

the catastrophic consequence of the pandemic, stating that: “*The very fabric of society would disappear, with family structures crumbling.*” The implication for school management and self-actualization is daunting.

Dr Liz Floyd, Director of the AIDS and Communicable Diseases section of the Gauteng Department of Health, believes that, from the available statistics in 1999, 10% of female learners and 5% of male learners could have been infected at that time. Research into the presence of AIDS amongst learners proves to be difficult and very expensive and the true rate of infection cannot be ascertained. An educated guess puts the figure at an estimated 258,000 HIV-positive learners in South Africa in 1999. Naidu (2004:2) reported as mentioned before that as many as 500,000 secondary school learners will be infected and many will die before the age of 30. The 1999 report predicted a “*future shock*” should more learners become infected and points to a 5% annual shrinkage in learner intake (Altenroxel 1999:4). Altenroxel reports further that according to a UNAIDS report on South Africa “*The reduction (in school intake) is only partially explained by declining fertility rates and the normalization of age/grade enrolment.*” Naidu (2004:1) confirms that fewer pupils will be attending school due to the ravages of HIV/AIDS. Moreover, should this trend continue and there is an additional consistent decline in learners of school entry age due to infant mortality, entry levels and enrolments may decline still further.

More recent studies indicate varying but similarly alarming statistics. The South African Department of Health has estimated that 2.65 million women and 2.09 million men between the ages of 15-49 are living with HIV/AIDS. Furthermore, an estimated 83,581 babies are infected with AIDS because of mother-to-child transmission (Avert 2002a:1). In total an estimated 4.74 million South Africans were infected with HIV by the end of 2001. This figure has risen to estimates of 6.29 million and 6.57million infected persons in 2005 (Health-e News Service 2005:1) surpassing all previous predictions. The adult population includes learners and tertiary students between the ages of 15-34. (See table 5). The available statistical evidence of the pandemic and its possible impact on learners, teachers, society and schools in South Africa will now be examined.

Figure 4a and b and Table 1 below illustrate HIV infection rates in women attending antenatal clinics in South Africa between 1990 and 2004.

Table: 1

HIV INFECTION AMONG WOMEN IN ANTENATAL CLINICS FROM 1990 to 2004

<u>YEAR</u>	<u>INFECTION %</u>	<u>GRAPH COLUMN</u>
1990	0.73%	1
1991	1.74%	2
1992	2.15%	3
1993	4.01%	4
1994	5.57%	5
1995	10.44%	6
1996	14.17%	7
1997	17.04%	8
1998	22.8%	9
2001	25%	10
2002	26.5%	11
2003	27.9%	12
2004	29.7%	14

Granelli 1999:4; **UNAIDS December 2004b:23**

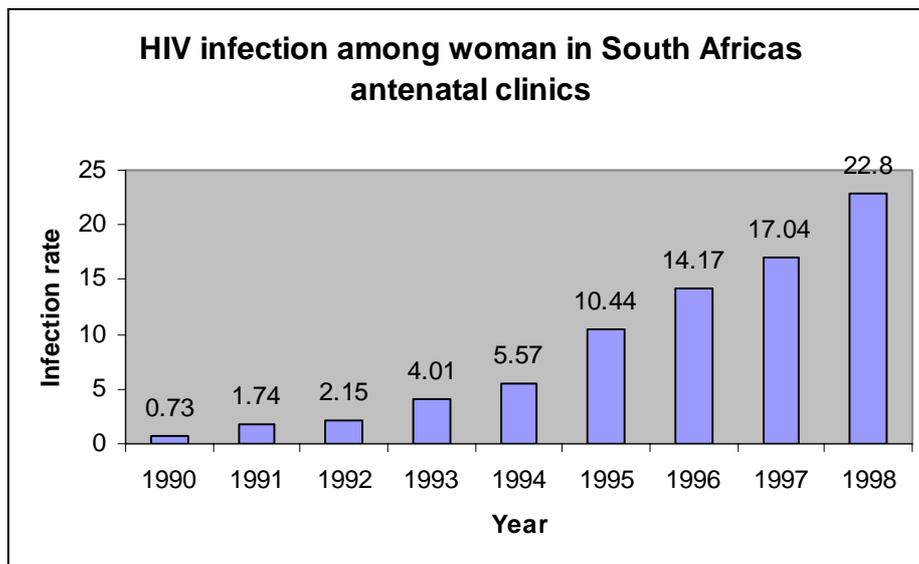


Figure: 4 a (Granelli 1999:4)

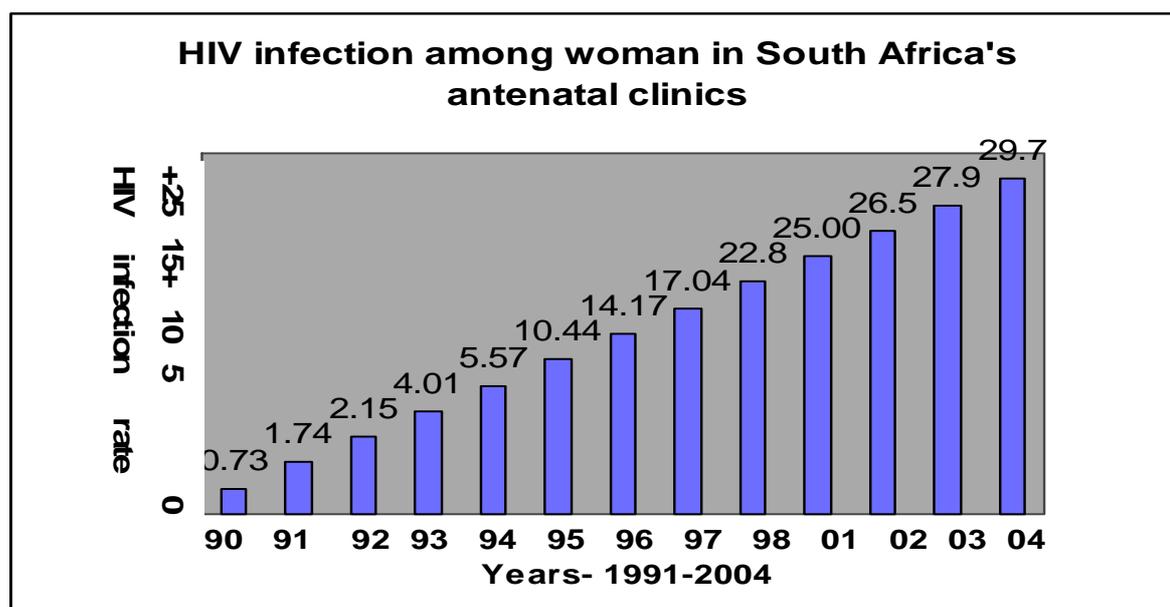


Figure: 4 b (Granelli 1999:4; UNAIDS 2004b:23)

The Figures show an exponential increase in serum-prevalence from 1990 to 2004. The infection rate increased from 0.73% in 1990 to 22.8% in 1998 (Granelli 1999:4) and again to 29.7 in 2004 (UNAIDS 2004b:23). Could the increase in HIV infection be ascribed at least partly to the fact that from 1990 onwards South Africa moved from a closed and movement-restricted

apartheid society to a free society migrating from rural areas into overcrowded squatter camps surrounding the cities? Jeter (2000:5) confirms that this may indeed be the case, stating that increased immigration across borders, which had been closed by the apartheid regime, ended the isolation that had spared South Africa the soaring HIV-infection rates that raged through its neighbouring countries. This fact is supported by findings in Angola, where decades of war restricted movement of civilians; seroprevalence in Angola is a mere 3% among women attending antenatal clinics, although much higher rates of infections are prevalent in the capital, Luanda among sex workers (UNAIDS 2004b:24)

2.2.1 THE POLITICAL STANCE ON HIV/AIDS IN SOUTH AFRICA AND THE AIDS MYTH

Many national leaders are still in denial about the impact of AIDS on their people and societies, according to a UNAIDS (2004a:14) report. According to Barnett and Whiteside (2003:5),

“politicians, policymakers, community leaders and academics have all denied what was patently obvious -that the epidemic of HIV/AIDS would affect not only the health of individuals but also the welfare and well-being of households, communities and, in the end, entire societies”.

In South Africa there are to date still government officials denying the fact that HIV causes AIDS, instead professing that poverty may be the cause. According to some officials, AIDS can be cured by a concoction made up of garlic, onions, African potatoes and virgin olive oil (Moodie & Van Rooyen 2003:4; Pienaar 2003:8; Schmidt 2003:4). *“HIV? It doesn’t exist”*, claimed Peter Mokaba, a leading ANC AIDS-dissident (Swarns 2002:1). A 114-page document circulated within the ANC with at least tacit top-level approval (Beresford 2002b:4; Haffajee 2002:1-2; Swarns 2002:1-4) launched a scathing attack at leading South African scientists, including the internationally acclaimed researcher, Dr Glenda Gray, referring to these scientists as *“cats and geese”*, who would do well to return to their ponds. (See Figure 5). The document further maintains that AZT and other anti-retroviral medication could cause AIDS.

Most social and economic statistics have political overtones, according to Barnett and Whiteside (2003:55). AIDS case data have always been political, and many countries’ leaders would prefer not to admit to its existence, because they feel that the presence of the epidemic reflects

negatively on the moral behaviour of their citizens, hence the denial, apportioning of blame and invention of a myriad of weird and wonderful causes of the epidemic. Parks Makahlana, the parliamentary spokesperson on AIDS, and Nkosi Johnson, internationally known AIDS activist, were said by these mythmakers to have died from taking anti-retroviral drugs. Mokaba, main author of the above-mentioned 114 page document, claimed (in Beresford 2002:1-4; Haffajee 2002:1-2; Swarns 2002:1-4) that AIDS does not exist and cannot be spread by sexual intercourse.

The message from the AIDS conference in Barcelona made it very clear that South Africa would have to find the political will to prevent further infections (Jordan 2002a:3). In the interim, infection has escalated to beyond 6 million (Health-e News service: 2005:1). UNAIDS (2004a:32) reports that there is no single explanation why the epidemic is so rampant in Southern Africa, but cites a combination of factors such as poverty and social instability, family disruption, other STI's, gender inequality, sexual violence and, importantly *ineffective leadership during the critical stages of the spread of HIV*.



Figure 5: This Zapiro cartoon refers to the 114-page document co-authored by a number of AIDS-dissidents. The main author was the late Peter Mokaba, who claimed that AIDS did not exist (Zapiro 2002).

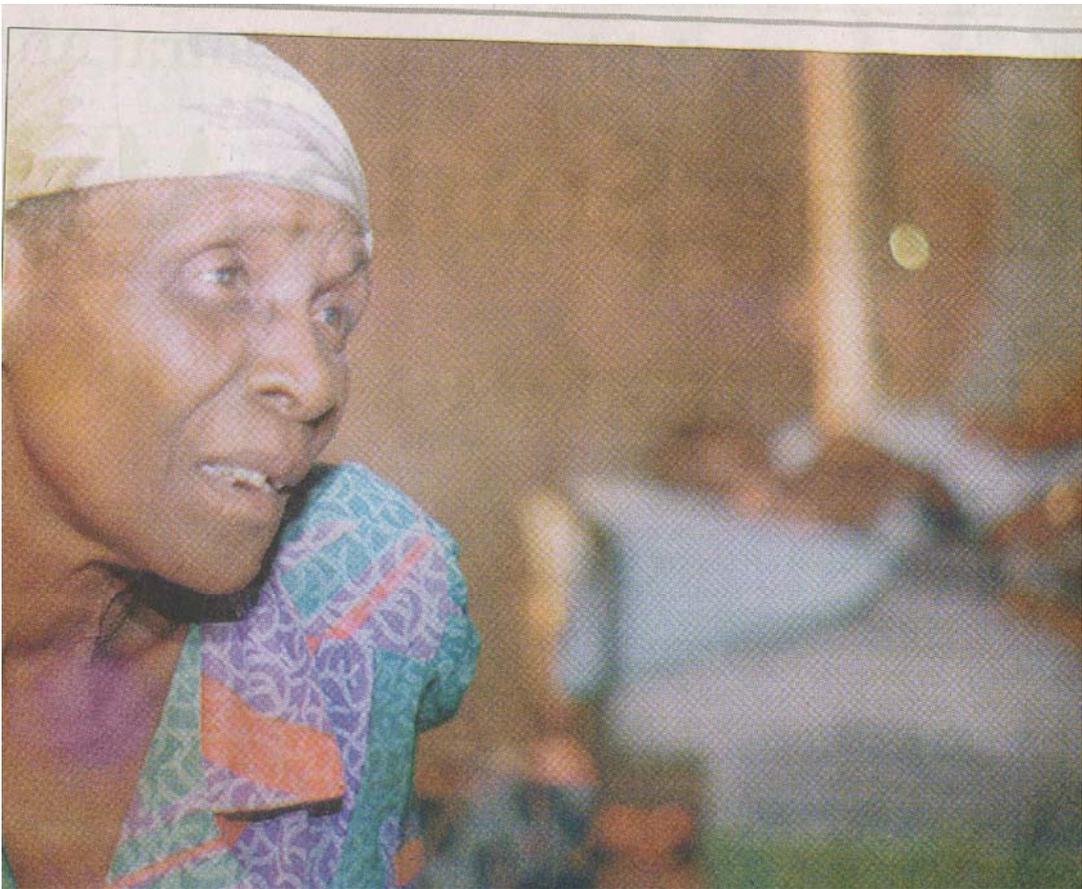
While the AIDS controversy continues, the statistics tell an increasingly tragic story in South Africa. In spite of being aware of the impact AIDS

could have in South Africa, prior to its un-banning in 1990, the ANC has made little effort to control the disease since they took over the government in 1994. Some senior members are still currently advocating denial. With thousands of its members living in exile in countries such as Zambia, Tanzania, and Uganda and elsewhere in Africa, the ANC recognized long before 1994 that they could be dealing with a major health crisis in the making. The health advisor for the ANC, Mr Mjijima (Jeter 2000:3) said in Lusaka: *“By 1989, we could see AIDS all around us in the countries where we were in exile; we were already seeing some HIV-positive comrades”*.

A major new study undertaken on behalf of the government finds that South Africa is in the midst of an AIDS crisis. The study predicts that there will be fewer teachers and learners in the future as a direct result of the HIV/AIDS pandemic. Moreover, the high rates of infection in the civil service have sparked fears that governance may be seriously affected as illness leads to death and increased absenteeism. More than 100,000 civil servants are reported to be infected with HIV (Naidu 2005: 1-3). This corroborates findings in a study carried out eighteen months earlier, but kept secret because of the government’s inability to act on it, according to the general manager of the Public Servant’s Association, Anton Lourens, who stressed that *“We are worried about how AIDS is affecting our members because the government, as the biggest employer in the country, has not shown a willingness to co-operate”* (Naidu 2005:2).

UNAIDS (2004a:51) describes AIDS as a negative factor for long-term development, and a significant obstacle to learners’ access to education, mainly due to the high costs incurred by the loss and absenteeism of teachers and incentives to keep orphans and other vulnerable learners in school. While over-extended ministries on limited budgets are overwhelmed by the need for action, many have added AIDS education to life-skills curricula. In South Africa this seems to be ineffectual as the pandemic rages on. Not enough has been done to estimate the impact of the epidemic on education, and to take appropriate action to curb the impact (UNAIDS 2004a:51). Moreover, while South Africa due to its years of international isolation, has been spared the early onslaught of the HIV/AIDS pandemic, which has been killing millions in sub-Saharan Africa, the country is currently the epicenter of the world’s epidemic, largely caused by the indecisive stance on AIDS from its leaders (Russel 2000:1-7) as mentioned above.

Shortly after Nelson Mandela was released in 1990, the ANC convened an AIDS conference in Maputo to address the perceived HIV/AIDS problem. South Africa at that time had a 0.73% infection rate, mainly among homosexual males. Other African countries already had soaring heterosexual infection rates. Chris Hani (Jeter 2000:1) voiced his concern, stating: “*We cannot afford to allow the AIDS epidemic to ruin the realization of our dreams.*” Sadly, the ANC’s return to open politics coincided with a seismic shift in the spread of AIDS, from the largely isolated gay male population in the 1980’s to primarily black heterosexuals from 1990 onwards (Jeter 2000: 3-6). Consistent denial, unwillingness or an inability to act has allowed the epidemic to spiral out of control. (See Figure 4a and b and table 1 discussed above).



Photograph 3: Elitha Mlombo has buried her son and daughter, both of whom died of AIDS. Now she too has tested HIV-positive. Her plight underscores that of many South Africans affected by HIV/AIDS. (African Eye News service *Pretoria News* 2002f:14)

Figures 6 and 7 depict the unfolding of a national disaster, with devastating implications for all sectors of society, and an adverse prognoses for school management and the self-actualizing potential of young South Africans, including learners and teachers.

Figure 6 shows the estimated prevalence of HIV/AIDS by province among antenatal clinic attendees from 1999-2001 (adapted from Avert 2002a:2-3.). In spite of its limitations, an antenatal survey is internationally recommended to determine HIV prevalence in any given community, because pregnant woman are sexually active and constitute an easily identifiable, accessible and stable population and are the most likely to represent the general public (Avert 2002a:3). The Figure was drawn from information given in Table 2. The overall prevalence among pregnant woman has subsequently increased to 29.7%; as shown in Table 1 and Figures 4a and b.

Table 2: ESTIMATED HIV PREVALENCE 1999-2001 BY PROVINCE AMONG ANTENATEL CLINIC ATTENDEES

PROVINCE	1999	2000	2001
	Prevalence%	Prevalence%	Prevalence%
National	22.4	24.5	24.8
Kwa Zulu Natal (KZN)	32.5	36.2	33.5
Mpumalanga (MP)	27.3	29.7	29.2
Gauteng (GP)	23.9	29.4	29.8
Freestate (FS)	27.9	27.9	30.1
North West (NW)	23.0	22.9	25.2
East Cape (EC)	18.0	20.2	21.7
Limpopo (LP)	11.4	13.2	14.5
Northern Cape (NC)	10.1	11.2	15.9
Western Cape (WC)	7.1	8.7	8.6

See Figure 6 overleaf.

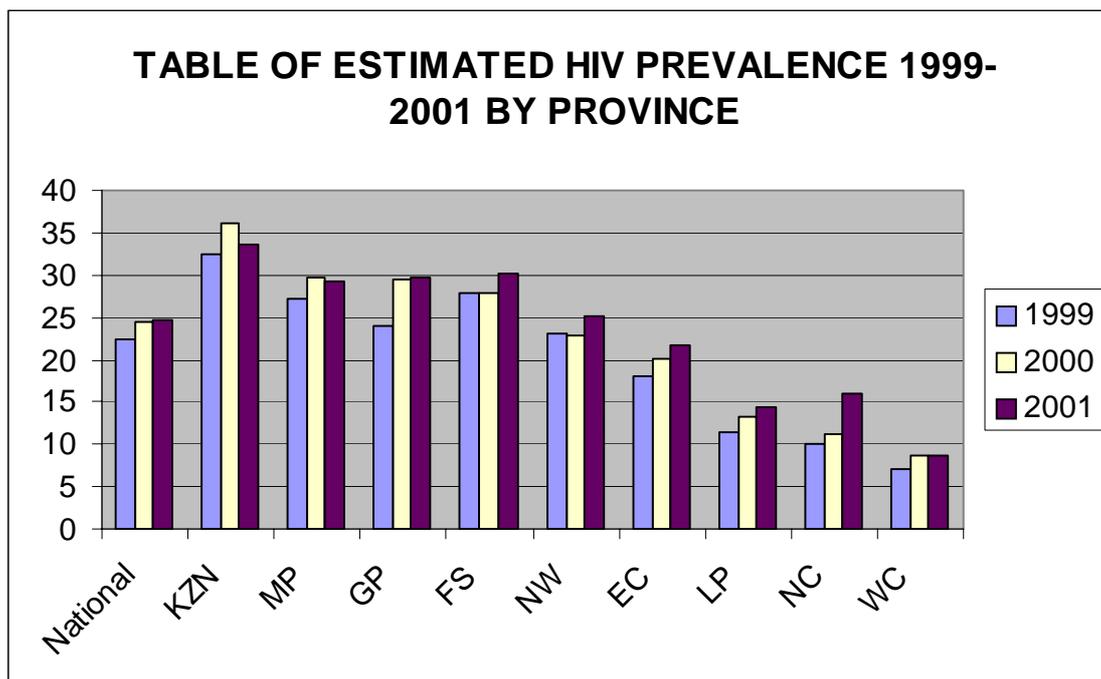


Figure 6: A graphical interpretation of table 2.

