INVESTIGATING THE EXISTANCE OF HIV/AIDS HEALTH ADVISORY COMMITTEE IN SELECTED SENIOR SECONDARY SCHOOLS IN THE AMATHOLE DISTRICT MUNICIPALITY SCHOOLS IN THE EASTERN CAPE, SOUTH AFRICA

by

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A mini-dissertation submitted in partial fulfilment of the requirements for the degree of

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ABSTRACT

This study investigated the question: Have the Amathole District Municipality Schools and higher education institutions established and successfully run Health Advisory Committees (HACs) in accordance with stipulations of the National Policy on HIV/AIDS for Learners and Educators in Public Schools Act No.27 of 1996 (DoE, 1996). The main focus of the study was to determine the existence and the performance of HIV/AIDS Health Advisory Committees in 16 senior secondary schools selected from the Amathole District Municipality in the Eastern Cape Province of South Africa.

The two main research questions which the study seeks to interrogate are: Does any of the selected 16 secondary schools have HIV/AIDS Health Advisory Committees? And if HIV/AIDS Health Advisory Committees had been established in any of the schools, are they managed in accordance with the stipulated guidelines of the national education policy? The decision to investigate this phenomenon stemmed from the researcher’s observation that schools might have failed to establish and to effectively manage the HAC. This assumption was based upon the fact that in rural schools located among the less educated and illiterate rural masses, semi-educated and illiterate parent members of the school governing bodies are more likely to be poorly informed about HIV/AIDS and might not be aware of the importance setting up committees and running them efficiently.

The study used a survey as its research design. Surveys typically rely on large scale data, e.g. from questionnaires, test scores, attendance rates results of public examinations etc., all of which would be enable comparisons to be made over time or between groups. Data was collected by means of questionnaires which were analysed using SPSS. The findings produced evidence that backed the above assumption. The study revealed that Data and
the findings indicated that some schools in the Amathole District do not have HAC. Instead of HACs, they have other health advisory structures. However, parents believed that there was the need for HIV/AIDS HACs in their school communities as they were considered capable of addressing health related challenges/ problems such as teenage pregnancy HIV/AIDS diseases, hygiene and healthy living style among the school stakeholders. The study concluded that the existence of the HIV/AIDS HAC is essential and necessary in all schools as it ensures a healthy living in the school communities as suggest by the findings of this study.
DECLARATION

I, Sizwe Michael Mbayeka, of the Faculty of Education, Walter Sisulu University (WSU) Mthatha do solemnly declare that this dissertation, which is submitted by me, is original and the direct result of my own efforts and study.

This dissertation is in no way a consequence of the efforts of someone else. I personally undertook it with the professional guidance of my supervisor whose name and signature appear below. This work is original and has never been submitted for any degree or examination to any university or institution.

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ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to people, whose crucial roles enabled me to complete this research study. The persons, whom I am indebted to, treated me with respect, patience and tolerance during the difficult and stress-laden period of researching and writing this mini dissertation. Their invaluable contributions, which created a nurturing academic climate that enhanced the completion of the dissertation, included provision of support, guidance and advice.

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- My colleagues at Bashee Comprehensive High School in Idutywa District.
And finally, I would like to thank the Almighty God for granting me strength and courage to conduct and complete this research study in spite of all the challenges, which confronted me during the period of the research.
DEDICATION

I dedicate this research study to my wife, Nonyaniso Catherine Mbayeka, my child Avela Okuhle Mbayeka, my late parents Reuben Mandlenkosi (1937—2008) and Mavis MkaSoga Nowinile Mbayeka (1940—2006). May their souls Rest in Peace.

Heavenly Father will bless and compensate you all abundantly.
TABLE OF CONTENTS

ABSTRACT............................................................................................................. i

DECLARATION..................................................................................................... iii

DECLARATION ON PLAGIARISM................................................................. iiv

ACKNOWLEDGEMENTS.................................................................................... v

DEDICATION ........................................................................................................ vii

CHAPTER 1

ORIENTATION AND BACKGROUND

1.1 INTRODUCTION ................................................................................................. 1

1.2 BACKGROUND TO THE STUDY .......................................................................... 2

1.3 INTERNATIONAL PERSPECTIVE ON HIV AND AIDS................................. 5

1.4 SOUTH AFRICAN PERSPECTIVE ..................................................................... 22

1.5 THE IMPACT OF HIV/AIDS ON EDUCATION SYSTEM................................. 26

1.5.1 SGBs and HIV/AIDS HEALTH ADVISORY COMMITTEES............................ 27

1.6 STATEMENT OF THE PROBLEM ..................................................................... 28

1.7 MAIN RESEARCH QUESTIONS ........................................................................... 29

1.8 HYPOTHESIS ..................................................................................................... 30

1.9 PURPOSE OF THE STUDY ............................................................................... 31

1.10 RATIONALE FOR THE STUDY ....................................................................... 33

1.11 RESEARCH DESIGN: SURVEY ........................................................................ 33

1.12 SAMPLING: NON-PROBABILITY SAMPLING................................................. 36

1.13 RESEARCH PARTICIPANTS .............................................................................. 37

1.14 DATA COLLECTION .......................................................................................... 38

1.14.1 QUESTIONNAIRE ....................................................................................... 38

1.15 DATA ANALYSIS ............................................................................................ 40

1.16 ETHICAL CONSIDERATION ............................................................................ 41
1.17. RELIABILITY AND VALIDITY.......................................................... 42
1.18 LIMITATIONS OF THE STUDY......................................................... 43
1.19 DELIMITATIONS OF THE STUDY..................................................... 44
1.20 DEFINITIONS OF THE PERTINENT TERMS AND ACRONYMS........... 44
1.21 STRUCTURES OF CHAPTERS.......................................................... 46

CHAPTER 2
THEORETICAL FRAMEWORK AND LITERATURE REVIEW
2.1 INTRODUCTION ............................................................................. 47
2.2 DEFINING THE THEORY OF MEN’S HEGEMONIC MASCULINITIES:
   GENDER-BASED VIOLENCE AGAINST WOMEN................................. 47
2.3 CULTURAL AND SOCIAL THEORETICAL PERSPECTIVE .................. 52
2.4 CONCLUSION................................................................................. 54

CHAPTER 3
AN OVERVIEW OF THE KEY DETERMINANTS OF HIV/AIDS EPIDEMIC IN
SUB-SAHARAN AFRICA
3.1 INTRODUCTION ............................................................................. 55
3.2 EPIDEMIC IN SUB-SAHARAN AFRICA............................................... 56
3.2. A HISTORICAL OVERVIEW OF HIV/AIDS EPIDEMIC IN SUB-SAHARAN
   AFRICA....................................................................................... 61
3.3 THE KEY DRIVERS OF HIV/AIDS INFECTIONS IN THE EASTERN CAPE
   ........................................................................................................ 68
3.3.1 Sexual Debut ............................................................................. 68
3.3.2 Multiple Sexual Partnerships...................................................... 69
3.3.3 Condom Use............................................................................. 72
3.3.4 Awareness of HIV status............................................................ 72
3.3.5 Teenage Pregnancy................................................................. 73
3.3.6 Intergenerational Sex............................................................... 73
CHAPTER 4
RESEARCH METHODOLOGY
4.1 INTRODUCTION ........................................................................ 91
4.2 RESEARCH DESIGN ............................................................... 92
4.3 RESEARCH METHODS APPLICABLE TO THIS STUDY .......... 92
4.3.1 Survey Research ................................................................. 92
4.4 SAMPLING ............................................................................... 97
4.4.1 Sampling Strategy Used ...................................................... 98
4.4.2 RESEARCH INSTRUMENTS ............................................... 100
4.4.3 VALIDITY AND RELIABILITY ............................................. 103
4.4.4 VALIDITY AND RELIABILITY OF QUESTIONNAIRES .......... 103
4.5 DATA ANALYSIS PROCEDURES ............................................ 104
4.6 SUMMARY ............................................................................. 105

CHAPTER 5
DATA ANALYSIS AND INTERPRETATION
5.1 INTRODUCTION ..................................................................... 106
5.2 RESPONSES FROM EDUCATORS ................................................................. 108
5.3 SUMMARY OF FINDINGS FROM THE INTERPRETATION OF ANALYSED EDUCATORS’ RESPONSES ................................................................. 135
5.4 RESPONSES FROM LEARNERS .............................................................. 137
5.5 SUMMARY OF FINDINGS FROM THE INTERPRETATION OF ANALYSED LEARNERS’ RESPONSES ................................................................. 154
5.6 RESPONSES FROM PARENTS ................................................................. 156
5.7 SUMMARY OF FINDINGS FROM THE INTERPRETATION OF ANALYSED PARENTS’ RESPONSES ................................................................. 163
5.8 SUMMARY OF CHAPTER 5 ........................................................................ 164

CHAPTER 6
DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS
6.1 INTRODUCTION ......................................................................................... 165
6.2 HIV/AIDS HAC AND ITS COMPOSITION ............................................. 165
6.3 Findings ................................................................................................. 166
6.4 THE ROLE OF THE HIV/AIDS HAC ..................................................... 166
6.5 Findings ................................................................................................. 167
6.6 THE INVOLVEMENT AND PARTICIPATION OF THE SCHOOL STAKEHOLDERS IN HIV/AIDS HAC ................................................................. 168
6.7 Findings ................................................................................................. 169
6.8 KNOWLEDGE OF HIV/AIDS HAC ....................................................... 169
6.9 Findings ................................................................................................. 171
6.10 THE STRATEGIES/ PROCEDURES EMPLOYED BY SCHOOLS TO PROMOTE A DISEASE-FREE ENVIRONMENT AND TO IMPROVE HEALTHY STANDARD/ CONDITIONS ......................................................... 172
6.11 Findings ................................................................................................. 173
6.12 CHALLENGES FACED BY HIV/AIDS HEALTH ADVISORY COMMITTEE IN SCHOOL ......................................................................................... 174
6.13 Schools with Non-HAC Structures: Their Challenges Include the Following: ................................................................. 174

6.14 RESOURCE ISSUES ................................................................................................................................................ 175

6.15 SUMMARY OF FINDINGS ................................................................................................................................. 176

6.16 RECOMMENDATIONS ..................................................................................................................................... 177

6.17 CONCLUSION OF THE STUDY ......................................................................................................................... 179

REFERENCES ......................................................................................................................................................... 180

LIST OF APPENDICES ............................................................................................................................................. 204

Appendix A: Questionnaires ........................................................................................................................................ 204

  QUESTIONNAIRE FOR EDUCATORS .................................................................................................................. 204

  QUESTIONNAIRE FOR LEARNERS .................................................................................................................. 207

  QUESTIONNAIRE FOR PARENTS ....................................................................................................................... 209

Appendix B: Letter to Circuit Manager: Department of Education ...... 211

Appendix C: Letter from the Circuit Manager ............................................................... 212

Appendix D: Letter from District Director: Department of Education. ..................................................................................... 213

Appendix K: Mandatory consent form ................................................................. 214
CHAPTER 1
ORIENTATION AND BACKGROUND

1.1 INTRODUCTION

This survey research study investigated the question: Have the Amathole District Municipality Schools and Higher Education Institutions established HIV/AIDS Health Advisory Committees and have effectively managed them in accordance with the National Education Policy Act (NEPA) 27 of 1996 on HIV/AIDS? Although the above question refers to all schools and tertiary institutions in the Eastern Cape Province of South Africa, the accessible population was the 18 secondary schools selected from the Idutywa District located in the former Transkei homeland situated in the Eastern Cape Province (South Africa).

To investigate a research problem associated with the complex problem of the spread, prevention and treatment of HIV/AIDS epidemic requires locating the topic within its historical, socio-economic, political and cultural contexts. The contextual dimensions of HIV/AIDS of this study include international, African continental, regional and national perspectives of the evolution of the HIV/AIDS epidemic. Research suggests that rates of HIV/AIDS infections, the successes and the failures of the prevention and treatment programmes are shaped and informed by the unique cultural history, political and socio-economic factors – the environmental systems – which determine the daily lives of the people who reside in these areas.

Researchers worldwide have recognised that although sexual orientations or risk-taking sexual lifestyle of individuals and communities may impact negatively upon the HIV/AIDS infection, treatment and prevention, the most single factor that poses the greatest challenge to eradication of the epidemic from the world
is the relationship between men and women. The review of literature and the discussions throughout this study will be focused on the thesis that that the global subordination of women/girls by all races in this world creates the fertile global environment for the past and ongoing spread of the HIV/AIDS epidemic. To explore this complex question and to determine why inequality between man and woman is at the centre of HIV/AIDS tragedy extant literature will be reviewed to measure the veracity of this hypothesis.

Secondly, the thematic, the meta-analytical, the ideological and the theoretical concerns of the study will also be preoccupied with probing the thesis that the global male domination of women constitutes the greatest challenge that negates all concerted efforts to eliminate the HIV/AIDS epidemic from the world. In the light of the above ideological and pro-man-feminist positioning adopted by the study, the question is how can HIV/AIDS Health Communities be used in reducing the number of new infections and enhancing the outcomes of prevention and treatment programmes.

1.2 BACKGROUND TO THE STUDY

Although the question – *What is HIV/AIDS?* – was posed when the HIV virus was going through its process of diagnosis during the early 1980s, we continue pose the same question and attempt to find the answer. According to Bennett and Greenfield (1995, pp.1), “Human immunodeficiency virus (HIV) is a blood-borne, sexually transmissible virus ... This virus is typically transmitted via sexual intercourse, shared intravenous drug paraphernalia, and mother-to-child transmission (MTCT) , which can occur during the birth process or during breast-feeding”. Once a person’s immune system is destroyed or weakened, even a common cold can become life-threatening. The cold-related infection of HIV/Aids person could get worse and
worse, and the person may even die from the cold. A HIV/AIDS infected person is more vulnerable to all infectious diseases. This state of becoming vulnerable to many HIV/AIDS related diseases tend to worsen progressively until eventually the body becomes too weak and the HIV/AIDS infected person dies (Anon., Facts about HIV and AIDS, 2005, pp.86).

As already stated HIV and AIDS infect the cells of the immune system; the very thing the body needs uses to fight against germs. Hopper (1999, pp.57) stated that it is unclear where the virus came from or originated from. A HIV positive result does not mean that the person has AIDS. A diagnosis of AIDS is made using certain information and tests. A definition of AIDS includes all HIV infected people who have fewer than 200 CD4 positive T cells of blood. Most of these conditions are opportunistic infections (e.g. tuberculosis), which generally do not affect healthy people.

A person infected with HIV can remain healthy for many years with no physical signs or symptoms of infection. A person with the virus displays flu-like symptoms in the beginning phase but may not display other symptoms. AIDS occurs in people who are HIV positive. It appears with specific infections e.g. TB and rare cancers are said to be HIV/AIDS-related. One of the measures designed for reducing the HIV/AIDS prevalence in South Africa is HIV/AIDS Health Advisory Committees, the focus of this study.

1.2.1 NATIONAL POLICY ON HIV and AIDS

According to the National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (DoE, 1999, pp.17), therefore, “Where community resources make this possible, it is recommended that each school and institution should establish its own Health Advisory Committee as a committee of the governing body or council”. The National Policy on HIV/AIDS
(DoE, 1999, pp. 17) also stipulates that where it is impossible to set up such a committee, the school or the institution should make use of the available “expertise” within “the education and health systems”. It is further stated that each Health Advisory Committee “may as far as possible use the assistance of the community health workers” under the supervision of qualified nurses “or local clinics”.

