

## **CHAPTER 2**

### **THE MANAGEMENT OF THE HIV/AIDS AWARENESS CAMPAIGN IN SCHOOLS**

#### **2.1 INTRODUCTION**

The world is well into the second decade of the most devastating pandemic in the history of modern civilisation (Crewe 2002:446). Since 1990 the total number of HIV infections worldwide have increased ten-fold from six million to nearly 60 million (cf 1.1) and it is nowhere near its peak (Crewe 2002:446). Medical researchers worldwide are battling to understand and find a cure for the virus in order to prevent the spread of this disease and prolong life. Drugs are provided to certain people who can afford them to slow down the process. But treatments are still complex and costly and least available where they are most desperately needed. A balanced diet is recommended to patients who are infected and who cannot afford the drugs (Orr 1986:35). In poor socio-economic communities even this advice is often difficult to follow.

In education, educators throughout the world are having to deal with learners whose lives are affected by the disease (cf 1.3). The number of orphans is increasing in schools as well as in the communities. In South Africa alone it is estimated that by 2008, 1,6 million children will have been orphaned by AIDS (Internet 2003c).

The South African Department of Education has devised a strategic plan to support, care for and educate learners and educators who are affected by HIV/AIDS (Louw et al 2000:5; Conference on HIV/AIDS 2002:73). In order to be successful, both educators and school principals will have to play a significant role.

#### **2.2 HIV/AIDS**

The Human Immunodeficiency Virus (HIV) is a retrovirus which enters a cell usually during intercourse with an infected person and inserts itself into the Deoxyribonucleic Acid (DNA) to reproduce itself, in order to exist. It then attaches itself to a cell that orchestrates the body's immune system (CD4) (Crothers 2001:9). The Acquired Immunodeficiency Syndrome (AIDS) is caused by HIV. By killing the cells of the body's immune system HIV progressively destroys the body's ability to fight infection.

According to Van Dyk (2003:24-28); Shorter and Onyancha (1998:7); Granite and Mermin (1999:56); Du Toit et al (1997:15) transmission of the HIV virus from one person to another is usually as a result of a sexual encounter, exchange of body fluids including needle and razor blade sharing, accidental injection and mother to child transmission which is estimated to be responsible for up to 20 percent of new infection in South Africa in 1995 (Crothers 2001:10). People with Sexually Transmitted Disease (STD) tend to get HIV infection more easily (Crothers 2001:1).

Medical researchers have developed criteria for the diagnosis of HIV/AIDS. Evian (1995:36) and Everett (1995:13) agree that there are two broad classes of tests. The first is HIV antibody test using the enzyme linked immunosorbent assay (Elisa) and HIV P24 antigen. The second test detects the actual virus in the blood, using the polymerase chain reaction (PCR) technique.

### **2.2.1 The stages of the infection**

Evian (1995:11) stipulates that the person infected with the virus is termed HIV positive. Van Dyk (2003:36) demarcates the following distinct phases of HIV infection.

- **The primary HIV infection phase**

This phase begins when an HIV antibody test shows that a person is HIV positive.

- **The asymptomatic latent phase**

A person at this stage displays no symptoms. However, during this stage, the HIV virus is actively multiplying, infecting and killing cells of the immune system (National Institute of Allergy and Infections Disease (NIAIDS) 2000:26).

- **The minor symptomatic phase**

During this phase, the patient manifest the following symptoms: weight loss; mild swelling of the lymph nodes in the neck, armpits and groin (NIAIDS 2000:26).

- **The major symptomatic phase**

This is the stage when the CD4 cell count falls below 200/mm<sup>3</sup>, while the viral load becomes very high. The last phase is the AIDS defining conditions. The patient is now said to have full blown AIDS and the symptoms become more acute. The immune system deteriorates exponentially and more persistent and untreatable opportunistic conditions begin to manifest. Typically a person not receiving treatment will die within a year and a half of reaching this stage (Dorrington et al 2002:20).

Overall 55 percent of all infected people in South Africa were in the first stage of infection in July 2002, with a further 20 percent in the asymptomatic latent stage. Only 18 percent were in the minor symptomatic stage and a mere 7 percent in the major symptomatic full-blown AIDS-stage (Dorrington et al 2002:6). Thus, in July 2002 approximately 75 percent of people in South Africa who were HIV positive showed little or no sign of infection and may not even have known their HIV-status.