Figure 7 gives an estimated average percentage of HIV prevalence 1999-2001 by age among antenatal clinic attendees (adapted from Avert 2002a:2-3). The Figure was drawn from information in table 3. Compare to Figure 4b

Table 3: ESTIMATED AVERAGE PERCENTAGE OF HIV PREVALENCE 1999-2001 BY AGE AMONG ANTENATAL CLINIC ATTENDEES

Age Group	Prevalence			
	1999	2000	2001	
<20	16.5	16.1	15.4	Impact group for education Learners/students
20-24	25.6	29.1	28.4	Students/junior Teachers
25-29	26.4	30.6	31.4	Teachers/senior Students
30-34	21.7	23.3	25.6	Senior Teachers/HOD's
35-39	16.2	15.8	19.3	Senior Teachers and principals
40-44	12.0	10.2	9.1	Senior Teachers and principals
45-49	7.5	13.1	17.1	Senior Teachers and principals

See Figure 7 overleaf

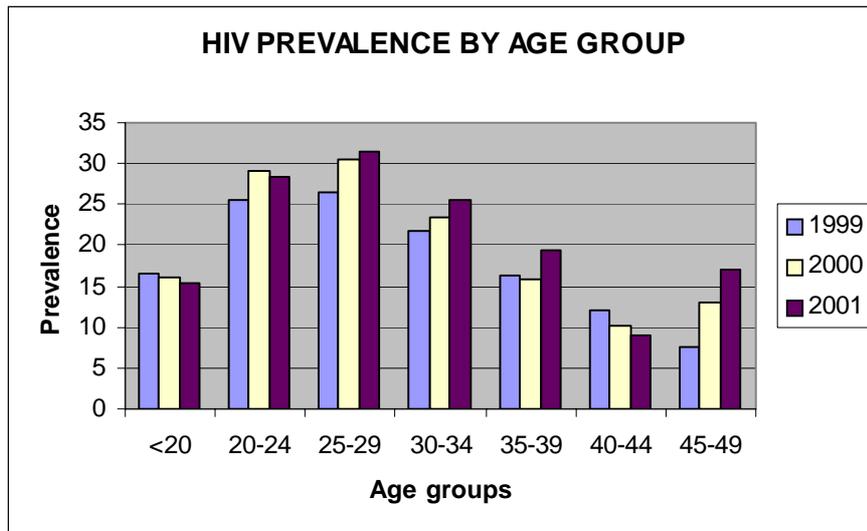


Figure 7: A graphical interpretation of table 3.

Table 3 and Figure 7 represent a survey in which 16,743 pregnant women and 421 clinics participated nationally. It is estimated that nationally 24.8% of pregnant women in South Africa were infected with HIV/AIDS by the end of 2001 (Avert 2002a:3).

Regarding the high infection rates, particularly among young females, Dr Lillian Dudley, Chief Executive Director of the Health Systems Trust points out the immediate concern caused by the continued year-by- year increase in HIV infections in young girls between 15-24 (Health-e New Service 2005:2). The survey findings are represented in Table 4 and Figure 8, indicating the serious progressive increase in HIV infections among females between 15-22 years of age.

Table 4: THE AVERAGE PERCENTAGE OF HIV PREVALENCE BY AGE AMONG YOUNG FEMALES OF 15-22 YEARS.

Age	% Infection Rate
15 years	10%
16 years	9.1%
17 years	12.3%
18 years	19%
19 years	19.9%
20 years	25.1%
21 years	28.5%
22 years	31.1%

Figure 8 and Table 4 indicates the high rates of HIV infections among young females (learners, young teachers and students) according to Health-e News Service (2005:2)

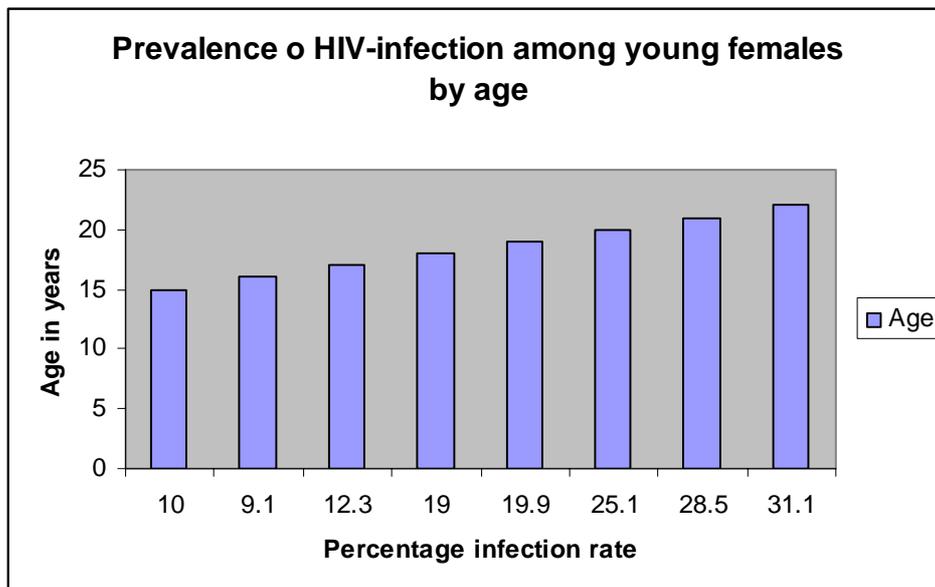


Figure 8: A graphical interpretation of Table 4.

A UNAIDS (2004a:95) report reveals that 20% of all sexually active girls between the ages of 16 and 18 in South Africa are infected. According to this UNAIDS (2004:15) report the epidemic is affecting young people, such as learners and students, disproportionately. 15-24 year olds account for 50% of all new HIV-infections. The estimated infection rates among the different age groups above may be an indication of managerial and self-

actualization problems that schools and persons affected by HIV/AIDS may face, particularly as the ages of secondary learners is between 14 and 22 (Rutenberg *et al.* 2001:1-58), as found in a survey among learners in Kwa Zulu-Natal.

The problem of managing the epidemic is compounded by the fact that, because HIV/AIDS is not a notifiable disease, the HIV-prevalence among non-pregnant women, men, newborn babies and children can only be ascertained by extrapolations from available data. Cornell (in Jeter 2000:6) put the reason for non-disclosure of HIV-status as follows “*How can the government make someone publicly reveal his or her HIV status when it has nothing to offer in return?*” This has changed since the South African government started a roll-out of anti-retroviral drugs shortly before the 2004 elections. This program however seems to be problematic and only a small percentage of AIDS patients currently benefit from this facility. The world cut-off level for treatment of AIDS patients is a CD4-count of 350 while in South Africa this has been reduced to 200, which means that the disease is much further advanced in South Africans who qualify for treatment than elsewhere. (The CD4-count is a measure of disease development; the lower the count, the sicker the patient is).

Underscoring problems with anti-retroviral delivery, Dr Kim Yong Kim, WHO Director of HIV/AIDS, voiced his concern about the delivery of anti-retrovirals in three countries: India, South Africa and Nigeria (The Lancet 2005: 365;1597). The burden of HIV/AIDS in South Africa remains great, but the distribution of anti-retrovirals remains poor. If the partnership between WHO and UNAIDS to treat 3 million AIDS-sufferers with anti-retrovirals is to reach its set targets, it needs the commitment of the South African government, as the leader in Africa, to implement its recommendations. South Africa has the infrastructure for delivery (The Lancet 2005: 365;1597). The National Teachers Association of South Africa in the mean time negotiated with seven medical-aid schemes, for better HIV-AIDS treatment for 5,000 of its 70,000 members. The schemes agreed to pay for anti-retrovirals for patients with a CD4-count of 350, equal to the international standard, thereby enabling them to live productive lives much longer (Blaine 2005:1). Hopefully this will lead to greater disclosure of serum status by sufferers. The UNAIDS report (2004a:52) says that collecting and keeping detailed HIV/AIDS data forms the basis of long-term planning to cope with the impact of the epidemic. The non-disclosure of HIV-status is one of the main reasons for the uncontrollable spread of the epidemic as people who are HIV-positive and unaware of their HIV-status

cannot take informed and responsible action to prevent themselves from spreading the virus.

2.2.2 PEOPLE LIVING WITH AIDS IN SOUTH AFRICA

The UNAIDS statistics for South Africa reveal a devastating picture of human suffering. The impact of the large numbers of individuals living with HIV/AIDS in all age groups reflects the innumeral problems facing school management in this country. The worst affected age group (15-49) includes a large percentage of learners, teachers, teacher-training students, parents, family members and secondary caregivers to AIDS orphans. Moreover, 50% of all new infections fall in the 14-24 year old age group (UNAIDS 2004a:15). The impact of this on education implies that in future, teaching strategies may need to be restructured to accommodate the vacancies in classrooms caused by affected teachers and learners. The UNAIDS fact sheet from Barcelona (2002:1) stated that:

“HIV/AIDS marks a severe development crisis in sub-Saharan Africa, the worst affected region in the world. Even if exceptionally effective prevention, treatment and care programs take hold immediately, the scale of the epidemic means that the human and socio-economic toll will remain massive for many generations.”

Figure 9 and Table 5 show the UNAIDS statistics for people affected by HIV/AIDS in South Africa by the end of 2001 (Avert 2002a: 2; UNAIDS 2004a:191).

Table 5: THE ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS AT THE END OF 2001

ADULTS		TOTAL	%	CHILDREN	TOTAL
Males	Females	Adults		0-14	adults/children
15-49	15-49	15-49		0-14	adults/children
2,000,000	2,700,000	4,700,000	20.1%	250,000	5,000,000

(UNAIDS 2004a:191). Figure 9 is a graphic representation of Table 5.

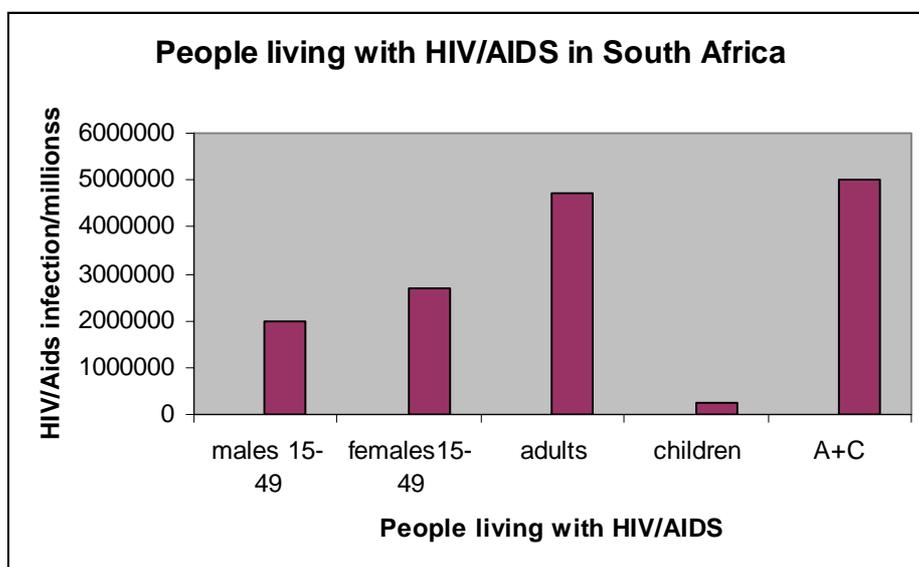


Figure 9: The figures released at the Fourth Global Report on AIDS by UNAIDS (2004a:190-194) show a marked increase in infection rates by the end of 2003. This is shown in Table 5a and Figure 9a.

Table 5a: THE ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS AT THE END OF 2003

ADULTS		TOTAL	%	CHILDREN	TOTAL
Males	Females	Adults		0-14	adults/children
15-49	15-49	15-49		0-14	adults/children
2,550,000	3,300,000	5,900,000	21.5%	350,000	6,200,000

Figure 9a is a graphical representation of Table 5a, showing the number of South Africans reported to be living with HIV/AIDS (UNAIDS 2004a: 190-194).

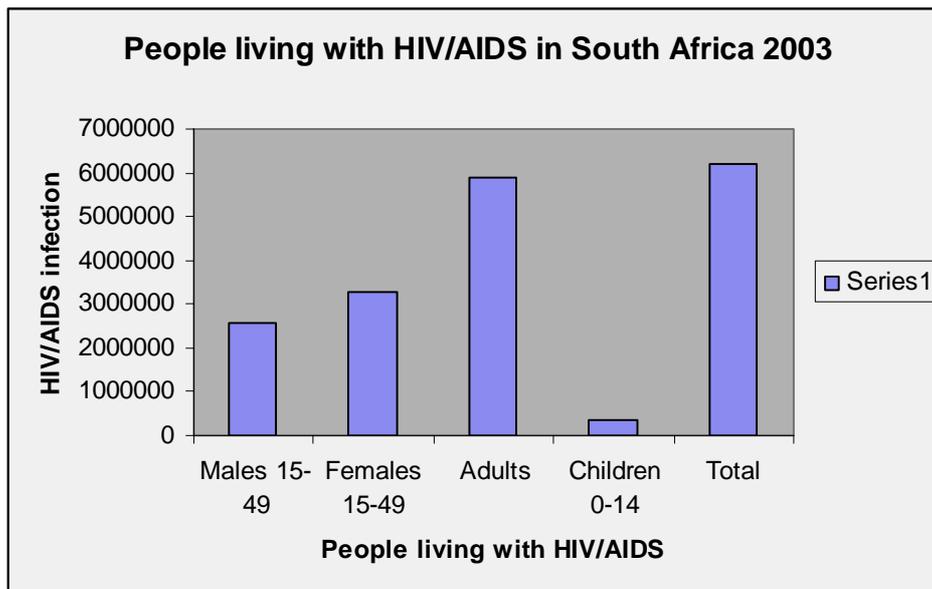


Figure 9a: Adults by definition, sexually active persons, include learners from the age of 15, and the highest rate of new infections (50%) fall in the 15-24 year age group (UNAIDS 2004a:15), indicating the managerial problems facing school principals particularly in secondary schools. School managers such as principals have to manage the needs of increasingly sick/dying learners and teachers as well as learners and teachers from households affected by HIV/AIDS. Moreover, self-actualization by definition implies physical well-being and emotional health, neither of which can be attained by chronically ill or emotionally overburdened persons (i.e. learners and teachers), a fact underscored by Caelers (2005:5) and UNAIDS (2004a:62-63).

The problems arising from the constantly spreading pandemic, must be examined with the role which the principal could play to stem the impact of the scourge on school management in areas such as teacher provision, curriculum coverage, coping with absenteeism among pupils/teachers affected by HIV/AIDS and the ever increasing numbers of AIDS orphans in need of schooling. This examination is to be found in chapter 3.

2.2.3 PROJECTIONS FOR HIV/AIDS EPIDEMIC 1997-2010

HIV/AIDS straddles the medical and social sciences, through its horrific physiological and emotional destructiveness. In order to plan a management structure for the epidemic the epidemiology of the virus must be studied from accurate data collections of the spread of the virus (Katzenellenbogen, Joubert & Karim 1997:5; Barnett & Whiteside 2003:46.)

Epidemiological data are important so that epidemics' location and its probable spread are known before a management structure is designed. It is essential to be able to predict how many people may fall ill and die, and to estimate approximately when this will happen. In education, the Department for example needs to know learner enrolment figures, and the effect of the epidemic on teacher provision (Barnett & Whiteside 2003:46). To this end a Metropolitan Life Insurance Company projection will now be examined, focusing on accuracy of prediction for the period 1997-2010.

Figure 10 represent estimates of the possible HIV/AIDS infections and deaths as calculated by Metropolitan Life Insurance Company for the period 1997 to 2010. The graph confirms the findings of the UNAIDS fact sheets (2002:1) in Barcelona. The current available statistics to the end of 2001 indicate that early estimates were far to low. By 2000 the infection rate had already exceeded the expected rate by 600,000 and it is still rising relentlessly.