The National Policy document on managing HIV/AIDS prescribes the following guidelines on the setting up Health Advisory Committees, the selection of committee members, and the functions to be performed by committees (DoE, 1999):

- The establishment of a committee vested in a school governing body or higher education institution council;

- Each committee to be composed of “educators and other” members of staff, representatives of the parents of learners at the school or students, and representatives from the medical or health care professions;

- Members of each committee expected to elect their own chairperson, and the person with knowledge in the field of health care should be elected as the chairperson;

- The following are the functions of the committees:
  - To “advise” the governing body or council on all health matters, including HIV/AIDS;
  - To be “responsible for developing and promoting a school or institution plan of implementation on HIV/AIDS and reviewing the institutional plan regularly, especially as new scientific knowledge about HIV/AIDS becomes available, and”
  - To be consulted on efforts aimed at the preventing “HIV transmission in the Code of Conduct” (DoE, 1999, pp. 17).

The thrust of this study is to probe the existence / non-existence of the HIV/AIDS Advisory Committees in the schools as well to
measure the effectiveness of the committees which have been established in schools.

1.3 INTERNATIONAL PERSPECTIVE ON HIV AND AIDS

Human Immune Deficiency Syndrome (AIDS) is the final stage of the HIV infection. The full-blown AIDS phase is reached when the HIV virus has successfully destroyed the white cells and overwhelmed the immune system of the infected human body (Metropolitan, 2009, pp. 30). The origin and the early spread of HIV need to be interrogated by the study. According to Caraël (2006, pp. 31), it took the Western scientific world a long time to realise that HIV was transmitted heterosexually. Although the transmission of the virus from man to woman was accepted, the transmission of the virus from woman to man was rejected by Western scientists. The financial rewards that might accrue from patent and intellectual property of having discovered the HIV virus and racial motives behind the fierce debate surrounding the origin of HIV/AIDS were exposed by Caraël (2006:31):

This scientific debate which was important for the future development of a vaccine, immediately caused northern countries to develop racial attitudes towards Africans and to offend the African intellectual elite. Threats to freedom [of movement] were obvious; sections of public opinion demanded control measures at border posts for those who were HIV positive, compulsory tests for at-risk groups and the isolated of those who had AIDS.

The Eurocentric scientists and journalists claim that the origins of HIV-1 could probably be traced from one or more cross-species transfers from Central African chimpanzees (Gao et al. (1999, PP 436-41). Hirsch et al (1989, pp.389-392) also argued that HIV-2 and HIV-1 are genetically similar, although each contains unique genes and its own distinct replication process. Hirsch et al (1989) assert that HIV-2 has a very close affinity viruses that infect sooty
mangabeys in West Africa. This thesis of origins of the HIV virus is rejected by Afrocentric scholars led by Hopper (1999), who argues that the HIV virus originated from polio vaccine trial project carried out in Central Africa and East African regions by Western scientists.

It is believed that, although HIV/AIDS was already around in the late 1970s (i.e. 1978 and early 1980s), it was not diagnosed and those infected with the HIV virus were not aware of.

Bennett et al (1995, pp.2) According to the US document The Origin of AIDS and HIV and the First Cases of AIDS (www.avert.org/origin-aids-hiv.htm, n.d:10), in 1981 medical doctors practising in Los Angeles, New York City, and San Francisco “began seeing young men who had sex with men with Kaposi’s Sarcoma, an otherwise rare cancer usually associated with elderly men of Mediterranean ethnicity. Medical scientists discovered that the syndrome included other manifestations, such as a rare fungal lung infection – Pneumocystis carinii/ jirovec pneumonia”.

“On May 20, 1983”, the French scientist, Luc Montagner, published a scientific paper claiming that the new retrovirus he and his group had isolated in January 1983 and had “christened LAV (Lymphadenopathy associated virus)” was the virus associated with AIDS. In May 1984, Robert Gallo, an American scientist and his group, also published papers in Science (224, pp.500), proving that “HTLV-II” they had discovered was “the retrovirus which caused AIDS” (Pai 2008, pp.3). The debate on the origin of the HIV virus, whether the crossover from monkeys to man was due to African culinary culture or Western scientists’ testing of polio vaccine on monkeys and Africans in Central and West Africa, has not been resolved. What is crucial to this investigation, however, is how to reduce the millions of HIV/AIDS related deaths in across the globe and specifically in the Dutywa District located within the Eastern Cape Province of South Africa.
The AIDS epidemic statistics indicates that the global annual new HIV infections in 2010 fell from 36% peak of the epidemic in 1997 to 21% (UNAIDS World AIDS Day Report, 2011, pp.6-7). Owing to the greater access to treatment, at the end of 2010 an estimated 34 million were living with HIV worldwide – an increase of 17% from 2001 (UNAIDS World AIDS Day Report, 2011, pp.6). Fatalities resulting from AIDS-related causes decreased from a height of 2.2 million in the mid-200s to 1.8 million in 2010. According to new calculations by UNAIDS, “total of 2.5 million deaths have been averted in low- and middle-income countries since 1995” due to the introduction of antiretroviral therapy (UNAIDS World AIDS Day Report, 2011, pp.6).

The proportion of women living with HIV across the world is reported to be stable at 50%. However, “women are more affected in sub-Saharan Africa (59% of all people living with HIV) and in the Caribbean (53%)”. The global new HIV infection figure for children in 2010 is estimated at 390,000. This figure was “15% less than in 2001 and 21% below the number of new infections at peak of the epidemic in 1997” (UNAIDS World AIDS Day Report, 2011, pp.6).


In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, although there was a notable decline in the regional rate of new infections. The epidemic continues to be most severe in the southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world.

UNAIDS (2010, 2011) research suggests that 50% of all deaths caused globally by AIDS-related illnesses in 2010 occurred in
Southern Africa. Since 1998 AIDS-related deaths have accounted for at least one million deaths annually in Sub-Saharan Africa. But as free antiretroviral therapy has become more widely available in the region and accessible to those infected with HIV, the number of AIDS-related deaths dropped steadily.

The total number of Sub-Saharan Africa’s new HIV infections fell from the estimated 26% at the peak of the epidemic in 1997 to 1.9 million in 2010. Research indicates that HIV incidence decreased by more than 25% during the period 2001-2009. This decline in HIV infections is experienced by some of the world’s largest epidemics (Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe). The 2010 annual HIV incidence statistics for the SADC region reveals the following:

The annual HIV incidence in South Africa, though still high, dropped by a third between 2001 and 2009 from 2.4% [2.1%– 2.66%] to 1.5% [1.3%–1.8%]. Similarly, epidemics in Botswana, Namibia and Zambia appear to be declining. The epidemics in Lesotho, Mozambique and Swaziland seem to be levelling off, albeit at unacceptable high levels (*UNAIDS World AIDS Day Report*, 2011, pp.7).

Research suggests that although the HIV infection statistics indicates that the incidence rate of the epidemic decreased considerably since the mid-1990s in the Caribbean, this region has recorded the second highest regional HIV prevalence after Sub-Saharan Africa. The *UNAIDS World AIDS Day Report* (2011, pp.8) also reveals that “in Eastern Europe and Central Asia the number of people living with HIV rose 250% from 2001 to 2010”.

The *UNAIDS World AIDS Day Report* (2011, pp.9) also indicates that the HIV epidemic in North America, and Western and Central Europe “remains stubbornly steady, despite universal access to treatment, care and support and widespread awareness of the epidemic and the causes of HIV infection. HIV incidence has
changed little since 2004". The report provides the statistical data on the HIV infection prevalence in this region as follow:

The total number of people living with HIV in North America and Western Europe and Central Europe reached an estimated 2.2 million [1.9 million – 2.7 million] in 2010, about one third (34%) more than in 2001. More than half (about 1.2 million) of the people with HIV in this region live in the United States of America (UNAIDS World AIDS Day Report (2011, pp.9)

The HIV/AIDS data reviewed above suggests that the fight against the pandemic is not yet won by the developed regions of North America, Western and Central Europe. The question that the study needs to interrogate is: *What interventionist strategies can eliminate HIV infections completely from the world?*

According to UNAIDS (2008, pp.100), owing to the emergence of different epidemic patterns countries have to construct “different national strategies for implementing effective HIV prevention programmes”: cultural-based treatment and prevention models that are capable of effectively reducing new HIV infections and enabling infected people to live longer with HIV. The HIV epidemic has been divided into four categories: (1) “low-level”, (2) “concentrated”, (3) “generalized” and “hyper-endemic”. The four types of HIV manifestations can be outlined as follow:

- “In a low-level epidemic, HIV may have exited for many years but has never spread to significant levels in any subpopulation.

- In a concentrated epidemic, HIV spread rapidly in a defined subpopulation, but is not well established in the general population. This pattern suggests active networks of risk within the subpopulation. The future course of the epidemic is determined by the frequency and nature of links between highly infected subpopulations and the general population.


In a generalized epidemic, HIV is firmly established in the general population. Although subpopulations at high risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic, independent of subpopulations at higher risk of infection.

In a hyperendemic country, the overall prevalence of adult HIV infection exceeds 15%.

Of 135 low- and middle-income countries, UNAIDS estimates that 97 countries have low-level or concentrated epidemics and 38 have generalized epidemics, of which 7 are categorized as hyperendemic” (UNAIDS, 2008, pp.100).

It must be reiterated that four categories of HIV infection patterns outlined above highlight the need for cultural- and environmental-related programmes for addressing the problems created by HIV/AIDS.

As already outlined above the HIV/AIDS pandemic has wreaked havoc in Sub-Saharan Africa. It is the leading cause of death in Southern Africa. And within the SADC region South Africa, Botswana and Zimbabwe have the highest rates of infection in the world. The economically active and productive age group is being decimated and millions of children have already been orphaned. The task of caring for these orphans is increasingly falling on the sagging shoulders of grandmothers. HIV and AIDS have brought despair and death to a region that was full of promise, following successful struggles for liberation. This pandemic threatens the future of millions of people and challenges the popular image of the youth as the leaders of tomorrow. Research predicts that in Botswana, South Africa and Zimbabwe an estimated 60% of the young men, who are 15 years old today, will be infected with HIV during the cause of their

The spread of HIV and AIDS in Southern Africa has followed some faults lines that were already in existence prior to the outbreak of the pandemic. From the late 1980s HIV and AIDS has spread rapidly throughout the region, reducing the previous high life expectancy of 62 years to 47 years (Weinrich & Benn, 2004, cited in Nicholson 2008, pp.50). It is within this context of multiple disadvantages that the populations in the region face the reality of gender inequality. The vital factor for understanding the spread of HIV and AIDS is the devastating multiple nature of its destructive impacts on every fabric of the society, particularly the youth.

In the early days of the pandemic people acted in strange ways. According to Bujo (1992, pp.87), the UK police turned up wearing gloves, masks overshoes to arrest a suspect, in case he had been infected with the HIV virus. Ambulance men turned up to transport someone who could have AIDS wearing ‘space-suits’. A priest, wearing gloves with a bit of bread stuck on the edge of a wooden spatula, offered someone Holy Communion. Old ladies in churches went back to their seats without drinking the wine. Meals-on-wheels delivery service of hot meal to the home of someone who was ill become a stone-cold meal left on the doorstep because the driver was too scared to ring the bell and go inside.

In Calcutta, India, a brand new AIDS clinic was padlocked shut because no doctors or nurses could be found to work in it. In the same city a mother and newborn baby were thrown into the streets when the medics found the mother had HIV infection. In Uganda fellow villagers have turned their backs (in the past) on dying HIV/AIDS infected people and denied them food and water.
because they believed that they might die if they enter the homes of the sick (Dixon, 2002, pp.20).

All over the world, mothers are regarded as the cornerstone of society and children as gifts, nowhere more so than on the African continent. However, on a continent plagued by extreme poverty and a growing HIV and AIDS pandemic it is the children, who suffer most. HIV and AIDS claim hundreds of lives daily, leaving vulnerable children in their wake and the plight of orphans to uncertain future. With instinct in abundance, but resources limited, rural women have rallied together to take responsibility for these children who are largely forgotten and left unsupported by the corporate sector. Campaigns to mobilise committees and to stop the spread of HIV and AIDS are part of the solution, but the immediate crisis of orphans and vulnerable children (OVC) remains largely unchanged by the efforts to alleviate poverty, create access to basic healthcare and adequate nutrition to those affected and infected by the disease.

This is a growing problem that sadly has left countless children without a future. Out of sight, out of mind is the recurring theme of the dire needs of children affected by HIV/AIDS, particularly in the rural areas. Spread out in far-reaching, underdeveloped areas these orphans and vulnerable children are a charity case that only very few commercial ventures consider. The result is a cluster of rural women doing what they can to help these children, even with very limited resources. These women, who remain unnamed and faceless to most of us, have to protect not only the safety and emotional well-being of these children, but also scope with the growing number of orphans left in their care.

*The origins and early spread of HIV needs to be interrogated here.* It is believed that, although HIV/AIDS was already around in the late 1970s (i.e. 1978 and early 1980s), it was undiagnosed and invisible. According to the US document *The Origin of AIDS*
and HIV and the First Cases of AIDS (www.avert.org/origin-aids-hiv.htm, n.d:10), in 1981 medical doctors from Los Angeles, New York City, and San Francisco “began seeing young men who had sex with men with Kaposi’s Sarcoma, an otherwise rare cancer usually associated with elderly men of Mediterranean ethnicity. Medical scientists discovered that the syndrome included other manifestations, such as a rare fungal lung infection – *Pneumocystis carinii/ jirovec pneumonia*”.

“On May 20, 1983”, the French scientist, Luc Montagner, published a scientific paper claiming that the new retrovirus he and his group had isolated in January 1983 and had “christened LAV (Lymphadenopathy associated virus)” was the virus associated with AIDS. In May 1984, Robert Gallo, an American scientist and his group, also published papers in *Science* (224, pp.500), proving that “HTLV-II”I they had discovered was “the retrovirus which caused AIDS” (Pai, 2008, pp.3).

“The story of AIDS”, according to Caraël (2006, pp29), “can be written in different hundred ways. There were many myths associated with the origins HIV; one this was that only gay men were vulnerable to the HIV/AIDS. The US and European epidemiologists’ claim that HIV infection was a gay syndrome was rejected when in 1983 medical reports confirmed the existence of in AIDS in sub-Saharan Africa as evident from the description of several cases amongst African patients who had been hospitalized in Belgium and France (Clumeck et al, 1983, pp. 642).

The existence of HIV in sub-Saharan Africa was re-affirmed by a research study entitled “Acquired Immunodeficiency Syndrome in Rwanda”, which was conducted by Van de Perre et al (1984, pp.62-65), who reported the existence the syndrome in the hospitals in Kigali (Rwanda). A second study by Piot et al (1988, pp.573-579) reported the existed of HIV/AIDS Kinshasa (Zaire).
During the same period a third study ("Slim Disease: A New Disease in Uganda and its Association with HTLV-III") described the existence of HIV/AIDS in Uganda under the name the slime disease (Serwada et al., 1985, pp.849-852).

As the HIV/AIDS epidemic spread across the globe decimating millions of human lives, the Western world and its scientists were previously concerned with finding somebody to blame for the origins of the HIV epidemic belatedly initiated a vertical global response during the period 1989-1990 to halt the spread of the epidemic. Drawing upon the study by Tarantola (1996:109-116) entitled “Grande et Petite Histoire des Programmes SIDA”, Caraël (2006, pp.33) describes the world’s belated response to the pandemic as follows:

Then, very rapidly in 1989, with the creation of the Global Programme for the Fight against AIDS (GPA, Global Programme on AIDS) modelled on the fight against smallpox, national programmes to fight against AIDS were set up and funds allocated to ministries of health. Priority was given to the African continent. By the end of 1989 in an effort without precedent, 160 countries had established, often in great hast, the basis of national programmes of struggle. At the end of the year, for the first time, an international summit devoted entirely to AIDS brought ministers of health together in London.

