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THE IMPLEMENTATION OF HIV/AIDS POLICIES IN PRIMARY SCHOOLS IN THE UMGENI NORTH WARD

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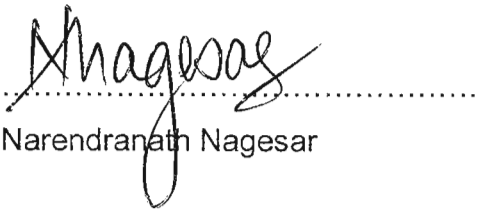
DECLARATION

I, Narendranath Nagesar (Student Number 205527603) declare that this study entitled:

"THE IMPLEMENTATION OF PRIMARY SCHOOL BASED HIV/AIDS POLICES IN THE UMGENI NORTH WARD"

is the result of my own investigation. I declare that this study represents the author's own research and it has not been submitted in part or full for any other degree or to any other university. No source material has been falsely used or unacknowledged.



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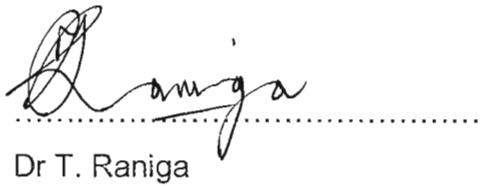
Narendranath Nagesar

September 2008

DECLARATION BY SUPERVISOR

This thesis, which I have supervised, is being submitted with my approval



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DEDICATION

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ABSTRACT

The 2003 UNESCO report indicated that the HIV/AIDS pandemic contributes to rapid breakdowns of existing structures that traditionally took care of the development of young children. There must be strategies to provide support, care and guidance to young children, families, parents and care givers that are directly or indirectly affected by HIV/AIDS. This is classified as interventions at the local level. There must be a conducive policy environment that allows safety nets and strategic interventions to take place, to grow and be inclusive (UNESCO, 2003:18).

The death of parents and other family members leave children in a vulnerable state, some of whom enter the school system and are at the mercy of others. School based HIV/AIDS policies and programmes are necessary to protect these children. A two phase research design incorporating quantitative and qualitative methods was utilized in this study. The first part of this study was quantitative (audit of HIV/AIDS policies in 23 schools) and the second was qualitative, which comprised 2 focus group interviews.

Findings from the quantitative audit from phase one of the study indicated that while primary schools attempted to comply with the National Schools policy on HIV/AIDS (DoE 1999), policy formulation, policy involvement, policy implementation (action plan) and policy review have not been conducted as per policy directives.

Four major themes and various sub-themes emerged from the phase two qualitative focus group interviews with participants from two primary schools. Process of policy formulation and implementation, school based HIV/AIDS action plans, support mechanisms and challenges emerged as the factors associated with the formulation and implementation of school based HIV/AIDS policies in the Umgeni North Ward. Much of the phase one data is triangulated with data from phase two, hence the triangulated methodology.

This study confirmed that in some schools, a fragmented relationship between the important stakeholders exists. This leads to the needs of those infected and or affected by the epidemic being treated in a vacuum. Hence, other intervention strategies are necessary. Institutional resources (educator support teams, funding, human resource and school nurse) as well as working closely with other departments are support mechanisms that can assist schools where children are infected and affected by the epidemic.

In light of this, HIV/AIDS related problems pose a dilemma for educators to handle. Educators feel insecure as a result of lack of training, lack of support, poor policy directives and a lack of support mechanisms in the school environment to deal with HIV/AIDS related problems in the school context.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARRM	Aids Risk Reduction Model
CBO	Community Based Organization
CRC	Convention on the rights of the Child
DOE	Department of Education
EST	Educator Support Teams
FBO	Faith Based Organization
HAC	Health Advisory Committee
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
LSEN	Learners with Special Educational Needs
NGO	Non Governmental Organization
SPSS	Statistical Package for the Social Sciences
UNAIDS	United Nations Programme for HIV/AIDS
UNESCO	United Nations Educational Scientific Cultural Organisation
UNICEF	United Nation International Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CHAPTER ONE
ABOUT THE RESEARCH

1.1 INTRODUCTION

It is estimated that every minute of every day worldwide, a child under the age of 15 becomes infected with HIV. Children under 15 account for one in six AIDS related deaths worldwide and one in seven new HIV infections. Ninety percent of the more than 5 million children who have been infected were born in Africa (UNAIDS, 2007). These figures indicate the need for an afro centric approach to handle this crisis as 4.5 million children who were infected were born in Africa. These figures indicate the need for people in Africa to work together to solve the problems in Africa.

"HIV/AIDS policies a must, principals agree" appeared as a headline in a local newspaper. The article stated that "*School principals across the province agree that it is imperative for every school to adopt an HIV/AIDS policy*" (POST, 5 September 2007). Even though the reporter, Yogus Nair (2007) interviewed principals from three secondary schools, the proposals are applicable to primary schools.

Primary school children are definitely infected and affected. As recently as September 2007, the KwaZulu Natal Department of Education launched an investigation into allegations that a six year old child was allegedly ostracized by a Chatsworth school teacher because of her HIV/AIDS status (POST, 5 September 2007). This particular case provides evidence that a primary school child was in a vulnerable position. This study is concerned with the policy environment in primary schools. The concerns expressed from a secondary school perspective by Nair may be applied to primary schools as learners in this context are also infected and or affected by the epidemic.

This opening chapter begins with an introduction and is followed by an overview of the background and outline of the research problem. The rationale, overall

purpose of the study, aims and objectives of the study, key questions and underlying assumptions are then presented. Subsequently, the theoretical framework incorporating the microsystem, mesosystem, exosystem and macro system is discussed in detail. The conclusion to this chapter indicates how the remaining chapters are presented.

1.2 BACKGROUND AND OUTLINE OF RESEARCH PROBLEM

"Sub-Saharan Africa is severely impacted by the HIV/AIDS pandemic" (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste and Pillay, 2005). Recent estimates suggest that of all people living with HIV in the world, six out of ten men (60 %), five out of ten women (50 %), and nine out of ten children (90 %) live in sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS a sub-Saharan and South African priority. HIV/AIDS contributes to orphan-hood due to the premature death of mostly young biological parents. The number of orphans in sub-Saharan Africa as at 2005 was 2 531 810. Of this, there were 455 970 maternal orphans, 1 745 715 paternal orphans and 330 125 double orphans (Shisana et al., 2005). In 2000, it was estimated that HIV/AIDS orphans in KwaZulu-Natal ranged between 197 000 and 278 000. In rural KwaZulu-Natal, 76 percent of girls and 90 percent of boys are sexually experienced by the time they are 15-16 (Coombe, 2000). The question arises whether there are support systems in schools to assist these children deal with the effects of the epidemic.

Dorrington, Bourne, Bradshaw, Laubscher and Timaeus (2001) indicated that HIV/AIDS deaths can be expected to grow to more than double the number due to other causes, resulting in 5 to 7 million cumulative AIDS deaths in South Africa by 2011. South Africa has one of the most extensive AIDS epidemics in the world. In South Africa, HIV/AIDS is the major cause of death (The World Bank, 2004). According to Coombe (2000), about half of South Africa's children who are 15 years old will probably die of HIV/AIDS. Therefore, South African children are in a vulnerable position.

Morrell (2002) indicated that young people display contradictory characteristics, for example, dependent but independence-seeking; risk taking in some ways but conformist in others. These characteristics make these young children particularly vulnerable to HIV infection. What adds to the complexity in South Africa is that some children from 15 to 18 are still in primary schools where these young people are prone to exploring their sexual identity and are therefore prone to risk-taking behaviour. Hence, sexually active children are in primary schools. These are over-aged learners who are in the adolescent phase of life and are ready to experiment with drugs and sexual activity. The schools are inhabited by these youngsters and this makes schools a high-risk environment. At the same time, schools are the key strategic ground on which the battle to mitigate the impact will be won or lost (Badcock-Walters, 2002).

Against this background, it is important to identify primary school children who are infected and affected by the epidemic. Children may be orphaned, absent themselves from school, do not have uniforms, do not have stationery, have no place to do their homework, come late to school, head households, end up on the street, become criminals, take drugs, engage in harmful sexual and cultural practices, are not accepted in school and communities, and contemplate suicide. This creates a challenge for all South Africans. The concern is on how and when do we respond to the needs of these vulnerable children? Well defined school policies and implementation of intervention programmes may be the answer.

One of the recommendations of The United Nations Special Session on HIV/AIDS Declaration of Commitment was to find ways to influence policy dialogue at local (micro), national (macro) and regional (mezzo) levels (UNESCO, 2003). The National Policy on HIV/AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (Government Gazette, Vol. 410, No. 20372) (hereafter referred to as the National School Policy on HIV/AIDS) for all schools in South Africa was rolled out in 1999 (Department of Education, 1999). Section 12.1 of the National Policy on HIV/AIDS indicates that the governing body of a school may develop and adopt its own implementation plan on HIV/AIDS (Department of Education, Government Gazette No. 1926 of 1999). The expectation of the Department of

Education both at national and provincial level is that each school should have its own policy on HIV/AIDS (hereafter referred to as the school based HIV/AIDS policy). The assumption made in section 12.1 of the National School Policy on HIV/AIDS is that all school governing bodies have the capacity to formulate and implement school-based policies. One of the key objectives of this study was to look at the challenges and the role of the school governing body in the formation of policies.

The Department of Education, in 2003, developed a guide for school governing bodies and management teams to assist with the formulation of school-based HIV/AIDS policies. The Department of Education (2003) guidelines provides an example of an action plan to implement the policy. The initial action of the school incorporates setting up a structure that implements the school based HIV/AIDS policy. This structure is known as the Health Advisory Committee (HAC). A letter indicating the role and responsibilities of the committee as well as criteria for serving on the committee should be sent out as an invite to interested parties to attend a meeting. The principal and school governing body chairperson should be part of this committee that works within timeframes and budget. This committee should look at ways to take action with respect to five critical priorities. The first action could involve direct interventions (correct information, condom provision, first aid, universal precautions). The second action could involve strengthening the Life Skills programme (evaluation, training, involving parents). The third action could incorporate partnerships (working together, peer education, workshops, networking). The fourth action involves creating a culture of caring and openness (awareness campaigns to fight blame and discrimination). Each school is expected to submit a copy of the school based HIV/AIDS policy to the district manager (Department of Education, 2003).

The Department of Education (2003) guidelines acknowledge that many schools struggle to implement their HIV and AIDS policy because of over-ambitious goals, poorly defined aims, weak leadership and loss of interest. The guide indicates that openness, compassion, the right information, local support teams and coherence are important for successful policy implementation (Department of

Education, 2003). In the struggle to implement policy, the question then arises, is policy implemented?

1.3 RATIONALE FOR THE STUDY

This study investigated whether primary school based HIV/AIDS policies are implemented in the Umgeni North Ward. The Umgeni North Ward was chosen as I am an educator who works in this region and have experienced children that are affected and infected in this Ward. Raniga (2006) in her study which investigated 'The implementation of the National Life-Skills and HIV/AIDS school policy and programme in the eThekwini region' indicated that a gap existed regarding policy awareness and implementation in the North Durban Region. The Department of Education has identified five critical priorities for addressing HIV/AIDS, namely, preventing the spread of HIV, care and support for learners, care and support for educators, protecting the quality of education and managing a coherent response. My personal experience as an educator of 22 years indicated that these critical priorities are being addressed on an ad-hoc basis in schools.

In recent years, I have had to deal with many children infected and or affected by HIV/AIDS on a daily basis. In some instances, the parents of the child who were infected with HIV provided consent for me to disclose this information to other subject teachers. After disclosing this information to the subject teachers, we worked as a team to assist this child. While we advised the child as well as the parent, we found it difficult to offer substantial assistance to this child as our school based HIV/AIDS policy did not provide clear directives. We referred the child and parent to social services.

Another child presented many problems in class. He was disruptive, he hid under the desk, he placed large amounts of cello-tape around his mouth, he refused to do his homework, and he refused to write the test. Educators complained about this child. This child informed the class educator that he was HIV positive. His parents were angry that the child disclosed his status as they are in denial. As I was not given consent to discuss his status with the other

subject teachers, all I could do was inform them that this child is having personal problems. The subject teachers were not satisfied with my explanation. We found it difficult to offer substantial assistance to this child as well. This child could not be referred to social services as parental consent was required. From these two examples my concern has been with the blatant lack of clear policy directives and support mechanisms in schools to deal with children infected and or affected by the epidemic.

A further concern that motivated my involvement in this study was my experiences with school governing bodies and their lack of capacity in formulating and engaging in enlightened policies. I am aware of a school where the school governing body did not develop a school based HIV/AIDS policy. The HIV/AIDS policy in that school was developed by educators. The policy, which was developed in 2002 has not been reviewed or updated since inception. The governing body at this school has since changed. To date, the personnel in that school have not established the Health Advisory Committee (HAC). Through this study I hoped to investigate whether this was a unique situation or applicable to other primary schools.

Very little research has been done on the implementation of primary school based HIV/AIDS policies. A study conducted by Mathews, Boon, Flisher and Schaalma (2006) in Cape Town secondary schools indicated that *"the existence of a school HIV/AIDS policy, a climate of equity and fairness and good school-community relations were the characteristics associated with teaching HIV/AIDS"*. Their findings demonstrate the value of training and policy formulation.

1.4 OVERALL PURPOSE OF THE STUDY

The overall purpose of the study was to investigate the implementation of primary school based HIV/AIDS policies in the Umgeni North Ward.

1.5 OBJECTIVES OF THE STUDY

The main objectives of this study were to investigate:

1.5.1 The extent to which 24 primary schools in the Umgeni North Ward have a school based HIV/AIDS policy.

1.5.2 The extent to which the HIV/AIDS policies are implemented in 24 primary schools

1.5.3 The processes involved in drawing up the HIV/AIDS policies in 2 primary schools.

1.5.4 The challenges experienced by educators in formulating and implementing the school based HIV/AIDS policies in 2 primary schools.

1.6 KEY QUESTIONS

The key questions that formed the basis of this study were:

1.6.1 How many of the 24 primary schools in the Umgeni North Ward have a school based HIV/AIDS policy?

1.6.2 To what extent are school based HIV/AIDS policies implemented in 24 primary schools?

1.6.3 What are the processes involved in drawing up the school based HIV/AIDS policies in 2 primary schools?

1.6.4 Who was involved in drawing up the school based HIV/AIDS policies in 2 primary schools?

1.6.5 What challenges have been experienced by educators in the implementation of the school based HIV/AIDS policies in these 2 primary schools?

1.7 UNDERLYING ASSUMPTIONS

The following basic assumptions formed the foundations of this study:

1.7.1 Primary schools in the Umgeni North Ward have not established the Health Advisory Committee (HAC).

1.7.2 School governing bodies lack the capacity to formulate enlightened school based HIV/AIDS policies.

1.7.3 Primary schools in the Umgeni North Ward do not have operational school based HIV/AIDS policies.

1.7.4 Primary school educators lack the skill and expertise to deal with HIV/AIDS related problems.

1.8 THEORETICAL FRAMEWORK

As primary school children are in constant interaction with the environment and the role players in the environment impact on the welfare of children infected and affected by HIV/AIDS, the ecosystems system theory formed the conceptual base of this study. The theoretical framework of this study is presented with emphasis on the Microsystem, Mesosystem, Exosystem and Macrosystem as the primary school child infected or affected is a social being in constant interaction with many social systems.

Social work seeks to understand human behaviour by utilizing particular theoretical perspectives. Berger, et al. (1996) indicate that a dominant theory that influences social work theory and practice is the ecosystems perspective. They argue that social workers use the ecosystems theory and view human behaviour from a holistic perspective developing from interplay of biological, psychological, social, economic, political, spiritual and cultural forces. Human beings develop and adapt through transactions with all elements in their environment. These transactions are not always mutually beneficial or entered into with equal power and status (Berger et al., 1996).

Against this background, the ecosystems theory was used as a framework to conceptualize this study. According to Berk (1998), Urie Bronfenbrenner was responsible for this theory. The Ecosystems theory views the person as developing within a complex system of relationships affected by multiple levels of the surrounding environment. Bronfenbrenner sees the environment as a series of nested structures that includes but extends beyond the home, school, neighbourhood and workplace settings. Bronfenbrenner identifies the microsystem, mesosystem, exosystem, macrosystem and chronosystem as layers in the environment which has a powerful impact on development (Berk, 1998).

1.8.1 The Microsystem

This is the innermost level of the environment. For the relevance of this study, the school system is conceptualized as the micro system. The microsystem refers to activities and interaction patterns in the person's immediate surroundings. Berk (1998) indicated that to understand development at this level, we must keep in mind that all relationships are bidirectional and reciprocal. Adults affect children's responses but children's characteristics, personality styles, ways of thinking also influence the behaviour of adults. A child who is either infected and or affected by HIV/AIDS may not pay attention in class and the educator may reciprocate with criticism.

A child's ability to function in the classroom depends on his or her holistic well-being (physical, social, emotional and mental). There is interconnectedness between the micro, mezzo and macro systems. Seventy eight to ninety three percent of children with symptomatic infection experience some development abnormality, which may affect classroom functioning (Taylor Brown, 1998). Many children need specialized placements in school. Medical appointments and hospitalization of the child infected or medical appointments of family members may result in the child being absent from school. The child who is HIV positive or is affected by HIV/AIDS may not be able to keep up previous academic performance. Parents of these children pressurize them to keep up their academic performance, hence creating further trauma for the child. Some

families experience isolation as they try to hide the diagnosis. Children who are HIV positive or have family members who are HIV positive may be excluded from participating in certain events or may even be ostracized.

In light of the above, all programs serving children should have policies. According to Taylor-Brown (1998), the national guidelines can be used to help develop local policies. The school system and the family system need to interact to solve such problems. The school should thus be an extension of the community. In a country like South Africa, the school system is an extension of wider society and should thus embrace the community and assist the community with problems like HIV/AIDS, poverty, and crime.

1.8.2 The Mesosystem

Berk (1998) indicated that the mesosystem is the second layer of Bronfenbrenner's model. For the purpose of this study, the mesosystem refers to the Provincial Department of Education which impacts the functioning of schools and the wider community. The mesosystem refers to the connections among Microsystems that foster development. The child's academic progress does not only depend on activities in the school (microsystem). It is promoted by parent involvement and the wider community (mesosystem) in the school life and the extent to which academic learning is carried into the home. The child whose parent is HIV positive may never attend parent meetings or report to school to find out about the progress of the child. The child whose parent is HIV positive may not have the ability to assist the child with homework. Development will thus be stifled. These problems are exacerbated in communities that lack basic resources. Some children in the Durban North Ward do not have access to basic resources. Some children in the Durban North Ward walk long distances to obtain water and to reach their respective schools. Raniga (2006) indicated that 41 % of rural school did not have access to running water.

The ecosystems theory applies to this research as the child cannot function in a vacuum. Problems at home invariably impacts on the child's ability to cope with schoolwork and failure to progress academically will not break the vicious cycle

of poverty and HIV/AIDS. A child infected with HIV/AIDS or a child affected by HIV/AIDS will not be able to function at optimal level. This will create problem in the classroom. The child may not do his/her homework as the child has to care for sick parents or relatives. The goal of any planned intervention is to manipulate the part of the child's system over which the teacher has control in a manner that will not cause conflicting expectations and experiences. Hence, the school based HIV/AIDS policy is necessary as this policy can provide a framework that will assist the educators.

1.8.3 The Exosystem

The exosystem refers to social settings that do not contain the developing person but affect experiences in immediate settings. In the context of this study, the school governing body is conceptualized as the exosystem. These could be the board of directors in the workplace or health and welfare organizations. Organizations in the communities that provide medical care, meals, day care and other services to the economically disadvantaged may reduce the devastating effects of poverty. Organizations in the communities that assist children and families that are infected or affected may alter the life experiences of these families. The child is not directly involved in these organizations. According to the National HIV/AIDS School Policy (Department of Education, 1999 hereafter referred to as DoE, 1999), the governing body is responsible for drawing the school based HIV/AIDS policy. Hence, the governing body is indirectly involved in the life experiences of a learner infected and or affected by HIV/AIDS.

1.8.4 The Macrosystem

This is the outermost level of Bronfenbrenner's model. In relation to this study, the National HIV/AIDS school policy (DoE, 1999) impacts on what happens at the microsystem, mesosystem and exosystem levels. Hence, in this study, the National school policy on HIV/AIDS (DoE, 1999) is conceptualized at the Macrosystem. It is not a specific context. It refers to the values, laws, customs and resources of a particular culture. The life experiences of a HIV positive child that lives in Kwa-Mashu (low income area) will be very different to the life

experiences of a HIV positive child that lives in Umhlanga Rocks (high income area). Nutrition may be one area that is worlds apart in these two areas. The priority that the macrosystem gives to the needs of children and adults affect the support they receive at inner levels of the environment. In a country that requires high-quality standards for child care and workplace benefits for its employed parents, children are more likely to have favorable experiences. The priority that national and provincial government gives to school based HIV/AIDS policies will determine the approach adopted by schools. The expectation of the National HIV/AIDS School Policy (DoE, 1999) is that every school establishes a Health Advisory Committee (HAC) which serves as a key support mechanism for dealing with HIV/AIDS problems in the school context.

1.9 Value of study

Through this study, I hope to provide valuable insight into the challenges experienced by educators and school governing bodies in formulating and implementing school based HIV/AIDS policies in the arena of HIV/AIDS.

Due to the maturation of the HIV/AIDS epidemic, more and more primary school children are being affected and infected. Hence, the ultimate aim of the study is to make recommendations to the KwaZulu-Natal Department of Education so that the needs of the most vulnerable members of society will not be treated in a vacuum. This study is valuable as Sewpaul and Raniga (2005), Matthews et al. (2006) and Raniga (2006) investigated HIV/AIDS school policy in secondary schools, however, very little empirical data exists in terms of primary school policies. This study is a unique and valuable one as it investigated the implementation of primary school based HIV/AIDS policies in the Umgeni North Ward.

1.10 CONCLUSION

In this chapter, the background, rationale, aims, objectives, key questions, underlying assumptions and theoretical framework of the study was outlined. Chapter Two provides evidence that many authors write widely about HIV/AIDS while little has been done with respect to policy formulation, implementation and challenges in primary schools. Chapter Three provides a comprehensive overview of the research methodology that was undertaken in this study. The Quantitative audit of 23 primary schools is discussed in Chapter Four while the analysis which deals with the factors associated with the implementation of HIV/AIDS policies in primary schools is discussed in Chapter Five. The summary of the findings, recommendations and conclusions are discussed in Chapter Six.

CHAPTER TWO
LITERATURE STUDY

2.1 INTRODUCTION

Chapter One provided an outline of the background, rationale, aims, objectives and underlying assumptions. The theoretical framework, the ecological systems theory, was presented.