### **2.2.2 Opportunistic diseases**

Opportunistic diseases common to people with HIV cause symptoms such as coughing, seizure, lack of coordination, severe persistent diarrhoea, nausea, abdominal cramp, vomiting, extreme fatigue and severe headache (NIAID 2000:26).

People with AIDS are also particularly prone to developing various cancers (UNICEF 2000:1). Many HIV positive patients develop phases of intense life-threatening illness followed by phases during which they are unable to do household chores. The HIV prevalence in tuberculosis (TB) patients is higher than 70 percent, and TB accounts for more than 2 million death annually in South Africa (Summers 2000:12).

### **2.2.3 Treatment**

There is no cure for HIV/AIDS. The only intervention is to prevent the spread of the disease and to slow down the progression of the illness. Coombe (2002:vii) states that there are different ways to prevent the spread of HIV/AIDS and treat those who are already infected.

#### **(i) Prevention**

Currently the best ‘treatment’ of HIV/AIDS is to prevent the spread thereof. The only totally reliable way of preventing the spread of HIV/AIDS through sexual intercourse is total abstinence. Abstaining from sex is the only 100 percent effective way to prevent the transmission of HIV (Van Dyk 2003:134). Other means of prevention includes being faithful to one partner or using a condom.

#### **(ii) Preventing mother to child transmission**

During the past decade research has been conducted to determine the causes and possible prevention of mother to child transmission (Ntsaluba 2000:4). One solution offered is to give the anti-retroviral drug to pregnant mothers during the last four weeks of pregnancy to decrease the viral load and inhibit viral reproduction of mother and decrease the possibility of mother to child transmission (Whiteside & Sunter 2000:147). Where mothers receive no

treatment, the mother to child transmission is approximately 20 percent. Where mothers receive anti-retroviral drugs the transmission is approximately 10 percent (Ziehl 2002:439).

In the United States of America (USA) anti-retroviral drugs for pregnant women proved to be most successful (Fauci 2000:19). In South Africa anti-retroviral treatment for mothers was started in recent years. Crothers (2001:21) warns that the failure of the government to lower the extent of mother to child transmission will result in much larger social costs which will have to be borne in the near future.

### **(iii) Supporting the immune system**

People whose bodies and especially immune systems have been damaged by malnutrition are more susceptible to secondary infections which ultimately kill them. Medical researchers suggest that a healthy diet consisting of vitamin and mineral supplementation may enhance the immune system to respond to HIV infection (Everett 1995:72).

According to Orr (1986:30) a healthy diet consists of natural unrefined and unprocessed food which may be found locally. Such a diet may be sufficient and adequate to protect the immune system and keep the person healthy for a long period of time. Unfortunately people living in poor socio-economic circumstances may be unable to afford the type of food necessary to assist their immune system in slowing the course of the disease.

### **(iv) Treatment of opportunistic diseases**

Opportunistic diseases are life-threatening infections that occur because the immune system is weakened (Evian 1995:7). Van Dyk (2001:40) agrees that the opportunistic disease are caused by micro-organisms which normally do not become pathogenic in a healthy person. Opportunistic infection is usually associated with HIV/AIDS, therefore the prevention treatment of opportunistic disease is generally based on CD4 cell count (Evian 2000:7).

Van Dyk (2000:72) lists the following opportunistic diseases which are associated with HIV/AIDS within the South African context.

- Tuberculosis (TB) is the most serious and common opportunistic infection. Because HIV/AIDS represses the immune system of people, the prevalence of TB has increased dramatically. It is estimated that 50 percent of all tuberculosis patients are co-infected with HIV. The patient is treated with the combination of Isoniazid drug which destroys the infected organism. This therapy is continued for six months until the disease is brought under control.
- Oral and vaginal thrush which can be prevented by prophylactic drugs. This is most important in the case of oral thrush as this condition makes eating and swallowing difficult often resulting in malnutrition of the person affected.
- HIV/AIDS infected people have depleted immune systems which make them vulnerable to opportunistic diseases. The patients can maintain a reasonable quality of life by protecting themselves against opportunistic diseases. This is done by strengthening the immune system so that the patient keeps as healthy as possible. In addition, it is important to keep the viral count as low as possible (Van Dyk 2000:72).