The World Health Organisation (WHO) set up the international first prevention strategy to counteract the spread of AIDS. The strategy by WHO is summarised by Caraël (2006, pp.33) as follows:

- "Priority to be given to the threatened rights of infected persons in a context where coercion, compulsory tests and means of isolating the sick were multiplying. The main effects of these prohibitionary policies was to drive at-risk people or groups underground, far from access to information and services, and to considerably limit preventive efforts.
Stress on the all-important role of information, education, communication and the control of the transmission of HIV by simple methods to reduce the risks: delay first sexual relations, limit the number of partners, develop a means of controlling STDs and the use of condoms.

A rational model of protection against the infection, based on individual responsibility, which presupposes that those who are informed of the dangers of transmission of this virus would choose a lifestyle that would protect them from the virus.

A psycho-medical perception of social conditions which reflects a humanistic but simplified vision of real societies. The first director of GPA, Jonathan Mann, defined the few general principles upon which the philosophy behind the Global Programme for the Fight against AIDS (GPA) and the conceptual framework of the war against the epidemic was based as follows: “Public health must be protected, the rights of man must be respected” and education is the key to the prevention of AIDS: the transmission of HIV can be prevented by informed and responsible behaviour (Mann et al. 1992, cited in Caraël, 2006, pp.33).

Research (Mann, Tarantola, & Netter, 1992) reports that HIV/AIDS stakeholders from the North succeeded in reducing the rate of infections by designing HIV/AIDS programmes that incorporated the strategies and principles created by GPA. However, the failure of the strategies designed by GPA and WHO to reduce the infection rate of HIV/AIDS in Eastern Europe, which experienced large increases in new HIV infections after the collapse of the Soviet Union reinforced the thesis that the spread and the rate of infection are determined by cultural, socio-economic and the political stability of the country.
Research studies (Denis & Becker, 2006; Caraël, 2006, pp.29-40; Carton, 2006:97-112; Colson, 2006:113-125; Denis, 2006, pp.13-26) have powerfully argued that Sub-Saharan Africa’s political and socio-economic crises during the period 1970-1997 created a fertile environment for the spread of the HIV epidemic. Borrowing from the study by Atlani et al (2000) entitled “Social Change and HIV in the Former USSR: The Making of a New Epidemic”, Caraël (2006, pp.33) argues that the high infection rate of Eastern Europe after the collapse of the Soviet Union “reminded the world that social changes and economic upheavals played an even more important role in the evolution of the HIV epidemics than individual efforts of prevention”. Caraël (2006:33) concludes: “Whilst for more than ten years the HIV epidemic had remained constant at an extremely low level in the USSR, the fall of the wall and the collapse of the system of values in the former Soviet Union bought about a rapid growth in the use of intravenous drugs and prostitution and a surge of HIV infection”.

Seckinelgin (2008, pp.30) observes that the internationalisation of the disease has also brought with it a certain way of understanding and looking at the disease. This can be observed in the international policy discussions in the documentation produced on HIV and AIDS by the international organisations. The first document was Global Programme for AIDS (GPA), which was produced through WHO’s initiative in 1989, set the stage for international frameworks for dealing with epidemics that threaten global security. During the period 1998 to date many HIV/AIDS documents have been produced by international HIV/AIDS organisations to mitigate the scourge of the HIV/AIDS epidemics.

The most important of these documents include:


Since their release, these international documents on HIV and AIDS have been adopted as the reference point by many counties across Sub-Saharan Africa for their funding arrangements and for the creation of many national HIV and AIDS programmes. The high level meetings of UN General Assembly on HIV/AIDS in New York, the UNAIDS Programme Coordinating Board’s meetings in Geneva, and the documents produced on HIV and AIDS are generally considered to reflect the international political will aimed at providing interventionist support systems for people in their fight against the epidemic.
In other words, the UNAIDS Programme Coordinating Board deliberations in Geneva and the resolutions and the declarations on HIV/AIDS by UN General Assembly sessions in New York have relocated the HIV/AIDS mitigation debates to a global political level as a central agenda item, which has since dominated many international political forums such as the G8 meetings of the World Trade Organisation (Seckinelgin, 2008, pp.30).

The 1989 GPA document and subsequent HIV/AIDS documents recognise prevention as the mainstay of the global response, with care, support and treatment seen as necessary parts for the effectiveness of such a response. The importance of vulnerable groups such as women, girls and children, which has been highlighted by *Operational Plan (2010-2014) for UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV* (2009) and *Children on the Brink 2002: A Joint Report on Orphan Estimates and Program Strategies*, is recognised. Characteristically, these documents are statements of understanding and guidelines for future action. Since each national HIV/AIDS programme is expected to be shaped and informed by local historical, cultural and socio-economic environment of each country, relevant details are deliberately omitted from these HIV/AIDS programme guidelines. Nonetheless, they provide a political momentum for future action.

The focuses of these HIV/AIDS documents also reflect the prevailing common sense before the XIV International Conference on HIV/AIDS was held from 7-12 July in Barcelona, which centred on the possibility of effective treatment delivery in developing countries. The review of the conference provided by United Nations Non-Governmental Liaison Service (NGLS) – *Roundup* – reports that the theme of Barcelona 2002 was "Knowledge and Commitment for Action which aimed at ensuring
that “knowledge gained from science and experience is translated into action” (NGLS, 2002, pp.1). The powerful personalities whose decisions determine the international funding of HIV/AIDS provided to African nations made promises which to date were not fulfilled. According to NGLS (2002, pp.12:

- In his opening remarks, the Executive Director of UNAIDS, Peter Plot, stated that global community must confront the challenge of mobilizing political commitment, scaling up AIDS prevention and treatment, eliminating stigma, developing a vaccine and finding US$10 billion to fight AIDS. The failure to do so would amount to the international community’s failure to fulfil its promise to respond effectively to AIDS. Failing to act immediately, Plot warned, would lead to disastrous consequences. Plot concluded: “We stood while AIDS overwhelmed sub-Saharan Africa, Never Again. We cannot stand by as passive observers while other continents repeat history, and we must fail Africa now, in her attempts to turn back the epidemic’s devastation …. International trade negotiations [WTO] may have as great an impact on how many people get AIDS treatment as any number of national treatment access plans.”

- Kevin Watkins, the Head of Research and Policy at Oxfam called for an immediate and complete debt cancellation for countries severely overwhelmed by the AIDS epidemic. Watkins’s recent paper reports that more than one-third of the world’s people living with HIV/AIDS live in the 38 countries categorised as “Highly Indebted Poor Countries”. Large chunks national resources, which need to be used for HIV/AIDS prevention and treatment are instead sent overseas to creditor countries in the North to repay interests on their crippling debt burden.
Activists protested vehemently and advocated for the US government and the richest countries must provide money for research and prevention programmes aimed at reducing the negative impacts of the epidemic.

Gender inequality was isolated by many experts as the greatest challenge that constrained the prevention and treatment programmes towards fighting the HIV/AIDS. It was observed that women are most at risk and bear a “disproportionate share of the burden of the growing HIV/AIDS pandemic. According to the United Nations Population Fund (UNFPA), women are increasingly becoming the main victims of HIV/AIDS, with 75% of new HIV infections globally being attributed to heterosexual sex. “Men are eight times more likely to transmit HIV/AIDS to women through unsafe sex than women are to transmit it to men, and the HIV infection rates among teenage girls are five times higher than rates among teenage boys. Once women contract the virus, they are more likely to be ostracized and to face discrimination and even violence as well as being blamed for spreading the epidemic” (NGLS, 2002, pp.2).

Socio-economic inequality between men and women is now fatal”, observed Geeta Rao Gupta, the Executive Director of International Centre for Research on Women. According to Rao Gupta, the stigma women bear from being infected with HIV/AIDS is the “single greatest challenge” that hinders attempts to reduce the spread of the pandemic and leads to catastrophic consequences in which pregnant women fear death less than HIV testing. According to UNAIDS, of the more than 40 million people living with HIV/AIDS globally an estimated 18 million are women. In sub-Saharan Africa, research reports that women account for 55% of adults infected with HIV/AIDS.
A joint international report published by USAID, UNAIDS and UNICEF) with estimates provided by the US Bureau of Census indicated that by 2010 the number of orphans will reach 42 million and 20 million of these children—or almost 6% of all children in Africa—will be orphaned due to HIV/AIDS.

The Barcelona 2002 review also summarized the economic and social impact of HIV/AIDS on Sub-Saharan Africa. According to the International Labour Organisation (ILO), the previous attempts by economists to measure the costs of HIV/AIDS in sub-Saharan Africa “were likely to be significant underestimates of the social and economic values of the losses of `human capital’ that that are being experience”. For Franklin Lisk, the Director of ILO’s Global Programme on HIV/AIDS, “The epidemic affects social and economic life in ways we have never seen before ... The main socio-economic impact of HIV/AIDS is its decimation of the labour force and the level and allocation of savings and investment. This portends a huge humanitarian disaster with dire economic and social consequences. An ILO study entitled Human Capital and the HIV Epidemic in Sub-Saharan Africa reports that across all occupational sectors in Sub-Saharan Africa it is becoming increasingly almost impossible to replace skilled as well as unskilled labour lost to HIV/AIDS and that many African countries are increasingly unable to locate resources badly needed to keep even current operational levels of economic development running.

The comments by the former South African President Nelson Mandela and the former US President Bill Clinton sum up the Barcelona 2002 conference analysis. Both former presidents called the global leadership to treat HIV/AIDS as a threat to the international peace and economic security. Mr Clinton asserts: "One hundred million AIDS cases mean more terror,
more mercenaries, more war, destruction and the future of fragile democracies. He appealed to the donor governments to “figure out what our share [US’ share] of the US$10 billion the UN says is needed annually to fund global programmes to combat HIV/AIDS”. Bill Clinton added that the United States should increase its spending by nearly US$2 billion, an amount that would be “less than two months of the Afghan war, less than 3% of the requested increase of defense and homeland security budgets”. He warned, ‘if we don’t do it, we will be spending far, far more than that to clean up the mess of this humanitarian tragedy” (NGLS, 2002, pp.3).

The refusal of the Spanish government to issue visas to all prospective participants whose conference fees were paid merely the grounds that they came from countries overwhelmed by HIV/AIDS epidemic appeared to foreshadowed the racial Western world’s holier than thou attitude that entrenched the stigma that plagues victims of the epidemic globally and led to false funding promises that never materialised.

1.4 SOUTH AFRICAN PERSPECTIVE

This subsection like the international subsection explores not only the South African context of the HIV/AIDS epidemic and its devastating impacts all fabrics of the society but also locates the discussion within the cultural, historical and the socio-economic underpinnings shaped and informed the evolution of the spread and infection rates across the nine provinces of South Africa. The target province, however, is the Eastern Cape. The cultural-cum-historical overview of the setting of the pathways of the spread and infection rates of HIV/AIDS in South Africa will be initiated by analysing a historical drivers that fuelled the spread of the HIV/AIDS epidemic in Sub-Saharan Africa and in particular, South Africa.
The most extensive data is based on the annual surveillance set up by the National Department of Health in 1990 to monitor the prevalence of HIV infection in women attending public antenatal clinics. Many additional surveys have been conducted in South Africa over the last 15 years. These surveys provide crucial information on epidemic trends, patterns of infection, and factors that contribute to the spread of the epidemic.

South Africa has experienced one of the fastest growing HIV epidemics in the world and bears about 10% of the global burden of HIV infection (Shisana and Simbayi 2002, pp7). The epidemic is characterised by high HIV prevalence, which is fuelled by high rates of new infections in young women and is predominantly subtype C. The prevalence varies by age, gender and geographic area. Data collected over recent years indicates that the epidemic has started to level off, a trend that is unlikely due to interventions, but simply reflects the national saturation of the epidemic. While the HIV prevalence is no longer increasing significantly, the incidence of new infections is balanced by rising mortality rates. Researchers’ understanding of the HIV epidemic in South Africa depends largely on a range of sero-prevalence surveys that have been conducted in a variety of settings and populations; a brief description of these sources of HIV data is provided.

The evolution epidemic in South Africa is described in relation to timelines that mark key milestones in the spread of HIV in South Africa. The early history of HIV/AIDS in South Africa can be traced to the first reported cases of AIDS in the early eighties as a localised subtype B epidemic among men having sex with men, haemophiliacs and recipients of unscreened blood products. The first cases of HIV/AIDS characterised by localised subtype B have involved into the current point of a generalised, mature, subtype C epidemic in which the prevalence of infection appears to have
stabilised although mobility and mortality are still on the increase. Distinctive characteristics of the South African HIV epidemic are described as ranging from the rapid spread of HIV infection to differences in terms of gender, age and geographic area.

In their article entitled “HIV/AIDS and SADC: How Are WE Doing?” Patient and Orr (2009, pp.20-21) observe that the scope of the impact of HIV/AIDS in the SADC countries is profound. They argue that South Africa being a member of the SADC cannot be left out. They go on to explain that HIV and AIDS reduces the average life span by more than 20 years, creates millions of child headed households, deepens poverty, reduces economic output, increases the resource disparities between rural and urban populations, reverses the educational progress, alters agricultural output types and production levels, kills young adults. This long list is by no means complete.

The *HIV and AIDS Peer Education Manual* (2008, pp.5-8) gives the following statistical information about the prevalence of HIV and AIDS in South Africa. Some incidences of prevalence were observed in a rural community in 1985, among sex workers in Transvaal in 1986, and among antenatal clinic attendees and out-patients in KwaZulu Natal in 1987. In a study conducted among 29 312 mine workers in South Africa in 1986, only 3 men tested positive for HIV infection. Despite the relatively late introduction of HIV infection in the heterosexual population compared to eastern and central Africa, the South African HIV/AIDS infection rate accounts for 10% of the global burden of infection.

During the ten-year period (from 1990 to 2000) HIV sero-prevalence among antenatal clinic attendees has increased ‘explosively’ from 0,8% to 24,5%. The period 1988-1993 marks the beginning of the generalised or ‘major epidemic of subtype C
HIV infection in South Africa. During the early stages of the epidemic, between 1990 and 1993, there was an exponential increase in HIV infection with a doubling time of a little over one year and by 1994, it had reached 10% among antenatal clinic attending women.

Between 1994 and 1998 the incidence of new infection reached its peak. Young women were at especially high risk and recombination of different infections became evident. Fitted to a logistic curve, the epidemic reached half its peak value between 1995 and 1996 and has an expected maximum prevalence at the plateau of the epidemic of 26.5%. Despite the high rates of new HIV infections and increasing morbidity, mortality remained relatively low during this period. The high prevalence of HIV infection during this period increased the demand for health care in the next period as HIV positive individuals progressed to AIDS. The period 1999-2002 exemplifies the maturation of the HIV epidemic in South Africa – a period characterised by the epidemic reaching saturation.

The overall HIV prevalence data as well as the provincial and the age specific data dating back to 2000 indicate that the epidemic has reached a plateau. While the HIV prevalence is not increasing any longer, the mortality continues to rise and the incidence of new infections balances HIV/AIDS deaths. South Africa’s HIV epidemic is classified as “a hyperendemic” epidemic because the country has more than 15% of the population aged 15-49 are living with HIV (UNAIDS, 2008, pp.100) the HIV status.