This Chapter provides valuable insights into the HIV/AIDS pandemic in the following contexts: Globally, Africa and Sub-Saharan Africa, South Africa and KwaZulu Natal. Additionally, a critique of The National School Policy on HIV/AIDS (Department of Education, 1999) and the HIV/AIDS emergency: Department of education guidelines for educators (Department of Education, 2002) as well as Develop an HIV/AIDS plan for your school: a guide for school governing bodies and management teams (Department of Education, 2003) which forms the foundation of this study, is presented and critiqued.

2.2 HIV/AIDS AND THE IMPLICATION FOR THE SCHOOL SYSTEM

The global summary of the AIDS epidemic as at December 2007 indicates that the epidemic is affecting everyone. The total number of people living with HIV amounted to 33.2 million. A total of 2.5 million children under the age of 15 are living with HIV. 420 000 children under the age of 15 were infected in 2007. Of the 2.1 million AIDS deaths in 2007, 330 000 of these were children under the age of 15 (UNAIDS, 2007). It is evident that this epidemic creates a challenge throughout the world.

Raniga (2006:41) provides an overview of the global context with respect to the socio-economic and political aspects of HIV/AIDS. She argues that *"at the onset of the new millennium, humanity faces a dire global challenge: HIV/AIDS. The responses to the pandemic both by the international community and nation states have exacerbated a three fold crisis that we have witnessed in the world: they*

have widened the gap between the rich and poor within societies, between the rich and poor nations and they have pushed stigmatized groups to the margins of society". Many of the children who are infected or affected become the stigmatized groups in schools. These children are then pushed to the margins of society. Hence, this study, which is based on the implementation of primary school policies in the Umgeni North Ward, questioned the capacity of educators to deal with the effects of HIV/AIDS on school-going children or that sector of the school population that are marginalized as a result of the epidemic.

A study undertaken by Dr Joan Atwood, involving girls aged 8 to 13 in the United Kingdom, United States, Australia and Canada (Dobson and Hodgson, 2006) indicated that some of these children are at risk for pregnancy and HIV/AIDS. Of the pre-adolescent girls who discussed sexual activity, nearly a third was younger than 12 and eight percent were under 10. The study highlights growing concern about sexually precocious behaviour in young girls, with many reporting that they feel pressured into sex at an early age (Dobson and Hodgson, 2006). The study by Dr Joan Atwood indicates that children are engaged in risk taking behaviour. Policies should be in place as these children will be infected or affected by the epidemic.

As the HIV/AIDS epidemic continues to grow, the responsibilities of the school are twofold. The first responsibility of the school is to provide education on HIV/AIDS and the second responsibility of the school is to deliver the curriculum with respect to the remaining learning areas. The school must provide appropriate education to children with HIV/AIDS in an atmosphere that is supportive of their special needs and conducive to learning. This requires that the schools have clearly defined written policies as some of the schools that faced initial lawsuits over the placement of HIV-infected children have subsequently formulated enlightened policies (Pozen, 1995:233-236). There is evidence that sexuality and HIV/AIDS education is integrated in the school curriculum both at primary and secondary schools in the country (Jameson and Glover 1993; Malaka 2003; Raniga 2006; Strydom and Strydom 2006).

Higher levels of education are associated with safer sexual behaviours and delayed sexual debut. Children who are in school benefit from school based sexuality education and HIV prevention programmes. Knowledgeable young people postpone sexual intercourse or when they do have sex, they use condoms (UNAIDS, 2007; Zambuko and Mturi 2005).

Strengthening school systems to meet the pressure posed by HIV related problems must be based on evidence of actual conditions. In a recent study, three quarters of the responding countries established management structures dedicated to coordinating the response of ministries of education to the epidemic. However, only 59 % of these structures had a dedicated budget. Cooperation between education systems and social protection enhances the capacity of schools to provide support for children affected by HIV. In Namibia, the involvement of the local school board is enhanced, and the local school board work together with members of the school to create circles of support (UNAIDS, 2007). Working together enhances the capacity of individuals to provide support. Hence, teamwork is absolutely vital in any attempt to halt the epidemic.

Taylor-Brown (1998) indicated that all programs serving children should have policies regarding the process for inclusion of children with HIV/AIDS. It is ideal for the policy to be in place before the child enters the school system. Taylor-Brown (1998) confirms the need for a policy environment to exist at a local level. Hence the policy would instruct stakeholders to cater for the needs of vulnerable children. The National HIV/AIDS School Policy (DoE, 1999) provides such directives.

The United Nations Special Session on HIV/AIDS Declaration of Commitment indicated that by 2003 there should be development of national policies and by 2005 the national polices should be implemented. There should be policies and strategies to strengthen government (macro), family and community (mezzo) capacity to provide a supportive environment for school-going children (micro) infected and affected by HIV/AIDS. Children should be enrolled in school and orphans and vulnerable children should be protected from all forms of abuse. There should be non-discrimination, and full and equal enjoyment of all human

rights through the active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS (UNESCO, 2003:7). The expectation of the United Nations is that such National polices should be operational from 2005.

The framework for the protection, care and support of orphans and vulnerable children living in a world of HIV and AIDS (Greenberg, 2007) was developed by a range of partners to provide guidance on how best to address the multiple vulnerabilities faced by children living with HIV and AIDS. Five key strategies were presented.

Strategy one deals with strengthening the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychological and other support. Strategy two calls for mobilizing and supporting community based responses. Strategy three demands that essential services are provided to children. Education, health care and birth registration are important essential services. Strategy four calls for improved policy and legislation by the government to protect the most vulnerable children. In this regard, government should channel resources to families and communities. Strategy five demands that awareness at all levels through advocacy and social mobilization to create supportive environments for children and families affected by HIV/AIDS (The United Nations Children's Fund (UNICEF), March 2007). The expectation is that the five strategies should be in place to assist vulnerable children. In South Africa, it is sad to note that many children are left to fend for themselves. It is extremely difficult for a young child to grow up without a supportive environment. It would be much more difficult for a child that is infected or affected by HIV/AIDS.

An Australian Study indicated that HIV/AIDS is managed on an ad hoc basis. The study suggested a Whole School Approach through the introduction of the Health Promoting Schools (HPS) model. The model encourages a multi-sectoral holistic approach to youth sexuality and HIV/AIDS in schools (Mitchell, 2000). According to the World Health Organization (1996), *"A Health Promoting School is a school that is constantly strengthening its own capacity as a health setting for living,*

learning and working." One of the goals for HPS in KwaZulu Natal is to develop all schools into Health Promoting Schools (Department of Health, 2000). One primary school in Phoenix has been awarded Health Promoting School Status. According to Soogrim (an official from the Inanda C Community Health Centre, at a workshop in 2007) Greenbury Primary achieved Health Promoting Status (HPS) as they adhered to five key elements of HPS as enshrined in the National guidelines (Department of Health, 2000). This school indicated that they network with appropriate services and resources, develop policies, builds skills, create a healthy environment and strengthen the interaction between the school and community.

The argument presented by Mitchell (2000) is strengthened by Badcock-Walters (2002) who indicated that *"multi-sectoral partnerships are necessary to deal comprehensively with the unprecedented scale of the crisis".* This is especially true in a country like South Africa as many children are vulnerable. Children are not in schools for various reasons. The Health Department, the Education Department and other arms of the Ministry should work as a team to put these children back in school. These children could be on the streets as a result of poverty, HIV/AIDS and various other reasons. It would be catastrophic to leave them on the street. As the scale of the problem is unprecedented, teamwork is of paramount importance. As indicated earlier, the UNAIDS (2007) report confirms that it is important for young children to be in school, hence, there should be appropriate school-based HIV/AIDS policies to assist children infected and affected by the epidemic.

2.3 THE PLIGHT OF HIV/AIDS IN SUB-SAHARAN AFRICA

In Sub-Saharan Africa, there are 22.5 million adults and children living with HIV. The regional HIV and AIDS statistics (UNAIDS, 2007) indicates that there were 1.7 million adults and children newly infected with HIV. There were 1.6 million adult and child deaths due to AIDS. It is estimated that 2.2 million children under the age of 15 were living with HIV in 2007 (UNAIDS, 2007). These statistics confirm the magnitude of the problem in Sub-Saharan Africa. These statistics should galvanize all in Africa to take action to deal with the crises.

The UNESCO report states that *"Young children's rights in countries in sub-Saharan Africa need to be protected further as the HIV/AIDS pandemic impact in most countries with prevalence rates reaching 20 to 25 percentage points. ... To date, 13, 2 million children have lost their mother or both parents to AIDS. The disease orphaned 2.3 million children in 2000 alone. It is estimated that 44 million will have lost their parents to the pandemic by the end of this decade. One third of them will be children under 5 years of age"* (UNESCO, 2003:7). These statistics further confirm that children in sub-Saharan Africa are vulnerable, hence, there should be action plans to assist these children.

The focus of most HIV/AIDS initiatives over the last twenty years has been on prevention, but these prevention strategies have been unsuccessful in stemming the tide of infections (Mufuka et al., 2006). According to Mufuka et al., (2006), prevention strategies in sub-Saharan Africa have failed to a large extent. The implication is that something else must be done as preventing the spread of the virus failed. Children are infected and affected, hence, other measures like care and support and dealing with bereavement become important to assist vulnerable children. There must be a planned strategy to provide care and support; hence a policy environment within the school environment is necessary.

A study in Kenya indicated that *"the rapid increase in adult mortality due to the AIDS epidemic in sub-Saharan Africa raises great concern about potential intergenerational effects on children"* (Yamano and Jayne, 2005). These sentiments are confirmed by Barnett and Whiteside (2006) who indicate that households can disappear. The disappearance of households applies in South Africa as well. Barnett and Whiteside (2006) write about a tragic case in Uganda. A remnant household was on the verge of disappearance. This was a substantial household which disintegrated as the wife and eight teenage and adult children died of HIV/AIDS. The man, who lives alone, is demented and is not expected to remarry. On his death, the household disappears.

2.4 HIV/AIDS: SOUTH AFRICA AND KWAZULU-NATAL

According to Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries (2002), KZN has the highest prevalence of HIV infections of all provinces in South Africa. They argue that the high rate of HIV infection reported in younger women between 15-29 years of age suggest that many were infected in their teens. They indicate that HIV in KwaZulu Natal is a mature epidemic and deaths outstrip births. These figures provide sufficient evidence to demand that all in KwaZulu-Natal be galvanized to take action to assist vulnerable children.

The National Department of Education, in South Africa, has acknowledged HIV/AIDS as an emergency. The Department of Education developed guidelines for educators to assist them to deal with this emergency. The HIV/AIDS emergency: Department of Education guidelines for educators, (Department of Education, 2002) indicate that it is a difficult fact that many children are already sexually active by the age of 12. The guide further indicates that we often forget that most children become aware of sex and want to know about it at a very young age. It must be noted that these 12 year old children are in primary school and are vulnerable to being infected.

South Africa has the fastest growing HIV/AIDS epidemic in the world, with more people infected than any other country. By June 2000, it was estimated that at least twenty percent of the population was infected. Of the eighteen million children that live in South Africa, 10.8 million children (sixty percent) live in poverty. One fifth of all children, about 3.6 million, do not live with their mothers (Coombe, 2000). All South Africans need to take responsibility to respond to the crises (MRC, 2001). The statistics presented here indicate that school-going children in South Africa are vulnerable.

Since 1994, there has developed a tradition of *"strategic planning that has led to the development of any number of visionary policies ... more recently published policy on HIV/AIDS in education"* (Badcock-Walters, 2002). He indicates that problems of implementation, which rests with provincial departments, exist. He maintains that it is necessary to identify all stakeholders, allies and inhibitors, to

engage in multi-sectoral partnerships to deal comprehensively with the unprecedented scale of the crisis (Badcock-Walters, 2002). It is clear that provincial departments (macro) have problems with implementation (Raniga, 2006). By the same token, the capacity at school level (micro) is limited. This study tested the status quo in primary schools.

The Child Health Policy Institute indicated that *"despite the fact that the presence of AIDS in South Africa was recognized over 15 years ago, very little has been done to mitigate the impact of AIDS on children and to address the needs of the millions of children left vulnerable by the pandemic"* (Child Health Policy Institute, 18:10:2006). Developing the National Policy on HIV/AIDS for Learners and Educators in Public Schools and Students and Educators in Higher Education and Training Institutions, (Department of Education, 1999) could be seen as one small step to assist these vulnerable children, however, the lack of institutional resources to implement this policy negates the positive effects of the National School Policy on HIV/AIDS (Department of Education, 1999 and Raniga, 2006).

Soul Buddyz is a mass media education and entertainment vehicle for South African children aged from 8 to 12. It is used to reach children with important messages about AIDS, youth sexuality and gender (The World Bank, 2004:13). The series was accompanied by an advocacy campaign to reach policymakers and enrich NGOs' ability to act as child right activists (The World Bank, 2004:13) While the series must be commended for trying to reach policymakers and enrich NGO's ability to act as child right activists, the advocacy campaign should target educators to act as child right activists.

The Love Life National educational program targets 12 to 17 years olds. Launched in September 1999, love Life was one of the largest and most ambitious HIV preventions efforts in the world. The program aimed to reduce the incidence of HIV among 15 to 20 year olds in South Africa by at least 50 percent by 2004 (The World Bank, 2004:12). It focused on reducing the negative consequences of premature and adolescent sex.

However, despite such efforts, an article in the Daily Sun indicated that a school in Inanda, Buhlebethu Primary, *"made headlines in the People's Paper earlier this year for having the highest number of pupils living with HIV/AIDS"* (Mhlophe, 2006). This article confirms that the gap between translating knowledge of HIV/AIDS to behaviour changes among the youth is complex and this makes it even more urgent for school-based HIV/AIDS policies to form an integral part of the school context, hence policy is necessary to assist these vulnerable children. As learners spend much time at school it is crucial that schools are transformed into places that not only promote intellectual development, but physical and emotional health and well being. The child who is infected or affected has to deal with many challenges. The child may have trouble coping with school work due to absence. Dealing with bereavement is an added challenge.

The Department of Education (2001) guide for educators acknowledges that social, emotional and spiritual support is vital for learners infected or affected by the HIV/AIDS epidemic. An infected or affected learner has similar problems like other children have; domestic problems, single parents, violence, unemployment, poverty, crime. However, this learner has an additional problem, HIV/AIDS. Factors that exacerbate the problem are siblings who may not understand the attention given to this child or siblings who may be angry with the infected child for spoiling the family outings. Siblings may also be angry with the HIV positive child as this child is getting all the attention. The HIV positive child may thus experience many different emotions; guilt, anxiety, fear and despair.

The Department of Education (2001) guide for educators acknowledges that orphans may suffer as a result of the loss of family, depression, lack of immunizations, lack of schooling, homelessness, vagrancy, starvation, increased demands for labour, crime and exposure to HIV/AIDS. The HIV/AIDS epidemic will create a lost generation. It is clear that these children will need emotional, social and spiritual support.

Gow et al., (2002). support the arguments made by the department regarding spiritual support. They indicate that "*The effects of bereavement are devastating*" (Gow et al., 2002). Many children do not have the opportunity to grieve properly.

Some may have to grieve in silence due to the silence around HIV and AIDS. Silent grieving can affect them for the rest of their lives. Grieving has to happen over time and the age and culture of the child must be taken into account. A child who is grieving needs patience and space.

Gow et al. (2002). maintains that one way to help children grieve is to talk to them about death. The Department of Education (2003) guidelines encourage school personnel to bring religious leaders into schools to talk about death or hold memorial services at school. There are many perspectives on death. Due to constraints, three perspectives are presented in this dissertation.

The Vedic view on death indicates that *"Those who are wise lament neither for the living nor for the dead"* (Bg. 2.11). The purport presented by His Divine Grade A.C. Bhaktivedanta Srila Prabhupada (2007) indicates that *"The body is born and is destined to be vanquished today or tomorrow; therefore the body is not as important as the soul. One who knows this is actually learned, and for him there is no cause for lamentation, regardless of the condition of the material body".*

The Christian view of death as presented by Flavel (2008) indicates that *"Death is harmless to the people of God; its shafts leave no sting in them".* He further indicates that *"the scriptures speak of but two ways in which the soul can properly live – that is, by faith and vision."*

According to Islamic beliefs, *"two of Gods angels come to the grave site immediately after the funeral ceremony is finished in order to inquire whether the deceased has lived a good life without sin"* (http://www.ukm.uio.no/utsillinger/farvel/islam-eng.html - accessed on 10:09:2008).

According to Leffel (2008), *"a world view is based on beliefs in four general areas".* He indicates that these are reality, human nature, values and truth. Reality relates to the question of "what exists". Human nature makes us form beliefs whether or not there is a spiritual aspect to our nature. Values refer to

the principles that people follow. Truth involves the beliefs about the nature and limitations of knowledge. The author of this dissertation is not qualified to express which of the perspectives can be classified as a "world view".

The Department of Education (2001) acknowledges that the emotional needs of the child must be met. Prabhavisnu (2006) supports the arguments presented by the department. He indicated that families undergo intense emotional pressure during death. It is a period that warrants dignity and gravity as the culture of the entire family comes to the fore. Relatives and friends must ensure befitting respect. Educators from different religious backgrounds need to assist learners from different religious backgrounds, hence the deeper and complex issues of transformation in the education system is of paramount importance. The question arises whether educators are skilled to deal with children who are grieving.

Schools fear that there will be negative response from the public if they teach sexuality education. The life skills programme (DoE, 1997) demands that sexuality education is taught at schools. If schools provide condoms, parents assume that schools are giving permission to children to have protected sex. Thus, educators need to be trained and developed. This argument is supported by Kerr (1991) and Raniga (2006) who indicate that schools need to provide staff and parents with in-service programs. Teachers need to meet educational as well as social needs of the children. Brotherton (2002) confirms the statements of Kerr (1991) and makes the important point about social needs. Are the social needs of children met? It therefore becomes necessary to encourage educators to teach the whole child. The question also arises whether school based HIV/AIDS policies make provision for quality care and support for children infected or affected with HIV/AIDS. The Department of Education (2003) guidelines indicate that there are five critical priorities. 'Care and support for learners affected by HIV/AIDS' is listed as priority two in the Department of Education (2003) guidelines.

Stigmatization and discrimination leave many desperate and force them to be secretive about their illness. Much work is needed to break the silence. Discrimination, degradation, assaults, dehumanization are all important human rights issues (Grandpre, 2001). The statements by Grandpre (2001) is confirmed by Preboth (2001) who indicates that fear with regard to HIV infection must be allayed by appropriate education of all school personnel. Human rights issues like violence used against women and girls with respect to sexual activity, hearing the voice of the child in matters that affect him/her, confidentiality with respect to HIV/AIDS, voluntary disclosure, voluntary counseling and testing (VCT) must be given due consideration. The question that follows is: Are school based policies designed to help learners and the community enjoy the full protection of their fundamental human rights?

Denial and reduced access to education may be the resultant effect of HIV infection in the home. The child may need to stay at home to care for sick parents, siblings or grandparents. The impact of HIV/AIDS exacerbates the scale of existing management problems: economic hardship, family care, agrarian duties, opportunistic infections, personal trauma (Badcock-Walters, 2002). A number of studies on HIV/AIDS have been undertaken in schools. An empirical study undertaken by Mbananga in 2004 investigated the content and perceptions about reproductive health information among school teachers and learners in a rural area of South Africa. Issues addressed were HIV/AIDS, sexuality, family planning, sexually transmitted diseases and reproductive cancers (Mbananga, 2004). While the study is very valuable and provides much insight, the study did not address school based HIV/AIDS policies as a response to the pandemic.

In 2006, the XVI International AIDS conference was held 25 years after the discovery of HIV. The theme of the Conference was 'Time to Deliver'. The conference report by Mash (2006) indicates that 600 to 800 a day die of AIDS in South Africa. The conference report by Mash (2006) indicates that HIV is a pandemic that feeds on poverty, malnutrition and lack of education. *"Unimpeded access to primary education is vital to prevention"* (Mash, 2006). These statements by Mash (2006) are confirmed by UNAIDS, 2007 which calls for

children to be in school. This current study investigated whether schools have delivered in accordance with the theme of the conference, 'Time to deliver'? Do schools have policies and have schools been innovative in caring and supporting children infected and affected by HIV/AIDS?

Dr. Suzanne Grant-Lewis, director of the International Education Policy Program at the Harvard Graduate School of Education, discussed the ways that school policy in South Africa retains the inequities created under the apartheid educational system (Kenyatta, 2002). The problems created by the apartheid educational system have serious repercussions for the school system and the family system (Raniga, 2006). The inequitable per capita spending per child created serious backlogs. Raniga (2006) maintains that *"the different locations of schools in KwaZulu-Natal continue to fuel racial, gender and class divisions, so evident in wider society".* She further poignantly asserts that *"rural schools are attended by Black learners and the schools are characterized by a lack of basic services such as electricity, water, inadequate number of classrooms, little or no access to recreational facilities, poor roads and minimal access to health and welfare services in the wider community."* While many schools in this study are based in urban settlements, these schools service learners that come from previously disadvantaged areas. Some of these schools are experiencing problems in collecting school fees. Hence, some schools will have the necessary resources to deal with HIV/AIDS problems while others may not.

Dr Z S T Skweyiya (Department of Social Development, 2002), Minister of Social Development, indicated that the devastating impact of HIV/AIDS cuts across all sectors of society. The consequences present major challenges for children, women and the elderly. It is important that well directed and purposeful programmes are in place to address the crises. School based HIV/AIDS policies should be well directed and purposeful.

2.5 Overview and critique of the Department of Education HIV/AIDS policy

In 2001, Sewpaul and Raniga conducted an audit of 18 secondary schools. They found that secondary school principals had little awareness of the National School Policy on HIV/AIDS (Department of Education, 1999) and there was limited implementation of the policy (Sewpaul and Raniga, 2005).

The National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions (G.N. 1926 of 1999 published in Government Gazette No. 20372 dated 10 August 1999) is presented and some aspects are critiqued.

Section 16 (1) of the National Policy on HIV/AIDS indicates that the policy applies to learners from grades R to 12 (Department of Education, 1999). Thus, primary schools should have school based HIV/AIDS policies as most primary schools enroll children from grade R to 7.

Section 2.11 of the National School Policy on HIV/AIDS (Department of Education, 1999) indicates that governing bodies, councils and parents should be included in the education partnership. In order to include parents and councils, the national policy is intended as broad principles only. The National Policy on HIV/AIDS (Department of Education, 1999) envisaged that *"a governing body of a school, acting within its functions under the South African Schools Act, 1996 and the Council of a Further Education and Training Institution, acting within its functions under the Further Education and Training Act, 1998, or any provincial law, should give operational effect to the national policy by developing and adopting an HIV/AIDS implementation plan".* The needs of each school, the mission, the vision and the ethos of that school or community should filter into the school based implementation plans. This fact is emphasized under section 12 which outlines the School and institutional implementation plans.