**(v) Anti-retroviral drugs for people who are HIV positive**

According to Du Toit (1997:13) and Evian (1995:210) there are currently three categories of anti-retroviral drugs which reduce the HIV load as much as possible and as long as possible and improve the patient's immune functioning system.

Van Dyk (2003:67) mentions the three main categories of anti-retroviral drugs.

- (i) The nucleoside reverse transcriptase inhibitor such as zidovudine.
- (ii) The non-nucleoside reverse transcriptase inhibitors are the Nevirapine.
- (iii) The protease inhibitor are the Indinavir.

According to the medical researchers the combination of two or three different anti-retroviral drugs produces the best effect and reduces the possible viral resistance. However, Fauci (2000:19) warns that in countries in which the per capita allowance for health care is limited anti-retroviral drugs are invariably beyond the reach of all but the privileged few.

Drugs, however, are unable to get rid of HIV/AIDS and cure a person of the disease, so the patient has to take the medication at specified times for the rest of his/her life.

## **2.3 HIV/AIDS IN SOUTH AFRICA**

South Africa has more HIV positive individuals than any other country in the world (Internet 2003b).

### **2.3.1 The prevalence of HIV/AIDS in South Africa**

The Actuarial Society of HIV/AIDS in South Africa (ASSA) model estimate that there were 6,5 million people in South Africa living with HIV/AIDS in 2002, of these over 6,1 million were in the age group 18-64 years. An estimated 3,2 million women of child-bearing age (15-49 years) were living with HIV/AIDS. However, research by the Medical Council puts the number of infections at 12 percent of all South Africans (Hall 2003:39).

The virus type most prevalent in South Africa is HIV-1 sub type C. HIV/AIDS which primarily affects young adults in the prime of their lives. About half of all people who acquire HIV in South Africa, become infected before they are 25 years and typically die of AIDS before their 35<sup>th</sup> birthday (UNICEF 2001:1).

HIV prevalence varies across different geographic regions. KwaZulu-Natal continues to be the province with the highest prevalence and one of the highest growth rates over the past four years. For example, tests show that HIV infections among pregnant women at antenatal clinics have increased from 19,9 percent in 1996 to 36,2 percent in 2000. The Western Cape

has the lowest infection rate in South Africa (Hall 2003:39). The prevalence of HIV/AIDS in the North West Province is discussed in section 2.3.3.

### **2.3.2 Government policy on HIV/AIDS**

In the early 1990's, South Africa was the only country in the world which had to contend with an exponential rise in HIV prevalence rates in the context of a major political transition (Crewe 2002:448). However, in 1994 a new democratic government was in place and a national AIDS plan was adopted. Nevertheless, the epidemic continued to grow rapidly and unchecked and hopes were soon dissolved that the spread of HIV infection could be contained (Marais 2000:7).

Coombe (2000:21-22) lists the following strategies put in place by the South African government to deal with the HIV/AIDS epidemic.

1. **The South African Strategic and Implementation Plan.** This was endorsed by Cabinet in 1994 and is a comprehensive and practical plan designed to:
  - prevent the spread of HIV/AIDS;
  - reduce the impact of HIV/AIDS;
  - harness existing potential resources.

By 1998 administrative structures were in place at national and provincial levels to implement this plan.

2. **The HIV/AIDS/STD Strategic Plan for South Africa 2000-2005.** This plan was announced by the Minister of Health in 2000 and is intended to guide the country's responses to the epidemic. The plan focuses on four areas:
  - prevention;
  - treatment and support;

- human and legal rights;
- monitoring research and surveillance.

However, Coombe (2000:22) concludes that the document was a step backwards since it excluded the potential impact of HIV/AIDS on social, economic and infrastructure vital to national sectors like labour, education, agriculture and business.

3. **National Integrated Plan for Children Infected and Affected by HIV/AIDS.** This plan was introduced in 2000 (Coombe 2000:22) and is designed to:

- strengthen the teaching of life skills in primary and secondary schools;
- develop strategies for caring for orphans and people living with HIV/AIDS;
- find ways of making voluntary testing and counselling available.