According to Nicholson (2008, pp.45), Young women all across the globe are more likely to be infected than their male counterparts, for a number of reasons. Most analysts attribute this to physiological differences and socio-economic factors. That the youth are more vulnerable to HIV infection is further endorsed by a research study conducted by Shisana et al (2009) entitled *South African National HIV Prevalence, Incidence, *
Shisana et al. (2009:xv) observe that “Young adults, particularly females, are at greater risk of acquiring HIV”

Within a few years every person in the world will probably know personally someone who has died because of AIDS. More than one in 200 of all adults living on the Planet Earth are infected already. It may be an older brother or a sister, a cousin, an uncle, a friend, a man in the same street, a shopkeeper, or someone at school or at work. This scenario is already the case in most of Africa and parts of South East Asia. By 2002 over 80 million people had probably been infected with HIV. No one knows the accurate HIV/AIDS infection figures. And HIV is spreading twice as fast across the world today as 5 years ago (Dixon, 2002, pp. 19).

Nelson Mandela’s speech that symbolizes AIDS as “a war against humanity ... which requires the mobilization of entire populations” and the plea to the wealth developed countries to make accessible anti-retroviral medication to “all those who need it, wherever they may be in the world, regardless whether they can afford it” appeared to ignored not only by the richest countries but also by South African government that has the resources to provide the drug to HIV infected South Africans. Since units of analysis are the members of the SMTs and the schools they were attached an outline of the HIV/AIDS impact on schools needs to be discussed.

1.5 THE IMPACT OF HIV/AIDS ON EDUCATION SYSTEM

According to Sharma (2006), throughout the world, HIV/AIDS is having a dramatic effect on the lives of individuals, families and communities. Where the HIV/AIDS prevalence of HIV is high, there are few households that had escaped the devastation wrought by the pandemic. The mortality rates are so high that
there are only few families that were lucky to have lost no family members to the epidemic.

Sharma (2006) also stated that the impact of HIV/AIDS on education systems in severely affected countries is particularly acute. Substantial numbers of teachers are ill, dying or caring for family members. Young people, especially girls are being withdrawn from school to assist in the home. Management of education is threatened by illness and death of qualified educators. Thus, the vicious cycle of increasing HIV/AIDS infections and the deaths lead ultimately to decreasing educational services. This cycle of HIV/AIDS fatalities poses a long term threat to attainment of *Education for All* (EFA) goals and, more broadly, to development.

Sharma (2006) suggested that beyond the education system, the HIV/AIDS epidemic is undermining the institution and human resources on which future health, security depends. These include both formal and non-formal (e.g. the family and community) systems of care and support. While education cannot, in itself provide the answer to all of these problems, action to strengthen the education system, and to ensure that both school and out-of-school education contribute more effectively to HIV/AIDS prevention can help communities and nations to respond more effectively. The provision of more flexible forms of education is essential for reaching vulnerable children and young people, and to ensure that they do not lose out on the knowledge and skills they will need in the future, (Sharma, 2006, pp.47-48).

### 1.5.1 SGBs and HIV/AIDS HEALTH ADVISORY COMMITTEES

According to the National Education Policy Hand Book for the Educators (2003), the HIV/AIDS Health Advisory Committee is a committee that is serving under the school governing body. It further stated that the governance of a school is vested in its governing body which stands in the position of trust in the
school. According to the module of the faculty of education titled Educational Policy and School Governance a governing body is a statutory group of people elected to govern the school. They are either elected or appointed. School governors represent the school community. They are expected to carry out their duties and function for the benefit of the school. They have to promote the best interest of the school and ensure that the learners at school receive the best education as possible.

The composition of the SGB is made up of the following members: the principal, parents, teachers, learners, non teaching staff and co-opted members. One of the SGB duties is to determine that the policies should be in line with the South African Schools Act (SASA) (No 84 of 1996). The HIV/AIDS Health Advisory Committee is a sub-committee established by all schools in order to deal urgently and purposefully with the HIV/AIDS emergency in and through the education and training system. This is the priority that underlies all priorities. For, unless we succeed, we face a future full of suffering and loss, with untold consequences for our committees and the education institutions that serve them (Understanding Policy 1997, pp. 46 – 47).

South Africa has the fastest growing HIV and AIDS epidemic in the world, with more people infected than in any country in the world. The report estimates that over 4 million South African are HIV positive. Prevalence rate are highest in young people, especially teenage girls while the methodology of those estimates is still being scrutinized, there is no question that HIV/AIDS represent a massive pandemic in the country (Understanding Policy 1997, pp. 39).

1.6 STATEMENT OF THE PROBLEM
Owing to the fact that there is scarcity of HIV and AIDS information in schools because of the absence of HIV/AIDS Health Advisory Committees in schools, young people are dying.
This lack of relevant information on HIV/AIDS leads to the unnecessary stress and deaths indicated above. The main causes of these deaths are HIV and AIDS-related diseases. The problems associated with the pandemic and the non-existence or poor management of Health Advisory Committees are affecting the smooth running of schools, economic development of the country at large and the social life of the populace. The negative impact created by this phenomenon has prompted me to embark on this study in order to investigate and design measures capable of reducing the prevalence in our schools and to recommend possible solutions.

The negative impact of HIV/AIDS leads to serious repercussions in schools. For instance, it affects knowledge acquisition and production. These adverse effects include (1) the poor academic performance of school learners; (2) the deaths of breadwinners who look after the children at these schools – leaving them with no one to support them; (3) a massive reduction in household income and pay for expenditures; (4) creation of major problems for health system and health care practices; (5) increase in absenteeism due to illness and (6) reduction of the capacity of societies to provide essential services since educators lose their lives due to the pandemic because they lack of the knowledge of the disease. The negative impact of the HIV/AIDS listed above created an environment in which planning for the future will be difficult since the future generation is badly affected by loss of potential manpower. The vacuum created by the loss of potential manpower threatens growth and upbringing of future leaders as well as defenders of the nation: human security.

1.7 MAIN RESEARCH QUESTIONS

The main research questions, which the study seeks to interrogate, are: Does any of the selected 16 secondary schools have HIV/AIDS Health Advisory Committees? And if HIV/AIDS
Health Advisory Committees had been established in any of the schools, are they managed in accordance with the stipulated guidelines of the national education policy? The subsidiary questions generated by the main research questions are:

- Is there any HIV and AIDS advisory committee at the Amathole District Municipality schools?
- What role does it play?
- How are the school authorities dealing with problems related to HIV and AIDS in the absence of Health Advisory Committee?
- If a committee had been established, is it working effectively?

### 1.8 HYPOTHESIS

Hypothesis refers to the suggestion that something is true, though without proof. Babbie and Mouton (2001, pp.643) define hypothesis as: “An expectation about the nature things derived from a theory. It is a statement of something that ought to be observed in the real world if the theory is correct. A hypothesis is essentially a statement that postulates that a certain relationship (correlation or causality) exists between two or more variables”. According to Wimmer and Dominick (2000, pp.428), however, hypothesis is “a tentative generalisation about the relationship between two or more variables that predict an experimental outcome”. Rosnow and Rosenthal (1996, pp39) describe hypothesis as a conjectural statement. Struwig and Stead (2004, pp.36) define hypothesis is “a tentative statement about relationship between two or more variables”. Struwig and Stead (2004, pp.36) further point out that the hypothesis “gives direction or focus to the research through the identification of measurable variables; is grounded in the quantitative research paradigm and seldom found in qualitative research projects”

Struwig and Stead (2004, pp.36) list the following common functions of hypothesis:
■ predicting the relationship between variables and is empirically verifiable,
■ demonstrating that the researcher has mastered the problem and can identify and control the main variables in it,
■ directing the investigation by suggesting the procedures to be followed and the type of data to be collected,
■ providing a basis for interpreting the results and drawing conclusions, and
■ .... data are collected so that the hypothesis can be accepted or rejected.

The above steps cannot be achieved without the investigation of the relevant literature (Struwig and Stead, 2004, pp.38). It means that a generous body of literature is needed to conceptually define themes. A hypothesis is a tentative solution to a problem under investigation.

In most schools in Idutywa district there is no HIV and AIDS Health Advisory Committee to assist schools in disseminating information to potential and victims of HIV and AIDS pandemic. In some few schools where the committee is, it is not working properly or not working at all. Moreover, the Department of Education has not yet intervened.

1.9 PURPOSE OF THE STUDY

The study focuses on making schools become aware of the fact that the HIV/AIDS committees are expected to work hand in hand with the local Health Centres. To perform this function successfully, schools must understand the intended underlying government objective behind the HIV/AIDS Health Advisory Committee policy: namely the need to provide interventionist support systems based at schools and tertiary institutions that could advise the more
vulnerable learners/students and teachers/academics infected or affected by the HIV and AIDS.

Research reveals that there are many purposes of social research. “Exploration, description and explanation” are the three “most common and useful purposes” (Babbie & Mouton, 2001, pp.79). “Although ... most” studies “do have more than one of these purposes....explaining them separately is useful because each has different implications for other aspects of research design” (Babbie & Mouton, 2001, pp.79).

The exploratory approach is used “when a researcher examines a new interest or when the subject of the study itself is relatively new” (Babbie and Mouton, 2001, pp.79). The second main purpose of research is description. According to Babbie and Mouton (2001, pp.79), “A major purpose of many social scientific studies is to describe situations and events”. The descriptive purpose requires the researcher to observe and to describe what was observed. “Many qualitative studies aim at description”. “The third general purpose of social scientific research is to explain things”. The preoccupation of explanatory studies “is to indicate causality between variables or events” (Babbie and Mouton, 2001, pp.79).

The general area of the research enquiry centres on determining the existence and the effective management of HIV/AIDS Health Advisory Committees in the 18 senior secondary schools selected from the Amathole District Municipality Schools. The study, however, is preoccupied with measuring how the different HIV key determinants impact on the school environment and how the HIV/AIDS Health Committees could be managed effectively to mitigate the epidemic in schools. Hence, the purpose of the study could be said to be both descriptive and exploratory. The study focuses on ensuring that the schools understand that it is their responsibility to establish the Health Advisory Committees (HACs) in
accordance with the guidelines and specifications stipulated in the National Policy on HIV/AIDS Act of 27 of 1996.

1.10 RATIONALE FOR THE STUDY

The rationale that informs and shapes this study is the fact that although many studies have been conducted by South African researchers on different thematic aspects of the HIV/AIDS epidemic, an internet search conducted by the researcher had not revealed any study, which investigated the existence and the effective management of HIV/AIDS Health Advisory Committees. The need to fill in this gap in the topic necessitated the mounting of this research enquiry that seeks to find solutions that might be used to turn the tide against the miserable life of learners and teachers in schools – the root cause of poor academic performance. The findings of the study would be beneficial to school committees and provide critical awareness campaign data that could help reduce the rate of HIV and AIDS infection.

1.11 RESEARCH DESIGN: SURVEY

The research design which is the most appropriate for this research study is the quantitative research survey. A research design is determined mainly by its purpose and objectives. According to Babbie and Mouton (2001, pp.230-231), “Survey research is perhaps the most frequently used research design in the social sciences .... In a typical survey, the researcher selects a sample of respondents [from the target population] and administers a standardized questionnaire to them”. In survey research, information is collected from the group of people and is used to describe aspects or characteristics. The group belong to the same population and the information is collected through questions.
Survey research can be thought of as either a method of data collection that can be used with other research designs (e.g. casual comparative or correlation designs), or a descriptive research design in itself. Survey research has the advantages of allowing the researcher to collect information from a large number of people, in contrast to experimental research, in which the size of the sample is usually more limited. Survey research can be associated with disadvantages if it relies on self-reporter reports of uninformed proxies, is retrospective, or suffers from response bias from poor worded questions.

Typically, surveys gather data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared, or determining the relationships that exist between specific events. Thus surveys may vary in their levels of complexity from those which provide simply frequency counts to those which present relational analyses. Surveys may be further differentiated in terms of their scope. A study of contemporary developments in post secondary education, for example, might encompass the whole of Western Europe; a study of subject choice, on the other hand, might be confined to one secondary school. The complexity and scope of surveys in education can be illustrated by reference to familiar examples.

Whether the survey is large scale and undertaken by some governmental bureau or small scale and carried out by the lone researcher, the collection of information typically involves one or more of the following data gathering techniques: structured or semi-structured interviews, self-completion or postal questionnaires, standardised of attainment or performance, and attitude scales. A survey has several characteristics and several claimed attractions; typically it is used to scan a wild field of
issues, populations, programmes etc, in order to measure or describe any generalized features.

It is useful (Morrison, 1993, pp.38-40) in that it usually:

- gathers data on a one-shot basis and hence is economical and efficient;
- represents a wide target population (hence there is a need for careful sampling) generates numerical data;
- provides descriptive, inferential and explanatory information;
- manipulates key factors and variables to derive frequencies;
- ascertains correlations (e.g. to find out if there is any relationship between gender and scores);
- presents material, which is uncluttered by specific contextual factors;
- captures data from multiple choice, closed questions, test scores or observation schedules supports or refutes hypotheses about the target population;
- makes generalization about and observes patterns of response in, the targets of focus;
- gathers data which can be processed statistically;
- generates accurate instruments through their piloting and revision;
- relies on large scale data gathering from a wide population in order to enable generalizations to be made about given factors or variables.

Surveys typically rely on large scale data, e.g. from questionnaires, test scores, attendance rates results of public
examinations etc., all of which would be enable comparisons to be made over time or between groups.

1.12 SAMPLING: NON-PROBABILITY SAMPLING
The researcher used the non-probability sampling method where the personal bias determined the elements to be included in the sample. In non-probability sampling, for various reasons, one attempts to define the sample in ways which over-represent groups with certain characteristics. Thus, in non-probability sampling, generalization to the population may be considerable more complex. The selectivity which is built into a non-probability sample derives from the researcher targeting a particular group, in the full knowledge that it does not the wider population; it simply represents itself. This is frequently the case in small scale research, for example, as with one or two schools, two or three groups of students, or a particular group of teachers, where no attempt to generalize is desired; this is frequently the case of some ethnographic research, action research or case study research.

Sampling is the process of selecting a subset of people to be studied from the larger universe to which it belongs (Payne & Payne, 2004, pp.200). Qualitative researchers use a sampling strategy that guides their choices of participants in order to enable the researchers to make systematic contact with their participants without wasting time (Boejie, 2010, pp.120). Qualitative research studies typically use non-probability samples where sample units are chosen purposively for their ability to provide detailed understanding (Richie, Lewis & Elam, 2003, pp.107). This means that the selection of sampling units is based on known characteristics relevant to the research topic. In this study sample units were 18 senior secondary schools (members of SGBs i.e. parents, teachers and learners).

Small scale research often uses a non-probability samples because, despite the disadvantages that arise from their non-
representativeness, they are far less complicated to set up, considerable less expensive, and can prove perfectly adequate where researchers do not intend to generalise their findings beyond the sample in question, or where they are simply piloting a questionnaire a prelude to the main study. Just as there are several types of probability sample, so there are several types of non-probability sample: convenience sampling, quota sampling, dimensional sampling, purposive sampling and snowball sampling. Each type of sample seeks only to represent itself or instances of itself in a similar population, rather than attempting to represent the whole, undifferentiated population.

This study targeted 18 Senior Secondary Schools in the district of Idutywa under the AMATHOLE District Municipality. Questionnaires will be given to 6 SGB members in each school to respond to the questions from the researcher in order to obtain the data. Therefore the total number of the SGB members that were estimated to respond to the questionnaires from the selected schools was 108.