While the policy is intended as "broad principles", the authors of the policy did not envisage that many previously disadvantaged schools have personnel on the

school governing body that do not have the capacity to deal with policy analysis, policy formulation and policy implementation. Raniga (2006) confirms that *"there has always been a disparity between policy ideals and policy implementation in the arena of HIV/AIDS".*

Raniga (2006) succinctly points out that there is contradictory statements in the policy. The policy indicates that the Ministry is committed to provide leadership. The policy then stipulates that the policy is intended as broad guidelines and the operational responsibility of the policy lies with the school governing body.

Other criticisms pointed out by Raniga (2006) is the lack of monitoring and evaluation of the policy. Further, the policy implies that communities have the necessary resources to implement HIV/AIDS related intervention programmes.

Mdziniso-Zwane et al. (2001) indicate that there are benefits in developing and adopting a workplace policy. The school's position on HIV/AIDS is defined as well as a strong message is sent that HIV and AIDS is a serious issue. The rights of all learners and educators are respected and it sets a foundation for HIV/AIDS programmes. Mdziniso-Zwane et al. (2001) makes the very interesting point of consistency of practice as there are policies in place that can be followed. This confirms the need for schools to have school based HIV/AIDS policies to ensure consistency in the treatment of all stakeholders, hence, principals, management and educators would not act in an ad hoc / uncoordinated faction to deal with the crises.

2.5.1 SCHOOL AND INSTITUTIONAL IMPLEMENTATION PLANS

In order to assist schools deal with the devastating effects of the HIV/AIDS epidemic, the National Schools Policy on HIV/AIDS was rolled out in 1999. To assist schools further, the Department of Education, in 2003, developed guidelines for school governing bodies, management and educators. One of the expectations of the Department of Education (2003) is for schools to use the guidelines as support mechanisms to the National School Policy on HIV/AIDS.

Section 12.2 *"A provincial education policy for HIV/AIDS, based on the national policy, can serve as a guideline for governing bodies when compiling an implementation plan."*

Section 12.3 *"Major role-players in the wider school or institution community (for example, religious and traditional leaders, representatives of the medical or health care professionals or traditional healers) should be involved in developing an implementation plan on HIV/AIDS for the school or institution."* Section 12.3 and section 13 (Health Advisory Committee) are interconnected as the Health Advisory Committee is made up of members in the wider community and school personnel that assists with HIV/AIDS and related problems. (DoE, 1999:20).

Section 12.4 *"Within the basic principles laid down in this national policy, the school or institution implementation plans on HIV/AIDS should take into account the needs and values of the specific school or institution and the specific communities it serves. Consultation on the school or institution plan could address and attempt to resolve complex questions, such as discretion regarding mandatory sexuality education, on whether condoms need to be made accessible within a school or institution as a preventive measure, and if so under what circumstances."*

A critique of "broad principles" as indicated in the National Policy on HIV/AIDS (Department of Education, 1999) follows. While the National Policy on HIV/AIDS for Learners and Educators in Public Schools (Department of Education, 1999) takes cognizance of the past injustices in society and thus provides governing bodies with the opportunity to develop implementation plans with respect to HIV/AIDS (concept of ownership and empowerment), the National Policy on HIV/AIDS (Department of Education, 1999) failed to research the capacity of governing bodies to undertake such a mammoth task. Further, the National Policy on HIV/AIDS (Department of Education, 1999) indicates that it is intended as broad principles only, thereby giving role-players the opportunity to exclude that which is important. The failure of schools to establish the Health Advisory Committees crystallizes this point. Raniga (2006) points out that secondary schools found it difficult to establish the Health Advisory Committees. In her

study on 'The implementation of the National Life-Skills and HIV/AIDS school policy and programme in the eThekwini region', Raniga (2006) indicated that 9 out of 74 schools established the Health Advisory Committee. The National Policy on HIV/AIDS (Department of Education, 1999) was rolled out in 1999. The government should have conducted an audit with respect to capacity of governing bodies regarding the implementation plans. It is of paramount importance that school implementations plans are collected, evaluated and the necessary recommendations provided so that the vulnerable members of society are protected.

2.6 DEVELOP AN HIV & AIDS PLAN FOR YOUR SCHOOL: A GUIDE FOR SCHOOL GOVERNING BODIES AND MANAGEMENT TEAMS

The Guide for school governing bodies and management teams issued by the Department of Education in 2003 deals with the development of an HIV and AIDS plan for schools (Department of Education, 2003). At the conference convened by the Ministry of Education in 2002, it was agreed that there must be quick action to protect the lives and well being of children. It was further agreed that no person can work alone to respond to the HIV and AIDS crises. Other agreements included the Department of Education working closely with parents, school governing bodies, learners and teachers to protect children who are infected so that they lead the best lives possible as well as supporting those who are affected by the disease or do not have parents because of the disease.

To act on the agreements, the Department of Education put together guides as reflected in the following quotation found in the Foreword by Professor Kader Asmal, MP, and Minister of Education in 2002. *"In order to act on the agreements we made at the conference, the Department of Education has put together guidebooks to help us – as school governing bodies and school management teams – to work together to respond to HIV and AIDS"* (Department of Education, 2003).

The guide (Develop an HIV/AIDS plan for your school: a guide for school governing bodies and management teams) has been designed to lead educators

through a number of important steps in the formulation of policy. The structure outlines five critical areas. Prevention, care and support for learners, care and support for educators, protecting the quality of education and managing a coherent response are five critical priorities that should be addressed by each school and should form part of the policy of each school. The school should also link the HIV and AIDS policy and action plan to the school development plan (Department of Education, 2003).

The guide provides an example of an action plan to implement the policy. The action plan indicates the action, the activities, the person responsible , when the action should be undertaken, the budget required, the resources needed, the support systems available, the evaluation and monitoring of events as well as the success indicators (DoE, 2003:17). The local District Education office or the local/district AIDS committee should also receive a copy of a school's HIV and AIDS policy. Chapter Six in this guide provides some information on what it takes to make the policy work in schools. The goal should be clear and the aims specific to the school. The school governing body, together with school management must work in partnership with the staff to ensure ownership of the policy. The governing body should lead the process and meet often with the staff so that interest is sustained. The guide indicates that openness, compassion, the right information, local support teams and coherence are important for successful policy implementation (Department of Education, 2003).

2.7 THE HEALTH ADVISORY COMMITTEE

According to section 13 of the National Policy on HIV/AIDS (Department of Education, 1999), where community resources make this possible, each school should establish its own Health Advisory Committee (HAC). The Health Advisory Committee should be set up by the governing body and consist of educators, parent representatives, learner representatives and representatives from the medical or health care professions. Other salient features of the health advisory committee include electing a chairperson from within who should have knowledge about health care. The health advisory committee should advise the governing body on all health matters, including HIV/AIDS. The health advisory

committee must develop and promote a school or institution plan of implementation on HIV/AIDS and review the plan as new scientific knowledge becomes available. The health advisory committee should be consulted with respect to the provisions in the code of conduct that deal with the prevention of HIV transmission. One of the requirements of the National Policy on HIV/AIDS (Department of Education, 1999) is for the school code of conduct to include information about HIV/AIDS. Section 13.2.5 states that the Health Advisory Committee should *"be consulted on the provisions relating to the prevention of HIV transmission in the code of Conduct".*

A criticism of the National Policy on HIV/AIDS (Department of Education, 1999) with respect to the Health Advisory Committee follows. The government indicates that the Health Advisory committee should be established if community resources allow for this. This is a strategy to shift the responsibility of the government to the community. The Constitution of South Africa, Act 108 of 1996 allows for devolution of power to local spheres. This would be a step in the right direction if communities had resources and capacity and there was equality between communities. The past imbalances and injustices created by the apartheid government in South Africa makes this an almost impossible task. Many schools do not have basic infrastructure like tarred roads, electricity, running water, adequate buildings (Raniga, 2006). These communities are pooling their resources to address these issues and thus there are no resources to address the issue of Health Advisory committees.

Adebayo Adedeji (1990) as cited in Raniga (2006) provides the following valuable insight with regard to colonialism. Abebayo Adedeji indicated that "if we are to understand the African condition of social deprivation and general underdevelopment, we must have a long historical perspective" as colonialism left nation states in Africa not only with difficult socio-economic and political turmoil but with a sense of helplessness and lack of self confidence among Africa's people. Therefore, one would have empathy for governing bodies that felt helpless in drawing up HIV/AIDS policies in schools as there is a history of disempowerment in South Africa and the role of school governing body in the management of schools is a contentious one. The South African Schools Act 84

of 1996 outlines the role and functions of school governing bodies in terms of school governance. However, the South African Schools Act 84 of 1996 is flawed in that the direction to school governing bodies with respect to HIV/AIDS is not very clear. Development of policy and implementation of policy is nowhere to be found in the South African School Act. Hence, school governing bodies that were previously disadvantaged find it difficult to find the terms of reference with respect to HIV/AIDS.

Morrow (1999) as cited in Raniga (2006) asserts that young people often feel excluded from wider societal decision making and are skeptical about their tokenistic representation. The South African Schools Act 84 of 1996 allow for secondary school children to form Student Representative Councils (SRC) or Learner Representative Council (LRC). The South African Schools Act 84 of 1996 is flawed as it makes no provision for children in primary schools to be represented. This goes against the 1989 UN Convention on the Rights of the Child (CRC) which calls for the voice of the child to be heard in matters that affect him or her. The challenge therefore lies in developing a culture that promotes the involvement of young people in policy formulation.

Raniga (2006) in her study on 'The implementation of the National Life-Skills and HIV/AIDS school policy and programme in the eThewini region' is quick to point out that there has *"always been a disparity between policy ideals and policy implementation in the arena of HIV/AIDS"*. She indicated that socio economic, political and legal factors are intertwined with global challenges. I tend to agree with Raniga in this regard. In 1999, the National Policy on HIV/AIDS (DoE, 1999) was rolled out. The ideal would be implementation of the policy at 'grass-root' level. The follow up by the department to check on policy implementation in KwaZulu-Natal is sadly lacking. Is this situation unique to KwaZulu-Natal or does these situations prevail in other provinces? The discussions presented on the analysis of the findings of this study in Chapter 4 and 5 provide some insight on these questions.

2.8 HIV/AIDS: IMPACT ON PRIMARY SCHOOL-GOING CHILDREN

The then deputy president, Thabo Mbeki, who is known for his controversial stance on HIV/AIDS, in 1998 indicated that we should pledge that when we meet and study, work and sing, play and enjoy ourselves, we should protect ourselves against HIV/AIDS. This is confirmed by Robenstine (1994) who sees education as the only cure for AIDS. As a major social institution, the school cannot ignore the increasing complexity of the AIDS epidemic nor to underestimate its impact on the adolescent population. Children with HIV/AIDS should be supported. Children need quality care and support. Even young children need to know that they are sick. Younger children may only need to know a little bit about HIV. A child with HIV may suffer silently because of shame or fear. According to Granich and Mermin (1999), a child may have problems sleeping or trouble at school and avoid family and friends. There are over-aged learners in primary schools who are engaged in sexual behaviour.

As a result of HIV/AIDS, there are students with new needs, orphans, children exposed to infectious diseases and emotional trauma, children who are discriminated against and children in households where parents are ill or parents/caregivers have died. There would be consequences for not caring for affected children. To avert this calls for imaginative responses. (Barnett and Whiteside, 2006). Many people in South Africa have suffered due to past injustices. Unemployment, crime and poverty affect many in people in South Africa. Students have to deal with crime, poverty, unemployment and the added pressure of bereavement, loss of income and stigmatization as a result of HIV/AIDS.

According to Berk (1998), most cases of school phobia appear during the transition from middle childhood to adolescence. These children usually find a particular aspect of school frightening, an overcritical teacher, a school bully, a threatening gang, parental pressure for school success. A child who is infected or affected by HIV/AIDS may not be able to maintain his or her previous results. The child may not develop physically and may be prone to attacks from school bullies. The teacher may be over critical as the teacher may not be aware of the

child's status and the child may respond negatively, hence the earlier and forthcoming reference to bidirectional and reciprocal relationships.

Morrell et al., (2002) argue that those who conduct interventions for the age group 6 to 16 have an opportunity to bring changes to reduce vulnerability to HIV through fostering and developing more equitable, safe, democratic and joyful norms of behaviour. They need to know that learners and educators participating in such interventions in the school setting connect with the diverse world beyond the school walls and that the social context of adolescence and schooling also needs changing.

Morrell et al. (2002) and Raniga (2006) further point out that there are many factors contributing to excess vulnerability of young people to infection. Young people are social and sexual beings, they experiment and take risks, and they seek independence from their parents and tend to conform to peer pressure. They argue that HIV/AIDS prevention strategies fail because parents shy away form discussing sex with their children. In addition, teachers shy away and school policies and practices also neglect to integrate these issues. They argue that the Life Skills programme which is part of the curriculum is considered to be the logical place where AIDS, sexuality and safe-sex are discussed. In 1999, European Union funding was made available for the purpose of teacher training. The cascading model was used and 1 000 out of a possible 70 000 educators were trained. Evaluations of this project indicate it was not successful (Sewpaul and Raniga, 2005).

The United Nations Special Session on HIV/AIDS Declaration of Commitment (2003) indicates that young children are suffering most. Documentation of the effects of HIV-AIDS on young children in South Africa illustrates how young children are coping with the effects of the illness; losing parents and family members to the illness; the collapse of household economy where there are no wage earners; the care of very young orphaned children, and lack of understanding and stigma. The burden of care often falls on the very young and very old. Young orphaned children are a particularly vulnerable group (UNESCO, 2003:9).

The Millennium Development Goals targets 2015. Some of the goals are to eradicate extreme hunger and poverty and combat HIV/AIDS. It is important to halt and reverse the spread of HIV/AIDS (United Nations, 2000). There must be action plans to achieve the Millennium Development Goals. Hence, local school based policies should be in place to assist vulnerable children.

2.9 CONCLUSION

This chapter provided literature written on HIV/AIDS in different contexts. This literature is linked to the remained of this study and the links are emphasized in Chapter Four and Chapter Five. The hierarchy of the presentation commenced with HIV/AIDS globally. This was followed by the situation in Sub-Saharan Africa. Subsequently, a discussion on HIV/AIDS in South Africa and KwaZulu-Natal was presented.

The National Policy on HIV/AIDS (Department of Education, 1999) was discussed and critiqued. Of relevance in the National Policy on HIV/AIDS were the clauses that referred to implementation and the role of the governing body in putting an operational plan into effect. The capacity of the governing body was challenged. The role and function of the Health Advisory Committee followed and a criticism of government devolving power to local spheres was presented. Aspects of the guide that was presented by the Department of Education (Department of Education, 2003) to assist school governing bodies and management teams was subsequently presented and critiqued.

The Chapter that follows provides an overview of the research process. A two phase research design incorporating Quantitative and Qualitative methodology is presented. The population in the ward, the sample, the data collection methods, and data analysis is presented. The Chapter concludes with ethical considerations and the limitations associated with this study.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides an overview of the research process. A two phase research design incorporating Quantitative and Qualitative methodology was used to guide the research process. The research design, sampling in phase one and two, data collection in phase one and two, data analysis in phase one and two as well as reliability and validity are subsequently discussed. This Chapter concludes with ethical considerations and the limitations associated with this study.

3.2 RESEARCH DESIGN

Research design is governed by the notion of fitness for purpose (Cohen et al., 2003). A research design is a strategic framework for action (Terre Blanche and Durrheim, 1999). A two phase research design incorporating quantitative and qualitative methods was utilized in this study. The first part of this study was quantitative (attempted audit of HIV/AIDS policies at 24 schools) and the second was qualitative (focus group interviews at two schools). Triangulation thus applied. Triangular techniques in the social sciences attempts to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint (Cohen et al., 2003). The methodology used in this study was similar to that used by Sewpaul and Raniga in their study of secondary schools. They used a triangulated methodology including both quantitative and qualitative research methods using various sources of data collection (Sewpaul and Raniga, 2005). This study was conducted in two phases.

The exploratory research design applied to this study as little was known about primary school based HIV/AIDS policies. There was no evidence to indicate that studies with respect to primary school based policies have been conducted.

Thus, this research was a unique attempt to investigate the implementation of HIV/AIDS policies in primary schools in the Umgeni North Ward.

3.3 SAMPLING

3.3.1 Sampling: Phase One

Sampling is described as taking a portion of a population or universe and considering it representative of that population or universe. The term universe refers to all potential subjects who possess the attributes in which the researcher is interested (De Vos, 2005).

A list of 48 schools in the Umgeni North ward was obtained from the ward manager of the KwaZulu-Natal Department of Education. The total sample of 48 was divided into sub-groups which included 24 primary schools, 14 secondary, 7 pre-primary schools and 3 Learners with Special Education Needs (LSEN) schools. While the initial proposal was to investigate the implementation of primary school based HIV/AIDS policies in 24 primary schools, not all principals responded. Of the 24 schools, one principal indicated that she was very busy and could not answer the questions. Furthermore, her school comprised of learners from grade 1 to 3. Of the remaining 23 schools, two principals answered the first two questions and then refused to continue. The informed consent provided them with the prerogative of withdrawing at any point, thus the matter was not deliberated. Of the 23 schools that participated, 21 had a school based policy and 2 did not.

Probability sampling, which is applicable to quantitative studies, was used in phase one while non probability sampling was used in phase two. In probability sampling, each person in the population has the same known probability of being selected. The selection of the sample is based on some form of random procedure (De Vos, 2005). Phase one involved a quantitative audit of 23 primary schools in the ward. The sample (n = 23) is 95.8 % of the population of primary schools as there were only 24 primary schools in the ward (N = 24).

3.3.2 Sampling: Phase Two

In non-probability sampling, the odds of selecting a particular individual are not known as the researcher does not know the population size or the members of the population. Accidental, purposive, quota, dimensional, target, snowball and spatial sampling are non probability sampling (De Vos, 2005). Using the results of the quantitative audit conducted in phase one, two schools who had formulated their policies were selected. Thus, purposive sampling was used in this instance as the sample was based entirely on the judgment of the researcher (De Vos, 2005). Criterion sampling was also used to select two schools to conduct focus groups.

The following criteria were intended to guide the researcher in selecting two schools from the group of schools that have a policy:

- The willingness of the principal to allow school personnel to participate in the study
- Availability and willingness of representative from the school governing body to participate in this study

The two schools that were selected developed the policy in 2002 and 2004 respectively. These two schools were used as they were the first two schools where the principals indicated that they were willing to assist and allow school personnel to be part of the study. The principals also confirmed that they will be able to secure the attendance of school governing body members.

3.4 DATA COLLECTION

3.4.1 Data Collection: Phase One

The researcher sent a copy of the letter (which granted permission to conduct the research) from the Department of Education to each of the 24 schools in the sample (Appendix 3). The letter from the Department of Education was accompanied by a declaration form that principals had to complete and fax back

to the researcher (Appendix 4). 11 out of 24 school principals signed the declaration form that provides for informed consent. In view of this, it was of paramount importance to ask each management member that participated in the study for verbal consent.

The researcher started by conducting the quantitative audit through telephonic interviews with principals. The researcher anticipated a positive feedback as some authors (De Vos et al., 2005 and Cohen et al., 2003) indicated that that advantage of the telephonic interview is that the response rate is high. Contrary to this popular view, the response rate was very low. Ten out of twenty four schools provided information over the telephone. In many instances, the secretary at schools indicated that the principal was very busy and the researcher should call back. Subsequent telephonic call received similar responses, principals were very busy. Research is not a linear process, it is cyclic and unanticipated changes need to be taken into account (De Vos et al., 2005) With this in mind, the researcher changed strategy and visited the 13 of the schools where data was collected using face-to-face interviews. The researcher found that one-to-one interviews yielded better results. Thirteen out of twenty four schools (54.1 %) responded favorably to the one- to-one interviews. The analysis of ten telephonic interviews and thirteen one-to-one interviews (two schools withdrew and two schools without a policy, hence 19) is presented in Chapter Four.

Telephone interviews are used mainly for exploratory research as opposed to in-depth research (De Vos et al., 2005). In this study, the researcher had to combine both methods (telephonic interviews and face to face interviews) to obtain data from majority of the respondents.

3.4.2 Data Collection: Phase Two

The objective of the second phase of the study was to conduct focus group interviews with two schools. During the data collection in Phase One of the study, the researcher asked principals and management members whether they could get members from the school governing body to participate in phase two of

this study. Two school principals indicated that they together with members of staff would participate in the focus group sessions. These two principals also indicated that they would get members from the governing body to be part of the focus group. The researcher sent a formal letter requesting the principals (Appendix 5) to arrange the focus group sessions. The researcher was impressed with the quick response of the two principals in setting up the focus group sessions. The criterion sampling used to select two schools was dependent on the willingness of the principals and the availability of governing body representatives.

Qualitative methodology using two focus groups was thus conducted in two schools. In School A, the principal, the head of department, one member of the school governing body and two educators formed the focus group. There were five key informants. In School B, the principal, the head of department, two educators and two members of the governing body were present. There were six key informants in School B. Focus groups allowed the researcher to investigate a multitude of perceptions as level one educators, level two educators (Head of departments) and level three educators (principal) together with school governing body members presented their viewpoints. (De Vos et al., 2005). The focus group sessions were tape-recorded.

The main advantage of the focus group is that information can be gained in a shorter period of time. Focus groups allow the researcher to listen to others, to learn from others and open up communication channels.

Focus groups draw on three of the fundamental strengths that are used in qualitative methods. According to De Vos (2005), the fundamental strengths that are shared by all qualitative methods are exploration and discovery, context and depth and interpretation. Focus groups are a powerful means of exposing reality and investigating complex behaviour and motivation. In this study, most participants were actively involved in sharing information on their experiences. The purpose of this study was to investigate the implementation of primary school based HIV/AIDS policies in the Umgeni North Ward.

De Vos (2005) indicates that sensitive research has traditionally relied on the use of one-to-one interviews. People may be more likely to share personal experiences in groups rather than in dyadic settings. People feel empowered and supported in group settings rather that in individual ones. Thus, the researcher chose to use focus groups to obtain information about the status quo of primary school based HIV/AIDS policies. This study supported the findings of De Vos (2005) as many of the key informants were willing to share their experiences in groups and the researcher was able to obtain much more information from the focus groups than the one-to-one interviews. Data gathered from the focus groups complimented the data gathered in the quantitative audit.

One is able to obtain concentrated amounts of data from the focus group. The focus group relies on the interaction of the group to produce data. The participants compare and share their experiences and one obtains valuable data. The success of the focus group sessions depend on the experiences of the researcher. My role as an educator and the skills that I acquired during my teaching career assisted me to act as facilitator in these sessions. Some participants may not get involved if the researcher is inexperienced or some participants dominate the sessions. These are some of the limitations of focus group sessions which I tried to overcome by listening critically to the participants and consistently asking others to get involved.