In spite of these plans HIV prevalence rates of woman attending antenatal clinics rose from 0,7 percent in 1990 to 22 percent in 1999.

Moreover, the plans were not implemented as envisaged. There is a lack of coherent policy document on crucial issues and the intervention plan of the government does not seem to have had any impact on the spread of HIV/AIDS in South Africa (Crewe 2002:448).

### **2.3.3 HIV/AIDS in the North West Province**

There are 3,5 million people residing in the North West Province (NWP), on some 116 320 km<sup>2</sup> of land. The human resource development in this province is poor with 22,7 percent of adults never having received any schooling (Internet 2003a).

Mining plays a dominant role in the ecology of the province, contributing some 55 percent of its gross domestic product (GDP) employing a quarter of the labour force (cf 1.5). The area around Rustenburg and Brits is the largest platinum producing area in the world (Internet 2003c). These contextual factors contribute to the rapid spread of the disease in the province. In the NWP, HIV prevalence of adults between 18-64 years is 24,8 percent (Dorrington et al 2002:5).

The provincial government of the NWP, is taking the fight against AIDS seriously. The collective efforts to combat the scourge of HIV/AIDS and in particular the involvement of schools, continue to make an immeasurable impact. This is evident in the new programme which is taking the fight to the school grounds (Internet 2003a).

With the increased number of infection in the mines, Lonmin, the world's biggest platinum group, will provide anti-retroviral drugs to those of its 26,000 employees who need them. By taking action the company expects to reduce the spread of HIV/AIDS to 20 percent by 2011. Mobile clinics are used to reach the community of women who are selling sex to the mine workers, encouraging them to use condoms. Researchers estimate that this has averted some 20 percent of possible HIV infection among miners (Internet 2003d).

#### **2.4 THE IMPACT OF HIV/AIDS ON EDUCATION**

The above statistics of the pandemic are also reflected in the education sector. This means, among others, that educators are also affected or infected with HIV/AIDS. Moreover, educators are well educated, mobile and relatively affluent and thus fall in a category which is particularly at risk. This means that the incidence of HIV infection among educators is likely to be above that of the population as a whole (Coombe 2000:1). This is in line with what is happening elsewhere in Africa. For example, Van Dyk (2003:153) states that the Central African Republic has a 33 percent shortage of primary school teachers, which has led to the closing of 107 schools. In Cote d'Ivoire the number of teachers who die of HIV/AIDS related disease is increasing. In Zambia teacher mortality is set at 4 percent almost 70 percent higher than the general public, with AIDS being the primary cause. In Botswana a 1999

survey suggests that the country is losing up to 5 percent of its teachers annually due to HIV/AIDS (Hepburn 2002:92). In South Africa, delegates at a conference on HIV/AIDS (2000:6) postulate that the disease affects the educational performance not only in schools but also at all levels of the sector, from early childhood development to post-graduate studies. When educators become ill, their teaching capacity decreases further limiting the quality of instruction. As HIV progresses into full-blown AIDS, educators are often forced to take long absences to recuperate from illness. Since substitute educators are rare, classes are often suspended. If teachers are physically able to attend classes, the emotional stress is traumatic and lesson preparation, homework correction and class interaction are often their last priority (Hepburn 2002:91).

Learners themselves may be HIV infected and will have to deal with this fact and the emotional trauma thereof. According to Gilbert (2001:135), the school is often the first place where behavioural and emotional problems of HIV affected children are exhibited. As the pandemic takes hold, drop-out rates and absenteeism among learners affected is bound to rise as a result of poverty, illness, lack of motivation and trauma (Valley 2001:13). Moreover, learners may be caring for sick or dying parents, or may have a parent or sibling who has died. This may leave young children in charge of the home, with little or no money.

Financial support of school may be decreased. Although primary education in South Africa is said to be free, there are still some costs involved, such as costs of a school uniform, school maintenance and construction and a nominal amount of school fees. These expenses are particularly difficult for households seriously weakened by AIDS (Hepburn 2002:91).