1.13 RESEARCH PARTICIPANTS
Research participants for this research study are mainly members of the School Governing Body (SGB) from the selected schools. According to SASA, SGB is a statutory (legal) body of people who are elected to govern a school. This statutory body is composed of the parents, educators, learners and non-teaching staff that are democratically elected by the community; the principal and the co-opted members. Subject to the South African Schools Act, the governing body of a public school has some functions, namely, must:

- Promote the best interests of the school and strive to ensure its development through the provision of quality education for all learners at school;
- Adopt a constitution;
Develop the mission statement of the school;
Support the principal, educators and other staff of the school in the performance of their professional functions;
Encourage parents, learners, educators and other staff at the school to render voluntary services to the school.

The researcher decided to select SGB members (teachers, parents and learners) whom I believe may supply me with the relevant data as the governors of the school.

1.14. DATA COLLECTION
Data collection is an essential part of conducting research (O’Leary, 2004) and can be derived from a number of methods that include interviews, focus groups, surveys, telephone interviews, field-notes, taped social interaction or questionnaires (Heaton, 2004). Wimmer and Dominick (2000, pp.126) have identified at least four sources of data that can be used in case studies: (1) “documents”, (2) “the interview”, (3) “observation/participation” and (4) “the physical artefact”. According to Wimmer and Dominick (2000, pp.126), “Documents, which represent a rich data source, may take the forms of letters, memos, minutes, agendas, historical records, brochures, pamphlets, posters, and so on”. That there are many types of data sources in case studies is confirmed by Remenyi, Williams, Money and Swartz (1998).

1.14.1. QUESTIONNAIRE
The method of collecting data instrument chosen for this study is the mail-administered questionnaires. According to research using questionnaires for data collection permits the collection of reliable and reasonably valid data relatively simply, cheaply and in a short space of time. Researchers’ decision to use questionnaire is generally motivated by a need to collect relatively routine data from a large number of respondents. They may be in one or several locations such as school, in which case a questionnaire
can be administered in a group setting, or they may be widely dispersed. According to the module titled Introduction to Quantitative Research: NME of the University of Pretoria (2002, pp.58) questionnaires are also most efficiently sent by mail: the method used in this study. Designing a good questionnaire involves:

- the selecting the questions needed to meet the research objectives;
- testing them to make sure that they can be asked and answered as planned;
- putting them into a form to maximise the ease with which respondents and interviewers can do their jobs.

The above aspects of questionnaire create an opportunity for the researcher to select different options available which are suitable for the specific survey. When carefully considered and applied, the questionnaire should be a natural-ready to use instrument to elicit information. There are two main types of questionnaires: (1) open-ended and (2) closed-ended questions. Questionnaires can be administered though different mediums: (1) mail surveys (2) telephone surveys, (3) personal or face-to-face interviews, (4) group/focus group surveys, (5) disk-by-mail surveys and (6) Internet survey (Wimmer & Dominick, 2000, pp.175-176).

There are several kinds of question and response modes in questionnaires, including for example: dichotomous; multiple choice; rating scales; and open-ended questions. Here the researcher is using the open-ended questions to collect the data for his research. Open-ended questions enable the respondent to write a free response in their own terms, to explain and qualify their responses and avoid the limitations of pre-set categories of response.
On the other hand the responses are difficult to code and to classify. The issue for researchers is one of the, ‘fitness for purpose’. The open-ended question is a very attractive device for smaller scale research or for those sections of a questionnaire that invites an honest, personal comment from the respondent in addition to ticking numbers and boxes. The questionnaire simply puts the open ended questions and leaves a space (or draws lines) for a free responses. It is the open ended responses that might contain the germ of information that otherwise might not have been caught in the questionnaire.

1.15 DATA ANALYSIS
The researcher used SPSS to analyse the data. Mahlagu (1987) stated that the researcher will analyse the data collected with the use of the institutions’ SPSS which includes the ordering and summarizing of the data using tables, graphs and calculating the descriptive measures and drawing meaningful conclusion relating to the population from which the sample was drawn.

According to Louis et al (2000, pp.77) the prepared researcher will need to consider the mode of data analysis to be employed. This involves the quantitative methods used to collect primarily numerical data; analysis based on numerical and statistical analysis; validity and reliability measures ensure data trustworthiness. The research plan must include a descriptive of the techniques that will be used to analyse study data. The hypothesis in a quantitative study determines the design, which in turn determines the data analysis. Selecting an analysis technique depends on a number of factors, such as how the groups will be formed, how many there are, the numbers of variables that will be studied, and the kind of data to be collected. Analysis of data in casual comparative studies involves a variety of descriptive and inferential statistics.
The primary researchers, research reviewers interpret data using rules of inference that build on standard statistical but are not the same. Analysis and interpretation methods are frequently idiosyncratic to the particular reviewer. This lead to criticism of subjectivity and a concern that a variety of methods which have been introduced into the reviewing process. Further, quantitative reviewing is based on certain premises. Methods of data analyses range from simple vote counting methods to sophisticated statistical techniques to obtain indices of the effect size.

1.16 ETHICAL CONSIDERATION

According to Mahlangu (1987) ethics generally are considered to deal with beliefs about what is right or wrong, proper or improper, good or bad. Ethical considerations play a role in all research studies, and all researchers must be aware of and attend to ethical considerations in their research. Many professional organizations have developed ethical principles for their members, and federal government has enacted laws to protect research participants from harm and invasion of privacy. Probably the most definitive source of ethical guidelines for researchers is Ethical Principles of Psychologist and Code of Conduct, prepared for and published by the American Psychological Association (APA). The two most overriding rules of ethics are that participant should not be harmed in any way (physically and mentally) and that researchers obtain the participants’ informed consent. The researcher developed data collection techniques and standards that ensured the protection of the study participants. The researcher has used the following methods to deal with any issue that might arise during the carrying out of the research procedures:

- Obtaining an informed consent before the study or the beginning of the interview; and
- Trying not to explore sensitive issues before a good relationship has been established with the informants.

The informants will be ensured confidentiality of the data obtained and try to learn a lot of the informants’ so as to ensure that it is respected during the collection of the data.

1.17. RELIABILITY AND VALIDITY
According to the course module compiled by the University of Pretoria titled Introduction to Quantitative research (2002, pp.108), reliability is the extent to which a test measured consistently that which is measuring. It further defines it as a degree of correspondence between 2 independent sets of scores for one person. It is an essentially a synonym for consistency and replicability over time, over instruments and over groups of respondents. It is concerned with precision and accuracy; some features, e.g. height, can be measured precisely, whilst others, e.g. musical ability, cannot. Reliability is expressed numerically, usually as a coefficient ranging from 0.0 to 1.0; a high coefficient indicates high reliability. For research to be reliable it must demonstrate that if it were to be carried out on a similar group of respondents in a similar context, then similar results would be found. Reliability provides information about the inevitable fluctuations in scores due to person and test factors. No test is perfectly reliable, but the smaller the measurement error, the more reliable the test.

Louis et al (2000) define validity as the degree to which a test measures what is intended to measure; a test is valid for a particular group. They added that validity of a questionnaire refers to the degree to which a test succeeds in measuring what it has set out to measure. Lastly validity is an important key that affects the research, and therefore if a piece of a research is invalid then it is worthless. All in all validity is thus a requirement
for both quantitative and qualitative/naturalistic research. In quantitative data validity might be improved through careful sampling, appropriate instrumentation and appropriate statistical treatments for the data. It is impossible for the research to be 100 per cent valid; that is the optimism of perfection. Quantitative research possesses a measure of standard error which is inbuilt and which has to be acknowledged. Validity, then, should be seen as a matter of degree rather than as an absolute state (Gronlund, 1981). Hence at the best we strive to minimise invalidity and maximise validity (Louis et al, 2000, pp.105).

1.18 LIMITATIONS OF THE STUDY

This study just like any other study is subject to limitations. Limitations consist of clearly defined and unclear factors that can affect the study negatively. As for the study, one of the setbacks of the true picture of its results might be affected by its failure to cover all the schools in the district. Only a sample of schools were selected thus this might affect the findings.

Time allocated to undertake the study can also be a drawback the successful completion of the study due to the following reasons:

- The researcher is a full time classroom practitioner who has to fulfil the obligations at work more especially that he is teaching a grade twelve class which is examinable, hence needs as much contact time with learners as possible. Therefore arrangements are going to be made with the administration to find time to cover up for the lost time during the research.

- Family commitments may have a negative effect on the study since the researcher has family responsibilities to fulfil, hence in cases of emergence he has to change the set dates for the study to a later date if such a problem arises.

Financial constraints may also affect speed of the study since the research has to go through certain procedures or use money from
his pocket to visit places and buy resources before the institution approves his budget and issue out the funds.

Respondents might decline to divulge the information required since they might think the information would reveal their weaknesses to the public. The researcher in this situation had to explain the benefits of the study to the respondents and its purpose which is not to tarnish their image. This would help them to have a better understanding and develop a positive attitude towards the research study.

1.19 DELIMITATIONS OF THE STUDY
This research study is carried out in the Eastern Cape Province of South Africa. However it is going to be confined in one district by the name of Idutywa. All senior secondary schools in their scattered around the district would be included in the study. Therefore the study covered the area where the schools are situated of which some of them are from the rural set up while others are from the urban centre of Idutywa.

1.20 DEFINITIONS OF THE PERTINENT TERMS AND ACRONYMS
- **Acquired Immune Deficiency Syndrome (AIDS)** – A disease of the body’s immune system caused by human immune-deficiency virus (HIV). It is syndrome (collection of diseases) that results from infection with HIV.
- **Amathole District Municipality (ADM)** – one of the mega district municipalities in the Eastern Cape Province of South Africa.
- **Anti-Retroviral (ARV)** - a type of drug that stops or weakens the strength of the virus in your body.
- **Confidentiality** - the right to privacy for every person, employee or job applicant to have their medical information, including HIV status.
- **Discrimination** - An act of treating someone differently. Sometimes people are treated differently because of gender, race etc.
- **Idutywa Education District (DED)** – one of the mega education districts in the Amathole District Municipality in the Eastern Cape in South Africa.
- **Epidemic** - A disease, usually infectious, that spread quickly throughout a population.
- **Human immune-Deficiency Virus (HIV)** - The virus that causes Acquired Immune Deficiency Syndrome (AIDS).
- **Infection** – having a diseases or germs that cause illness.
- **Orphan and Vulnerable Children** – These are children with no biological parents.
- **PMTCT (Prevention of mother-to-child transmission)** - This is a commonly used term for programmes and interventions designed to reduce the risk of mother to child transmission of HIV.
- **Policy** - a document setting out a department’s or organisation’s position on a particular issue.
- **Prevalence of HIV** - the number of people with HIV at a point in time, often expressed as a percentage of the total population.
- **Senior Secondary Schools (S.S.S)** - all high schools with grade 10, 11 and 12 in South Africa.
- **School Governing Body (SGB)** - a constitutional school governing structure constituted according to the South African Schools Act (Act 84 of 1996).
- **UNAIDS** – United Nations Joint Programme on HIV/AIDS
- **WHO** – World Health Organisation
1.21 STRUCTURE OF CHAPTERS

1. Chapter 1: Orientation and Background
2. Chapter Two: Theoretical Framework and Literature Review
3. Chapter 3: An Overview of the Key Determinants Of HIV/AIDS Epidemic In Sub-Saharan Africa
4. Chapter 4: Research Methodology
5. Chapter 5: Data Analysis and Interpretation
6. Chapter 6: Discussion of Findings, Conclusion and Recommendations
CHAPTER 2
THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 INTRODUCTION
The purpose of this chapter is to review the extant literature and to locate the study within an appropriate theoretical framework. The studies analysed under the background to the study have suggested the appropriate theoretical underpinnings for this study. The fundamental single factor identified as the greatest contributor responsible for intensifying the HIV/AIDS infection rates globally is male-female sexual relationships and associated gendered interactions. The theoretical groundings will be focused on (1) the gender-based violence (hegemonic masculinities) and (2) African cultural and social factors.

The blend of theories, which will be analysed in this chapter, is aimed at locating the study within the main theoretical thrust of the study: transforming patriarchal hegemonic masculinities towards gender justice in an era of HIV and AIDS in the Eastern Cape.

2.2 DEFINING THE THEORY OF MEN’S HEGEMONIC MASCULINITIES: GENDER-BASED VIOLENCE AGAINST WOMEN
Both international and South African research studies have identified the subordination of women and hegemonic masculinities as the most important cultural and social determinants that drive and fuel the spread and the rates of HIV/AIDS infections across Sub-Saharan African countries. The term “hegemonic masculinities” forms the theoretical core of R.W. Connell’s (1987/1995/2005) groundbreaking work Masculinities, which argues that power relations between men and women and social constructions of masculinity and femininity determine how men and women perceive themselves and how
they are perceived by the society. The study employs Kenneth Clatterbaugh’s (1998, pp.24-45) definition of masculinity. According to Clatterbaugh (1998, pp.32), “[a] masculine person is one who exemplifies those characteristics that have been shown to differentiate the sexes. A particular masculinity is the set of differentiating characteristics of a particular group of individuals determined by sex and some other set of ascriptive characteristics”. Conaway (2007, pp.3) observes that the phrase “‘those characteristics that have been shown’ refers to discourses and images of masculinities promoted and perpetuated by ‘groups of individuals, that is, groups of men’.

The theory of hegemonic masculinities created by Connell (1987/1995/2005) has been modified and re-named “Relative Deprivation Masculinities” by Ted R. Gurr (1970) in his work Why Men Rebel. The first question that the study poses in this chapter is: What does the theory “hegemonic masculinities” say about the reasons behind men’s violence against women, other men and themselves when they resort to actions that reduce their abilities to survive? Research suggests that Connell’s theory says very little on this theme.

Studies by Laura O’Toole (2007), Kimmel (2007), Kauffman (2007), Schur (2007) and Conaway (2007) have applied the theory of relative deprivation masculinities in successfully explaining “why some men are able to resolve their differences with dominate discourses of masculinity while others use illegitimate means—i.e. gender violence—to realize their internalized depiction of masculinity” (Conaway, 2007, pp.20). What is relative deprivation? Gurr (2007, pp.24) describes “relative deprivation” as “actors’ [men’s] perception of discrepancy between their value expectations and their value capabilities. Value expectations are the goods and conditions of life to which people believe they are rightfully entitled. Value
capabilities are the goods and conditions they think they are capable of getting and keeping”.

Conaway (2007, pp.4) further explains the theory of relative deprivation – the discourses on masculinities, men, and gender violence – within which this study theoretically framed as follows: “‘Values expectations’ applies to images and discourses of masculinity—i.e. through the media, peer structures, history, etc—within a given society that certain populations of men aspire to embody. ‘Value capabilities’ refer to men’s capabilities to reach these idealized concepts of masculinity, of which often falls short”.

Owing to historical, cultural-cum-social, socio-economic changes coupled with global fight against gender iniquities, men’s ability to embody dominant discourse of masculinity have been eroded. The outcomes of this scenario is that groups of men who have failed to realize their expected idealized masculine identity through the socio-economic manifestations of what means to be a man (masculine) in a given society have chosen to achieve their masculine goals though gender-based violence. As Conaway (2007, pp.4) puts it:

What cannot be met through economic and social means (such as wealth, athletic ability, physical attractiveness, etc) can be met through physical and sexual violence to gain power—i.e. alternative forms of performing dominate depictions of masculinity. Although some men are more prone to violence, others adopt or adjust discourses of masculinity that are more appropriate for their value capabilities. This leads to less violent or non-violent men that escape the cycle of masculine relative deprivation by not utilizing gender violence to embody dominate discourses of masculinity.