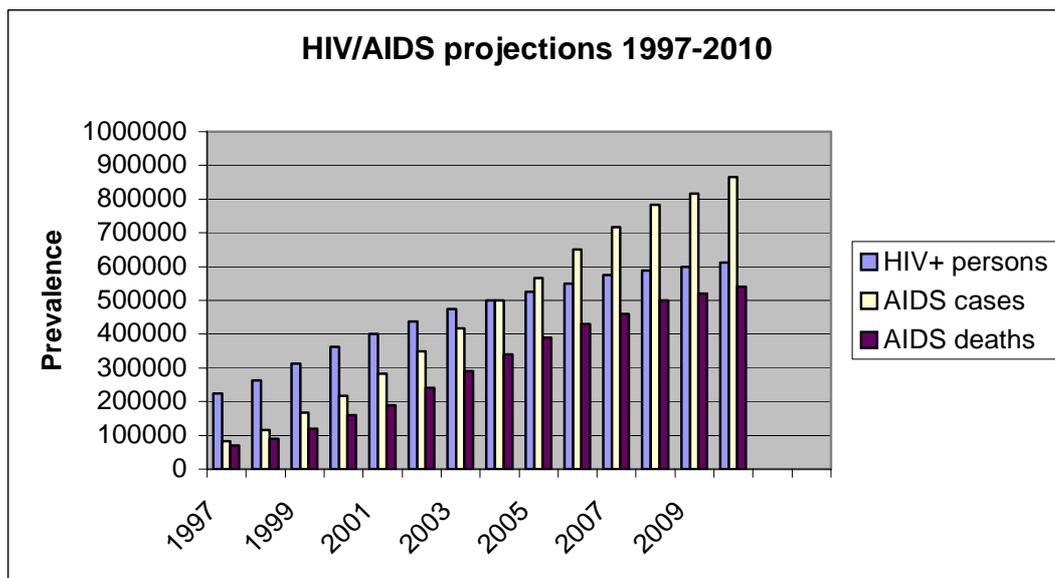


Figure 10 (adapted from Metropolitan Life Insurance Company projection sheet 1999)

Several aspects of these above projections need to be considered:

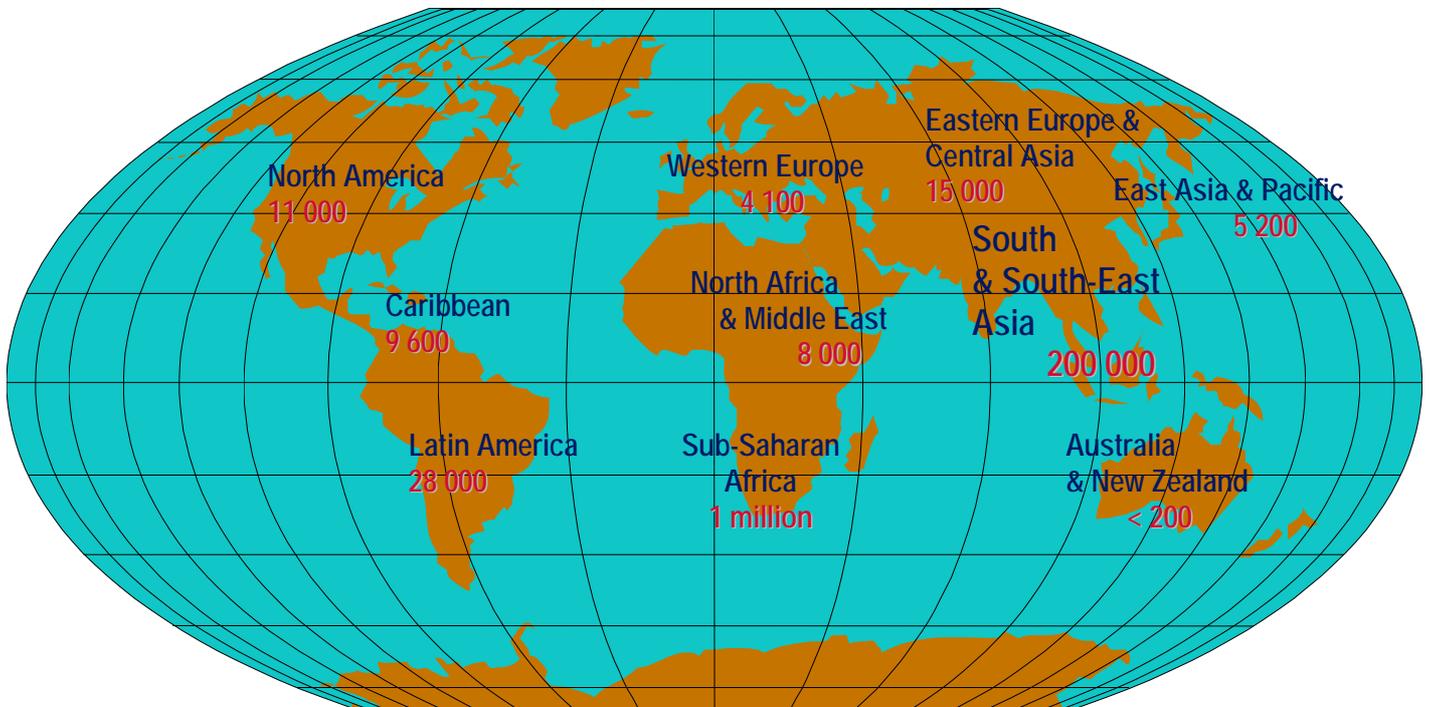
- The infection rate in South Africa is already beyond the limits of the projections, since the estimated infection rate by 2000 was a mere 3.6 million, but in reality was a staggering 4.2 million. South Africa was only expected to reach an infection rate of 4.2 million by the end of

- 2002, whereas the number of HIV positive persons in South Africa was 5 million at the end of 2001. This has increased to 6.2 million by 2005 (Health-e News Service 2005:1), which is significantly higher than the 1997 predictions.
- Another aspect of the infection rate is the fact that the number of AIDS cases and AIDS deaths were initially significantly lower than the number of HIV-positive people, but should rise relentlessly between 1999 and 2010. Thus though it appear that the number of HIV-positive persons decreases toward the end of the projection, in actual fact the incidence is still high is but offset by the increasing number of AIDS deaths. Altenroxel (2003:4) puts the current death rate among South Africans at 600 per day. The latest figures for 2004 are 900 deaths per day (News 7 Days: 5) and could rise to as many as 900,000 deaths per year by 2010 (U.N. WIRE 2003:1).
 - While in the Metropolitan model the infection rate for adults would be 22% by 2010, it was already above 20% at the end of 2001 and in the light of the situation elsewhere in Africa may well rise to 30%. (See Table 5). This would imply that eventually a total of 8 million South Africans could be infected by 2010 almost double the current figure of 5,000,000. The U.S.Census Bureau cited that as many as 37.9% of sexually active South Africans could be infected by 2010, with an annual death rate of 900,000 individuals (U.N.WIRE 2003:1).
 - Furthermore, the projected dramatic rise in the number of AIDS deaths will leave behind a crippled society and a devastated workforce, which includes the teaching corps and learners (HIV Management 2002:1,2,3).

2.2.3.1 ACTUAL HIV/AIDS STATISTICS

While the government debates the existence of HIV/AIDS and/or its causes and cures, the statistics tell a horrifying story. South Africa has become the country with the fastest growing epidemic, the largest number of HIV cases, the highest number of AIDS orphans and the highest number of children who have lost their teachers because of AIDS (see Tables 5 and 5a). In sub-Saharan Africa AIDS affected more than 24 million adults and 1 million children by 1999 (see Figure 11) of which 4,200,000 were South Africans. By December 2002, as mentioned before the number of South Africans infected with HIV was estimated at 4.7million (See Table 4 and Figure 8), which increased to an estimated figure between 6.29 million and 6.57 million (Health-e News Service: 1). Moreover, South Africa is currently home to a reported 2.3 million AIDS orphans, which is expected to rise to 3.1 million by 2010 (UNAIDS 2004a:61).

**CHILDREN (<15 YEARS) ESTIMATED TO BE LIVING WITH
HIV/AIDS AS OF END 1999**



Total 1.3 million

Figure 11: UNAIDS (2000b)

95,000 South African children were infected with HIV at the end of 1999 according to a UNAIDS and WHO update (2000). By the end of 2001 the infection rate for children between 2-14 years of age rose to 250,000, and by December 2002 it was 263,200 (5.6%). By 2004 this figure stood at an estimated 340,000 (UNAIDS 2004a:192). Infected youths (learners) aged between 15-25 numbered 437,000, that is 31.4%, (Journ-aids 2003:1). The current figure could be as high as 500,000 for secondary school learners in South Africa, according to Naidu (2005:2). These figures represent a large percentage of school learners in South Africa, and confirm the management dilemma faced by school principals who are expected to deliver quality education to sick, dying, emotionally disrupted and orphaned learners.

Furthermore, 250,000 South Africans died in 1999 according to the UNAIDS update (2000). These figures have increased dramatically since 1999, as the graphs above indicate (Figures 4-10). According to current statistics, AIDS will account for 44.7% of adult deaths in 2002. This will increase to 78.6% by 2010. The disease will kill an estimated 194,892 in 2002 and 719,098 by 2010 (Cohen 2003:2). U.N.WIRE (2003:1) puts this figure at 900,000. Researchers estimate that AIDS could kill as many as 7 million South Africans by 2010 (Cohen 2003:1). A third of all deaths in 2001 could be ascribed to HIV/AIDS (Ananova 2001:1). Moreover, 4000 teachers died of HIV/AIDS-related illnesses in South Africa in 2004 (Khangale 2005:1).

Journ-aids (2003:1) gives the 2002 global AIDS deaths as 3.1 million, of which 2.5 million were adults, 610,000 were children under 15 and 2.5 million were woman. The implication for education speaks for itself. In South Africa the situation looks bleak. According to Altenroxel (2003:4), 600 South Africans die of AIDS-related causes each day, while News 7 Days (2005:5) puts the figure at 900.

In Kwa Zulu-Natal, 55 teachers die each month (De Bruin 2003:1-2). According to the University of South Africa's Bureau of Market Research (BMR), HIV/AIDS could slash 12 million off South Africa's population growth by 2015 (SABC news 2003:1). From 1997 to 2001 22.5% of deaths among 15-29 year-old females, and 8.5% of deaths among 15-29 year old males were due to AIDS (SABC news 2003:1). Dorrington *et al.* (2003:1-3) make it clear that in 2000 40% of deaths in the 15-49 year age group were due to AIDS, 20% of all adult deaths were due to AIDS and when combined with childhood deaths, it is estimated that AIDS accounted for 25% of all deaths in South Africa. (See Figures 9 and 9a and table 5 and 5a). Galloway (2001:2-4) notes that there has been a steady increase in AIDS related deaths in South Africa from 10% in 1995 to 40% in 2000/2001. Registered adult deaths in South Africa increased from 272,000 in 1998 to 456,000 in 2003 (Bradshaw *et al.* 2004:278-279). (See figure 12). UNAIDS (2004b:25) shows that registered adult deaths in South Africa increased by 40% and in the case of woman in the 20-49 age group by 150% (UNAIDS 2004b:25).

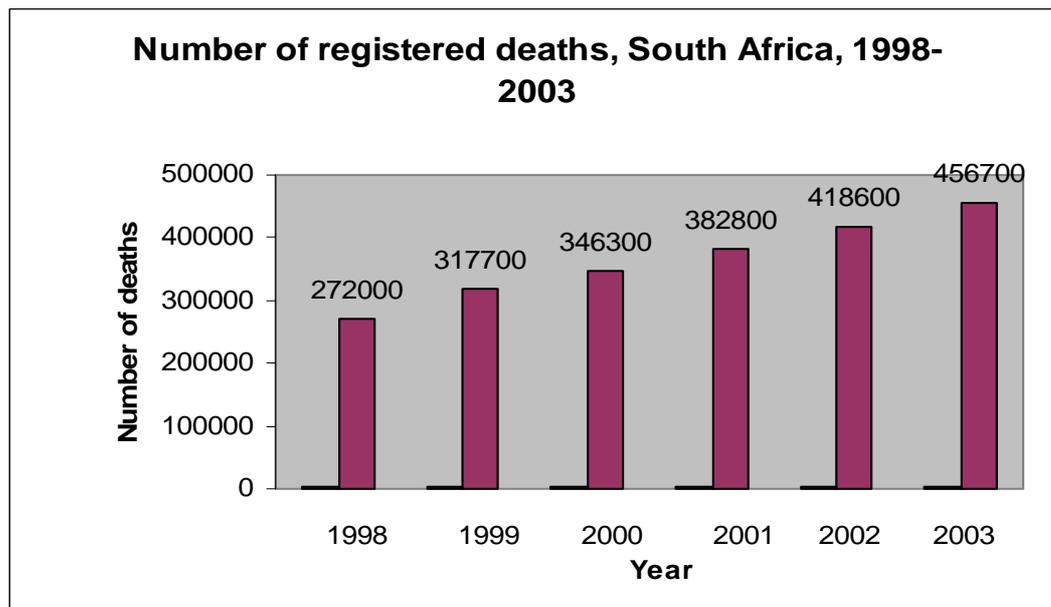


Figure 12: A graphic representation of adult deaths in South Africa between 1998 and 2003 (adapted from Bradshaw et al. 2004:278-279)

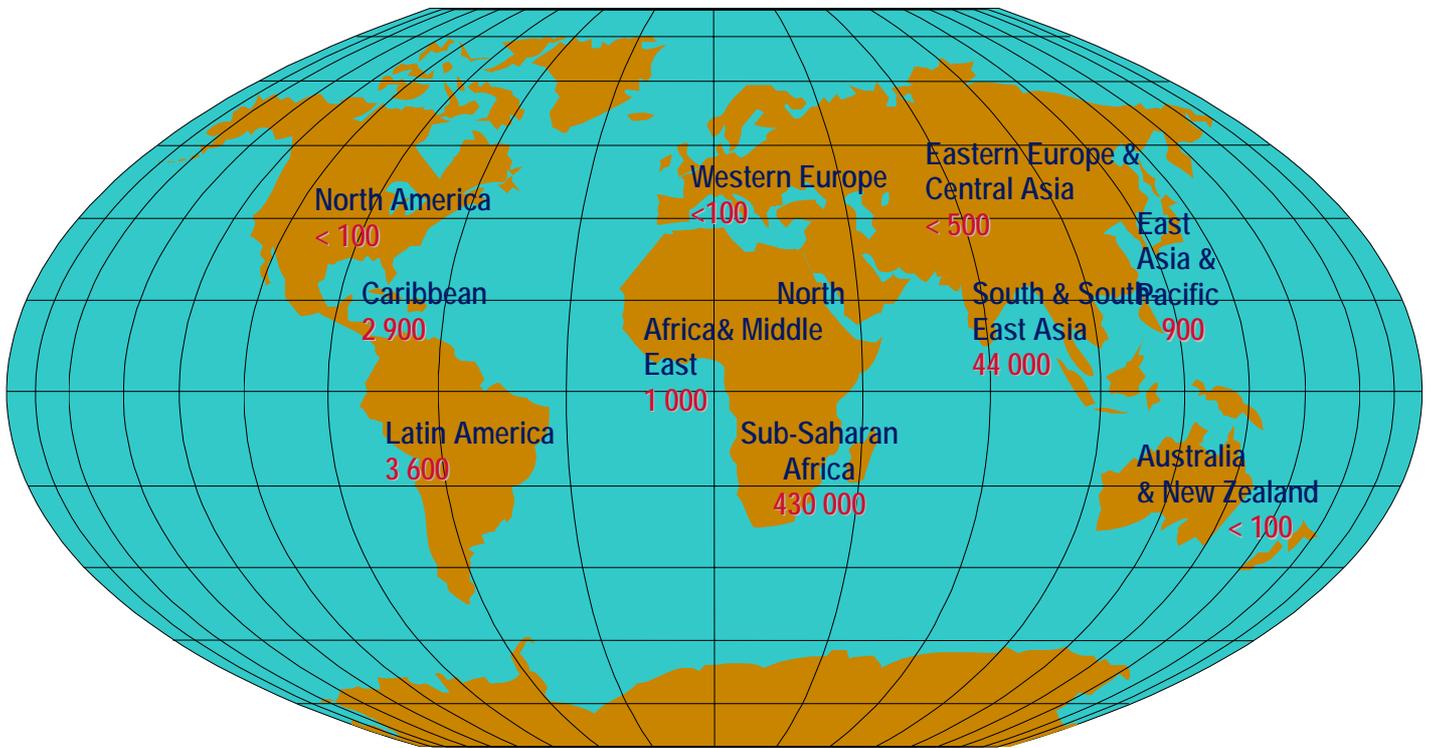
The statistics make it clear that school management and planning may face an impossible task, namely to deliver quality education to young South Africans in the face of HIV/AIDS.

There were about 15,000 new HIV infections a day in 1999, of which

- More than 95% were in developing countries,
- 1,700 were in children under 15 years of age,
- About 13 000 were in persons aged 15 - 49 years, of whom:
 - Almost 50% were women
 - About 50% were 15–24 year olds.

The infection rate of South Africans was 1,600 daily by 2000 - the highest number worldwide (UNAIDS update 2000). Half of all new infections are in Southern Africa and 10% of new infections worldwide, in South Africa, now experiencing the fastest growing AIDS disaster in the world (The Whitehouse report 2000:1). The number of people newly infected with AIDS rose to 5 million in 2002, of whom 4.2 million were adults, including 2 million women and 800,000 children (Journ-aids 2003:1). Tables 2 to 5a highlight the increasing prevalence in South Africa.

ESTIMATED DEATHS IN CHILDREN (<15 YEARS)
FROM HIV/AIDS DURING 1999

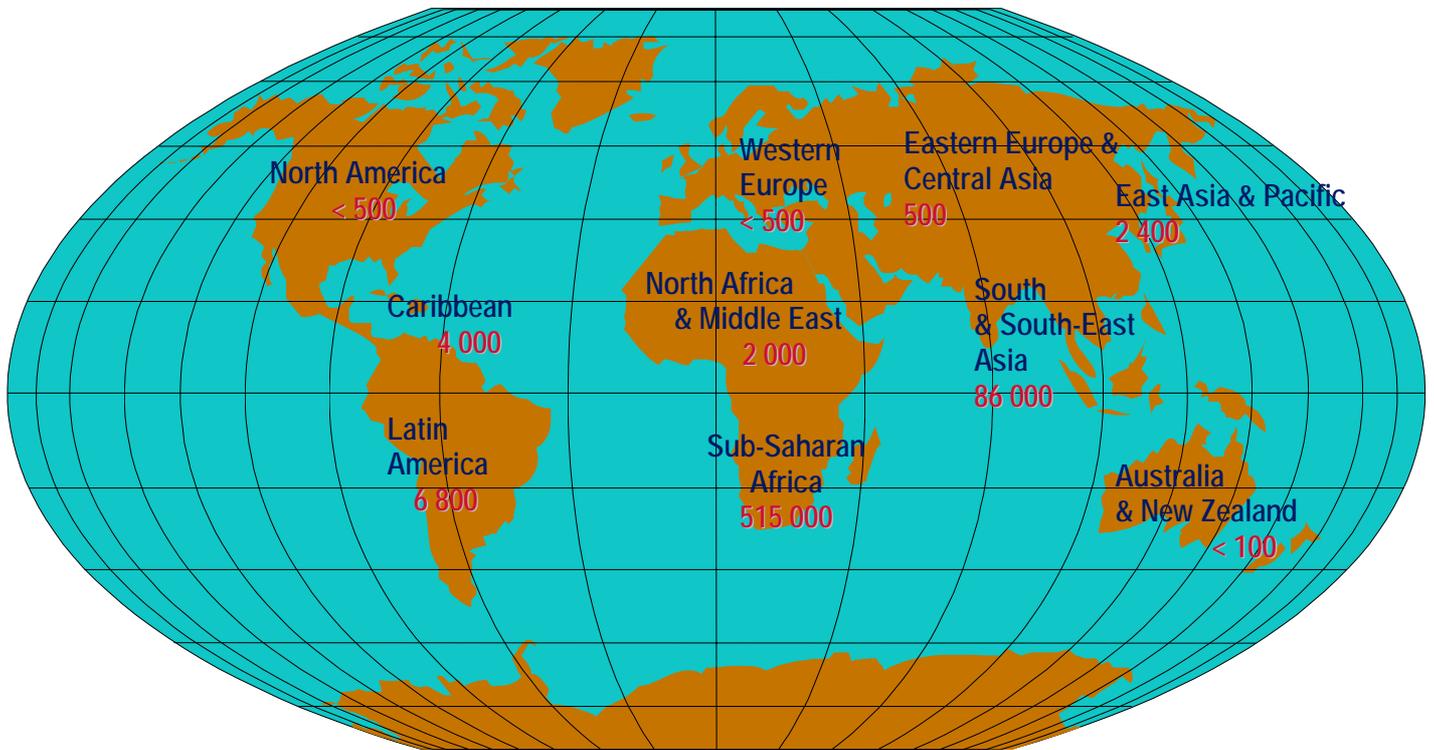


Total: 480 000

Figure 13: (UNAIDS update 2000).

The number of child deaths due to AIDS rose to 610,000 (Journ-aids 2003:1).

ESTIMATED NUMBER OF CHILDREN (<15 YEARS)
NEWLY INFECTED WITH HIV DURING 1999



Total: 620 000

Figure 14: (UNAIDS update 2000)

According to Journ-aids (2003:1), the number of children infected with AIDS by December 2002, was 800,000. The number of children infected with AIDS living in South Africa was 263,200. The UNAIDS update for 2004 (2004b:1) put the number of newly infected children at 750,000, of whom 340,000 were living in South Africa (UNAIDS 2004a:191). This excludes the possible 500,000 secondary school learners who could be infected (Naidu 2005:2) as they are regarded as adults and included in adult statistics.