3.5 DATA ANALYSIS

3.5.1 Data Analysis Strategy: Phase One

The responses of the school management members were written down on a pre-determined format. [Phase one audit]. Quantitative data analysis with respect to the survey was done using the statistical package called EvaSys by transcribing the responses to a predetermined format suitable for decoding by EvaSys (Appendix 6). This package is produced by Quantum Solutions and the representatives from this global company indicated that the package is similar to SPSS. The global indicators are listed first, followed by individual average values. Phase one data analysis is presented in detail in Chapter Four.

3.5.2 Data Analysis Strategy: Phase Two

Qualitative data was analysed according to themes and common threads that emerged from the study. Relationships were then established (Cohen et al., 2003). According to Silverman (2000), when analyzing different kinds of qualitative data, different issues arise. Is the aim of the interview to describe the gritty reality of people's lives (realism) or to access the stories or narratives through which people describe their worlds (narrativism) (Silverman, 2000). According to De Vos (2005), the data that is collected represents the reality of the experiences of group members. In qualitative research, we strive to be open to the reality of others. Some of the critical ingredients of qualitative analysis are that it must be systematic, sequential, verifiable and continuous; should enlighten and is a process of comparison. De Vos (2005) also maintains that analysis should seek to entertain alternative explanations, is improved by feedback and is jeopardized by delay. The tape recordings used in the data collection phase were replayed and transcribed for improved analysis.

3.6 RELIABILITY AND VALIDITY

Valid inquiry in any sphere must: demonstrate its truth value, provide the basis for applying it and allow for external judgments to be made about the consistence of its procedures and the neutrality of its findings or decisions. Just like a quantitative study cannot be valid unless it is reliable, a qualitative study cannot be transferable unless it is credible, and it cannot be credible unless it is dependable (Siegle, 2006). According to Siegle (2006), peer debriefing is discussing the project with a similar status colleague who is outside the context of the study and who has a general understanding of the nature of the study. A colleague at school who is an experienced educator and has since been promoted to principal discussed various aspects of poverty and HIV/AIDS with me. Perceptions, insights and analysis were discussed with this colleague.

Perakyla (1998) indicate that reliability *"is the degree to which the findings are independent of accidental circumstances of the research".* Perakyla (1998) *argues that "tape recordings and transcripts based on them can provide for highly*

detailed and publicly accessible representations of social interaction". In this study, the tape recording of the interview at both schools was played and replayed numerous times to ensure that the correct data was transcribed. In order to ensure reliability, appointments were made with each of the two selected schools in order to conduct the focus groups and to secure availability and commitment by the key informants in the study. To ensure validity, the interview guideline for phase one (Appendix 1) and the focus group guidelines (Appendix 2) for phase two were developed using the aim and objectives of the study. The multiple use of data collection sources (principal, educators, management member and school governing body representative) and strategies (focus groups, telephone and one-to-one interviews) increased the content validity of the findings. The structured interview guidelines (Appendix 1) was pre-tested with four primary schools in the Chatsworth ward and in so doing the necessary amendments were made (Appendix 6) to the interview schedule, content and the sequencing of the questions for phase one of the study. The pre-testing of the structured interview guideline for phase one of the study ensured that changes could be made to the structured interview guideline.

Marlow (1998) argues that "test-retest" implies the same instrument is administered to the same participants on different occasions and if the results are similar, the reliability of the instrument is high. The findings of the four schools in the pre-test stage were similar for majority of the questions. The initial structured interview guideline did not request biographical details. Gender, designation, years in post and teaching experience was included in the improved structured interview guideline. Pertinent information was omitted from the initial structured interview schedule (Appendix 1). Number of over aged learners, number of learners infected, number of learners affected, number of parents infected, the roll of boys and girls were included in the improved structured interview guideline (Appendix 6). This information provided details in terms of the challenges experienced by educators. The information enabled the researcher to gain a sense of HIV/AIDS related problems in the primary schools they formed part of the sample. The amended phase one interview guideline is reflected in Appendix 6 which is in EvaSys format.

3.7 ETHICAL CONSIDERATIONS

Voluntary participation and informed consent, no harm to participants, anonymity and confidentiality as well as not deceiving subjects are important considerations in research (Ruben and Babbie, 1989). All ethical considerations in the study were adhered to. The ethical clearance form from the University of Kwa-Zulu Natal was duly completed. Written permission from Dr R.C. Lubisis (KwaZulu-Natal Department of Education – appendix 3) was obtained. The schools and personnel selected were given a choice to withdraw form the study at any time. Schools were reassured that confidentiality will be maintained throughout the research process and more especially in the reporting of the findings.

In phase one of the study, a letter from Dr Lubisis office addressed to the researcher was faxed to each of the 24 schools. A letter indicating the nature of the study was also faxed to each principal of the 24 primary schools in the ward. Principals were asked to complete a declaration (informed consent) and fax this to the researcher. 11 out of 24 school principals faxed back the informed consent. The researcher then secured verbal consent form the principals prior to asking the key and subsequent questions.

In phase two of the study, the researcher explained that the sessions will be recorded. The researcher indicated that the proposal was accepted by the Higher Degrees committee at University of Kwa-Zulu Natal. The researcher also indicated that the participants are free to contact Dr T. Raniga (Supervisor) if they so desire. The researcher informed the participant's that their responses will be confidential and anonymous.

3.8 LIMITATIONS

The limitations of this study are presented. The quantitative aspect of the study used the telephone as a tool for data collection. This method of data collection had limitations. Cohen et al., (2003) indicated that the reduction of the interview to just auditory sensory cues can be problematical. One of the two schools without a school based HIV/AIDS policy indicated that the school was a small

school. The other school indicated that there were no obstacles, they just did not have a school based HIV/AIDS policy. As this data was sought using the telephone, probing by the researcher yielded very little information as both schools were not comfortable in presenting information. Hence, the claims by Cohen et al. (2003) that reduction of interviews to just auditory sensory cues can be a problem are substantiated.

A further limitation was the possibility of respondent bias as I am an educator and this may have resulted in colleagues not presenting the entire truth regarding the formulation and implementation of HIV/AIDS policies in their respective schools. I dealt with this by informing colleagues that confidentiality and anonymity is guaranteed. Additionally, this study involves a single ward. Thus, all observations are defined by the specific contexts in which they occurred (Siegle, 2006). Time constraints and cost constraints were a further limitation. Self report, educators and principals reporting about their own implementation of their policies, is a further limitation as some schools may have said they implemented the policies but they do not.

During the focus group sessions, the principals dominated the sessions. Due to time constraints, the researcher had to adhere to the focus group guidelines and had little time to probe and get the governing body members to be more actively involved in the sessions. The principal in one school indicated that the governing body member is new. It is possible that the governing body members were intimidated by the sessions. Language barrier may have impeded information in this study as two of the governing body members in one school were Zulu speaking and the sessions were conducted in English without any translation.

CHAPTER FOUR
FINDINGS FROM THE QUANTITATIVE AUDIT UNDERTAKEN IN PRIMARY SCHOOLS

4.1 INTRODUCTION

This chapter provides the analysis for phase one of the study. The initial proposal attempted to conduct an audit with 24 schools. Phase one of this study involved a Quantitative audit of 23 primary schools for the first two questions and a Quantitative audit of 19 primary schools for the remainder of the questions in the Umgeni North Ward as one school refused to participate, two schools answered the first two questions and refused to continue, two schools did not have a school based HIV/AIDS policy.

The first two objectives of this study, the extent to which primary schools in the Umgeni North Ward have a school based HIV/AIDS policy as well as the extent to which the HIV/AIDS policies are implemented in primary schools forms the basis of this chapter. The data obtained from the quantitative audit is presented from Figure 1 to Figure 10 as well as in Table 1.

4.2 FIGURES AND TABLES

4.2.1 Gender

Campbell (2003) as cited in Mathews (2006) indicated that a school climate characterized by an authoritarian approach to student teacher relationships promotes gender inequalities and undermines effective, student-led HIV prevention programmes. Mathews (2006) further argues that females were more likely to perceive a consensus among their colleagues about the importance of teaching HIV/AIDS education and to report that their school had an HIV/AIDS policy.

The following graph indicates the number of male and female management members that participated in the telephone and one-to-one interviews in phase one of the study. Of the 23 schools, 21 management members provided answers in this regard.

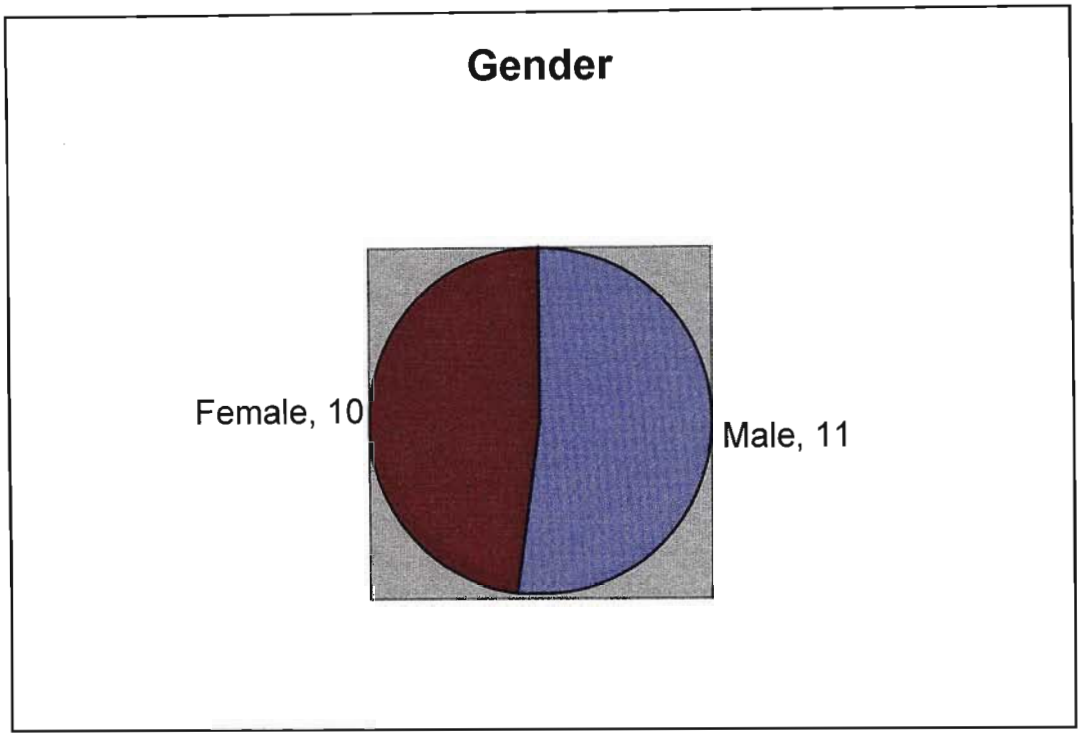

Figure 1: Gender profile of management

In figure 1, the pie graph indicates that 11 out of 21 (52.38 percent) of management members who formed part of the sample were males while 10 out of 21 (47.62 percent) of management members who formed part of the sample in primary schools in the Umgeni North Ward were females. The gender profile of management members in this ward is not in correlation to the workforce in this ward. The Department of Education (as cited in Raniga, 2006) asserts that more female educators work in primary schools. As more females than males work in primary schools, it is expected that more females hold senior positions. This is sadly not the case in this ward.

As at November 2006, the national total of educators in independent (19 463) and public (362 670) schools, amounted to 382 133. Of this total, 80 979

educators are in KwaZulu-Natal. In KwaZulu-Natal, the total of 80 979 educators is made up of 56 645 female educators and 24 334 male educators. The national total of 382 1333 is made up of 256 782 female educators and 125 351 male educators. These statistics clearly indicate that the number of female educators greatly exceeds the number of male educators both at the national and provincial levels (Department of Education, 2006).

Figure one indicates the gender bias in education. In the Umgeni North ward, the male management members that formed part of the sample are greater that their female counterparts, yet the Department of Education statistics (2006) as indicated above clearly indicates that there are more female than male educators in the education system. This implies that there is greater number of male educators in management positions than female educators.

A study by Mathews et al. (2006) indicated that equity and fairness in the general school climate influenced the implementation of HIV/AIDS education. Females should be given a greater role to serve as managers. The study by Mathews et al. (2006) indicate that *"female and life orientation teachers were more likely to have implemented AIDS education".* Hence, transformation is necessary in respect of addressing the gender bias in senior positions in primary schools.

4.2.2 Access to School Based HIV/AIDS Policy

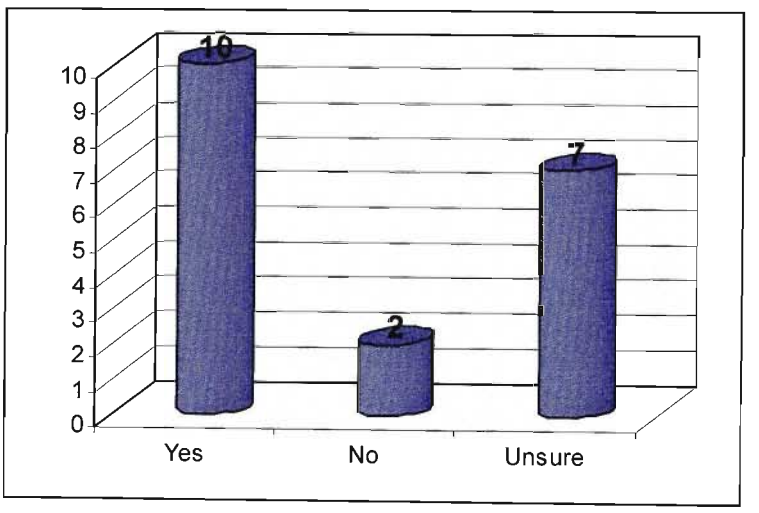

Figure 2: Access to school based HIV/AIDS policies

Figure two indicates that ten schools out of nineteen schools were willing to provide a copy of the school based HIV/AIDS policy to the researcher. Two schools indicated that they require the permission of the school governing body to hand out the policy to the researcher. Seven schools were unsure if they could give a copy of the policy to the researcher.

A content analysis of two school policies indicates that the policies could be improved. The policy should include the five critical priorities. Prevention of HIV/AIDS, care and support for learners, care and support for educators, protecting the quality of education and managing a coherent response should be included in the policies. The action plan which should include an HIV/AIDS co-ordinator, time frames, budget, resources and success indicators should be part of the school policy. The role and functions of the health advisory committee together with review, implementation and evaluation should be part of the policy.

Some of the variables that impact on the formulation and implementation of school based HIV/AIDS policies would be the history of the school, the size of the school, resources and location. The smallest school in the sample had 166 learners and this school would qualify for a staff establishment of 6 educators. The largest school in the sample had 1140 learners. This school would qualify for a staff establishment of 33. The average number of children per school is in the region of 645. The average number of educators per school is in the region of 19. Some of the schools are located in previously 'Indian' areas while some of the schools are located in previously 'White' areas. Some of the schools are on the border of 'Indian' and 'African' areas while some of the schools are on the border of 'Indian' and 'Coloured' areas. These variables provide some evidence that schools had difficulty in formulating and implementing school based HIV/AIDS policies due to the diverse nature of schools. Schools that are well resourced and that are located in 'previously advantaged' areas stated that they had no problems in formulating and implementing school based HIV/AIDS policies. One school engaged the services of an American researcher to develop their policy.

4.2.3 Policy Formulation

Of a sample of 21 schools, 19 school representatives (90.47 percent of the management) indicted that they had a written HIV/AIDS policy formulated by their school. It is encouraging to note that a large majority of primary schools in this ward have developed a school based HIV/AIDS policy which is one of the expectations of the Department of Education (2003). Developing the school based polices will definitely benefit learners infected and affected by the epidemic as those personnel that follow the policy will be guided by a framework to act consistently. A study by Matthews et al. (2006) indicated that the presence of a school HIV/AIDS policy was a predictor for implementing HIV/AIDS education. Hence, Matthews et al. (2006) indicated that formulation of school based policy is valuable. The graph below indicates the time frame when the school based HIV/AIDS policy was formulated in the Primary schools in the Umgeni North Ward.

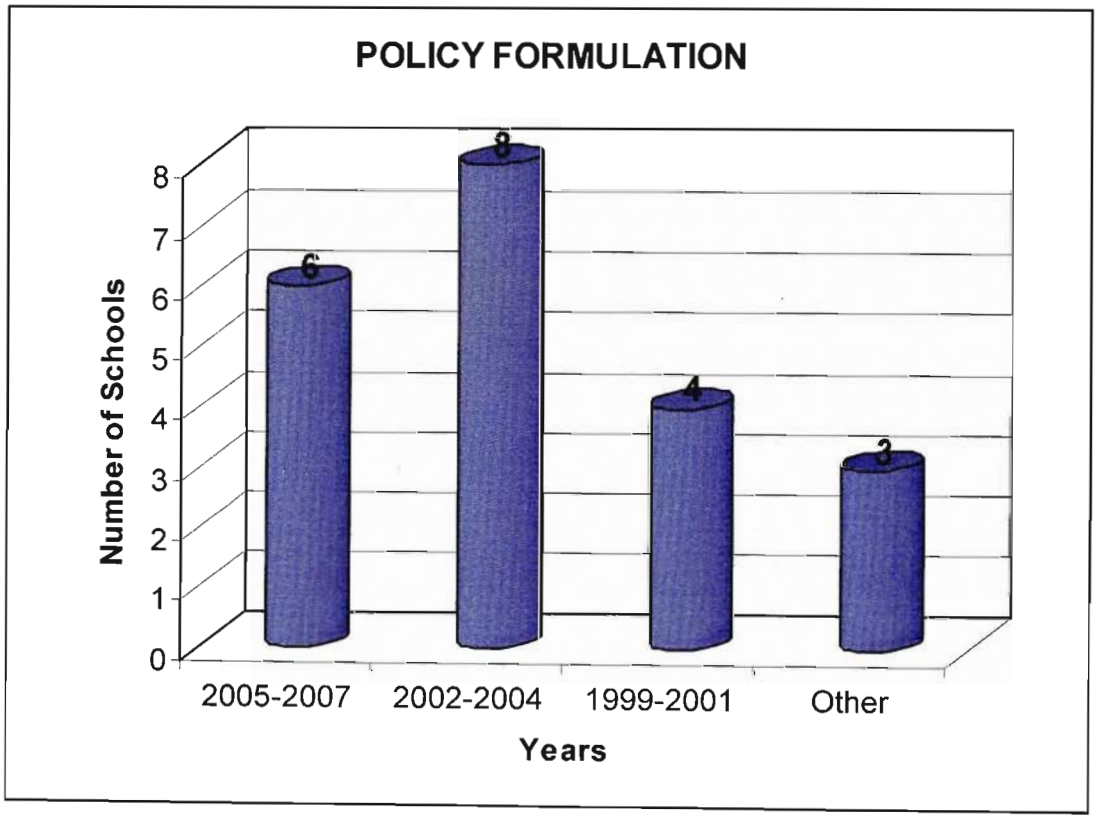

FIGURE 3: POLICY FORMULATION

The National Department of Education rolled out the National Schools Policy on HIV/AIDS in August 1999. Section 14.1 of the National Schools Policy on HIV/AIDS indicated that the Director General of Education and the Heads of Provincial Departments were responsible for implementing the National Schools Policy on HIV/AIDS. The Director General and Heads of Provincial Departments was tasked to communicate this policy to all staff and there had to be strategies to implement, monitor and evaluate. Section 14.2 stated that the Principal is responsible for the practical implementation of the National Schools Policy on HIV/AIDS. Section 12.1 of the National Schools Policy on HIV/AIDS indicated that the *school governing body* may develop and adopt its own implementation plans on HIV/AIDS to give operational effect to the National Policy. As one of the objectives of this study was to investigate the implementation of school based HIV/AIDS policies (that could be used as a mechanism to give operational effect to the National Schools Policy on HIV/AIDS) it was important to determine the time frames that separated policy awareness and implementation.

In figure 3, it is evident that only 18 out of a total of 23 management members from primary schools in the Umgeni North Ward were able to provide information in respect of the year the school based HIV/AIDS policy was formulated. Six out of 18 respondents formulated the policy during the period 2005 to 2007. Eight of the schools formulated the policy from 2002 to 2004. Four schools formulated the policy during the years of 1999 to 2001. One of the schools was not sure when the policy was formulated and two principals refused to answer this question. Only 4 schools formulated the school based HIV/AIDS policy immediately after the National School Policy on HIV/AIDS was rolled out in 1999. This clearly indicated that there is a huge time delay in implementing National directives as well as the Department of Education (2003) guidelines as 6 schools formulated their policies from 2005. One of the key concerns that formed the central focus of this study was the non implementation of policy at a mezzo level. Are there genuine practical reasons for non implementation immediately after the National policy was rolled out?

Raniga (2006) in her study on "The Implementation of the National Life-Skills and HIV/AIDS School Policy and Programme in the eThekwini Region" confirms that

68 out of 74 secondary school principals were aware of the National HIV/AIDS School Policy. In the preliminary study conducted by Sewpaul and Raniga (2005), secondary school principals unanimously agreed that they had little awareness of the policy. The findings by Sewpaul and Raniga (2005) and Raniga (2006) is consistent with the findings of this study. In this study, Figure 3 clearly indicates that a large majority of principals did not implement the policy immediately, as only 4 out of the 18 respondents formulated the policy from 1999 to 2001.

4.2.4 Stakeholders Involved In Policy Formulation

One of the key objectives of this study was to understand the processes involved in drawing up the school based HIV/AIDS policy. Figure 4 indicates the different stakeholders that were involved in formulating the school based HIV/AIDS policy in the primary schools in the Umgeni North Ward.