Three patterns of relative deprivation masculinities have identified: (1) “decremental deprivation masculinity”, (2) “aspirationnal masculinity” (3) “antithetical masculinity” (Conaway, 2007:5).
Concerning the first pattern relative deprivation masculinities, research suggests that decremental deprivation masculinities “explains why certain men are prone to commit gender violence because of the perceived loss (Conaway, 2007, pp.5) ‘of what they once had or thought they could have’ regarding their realization of masculinity’” (Gurr, 2007, pp.46). According to Gurr (2007), this group of men’s masculine discourse remains unchanged but their capabilities (gender performance) to reach an image of these discourses on masculinity is perceived to be on the decline. When this happens men are prone to resort to gender-based violence in order to achieve their group-defined masculine status.

The second pattern, aspirational deprivation masculinities, according to Conaway (2007, pp.6), “represents an increase in the idealized discourses of masculinity without a subsequent rise in the abilities of men to realize these discourses of masculinity”. Gurr (2007, pp.50) observes that the men in this group do not experience a loss of their ability to perform masculine behaviours, but they, their peers, and the media increase the standards through discourse for what it means to be masculine in a given culture or sub-culture. Hence, the men in this pattern of hegemonic masculinities are more prone to commit gender-based violence against women and gay persons because they are frustrated by being unable to reach increasing discourses of masculinity, set by themselves, peers and the media.

The third and the final pattern – an antithetical deprivation masculinities – projects a decline in gender performance of men to achieve idealized discourses of masculinity with an attendant increase in performance of men to reach idealized images of masculinity in group and sub-cultural discourses of masculinity. The men epitomised by this pattern “experience a decrease in the ability to legitimately reach masculine images promoted by the
group” (Conaway, 2007, pp.9). These men’s problem is further compounded by the fact that the group or the sub-cultural ideal of what it means to “be a man” has increased. How do they resolve this problem? According to Conaway (2007, pp.9), “To increase their gender performance, these men often commit acts of gender violence to reach ideal images of masculinity, rather than the seeking of legitimate social, political, and economic means of decreasing their idealized concepts of masculinity”. Although this study outlines only three basic patterns of masculine relative deprivation, masculine relative deprivations can take many forms.

How do the three patterns of the theory of masculine relative deprivations illuminate the determinants that serve as cultural and social drivers that impact on the HIV/AIDS spread and rates of prevalence and incidence across Sub-Saharan countries? The South African studies on gender-based violence are linked to historical, cultural-cum-social and socio-economic factors that impacted negatively upon patriarchally-held notions of masculinity and fatherhood (Carton, 2006; Denis, 2006; Caraë, 2006; Sathiparsad & Taylor, 2006; Mchunu, 2005; Morrell, 2005; Richter & Morrell, 2006).

The first generation fathers had a lot of respect for women and avoided premarital sexual intercourse and indulged in only “dry sex” and did not feel practising dry-sex reduced their masculine identity as a man. But the second and the third generation young South African men frown upon the traditional cultural practices that uphold African moral and sexual relations as being primitive, decreasing the idealized masculine images of man. Even the use of condom is sometimes considered “not cool” by today’s young men.
2.3 CULTURAL AND SOCIAL THEORETICAL PERSPECTIVE

The theory of men’s masculine identities outlined above is closely linked theoretical groundings that shape and inform African cultural and social studies – theories which unravel how hegemonic masculinities impact on the HIV/AIDS pandemic.

In his study, “Zulu Fathers and Their sons: Sexual Taboos, Respect and Their Relationships to the HIV/AIDS Pandemic”, Mchunu (2005, pp.2), drawing on Morrell’s (2001, pp.8) Changing Men in Southern Africa, observes that: “Contemporary masculinity theory states that masculinity is not inherited nor is it acquired in one-off way. It is constructed in the context of class (and/or culture), race and other factors which are interpreted through the prism of age”. The view above re-echoes those of Epstein and Johnson (1998, pp.15) that argued that boys and men are not entirely free to select images of hegemonic masculinities, which please them because they are also controlled by cultural values:

Human agents cannot stand outside culture and wild power precisely as they wish. Power is always limited and shaped by systems of knowledge which also shape subjects and objects of power....power/knowledge position us as subjects of particular kinds. They put pressure on us to adopt particular identities...in this particular sense, power and knowledge as discourse ‘constructs’ social identities.

Morrell (2001) reiterates how different men react to situations prevent them from achieving their idealized masculine images. In accordance with the theory of hegemonic masculinities outlined above some men adjust and modify the idealized masculine expectations to meet the prevailing socio-economic conditions of the time in order to survive; these men make realistic decisions that deter them from resorting to gender-based violence to prove their masculine identity as men. They do whichever job available and help their spouses and partners to live harmoniously together. Mchunu (2005, pp.2) conveys Morrell’s view as follows:
“Morrell continues by commenting that while the majority of men mostly perpetuate and reproduce dominant gender relations and forms of masculinity, there are some men who either consciously or unconsciously oppose the hegemonic perceptions of `exemplary’ masculinity”.

The Zulu researcher and African-centred scholar, Mchunu (2005), envisions an Africa whose HIV/AIDS-devastated communities are transformed by the third generation young male Africans from the rural areas and urban centres through uncompromising commitment to uphold the moral ideals and cultural values of Mother Africa instead of resorting to being transgressors “outside societal norms”. In his seminal work, Sexual Dissidence: Augustine to Wilde, Freud to Foucault, Dollimore (1991) divides the choices men make regarding hegemonic masculinities into two categories: (1) transgressive behaviour and (2) transformative behaviour. The two types of behaviour describe two forms of deviant behaviour pattern.

The transgressive behaviour involves a transgressor whose rebellion against the society takes him/her beyond the dictates of the social norms or outside societal norms. The transformative behaviour entails a transgressor rebels against the society but does not live outside the social boundary. Instead he/she transforms or forces change within the existing social norms and conditions.

Many African studies on HIV/AIDS have singled out gender-based violence as the most crucial topic to be targeted by research in order to lay bare all the hidden factors that nourish the pandemic. Hinga (2008:viii) states the need to focus describes as focus gender-based-violence related aspects of HIV/AIDS as follows: “Because women bear the brunt of the impact, we identified that a gendered analysis of the HIV/AIDS pandemic in Africa was one of the most urgent issues crying for attention....”
That gender inequality and gender-violence-related issues have become battleground upon which the fight against HIV/AIDS is being fought is re-invoked by Stephen Lewis, the UN Special Envoy for HIV/AIDS:

There has been a disease so rooted in the inequality between sexes. Gender is at the heart of the epidemic, and until governments and the world understand that, it will be very difficult to overcome it (Lewis, 2001 as cited in Mabala, 2006, pp.412).

The comment made by the UN Special Envoy for HIV/AIDS clearly endorses the collective views of the voiceless and powerless African women and child girls whose endless journey of agony through the past precolonial patriarchal African terrain now made lethal by HIV/AIDS that is further has been transformed into a living hell by gender-based violence – most power determinant that nourishes and renders the HIV‘AIDS pandemic an insurmountable global humanitarian problem, whose complex and deadly determinants are discussed in the next section. The purpose of the next section is to analyse and locate the factual dimensions of HIV/AIDS within the theoretical framework outlined above.

2.4 CONCLUSION
Several African studies on the epidemic, especially those undertaken by African female researchers identified the need to adopt gender-based theoretical approaches that borrow freely from Christian, African traditional religious, ethical and cultural values that veer away from patriarchal and masculine identities that treat women and girls as subordinate members of the society. What has emerged from studies reviewed suggest that gender-based violence against women and girls plays the greatest role in the spread of the HIV/AIDS pandemic.
CHAPTER THREE
AN OVERVIEW OF THE KEY DETERMINANTS OF HIV/AIDS EPIDEMIC IN SUB-SAHARAN AFRICA

3.1 INTRODUCTION

This chapter unravels the key determinants that fuel HIV/AIDS infections particularly among women. And in accordance with the predetermined major thrusts of the study, the focus of this chapter is aimed at reviewing the relevant literature, and analysing the epidemic’s history of the evolution, spread and massive destruction of human lives and socio-economic structures across the world. The most important thrust of this section is the impact of the endless global subordination of women to men on HIV/AIDS epidemic – the negative effects of the new forms of patriarchy which cultural studies scholars categorised as “gender and power” and “hegemonic masculinities” (Connell, 1987, pp. 1995).

The study aims to find ways to mitigate the spread of the epidemic amongst school learners and educators and create a healthy climate for education. To achieve this goals the study intends to investigate determine whether there is research evidence to substantiate the thesis the global failure halt the HIV/AIDS spread and deaths stems from the fact that all societies across the world encourage men and boys to treat women and girls as inferior beings. To probe this postulation, the study intends to focus on the following: (1) providing a general outline of the international perspective on HIV/AIDS (including Sub-Saharan African and countries) that interrogates the impact of male-female relationship on the spread and the infection rates of the HIV/AIDS epidemic; (2) reviewing the relevant literature to determine whether man-woman relationship played and continues to play the greatest role in South African
status as the country with the highest HIV/AIDS infections and HIV/AIDS related deaths.

### 3.2 EPIDEMIC IN SUB-SAHARAN AFRICA

Research suggests that historical, cultural and socio-economic factors as well as personal sexual behaviours and individual socio-economic indicators determine the pathways of the spread of HIV/AIDS across the world. Research studies (Denis & Becker, 2006; Caraël, 2006:29-40; Carton, 2006, pp.97-112; Colson, 2006, pp.113-125; Denis, 2006, pp.13-26; Familusi, 2011, pp.13; Hinga et al, 2008:viii-214; van Kilnken, 2010, pp.2-18; UNAIDS World Day Report, 2011) argue that HIV/AIDS programmes that are tailored for local cultural-based conditions and combine a variety of strategies aimed at the different forms of the HIV/AIDS infection patterns and the spread of the epidemic within each social group are likely to be more effective. Hence, this study is preoccupied with the review of literature that unravels the historical and the cultural dynamics of the epidemic within the different socio-economic contexts of Sub-Saharan South Africa, particularly within the Southern African and South African contexts. The next focus of this section is the scale of the infection and infection statistics of the HIV/AIDS of South Africa.

According to the HIV and AIDS Peer Education Manual (2008, pp.6), in March 2001 the government reported that an estimated 4.7 million South Africans (1 in 9) were infected with HIV and it is estimated that 3 quarters of all new HIV infections occurred among those aged between 15 and 25. A national survey of teenagers has established that one third of all youths between the ages of 12 and 17 have had sex (South African National HIV Survey, 2005, pp.49). The survey further reveals that the majority of children enter the education system HIV-negative. However, a growing number of school children leave school HIV
positive, and many more become HIV positive shortly after leaving school.

The 2001 estimated infection rate of 4.7 million of South Africans living with HIV/AIDS (HIV & AIDS Peer Education Manual, 2008, pp.6) cited above increased tremendously during the period 2002-2010. UNAIDS Report on the Global AIDS Epidemic (2010, pp.28) and UNAIDS World Day Report (2011, pp.7) confirm the increase in the following statistics: (1) the total number of people living with HIV/AIDS – 5.6 million; (2) adults aged 15 and more living with HIV/AIDS – 5.4 million; (3) women aged 15 and more living with HIV/AIDS – 3.2 Million; (4) children aged 0 to 14 living with HIV/AIDS – 280 000; (5) deaths due to AIDS – 350 000; (6) orphans due to AIDS aged 0 to 17 – 1.4 million and (7) adults aged 15 to 49 prevalence rate – 16.1%.


Research (Shisana & Simbayi, 2002, pp.7) suggests that in the early days of the epidemic it was assumed that if the public had the necessary information about the transmission of HIV and AIDS, people would take the necessary steps to protect themselves from infection and the epidemic would be contained. This did not happen. While HIV/AIDS education and awareness strategies deployed in South Africa did alert people, they were insufficient to promote or sustain behaviour changes. Hence, today, South Africa’s healthcare system is still far from making a difference as HIV infection rates climb higher and higher. The most catastrophic impacts of HIV/AIDS are those responsible for
decimation of national educational systems, healthcare, social and economic structures across developing countries globally.

According to Mehta and Sodhi (2004, pp. 35-53), all over the world HIV and AIDS is causing devastation, destroying communities and families, and taking away hope for the future. The impacts of HIV and AIDS are many. In the absence of a cure and in most cases in the absence of adequate treatment and mitigation of the epidemic, HIV and AIDS diminishes or destroys quality of life before taking away life itself. Its emotional and economic impact on quality of life affects family, friends and communities. It impacts production as well as household income and expenditures; it poses major challenges for health system and health care practices; it reduces the capacity of societies to provide essential services and plan for the future; and it threatens good governance and human security.

Particularly severe is the epidemic’s impacts on schools and education. Ramamurthy (2000, pp. 8-20) argues that HIV and AIDS reduces the supply of education by reducing the number of teachers, teachers’ capacity to effectively perform their professional duties, and the resources available for education. The negative impact of HIV/AIDS also reduces the demand for education. The reduction of demand for education stems from the fact that children are withdrawn from school and college in response to rising household expenditure and the need to provide care for family members.

The epidemic affects the quality of education because of the strains on the material and human resources of the system on health and class attendance by learners. Beyond this, the epidemic also undermines the quality of education, and consequently, the progression through the educational system. The quality of education suffers in the form of teacher absenteeism and attrition, less time for teaching, and disruption
of classroom. The overall outcome of these constraints also affects the kind of learning that can take place.

Teacher education also suffers as those working in universities and colleges become affected. To mitigate the impact of HIV and AIDS on the education sector, concerted action on a variety of fronts is needed. Education systems should provide leadership in working together with economic, health, agriculture, labour, and social development sectors to alleviate the social and economic impact of the disease. Moreover, national effort cannot easily be separated from the need to tackle broader issues including debt relief, poverty reduction and sustainable development (Ramamurthy, 2000:8-20; Mehta & Sodhi, 2004, pp.35-53).

Throughout the world, HIV and AIDS have a dramatic effect on the lives of individuals, families and communities. Where the prevalence of HIV/AIDS is high, there are few household untouched by the epidemic. The countless problems created by the epidemic range from family members having died, others being sick or needs care. All HIV/AIDS victims face the daily threat of stigmatisation and discrimination. Elsewhere, the rates of HIV infection may be rapidly rising, with demand for care and support stretching already-overburdened health and education systems (Nelson Mandela/HSRC Study of HIV/AIDS, 2002, pp.78).

The impact of HIV and AIDS on education systems in severely affected countries is particularly acute. Substantial numbers of teachers are ill, dying or caring for family members. Ramamurthy (2000, pp.67) describes the gravity of the situation as follows “Young people, especially girls, are being withdrawn from schools to assist in the home”. Management of the system is threatened by illness and death of qualified persons. Thus, the vicious cycle of the increasing infection rate of HIV and AIDS leading to decreasing educational services, which thereby leads to greater vulnerability, is dramatic. Ramamurthy (2000, pp.67)
further observes that: “Governments and their constituents should be aware, however, that high subsidy levels will be extremely difficult to sustain in the face of a large epidemic.” This cycle poses a long-term threat to attainment of Education for All (EFA) goals and, more broadly, to development. Education systems in many countries must undergo substantial change if they are to survive the impact of HIV and AIDS and to play an effective role in the provision of education for HIV/AIDS prevention and mitigation. In particular, teacher education and the organisation of educational institution may require re-designing so as to meet radically-changed circumstances.