THE NUMBER OF CHILDREN ESTIMATED TO HAVE BEEN ORPHANED BY AIDS AT AGE 14 OR YOUNGER BY THE END OF 1999

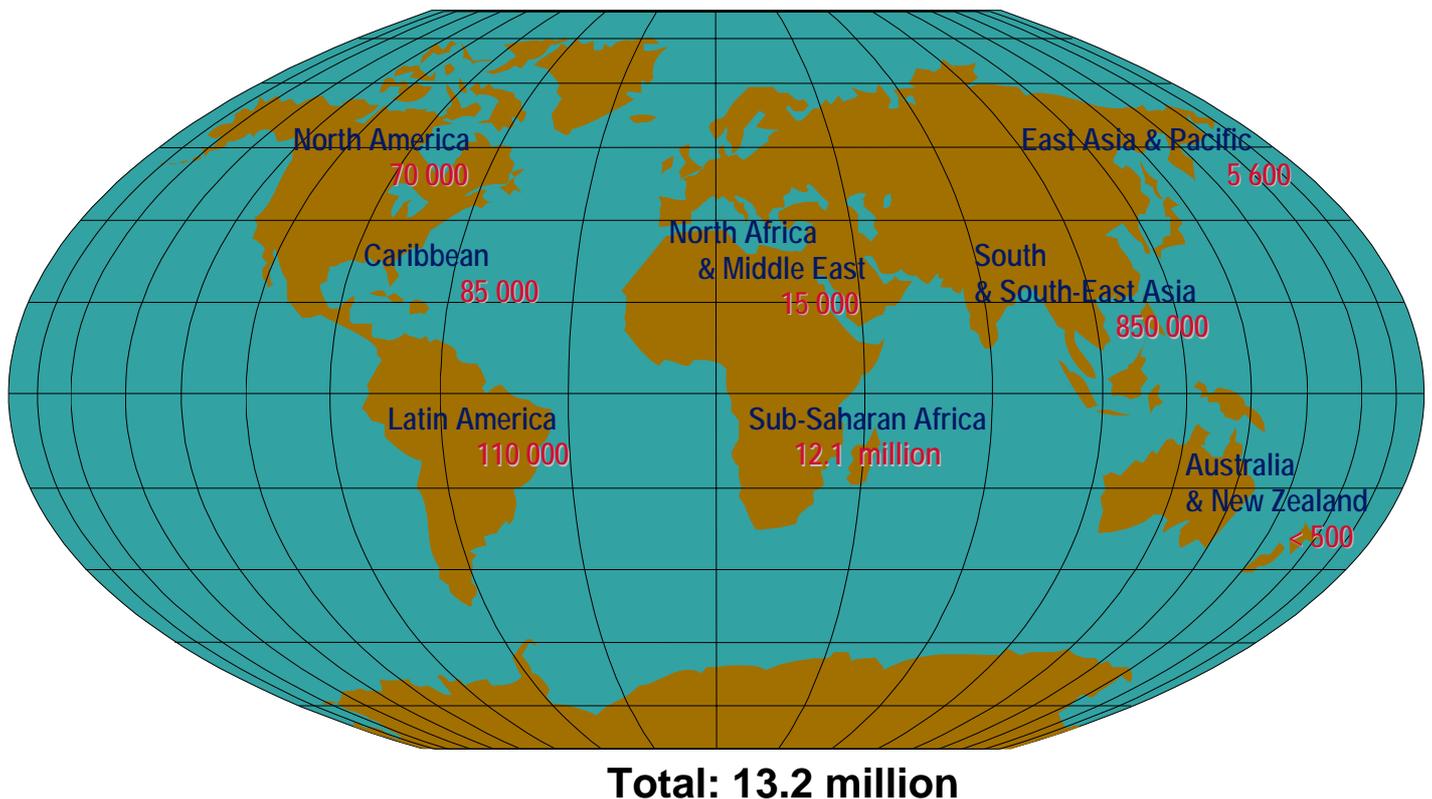


Figure 15: (UNAIDS update 2000)

Of the estimated 12.1 million orphans in sub-Saharan Africa 420,000 was South African as stated above. In South Africa the number of orphans rose to a staggering 2.3 million in 2003 and is expected to reach 3.1 million by 2010 (UNAIDS 2004a:61) this represents 17% of all South African children. One of the most frightening aspects of the AIDS pandemic is the number of children/learners orphaned by AIDS. These children/learners lack the most basic needs for survival; with their need for food and shelter not met schooling is not possible. In the face of the AIDS pandemic these orphaned learners present one of the biggest challenges to the principal, since because of their disadvantaged living circumstance they have to fend for themselves and often for younger siblings as well. The HSRC found that children headed 3.3% of households, representing 1 million people in 300,000 South African households, less than 18 years of age, some of whom were as young as 8 years of age (Battersby 2003:1).

It is estimated that by 2010 25% of all children in sub-Saharan Africa will be orphaned by AIDS. The majority of these will be living in South Africa. UNAIDS (2004a:61) estimates that by 2010 17% of South African children could be orphaned. In 1999 there were an estimated 370,000 living orphans in South Africa (UNAIDS update 2000:1), the and figure for 2003 is 2.3 million and still increasing (UNAIDS 2004a:61)

2.2.3.2 CONCLUDING REMARKS REGARDING HIV/AIDS IN SOUTH AFRICA

Considering the devastating statistics currently available, the South African government's lack of urgency concerning the battle against HIV/AIDS is cause for concern. The government has persistently refused to present a global treatment plan with time frames for implementation. The Treatment Action Campaign (TAC) has in fact laid charges of culpable homicide against the Ministries of Health and Trade and Industry for failing to use state resources in the fight against AIDS (Lombard 2003:13).

The Minister of Health advocated a food combination recommended by AIDS-dissidents to boost the immune systems of AIDS sufferers. The Health Minister reported to the parliamentary Portfolio Committee on Health that AIDS dissident Dr Roberto Giraldo, known to question the link between HIV and AIDS, recommended a combination of garlic, onions, African potatoes and virgin olive oil to combat AIDS (Moodie & Van Rooyen *et al.* 2003:13). Local researchers maintain that there is no scientific basis for a nutritional cure for AIDS (Moodie & Van Rooyen *et al.* 2003:13). In fact, Dr Roy Kennedy of the Medical University of Southern Africa, who produced national guidelines on nutrition and HIV/AIDS for the Health Department in 2001, confirmed that there are no (proven) studies available that any specific food helps to fight the HIV virus in the same way anti-retroviral drugs do. Moreover, organic chemistry professor Roger Hunter of Cape Town University said garlic could not promote the immune system but only protect it. However, if garlic is to have any effect it has to be eaten raw in large quantities daily. Nutritionist Marianne Visser says the only oil with a possible immune stimulating properly is fish oil and the tests are inconclusive. Olive oil can at best be an energy source for ill patients (Moodie & Van Rooyen *et al.* 2003:13). Furthermore, studies on the African potato were stopped ten years ago after researchers found that it damaged bone marrow in the long term, according to Professor Patric Bouic of Stellenbosh University's immunology department (Moodie & Van Rooyen

et al. 2003: 13) and therefore causes immune suppression, which is already a problem for people who are HIV-infected.

Considering the statistics and these facts, this study aims to highlight the possible difficulties principals and other educational managers may encounter in the face of the ongoing HIV/AIDS pandemic. Particular attention will be given to the impact of:

- AIDS on society,
- Teachers affected by HIV/AIDS,
- Learners affected by HIV/AIDS,
- AIDS orphans and their problems,
- The effect of drug abuse on the spread of HIV infection in schools,
- Sexual abuse of learners on the spread of HIV infection in schools,
- The effect of gender inequality on the spread of HIV/AIDS,
- Absenteeism of learners and teachers affected by HIV/AIDS and
- The role of the principal to combat the effect of HIV/AIDS in schools.

2.3 THE IMPACT OF AIDS ON SOCIETY AND EDUCATION

2.3.1 GENERAL IMPACT

Already in 1993 it became clear that HIV/AIDS could become an educational management crisis if structures were not put in place to combat the effect of the disease (see chapter 1). Although the HIV/AIDS infection rate in 1993 was a mere 2.5% (Granelli 1999:4), the consistent denial that AIDS exists and /or was a plot against Africa, from the eighties to date, hampered efforts to stem the spread of the disease (Haffajee 2002:1-2; Swarns 2002:1-4). As acting head of department for education and school management, as well as senior lecturer in biology, the researcher suggested an AIDS education program at the Transvaal College of Education, and offered to present it in 1993. It became clear that misinformation and denial among the students could present a future problem. Permission for the program was unfortunately denied. It was already obvious in 1993 that education lay at the core of eradicating denial, misinformation and myths about AIDS. The failure to acknowledge the need for information led to a whole generation of new school teachers being sent out to teach lacking the basic knowledge to protect themselves and their learners from AIDS. Professor Mwamwenda, Dean of the Faculty of Education at the University of Transkei, confirmed the imminent chaos HIV/AIDS could cause in education in his book *“Educational Psychology an African Perspective”* (Mwamwenda 1996:180-182). HIV/AIDS could cripple not only education

but the economy of South Africa as well. AIDS is mowing down the economic core of society comprising adults between the ages of 15-49.

The cost involved in training teachers/learners/students, and in coping with the emotional upheaval, deprivation, loss of security and nurturing caused by the impact of HIV/AIDS, cannot be estimated. Before looking at the cost already incurred by the supply side of education (materials and teachers), it is necessary to have an overview of the perceived cost to the country to date and in the future.

The president of the Medical Research Council, Professor Maleguru Makgoba, presented the presidential advisory committee on AIDS with the following data in 2000 (Taitz 2000:1-2). Prof. Makgoba noted that available statistics for 1990 and 1999/2000 proved that AIDS was taking a devastating toll among South Africa's most economically productive citizens, which includes both learners and teachers. According to Makgoba, the number of South Africans dying before the age of 50 has doubled from 1990 to 2000. These are not only the economically most productive people, but also pay the bulk of the taxes, money which is needed to pay for among other things teachers, salaries, books and school buildings, and subsidies for learners affected by AIDS. Makgoba reported that the only other thing that could explain the high number of youthful deaths would be a major war (Taitz 2000:1; Thom 2003:1-3).

Makgoba (Taitz 2000:1) states: "*something is decimating our people. If you look at the changes in death patterns... you can see what use to happen before AIDS became an issue in South Africa.*" The death rate has risen since 1994, despite better access to health care and improvement in the quality of life of most South Africans. Makgoba (Taitz 2000:2; Galloway 2001:2) made it clear that in any normal population you expect the old to die, not the young – but in South Africa you have young people dying, with young women dying earlier than young men; "*which is unheard of in biological terms.*" This could only be ascribed to the peak in the incidence of AIDS, a fact which is confirmed by Thom (2003:1). Furthermore, Sidley (2002:2) claims that 25% of South Africans are HIV-positive and that between one half and three quarters of people between the ages of 15-49 will contract AIDS and die from it. Moreover, Alan Whiteside (Taitz 2000:2), a health economics researcher at the University of Natal, says the full impact of AIDS will only unfold over the next years, which will have a devastating effect on all sectors of society including education.

The cost of AIDS is staggering. An estimated R7.2 billion was spent on educating those of a productive age who died of AIDS in 1999-2000. These include teaching professionals. It is estimated that by the end of 2003 12% of highly skilled workers, 20% of skilled workers and 27.2% of low skilled workers will be infected with HIV, according to a study undertaken by ING Baring (Taitz 2000:2; Creativepr: 2003:3). It costs an estimated R250,000 to replace every skilled labourer who can no longer work or has passed away. In fact, according to a Secure the Future (2000:2) report, HIV/AIDS will cost South Africa 1% of its gross domestic product by 2005 and consume 75% of the country's health budget.

Moreover, medical aid claims are expected to rise rapidly and some schemes could face bankruptcy. Besides this, it will cost the public health sector R16,000 a year to treat each AIDS patient. Eskom alone estimates it will have to spend R400 million annually on pensions, medical aid, lost productivity and recruitment of new workers, should the pandemic not be curbed (Taitz 2000:2; Lakay 2001:9) An ANC MP, who refused to be named, confirmed this and stated: “ *We're seeing death in our constituencies week after week,*” (Haffajee & Bissiker 2002:1).

The health and welfare sectors are feeling the impact due to the number of children who are orphaned as a result of HIV/AIDS and are becoming a burden for the state. Moreover,, most admissions in medical wards are due to HIV/AIDS, and people are being pushed deeper into poverty when family members become affected by AIDS or fall ill (Creativepr 2003:1-3).

Nelson Mandela underscored the AIDS tragedy in a February 1997 address to the World Economic Forum when he stated that:

“AIDS kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern countries... It creates new pockets of poverty when parents and bread winners die and children leave school earlier to support the remaining children” (Secure the Future 2000:1).

A UNAIDS (2004a:61-63) report confirms this statement indicating the devastation caused in societies and families by the epidemic. The impact of HIV/AIDS on society, and by implication on school management and self-actualization of affected learners, teachers and principals, cannot be over-emphasized. A report titled “*Impact of AIDS on the economy*” (Creativepr 2003:1-3) underlines the following issues with regard to the HIV/AIDS pandemic in South Africa:

- The epidemic is still growing and will only peak by 2010;
- The increasing illness and death due to HIV/AIDS will effect individuals, families, communities, public health sectors and employees, by implication also schools, school managers, learners and teachers;
- HIV/AIDS has its most devastating impact in the poorer communities, increasing the burdens on already over burdened households (van Aardt 2003:1-3; Creativepr (2003:1-3). Mandela (Secure the Future 2000:1) stresses the effect this had on learners, who can no longer attend school because of dire need. It stands to reason that teachers affected by AIDS would face the same devastating dilemma.

According to Jeter (2000:1-7), AIDS threatens to slow down social change and undo economic development with the staggering costs of caring for the sick, the dying and those they leave behind. Amid this chaos it is the pivotal role of the school principal and his/her management and leadership skills that will be of supreme importance in coping with the impact of HIV/AIDS in school management.

2.3.2 THE IMPACT OF AIDS ON EDUCATION

The impact of HIV/AIDS will most certainly be felt in the education section, as more and more resources have to be channelled to cope with the health impact of AIDS. This will cause disruption in school management and place a greater burden on the principal to deliver effective schooling, particularly in the poorer rural schools. In most societies, the local churches and school form the centre of the society, and so anything that affects the society will have a ripple effect in both church and school and vice versa, destabilizing society as a whole.

The education sector will feel the impact of HIV/AIDS for several reasons according to a Creativepr report (2003:1-3), which is confirmed by reports from UNICEF (2000:2), Lackay (2001:9) and Secure the Future (2000:1-2). Many education ministries are adding HIV-prevention programmes to their curricula, i.e. the Department of Education's Life skills Programme in South Africa, which forms a valuable part of AIDS response. However, few are looking at the epidemic's impact on the education system as a whole, and implementing appropriate action in their school-management strategies (UNAIDS 2004a:51). AIDS is currently causing problems in education due to:

- Illness and death of teachers, which cause a high teacher turnover; disrupting continuation of quality instruction (UNICEF 2000:2;
- The orphan crisis, which implies that some children will have to drop out of school due to lack of finances and to look after younger siblings (Lackay 2001:9; Secure the Future 2000:1; UNAIDS 2004a:61-63);
- Infected learners, who cause a further decline in the number of students passing matric. This will be in spite of improved public expenditure on education. Matari (2001:9) reports a drastic decline in matriculants, which is confirmed in Lackay (2001:9). Moreover, because a school is essentially an economic unit, funded with public money, and dependent on an economically active age group (learners/teachers) where HIV/AIDS infection is at its highest level, illness and death will lead to a decline in effective delivery of the end product, namely quality education. Naidu (2004:1) says enrolment figures will decline in future as a direct result of HIV/AIDS, and indeed have already declined dramatically from 1990-2000. Schools and the education department will feel the direct and indirect systemic costs of HIV/AIDS (Creativepr 2003:2-3).

Direct costs to the Education Department/schools could include a rise in cost of benefits such as:

- Medical aid/health insurance,
- Disability insurance,
- Pension funds,
- Death benefits/payouts,
- Funeral expenses and
- Subsidized loans.

Also adding to costs are:

1. The escalating cost of recruitment:

- *Recruitment and retraining expenses of new teachers, admin and support staff,*
- *Cost of having vacant positions and*
- *Cost of temporary staff to fill vacant positions while looking for suitable replacements.*

2. The increased cost of training:

- *Training larger numbers of new teachers to fill vacant posts,*
- *Increase in service training cost, to fill vacancies and*
- *Salaries for temporary staff and under-trained replacements*

3. HIV/AIDS prevention and information programs:

- *Direct cost of programs (materials and training staff and*
- *Time lost by teachers on training courses.*

The indirect cost of HIV/AIDS to the school system includes the following:

- **Absenteeism** among pupils and teachers due to:
 - sick leave (teachers, admin and ground staff), illness (learners),
 - compassionate leave to take care of sick family members (teachers, admin and ground staff and learners),
 - bereavement and funeral leave (teachers, admin and ground staff and learners), and
 - leave to care for dependants (parents/siblings/children) with AIDS (teachers, learners and admin and ground staff).

While absent staff members need replacement and moral support, learners present a more subtle problem. They need repetition of work, extra lessons to catch up lost work, particularly in already-overburdened science and mathematical subjects. This could present principals with an increasingly difficult management task, in their efforts to deliver quality education.

The way in which HIV/AIDS will impact on educational role players takes on many forms, depending on the severity of the problem at any given school, and may include the following adverse conditions:

- **Morbidity** on the job, with resulting lack of self-actualization possibilities and reduced performance standards of all role players, due to HIV/AIDS illness and/or stress caused by caring for ill dependents;
- **Over extension of management resources**, including the role of the principal and heads of department should the holders of these jobs be ill. Strains on resources include: The principal's time and effort to respond to workforce constraints caused by AIDS;

impacts on the time available for normal planning and running strategies of the school since this time must now be spent on planning, preventing the spread of the virus and caring for HIV/AIDS-affected members of the school society (learners, teachers, admin and ground staff, parents of ill learners and orphans; Legal and human-resource staff for HIV-related policy development and problem-solving strategies, which will add to the cost of schooling in affected communities. (Kruger & Steinman in Van Deventer *et al.* 2003:16; Van der Merwe in van Deventer *et al.* 2003:52-54).

- **Systemic costs**, including a loss of cohesion in the school setup due to reduction in morale, motivation and concentration amongst affected learners and teachers. Work schedules become disrupted because of absenteeism of staff and learners, causing learners and teachers to fall behind schedule, adversely affecting academic outcomes and self-actualization of role players. Furthermore, the resulting indiscipline and unauthorized absenteeism of affected individuals in the school system relates to poor academic outcomes in affected schools, which in turn increases the burden on management structures in these schools (Mwamwenda 1996:311-317 and 180; Badenhorst & Kruger in Badenhorst *et al.* 2003:87-95; Creativepr online 2003:1-3)

Barnett and Whiteside (2003:249-270) confirm these findings that calculating the impact of HIV/AIDS on large organizations such as education systems is not simply an accounting exercise. Research indicates that the impact goes far beyond monetary cost, creating problems with management and service delivery and a drop in the demand for education.