#### **2.4.1 The effects of HIV/AIDS on learners**

Learners in South Africa are affected in three ways:

- Educators who are affected are absent from school for increasing periods, thus disturbing their schooling.
- Learners are not helped to cope with grief and death.

- Learners themselves may have to face death at any early stage.

Qualitative studies of HIV/AIDS of South African youth have shown that adolescents girls are often more worried about falling pregnant than becoming infected with HIV (Uys 2002:387). Porteus (2001:35) also cites research which indicates that even when young people have a fairly solid understanding of HIV/AIDS and prevention methods, a large number of young people do not act on this knowledge. Likewise, learners do not consider themselves to be at risk of contracting HIV/AIDS. They believe that it only happens to other people, like uneducated people, rural people and homosexuals (Uys 2002:388). Thus, in research cited by Porteus (2001:35), 22 percent of knowledgeable learners who categorise themselves as 'low-risk' were in fact infected with the virus.

Adolescents in South Africa are aware of HIV/AIDS but both urban and rural myths confuse them and prevents them from protecting themselves (Tillotson & Naharaj 2001:88). These authors list the following myths to illustrate this:

- HIV/AIDS can be cured by having intercourse with a virgin.
- Tradition healers can cure HIV/AIDS.
- The African potato can cure HIV/AIDS.
- HIV does not inevitably lead to AIDS.

In addition, adolescents may also have a fatalistic attitude towards HIV/AIDS and feel that their efforts to protect themselves are futile (Tillotson & Maharaj 2001:91).

## **2.5 THE ROLE OF EDUCATION IN THE HIV/AIDS CAMPAIGN**

### **2.5.1 HIV/AIDS awareness**

In America educators play a vital role in HIV/AIDS awareness programmes. According to Ainsa (2000:16) professional preparation programmes are provided to educators to help them

improve knowledge and effectively manage the classroom situation involving infected children.

In South Africa many educators will first need to be trained in order to train the learners.

### **2.5.2 Support for educators affected by HIV/AIDS**

This implies making arrangement so that schooling is not disrupted when educators are sick or attending funerals. According to the Department of Education (1999:15), demands are made on other members of the staff to support infected educators by taking over their duties when they are ill. This means that educators will need to be taught how to deal with large groups of learners and occupy learners whose educators are absent.

### **2.5.3 Support for learners affected by HIV/AIDS**

Affected learners should be supported by educators and other learners. Educators should allow learners affected to take their medication when necessary. Learners who develop behavioural problems should be assisted to cope with the emotional trauma associated with HIV-infections. Louw et al (2001:8) suggest that educators should display a willingness to assist, even if it is only by giving emotional support, which can alleviate stress. Learners can support infected learners by not discriminating against them (RSA 1999:11).

### **2.5.4 Partnership with parents**

Parents need to understand HIV/AIDS so that they can support the efforts of the school to educate the children. Coombe (2000:30) postulates that parents and communities need comprehensive health education aimed at preventing and controlling the spread of the disease and to support infected children in and out of school. Cohen (2002:15) argues that it is

difficult for schools to change the sexual behaviour of children unless the parental and community values also change.

According to the Conference on HIV/AIDS (2002:32), parents should be closely involved in the HIV/AIDS campaign in partnership with the school and mobilised through training sessions and discussion. There should be closer links between parents and schools to work together to create support systems in the school and community.

## **2.6 THE ROLE OF THE SCHOOL PRINCIPAL IN MANAGING THE EFFECTS OF HIV/AIDS ON EDUCATION IN SCHOOLS**

The principal and his/her management team play a pivotal role in schools and need to play an important role in ensuring that the school is knowledgeable and supported in accordance with the policies of the Department of Education.

Although the focus of this research is on the HIV/AIDS awareness campaign, the support of educators, learners and the community is also relevant and will be briefly included in this section. This implies that the principal needs to fulfil a number of roles.

### **2.6.1 Interpreting and implementing policy**

In 1999 the Department of Education published policy and guidelines for learning institutions, where increasing number of staff and learners are HIV positive. This policy set out procedures to protect learners and staff who have divulged their HIV status.

The principal has to see to it that the HIV/AIDS awareness campaign is implemented and that no learner or staff is discriminated against should they choose to make their status known. To prevent discrimination, all learners and educators should be educated about fundamental human rights (RSA 1999:11).