Beyond the education system, HIV and AIDS epidemic is undermining the institution and human resources on which future health, security and progress depend. These includes both formal and non-formal (e.g. the family and community) systems of care and support. While education cannot, in itself, provide the answer to all of these problems, action to strengthen the education system, and to ensure that both school and out-of-school education contribute more effectively to HIV and AIDS prevention can help communities and nations respond more effectively. The provisions of more flexible forms of education is essential for reaching vulnerable children and young people, and ensuring that children do not lose out on the knowledge and skills they will need in the future (Anon., Facts about HIV and AIDS, 2005).
3.3 A HISTORICAL OVERVIEW OF HIV/AIDS EPIDEMIC IN SUB-SAHARAN AFRICA

The question posed by advocates of cultural studies is why the scale of HIV/AIDS infection and the destruction of human lives and the negative impacts of the epidemic so severe and the suffering of the victims, their families and the communities so agonising? The earliest Western researchers and scientists blamed everything on the promiscuous lifestyle of Africans and polygamous marriages that grant men the freedom to have many sex partners. But cultural study scholars and HIV/AIDS historians argue rejected the argument that African cultural and traditional attitudes sex are responsible for the large numbers of HIV/AIDS infection in Sub-Saharan African countries.

Citing the post-Soviet-Union high HIV/AIDS infection figures, the HIV/AIDS historian, Caraël (2006), argues that research (Atlani et al, 2000) has proved that the absence of political, social welfare, political and the breakdown of law and order together with the crippling massive employments created the fertile preconditions that led to huge HIV/AIDS infections after the collapse of Soviet Union. What historical, political and socio-economic factors created the ideal environment for the spread and the highest scale of HIV/AIDS infections in South Africa during the period 1984-to date?

To interrogate this question entails probing the extant literature from a variety of stances and objectives and contexts and written by different creative visions and didactic approaches: (1) HIV/AIDS historians, (2) cultural studies scholars, (3) research studies that deal with “hegemonic masculinities”, (4) those that focus on “men as partners” in the fight against HIV/AIDS and (5)
those which focus African religion as a medium for addressing the problem.

One the research studies that historicise is a study by Benedict Carton (2006, pp.97-112) entitled “Historicizing the Unspeakable: Legacies of Bad Death and Dangerous Sexuality in South Africa”. According Carton (2006, pp.97), the failure of new democratic South Africa to create jobs for the masses of unemployed black youths created by the legacy of apartheid ideology, who were already the most vulnerable “risk groups”, led to anger, frustrations, and adoption of lifestyles and sexual behaviours that compromise their ability protect themselves against HIV/AIDS infections. For Carton, however, prevailing conditions that is responsible the KwaZulu Natal Province having the highest HIV/AIDS infection rate province in South Africa could be traced the cultural history and erosion of precolonial cattle culture based on the ownership of large tracks of land and large herds of cattle – a cattle herding culture that created a healthy protective environment for young adults and children, particularly young men – highly moral-based society that tolerated no “premarital sexual intercourse” (Carton, 2006, pp.97-98). But colonialism and its attendant seizure of land from Zulu kings, the absence of cattle to pay *lobola*, and the need to pay European colonists’ impositions of heavier taxes, the youths were forced to work for wages and no longer controlled by the strict moral rules of cattle-owing culture.

A poem by Benedict (Bambatha) Wallet Vilakazi (1935, pp.61) entitled *Ikondlo kaZulu*, which depicts the decimation of cattle in Zululand by "rinderpest" cattle disease in 1897. The graphic, evocative and symbolic stylistic patterning of this seminal poem foreshadows the contemporary depiction of HIV/AIDS epidemic and the role played by young adults who were alienated from the African traditional cultural and moral moorings. Just like the in
In 1897, the violent bovine virus had left the “Velt strewn in carcasses and the cattle kraals emptied of every ox, cow or calf their owner possessed” (Minute Paper, 1897; Petersen, 2000, pp.95-99), South African youths’ reckless lifestyles induced by poverty, unemployment and the need to survive the hardships of the 20th century and the uncontrollable desire to mimic the wealthy led to “dying in their prime”, which the study by Phillips (2001, pp.11) – “AIDS in the Context of South Africa’s Epidemic History: Preliminary Historical Thoughts” – blames on “the lust of youths”.

Carton (2006, pp.98) observes that: “The similarities between AIDS and rinderpest extend beyond linguistics”. The “Testimony of Mabaso and Kumalo” cited in (Webb & Wright, 1976, pp. 236-237) describes the unfolding calamity of epochal outbreak of epidemics among cattle that re-invokes the destructive characteristics of HIV/AIDS: “When the abasha (‘new or modern ones’) searched for better prospects, they exercised greater sexual autonomy, which apparently led to a rise in premarital ‘seduction (making pregnant)’. At the centre of this era’s ‘loose morality’ tales of izinkhanmuka, so-called wayward children, but particularly young women, some of whom became prostitutes infected with isimpantsolo, gonorrhoea”.

Forbidden sex, a source of hazardous bodily pollution, now coincided with strong umnyama conveyed by a killer disease, rinderpest, which colonists allegedly battled but appeared to abet.

Other studies that focus on the similarities between animal epidemics during the colonial period and the colonialist responses to eradicate the epidemics contend that there is a correlation between the contemporary responses of wealthy European countries to the sufferings caused by HIV/AIDS across Sub-Saharan African countries and the colonialists’ attitudes to rinderpest epidemic that destroyed cattle in Eastern and Southern Africa.

Carton (2006, pp. 100) contends that the following studies – "AIDS in the Context of South Africa’s Epidemic History by Phillips (2002, pp.11-12); "Sexual Socialization in South Africa: A Historical Perspective" by Delius and Glaser (2002, pp.27-54); “Sexually Transmitted Diseases in Nineteenth- and Twentieth-Century South Africa” by Jochelson (1999, pp.217-243); “Epidemics and Revolutions: The Rinderpest Epidemic in Late Nineteenth-Century Southern Africa” by Phoofolo (1993) – demonstrate that “humanity’s deadliest cataclysm” can be used to deconstruct the complex politicking involving HIV/AIDS if HIV/AIDS research are placed within the ‘mainstream narratives of the country’s history”. Hence, Carton (2006, pp.99) concludes that “AIDS could be better comprehended ... if `set comparatively against’ previous `epidemic experiences’” (Phillips, 2002; Delius & Glaser, 2002; Jochelson, 1999; Phoofolo, 1993).

The historical, the cultural and the socio-economic conditions of the Eastern Cape Province were not different at the outbreak of HIV/AIDS in 1983 from those of KwaZulu-Natal already discussed. Carton’s (2006) meta-analysis of Vilakazi’s
(1935/1973) Zulu poem “Ezinkompini (Dangerous Symbiosis)” referred to earlier naturally links Vilakazi’s epic poem on Nongqawuse and the Xhosa Cattle-Killing (1891-1937) entitled “Inkelenkele yakwaXhosa”. This poem generated a multiplicity of narratives from different ethnic groups of the within the new “Rainbow Nation”. Vilakazi (1935/1973, pp.9) observed that “treacherous” girlhood shaped this Xhosa tragedy. In his The Dead Will Rise: Nongqawuse and the Great Xhosa Cattle-Killing Movement of 1856-57, Jeff Peires (1987) argues that colonial intrusions and Xhosa fears of pollution and dissipation, i.e. improprieties such as adultery led to the cattle killing. The prevailing historical and the socio-economic factors of poverty, military defeat and epidemic disease that prepared the way for the Cattle-Killing were illuminated further by Pieres (1987, pp.381): “The Xhosa Cattle Killing movement suggested in the first instance by the lung-sickness epidemic of 1853 tapped a deep-seated emotional and spiritual malaise resulting from material deprivation and military defeat”. Carton’s (2006:99) analysis of Vilakazi’s (1935/1973, pp.124-128) “Ezinkompini (Dangerous Symbiosis)” does not only vilify the colonialists’ evil manipulation of the rinderpest epidemic as epitomised by the responses of “Testimony of Mabaso and Kumalo” but also suggests that the colonialists’ ideological handling of the rinderpest epidemic foreshadowed the contemporary European power games involving the HIV/AIDS prevention and treatment programmes across Sub-Saharan African countries.

In her University of Cambridge doctoral thesis entitled History in the Literary Imagination: The Telling of Nongqawuse and the Xhosa Cattle-Killing in South African Literature and Culture (1891-1937), Sheila Boniface Davies (2010, pp.1-257) listed sixty-three literary accounts or narratives generated by the cattle-killing. Lewis Nkosis’ critical commentaries of two novels based on the Xhosa Cattle-Killing illuminates the didactic and the
ideological stance of the study’s focus on the cultural history that framed African responses to epidemics.


The historical factors outlined above unravel historical and the cultural dynamics that account for the phenomenal high HIV/AIDS infection rates experienced by KwaZulu-Natal – the microcosm of the high rate of HIV/AIDS infection across Sub-Saharan African countries – is further re-affirmed by studies conducted by the cultural studies researchers.

The study area is the Province of the Eastern Cape. That historical, cultural and the socio-economic conditions of the province are similar to those of KwaZulu-Natal does not suggest that the Eastern Cape and its Xhosa-speaking populations do not have environmental and social features that are unique to the province. As Louis Pasteur rightly pointed out “The microbe is nothing, the terrain everything”. But first, the socio-economic indicators and the provincial and district estimates of HIV/AIDS prevalence for the province need to be stated.

The Eastern Cape, the second largest of South African nine provinces, which occupies 13.9% of the country’s land area and
whose 2001 population is 6.6 million (Statistics SA, 2009). The majority of the population (two-thirds) live in the rural areas. In 2009, Statistics South Africa (2009) estimated that over one-third of population was were children under the age of 15 years. This might be due to migration of their parents to the industrialized urban areas for work. The province is not only one of the poorest provinces but also lags behind development and is has one of the highest unemployment rates in the country – 27% in 2009 (StatsSA, 2010), particularly in the former Transkei Homeland.

According to a study by Phaswana-Mafuya, et al (2010, pp.19) entitled *Social Determinants in the Eastern Cape*, "KwaZulu Natal continues to have the highest HIV prevalence (38.7%), followed by Mpumalanga (35.6%), Free State (32.9%), North West (31.0%), Gauteng (29.9%), Eastern Cape (27.6%) and Limpopo (20.4%)". Two provinces that had experienced the lowest prevalence were Northern Cape (16.2%) and Western Cape (16.1%).

The HIV/AIDS prevalence estimates for the Eastern Cape by districts reveal the prevention and treatment performance of Amatole District, the area of focus for the study.

**Table 1: HIV/AIDS Prevalence in Eastern Cape from 2006 to 2008 in Districts.**

<table>
<thead>
<tr>
<th>HIV/AIDS PREVALENCE ESTIMATES FOR DISTRICTS OF EASTERN CAPE PROVINCE</th>
<th>2006</th>
<th>2008</th>
<th>Decrease/Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cacadu</td>
<td>22.8%</td>
<td>27%</td>
<td>4.2% Increase</td>
</tr>
<tr>
<td>Alfred Nzo</td>
<td>25.1%</td>
<td>29.8%</td>
<td>4.7% Increase</td>
</tr>
<tr>
<td>Chris Hani</td>
<td>27.1%</td>
<td>29%</td>
<td>1.9% Increase</td>
</tr>
<tr>
<td>Ukhlahlamba</td>
<td>27.9%</td>
<td>21.9%</td>
<td>6.4% Decrease</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS Prevalence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Amatole</td>
<td>28.7%</td>
<td>26.5%</td>
<td>2.2% Decrease</td>
</tr>
<tr>
<td>OR Tambo</td>
<td>29.7%</td>
<td>29.6%</td>
<td>0.1% Increase</td>
</tr>
<tr>
<td>Nelson Metropole</td>
<td>31.9%</td>
<td>29%</td>
<td>2.9% Increase</td>
</tr>
</tbody>
</table>

The HIV/AIDS prevalence estimates during three-year period (2006 - 2008), according to Phaswana-Mafuya et al (2010, pp.19), suggested in the exception of Ukhlahlamba (6.4% decrease) and Amatole (2.2% decrease), the province experienced a general increase in HIV/AIDS prevalence.

### 3.4 The Key Drivers of HIV/AIDS Infections in the Eastern Cape

The question to consider is now is: What determinants (environmental and socio-economic factors) fuelled the spread and the destruction of the HIV/AIDS epidemic within the Eastern Cape – a province whose five districts were located within the former homelands of the Transkei and the Ciskei? Research suggests that many different determinants influence the HIV/AIDS prevalence and incidence in the Eastern Cape Province, which includes former Transkei region. The determinants isolated for analysis (1) sexual debut, (2) multiple sexual partners, (3) condom use, (4) awareness of HIV status, (5) teenage pregnancy, (6) intergenerational sex, (7) gender-based violence, (8) labour-related migration, (9) transactional liaisons, (10) poverty, (11) stigma and denial and (12) culture and social norms.

#### 3.4.1 Sexual Debut

Research studies (Phaswana-Mafuya et al, 2010; Geary et al, 2008; Donenberg et al, 2008) observe that sexual debut is undoubtedly a crucial factor in vulnerability of young adults to HIV infection. The SABSSM study by Phaswana-Mafuya, et al (2010, pp.29) stated that
generally a small proportion of young people had started having sex before the age of 15 years and this has been the case over the last three [2002, 2005 and 2008] surveys in the Eastern Cape (7.7%, 6.7% and 7.8% …). This is one of the lowest prevalence of early sexual debut in the country and may be linked to the predominantly rural nature of the province”.

Studies suggest that early sexual debut is linked to the fact that the young adults are less likely to use contraceptives (Geary et al, 2008) and unplanned pregnancies among teenagers (Baumgarther et al, 2009). It is observed that sexual abuse is also another determinant that impacts on early sexual debut and research suggests that young girls plagued by sexual abuse are more likely to adopt riskier sexual behaviours than their peers. Geary et al (2008) argue that due to the dangerous potential state of vulnerability created by sexual abuse, it is critical to protect children from sexual abuse and encourage young adults to delay sexual debut for as long as possible. Phaswana-Mafuya et al (2010, pp.30) argue that early sexual debut campaign and programme must now “target young boys to delay their age of sexual debut. In particular, moulding of masculine identities in ways which discourage early sexual experience....”

3.4.2 Multiple Sexual Partnerships
The next HIV/Aids determinant to be reviewed is multiple sexual partnerships. There is a general consensus among HIV/AIDS researchers worldwide that having multiple sexual partners increases chances of getting infected with HIV virus through sexual networks that facilitate HIV transmission. The studies that focused on the Eastern Cape confirmed the above thesis. The SABSSM study by Phaswana-Mafuwa et al (2010, pp.41) re-affirms the above findings: “[T]he Eastern Cape respondents reported increased rates of multiple sexual partners (13.1% in 2008 vs. 8.1 in 2005…), although the increase is not statically significant….The densely clustered
sexual networks that result from partner overlap pose a high risk for HIV transmission”. In a study that targeted academic and support staff in eight tertiary institutions from the Eastern Cape, Phsawana-Mafuwa and Peltzer (2006) discovered that more men (significantly high) had more than one sex partner in the past 12 months.

The higher risks posed by multiple sexual partnerships are also investigated by other HIV/AIDS researchers. In their study, which was a cluster randomized controlled trial of an HIV behavioural intervention involving women in 70 Eastern Cape villages, Jewkes et al (2006) found that HIV prevalence and incidence was associated with multiple sexual partnerships involving three or more past year partners. Malamba et al (1994), Waver et al (1994) and McFarland et al (1991) observe that owing to the poor levels of knowledge about the risk posed by this factor it is crucial to address this issue in future HIV prevention campaigns across South Africa to ensure that the message on multiple partners targets all age groups and most-at-risk populations. The studies referred to above conclude that having unprotected sex with more than one partner significantly increases the chances of HIV transmission. The findings of the studies by Malamba et al (1994), Waver et al (1994) and McFarland et al (1991) are new qualitative findings of the 2008 HSRC unpublished study entitled “Social Cultural Values and Norms Relating to HIV Risk Perception and Behaviour: National Qualitative Study”.