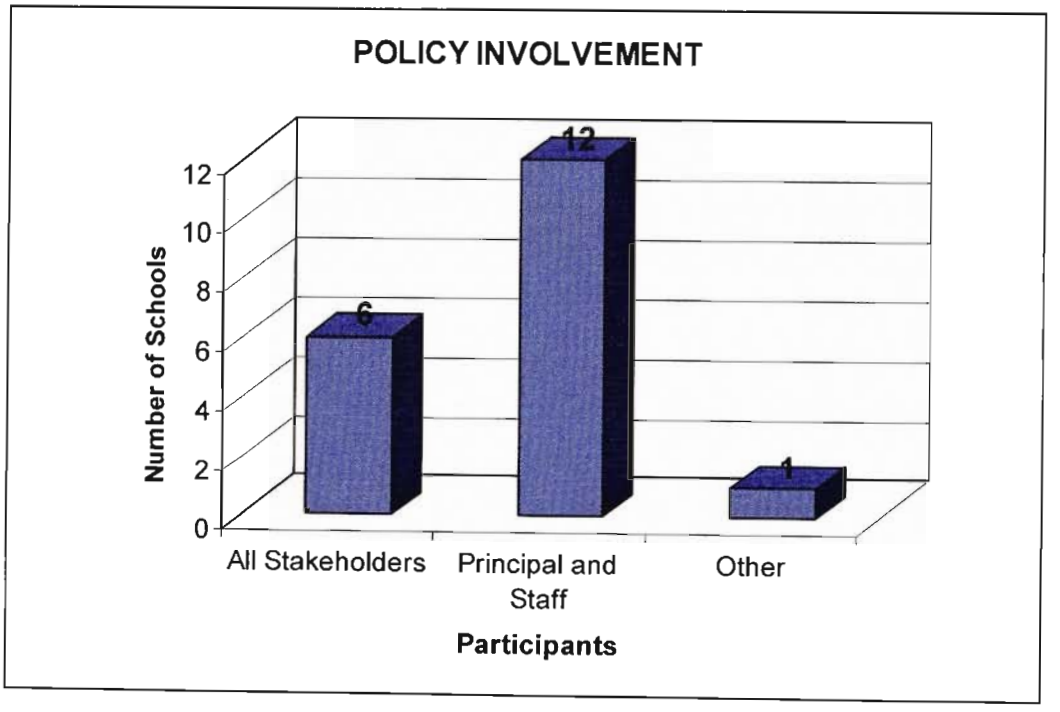

Figure 4: Stakeholders Involved In Policy Formulation

Post 1994 resulted in the formulation of numerous policies by the democratically constituted government. One of the expectations of the ANC Government was participatory decision making and devolution of power to local spheres. In light of this, all stakeholders in the school structure would be expected to adopt a participatory approach to school governance. Stakeholders in the school setting implies the involvement of the school governing body members, educator representatives, learner representatives in secondary schools and the principal as an ex officio member. The South African Schools Act, 84 of 1996 acts as a frame of reference that stakeholders must follow. It is sad to note that in primary school, the learner representatives are omitted as the South African Schools Act 84 of 1996 is flawed in that it does not make provision for the involvement of primary school learners. International policies such as the 1989 UN Convention on the Rights of the Child calls for the voice of the child to be heard in matters that affect him or her.

Of the 19 schools that responded, it is clear that the school governing body played a minimal role in formulating the school based HIV/AIDS policy. Twelve out of 19 schools (63 percent of the schools) had the policy formulated by the principal, management and staff. A large majority of schools excluded the school governing body from this process. The statistics that indicate 6 out of 19 (31 percent) schools had all stakeholders involved in policy formulation is misleading as the policy in some cases were given to the school governing bodies for amendment and acceptance. The focus group sessions in phase two of this study confirmed that policies were given to the governing body for ratification. It is interesting to note that one school (5.3 percent as indicated in figure 4 under the heading other) engaged the services of an American researcher to draw up the policy. This goes against the participatory approach of involving stakeholders (Section 2.11 of DOE, 1999) at grass-root level where the process in practice is non-inclusive instead of a paternalistic one.

4.2.5 Action Plan

The Department of Education (2003) guidelines provides an example of an action plan to implement the school based HIV/AIDS policy. The objective of the

action plan is to create a legitimate structure to implement the HIV and AIDS policy. The chairperson of the school governing body and the principal of the school are expected to give legitimacy to the structure that drives the HIV/AIDS policy. One member of this new committee should serve on the school governing body (Department of Education, 2003).

Figure 5 indicates the responses of management members to the question: "Do you have an action plan to implement the school based HIV/AIDS policy?"

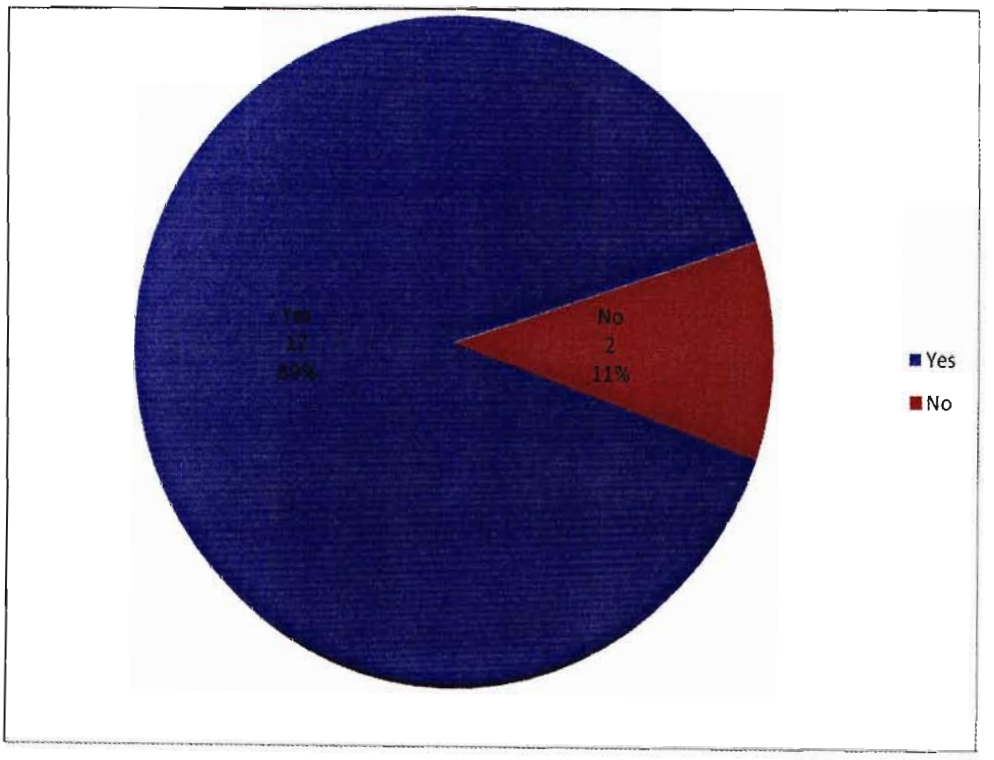

Figure 5: Action Plan

Of the 19 respondents who provided answers with respect to the action plan of schools, it is encouraging to note that 17 out of 19 (89.47 percent) indicated that they had an action plan to implement the school based HIV/AIDS policy. In respect of the 17 schools who indicated that they had an action plan for handling HIV/AIDS related problems at school, different strategies were presented. Of the 17 schools, 10 schools indicated that they had a first aid kit. One school (5.26 percent) indicated that additional staffing was in place. One school indicated that a large first aid kit is in the office and each educator has a smaller kit in the

classroom. One school indicated they had a qualified counselor employed to assist children. Another school indicated that a social committee was in place that helps children infected or affected with HIV/AIDS and other social problems. An affluent school that has resources and facilities indicated that the educators and the school governing body had set up an outreach committee (a group of parents and educators that assist members in the community). One school indicated that a handbook (indicating procedures) was given to staff members. One school asked each learner to carry a basic first aid kit in their bags. One of the ex model C schools (previously advantaged) was fortunate enough to have a full time nurse on the premises. The institutional capacity of the ex model C school (previously advantaged school) differs from the poorer schools. Raniga (2006) maintains that post 1994 schools have not escaped the impact of the expansion of globalization and neoliberal capitalist policies. Raniga (2006) implies that structural forces like globalization and neo-liberal capitalist polices impact the institutional capacity of schools. Raniga (2006) maintains that *"social institutions such as welfare, the school system and government departments contain both liberating and oppressive features, and they represent the fruits of the struggles of oppressed people in the country. Yet, at the same time, these institutions represent agents of control by the dominant groups in South Africa."* This has resulted in a huge disparity between schools across different locations in Kwazulu-Natal in respect of access to resources.

One school indicated that the action plan is in the policy while another school indicated that the action plan is individualized, that is, the action plan is learner specific. In the latter school, the action is taken when learners present with HIV, thus, each learner is attended to on an ad hoc basis. Of concern, is the 2 out of 19 (10.53 percent) schools that indicated they do not have an action plan to implement the policy as well as the two school that do not have a policy. The focus group sessions confirm that the action plans differed across schools and that there is a lack of consistency across schools in respect of how learners who are either infected and or affected are treated. It is clear that factors such as the needs of the school and the funding available influenced the strategies that constituted the action plans.

4.2.6 Policy Review

One of the expectations of the Department of Education (2003) guidelines is for the frequent review (yearly) of school based HIV/AIDS policy. It was important to find out from schools when they had reviewed their policies.

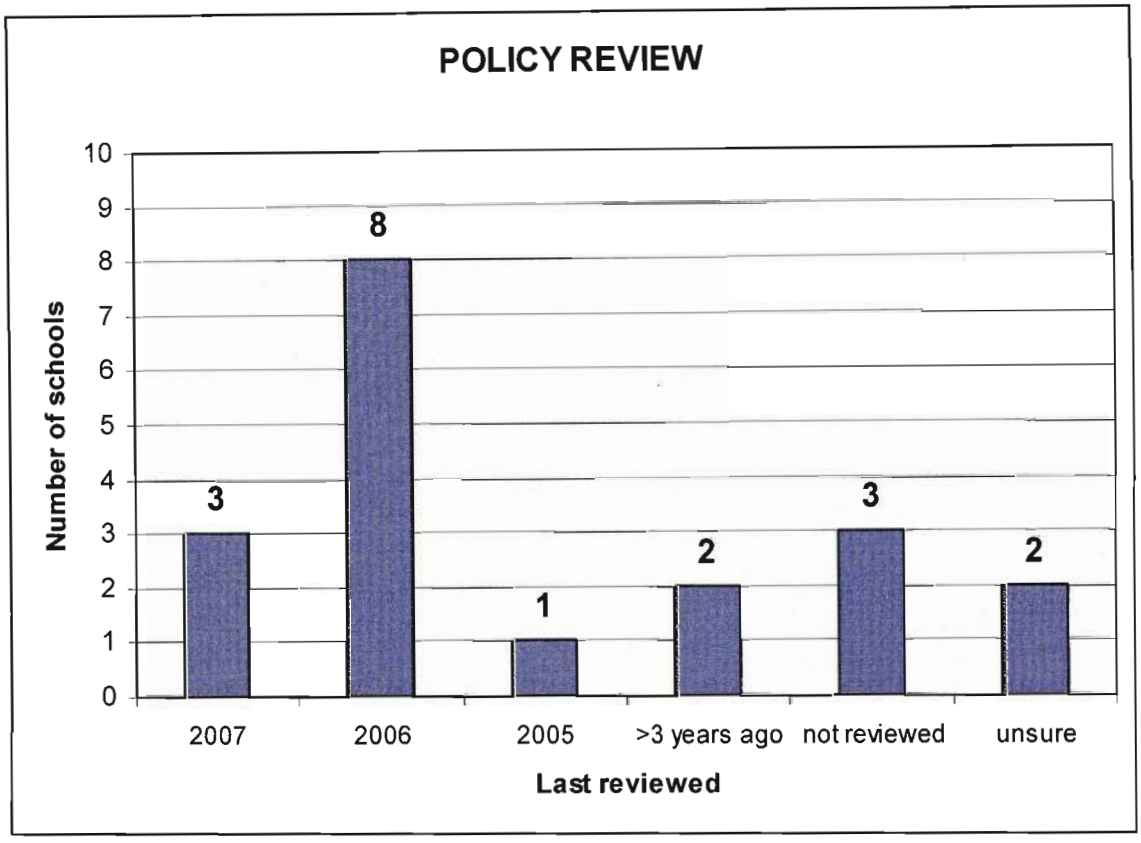

Figure 6: Policy Review

Of the 19 schools, 8 schools (42.1 percent of the respondents) indicated that the policy was reviewed in 2006 while 3 schools (15.8 percent) indicated that the policy was reviewed in 2007. The statistics provided indicate that policy review is not taken seriously. Figure 3 indicated that 6 schools formulated the policy between 2005 and 2007 and 8 schools formulated the policy between 2002 and 2004, hence, the possible delay in policy review. Section 15 of the National Policy on HIV/AIDS (Department of Education, 1999) indicated that the National Policy will be reviewed regularly and adapted to changed circumstances.

Similarly, school based policies should be reviewed regularly and adapted to changed circumstances. The school governing body members, the educator representatives as well as the principal acting as an ex officio member of the panel must review the school based HIV/AIDS policy on a regular basis.

4.2.7 Number of Learners Infected (HIV +)

School based HIV/AIDS policies provide the action plan to deal with learners that are infected or affected by the epidemic. It was therefore pertinent to find out from the schools the number of known cases of children either infected and or affected by the epidemic.

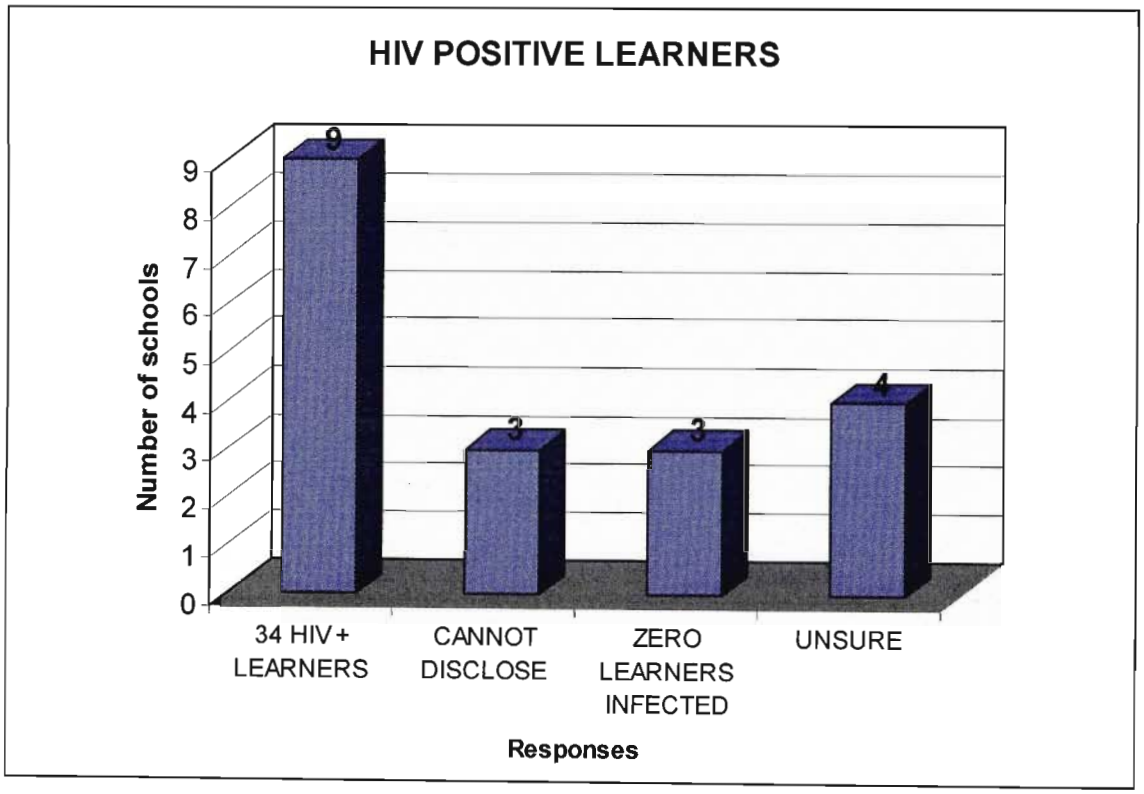

Figure 7: Number of Learners Infected (HIV +)

Of the 19 schools that provided data with respect to the number of learners infected, the total number of HIV positive pupils in nine primary schools amounted to 34. The presenter of "Global Initiatives on Preventive Education

against HIV/AIDS with emphasis on the African Experience", Dr Inon Schenker, visited a primary school and was wondering how many children he saw would be alive in 20 years time, how many would be orphaned and how many would be living with HIV/AIDS. Three schools indicated that they were not at liberty to disclose sensitive information. The possible reason for non disclosure from three schools is the fear of legal repercussions should they disclose sensitive information. Three schools indicated that there were no HIV positive learners in their schools. These statements are unrealistic as the epidemic is affecting everyone. Four schools were unsure of the number of learners infected.

The directive as promulgated by the National HIV/AIDS School Policy (Department of Education, 1999) encourages voluntary disclosure to appropriate authorities. The National HIV/AIDS School Policy is clear that no learner or student (or parent on behalf of the learner or student) or educator is compelled to disclose his or her status. When information is divulged, confidentiality must be maintained as unauthorized disclosure can result in legal liability. A holistic HIV/AIDS and life skills programme should be in place that promotes voluntary disclosure.

In terms of section 39 of the Child Care Act, Act 74 of 1983, any learner or student who is above the age of 14 may disclose his HIV status voluntarily. The parent of any learner or student who is under the age of 14 may disclose the HIV status of the learner or student to appropriate authorities. The environment must be supportive of the learner and confidentiality must be assured. Moreover, unfair discrimination must not be tolerated.

When the National HIV/AIDS schools policy was rolled out in 1999, there were no known cases of HIV positive learners in schools. As there are no invisible children in South Africa, every effort should be taken to assist the 34 known cases of HIV positive children in primary schools in the Umgeni North ward. These findings confirm the findings of Raniga (2006) who indicated that 29 secondary schools out of a sample of 74 secondary schools in the Ethekwini region had cases of HIV/AIDS amongst learners.

4.2.8 Approximate Number of Learners Affected (HIV positive caregivers)

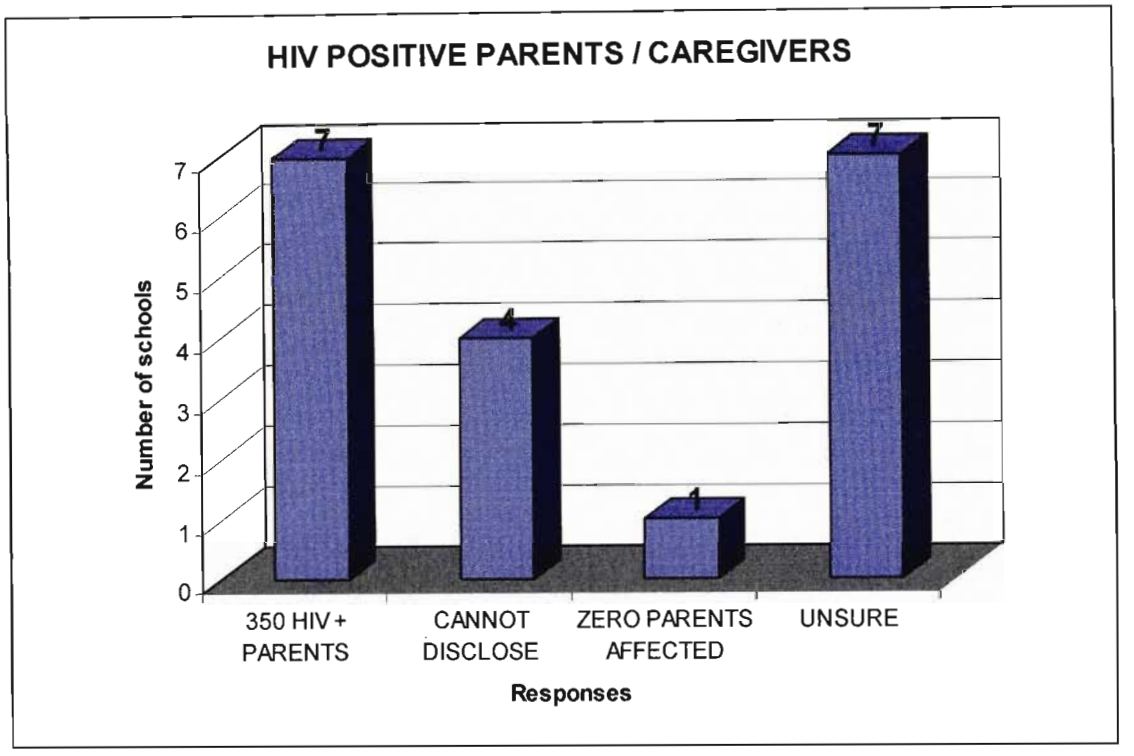

Figure 8: Approximate Number of Learners Affected

Of the 19 schools that provided data with respect to the number of learners affected (mother, father, sibling, grandparents who were HIV positive), there were 350 caregivers who were HIV positive in seven schools. Four schools indicated that they could not disclose this information while seven schools indicated they were not sure as to the number of caregivers that were HIV positive. One school indicated there were no known cases of parents who were HIV positive. These and the previous statistics confirm that policy is necessary as there are learners who are infected and affected by HIV/AIDS.

The South African adult HIV-prevalence rate is shown in the following table. The adult HIV-prevalence rate refers to the proportion of adults who are infected. Of the 47 390 900 population in South Africa, the HIV positive population is estimated at 5.2 million (Statistics South Africa, 2006).

4.2.9 Table 1: Table of Estimated Adult HIV-Prevalence Rates in 2006

(Statistics South Africa, 2006)

Women	15-49 years	20.0 %
Women	20-64 years	17.8 %
Men	20-64 years	17.5 %
Adults	20-64 years	17.7 %
Adults	15-49 years	18.2 %

Table one indicates that 20 percent of women in the age group 15 to 49 are HIV positive while 17.8 percent of women in the age group 20 to 64 years are infected. Women are the primary caregivers to many of the learners in KwaZulu-Natal. The learners who should be cared for by caregivers instead become caregivers themselves as the adults are HIV positive. The ecosystems theory confirms that the home environment impacts the school. Any alteration in any of the systems impacts negatively on the welfare of the child. Berger et al. (1996) confirmed that humans are dependent on all the elements in the environment.

Mathews et al. (2006) maintains that the existence of a school HIV/AIDS policy, good human relations with the school community as well as equity and fairness are the characteristics associated with teaching HIV/AIDS.

4.3 Conclusion

> *"Many of our children come form poor home backgrounds, unstable homes – where there is poverty, alcoholism and substance abuse. The home environment is not conducive to learning and not supportive to the learners".*

The above extract is taken from Muthukrishna (2002) who quotes a secondary school principal. The home environment is not supportive to learners due to various factors. The school should take cognizance of this and provide a supportive environment by developing enlightening policies to assist learners.

The objective of this study was to investigate the implementation of primary school based HIV/AIDS policies in the Umgeni North ward. This chapter provided the analysis of the Quantitative audit conducted with 19 schools in the Umgeni North Ward. This chapter provided evidence that while the majority of schools did formulate the school based HIV/AIDS policy, there are huge gaps in implementation. The central finding that formed the basis of this chapter is that more and more children who are infected and or affected by the epidemic will enter the school system and without appropriate action plans and empowerment of all delegated role-players (educators, learners, parents, school governing body, nurses, doctors, psychologists, etc), their needs will be treated without due regard for their inherent right to human dignity.

Chapter five encapsulates the factors associated with the formulation and implementation of school based HIV/AIDS polices.

CHAPTER FIVE

FACTORS ASSOCIATED WITH THE FORMULATION AND IMPLEMENTATION OF HIV/AIDS POLICIES IN PRIMARY SCHOOLS

5.1 INTRODUCTION

The objective of phase two of this study was to investigate the process involved in drawing up the school based HIV/AIDS policies in two primary schools as well as the challenges encountered in formulating and implementing school based HIV/AIDS polices in two primary schools in the Umgeni North ward.