### **2.6.2 Creating a positive school climate**

The principal has a duty to create a school climate conducive to the protection of girls, one of tolerance towards people affected by HIV/AIDS and one where knowledge regarding HIV/AIDS is seen as important.

According to Van der Westhuizen (1996:92) climate in school refers to the 'team spirit' and the social interaction between educators and learners irrespective of whether they live with HIV/AIDS or not.

The principal should preempt misconceptions by providing accurate and understandable information on HIV/AIDS to all educators, learners and parents in the case of a refusal to study with a learner or to be taught by an educator perceived to have HIV/AIDS (Tutorial Letter 103/2000:43). Genuine voluntary disclosure of a learners HIV/AIDS status should be welcomed by the principal to enable an environment of confidentiality among educators.

Hoy and Miskel (1991:413) regard the school climate as a relatively enduring quality of the school environment that is influenced by educators, affects their behaviour and is based on their collective perceptions of behaviour in school. In the case of HIV/AIDS, school climate should allow learners and educators with HIV/AIDS to be supported, loved and understood. They should be allowed to take their medicine at set times in order to get maximum benefits from it (Guideline for Educator 1999:15).

### **2.6.3 Leadership role**

The important position that the principal holds and the role he/she plays in the school in HIV/AIDS awareness campaign cannot be underestimated. The principal needs to be a leader in the fight against HIV/AIDS and the manner in which the problem is addressed in schools and the success of the awareness campaign. As a leader, the principal has to create a vision with his/her management and staff, make that vision a reality, communicate this vision and

translate the vision into reality concerning the HIV/AIDS awareness campaign (Bennet et al 1994:18). According to Keith and Girling (1991:57) the principal as a leader must lead the staff to commitment to the vision of the school about HIV/AIDS and empower them so that their combined efforts result in the attainment of and success of the awareness campaign. The principal, according to Eyre (1993:193), must see to it that the staff has a common purpose regarding HIV/AIDS for the success of the awareness campaign.

#### **2.6.4 Providing in-service training for educators**

According to Webb et al (1994:234) development of educators include in-service training, professional growth, continuing education, on the job training and staff improvement.

In 1995 the Department of Health and the Department of Education formed the National Coordinating Committee for Life Skills and HIV/AIDS in secondary and primary schools. The goal of the programme is to increase knowledge, develop skills, promote positive and responsible attitudes and provide motivational support. Therefore, according to Coombe (2000:38), educators need in-service training and constant retraining.

Training educators will equip them with skills to help learners affected by HIV/AIDS cope. Traumatized children are prone to feelings of inadequacy and depression and may suffer post traumatic stress disorder. Thus, educators need to be able to identify such psycho-social stress early and be able to care and support them. Ebersohn and Eloff (2002:78) state that caring for children of today will give them a better chance of becoming the resilient adults of tomorrow.

The in-service training will also spark the interest of educators in research into ways of assisting HIV bereaved children. This is particularly needed in the case of children who do not have the support of the extended family due to the stigma associated with HIV/AIDS.

Castetter (1986:291) regards the following as the principal goals of personnel development in a HIV/AIDS awareness programme.

- To improve educators' performance especially with regard to knowledge on HIV/AIDS.
- To provide a meaningful HIV/AIDS awareness programme in which the strengths and talents of each educator can be utilised.

Educators must be empowered in every way so as to meet the challenge of creating HIV/AIDS awareness campaign in school and in every sphere in the community. According to Sergiovanni (1984:211), empowering educators should offer them more opportunities in many areas of the school situation. This empowerment is seen as one of the tasks of school principals.

### **2.6.5 Staff motivation**

The principal needs to motivate the staff to remain committed even when conditions in school may be difficult. Issues relating to HIV/AIDS which could impact on motivation could include a marked decline in school attendance, educators becoming ill and financial problems of the school due to community not being able to support the school. According to Everard and Morris (1990:35), the principal should use 'motivators', this is to provide for educator's need for achievement, recognition, responsibility, job interest, personal growth and advancement potential.