In conclusion, it can be said that the impact of HIV/AIDS on education has far-reaching implications for development. Globally, AIDS has become a significant obstacle to the goal of universal access to primary education by 2015 (UNAIDS 2004a:51). Furthermore, an estimated 1 billion US dollars per year is the net additional cost calculated to offset the impact of HIV/AIDS on global education, i.e. to cover the costs of losing teachers, teacher absenteeism and the cost of keeping growing numbers of disrupted children and orphans in school (UNAIDS 2004a:51).

2.4 THE PROBLEM OF TEACHERS WITH HIV/AIDS IN SOUTH AFRICAN SCHOOLS

This section will probe the possible effect of teachers with HIV/AIDS on learning outcomes and school management in South African schools. Attention will be given to the role of the principal in alleviating the effects of teacher absenteeism, illness and death on learning outcomes and self-actualization in affected schools.

Considering the large numbers of people infected with HIV/AIDS in the 15-49 year age group, 5.9 million according to the latest 2004 UNAIDS update report, as well as an estimated 354,000 children between the ages of 2-14, it stands to reason that both teachers and learners as well as members of their families and support staff at schools could be infected with HIV/AIDS, thereby reducing their ability to function optimally in schools and society. Moreover, UNAIDS (2004a:51) stresses that teachers and lecturers belong to the worst HIV-affected group, and Naidu (2005:2) reports that 500,000 secondary school learners in South Africa would be infected and could die before the age of 30.

According to a report by Avert (2002c: 1-3) the effect of AIDS on education has become so serious that it threatens the coverage and quality of education. Furthermore, the provision of quality education is threatened by a shortage of teachers (Avert 2002c:3). Avert maintains that teachers are dying of AIDS, leaving vacancies in schools. Furthermore, Mwamwenda (1996:180-186), Creativepr (2003:2-3), and Caelers (2005:5) agree that many teachers who are ill or have to tend to sick relatives are unable to cope with their teaching responsibilities, because they feel depressed by the impact of HIV/AIDS on their lives, leaving the principal as school manager with an increasing managerial dilemma.

Research indicates that the managerial costs of HIV/AIDS for education include absenteeism, lost productivity, hospitalisation and replacing workers/teachers affected by AIDS. Barnett and Whiteside (2003:202) stress that not only has AIDS increased teacher deaths, but also teachers are difficult to replace, and furthermore, teachers' illness leaves classes untaught for extended lengths of time, due to problems with finding suitable replacements. These factors impact negatively on school management, academic performance and self-actualization. HIV-infected employees cost companies, and by implication education, between 2% and 6% of salaries (labour costs) annually (Jordan 2002b:3). Dr Jack van Niftrik, medical director of Lifeworks, who specializes in managing AIDS in the work place,

underscores the above, stating that without proper AIDS management, companies will die (Jordan 2002b:3). It can be assumed that the same applies to the management role of school principals. Should the principal fail in his/her task as leading HIV/AIDS manager, academic achievement could be adversely affected, which impacts negatively on the self-actualization potential of both teachers and learners. UNAIDS (2004a:52) confirms the fact that without long-term planning it will be difficult to maintain school enrolment targets, which as Naidu (2004:1-3) reports are steadily declining, and also the numbers of teachers employed by the state.

Although reliable figures on teacher mortality rates are not readily available, due to the fact that HIV/AIDS is not a notifiable disease, available statistics show a marked increase in teacher mortality. While Otto (2001:2) refers to "*startling rates of infection*", Pretorius reports (2002a:9) that an increase in teacher mortality will worsen the existing shortage in key subjects such as mathematics and science. Engela (2003:13) illustrates the serious problem that exists in specialized subjects, stating that of the 305,774 matriculants that passed at the end of 2002, only 75,048 obtained university entrance, of these 20,528 passed mathematics on higher grade and 20,888 passed science on higher grade. The alarming statistic is exacerbated by the number of teachers who are reported to be HIV-positive, according to Pela (2001:1-2), who states that "*Up to one fifth of teachers test positive*". Pela reports further that as many as 16% of teachers in most provinces and up to 20% in Kwa Zulu-Natal (KZN) are positive. This percentage is much lower than the antenatal averages given in tables 2-5, and the incidence may well be higher. Dr John Wright in fact suggested that Kwa Zulu-Natal should be declared a disaster area (Clarke 2002d:12). Pela (2001:1-2) reports further that 8% of principals and heads of department were infected with HIV at the end of 2000. The fact that 8% of school leaders are infected with HIV/AIDS further complicates the problems faced by school management. If one accepts that the same percentage of school board and other educational managers could be HIV/AIDS-affected or infected the problem takes on an even more serious character.

De Bruin (2003:1-2) agrees in a report stating that the AIDS pandemic could cause a serious educational crisis in Kwa Zulu-Natal within the next few years. Research figures showed that by 2010 Kwa Zulu-Natal could face a teacher shortage of 60,000, should the current death rate due to AIDS continue. The chaos this would create in schools speaks for itself. Research by Health Economics and HIV Research (Heard) at the University of Natal indicates that more than 55 teachers a month died of AIDS during 2000 (De Bruin 2003:1). This is confirmed in reports by Ananova (2003:1) and

Agence France-Presse (2001:1), that the South African Democratic Teachers Union (SADTU), which represents 216,000 teachers, lost 1011 teachers due to HIV/AIDS between June 2000 and May 2001, which is almost 3 (2,76) daily. The average age of the teachers was 39 years old, according to the AFP report. This represents the experienced teachers, probably including heads of department and young principals who represent the future leadership structure of schools. Education ministry officials undertook to look into these figures (Ananova 2003:1). Since then the death rate among teachers has increased to 4000 (11 per day) in 2004 (Khangale 2005:1). Pela (2001:1) reports that “*the Department of Education has been caught napping by the marauding scourge of the pandemic*”. This is confirmed by De Bruin (2003:1), who reports that the average age of teachers dying from AIDS is 36, 3 years younger than the SADTU report. According to De Bruin, there has been a 70% increase in mortality amongst female teachers aged between 30 and 40. This in itself spells out a social tragedy of immense proportions. South Africa is not only losing teachers. In education alone it is losing teachers, mothers and daughters, leaving behind young and often sick children, needing others who could well be from the teaching fraternity to tend to their needs, creating an increasing management dilemma in schools and education in general. Caelers (2005:5) reports further that of the 4000 teachers reported to have died from AIDS-related illnesses in 2004, a quarter were between 25 and 34, which means that South Africa is losing its youngest teachers, those who were trained to carry the profession for the next 20 to 40 years. The young age of the dying teachers is an indication that the very backbone of the teaching fraternity is being eroded, a fact that points to a devastating management dilemma for South African education.

Considering the 1999 figures, it becomes clear that Kwa Zulu-Natal would have to train at least 60,000 teachers by 2010 to supply in the demand for teaching staff (De Bruin 2003:1). This means that between 5,500 and 6,000 teachers a year will have to be trained at a cost of approximately R100,000 each (De Bruin 2003:1) for Kwa Zulu Natal alone. The possibility of attaining this seems remote. Jansen (2004b:1) warns that South Africa will be facing a serious teacher shortage over the next five years, since South Africa needs at least 20,000 newly qualified teachers annually, while the 25 higher education institutions are turning out only 5000 per year, which does not even cover the need in Kwa Zulu-Natal. Adding to this the fact that 5000 teachers leave the profession annually (Engela 2003:13), and a further 4000 died in 2004 (Khangale 2005:1), it becomes clear that education in South Africa is faced with a management dilemma of disastrous proportions. Moreover, according to a fiscal report on service delivery in education (Engela 2003:13), a total of R8.2 billion has been set aside for education of

which most will be for improved support structures for learners, such as textbooks and stationary. Rising staff expenditure has been curbed, which points to a lack of insight with regard to the impact of AIDS on teacher provision. The department and teacher trade unions in fact agreed on the rationalization of teaching posts and staff expenditure in 1999 (Engela 2003:13). (The possible effect of this on management and planning will be probed in depth in chapter three, which deals with the effect of AIDS on school management.)

According to the fiscal report, learner numbers in 2003 reached 11.9 million and the teacher-learner ratio was decreased to 1-32. This statistic contradicts independent reports of 5000 teachers leaving the profession annually (Engela 2003:13), a death rate of up to 11 per day among teachers (Khangale 2005:1) (which is more than treble the number reported by AFP (2001:1) and Ananova (2003:1) previously) and the estimated teacher shortage reported by Jansen (2004b:1). The statistics in the fiscal report also fly in the face of the UNICEF (2000:1-2) report quoted above, which states that, 860,000 primary school children lost their teachers to HIV/AIDS in sub Saharan Africa in 1999, of which a 100,000 were South Africans (see figure 1). In fact, South Africa already topped the list of teacher deaths worldwide in 1999 (Dispatch 2000b:1). If the teacher/learner ratio is truly 1/32 this represents a loss of 3,125 primary school teachers alone! Either the ratio is bigger or the teacher mortality rate is misrepresented. Considering the alarming increase in teacher deaths in 2004, one can begin to understand that the lack of accurate statistics may be one of the complicating factors facing principals as school managers trying to maintain quality instruction in their schools.

The UNICEF report (2000:1-2) just mentioned in fact supports the supposition that the teacher/learner ratio is far bigger than given and that teacher mortality is underestimated. The report goes on to say that schooling is disrupted when teachers are absent from class due to illness, death or the need to care for ill family members, or when a decreasing number of teachers has to take larger classes (UNICEF 2000:1). Caelers (2005:1) finds that teachers consistently take days off, either because they are ill or affected by others who are ill as a result of AIDS. More than one fifth of teachers reported attending a funeral at least once a month, resulting in ever-rising rates of absenteeism, and many of the teachers reported feeling depressed by the adversity HIV/AIDS created in their lives. De Bruin's report (2003:1-2) underscores this fact with devastating statistics, for Kwa Zulu-Natal in particular. Moreover, teachers who are ill leave schools in remote areas, which lack healthcare facilities, requesting postings near hospitals, which

leaves vacancies in rural schools and compounds the managerial problems facing principals who have to oversee the delivery of quality education to learners in emotionally and financially disrupted communities.

Moreover, Rutenberg *et al.* (2001:26), in a survey among Secondary school learners in Kwa Zulu-Natal, found that the overall impression of schools in the area was one of disorder, and that a quarter of the students reported that teachers were often absent, and eight percent of respondents cited drunken teachers as a problem at their schools. All the factors mentioned above impact negatively on school management and self-actualization.

Chapter three will probe the impact of teachers with AIDS, and the role the principal could play in facing this problem in greater detail.

2.5 THE PROBLEM OF LEARNERS WITH HIV/AIDS IN SOUTH AFRICAN SCHOOLS

Not only teacher absenteeism and death impacts negatively on school management, but also pupil absenteeism; pupils affected by HIV/AIDS are not able to attend school regularly (Pela 2001:1), since many AIDS-affected families may withdraw their children from school to compensate for labour losses and increased care responsibilities and to combat increasing costs. In South Africa, a 2000 survey of 771 AIDS-affected households in three provinces found that more than 40% of primary caregivers took time off from school to care for ill family members. Nearly 10% of households removed girls from school compared to 5% who removed boys (Steinberg *et al.* 2000 in UNAIDS 2004a:52), pointing to the disturbing presence of gender inequality which increases the negative impact of HIV/AIDS on the self-actualization potential of female teachers and learners.

The UNAIDS report (2004a:52-53) just mentioned thus confirms Avert's (2002c:3) finding that HIV is reducing the numbers of children in school. Not only do HIV-positive woman have fewer children, but also a third of the children born to HIV-positive women are infected with HIV and many may not survive until school going age. Moreover, many AIDS orphans simply do not have the means to continue schooling, having instead to find jobs to fend for themselves and often for younger siblings as well (UNAIDS 2004a:53). These children are faced with the ravages of AIDS among their families and friends, and many have to grapple with full-blown AIDS in the face of dire need. Ingham (2000:1) found that of the seventy-nine deaths over a six-month period in an AIDS-care centre in Boksburg, Gauteng, ten were children. A UN Progress of Nations report places the infection rate of

South African teenage-learners as the third highest in the world (Dispatch 2000b:1). This finding is confirmed in a report stating that an estimated 258,000 learners in South African schools were HIV-positive in 1999 (Altenroxel 1999:4). Naidu (2004:2) reports, as mentioned before that as many as 500,000 secondary-school learners in South Africa could be living with HIV/AIDS and will probably not live beyond the age of 30. Moreover, the Altenroxel report predicts a 'future shock' in education, pointing to a 5% annual shrinkage in annual intake since 1996. "*The reduction is only partly explained by declining fertility rates and the normalization of age/grade enrolment*" the report claimed and states; "*If this continues and there is an additional decline in children of school-going age due to increased infant and child mortality, entry-level enrolment may decline still further*"(Altenroxel 1999:4). Naidu (2004:1) agrees, stating that the average rate of school enrolment-increases declined from 3.63% in 1980-1985 to a mere 0.05% in 1995-2000. The difficulty with AIDS-statistics for school management and planning is highlighted if these figures are compared with the fiscal report on service delivery in education (Engela 2003:13) mentioned above, which states that learner numbers have increased to 11.9 million and the teacher-learner ratio was reduced to 1-32.

Considering the importance of regular school attendance for scholastic achievement and the self-actualization potential of learners, special attention should be given to the plight of children affected by AIDS, to ensure the maintenance of regular school attendance (Buchel 1992:112-115). Not only do statistics indicate that large numbers of learners in South African schools may be infected with HIV/AIDS (Naidu 2004:1), they also suggest that many others who are not infected are affected by HIV/AIDS, through ill parents, siblings, orphans taken in by their parents or caregivers, or have been orphaned by AIDS themselves and cannot attend school regularly. The enormous social impact of this cannot be overemphasized. This impact on society will automatically filter through into education via the school system, creating problems at all levels of school management and planning.

South Africa's most prominent AIDS-affected learner, Nkosi Johnson, who was born with AIDS, spoke at the opening ceremony of the International AIDS conference in July 2000. The young Nkosi spoke about the debilitating effect of AIDS on his young life and made a plea for AZT to be made available to pregnant mothers, to prevent the transmission of HIV to their unborn infants. At the same conference the South African President questioned the link between HIV and AIDS (Mason 2001:2). Nkosi was hospitalised in January 2001, but was discharged home to die. Brain seizures left him immobile and unable to speak, and he had to be fed through a tube.

He subsequently died in April 2001 at the age of 12 (*Pretoria News* 2002c:8). The devastating effect of AIDS was illustrated graphically through the short life of this brave young learner (Mason 2001:2). St. Mary's Hospital in Durban, started the role-out of Nevirapine ahead of the final government go-ahead for anti-retroviral drugs (Clarke 2002a:5). The role-out of Nevirapine for pregnant mothers at Ga-Rankuwa Hospital was marred by the fact that mothers who tested positive for HIV, refused to take the drug, while others refused to be tested (Govender 2002g:2), not realising the jeopardy they place their unborn babies lives in.

Nkosi was lucky enough to have access to antiretroviral drugs to try to stem the disease. Many young learners and prospective learners in rural areas, townships and squatter camps do not have this facility and face far more debilitating consequences of the disease; their plight is further acerbated by the abject poverty in which they live. The impact of the disease on their ability to attend school and learn effectively was forcefully illustrated by the debilitating impact on Nkosi who, in spite of his optimal living conditions, was not able to attend school towards the end of his short life, due to his increasing frailty. It is clear from the life of this young learner-hero that other learners who are HIV-positive, with no access to antiretroviral drugs or social and emotional support, face an even more devastating ordeal, which could ultimately paralyse the school system because of increasing numbers of ill learners being constantly absent from school. UNAIDS (2004a:53) stresses emphatically that the impact of AIDS on education needs to be tackled both socially and economically if children are to remain in school, underlining the importance of proper long-term planning and school management for the self-actualization potential of both teachers and learners in the education system.

According to Mason (2001:3), by 2010, the life expectancy of black South Africans will have fallen from 55 years of age to a mere 44 years due to AIDS. Moreover, apart from the staggering numbers of South Africans infected with HIV/AIDS by the end of 2001, the situation will only worsen since, as Christian Aid quotes, the United Nations AIDS figure for the likelihood of a 15-year-old South African male-learner contracting HIV is a two-in-three probability (Mason 2001:3). Bartlett (2002:1) reports that 29% of 12-17 year-old teenage learners are sexually active, of these 52% have multiple sexual partners and a staggering 51% of sexually active learners admitted to having intercourse before the age of 15. Many schoolgirls also have sexually transmitted diseases, but are mainly concerned about pregnancy, and not HIV (Dispatch 2000a:1). The survey further indicates that most of the sexually active teenage learners engaged in risky sexual

behaviour, with the younger teenagers aged 12-14 the most irresponsible (Bartlett 2002:1). It is in response to figures like these, and in an effort to curb further infections among teenage learners, that Dr Olive Shisana, executive director for HIV and AIDS at the Human Sciences Research Council, suggested that learners should have access to free condoms at school (Caelers 2005:5).

In South Africa (Mason 2001:3) it is estimated that, by 2010, six million people, including learners in various phases of schooling, will have died of AIDS, leaving behind a staggering two million orphans, many of them of school-going age. That is, a third of South African children (learners and prospective learners) will have lost a parent or parents to HIV/AIDS. The number of AIDS orphans in South Africa has already passed the two million mark in 2003 and is expected to be 3.1 million by 2010 (UNAIDS 2004a:61). Considering that many South African children live in very poor one-parent female-headed families, the problem becomes graver. Furthermore, Mason (2001:3) reports that infant mortality in South Africa is expected to be 60% higher by the end of the decade than it would have been in the absence of HIV/AIDS. This is corroborated in a report from the US Bureau of Census, which predicts that 146.6 of every 1000 South African children will be dying by 2010 (Altenroxel 2002:5).

The Teacher (1999:1) shows that one in five South African youths (learners) is infected with HIV/AIDS. Besides the high rate of infection among teenage learners, 5.6% of children between the ages of 2-14 are HIV-positive (Pienaar 2002:1). Surveys have found that fear of contracting HIV/AIDS and knowledge about the transference of HIV/AIDS does not necessarily lead to change in behaviour. Rutenberg *et al.* (2001:38-41) confirm this worrying finding in a survey among secondary school learners aged between 14-22, citing that the learners did not necessarily use condoms, and that multiple partnerships were common, although less frequent among female than male learners. Worse is a report by Caelers (2005:1), which states that only a third of teachers who know that they are HIV-positive used a condom consistently, thereby not only risking the spread of HIV-infection, but also setting a poor example for learners. According to *The Teacher* (1999:1-2), new approaches to the problem are needed. The problem of behaviour change is underscored by the revelation by Yfm DJ Fana 'Khabaleza' Khaba that he is HIV-positive. Khaba (*Saturday Star* 2003:12,) was one of South Africa's multi-million Rand PR anti-AIDS messengers. The government spent millions, if not billions, of Rand, running communications campaigns and music concerts in an effort to bring about behavioural change. Khaba was what was called a part of this campaign. The escalating AIDS pandemic

clearly indicates that the messages did not reach the set goal. The fact that Khaba as a messenger was HIV-positive speaks for itself. HIV/AIDS is a disease of behaviour (Mwamwenda 1996:181; *Saturday Star* 2003:8) and exacerbated by careless promiscuity. Khaba died in January 2004 leading to a heartrending outpouring of grief among young admirers (*The Star* 2004a:8; *The Star* 2004b:25). Learners most at risk of becoming infected are the ones who tend to engage in irresponsible sexual behaviour, such as poverty-stricken youths who feel a sense of hopelessness about their lives (Crosby, Leichliter & Brackbill 2000:312-317). The time has come for the principal as school manager and community leader to become actively involved in combating AIDS, by seeing to it that the correct moral codes of conduct are adhered to by his/her charges and the broader community served by the school.