Using the criteria listed in Chapter 3 (availability of principal, head of department, level one educators and securing the attendance of school governing body personnel) two primary schools in the Umgeni North Ward was selected from the broader sample of Phase one. Separate focus group interviews were conducted with the two schools. De Vos (2005) maintains that the aim of analysis is to look for trends and patterns that reappear within a single focus group or among various focus groups.

This Chapter outlines the factors associated with the implementation of primary school based HIV/AIDS policies in primary schools in the Umgeni North Ward. The factors associated with the implementation of primary school based HIV/AIDS policies cannot be separated into individualized compartments as they are interrelated. However, in this dissertation, the factors are discussed under four major themes that emerged from the data analysis, namely, the process involved in formulating school based HIV/AIDS policies, implementation of school based HIV/AIDS policies, support structures as well as the challenges associated with implementing primary school based HIV/AIDS policies in the Umgeni North Ward. In the data analysis, various sub themes emerged which are presented under each of the four major themes.

The central argument/s in each theme is presented and then supported with empirical evidence. The implication/s of the argument/s is explored and the recommendations are provided in chapter six.

5.2 FACTORS ASSOCIATED WITH THE FORMULATION AND IMPLEMENTATION OF SCHOOL BASED HIV/AIDS POLICIES IN THE UMGENI NORTH WARD

Walberg (2002) argued that the school can serve as a catalyst for:

> *"the development of HIV related policies that are based on the most current scientific knowledge about HIV and AIDS".*

It is clear that schools have the opportunity and responsibility to serve as a 'vehicle' to improve the lives of young children when they act as a medium to develop and implement policy (Department of Education 2003).

The process of formulation the school based HIV/AIDS policy, school based HIV/AIDS action plans, support systems/mechanisms in formulating and implementing policy as well as the associated challenges are the major factors associated with school based HIV/AIDS policies.

5.2.1 PROCESS OF FORMULATING SCHOOL-BASED HIV/AIDS POLICIES

There were a number of sub-themes within this broad theme. The process of formulating primary school based HIV/AIDS policies in the Umgeni North Ward is presented within three main sub-themes.

The first sub-theme that emerged is the disparity with respect to implementation of legislation at national, provincial, district and school level. The wide gap in this hierarchy impacts negatively on providing care and support for learners and educators infected and affected by the HIV/AIDS epidemic. Secondly, the inappropriate communication channels in the dissemination of information leaves learners, educators, parents and community members in a state of disarray.

Thirdly, the lack of will and intent to review school based HIV/AIDS policies means that changing circumstances in the arena of HIV/AIDS are not considered.

5.2.1.1 Disparity in Policy Implementation

The democratically constituted South African Government came into power in 1994. The immediate pressure on the new ANC government was to improve the lives of the masses as the apartheid era demoralized the majority of South Africans. The masses expected and demanded overnight change. The new government had to act in order to meet the demands of society. Some of the pertinent issues that had to be addressed were poverty, unemployment, housing, the separate education systems and redressing other past imbalances. (Raniga, 2006; Van Rensburg et al., 2002; Muthukrishna, 2002). Parallel to the numerous problems of the new government was the HIV/AIDS epidemic.

In 1996, the South African Schools Act (Act Number 84 of 1996) was developed. The purpose of this Act was to regulate the modus operandi of schools, that is, the plan or protocol of schools. This Act allowed the professional functioning of schools to be undertaken by the principal and school governance to be undertaken by the school governing body.

Part of the priorities of the new government post 1994 was the formulation of various policies and acts to address the impact of the HIV/AIDS epidemic on the education sector. One such policy was the National School Policy on HIV/AIDS (DoE, 1999) which was given to each province to implement. The provinces then instructed schools to implement the National schools policy on HIV/AIDS (DoE, 1999). It is important to note that provinces including local District offices and schools were not involved in drawing up the National schools policy on HIV/AIDS (DoE, 1999). The following extract from the principal of School A supports these contentions.

Extract 1

> *"Most of the policies that are drawn up would have come due to some regulation".*

The principal indicated that the policy is a result of a regulation. The inference is that he is expected to follow the directives and outcomes of the National Schools Policy on HIV/AIDS (DoE, 1999). This is supported by Raniga (2006) who indicated that there was a gap between policy ideals set at central government level and policy implementation at provincial level. Raniga argued that one district co-ordinator indicated that the relationship between national and provincial government is not merely hierarchical but in fact 'blurred' and unclear. These sentiments are posited by Van Rensburg et al. (2002) as well as Barnett and Whiteside (2006). I therefore contend that school principals find it difficult to involve significant others in the process of formulating policies as they themselves were not significantly involved in formulating the National school Policy on HIV/AIDS (DoE, 1999) due to no fault of theirs. Their exclusion impacts negatively on the remainder of the processes.

In addition to the National Schools Policy on HIV/AIDS (DoE, 1999), the Department of Education developed guidelines (DoE, 2003) which serves as broad principles. The expectation is the participatory approach to formulation the school based HIV/AIDS policy. Extract 2 indicates that this is sadly not the case as reiterated by one of the principals.

Extract 2

> *"We drew up a draft and the governing body members went through the draft and they edited that at that stage."*

Extract 3

> *"I headed that part of the committee in terms of the policy"*

Extract 4

> *"I structured it and revised it"*

Extract 5

> *"I think more often that not, it is always the school management team that leads the process with regards to any departmental requirement ..."*

The implication is that both schools indicated that management and staff were responsible for drafting the school based HIV/AIDS polices. The principal of school A indicated that the process was to draft the policy, amend the policy and then send the policy to the school governing body for acceptance. It is clear that the school governing body is left out from the first stage in the policy making process as they are only involved in editing. This is triangulated by the findings in the Quantitative audit that clearly indicated that 12 schools out of 19 schools had the principal and staff involved in the policy process (Figure 4). It is possible that members who sit on school governing bodies do not have the knowledge and skills about engaging with policies and as an educator I believe that there is little or no opportunity provided by the Department of Education to address this gap.

Mdziniso-Zwane et al. (2001) indicated that step one in the policy process is to consult all stakeholders. In this regard, Matthews et al. (2006) confirms that good relations with stakeholders are important. Hence, the importance of involving the school governing body in the first stage of the policy process and thereby improving and creating a participatory relationship.

The National Department of Education (macro system) developed the policy which served as a frame of reference to the Provincial Department of Education (mezzo system). The school personnel which should include the school governing body (micro system) is charged with the responsibility of using the frame of reference to develop a policy that is conducive to the local needs of specific communities. It is evident that there is a lack of support from national to provincial to district to schools.

The implications of excluding the governing body from the process follow. Firstly, the concept of participatory decision making is not given due recognition as

encapsulated in section 12.4 of the National schools policy on HIV/AIDS (DoE, 1999). Secondly, the suggestions by Muthukrishna (2002) to mobilize resources in communities are ignored. Thirdly, the National Policy on HIV/AIDS (DoE, 1999) which is a directive from National Government is ignored. The National policy on HIV/AIDS (DoE, 1999) is not a suggestion, it is policy.

5.2.1.2 Communication of policy

Walberg (2002) maintains that:

> *"In combating HIV infection, the crucial responsibility of schools is to teach young people how to avoid either contracting the infection or transmitting it to others"*

Hence, communication is essential. In this section, the central argument is that the inappropriate communication channels used by the schools leave learners, educators and parents in disarray.

The school based HIV/AIDS policy must be disseminated to learners, educators and the parent community. The methodology used to disseminate the policy varied from school to school. The next three paragraphs are devoted to policy dissemination to learners, educators and the parent component.

School A indicated that they were not sure if learners were aware of the policy. School B initially indicated that learners were aware of the policy and then qualified their response by indicating that only grade 6 and 7 learners were aware of the contents of the school based HIV/AIDS policy. The respondents confirmed that learners were aware of AIDS but were not aware of policy per say.

Extract 6

> *"I would say they are aware of AIDS but I don't know if they are aware about policy but we do teach them and make them aware about HIV"*

The National Department of Education Curriculum (C 2005), the National Curriculum Statements (NCS) and the National HIV/AIDS Schools Policy (DoE, 1999) prescribe that sexuality and HIV/AIDS is part of the Life Orientation learning area. In school A, educators maintained that HIV/AIDS is taught across various learning areas in the curriculum, an integrated approach. They indicated that the school nurses and the health department communicated messages to the learners. It is evident that HIV/AIDS awareness programmes were communicated to learners, however, the policy was not communicated. In school B, management maintained that the policy is communicated to learners in the life orientation lessons, assembly announcements, special days and the help of outside speakers.

The key informants in School A indicated that they disseminated the policy to staff via circulars. The key informants in school B indicated that they disseminated the information to staff by first conducting a workshop and then presenting staff with a manual. This workshop was conducted by the management members of the school.

The principal in School A indicated that the policy was disseminated to the parent component by means of a circular. In school B, there was some confusion regarding the dissemination of the school based HIV/AIDS policy to the parent component. This is confirmed in the following extract from the principal of School B.

Extract 7

> *"It is not an outside policy. It's not meant for the community, it's what you do here with regards to AIDS".*

Extract 8

> *"Now I think this particular policy I don't think has been communicated via circular to parents, rely on community based organizations"*

The principal indicated that the policy was not for the wider community. School B relied on community based organizations to impart knowledge to the parent community. This school was adamant that this was an internal policy and should not be passed out. There are serious implications regarding the sentiments of the principal. This principal is the head of an institution that serves mainly disadvantaged learners and communities. The majority of learners and parent component live in informal settlements (peri urban) near the school. It is clear that the resources in this area are limited, basically non existent. If this school does not empower the community in terms of policy awareness and implementation, how then will they become informed? The ex-Minister of Education, Professor Kader Asmal embraced the ecosystems theory that schools must become centers of community life (Department of Education, 2000). The mesosystem links the elements of the microsystem. The school, the community, the church, the temple, the mosque, the social clubs and the sporting organizations amongst others are interconnected and together form the mesosystem. They impact on the way the child participates in society, for example, some communities do not have structures that promote sport and they lack access to fully equipped churches, mosques and temples. These communities are struggling with day to day survival. Unemployment and poverty impact negatively on these communities (Raniga, 2006). Hence, it is important that the school becomes the centre of the community life. Hence, it is important that school (micro) principals allow religious organizations the use of school premises to set up churches, mosques and temples. It is important that schools become the centre of activities so that communities (mesosystem) have support structures available to them. Muthukrishna (2002) reinforces the concept of building school-community links. School B needs to be developed in this regard. However, this school must be commended as they made it clear that the policy will be given to the parents or caregiver of any child who is infected.

Extract 9

"the community and the counselor have been"

Extract 10

> *"Perhaps greater awareness and to our parents, we need to inform them about the policy"*

Extract 9 is the response from the parent component of the school governing body (one of few responses) with respect to communication of the policy to parents. From the findings of this study, it is evident that the method of communicating the policy to the relevant stakeholders is inappropriate. It is clear that learners are not aware of the policy. It was evident from the focus group sessions that most educators did not have a copy of the policy. It is clear that communication of the policy to the community is left to the non government organizations as well as the counselor. The school is neglecting its responsibility to build the school community link; hence, important stakeholders are left out.

5.2.1.3 The lack of policy review

A further sub-theme that builds on the findings in Chapter Four is the lack of review the school based HIV/AIDS policy. The quantitative data in phase one of this study indicated that of the 19 schools that responded, 8 schools reviewed the policy in 2006 while 3 schools reviewed the policy in 2007. The phase one findings indicate that policy review is ad hoc and uncoordinated. One should not be idle when the epidemic is all around us or one would languish. With the unprecedented scale of the epidemic, what worked last year may not work this year. With technology and a highway of information (World Wide Web), it is of paramount importance to those infected and affected that their caregivers keep abreast with the latest trends. Hence, frequent (yearly) policy review is necessary as reiterated in the Department of Education guidelines (DoE, 2003).

The key informants in school A and school B indicated that the policy was not reviewed. Time constraints, poor leadership and lack of district, regional and provincial support were provided as the reasons for not reviewing the policies. These statistics triangulate the statistics in the phase one Quantitative audit that provided evidence that policy review is not taken seriously. Figure 6 in the

Quantitative audit clearly indicates that two schools were not sure when the policy was reviewed, three schools did not review the policy and only three schools reviewed the policy in 2007.

Policy review should have taken place in 2000 or latest 2001 and thereafter on a yearly basis as the National Schools Policy on HIV/AIDS was rolled out in 1999. The National Schools Policy on HIV/AIDS (DoE, 1999) does not provide clear direction with respect to policy review. It is however important to note that all schools should have taken policy review seriously as the Department of Education (2003) guidelines provides clear directives on policy review.

In the review process, the stakeholders that formulated the policy are expected to take the following into account:

- Does the policy give clear information about procedures that are followed at the school?
- Does the policy take into account the recommendations in the Department of Education guidelines?
- Does the policy set out the need for certain actions and how these actions will be monitored?
- Does the policy mention specific partnerships and the purpose?
- Does the policy indicate what educators should do and when the educators must hand over to health and or social services?
- Are the procedures for liaising with health and social workers listed?
- Are there clear steps to protect against discriminations?
- Does the policy include details about local funding?
- Is there sufficient information on how to use community resources?
- Are training issues presented?

It is fundamental to take the regular review of the school-based HIV/AIDS policy seriously. Each year, local funding could increase or decrease. Hence, it is important to review the policy so that arrangements can be made to cope with the maturation of the epidemic. During the course of the year, role-players

(educators, governing body members, learners) may find that discrimination issues arise. Hence, these can be clarified and strengthened in the review process. The staff may find that there are new training needs that should be incorporated into the policy, example the use of the AIDS Risk Reduction Model (ARRM) that assumes behaviour change is a process (Rawatlal, 2007). Hence, non review of the school based HIV/AIDS policy will result in outdated methodology, support structures will collapse and the challenges associated with HIV/AIDS will increase exponentially.

5.2.2 SCHOOL BASED HIV/AIDS ACTION PLANS

The second major theme that builds on the arguments presented in chapter four is the inconsistency in terms of school based HIV/AIDS action plans. The 2003 UNESCO report indicated that the HIV/AIDS pandemic contributes to rapid breakdowns of existing structures that traditionally took care of the development of young children. There must be strategies to provide support, care and guidance to young children, families, parents and care givers that are directly or indirectly affected by HIV/AIDS. This is classified as interventions at the mezzo and micro level. There must be a conducive policy environment that allows safety nets and strategic interventions to take place, to grow and be inclusive (UNESCO, 2003:18).

Two central arguments form the basis of this section. Firstly, it was clear from the respondents that action plans means different things to different schools due to poor policy directives. Secondly, evidence from the data indicates that schools adopt an ad hoc and uncoordinated response to the HIV/AIDS epidemic.

5.2.2.1 Fragmented School based HIV/AIDS Action Plans – Poor Policy Directives

The inclusive process that allows the Governing Body members to lead the process is the ideal situation for all schools. It is evident from the discussion above that schools did not follow critical processes in the formulation and implementation of school based HIV/AIDS policies.

Extract 11

> *"in the policy, if there could be some kind of plan of who is responsible in the school for whatever in terms of all the activities for the year and indicators whether we are reaching our goals, more like an action plan into the policy"*

The principal is of the opinion that an individual should be responsible for all the activities regarding HIV/AIDS. The principal is thus referring to an HIV/AIDS director. The principal wants this individual to have a year plan and check if goals and activities of the school have been reached. The principal requires an action plan to be built into the policy. These sentiments confirm the confusion in terms of action plans. Poor policy directives result in this confusion as the National Schools policy on HIV/AIDS (DoE, 1999) is vague in terms of the HAC and action plans.

In school A, the key informants indicated that if the child is HIV positive, they take care of the child by providing nourishing meals and allowing the child to go to the sick room when necessary. The educators and staff indicated that they maintain confidentiality in terms of the learner's status. The principal in school A indicated that the policy is a good guide.

According to the Department of Education guidelines (2003), a committee that implements the school based HIV/AIDS policy should be formed. The school governing body chairperson and the principal of the school should give legitimacy to this new committee (HAC) to implement the school based HIV/AIDS policy. The principal and chairperson of the school governing body should be members of this new committee (HAC). Both schools failed to mention the formation of a new committee (HAC) that structures the action plan to implement the school based HIV/AIDS policy.

In this study, both schools indicated they had an action plan to implement the school based HIV/AIDS policy; however, it must be categorically noted that the action plans were not according to the Department of Education guidelines

(2003). The phase one Quantitative audit triangulates the focus group sessions as the phase one Quantitative audit (figure 5) also indicated that there was confusion with regards to the action plans for implementation. The following extract indicate some of the phase one responses to the question: Do you have an action plan to implement the policy?

Extract 12

"every term – one week talk and the children make posters"

"not quite – outreach committee and first aid kit"

"action plan is to send to clinic and hospital"

"qualified counselor"

The above quotations in extract 12 confirm the first argument that action plans mean different things to different schools. It is thus evident that while policy is formulated by the majority of schools, there is definitely a huge gap in policy implementation and that clear policy directives are required to translate the proposed plans into action.

Hartell et al. (2003) confirms the findings of this study in terms of the disparity between legislation and implementation. Hartell et al. (2003) indicate that "there is a distance between policy and practice". Hartell et al. (2003) in their study of "how a selection of school governing bodies in Mpumalanga understand, respond to and implement legislation and policies on HIV/AIDS" confirm that there is "*a general ignorance of basic human rights issues, the right to confidentiality, and the right to security from discrimination if it is known that a pupil is HIV positive, the right to privacy and the right, under certain circumstances, to disclosure*". Their findings reveal that governing bodies should develop vigilance with respect to any legal challenges they might face at the mezzo level. They also argue that governing bodies should be made aware of the general legal issues surrounding

the individual and HIV/AIDS. Only when governing bodies are empowered, can they introduce fair and balance policies.

5.2.2.2 Ad hoc and uncoordinated response to the HIV/AIDS epidemic

A second sub-theme that emerged from the data analysis is the ad hoc and uncoordinated response to the epidemic. Without carefully devised action plans, individuals are forced to respond on an ad hoc basis. In school B, the principal indicated that policy is implemented when a learner discloses his or her status to an educator. The following extracts confirm the postulations that the response is ad hoc and uncoordinated.

Extract 13

> *"Whenever we have a case we look at what needs to be done and the normal processes in terms of informing parents, helping the child out, making the child go for treatments"*

This principal indicated that more often than not, they are the last ones to know. The principal confirmed that he was certain that one child was HIV positive in his school. He indicated that there could be other cases but he was not informed about them. The phase one quantitative audit (34 HIV positive learners – figure 7) supports the contentions made by key informants in the focus group that there are cases of HIV positive learners in primary schools.

Mitchell (2000) maintained that HIV/AIDS is managed on an ad hoc basis. This study supported the contention made by Mitchell (2000) as both schools in the focus group and 17 schools in the phase one Quantitative audit (19 in total) have developed school based HIV/AIDS policies, however, learners are assisted on an ad hoc and uncoordinated basis.

It is evident that implementation is fragmented due to the process being compromised from the formulation phase of the policy process. As the school governing body was not totally involved from step one, they are automatically

omitted from assisting with the implementation of the school based HIV/AIDS policy. Mathews et al. (2006) indicated that *"community involvement influenced the implementation of HIV/AIDS education"*. Mathews et al. (2006) further supports the implementation of school based polices. They argue that it is important to ensure that interventions are implemented in order to avoid missed opportunities. They argue that processes to develop the school HIV/AIDS policy must be supported and interventions should go beyond HIV/AIDS or sexual health agendas.

Allemano (2003) argues that the theme of educational quality is particularly appropriate for developing policy responses to HIV/AIDS as responses must be multi-faceted and holistic. Without proper guidance on implementation, educators will act based on their personal belief systems. This will result in a disjointed effort to assist children infected and or affected by the HIV/AIDS epidemic. Hence, consistency in treating learners without discrimination will be compromised.

Mathews et al. (2006) confirmed that a group of Dutch investigators studied the antecedents to the adoption of classroom based AIDS education programmes in secondary schools. They showed that educator's adoption and implementation of HIV/AIDS programmes were strongly influenced by their attitudes, subjective social norms and self efficacy. They further indicated that many programs proven to be effective have not been implemented in schools other than those in which effectiveness was demonstrated.

Previously disadvantaged schools are struggling to meet their financial obligations with respect to water and lights, telephone and other school related expenses. Schools are allocated funds based on their quintiles (South African Schools Act, 84 of 1996). The idea of the government is to provide finances to schools based on the conditions of the surrounding areas. Schools in affluent areas receive little funding from the government as the government is targeting the poorest of the poor schools. Hence, schools that are poor may also not receive sufficient funding as the poorest of the poor is targeted. Schools perceived to be advantaged receive a low allocation compared to disadvantaged

schools. As many of the schools in the Umgeni North Ward have *decent* school buildings and tarred roads, they are perceived as advantaged, however, in reality, they are attending to the needs of learners from previously disadvantaged communities.

It is thus evident that action plans meant different things to different schools as a result of poor policy directives as the instructions in the National Schools policy on HIV/AIDS (DoE, 1999) is limited. The National Schools policy on HIV/AIDS merely mentions the establishment of action plans.

5.2.3 SUPPORT SYSTEMS/MECHANISMS IN FORMULATING AND IMPLEMENTING SCHOOL BASED HIV/AIDS POLICIES

Data from the focus group sessions in School A and School B indicate that there are not enough support systems to assist children vulnerable to the HIV/AIDS epidemic. It is a tangible outcome of the National HIV/AIDS School Policy (DoE 1999) that learners and educators infected or affected by the HIV/AIDS epidemic should be supported. In this section, the two main arguments, the relationship between the child and wider society is bi-directional and reciprocal (two way process) and the perplexity concerning the Health Advisory Committee are presented.

Andersson et al. (2004) conducted a national cross sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils. One third of the 269 705 respondents aged between 10 and 19 thought they were HIV positive. Taylor et al. (2002) and Sathiparsad and Taylor (2005) confirm that *"Some learners began sexual activity as early as at age 10".* Hence, it is important for support structures to be in place.

Mturi and Nzimande (2006) confirm the hardship encountered by South African youth. They indicated that the *"existence of unconventional families in South Africa are mainly an outcome of the HIV/AIDS epidemic".* They conclude that children *"as young as 11 years old were identified as looking after themselves*

and their siblings". Hence, support structures are necessary in schools as these children cannot continue supporting themselves and their siblings.

A study by Reddy et al. (2003) confirmed peer pressure and the media are factors in the environment that influences the child. Reddy et al. (2003) indicated that male and female students expressed doubt in their ability to resist peer pressure from friends to engage in sexual activity. At least 60 percent of students indicated that they would benefit from learning the necessary skills to resist peer pressure from friends and to help them talk to their parents.

Walberg (2002) maintained that in schools were there were no clear policies on prevention; even motivated educators find it difficult to lecture on HIV/AIDS. Thus, a team of people could work together to develop and monitor policies. This would lend strength and support as diverse members of the community could be involved. The following diagram places the learner in the centre of the elements in the environment that impacts on the learners well being (ecosystems theory).