Receiving certificates of attendance for workshops on HIV/AIDS can motivate educators extrinsically and create awareness of the pandemic. T-shirts, bags, stickers can also be considered as a means of motivating educators. McEvoy (1990:8) agrees that staff who are praised for their work, develop a sense of pride and tend to share an interest in innovations that might lead to improved performance.

Intrinsic motivation is related to feelings of competence, achievement and prestige (Hoy & Miskel 1991:198). This can be fostered if the important role of education in combatting the spread of HIV/AIDS is emphasised and the contribution of educators highlighted.

### **2.6.6 Creating a positive school culture**

The school culture is the shared convictions, values, norms, temperament, assumptions and expectations that bind individuals and shape their behaviour within the school (Peterson 1988:252). Torrington and Weightman (1993:46) add that the culture of the school is the characteristic spirit and belief, demonstrated in the norms and values that are generally held about how people should treat each other and the nature of working relationships that should be developed. Relating this to HIV/AIDS, it implies that a culture of tolerance should also be developed in which learners and educators who are suffering from HIV/AIDS will be supported. The attitude of leadership of principals can make a valuable contribution towards this. Likewise, educators and learners infected with the HIV virus, or affected by HIV/AIDS within their family need to be encouraged to form support groups (Guidelines for educators 1999:15).

According to Hoy and Miskel (1991:254), the culture of the school is expressed by rituals such as when a school lights candles each year in memory of educators, learners or family members who have died of AIDS-related illnesses during the past year.

### **2.6.7 The principal as instructional leader**

According to Donmoyer and Wagstaff (1990:20) the most direct way for a school principal to exercise instructional leadership is through the managerial tasks he/she engages in every day. The management of the school's instructional programme pertaining to HIV/AIDS awareness programme remains a most important aspect of the principal's task, since the success of the awareness programmes depends to a large extent on the knowledge and insight of educators offering the programmes.

### **2.6.8 Curriculum coordination**

It is the work of the principal to adjust the overall department curriculum according to the HIV/AIDS programme included in the life-skills classes. When doing so the principal and educators need to take the customs and beliefs of the school community into consideration.

A holistic programme for life skills and HIV/AIDS is to be implemented in the school according to the directives of the Department of Education (Tutorial letter 103/2000:43).

### **2.6.9 Enrichment programmes**

Sergiovanni and Starratt (1988:155) see enrichment programmes as the educators' internal motivation to continually produce good work in order to experience positive feelings about their performance. Related to HIV/AIDS this could include:

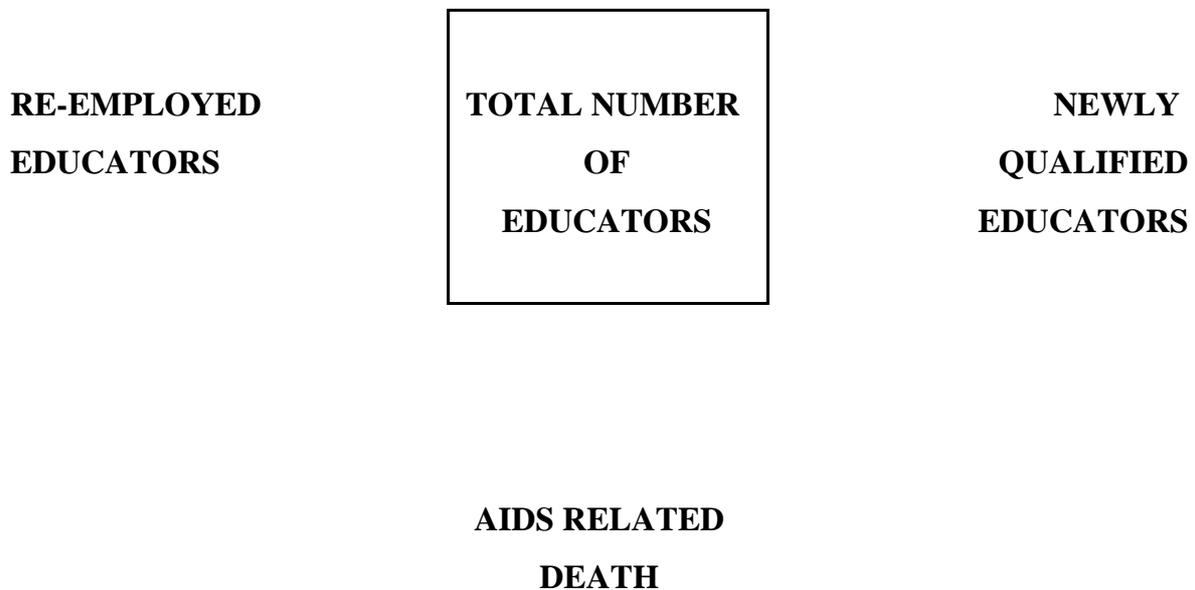
- an awareness of HIV/AIDS and the impact of this on education in South Africa;
- a sense of responsibility to see that learners receive accurate knowledge about HIV/AIDS;
- a feeling that as they perform their duty in this regard, they are contributing to combatting the spread of HIV/AIDS among young people.