Apart from the high incidence of HIV-infections, medical experts are also concerned about the increasing incidence of other sexually transmitted infections (STI's) among 14-24 year old youths. The prevalence among young males is set at 17% and among young females at a staggering 53% (Oliphant 2003:8). The incidence of genital herpes increased from 18.6% among 14-15 year-old female learners to 94% among 24-year-old females, who could themselves be secondary-school learners or students. Herpes is thought to be one of the strongest risk factors in becoming infected with HIV/AIDS (Oliphant 2003:8), as confirmed in a report in *AIDS Bulletin* (2002:1), which calls Herpes the silent friend of HIV/AIDS infection.

The national health and education departments did in the late 1990's devise a joint strategy to combat HIV/AIDS, starting in the schools (*The Teacher* 1999:2). Over and above largely unsuccessful advertising and billboards campaigns, the government trained 10,000 teachers to conduct AIDS education (Jeter 2000:7). This was the so-called broomstick and condom instruction that caused a furore among primary-school parents and teachers. A concerned Africa Christian Action researcher, McCafferty (2002:16), pleads in this regard that US-style sex education advocated by Love life be taken out of South African schools because of the harassment young female teenage learners suffer at the hands of their male counterparts as a result of this explicit sex education. The African Christian Action group asked that sex education should teach children values, self-respect and above all how to say no, rather than explicit safe-sex techniques unsuited for their age (McCafferty 2002:6). Van Eeden (in *Pretoria News* 2002a:2) while saying that a drive to make safe sex advice available to learners may serve some purpose, there should be a measure of choice in accessing this, and it should be made available on request. Epstein (2003:10) found a correlation between

learners' sexual behaviour and their self-value and confidence in the future. The problems surrounding successful AIDS education and AIDS management in schools denotes a definite future role for the principal as school manager in combating the scourge by ensuring that learners and teachers have a purposeful hope for the future.

“Only by interacting with youth can we deliver messages that will assist us in the fight against AIDS”, says Ms Tshabalala-Msimang (*The Teacher* 1999:2). However, the AIDS campaign in the absence of antiretroviral medication failed miserably, with HIV infections increasing exponentially. Clearly, treatment of positive individuals should coincide with changes in behaviour of both HIV-positive and healthy learners to prevent further spread of the disease in schools. International diplomat Richard Holbrook (*BBC news* 2002:2) put it as follows: *“You cannot do prevention without treatment. It is a ridiculous debate. You need both”*.

The actual prevalence of HIV in schools, as mentioned above, is not known, and this complicates management strategies. This is a problem which could give raise to various legal questions, i.e. what are the rights of HIV-positive learners as opposed to the rights of healthy learners in the school system, given the high levels of abuse at school level, and the prevalence of sport injuries where learners could come into contact with infected blood? The rights dilemma of parents of healthy HIV-negative learners as opposed to that of parents of HIV-positive learners was clearly demonstrated by the fact that a 4-year old HIV-positive girl, Tholakele Nkosi, was in 2002 denied admission by three nursery schools. The Minister of Education called this *“blatant discrimination,”* (Pretoria News 2002e:2). Nkosi was eventually admitted to Anne's Little Nursery School, Midrand, which subsequently closed down. Parents of HIV-negative children removed their children once they discovered Nkosi's HIV-status. Mbele Phethe, spokes-person for the Gauteng Department of Social Services and Population Development, said there was no departmental policy concerning the admission of HIV-positive learners to schools (Pretoria News 2002e:2). The case was referred to court, after two private nursery schools refused to admit Nkosi on grounds of concern that HIV could be spread through biting, which does occur among nursery school learners (Kalideen 2002:3; Pretoria News 2002e:2; SAPA 2002d:2). A 1998 law commission report, project 85 on AIDS and discrimination in schools, was inconclusive, in spite of serious concerns voiced by the principals of several leading schools in Pretoria and elsewhere concerning health risks to healthy learners in school (Cameron & Havenga: 1998).

Illustrating the extent of HIV infections among students and learners, Kirby (2000:2) emphasizes that at the University of Durban-Westville 25% of the student body in 2000 was HIV-positive. Furthermore, Pela (2001:1) states that the impact of the epidemic has shaken the entire education system, calling it an emergency that calls for a complete overhaul and re-planning of education management strategies. According to Pela, the epidemic threatens to lead to declining and delayed enrolment rates of learners from affected families, and could shatter the quality of education and skills development, leading to a generation of university and technical school learners unable to work and so unable to pay back study loans. This does not take into consideration learners who are themselves ill from AIDS or who have to stay home to take care of ill family members (Soul City 2003:22-29; UNAIDS 2004a:52).

The higher education system seems to be particularly vulnerable, with one in four under graduates and one in eight postgraduate students HIV-positive. The sero-prevalence among technical learners is 20%. Given the estimate that one in five senior school learners may also be infected, the picture looks bleak. Moreover, a survey conducted among South Africans in general indicated that although 85% of South Africans understood the danger of AIDS and its sexual transference, only 10% used condoms (Jeter 2000:7). Moreover, Matari (2001:9) reports that the number of black learners matriculating decreased markedly in comparison to their white counterparts, Jansen (2004a:15) confirmed that there was 70,000 less matriculants in 2003 than in 1999, while La Grange (2003:10) cites a 4.7% decrease in learners between 1999 and 2003. Mr Salim Vally, a senior researcher in education policy at the Witwatersrand University, makes it clear that South Africa could face a serious education crisis in the near future, because very few black students would complete their school end examination (Matari; 2001:9). According to Vally, the main reasons for the decline in black matriculants were HIV/AIDS, pregnancy and joblessness. SADTU gives the reasons for the decline in matriculants as HIV/AIDS, drug abuse and pregnancy (Monare 2004a:1; 2004b:4). Many parents can no longer afford to send their children to school and AIDS is taking its toll among increasingly young learners; furthermore, a large number of female learners drop out of school due to pregnancy. Mr Ismail Wadee, spokesperson for the Gauteng Education Department (Matari 2001:9), confirms the decline in black matriculants with the following statistics: in 1999, 124,960 candidates wrote the final examinations in Gauteng; this figure declined to 118,500 in 2000 and a mere 115,600 in 2001. Furthermore, a marked decline was recorded in the Western Cape Province; 55,440 (1999), 37,199 (2000) and 27,287 (2001). The Northern Province recorded a similar decline in candidates:

141,000 (1999), 99,568 (2000) and 85,000 (2001). The staggering decline in matriculants prompted the national Education Department spokes person Mr Likhetho, to confirm that the department is investigating the problem, because it does not want to build schools, universities and other tertiary institutions if there will be no students/learners to fill them (Matari 2001:9)

In the light of these statistics, it is clear that recognizing the needs of vulnerable learners before they drop out of school is a task facing teachers and principals everywhere in South Africa. To help with effective AIDS management in schools, Gauteng Education MEC, Ignatius Jacobs, appealed in 2001 for voluntary HIV/AIDS testing of learners and teachers (Jacobs 2001:1). UNAIDS (2004a:52) emphasizes the importance of correct AIDS data for long-term educational planning. This call was echoed by the reformed churches in South Africa, in a bid to identify and manage AIDS sufferers more effectively (Jackson 2003:6). To date this has not been implemented, leaving principals with the dilemma of not knowing the extent of the problem they are facing. However, Cornell (in Jeter 2000:6), an AIDS activist, points out that, the government cannot make someone reveal his/her AIDS status when it cannot offer anything in return. While this may be a valid argument for someone who is HIV positive it ignores the rights of people who are healthy and may unwittingly be subjected to infection. New legislation has been proposed to make the transference of HIV/AIDS a crime (Joubert 2004:1), but for this to be effective the serum status of the transferer and transferee would have had to have been previously known to both individuals, underscoring the importance of HIV testing.

Another face of the AIDS dilemma that needs special attention is the numbers of learners who do not have HIV/AIDS, but who drop out of school when their families can no longer afford school fees, because the breadwinner is ill and no longer working, or where AIDS treatment devours the family budget (UNICEF 2000:1-2; Soul City 2003:22-29; UNAIDS 2004a:52). In some countries in sub-Saharan Africa, parents are keeping their daughters home to prevent them from being infected, thereby increasing gender inequality and hampering their self-actualization. In South Africa this is a possibility not to be overlooked, particularly not in rural communities where young girls are being subjected to so called virginity testing. These trends add to the learning process in some schools being hampered by high rates of teacher turnover and fluctuating numbers of learners attending school, which prevent effective educational planning, making the role of the principal as school manager difficult.

An alarming aspect with regard to the spread of HIV/AIDS among teenage learners and students in South Africa was revealed in a discussion group consisting of grade 9-11 male and female learners held in 2002 (Frizelle & King 2002:2). Responses gleaned from black learners' groups highlighted the fact that many young black women were forced into sexual relationships for financial gain to relieve their families' financial hardship, or pressured by male peers to have sexual relations at a very young age (Frizelle & King 2002:2). Furthermore, many of these young black women were injured during their first sexual experiences, indicating that this probably took place against their wishes. The injuries make them more susceptible to STI's , including HIV. This fact is underscored in a report stating that a third of women canvassed at antenatal clinics in Soweto, South Africa, admitted to having 'transitional' sex in return for food, clothing, transport, school fees, cash and gifts for their children and were HIV-positive (AIDS Bullitin 2002:3).

Findings in the report by Frizelle and King (2002:3) indicate that peer pressure and the need to conform to community-specific belief systems are serious risk factors in the spread of HIV/AIDS among teenage-learner groups. Being accepted by the peer group is a strong underlying requisite for self-actualization in teenage learners (Buchel 1994:62). This presents a further problem for the principal as school manager trying to combat HIV/AIDS in schools. If the peer group accepts indiscriminant sexual behaviour, chances are that it will be very difficult to bring about behavioural change. News 7days (2005:5) and Apps (2005:1) illustrated the impact of peer acceptance on behaviour in reports which stated that "*men who are infected...attract a kind of respect because they did it straight*", that is, not using a condom to prevent the spread of the virus.

Complicating matters, still further Wilbraham (2002:1) finds that though it has become imperative for parents to talk to their children about sex in an environment of health risks, many parents find this a difficult task since many are HIV positive and in some societies talking about sex is taboo. This is disastrous at a time when the onset of sexual maturity and activity is at ever-younger ages, with learners as young as 12-14 facing unwanted pregnancies, STI's and HIV/AIDS infection. Young people (learners and students) from 12-21 years of age have been labelled as '*at risk*' in South Africa, with young women particularly vulnerable (Wilbraham 2002:1).

These trends illustrate the grave problems facing learners, teachers and principals in schools, colleges and universities in the face of the HIV/AIDS epidemic. Not only are vast numbers of learners infected with HIV/AIDS,

suffering the ravages of the opportunistic diseases that attack their frail immune systems, but also many healthy learners from households affected by AIDS drop out of school because of dire financial need. Battersby (2003:1-4) found that children between the ages of 12-18 were mothers and fathers to a million AIDS orphans, foregoing their chance to attend school and fulfilling their self-actualizing potential. The Human Sciences Research Council (HSRC) statistics stated in chapter 1 underscores this report, stating that 3.3 percent of South African households (that is, 300,000 households, representing 1,000,000 individuals) were headed by learners younger than 18 years of age, some as young as 8. In the Free State it was found that 3% of learners lived alone (15,774 learners out of a battery of 502,033) were in this situation (*Pretoria News* 2001b:2). Furthermore, Barnett and Whiteside (2003:201-202) found that children from HIV/AIDS-affected households with smaller disposable incomes are often malnourished, wasted and stunted, which will in the long-term impact negatively on their self-actualization, as well as present problems for school management. According to the MEC for Education, in the Free State, Mr Kganare, learners from socially dysfunctional backgrounds affect school management, planning and learning adversely. Mr Kganare said; *“We have realized that the social conditions under which the majority of our children grow (up) are conducive to acts of crime, aggression and indiscipline”* and stated further that; *“This obviously affects management of schools and learning and teaching”* (*Pretoria News* 2001b:2). This highlights the problems facing school managers and, by implication, the difficult role facing the principal who has to deliver quality education with often ill and/or absent teachers to often ill, disrupted/disruptive and absent learners in the face of the HIV/AIDS pandemic.

The next section will look at the dilemma presented to school managers by ever-increasing numbers of AIDS orphans as the disease takes its toll on parents and teachers alike.

2.6 THE IMPACT OF AIDS ORPHANS ON SOUTH AFRICAN SCHOOLS

Samantha Mundeta, an 18-year old Red Cross-volunteer (Reuters 2002a:6) said of AIDS at a UN meeting: *“It’s more a children’s issue than an adult’s issue, because the parents die from AIDS but then more children are left behind to deal with the consequences of the death.”* The statement illustrates the plight of millions of AIDS orphans worldwide. By the end of 2001, an estimated 13.4 million children under the age of 15 years had lost a mother, father or both parents to AIDS. At the current rate of infection this number is

expected to jump to 25 million by 2010. In South Africa alone it is expected that 16% of all children/learners will be orphans, and more than 70% of these cases will be due to AIDS. The rapid increase in HIV prevalence from <1% in 1990 to >20% in 2001 will see an orphan explosion over the next decade, with numbers beyond initial estimates of to 2.3 million in South Africa (UNAIDS 2002:3-8), to new other estimates at 3.1 million (18%) of all children by 2010 (UNAIDS 2004a:61). The implication of this for society in general and the school system in particular is awesome.

The impact of HIV/AIDS on children/learners is complex and multifaceted. AIDS is increasing the number of emotionally vulnerable, malnourished, undereducated and socially maladjusted young learners. UNAIDS (2004a:62) puts it as follows: *“Even people who work with orphaned children struggle to understand the emotional anguish a child experiences as one or both of his parents die”*. These learners, because their basic needs are not met, have no possibility of achieving their full potential, and the frustration caused by their inability to fulfil their needs increases the prospect of social instability and disruption of schooling, such as it may be (Altenroxel 2002:5; Clark 2002b:6; UNAIDS 2002:9). Because AIDS orphans are exceptionally vulnerable, even more so than children/learners orphaned by other causes, the impact of AIDS on their emotional and physical wellbeing is devastating. Many experience depression, anger, guilt and fear for their futures. This could lead to serious psychological disturbances such as posttraumatic stress disorder, drug abuse, aggression and even suicide (Foster in UNAIDS 2004a:62-64). Many are not able to make use of educational opportunities even when these are available; instead their emotional and physical disruption creates problems in their schooling, and presents a serious challenge to teachers and principals who have to accommodate their needs.

The social and economic impact of AIDS also threatens the wellbeing and security of learners from affected households. As parents and other family members succumb to the illness, the children/learners take an increasingly responsible role in generating income, preparing food and caring for sick family members. These learners face decreased access to adequate nutrition, healthcare, clothing and other basic needs such as nurturing and parental care. In their state of dire need, schooling is not an option as survival is paramount. As the AIDS pandemic rages on, fewer families can afford to send their children to school, and young girls in particular are at a risk of being denied a proper education, as they represent the frontline of caregiving duties when parents become ill (UNAIDS 2002:9; UNAIDS 2004a:52). Moreover, Neville (2000:1) reports that AIDS is *“overwhelming*

the extended family system as it creates millions of orphans, fills hospital beds and cemeteries and kills millions in the prime of their lives”. It is impossible to gauge the trauma and hardship learners affected by HIV/AIDS endure as they watch their parents die one after the other, and have to care for younger siblings who may also be ill and in need of special care (Terreblanche 2001:3; UNAIDS 2002:9; UNAIDS 2004: 62).

Because half of the people infected with HIV currently, become infected before age 25, they acquire AIDS and die by the time they reach 35 (2002d:1), leaving behind them a generation of orphaned children to be raised by their elderly grandparents, or worse, to fend for themselves in child/learner-headed households. Since HIV can spread sexually between father and mother, once AIDS has claimed one parent, the children/learners are faced with the eminent illness and death of the second parent. The children/learners are thus faced with the responsibility of parenting and care-giving roles (Avert 2002a:3; UNAIDS 2002:2, Soul City 2003:22-29; UNAIDS 2004:62). Grandparents and other caregivers are often impoverished themselves and face economical crisis in the face of AIDS.

According to Neville (2002a:1) *“those who take in orphaned nephews and nieces cannot afford to pay for their schooling alongside that of their own children, and in many cases those good Samaritans are dying too”*. The Minister of Social Development, Mr Zola Skweyiya, in an effort to address the dire need of increasing numbers of AIDS orphans and their foster parents, have urged the cabinet to facilitate the staggering increase for foster grants and pensions as soon and effectively as possible (Terreblanche 2001:3). The plight of many AIDS orphans without foster-parent grants has worsened, since not only do they not receive grants because of government red tape, but also their numbers are increasing while they live in abject poverty (Jubasi 2002:6).

Moreover, AIDS orphans not only have to cope with the grief of losing their parents, but are also faced with a mass of interrelated hardships, such as fear of the future, separation from siblings, distressful economic deprivation, AIDS discrimination and isolation, which according to Barnett and Whiteside (2003:177) lead to increased despondency in these learners. Furthermore, widows under tribal law often lose their inheritance and homes to male a family member, which impoverishes the widows further. HIV/AIDS-affected children/learners face the cruel reality of physical and sexual exploitation; many are used as slave labour while others take to the streets to eek out an existence, often forming gangs that become involved in crime in order to survive. Female learners turn to prostitution for survival,

increasing the risk of contracting HIV or falling pregnant. While most of these learners were born HIV-free their chances of becoming infected are much higher than their counterparts from homes that are not affected by HIV/AIDS (Clark 2002b:6; Jubasi 2002:6; Peta 2002:5; Barnett and Whiteside 2003:198).

One of the strongest indicators of orphaned learners' dire need and suffering is their absence from school. Not only do they lack security and nurturing at home, but also their dire need prevents them from attending school, where education can provide them with a sense of security and purpose. The lack of proper education pushes them further back into poverty, and a sense of hopelessness, which prevents them from fulfilling their innate potential as human beings. The principal as community leader and school manager could play an important role in identifying children/learners in need and organize a support system through the school, under the guidance of the head of the Department for Educational Guidance.