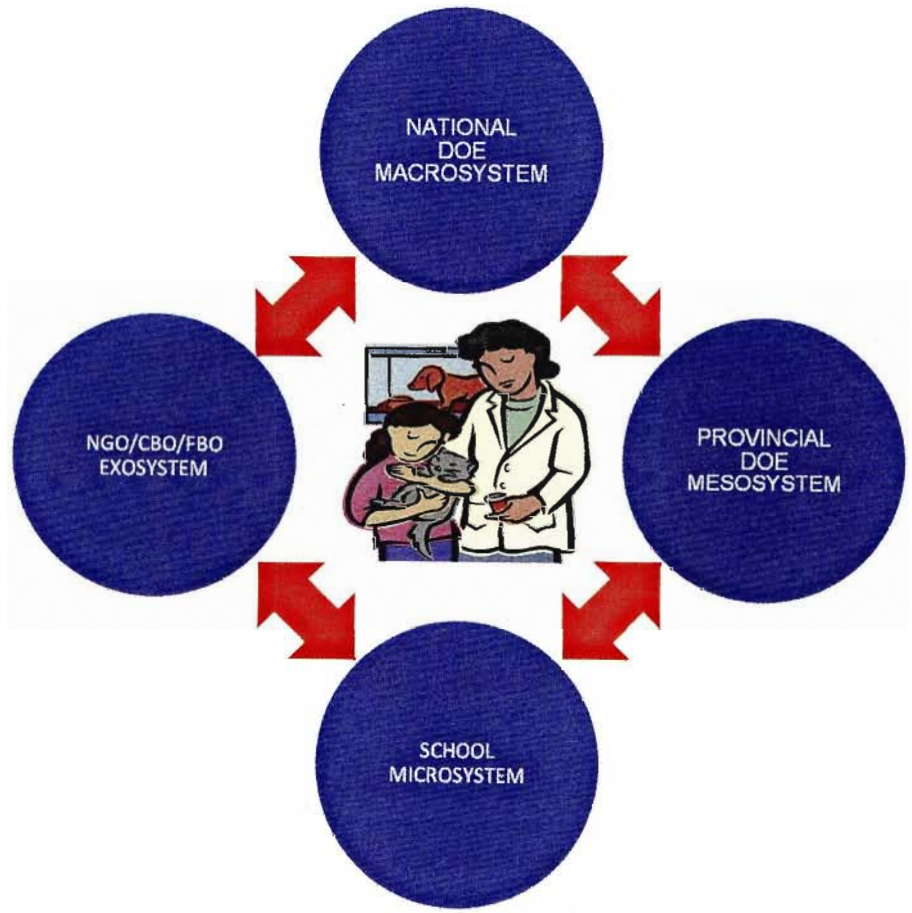

Figure 9: Interconnectedness with school and wider society

Figure 9 indicates the bidirectional (reciprocal) relationship between the learners and the wider society as encapsulated in the theoretical framework (the ecosystems theory) that formed the conceptual base of this study.

The removal of important support systems from schools will have a negative effective on this relationship. The head of department in School A indicated that the department should give back the health workers to the schools. The work load of health department prevents them from attending to the various needs of schools. One educator commented that guidance services and psychological services were taken away. The removal of psychological and guidance services implies that educators must now deal with children who have special needs (LSEN). Laurence et al. (2002) indicated that the National Ministry defers HIV/AIDS education in secondary grades to 'guidance counselors'. Primary schools are not in the fortunate position to have the services of guidance counselors and thus educators are charged with, amongst other responsibilities, the responsibility of HIV/AIDS education, care and support.

Laurence (2002) indicated that most education sector policies contain detailed HIV/AIDS programs which included protective skill building, life skills education, and safer sex education for current students but rarely included plans for future school-age populations.

One educator in school A indicated that it is a major challenge to assist the child who is HIV positive who cannot cope with the work. Another educator confirmed that some children are very sick as a result of HIV/AIDS and indicated that one child passed away recently.

Laurence (2002) indicated that in Lesotho, the strategic plan of the Ministry of Education describes a comprehensive participatory approach to HIV/AIDS prevention in primary education. Hence, it is expected that the school, non governmental organizations, the Department of Education and other role-players work together to assist the most vulnerable members of society. In the South African context, the Macrosystem (the National Department of Education) devolves this responsibility to the Mezzosystem (school and community) that

undertakes the mammoth task of establishing the Health Advisory Committee (HAC) which serves as the main support system regarding HIV/AIDS in the school context.

5.2.3.1 Health Advisory Committee (HAC)

The rationale for the establishment of the Health Advisory Committee (HAC) is to provide a multidisciplinary committee which is meant to be a support system in schools to assist learners that are infected and affected by the epidemic.

According to the National Policy on HIV/AIDS (DoE, 1999), where community resources make it possible, the Health Advisory Committee should include members from the Health department. The National Schools Policy on HIV/AIDS (DoE, 1999) indicated that *"The Health Advisory Committee may as far a possible use the assistance of community health workers led by a nurse or local clinics"*

Raniga (2006) indicated that there is "the lack of institutional capacity at school level to deal with the problem of HIV/AIDS". She maintains that the HAC would be *"better able to enhance care and support for those learners, families and educators who are infected and or affected by HIV/AIDS".* I therefore posit that the establishment of the HAC is not a suggestion, it is policy, and therefore schools must establish this important support structure.

In the phase one Quantitative audit, 13 out of the 19 key informants (68 percent) indicated they do not have a health advisory committee. Six out of 19 (31.57 percent of the respondents) indicated they have a health advisory committee. The two schools in the second phase of the study (focus group interviews) indicted that they do not have a health advisory committee.

The following diagram indicated the responses from 19 schools.

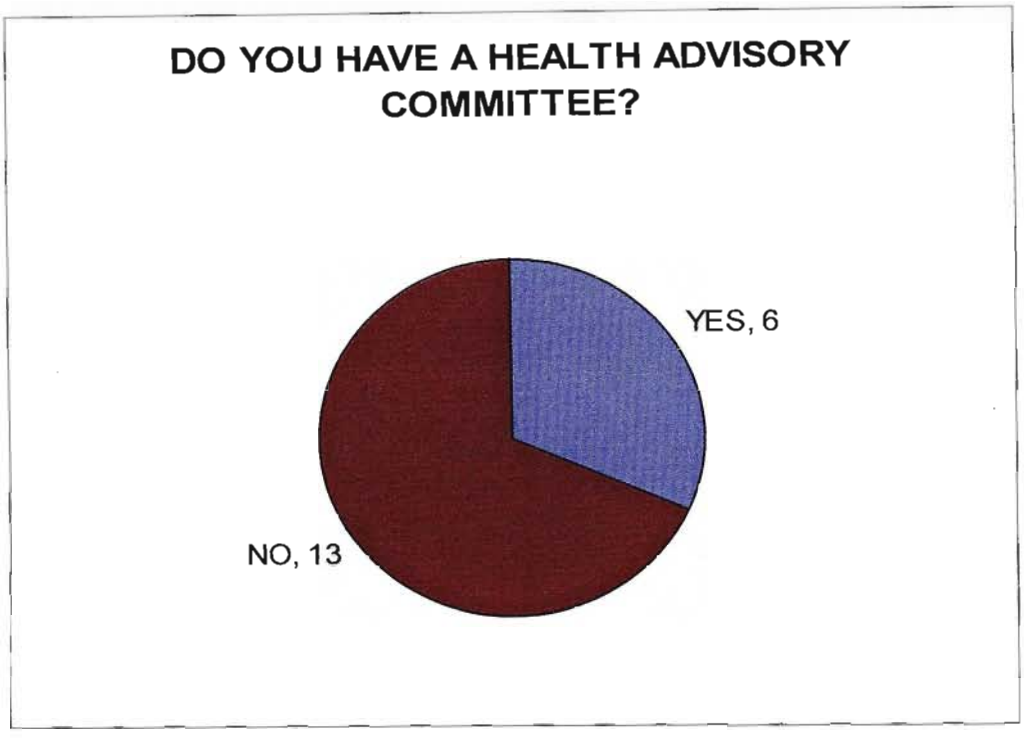

Figure 10: Health Advisory Committee

The central argument presented is this chapter is the incongruent perceptions with respect to the HAC that results in a diluted multi-sectoral approach to implement initiatives to deal effectively with the HIV/AIDS epidemic. The focus group interview in phase two of this study confirmed the confusion regarding the establishment and the function of the Health Advisory Committee in phase one of this study. The following extracts confirm the confusion in terms of the HAC.

Extract 14

> *"No. We don't have a Health Advisory Committee. Getting back to your answer in terms of resources, and it says if permitted, we being a small staff, every staff member here is a health practitioner, you know what I am saying, anything that pertains to the kids health and so on, everybody is involved in it, so if a kid gets injured outside, first aid, everybody administers, even the secretary, so what I am saying, its all inclusive."*

Extract 15

"All of us. We have a lunch club."

Extract 16

"Our entire staff is our health advisory committee"

Both schools believed the staff was the Health Advisory Committee. Hence, it is clear that schools have difficulty in putting this system in place. The intentions of both schools are excellent as the entire educator component is involved in first aid and other health related matters. It is evident that both schools support the inclusive approach to dealing with the HIV/AIDS epidemic. However, it must be pointed that important stakeholders are omitted form this process and this has serious implications for the most vulnerable members of society.

The function of the Health Advisory Committee is to assist the school in all health related matters. There are serious implications for schools that do not establish the health advisory committee. Firstly, schools would not be able to get continuous and updated advice and support on health matters. One of the functions of the HAC is to *"advise the governing body or council on health matters, including HIV/AIDS"*. Secondly, schools without the HAC would be in disarray in terms of who develops the implementation plan. The most important function of the HAC is to develop the implementation plan (Action Plan). The National Schools Policy on HIV/AIDS (DoE, 1999) indicates that the HAC should take the responsibility for *"developing and promoting a school or institutional plan of implementation on HIV/AIDS"*. Thirdly, the implementation plan is not reviewed. The other functions of the HAC are to *"review the plan"*. Finally, the code of conduct is compromised in terms of health matters as the HAC is not consulted. The National Schools policy on HIV/AIDS (DoE, 1999) indicated that the HAC be *"consulted on the provisions relating to the prevention of HIV transmission in the Code of Conduct"*.

Mathews et al. (2006) clearly indicated that in order to enhance teachers implementation of HIV/AIDS education, the focus should be on broad school development plans which improves school functioning. In the South African context, the establishment of the Health Advisory Committee is a broad structure that would improve school functioning.

This study confirmed the perplexity that exists in primary school with regard to the HAC. It is also evident that the establishment of the HAC is a complex issue in secondary schools as well. Empirical data by Raniga (2006) supports the findings that school are finding it difficult to establish the HAC. She indicated that only nine out of 74 schools (12 %) established the HAC in secondary schools while 65 schools out of 74 secondary schools did not establish the HAC.

This study provides sufficient evidence that the relationship between the child and the caregivers is bidirectional and reciprocal and the perplexity with the establishment of the HAC impacts negatively on the relationship between the child and his caregivers. Time constraints, financial muscle, apathy on the part of stakeholders are possible reasons why some schools do not establish health advisory committees. It is evident that schools have not been empowered by the Department of Education with respect to establishing the Health Advisory Committee. Hence, the role of educators as well as the challenges they face increase.

5.2.4 CHALLENGES ASSOCIATED WITH THE FORMULATION AND IMPLEMENTATION OF SCHOOL BASED HIV/AIDS POLICIES

Cullinan and Thom (2007) postulates that South Africa has taken "giant leaps" by reaching consensus on a national response to HIV/AIDS, however, the biggest challenge is implementation.

There are two main arguments with respect to challenges associated with the formulation and implementation of primary school based HIV/AIDS policies in the Umgeni North Ward. The first argument I present is that educators are not equipped to deal with their changing role as educators in the arena of HIV/AIDS.

The second argument I present is the ineffectiveness of the methodology used by the Department of Education to re-skill educators and empower school governing bodies.

5.2.4.1 The inability and unpreparedness of educators to deal with HIV/AIDS and related problems

Sathiparsad (2005) in a quantitative descriptive study indicated that educators identified substance abuse, behavioural problems, poverty, individual and learning difficulties, violent behavior, sexual behavior as well as communication difficulties as the main problem categories they face. Khoza (2002) and Raniga (2005, 2006) discuss the changing role of educators, form curriculum presenter to one who helps these learners cope.

Charles (2002) maintains that there must be a shift from the focus of viewing HIV/AIDS as a primarily medical issue and find the right points of intervention by educators who are seen as prime agents in nurturing behavior change. Hence, the paradigm shift of the educator form the one who should deliver the curriculum to one who delivers the curriculum and nurtures behavior change.

The first challenge associated with the formulation and implementation of school based HIV/AIDS polices is the paradigm shift in terms of the role of educators. In the focus group session in School B, one graduate indicated that his University qualification was education geared and not HIV/AIDS related. The following extract confirms his response to the question "Do educators possess the skills and expertise to deal with HIV/AIDS related problems?"

Extract 17

> *"No. I don't think we had enough training or exposure to the problems because what we learned in our Universities and Technikon is education geared. It wasn't focused on AIDS because it was not there at that time so now maybe we need to do more training on AIDS."*

Hence, it is evident that educators lack the necessary skills to deal with the effects of the epidemic. Khoza (2002) supports these contentions as he indicated that as educators are confronted with more cases of sexual violence and child abuse that leads to children being exposed to HIV, educators reach the point of feeling incompetent. The next four extracts taken from three separate educators in school A confirm the sentiments of Khoza (2002). In response to the question "Do educators possess the skill and expertise to deal with HIV/AIDS related problems?"

Extract 18

> *"Minimal, I would think"*

Extract 19

> *"At a very amiable level"*

Extract 20

> *"What do we have in terms of skills? Its just universal precautions"*

Extract 21

> *"I don't know what to do, I say, you must get better and come back, she stays away ever so often"*

The extracts clearly indicate that educators are desperate in terms of providing assistance to learners. 'Minimal', 'Its just universal precautions' and 'I don't know what to do' is evidence that educators are disorientated with respect to the HIV/AIDS epidemic.

The focus group sessions confirmed that the role of educators change further as they have to deal with over-aged learners who are in primary schools. The following extract substantiates this fact.

Extract 22

> *"if you look at it, the grade 7 is in the wrong place, they should be in the secondary school"*

Taylor et al. (2002) confirm that educators will experience problems as they conducted a descriptive study in Ugu North in southern KZN. Two high schools with approximately 1 000 learners each were selected. The findings of Taylor et al (2002) confirm that having adolescent learners (10 – 14 years) in the same class as adults (above 18 years of age) with very different developmental needs is a major constraint.

Educator roles change as they sometimes have to take on additional responsibilities due to the attrition of their colleagues. An article on the educator supply and demand in the South African public education system (Peltzer et al., 2005) indicated that fifteen out of every thousand educators died during the period 1997 to 2001. The resultant effect is continuous change in school personnel which compromises fluent implementation of HIV/AIDS policies.

Two decades ago, educators were skilled to teach in specific subjects. They were specialists in their field in terms of subject matter. In the current climate of HIV/AIDS, the role of the educators changed as they have to deal with new problems. Bereavement and child headed families are examples.

Extract 23

> *"about the child headed families, they need so much of counseling, for a child to see his parents dying is traumatic, how to handle bereavement, how do they cope with it"*

Extract 23 proves that educators are struggling in assisting children deal with bereavement as a consequence of the maturation of the epidemic. Kasiram (2006) indicated that *"spiritual connections are sought and educators and practitioners need to heed this call".* She maintains that people infected and affected by HIV/AIDS seek *"solace from what they refer to as God, religion and spirituality"* and she recognizes that this request is often left unfulfilled.

Partab (2006) indicated that she was inspired to comment on dignity at death and the challenge posed by HIV/AIDS due to *"the dearth of literature on death, dying and bereavement in the area of HIV/AIDS".* Prabhavisnu (2006) confirms that there should be dignity at death. Extract 23 clearly indicates that the educators wonder how children cope. Partab (2006) maintains that communal grieving helps bring back the "ubuntu" concept; we are who we are through others. There must be caring, sharing and honouring to counteract the shame associated with death as a result of HIV/AIDS. The contrary view by Prabhupada (2007), the founding spiritual master of the International Society for Krishna Consciousness is that one should not lament for the material body. These arguments are beyond the scope of this dissertation; however, care should be exercised in presenting views in this regard. Kasiram (2006) maintains that caution must be exercised as authoritatively commenting on religious practice and belief requires years of study and application.

In extract 23, the educator made an important point about the child headed families. She maintained that they need counseling. Mturi and Nzimande (2006) indicated that currently in South Africa, research is being conducted with regard to child headed families. They used a triangulated study to conduct research in KwaZulu-Natal, Limpopo and Eastern Cape using a quantitative survey of 3 839 families and qualitative interviews with individuals and focus groups. They maintained that one of the challenges is the denial associated with child headed families, hence the failure to acknowledge and assist them. Mturi and Nzimande (2006) indicated that these children do not qualify for grant, hence some engage in prostitution which results in absenteeism. This study confirmed the findings of Mturi and Nzimande (2006) as educators in the focus group sessions point out

that children are the heads of households. Further, educators are struggling to support and assist these children.

Extract 24

> *"She is taking care of the grandmother before she comes to school. Why is she late? Every day I put that child in detention. I am double punishing the child. The child got no life now."*

The educators are concerned about the welfare of the child. This educator acknowledged that the child is punished twice due to no fault of the child. The child is firstly punished as the child has to take on the role of a parent (Child headed household). The second punishment the child receives is the fact that the child has to serve detention. The hidden implication is that she also has lesser time to take care of her grandmother as she is in detention. The educator acknowledges that the child has no life now, assume the role of mother, come late to school and serve detention. What should be a pleasant experience for children, laugh in school, play in school, learn in school has in fact become a nightmare. The role of the educator has thus changed; the educator is the key support for this child with so many problems.

Bhana et al. (2006) as well as Sathiparsad and Taylor (2005) provide sufficient empirical evidence that the role of the educator has changed. Bhana et al (2006) maintain that for many men, it is *"still anathema to express concern and care for the self and others".* Herein lies the problem as there are male educators in primary and secondary school and children who are infected and affected by HIV/AIDS need the support of every available resource. The study by Bhana et al (2006) confirms that only a few men provided care by listening, advising and actively assisting. This is not good enough as every educator should serve as a support structure for our vulnerable learners. Hence, the paradigm shift is necessary for male educators in the Department of Education.

Educators will be confronted with more HIV-positive children in the class; hence, the feeling of being incompetent is exacerbated. Adara (2002) maintains that

teachers are instrumental in educational programme implementation. They need to have fundamental knowledge about the basic facts of HIV/AIDS. They should be versatile in introspective methods, cooperative and participatory learning and techniques which clarify values, feelings and behavior change. Teachers should be open minded and their personal views should not colour issues. Teachers should be retrained through a multi-disciplinary approach which should be gender sensitive.

Jacques (2006) indicated that *"children subjected to different forms of abuse constitute a significant category of special needs. Within this population, are many whose circumstances have been adversely affected by AIDS".* Educators need to be more observant of abuse and sexual exploitation so that they can provide support and arrange for the child to be referred to specialists. The categories presented by Jacques (2006) include physical, emotional, sexual, structural, neglect and violent families. Teachers should also be aware of orphans and assist them with food, cultural barriers, residential care, separation from siblings, property grabbing by relatives, incest or defilement of the girl child and stigmatization.

5.2.4.2 The ineffectiveness of the methodology used by the Department of Education to re-skill educators and empower school governing bodies.

The ineffective method used by the Department of Education to re-skill educators dilutes intervention and preventative strategies. The following is an extract from school B.

Extract 25

> *"sometimes these workshops are held within school hours and sometimes after work; ... it is restricted to a number..."*

Educators in school A and school B indicated that the KwaZulu-Natal Department of Education had workshops to empower them using the cascading model of

training. Mathews et al. (2006) confirmed that their study indicated that teacher training is important in the arena of HIV/AIDS. They argue that teacher training will improve the implementation of HIV/AIDS programs by raising awareness and the importance of responding. Teacher training can provide concrete ideas about interventions that educators can implement. They argue that those with more positive generic dispositions take on the responsibility of HIV/AIDS programs.

Educators indicated that these workshops were some two years ago and they need new information. The criticism leveled at the department was the fact that the number of participants to workshops is restricted. The sentiments echoed by the educators in phase two of this study supports the findings of Raniga (2006) who indicates that the National Integrated Plan (DOE, 2000) *"rationalizes the use of the cascading model due to lack of human and financial resources".* Training loses impact, time constraints in empowering staff, educators may lack confidence to train others, and inexperienced teachers may not be able to convince principals are the criticisms leveled against the cascading model. The audit conducted by Raniga (2006) indicated that 28 educators out of a total of 61 educators did not share information with other staff members.

The second argument presented with respect to the formulation and implementation of school based HIV/AIDS policies is the lack of will and intent of the National Department of Education to empower school governing bodies. The following extracts from the principal of school A and school B confirm that school governing bodies are not empowered by the Department of Education. In response to the question "What has the department done to empower the school governing bodies?" the following emerged.

Extract 26

> *"Well in the last two years that you'll are here, I don't think they did. Nothing in regard to HIV/AIDS"*

Extract 27

> *"Over the last few years or few months, I haven't seen anything with regards to governing bodies with regards to HIV"*

The South African Schools Act 84 of 1996 acknowledges that the department has an important role to play with respect to enhancement of the capacity of the school governing bodies. From the funds appropriated by provincial legislature, the head of department must establish a programme to provide training to school governing bodies. The KwaZulu-Natal Department of Education must provide continuous training to governing bodies to ensure that governing bodies function effectively as well as empower school governing bodies to assume additional functions.

5.3 CONCLUSION

This chapter provided insight into the factors associated with the formulation and implementation of school based HIV/AIDS policies in the Umgeni North Ward. The central argument with respect to each theme and sub-theme was presented and supported with empirical findings. The implications of each theme were explored.

In theme one, the major argument centered on process of formulating school based HIV/AIDS policies with sub-themes that involved the disparity in legislation from national to provincial to district and to school level; the inappropriate communication channels; and the lack of political will and intent to review school based HIV/AIDS policies.

In theme two, the major argument centered on implementation of the school based HIV/AIDS policy with the sub-themes that dealt with fragmented action plans and the implications of adopting an ad hoc and uncoordinated response to the epidemic.

In theme three, the major argument centered around support structures with the sub-themes that discussed the bi-directional and reciprocal relationship between the learner and the environment as well as the perplexity with respect to the establishment of the Health Advisory committee.

In theme four, the argument centered on the challenges in the arena of policy formulation and implementation with the sub-themes that involved the paradigm shift in the role of educators in the arena of HIV/AIDS as well as the lack of political will to re-skill educators and empower school governing bodies.

The summary of findings and conclusions, recommendations as well as implications for further research is presented in Chapter Six.