## **2.7 THE EFFECT OF HIV/AIDS ON THE SUPPLY OF EDUCATORS IN SOUTH AFRICA**

In this study, an attempt to understand the effect of HIV/AIDS on educators is located within an understanding of the factors that influence the supply and demand for educators.

Educators are lost to the teaching profession for a variety of reasons: normal retirement, resignation and death (Hall 2003:35). Newly qualified educators enter the profession after a period of three to four years of training and a small number of educators re-enter the profession after having left it for a number of years. This is illustrated in Figure 1.

**RESIGNATION OR  
RETIREMENT**



**Figure 1: Educators demand and supply model**

Working on figure prior to the onset of the HIV/AIDS epidemic, the National Educator Audit (1995) indicates that the average national attrition rate from the educating profession was between four percent and five percent. Hall (2003:40) argues that there is a higher infection rate nationally among females than men and a higher infection rate among people younger than 50 years of age. The teaching profession is 65 percent female and 85 percent are younger than 50 years making it particularly vulnerable to infection rate. However, if one takes the present infection rates of the general population and the estimated number of deaths between 2001 and 2004 based on life expectance of 10 years after infection, then 41400 educators will die of AIDS-related diseases if an infection rate of 11,1 percent is accepted. This means that in the near future, South Africa may experience a severe shortage of qualified educators in schools.

This is not unique to South Africa. Hepburn (2002:92) states that in Zambia educators mortality is set at four percent - almost 70 percent higher than the general public with AIDS being the primary cause. In Botswana, 1999 estimates suggest the country is losing up to five percent of its educators annually.

Educators have a very important role to play in educating learners about HIV/AIDS and to support learners whose parents have died due to AIDS related infections (Hall 2003:34). Therefore, if educators are affected by HIV/AIDS, the quality of learning and teaching will also be affected (Coombe 2000:40).

When teachers become ill, their teaching capacity decreases, further limiting the quality of instruction. As years go by, HIV progresses into full blown AIDS and educators are forced to take long absences to recuperate from illnesses. Substitute educators are rare and classes are often suspended. If infected educators are well enough to attend classes, the emotional stress is traumatic and lesson preparation, homework and correction of class tests are negatively affected (Hepburn 2002:18). Once educators know they are infected, morale is likely to fall significantly. The infected educators have to cope both emotionally and financially with sickness and death among relatives, friends and colleagues and wrestle with the uncertainty about their own future as well as their dependents (Coombe 2000:18).

Education management and development is also likely to be affected. Coombe (2000:18) anticipates that the system will lose experienced educators and managers whose experience cannot be replaced. Younger and less-experienced educators will take their place. As a result, the quality of teaching and learning will decline in the schools.

## **2.8 CONCLUSION**

HIV/AIDS is spreading dramatically in South Africa, disrupting the functioning of society and causing widespread human losses (Coombe 2000:9). Education is one of the vital sectors which is severely affected. According to Kelly (2000:2) education in a world with AIDS must of necessity be different from education in an AIDS free world.

Awareness programmes should take a lead in informing learners so that the disease is prevented from spreading further. Thus, the entire educational edifice has to be taken down and reshaped to suit the world with AIDS. The principal and his/her management have to play a vital role to ensure that the HIV/AIDS awareness programme is successful.

In the next chapter (Chapter 3) the researcher discusses the research design.