All over Africa, and also in South Africa, UNICEF finds that learners between 5-14 who have lost one or both parents, are less likely to go to school and more likely to work more than 40 hours a week to survive (UNAIDS 2002a: 9-12). Soul City (2003:22-29) underlines the role the school can play in assisting learners affected by HIV/AIDS. Govender (2002i:1) reported that thousands of children in South Africa are burdened with responsibility beyond their capabilities, becoming breadwinners overnight after their parents died. While it is illegal for children/learners younger than 15-years of age to work, AIDS orphans cannot afford not to, making a mockery of so-called child protection laws in the country. In fact young female-learners between the ages of 6-16 were involved in prostitution to help their families survive, literally risking their lives for survival (Govender 2002i:1). Sunnyside in Pretoria, home to many street children, has been described as an AIDS '*time bomb*' (Jacobs, E 2002:1). People with a high risk of being HIV-positive include among other, prostitutes, street children, homosexuals and drug users, illustrating the negative impact of HIV/AIDS on children/learners in the absence of parental care and positive role models enhanced by proper schooling (Jacobs, E 2002:1). The lack of care and the dire need for survival strategies prevent these children/learners, who hang around the streets of the city centres in gangs getting involved in crime, from attending school and improving their lives. In school they present a problem by disruptive behaviour, and hamper proper discipline and school management (*Pretoria News* 2001b:2). According to the MEC for Education, Mr Kganare (*Pretoria News* 2001b:2)

a survey done at 1450 schools in the Free State brought the following disturbing facts to light in 2001:

- *15% of Free State children/learners stayed with relatives,*
- *21% stayed with a single parent,*
- *21.1% were hungry and in need of assistance, at farm schools the figures were double,*
- *9% of these children were neglected, at farm schools this was 18%,*
- *3% were victims of violence,*
- *6.5% witnessed violence,*
- *5.7% were involved in violence and*
- *6.8% showed emotional and troubled behaviour in class.*

There seems to be a link between the deprivation suffered by AIDS-affected children/learners and their ability to respond effectively to teaching/learning in the school system. They clearly need special attention and also alleviation of their plight. The fact that their numbers are rising exponentially could have a devastating effect on school management and planning, leaving principals in a serious predicament. The fact that of the current estimated 11 million school learners/prospective school learners, an effective 3.1 million may be AIDS orphans by 2010 points to a major future problem for education provision in South Africa. The South African Medical Research Council (MRC) underscores the AIDS-orphan crisis, calling it a “*massive challenge*”, and predicts that the statutory systems of care in the country will eventually be completely overwhelmed by the vast tide of homeless orphans (Clark 2002c:2). The hazardous social circumstances, under which learners orphaned by AIDS live, are clearly not conducive to coping in a normal school situation. AIDS orphans not only have to cope with material deprivation, they lack security and nurturing which are special needs to ensure optimal self-actualization. Those who are fortunate enough to have the material resources to attend school could be emotionally labile due to loss, grief and anxiety caused by their parents’ illness and death. Emotionally disrupted children do not cope optimally in school and need special attention, which complicates school management and therefore the role of the principal.

Because of the large number of potential and actual AIDS orphans in the school system, it is becoming increasingly more evident that special arrangements may be needed to accommodate their needs. In the light of the constraints that HIV/AIDS is already putting on teacher provision, together with the number of AIDS orphans and HIV-positive learners attending schools, the Education Department and schools may find themselves in the

unenviable position of budget constraints coupled to lack of human resources when having to deal with the AIDS-orphan crisis.

Moreover, due to their disrupted social situation, AIDS orphans, like other AIDS-affected learners, tend to give vent to their frustrations through disruptive behaviour in school, complicating efforts to accommodate their needs (Jacobs, E 2002:1; *Pretoria News* 2001b:2). Mr Kganare, MEC for Education in the Free State (*Pretoria News* 200b1:2) and a UNAIDS (2004a: 62-63) both conclude that the problems facing principals in dealing with socially disrupted learners, such as AIDS-affected learners, stem from the social dislocation, alienation and stress suffered by these learners. Mr Kganare emphasizes that the adverse living circumstances of these learners obviously affects school management, teaching and learning. Considering that South Africa has 2.29 million AIDS orphans which as mentioned above is expected to increase to 3.2 million by 2010 (UNAIDS 2004a:61-62), the problem of AIDS orphans is clearly enormous and the impact this could have on school management cannot be over emphasized. Dr Peter Piot (Du Venage 2002:1) says, "*AIDS has created an orphan crisis*". Furthermore, UNAIDS (2004a:63) makes it quite clear that staying in school offers orphaned children the best chance of escaping poverty and its associated risks. This view is shared by Ms Minnie Themba, a community AIDS-worker in Vosloorus township (Du Venage 2002:2-3) who says "*Some orphans continue to go to school even after their parents die, which means we can keep track of them and provide them with assistance...others drop out, and when they do, they disappear.*" This underlines the important role school plays in the salvation of AIDS orphans and the role the principal as school manager could play in assuring that they remain in school as long as possible.

2.7 THE IMPACT OF AIDS AND SEXUAL ABUSE ON SCHOOL MANAGEMENT

Abuse may be one of the major factors hampering the self-actualization of learners. Whatever the form of abuse, it can render the learner emotionally labile and therefore unable to cope with the challenges which normal schooling presents, thus interfering with scholastic achievement and eventual self-realization. In South Africa we not only have to cope with the ravages of AIDS among our learners, but also face the horror of sexual and other forms of abuse suffered by learners (Monare 2002:1). It has been estimated that in a third of all child-abuse cases in South Africa, teachers are the perpetrators (SAPA-AFP 2002a:3). This report stated that 5-8% of rapes involve girls/learners between 10-14 years of age, and 15% girls aged

between 5-9 years old. Teachers committed 33% of the rapes; relatives were to blame for 21%; strangers and recent acquaintances 21% and boyfriends 21%. Researchers were horrified by the fact that teachers were implicated in the rape of female learners. South Africa and the teaching fraternity stand accused of wilfully allowing perpetrators of this heinous crime to carry on with their evil deeds, whilst turning a blind eye. Dickerson (2001:2) asks whether laws alone will prevent the sexual abuse of schoolgirls by their teachers, considering the fact that the “*authorities continue to hush up abuse while government officials pass the buck*”.

Rice (2002:13) stresses that dealing with sexual abuse in schools is a complex matter. Schmidt (2001:11) reports in the *Sunday Times* the case of a teacher accused of abusing twenty girls, of whom several are pregnant. A doctor interviewed at an Eastern Cape hospital stated that she was seeing a growing caseload of children as young as two years old infected with syphilis and gonorrhoea, which is the result of an epidemic of child abuse (Epstein 2000:1). Abuse of learners constitutes serious misconduct and should be dealt with accordingly (Buchel 1993: 283-286; Van Wyk in Badenhorst *et al.* 2003:191-192). Taking the high rate of HIV-infection amongst schoolteachers in South Africa into account, abuse could have a serious impact on school management and the spread of HIV amongst learners. Complicating the problem, is the fact that unreported statutory rapes of learners take place under the parents’ noses, but is ignored for the sake of financial support (Monare 2002:1).

The principal of any school should at all times be aware of misconduct amongst staff members under his/her management. Any principal who fails to do this should be brought to book, if not as an accomplice then certainly on account of serious mismanagement of human resources and poor leadership. The problem of abuse, and particularly sexual abuse, by a person in a position of authority on the victim within the school structure, presents a moral dilemma as well as a social and school management dilemma. Parliament’s education budget committee has delivered a plea to ‘*name and shame*’ teachers who abuse their wards. Prof. Shepherd Mayatula, chairperson for the said committee gave a rendition of learner’s tales of abuse to the Education Departments HIV/AIDS conference, stating that abusing teachers are taking advantage of vulnerable learners, who are not in a position to say no to these advances. Furthermore, they do not just “*deflower and demoralize them – they also infect them with HIV/AIDS*” (Terreblanche 2002e:2). Mayatula called for a joint effort by communities, teacher and student unions, schools and school boards to break their silence and report abuse cases, so that perpetrators could be flushed out of the

school system. Female learners are not only subjected to abuse by their teachers, but are often abused by male learners at school. Rutenberg *et al.* (2001:26) support this showing that more female and urban school learners perceive that sexual harassment by other learners and teachers took place at their schools than did male or rural school learners. Sylvester (2001:15) reports that one of the greatest threats to a female learner is the male learner sitting next to her. Schoolgirls interviewed by Human Rights Watch reports being raped on school property by other learners, they received no counselling, and their trauma impacted negatively on their education. A 2001 report titled “*Scared at school: sexual violence against girls in South African schools*” finds that girls who were gang raped by classmates and teachers received hostile or indifferent responses to their complaints from school authorities and many had dropped out of school because of the trauma (Kgosana 2001:1). Barnett and Whiteside (2003:86) underscored the vulnerability of learners, who are abused by teachers at school, saying; “*People will go to any length to find education, employment and housing. Sometimes those lengths may include provision of sexual favours*”. Males who are in a position of authority over female subordinates often abuse this fact.

DA spokesman Martin Slabbert has slammed the government for its tardiness in reacting to the problem, stating; “*When children are the victims of sexual violence at schools, not only is it an assault on their physical and psychological well being; it is also an attack on their constitutionally enshrined right to safety*” (Kgosana 2001:1). The Departmental spokesperson, Mr Molatwane Likhetho, said that the government was aware of the problem and had for that reason started to address the problem four years previously (Kganare 2001:1). Mwamwenda (1996; 312-313) cites lack of discipline, therefore by implication poor school management and a negative school climate, as the main reason for abusive behaviour in schools.

Considering these factors, the future role of the principal clearly includes creating structures at school where victims can complain without fear of retribution by perpetrators. There should be support systems for learners who are infected with HIV/AIDS and also those learners who fall pregnant. From media reports it has become clear that HIV/AIDS, abuse and also pregnancy among learners is widespread. Attention must be given to the following aspects of HIV/AIDS and abuse in schools:

- *What should the role of the principal be with regard to abuse at his/her school?*
- *Can a teacher/staff member who is known to molest learners or other teachers be tolerated on the staff?*

- *To whom must the misconduct be reported? What happens to a teacher under investigation? Considering that abuse is a crime punishable by law, should the teacher be suspended and should it be with or without salary? Or can the teacher remain at the school, given the fact that abused learners seem to have very few avenues of complaint and are scared to attend classes (Kgosana 2001:1)?*
- *How does a situation arise where a perpetrator can in fact impregnate as many as twenty learners before anyone takes note (Schmidt 2001: 11)?*
- *Can this problem be addressed via a parent teacher association or should it be strictly departmental or legal?*

The legal problems pertaining to abuse seem intricate, and there is a fine balance between the rights of learners in an abusive situation and the possibility of wrongful accusation of an innocent teacher as has happened in the past. Looking at the situation; the question arises as to what life skills can be brought into the classroom situation or school system to prevent abuse? Rutenberg *et al.* (2001: 44-45) report that girls often feel that they have little choice but to have sex with their partner, and in many first experiences this may have been coerced with gifts or forced, leading to subsequent injuries and a greater risk of HIV infection. Moreover, because gift giving is widely accepted as a strategy for achieving sexual goals among South African youth, this form of abuse may go unreported as it is probably not seen as abuse, underscoring the perception that gender inequality may not only be the root cause of abuse, but also a serious factor in the spread of HIV/AIDS. Van der Merwe (2002b:7) reports that gender inequality prevents reporting of sexual abuse of girls because it is not regarded as important. She reports further that the attitudes held by some people makes it difficult for them to see their behaviour as abusive or as sexual harassment. Furthermore, *“many teachers genuinely believed it was acceptable for them to have relationships with their pupils, and that because of the powerful positions held by teachers, pupils often felt that they had no choice but to have relationships with teachers”* Van der Merwe 2002b:7).

Female learners and teachers, like other woman worldwide, are physically more susceptible to HIV infection than their male counterparts, and the epidemic has a disproportionate impact on women world wide, confirming an underlying gender inequality fuelling the spread of HIV infection (UNAIDS (2004a:12). Female teachers and learners face a range of HIV-risk factors, which their male counterparts do not. Many of these risk factors are embedded in the social relations and economic realities in which they live, and the societal norms to which they are subjected. Multiple

partnerships, complicated by “gifts” have become the survival strategy for many women, (Rutenberg *et al.* 2001:44-45; UNAIDS 2004a:10). It has been found in many parts of Africa that older men (probably including male teachers) often help female learners’ families with school fees and other living costs (UNAIDS 2004b:11). For many South African female learners and teachers, violence and coercion have become a way of live, and in the school environment male teachers and learners pose a threat to their female counterparts and also culturally there is a problem with reporting sexual abuse, because victims are often afraid of being victimised (Van der Merwe 2002b:7; Ntshingila 2005:13). This problem is further acerbated by exaggerated expressions of maleness and frequent partner changing, caused by an extended period of ‘youth’, orphaning and interrupted education and socialization, probably often due to HIV/AIDS (Barnett & Whiteside 2003:82-83). Rawlings (in Matsebula 2002:2) stresses that the ‘*polygamous lives*’ led by African men under the disguise of tradition and culture is another factor responsible for spreading HIV/AIDS. Rutenberg *et al.* (2001: 6-7) report the ages of secondary school learners in Kwa Zulu-Natal to range between 14-22 years of age, and confirm the high value placed on multiple partners by men. SAPA (2005:3) confirms the overage problem of learners in the school-system, saying that 57% of learners in the Eastern Cape were too old for their grades. The fact that so many learners are overage may be a contributory factor to sexual abuse in schools, as these young adults do not belong in school, but should be working and completing their studies extra-murally.

Considering the high sero-prevalence of HIV amongst teachers and learners of all ages, providing a management strategy to prevent sexual abuse in schools becomes very urgent. Furthermore, considering the plight of women and children in the face of HIV/AIDS, it is imperative that realistic strategies are put in place to combat the impact of gender inequality on the spread of HIV/AIDS. In sub-Saharan Africa 57% of infectees are women (UNAIDS 2004b:5). In later chapters attention will be paid to possible solutions for these problems.

2.8 THE EFFECT OF DRUG ABUSE ON SCHOOL MANAGEMENT AND THE SPREAD OF AIDS IN SCHOOLS

The impact of drug abuse as an aggravating agent in the spread of HIV/AIDS should not be underestimated (Ellis 2000:8; Johns & Schronen 2001:8; Venter 2002:6,). Rutenberg *et al.* (2001:26) reported that eight percent of secondary school learners in a survey in Kwa Zulu-Natal reported

drunkenness among teachers as a problem in schools, while a third of urban learners and 12% of rural learners cited drug dealing at their schools as a reality. This report (2001:44) further states that alcohol and drug abuse among teenage learners, apart from being a serious problem in its own right, is often associated with risky sexual behaviour. Taylor *et al.* (2003:97-100) confirms that smoking and drinking among learners could be associated with an increased risk of early sexual activity, increasing the risk of HIV infection. Furthermore, (Venter 2002:6) finds that teenagers often engage in prostitution to obtain money for drugs, not only putting themselves at risk of contracting HIV, but also being instrumental in spreading HIV infection, via sexual contact and mainline drug abuse. Berk (2003:208) confirms a definite link between drug abuse and the spread of HIV/AIDS. Drug and alcohol misuse in school by teachers and learners constitutes misconduct and must be dealt with accordingly (Buchel 1992:283-286). Apart from the threat of HIV infection via mainline drug abuse, alcohol and drug abuse leads to risk behaviour, including illicit sex and sexual abuse as mentioned above. Crosby, Leichliter and Brackbill (2000:312-317) find that teenagers who are the most likely to engage in risky sexual behaviour are more often poverty-stricken learners, because they feel a sense of hopelessness, which prevents self-actualization. UNAIDS (2004a:62-64) underscore this in a report which states that AIDS orphans who fear for their futures often turn to alcohol and drug abuse to escape the stresses of their AIDS-affected lives. Taylor *et al.* (2003:97-100), on the other hand found that learners who live at home with parents are less likely to indulge in alcohol or drug abuse, confirming the importance of a stable environment and nurturing for successful school management and self-actualization.

Thus apart from the already serious problem of HIV-positive learners and teachers in the school system, Principals also face widespread drug abuse in South African schools, has become a serious aggravating factor Rutenberg *et al.* (2001:26 and 44). Hoberg (2001:250) confirms the seriousness of drug abuse in schools, saying that drug taking has become the “*in thing*” among adolescent learners. Not only drugs, but also alcohol and other substances have become a headache for many school principals. Both teachers and learners are culprits.

Because of the serious increase in the use of drugs among teenage learners, it is necessary that school principals, teachers and parents be empowered with knowledge, in order to be able to render meaningful assistance to learners with drug problems (Hoberg 2001:254, 267-269). Management strategies by concerned schools, however, have been seriously frustrated by parents of offending learners, and, while the rights of all learners must be taken into

consideration, the seriousness of the problem needs harsh action by the Education Department in the form of strict legislation, with ruthless implementation by school managers. Van der Merwe (2002c:7) reports however, that in spite of the seriousness of drug abuse in schools the Department of Education put forward a new legislation which prevents random drug tests in schools, unless “*reasonable cause or belief*” warranted such checks, leaving principals in many instances unable to help eradicate a social malady of ever increasing proportions.

2.9 THE IMPACT OF HIV/AIDS ON SCHOOL ENROLEMENT AND TEACHER PROVISION IN SCHOOL MANAGEMENT

One of the most basic planning structures in orderly school management, as mentioned in chapter 1, is a structured system of enrolment and register keeping to check learner attendance (Buchel 1992:112-119, 129-151). Knowing how many learners are enrolled in any one school, and for which subjects, forms the basis of teacher provision. Principals must know at all times what the needs of the learners are so that they can be catered for. The quality of schooling becomes threatened if sufficient provision of teachers is not made for all learners, in all subjects in the school. Reports on lower enrolment figures in Grade 1 and a declining number of matriculants lead to the suspicion that AIDS may be a contributing factor. Ismail Wadee (in Matari 2001:9), spokesperson for the Gauteng Education Department, confirms the decrease in numbers of black matriculants in 2001. The worrying trend is underscored by Lackay (2001:1), who reports that a recent HSCR survey found that HIV/AIDS will have an enormous impact on the demographics in South Africa. This may in turn influence school enrolment and teacher provision in the future, causing serious problems with school management in the most affected schools. Principals in these schools are faced with a huge dilemma since salaries and post-allocations are coupled to enrolment figures.

Table 6 depicts the decrease in the number of matriculants in Gauteng, the Western Cape and the Northern province.

Table 6: DECLINE IN NUMBERS OF MARICULANTS IN THREE PROVINCES FROM 1999-2001

Table 6

Province	1999	2000	2001
Gauteng	124,960	118,500	115,600
The Western Cape	55440	37,199	27,287
Northern Province	141,000	99,568	85,000

(Adapted from Matari 2001:9)

These findings are confirmed by a UNICEF 2000 update, which states that a report “*on education found that high rates of teacher turnover and fluctuating numbers of learners constrain educational planning*” (UNICEF 2000:2). Moreover, Avert (2002c:3) in a report on the effect of AIDS on education, found that “*AIDS now threatens the coverage and quality of education*”. On the demand side, there are less and fewer children, many of them orphaned (Naidu 2004:1) and on the supply side teacher shortages are looming everywhere (Jansen 2004b:1). Naidu (2004:1) further reports that a major study on school enrolment undertaken on behalf of the government found a steady decline in the numbers of learners enrolling for school. Enrolment figures are down, and a UNAIDS survey (2004a:52) among 771 AIDS-affected households in South Africa found that more than 40% of primary care-givers (including teachers and learners) took time off to care for ill HIV-infected family members. As mentioned before almost 10% of households removed female learners from school as opposed to 5% of male learners increasing the gender inequalities between the sexes UNAIDS (2004a:52). The epidemic affects school enrolment negatively in other ways; Naidu (2001:1) and UNAIDS (2004a:53) cite lower fertility and younger adult deaths caused by HIV/AIDS as contributing factors, leaving fewer school age children, increasing numbers of orphans and a decreasing demand for education.