CHAPTER SIX
CONCLUSIONS

6.1 INTRODUCTION

> *"Many children are living with HIV/AIDS. Many babies are born with HIV. Also, many sexually active young people are being infected with HIV. They face numerous forms of discrimination. Babies are abandoned or refused access to crèches. School children are victimized or marginalized by teachers and other children. Learners are refused bursaries". (Department of Health, 1999)*

The quote taken from the HIV/AIDS and STD Directorate (Department of Health, 1999) clearly supports the need for operational school based HIV/AIDS policies as children are victimized or marginalized.

According to Pembrey, (www.avert.org) Peter Piot (head of UNAIDS) clearly indicated that "AIDS is one of the most serious challenges currently facing the education systems of poorer countries". He indicated that as HIV prevalence increases, teacher deaths increase, teaching quality declines and orphans and out of school youth increases. The country's ability to compete suffers and the public budget for health and education decrease.

The overall purpose of this study was to investigate the implementation of school based HIV/AIDS policies in Primary Schools in the Umgeni North Ward. This chapter outlines a summary of the findings and conclusion that is drawn from this study indicating whether the key assumptions were confirmed or not. The value of this research and the recommendations to the KwaZulu-Natal Provincial Education department are then presented. This Chapter concludes with the implications for future research.

6.2 SUMMARY OF FINDINGS AND CONCLUSIONS

The first phase of this study was a quantitative audit of 23 schools in the Umgeni North Ward. The data obtained through telephonic and face to face interviews with school principals or their nominees was analyzed using the Evasys statistical package. The first two objectives of this study were to determine the number of schools that have school based HIV/AIDS policies and the extent to which the policies were implemented in primary schools in the Umgeni North Ward. The first two objectives were linked to two of the four assumptions that was posited in this study, namely, school governing bodies lacked capacity to develop enlightened policies and primary schools in the Umgeni North Ward did not have operational school based HIV/AIDS polices.

The Quantitative audit conduced in phase one of this study indicated that 19 out of 23 schools in the Umgeni North Ward have a school based HIV/AIDS policy. Hence, 4 schools are in disarray. One of the expectations of the National Schools policy on HIV/AIDS (DoE, 1999) and the Department of Education guidelines (DoE, 2003) is for schools to have an action plan that servers as a tangible structure to implement the policy. While 17 out of 19 schools indicated that they had an action plan, the findings in this study confirm that schools merely made utterances in this regard as their perceptions of action plans were not consistent with departmental regulations. The quantitative audit revealed that 12 out of 19 schools did not significantly include the school governing body in the policy process. The focus group interviews conducted in two schools during phase two of the study confirmed this finding.

The purpose of the phase two qualitative focus group interviews with two primary school personnel (principal, head of department, educator, and representative from the school governing body) was to gain first hand experience in terms of the challenges associated with the formulation and implementation of primary school based HIV/AIDS policies in the Umgeni North Ward. Two of the objectives in this study, the process involved in drawing up the HIV/AIDS policies as well as the challenges were linked to the assumptions that primary schools have not

established the Health Advisory Committees and educators lacked the necessary skill and expertise to deal with HIV/AIDS related problems.

The central argument in this study, the multi-dimensional realities of policy formulation and implementation, indicated that the factors associated with the formulation and implementation of primary school based HIV/AIDS polices cannot be separated into individualize compartments, hence, the complex nature of policy development, implementation and ratification. This study confirmed that school governing body members are intimidated and they merely, with the stroke of a pen, accept that which was presented to them. The question then arises: Are governing body members given the power to play their part? Do governing body members want to play a part? This study confirmed the findings of Khoza (2002) who indicated that *"while the school may have a plan of action and new skills, these have not been adequately implemented".* He argues that parents need to be encouraged to participate so that schools become a centre for community networking and development.

The phase one quantitative audit indicated that 17 out of 19 schools had an action plan to implement the school based HIV/AIDS policy. The phase one quantitative audit also confirmed that 13 out of 19 schools did not have a health advisory committee. The lack of correlation with respect to these statistics clearly indicates the poor policy directives that filter down form national government. Primary schools did not interpret the National Schools policy on HIV/AIDS (DoE, 1999) or the Department of Education guidelines (DoE, 2003) as the health advisory committee is the new structure that implements the action plan of schools. Further, the five critical priorities as promulgated by the Department of Education guidelines (DoE, 2003) with respect to prevention, care and support for learners, care and support for educators, protecting the quality of education and managing a coherent response were sadly ignored.

This study further confirmed the disparity that exists in legislation from national to provincial to district and to school level. In 2007, two schools are yet to start formulation of the school based HIV/AIDS policy. The department of Education should have conducted an audit in 2000 and use the results of the audit to assist

schools formulate policies and establish health advisory committees. While the Department of Education must be commended in terms of policies and guidelines (DoE, 1999; DoE, 2000; DoE, 2001; DoE, 2002 and DoE, 2003), the department must develop vigilance and diligence to monitor consistent and regulated implementation of policy. The department must make it clear that the policy is not a suggestion, its suggestions is policy.

The inappropriate communication channels as well as lack of political will and intent to review policies was evident in this study. It is necessary for the department to empower principals who are unaware of their role to establish and develop community networks. The paradigm shift with respect to the role of educators in the climate of HIV/AIDS exposed their vulnerability to deal with the ravaging impact of the epidemic. They demanded that social workers, psychologists and guidance services be brought back into the school environment as they are struggling with the effects of the epidemic. They are struggling and find it difficult to assist children and colleagues with the trauma associated with bereavement. A quantitative descriptive study by Sathiparsad and Taylor (2005) indicated that 92.2 percent of educators felt that having a social worker at school would be beneficial as educators felt frustration and despair as they were overwhelmed and de-motivated. The educators in the focus group sessions in this study appealed for social workers to be part of the system, if not one per school, at least cluster schools and provide one social worker per five schools.

Educators and management members in primary schools had a genuine concern for learners infected and affected by HIV/AIDS. Educators and management members in primary schools are working under difficult conditions and in trying times. They are witness to the devastating impact of the epidemic. The educators and management members use the little resources available to assist learners. Educators are aware of universal precautions in handling blood but some educators are forced to respond to emergencies without gloves due to lack of institutional resources, placing themselves and students at risk.

This study confirmed that current approaches to care are disconnected with local realities of care. Caroline (2007) concludes that polices need to be reformulated to take into account local practices of care. Raniga (2007) in her critique of the 'South African National Life-Skills and HIV/AIDS school Policy: Lessons for policy adjustment' clearly indicates that the "ultimate objective of all HIV/AIDS policies should be to strengthen central, provincial, local government and civil society responses to the HIV/AIDS epidemic. This study confirmed that due to poor policy directives, the establishment of EST (Educator Support Teams) becomes necessary as the government devolved its responsibility to school governing bodies that are operating according to third world standards, hence the lackadaisical approach concerning the HAC.

The general educator component and the parent component are struggling to form genuine partnerships. The gap between theory and practice is evident. Jacques (2006) indicted that *"teachers are the first community bastion of defense, support and protection for children but they cannot perform this service alone".* Educators are not free to teach sexual matters without first sending letters to parents. Educators want greater parental involvement, while the parental representatives sit silently, due to no fault of theirs. The devastating impact of apartheid lingers on.

The parent component is struggling with the educator component in respect of HIV/AIDS. When the educators provide condoms, the parents are up in arms. They view this as the 'green light' to have sex. When educators don't provide the condoms, some of the grade 7 learners are engaging in sexual behaviour, falling pregnant and leaving school. It is evident that there is a constant struggle to forge genuine partnerships.

Godden (2002) indicated that while South Africa was busily fighting the apartheid regime, South Africa neglected the fight against HIV/AIDS, only for South Africa to defeat apartheid and be faced with the HIV/AIDS epidemic. The imbalance created by apartheid and its devastating effects was clearly evident in this study. The ex model C schools are operating at a much higher level in terms of capacity

of school governing bodies. They have personal researchers, school nurses, counselors and an abundant supply of institutional resources.

According to Freire (2000), conscientisation does not occur automatically. It stems from critical educational effort based on favourable historical conditions. The history in this country has marginalized certain sectors of the community. The preamble to the Constitution, Act 108 of 1996, highlights the need to redress past imbalances. Unless the disjointed efforts are replaced by concerted ones, unless there are adequate human and material resources in place to operationalise policies, the needs of children infected and affected by HIV/AIDS will be treated in a vacuum.

6.3 CONTRIBUTIONS OF THIS RESEARCH

It is hoped that a conducive policy environment exists. It is hoped that educators use the policy, not as guidelines but as an instrument that has the force of law, to deal fairly and justly with children infected and affected by HIV/AIDS. It is hoped that this research contributes to a better life for our most vulnerable members of society. It is hoped that the Department of Education instructs all in the hierarchy entrusted with the lives of our little children to establish the HAC (action plan).

6.4 RECOMMENDATIONS FOR SCHOOLS

- Lobby and advocate for more resources, training and workshops in respect of implementation of policies
- Engage the active and meaningful participation of the parent community in policy development, leadership, ratification and implementation
- Develop networks with other schools and districts as support structures are needed due to the maturation of the HIV/AIDS epidemic
- Facilitate regular counseling and supportive services for children infected and affected by HIV/AIDS, a multidisciplinary approach
- Establish the Health Advisory Committee (HAC) as a major support structure

- ❖ One HIV/AIDS coordinator per school who is employed through the Department of Education
- ❖ Strive for health promoting school status (Department of Health, 2000)

6.5 RECOMMENDATIONS TO THE KWAZULU-NATAL EDUCATION DEPARTMENT

- ➢ Conduct more workshops more frequently for educators, management and school governing bodies in different venues across the province
- ➢ Develop a central body of advisors that deal only with HIV/AIDS related problems
- ➢ Revisit the National School Policy on HIV/AIDS (DoE 1999), change words like 'may' to 'must' and empower school management to follow the policy rigidly, instruct all schools to develop Health Advisory Committees, thereby creating a conducive policy environment that is beneficial to all
- ➢ Recruit social workers as part of the personnel that are employed in schools, at least one per five schools (Cluster and allocate)
- ➢ Visit schools physically to determine quintile rankings and provide greater monetary support to schools that are struggling to survive and assist communities
- ➢ Assist schools to form genuine partnerships with district offices, wards, schools and the parent community (community links) to form a coherent response to the epidemic
- ➢ Instruct schools that policy is not a suggestion, the suggestions in the policy is policy.

6.6 IMPLICATIONS FOR FURTHER RESEARCH

This study was a small scale study that concentrated on the implementation of primary school based HIV/AIDS policies in the Umgeni North Ward. The findings from my study indicate that there is need for further study in this area. It would be interesting to replicate this study five years from now to determine the status quo with respect to the implementation of school based HIV/AIDS policies in the Umgeni North Ward.

This study involved a single ward in the eThekwini region with a relatively small sample of 23 schools. A two phase research design incorporating Quantitative and qualitative methodology could be conduced with a larger sample of primary schools in the Ethekwini region.

While Godden (2002) stresses that temporary educator loss, educator attrition, educator training, specialist educator losses and rehabilitation planning impacted on labour, he neglected to discuss the role of school governing bodies in the fight against HIV/AIDS. However, the emphasis on gender and decline in enrollment, the increase in orphans, the decline in school fees and the low transition rates between primary and secondary schools and the even lower transition rates for graduates are important factors covered in his presentation. This study did not investigate gender equity, decline in school fees, low transition rates and the increase in orphans. Further qualitative research in this regard is necessary.

Further quantitative research in respect of the integration of social workers into the education system is necessary. (Raniga, 2006; Sathiparsad and Taylor, 2005). This is necessary to allow specialists to deal with social issues, specialists to educate and specialists to manage.

The UNESCO Newsletter dated November 2007 indicated that teachers infected or affected by HIV and AIDS may face HIV related stigma and discrimination within and outside school. Further qualitative research in both primary and secondary schools to investigate this is necessary.

The researcher concurs with the senior examiner and postulates that further research should include history of schools, size of schools, resources and other variables that can provide more information on the difficulties experienced formulating and implementing school based HIV/AIDS polices.

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INSTRUMENTS

The Child Care Act, Act 74 of 1983

The South African Constitution, Act 108 of 1996.

The South African Schools Act, 84 of 1996.

The 1989 UN Convention on the Rights of the Child (CRC)

APPENDIX 1

PHASE ONE INTERVIEW GUIDELINES

Do you have a written HIV/AIDS policy formulated by your school?

If the answer to the key question "Do you have a written HIV/AIDS policy formulated by your school is "YES", the follow up questions are:

1. When was the policy formulated?
2. Who was involved in formulating the policy?
3. Do you have an action plan to implement the policy?
4. What structures are in place to implement the policy?
5. When was the HIV/AIDS policy last reviewed?
6. Do you have a health advisory committee?
7. What is the composition of the health advisory committee?
8. May I have a copy of the policy?

If the answer to the key question "Do you have a written HIV/AIDS policy formulated by your school" is "NO", the follow up questions are:

1. What were the obstacles you faced in drawing up a HIV/AIDS policy?
2. How do you respond to children infected or affected by HIV/AIDS?

APPENDIX 2

FOCUS GROUP GUIDELINES

Using focus groups, the key questions for two schools that have a policy are:

Question 1: Process

1.1 Who was involved in drawing up the school based HIV/AIDS policies?

1.2 Who was responsible for leading this process?

1.3 What was the role of the school governing body in drawing up the policy?

1.4 What were the processes involved in drawing up the school based HIV/AIDS policy?

1.5 What are your recommendations in respect of drawing up the HIV/AIDS policy?

Question 2: Knowledge and Awareness

2.1 Are learners aware that the school has a HIV/AIDS policy?

2.2 Are learners familiar with the contents of the policy?

2.3 How does the school communicate the policy to learners?

2.4 How does the school communicate the policy to educators?

2.5 How does the school communicate the policy to parents?

2.6 What has the school done in respect of knowledge and awareness?

2.7. What are your recommendations in respect of knowledge and awareness?

Question 3: Implementation

3.1 To what extent are the policies implemented?

3.2 What recommendations do you have to improve implementation?

Question 4: Support systems/mechanisms

4.1 What support structures are there to assist the school?

4.2 Do you have a Health Advisory Committee?

4.3 What are the roles and functions of the Health Advisory Committee?

4.4 Are there any other support systems that could be used to assist the school?

4.5 What are your recommendations in respect of support systems?

Question 5: Role of the department

5.1 What has the department done to empower school governing bodies?

5.2 What has the department done to empower educators?

5.3 Do educators possess the skills and expertise to deal with HIV/AIDS related problems?

5.4 How many times were educators called for training or workshops?

5.5 What was the duration of the workshops/training?

5.6 What recommendations would you suggest in respect of the departments role?

Question 6: Challenges

6.1 What were the challenges in drawing up the school based HIV/AIDS policy?

6.2 What are the challenges in implementing the school based HIV/AIDS policy?

6.3 What are the challenges in following the National Policy on HIV/AIDS?

6.4 What are the challenges in respect of the Health Advisory Committee?

6.5 What are your recommendations with respect to drawing up the school based HIV/AIDS policy?

6.6 What are your recommendations with respect to implementation of the school based HIV/AIDS policy?

APPENDIX 3

PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI
PROVINSIE KWAZULU-NATAL

DEPARTMENT OF EDUCATION
UMNYANGO WEMFUNDO
DEPARTEMENT VAN ONDERWYS

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228 Pietermaritz Street
Pietermaritzburg, 3201

RESOURCE PLANNING

INHLOKOHHOVISI | HEAD OFFICE | PIETERMARITZBURG

Enquiries: Mrs M Francis
Imibuzo:
Navrae:

Reference: 0032/2007
Inkomba:
Verwysing:

Date: 23 August 2007
Usuku:
Datum:

Mr N Nagesar
P.O.Box 629
Mt Edgecombe
4300

RESEARCH PROPOSAL: IMPLEMENTATION OF HIV/AIDS POLICIES IN PRIMARY SCHOOLS IN THE UMGENI NORTH WARD

Your application to conduct the above-mentioned research in schools in the Umgeni North Ward District has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educator programmes are not to be interrupted.
5. Should you wish to extend the period of your survey at the school(s) please Mrs M Francis at the contact numbers above.
6. A photocopy of this letter is submitted to the principal of the school where the intended research is to be conducted.
7. Your research will be limited to the Schools submitted.
8. A brief summary of the content, findings and recommendations is provided to the Director: Resource Planning.

1

9. The Department receives a copy of the completed report/dissertation/thesis addressed to

The Director:Resource Planning
Private Bag X9137
Pietermaritzburg
3200

We wish you success in your research.

Kind regards

for R Cassius Lubisi(Phd)
Superintendent-General

2

APPENDIX 4

INFORMED CONSENT FROM PRINCIPALS

9 Coucal Close
Woodhaven
4004

5 November 2007

To: The Principal

Dear Sir/Madam

RESEARCH: HIV/AIDS POLICIES

I am an educator and a student at University of KwaZulu-Natal. I am currently undertaking research on the above topic. I humbly request that you answer approximately ten questions on HIV/AIDS policies.

Permission has been obtained from Dr R.C. Lubisi (Superintendent-General: KwaZulu-Natal Provincial Education Department). The KZN Department of Education fully supports this study with certain conditions (refer attached correspondence). Participation is voluntary. In this study, no individual or school will be listed, thus anonymity and confidentiality is guaranteed.

Participants in this study will contribute to the knowledge base. Recommendations will be submitted to the KZN Provincial Education Department. Data collected in the course of this study will be made available to the supervisor and stored for a period of five years, thereafter incinerated and shredded.

I thank you for your time and effort in assisting in this research.

Mr N. Nagesar
Researcher

Dr T. Raniga
Lecturer: UKZN

DECLARATION

I, the Principal/Deputy Principal/HOD of a Primary School hereby confirm that:

- I received a copy of the letter from the Superintendent-General
- I understand the contents of the Informed Consent Letter
- I am available to assist the researcher
- I understand that I may withdraw at any time, should I so desire

_____ _____

Signature of Participant Date

FAX DECLARATION TO: **031 7012704**

APPENDIX 5

9 Coucal Close
Woodhaven
4004

Dear _____

_____ Primary School

Sir

RE: FOCUS GROUP INTERVIEW AT YOUR SCHOOL

I thank you for the interest that you showed regarding HIV/AIDS policies. Your assistance will be greatly appreciated as your school was selected as one of the schools from the phase one quantitative audit.

I humbly request that you arrange a meeting so that I can conduct the focus group. The following personnel should be part of the focus group.

Principal
At least one management member
At least one educator
At least one member of the School Governing Body

Your assistance in this research is greatly appreciated.

Once again, I thank you

_____

Mr N. Nagesar

EvaSys | Student Number. 205527603 | vivid

Mark as shown: ☐☒☐☐☐ Please use a pen or a thin marker. This form will be processed automatically.
Correction: ☐■☐☒☐ Please follow the examples shown to help optimize the reading results.

1. BIOGRAPHICAL DETAILS

1.1 Gender ☐ Male ☐ ☐ Female

1.2 Designation
☐ Principal ☐ Deputy Principal ☐ HOD
☐ Staff Member

1.3 Years in Post
☐ 0 - 3 ☐ 4 - 6 ☐ 7 - 10
☐ 11 - 15 ☐ >15 ☐ No Data

1.4 Teaching Experience
☐ 0 - 5 ☐ 6 - 10 ☐ 11 - 15
☐ 16 - 20 ☐ > 21 ☐ No Data

2. KEY QUESTION

2.1 Do you have a written HIV/AIDS policy formulated by your school? Yes ☐ ☐ No

3. IF ANSWERED YES TO KEY QUESTION, PLEASE ANSWER THE FOLLOWING QUESTIONS

3.1 When was the policy formulated
☐ between 1 and 3 years ago ☐ between 4 and 6 years ago ☐ between 7 and 9 years ago
☐ more than 9 years ago ☐ other

3.2 Who was involved in formulating the policy
☐ Management ☐ All stakeholders (SGB/ Principal/Staff) ☐ Principal
☐ SGB ☐ Staff ☐ Principal and staff
☐ Other

3.3 Do you have an action plan to implement the policy Yes ☐ ☐ No

3.4 What structures are in place to implement the policy
☐ Resources allocated during budgeting ☐ additional staffing in place ☐ first aid kit
☐ other ☐ none

3.5 When was the policy last reviewed
☐ 2007 ☐ 2006 ☐ 2005
☐ > 3 years ago ☐ has not been reviewed ☐ unsure

3.6 Do you have a health advisory committee Yes ☐ ☐ No

3.7 What is the composition of the Health Advisory Committee?
☐ Principal and staff ☐ Including member from Provincial Health Department ☐ Excluding member from Provincial Health Department
☐ Management ☐ n/a

3. IF ANSWERED YES TO KEY QUESTION, PLEASE ANSWER THE FOLLOWING QUESTIONS [Continue]

3.8 Number of male learners
- ☐ < 100
- ☐ between 100 and 199
- ☐ between 200 and 299
- ☐ between 300 and 399
- ☐ 400 or more
- ☐ unsure

3.9 No of female learners
- ☐ < 100
- ☐ between 100 and 199
- ☐ between 200 and 299
- ☐ between 300 and 399
- ☐ 400 or more
- ☐ unsure

3.10 Number of learners older than 13 years
- ☐ between 1 and 20
- ☐ between 21 and 40
- ☐ between 41 and 60
- ☐ between 61 and 80
- ☐ > 80
- ☐ unsure

3.11 How many learners are infected?
- ☐ do not know
- ☐ 1 - 10
- ☐ 11 - 20
- ☐ >20
- ☐ cannot disclose

3.12 How many learners are affected?
- ☐ do not know
- ☐ 1 - 10
- ☐ 11 - 20
- ☐ > 20
- ☐ cannot disclose

3.13 Approximate number of parents infected
- ☐ do not know
- ☐ 1 - 10
- ☐ 11 - 20
- ☐ >20
- ☐ cannot disclose

3.14 May I have a copy of the policy?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Hesitant

4. IF ANSWERED NO TO KEY QUESTION, PLEASE ANSWER THE FOLLOWING QUESTIONS

4.1 What were the obstacles you faced in drawing up the policy?
- ☐ Lack of co-operation from stakeholders
- ☐ no need for policy
- ☐ time constraints
- ☐ lack of resources
- ☐ work in progress
- ☐ other

4.2 How do you respond to children infected or affected by HIV/AIDS?
- ☐ on a needs basis
- ☐ refer to hospital or clinic
- ☐ refer to social worker
- ☐ no infrastructure
- ☐ other

4.3 Number of male learners
- ☐ < 100
- ☐ between 100 and 199
- ☐ between 200 and 299
- ☐ between 300 and 399
- ☐ 400 or more
- ☐ unsure

4.4 No of female learners
- ☐ < 100
- ☐ between 100 and 199
- ☐ between 200 and 299
- ☐ between 300 and 399
- ☐ 400 or more
- ☐ unsure

4.5 Number of learners older than 13 years
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- ☐ do not know
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- ☐ 11-20
- ☐ >20
- ☐ cannot disclose