In addition, while teaching was once a career of choice for many bright township matriculants, this is no longer the case. Today the career tends to be spurned (Pretorius 2002b:17). Not a single African student enrolled for a primary school qualification in the Western Cape in 2002, and education faculties in Venda, Zululand and the Free State, all report a low African intake (Pretorius 2002b:17). In the early 1990’s there were approximately 100,000 teachers in training, but this number dwindled to a mere 12,000 in 2002, of which 3,000 were due to qualify. Considering the fact that as mentioned above Kwa Zulu-Natal alone is estimated to face a teacher

shortage of 60,000 by 2010 (De Bruin 2003:1-2), that 5000 teachers a year leave the profession, and that large numbers are dying of AIDS (AFP 2001:1; De Bruin 2003:1-2; Khangale 2005:1; see 2.4), it is clear that teacher provision is seriously threatened. Moreover, Professor Meerkotter, Dean of Education at the University of the Western Cape says South Africa is “*losing its capacity to train teachers*” (Pretorius 2002b:17). The number of training institutions has shrunk from 150 to 23. To complicate matters, an HRSC survey into school leavers’ choices confirmed a shift away from teaching, with only 1.4% of 12,204 interviewees listing education as an option (Pretorius 2001b:17). Recent reports indicate that the Education Ministry is facing a rapidly deteriorating ability to maintain teacher provision. 4000 teachers died during 2004 (Caelers 2005:5; Khangale 2005:1), and Jansen (2004b:1) warned that South Africa would face serious teacher shortages over the next five years. Reports concerning the looming teacher shortage and a poorly structured development programme, for in service training has prompted the Minister of Education to suggest the import of teachers from abroad (Rademeyer 2005a:11). The reports indicate that the teacher shortage was under estimated (Rademeyer 2005b:12).

Furthermore, considering the impact of AIDS on South Africa as a whole, and the implications thereof on education in particular, as set out in the previous sections, it is with amazement that one reads that a new model for teacher provision is being implemented in schools. According to Smetherham (2002:1), Gauteng principals were forced to lose teaching posts in January 2003. Some Cape schools lost up to 20% of their State-sponsored teaching complement and Cape education authorities feared a loss of some 340 posts due to budget constraints. Many principals said they did not understand the model, and while some schools were to benefit others feared that larger classes in some schools would impact negatively on remaining staff and learners (Smetherham 2002:1). Complicating matters further, a new drive was launched to represent the demographics of South Africa among teachers (Mchunu 2003:1). Tim Makofane, district manager of the Gauteng education department’s Tswane South region, felt that although black learners were well represented in former white schools the staff rooms were not “*reflecting the demographics of our society*” (Mchunu 2003:1).

Another concern is the link between lower matric pass rates and fewer matriculants and the impact of HIV/AIDS on both teachers and learners. A recent report in *Beeld* states: “*getal Matrikulante drasties minder*” (Matari 2001:9), highlighting the possibility of an HIV related impact on teenage learners, sitting for their final school examinations. The looming teacher shortage, mentioned before, will reportedly further impact on matric results,

and lead to even worse results (Rademeyer 2005a:11). Cornia Pretorius of the *Sunday Times* reports that one in eight of the country's sexually active population, those who are over 14 years of age, is now infected with HIV, a figure that experts warn will increase the future shortage of teachers, apart from affecting their ability to teach. The same report says that an increase in infection rates among pupils and changing patterns in enrolment will generally disrupt schooling, while the erratic attendance rates of learners and teachers who are ill themselves or tending to family members sick with AIDS will compound the problem (Pretorius 1999:1). SADTU (in Monare 2004a:1; 2004b:4) ascribed the decline in matriculants in 2003 to HIV/AIDS, pregnancy and drug-abuse, as mentioned above, underlining the seriousness of the problem.

The question now arises of the planning strategies that can be put in place to allow infected and affected learners to complete their schooling successfully though they are unable to attend classes. Could a system of distance learning with regular home-study groups be implemented for these learners, and can an already over-burdened education system accommodate this?

Other factors also hamper future teacher provision. According to Neville, education is receding as teachers die and the pyramid of society is cut through the middle, leaving the old and often frail to tend the young (Neville 2000a:1). The problem is aggravated by the disruption of schooling due to teacher absenteeism caused by illness or the impact of AIDS on their families (Pretorius 1999:1; Caelers 2005:5). In an article titled '*Teachers must pull up their socks: truancy won't be condoned*', Nthite (2005:1) reports that teacher absenteeism and a lack of control over leave registers are two of the main problems which education officials in the Greater Tswane Area need to address. Timothy Makhofane, senior manager for the Tswane Education District, confirmed that these issues were matters of serious concern, as they impact negatively on learners' education and academic outcomes. Makhofane believes that the matric pass rate would improve if teacher absenteeism could be dealt with effectively, saying a system was being put into place to address the problem, but ignoring the possible role of HIV/AIDS inacerbating the problem. Caelers (2005:1) points out that teachers consistently take days off, because they are ill or affected by others ill as a result of HIV/AIDS. One in five teachers report, having attended at least one funeral a month, resulting in high rates of absenteeism and morbidity on the job. Caelers (2005:1) and Blaine (2005:1) further report that the highest infection rate is currently among the 25-34 year age group (21.4%). This is significantly higher than the national average. Dave Balt, president of the National Professional Teachers Association of South Africa

(NAPTOSA), states that “*This has enormous implications...we will lose 20 to 25% of these teachers to AIDS and they are suppose to carry the system for the next 20 to 30 years*”. This leaves a decreasing number of teachers facing larger classes (UNICEF 2000:1), with principals struggling to fill vacancies with temporary staff, which, according to Barnett and Whiteside (2003: 202), is difficult and thus an ongoing management dilemma for schools. This, together with implementation of the new Outcomes Based Education system, could create serious disciplinary problems in classroom management. Many of the already overburdened teachers, who do not even feel competent to do ‘talk-and-chalk’, are now expected to teach through a completely new language medium, Curriculum 2005. School principals face the daunting task of providing a quality service in the face of AIDS taking its toll on human resources, while they have not yet overcome the problems caused by redeployment and the loss of many of their best teachers, including principals, deputies, heads of department, and mathematics and science teachers. The poor pass-rate for mathematics and science at the end of 2002 underscores the problem facing principals in key subjects where it is feared that an increasing mortality rate among teachers will aggravate the shortage (Pretorius 2002a:9; Engela 2003:13). Jansen (2004a:15) laments the dismal pass rate for mathematics and science in 2003. Considering the possible further teacher shortages caused by the relentless impact of HIV/AIDS, as described in the sections above, the prospects for improvement seem bleak.

The government is looking at recalling retired and unemployed teachers to substitute sick or dying teachers (Pela 2001:1-3; Pretorius 2002a:9). Principals as school managers are hampered in their task of providing quality education by high rates of teacher turnover and fluctuations in student numbers (UNICEF 2000:2). To cope with this problem, it is vital that education systems to collect precise data on the epidemics impact on personnel, as this is needed for planning, training and recruitment strategies as well as for the creating of staff healthcare budgets, when treatment and funding resources increase (UNAIDS 2004a:52).

In South Africa at the moment school management, which lies at the core of effective education, may be in danger of failing in its ultimate aim, namely the self-actualization of learners (Cangemi 1984:105). Education could be the country’s strongest weapon against HIV/AIDS, but “*failing that, it could become its worst victim reversing decades of hard-won gains,*” according to a World Bank report (in Pretorius 2002a:9).

2.10 CONCLUSION

Looking at the vast numbers of learners and teachers affected by HIV/AIDS and the devastating impact the fast-spreading disease has on communities, families and the economics of the country at grass roots level, it is clear that, from a managerial point of view, education like other societal structures could well be severely debilitated. It is therefore clear that multifaceted strategies must be employed to address the impact of the epidemic, and related factors which are depriving school systems of the teachers needed to maintain and increase school enrolment and quality education (UNAIDS 2004a:52). The UNAIDS maps below- (Figure 16-18), give a graphic indication of the global spread of HIV/AIDS and the impact it has on civil society.

In the next chapter the effect of HIV/AIDS on school management and the role the principal could play in a bid to manage the impact of HIV/AIDS in South African schools will be examined.

The three maps below show the latest AIDS epidemic update (UNAIDS 2004b:77-79)

ESTIMATED NUMBER OF ADULTS AND CHILDREN NEWLY INFECTED WITH HIV DURING 2004

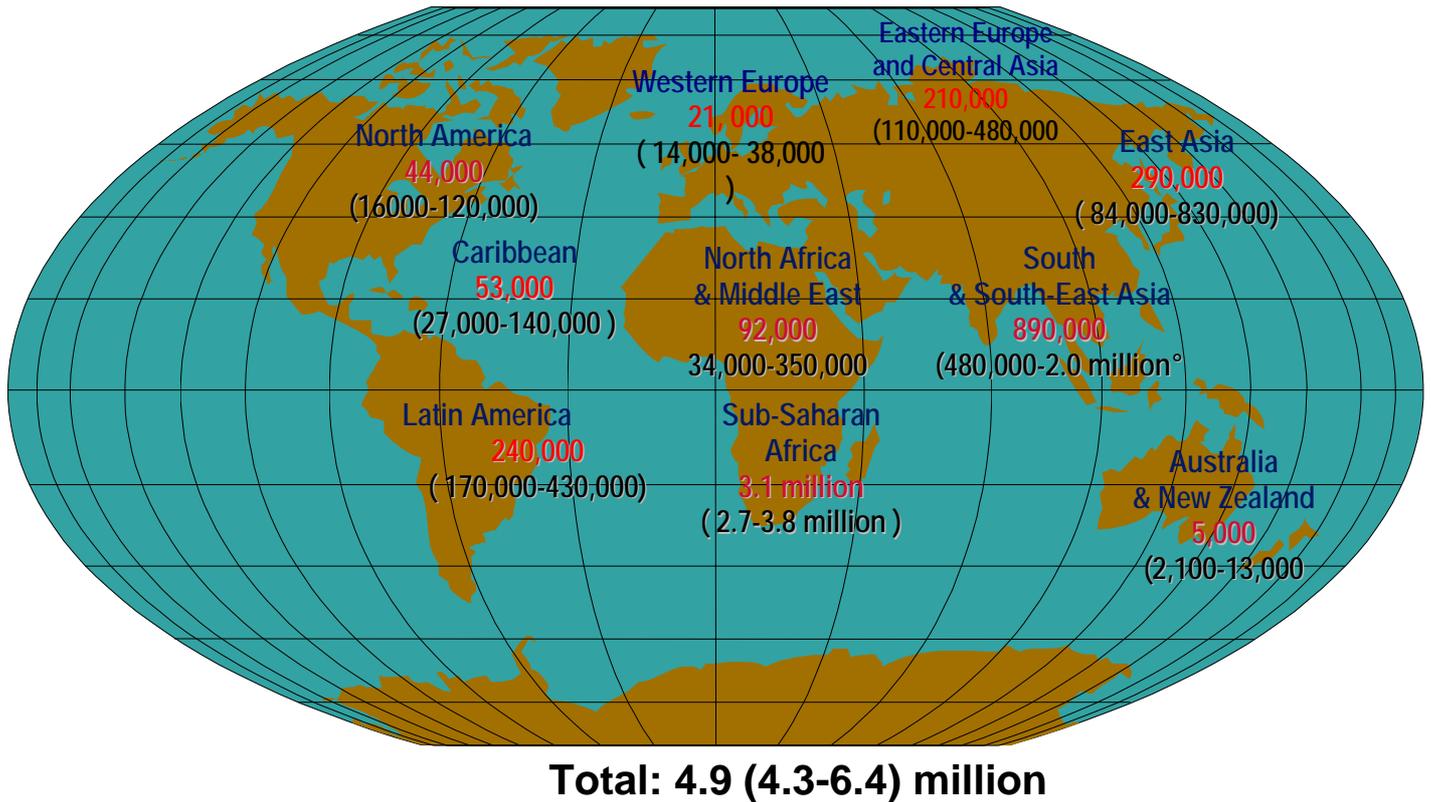
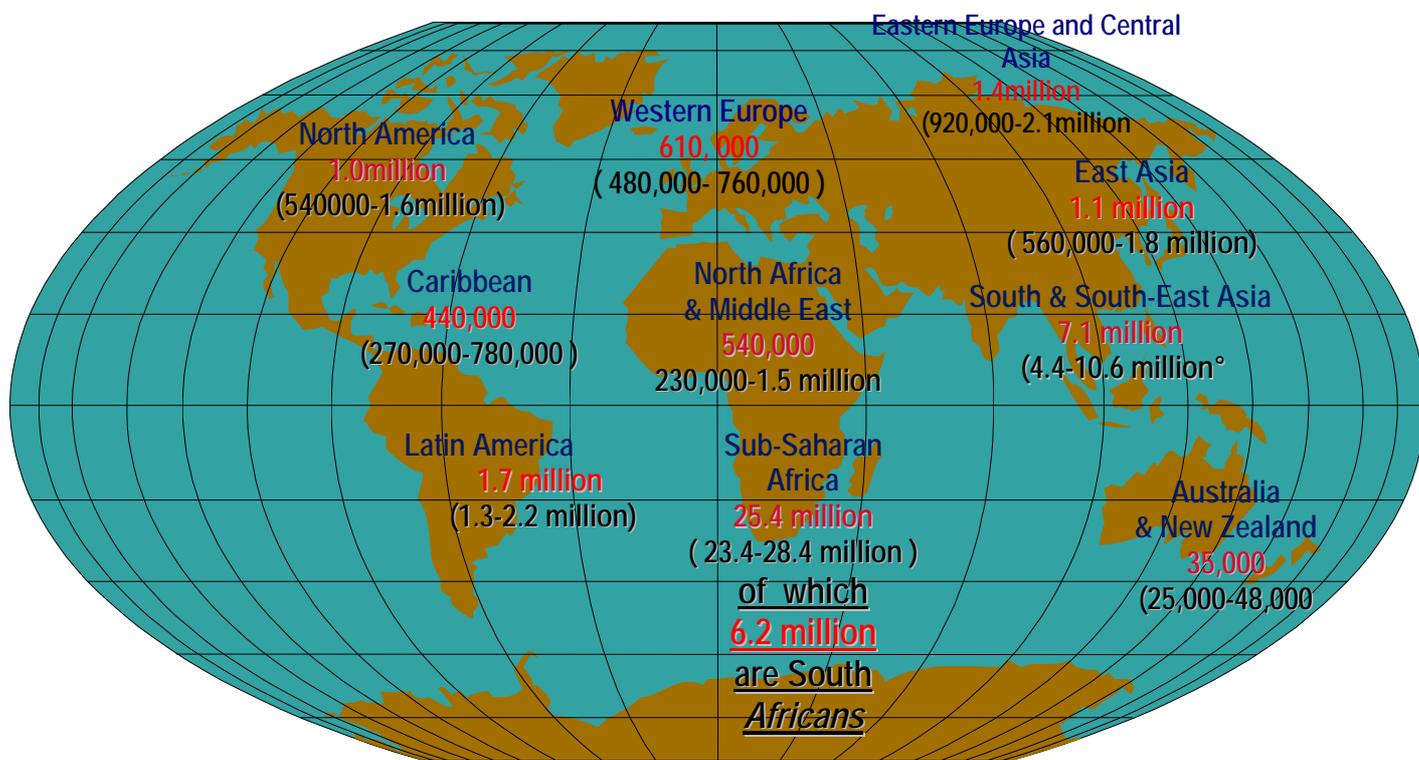


Figure 16: UNAIDS epidemic update (2004b:78)

THE HIGHEST NUMBER OF NEW INFECTIONS IS IN SOUTH AFRICA

ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV DURING 2004

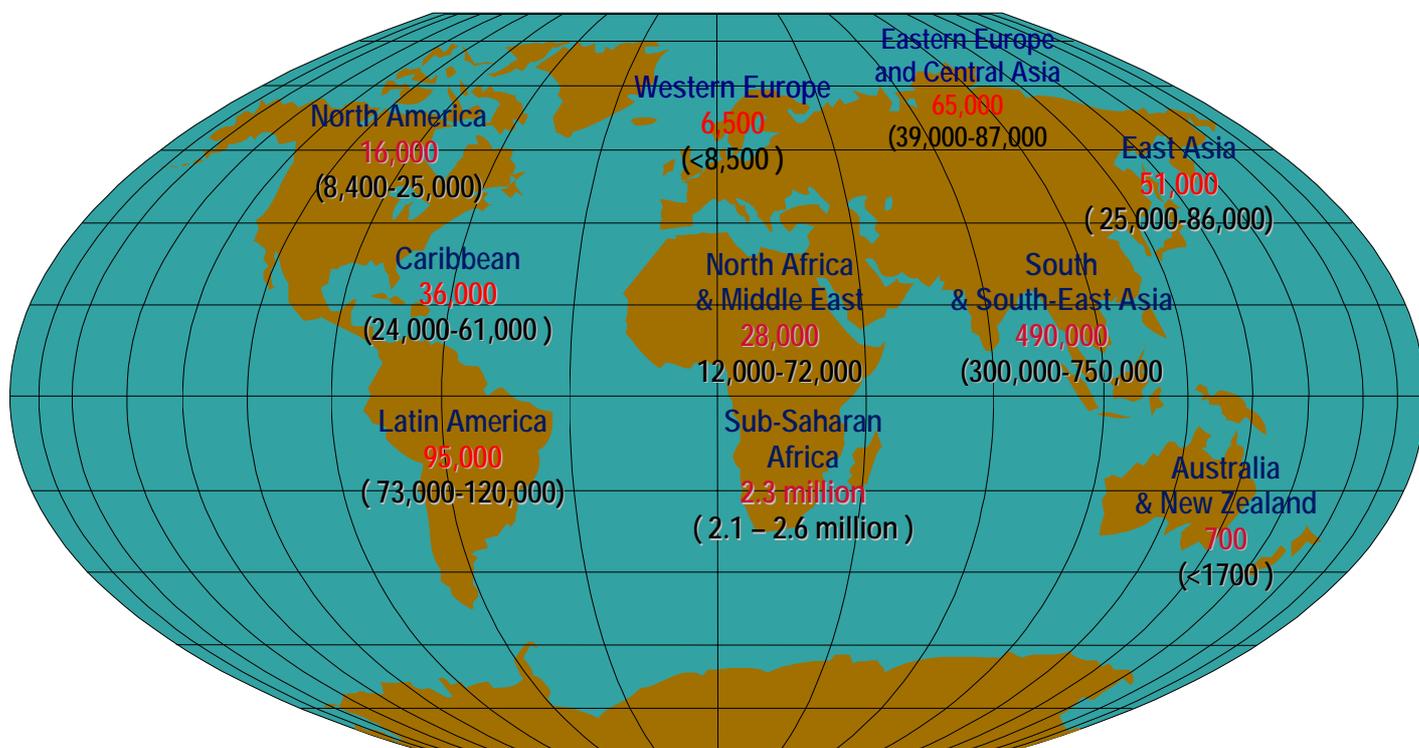


Total: 39.4 (35.9-44.3) million

Figure 17: UNAIDS epidemic update (2004b: 77)

ONE OUT OF EVERY SEVEN PEOPLE LIVING WITH HIV WORLDWIDE IS A SOUTH AFRICAN

ESTIMATED NUMBER OF ADULT AND CHILD DEATHS FROM HIV DURING 2004



Total: 3.1 (2.8-3.5) million

Figure 18: UNAIDS epidemic update (2004b:79)

SOUTH AFRICA HAS THE HIGHEST NUMBER OF TEACHERS DYING FROM HIV IN THE WORLD. ADULT DEATHS HAVE INCREASED BY 40%.