Behavioural survey research studies, however, suggest that men in African countries are no more likely to have multiple sexual partners than men in many other parts of the world. Studies by Wellings et al (2006) and Caraël (1995) have demonstrated that Africans in general tend to have fewer sexual partners during their lifetime than people in for instance Europe or US. While Caraël (1995) pointed out that men in Thailand and Brazil, for example, were more likely to report five or more partners in the previous year than were men in Kenya,
Lesotho, Tanzania or Zambia, Halperin and Epstein (2004) revealed that the research has shown that men and women in Africa are reporting the same number or fewer multiple sex partners than in the industrialised countries.

A 2006 SADC Report entitled “A SADC Expert Think Tank on HIV Prevention in High-Prevalence Countries in Southern Africa” confirmed the findings that suggest that sexual multiple partnerships do have a negative impact of HIV transmission. The study reports that sexual networking patterns, especially concurrent sexual partnerships constitute the key determinant in fuelling the HIV epidemic throughout the Southern African region including South Africa. The report has identified three levels of drivers: social and structural drivers, contributing drivers and key drives. The social and structural drivers are described as “High population mobility, inequalities of wealth, cultural factors and gender inequalities”. The contributing drivers, on the other hand are defined as “Male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness and untreated viral STIs. Lack of consistent condom usage in long term multiple concurrent partnerships”. And finally, the key drivers are identified as “Multiple and concurrent partnerships by men and women with low consistent condom use, and in the context of low levels of male circumcision” (SADC, 2006:3). Research studies (Cadwell et al, 1994; Cambell, 1997; Meekers, 2001; Gubrium, 2000) have argued that sexual multiple partnership are said to be supported by the patriarchal system that manifests itself through the macho image nurtured among men and projected to perceive themselves as superior to women. This self-consciously inflated manly ego, therefore, allows men to have multiple sexual partners with the attendant number of sexual conquests being generally equated with the concept of masculinity (Connell, 1995).
3.4.3 Condom Use
What does research on condom usage in the Eastern Cape say about attitude condom use? Research suggests that there were indications of improvements in frequency of condom use among young (15-24 years) young male and female adults who have previously reported low rates of condom use in the Eastern Cape. Phaswana-Mafuya et al (2010, pp.33) have explained the condom usage increase: “One possible explanation of the findings is that not only might there have a shift in the levels of condom negotiating skills, but there is also an increased openness in the community to discuss sex and condom use among youth”.

3.4.4 Awareness of HIV status
The fight against the HIV/AIDS epidemic appears to meet a brick wall when the issue of Voluntary Counselling and Testing (VCT) is assessed. It is asserted that VCT is an important entry strategy for both prevention and access to treatment, care and support services. Research suggests that there is a general pervasive, psychologically rooted fear of undergoing testing to establish one’s HIV status, which might be linked to the saying *that what you do not know might not kill you*. In his qualitative study, “Barriers and Enablers to Acceptance of Voluntary Counselling and Testing (VCT) Services to Youth Males in the Eastern Cape”, which targeted male young rugby players and development programme graduate students in Uittenhage (Eastern Cape), aged 18 to 25 years, William (2007) found that the participants displayed a pervasive, psychologically rooted fear and possible low perception of risk involved in not submitting voluntarily to testing for HIV. This practice is deemed to constitute one the major barriers to HIV/AIDS prevention. According to William (2007), negative perceptions regarding poor service delivery in the public health sector and peer pressure were regarded as contributing to the low levels of HIV test acceptance among these young males.
3.4.5 Teenage Pregnancy
The question whether a pregnant woman is more vulnerable to HIV infection than a woman who is not pregnant has been investigated in Rwanda, Uganda and Zimbabwe. The findings by Leroy et al (1994), Gray et al (2005) and Abizvo et al (2001) that might be an association between pregnancy and HIV risk have been proved to false by a study conducted in Uganda and Zimbabwe by Morrison et al (2007). The results of the 2010 HSRC survey conducted by Phaswana-Mafuya et al (2010), which indicated that from 248 female teenagers for the overall Eastern Cape, 17.9% reported pregnant. According to Phaswana-Mafuya et al (2010, pp.37), “Teenage pregnancy was highest among the Black African population (19.8%) and Coloured teenagers (6.2%). Regarding geolocality, female teenagers from rural areas (21.7%) had much higher rates of teenage pregnancy than those from urban formal (11.9%) and urban informal (8.4%) areas....”

3.4.6 Intergenerational Sex
Another determinant that fuels the epidemic is intergenerational sex. In a study by Jewkes et al (2006) – a cluster randomized controlled trial of an HIV behavioural intervention involving 1295 sexually active female volunteers aged 15-26, from 70 villages in the Eastern Cape – HIV infection was associated with having a partner three or more years older. Research studies (Shisana et al, 2005; Luke, 2005; Kelly et al, 2003; Gregson et al, 2002; Glynn et al, 2001) have suggested a young woman’s chances of getting infected tend to increase with the age gap between her and her partners. Gouws and Staneki (2008) have reported that epidemiological evidence in Southern Africa shows clearly that older men are more likely to be HIV-infected. This, according to Shisana et al (2009), is especially true for women who are less than 20 years old and whose partners are more than 5 years older. These types of sexual relationships put young women at more risk because the dependencies built into such relationships can severely reduce women’s abilities to protect
themselves from HIV infection (Gregson et al, 2002; Preston-Whyte et al, 2000). There is evidence to support the thesis that fundamentally, transactional sex and age-mixing need to be understood within the broader context of men’s superior economic position and access to resources and general women’s subordination within the society (Jwkes & Wood, 2002). Dunkle et al (2007) further re-affirm this view by arguing that conceptions of masculinity that place high premium on sexual conquest and control of women across the world intensify these sexual practices.

Phaswana-Mafuya et al (2010) reiterate that intergenerational sex is a common practice in South Africa. According to Shisana et al (2005a), what differentiate the HIV risk between young females and young males is the age group with which each has sex. Young females tend to have sex with older male partners. The 2005 national HIV household survey revealed that a high HIV prevalence of 29.5% among females aged 15-19 years, who had male partners who were at least 5 years older than themselves (Shisana et al, 2005a). A study by Pettifor et al (2004) reported that the inter-generational age-disparate sexual relationships are very often based on the economic dependence on older men by the young females. Leclerc-Madlala (2008) observes that a growing number of studies have suggested even relatively well-off young women tend to seek older male partners for “top-up” income or for social and emotional reasons. It is, however, intimated that the stereotyped typical wealthy “sugar daddies” are not the only players in this “sexual game” and that even poor men turn out to be bigger role-players than often recognised (SADC, 2006).
3.4.7 Gender-Based Violence

The risky stances adopted young women in HIV/AIDS infected environment are identified by many studies. Firstly, the studies by Hunter (2007), Leclerc-Madlala (2008) and Steinberg (2008) reported how young women repeatedly challenge being classified as the powerless victim and exercise their individual right to freedom of action by pursuing sexual liaisons that involve various forms of material and emotional reward. Phaswana-Mafuy et al (2010, pp.37) observe: “That agency, however, can be highly circumscribed and risky, especially, when exercised in the context of severe HIV epidemics, and of aggressive constructions of masculinity that valorise sexual risky-taking and the `conquest’ of women”.

Gender-based violence, one of the drivers HIC/AIDS infection, Garcia-Moreno et al (2005) argues, is common throughout the world and is widespread in South Africa. In their study conducted in Lesotho Brown et al (2006) reported that several studies on HIV/AIDS in Lesotho have confirmed an existence of widespread incidence of gender-based violence and its association HIV/AIDS infection. Dunkle et al (2006) and Jewkes et al (2006) have also reported that many studies undertaken in South Africa reported a high prevalence of gender-based violence and its negative impact on HIV/AIDS infection. Research studies have revealed that intimate partner violence (IPV) The HIV-risk indicators associated with gender-based violence outlined above suggest that all prevention interventions must specifically target the links between the perpetration of intimate partner violence and HIV risk behaviour among men as well as the underlying gender and power dynamics that contribute to both (Gupta et al, 2008). Anderson, Cockroft and Shea (2008) have pointed out that addressing the prevention interventions aimed at gender-related violence and HIV/AIDS infection will be a massive undertaking that includes perpetrators and victims – a situation compounded by the fact that perhaps one
third of one-third of the Southern African population is involved in gender-based violence-HIV dynamic.

Research has overwhelming proved that sexually risky behaviours and HIV infection are closely linked. According research studies conducted in South Africa and Tanzania, women subjected to intimate partner violence are three times more likely to acquire HIV than women who have not experienced gender-based violence (amfAR, 2005; Dunkle et al, 2004; Maman et al, 2002). Dunkle et al (2004) and Jewkes et al (2006) observe conclude that the perpetrators are more likely to engage in transactional sex – view that reiterates the argument that both sexual violence and transactional sex involve attempts to exercise control over women.

The HIV-risk indicators associated with gender-based violence outlined above suggest that all prevention interventions must specifically target the links between the perpetration of intimate partner violence and HIV risk behaviour among men as well as the underlying gender and power dynamics that contribute to both (Gupta et al, 2008). Anderson, Cockroft and Shea (2008) have pointed out that addressing prevention interventions aimed at gender-related violence and HIV/AIDS infection will be a massive undertaking that includes perpetrators and victims – a situation compounded by the fact that perhaps one-third of the Southern African population is involved in gender-based violence-HIV dynamic.

The gender-based violence statistics and its impact on the rates HIV/AIDS infections in South Africa indicate the scale of this determinant in HIV prevalence and how to mitigate the spread of the epidemic. It is common knowledge that South Africa has one of the highest rates of violence against women in the world. In 2000 over 53 000 rapes were reported to the police – a figure that translated into a rape reporting rate of 123 women per 100 000 population (Jwekes and Abrahams, 2002). This figure excludes those who were raped but the incident was not reported to the police. Phaswana-
Mafuya et al (2010:39) observe that research has linked sexual violence with a culture of violence involving negative attitudes (e.g., deliberative intention to spread HIV) and reduce capacity to make positive decisions or to respond appropriately to HIV prevention campaigns”. But more importantly, research studies have linked sexual assaults to risks for HIV infection (Ajuwon et al, 2002; CADRE/DoE, 2003; Dunkle, et all, 2004b; Jewkes et al, 2006; Hink & Thomas, 1999; Wojcicki & Malala, 2001; Wood & Jewkes, 2002).

Two recent studies by Kalichman et al (2007) and Simbayi et al (2006) that focused on men in a township community and in an STI clinic showed that men with a history of sexual violence were also at significantly higher risk for HIV transmission than their non-sexually violent counterparts. It is argued that since men are HIV high risk groups and tend to rape women it is very likely that they transmit HIV to their victims. In South Africa, research suggests that the gender system fosters power imbalances that facilitate women’s risks to sexual assault and sexually transmitted infections (Farmer et al, 1996; Jewkes et al, 2001).

Several research studies have shown that women with the least power in their relationships are at the highest risk for both sexual assault and HIV infection. The vulnerability of these women to both sexual assault and HIV infection stem from their inability to control the actions of their sex partners (Ajuwon et al, 2001; Jewkes & Abrahams, 2002; Kalichman & Simbayi 2004b; Wojcicki & Malala, 2001). A study by Boonzaier (2005) reports that men, who have limited resources and lack of opportunity for social advancement, often resort to exerting power and control over women. It is contended that sexist beliefs and negative attitudes toward women are held by men who have not been sexually violent as well as men who have a history of sexual violence (Simbayi, et al, 2006). Negative attitudes toward women are so pervasive. Hence, it is not
surprising that there is evidence to the thesis that they are often held by women as well (Kalichman et al, 2005).

Their HSRC study Phaswana-Mafuya et al (2010, pp.40) observe:

Power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms. Unfortunately, men’s attitudes toward women impede HIV preventive actions and can culminate in the acceptance of violence against women.

Qualitative studies in South Africa have consistently shown men believe they are more superior and powerful than women and that men are expected to control women in their relationships (Jwkes et al 2001; Morrel, 2002). Smbayi et al (2006) reported that men often adopted attitudes that sanction violence against women including beliefs that women should be held responsible for being raped. Phaswana-Mafuya (2010) concluded that “The widespread and normative acceptance of sexual violence and male sexual irresponsibility plays a significant role in perpetuating high-risk behaviours and continued high rates of HIV”. According to the statistical data provided the study by Phaswana-Mafuya (2010, pp.40) – “Table 15: History of having been physically forced to have sex by province 2008” – rape rates range from the highest 51-4% (Limpopo) to the lowest 29.9% (Northern Cape). The Eastern Cape had the third highest rape rate of 47.6% after Limpopo (51.4%) and Mpumalanga (48.2%).

In a study conducted by Dunkle et al (2006) targeted 1275 sexually experienced men aged 15-26 years from 70 villages in the rural Eastern Cape. The study was a cluster randomised controlled trial of an HIV behavioural intervention. The study revealed that men who reported both physical and sexual violence against a partner, perpetration both before and within the past 12 months or more than one episode of perpetration reported significantly higher levels of
HIV risk behaviour than men who reported less severe or less frequent perpetration of violence.

A study conducted by Jewkes et al (2006) targeted 1295 sexually active female volunteers aged 15-26 from 70 villages in the Eastern Cape, who participated in a cluster randomised trial of an HIV behavioural intervention. It was found that IPV was associated with HIV in two-way analyses. This study suggested that the experience of IPV was strongly associated with past year partners, time of last sex, and partner’s education; it was also marginally associated with partner age difference. Also indicated was the evidence that adverse experiences in childhood, including sexual abuse, increased the likelihood of having more past year partners. Intimate partner violence was strongly associated with most of the identified HIV risk factors. Jewkes et al (2006) concluded that the above findings provide further evidence of links between IPV and HIV among women and the need for joint prevention campaigns.

A study by Phaswana-Mafuya et al (2009), which investigated intimate partner violence (IPV) and HIV risk among antenatal care attendees at primary health care facilities (35 antenatal clinics) in the Eastern Cape, focused on 984 pregnant women (of mean age of 26.1 years) selected through a convenient sampling procedure. The logistic regression analysis showed high rates of intimate partner violence and HIV risk:

- 14% of the women had experienced physical partner violence in the past 12 months.
- 14% reported a history of having an STI in the past 12 months.
- 70.1% reported knowing that their primary partners placed them at risk for HIV transmission.
- 78.6 were worried that they might already have or in the future get HIV, the virus that causes AIDS.
According to Phaswana-Mafuya et al (2010, pp.41), the Eastern Cape is rated sixth for reports of males who were raped and second for female victims who were raped and third overall. It is suggested that the low male figure for rape could be attributed to the fact that men tend to under-report forced sex owing to social acceptability bias in responses. The results of this study suggest that gender violence could be a key determinant of HIV transmission in the Eastern Cape.

3.4.8 Labour-Related Migration

Having multiple partners and its association with higher HIV risks and infection rates already outlined are closely linked to labour-related migration as one of the important determinants in HIV infection. Research studies (Coffee et al, 2005; Mwaluko et al, 2003; Nyanzi et al, 2004) have confirmed that being away from home tends to be associated with sexual concurrent partner relationships and an increase in risk behaviours. Research reports that employment-related migration links people to wider social and sexual networks, which increase their risk of HIV exposure. Shisana et al (2005) reported that potentially protective factors such as normative regulations and social surveillance usually are less important in areas of intense economic activity and circular migration. That in South Africa’s burgeoning urban “informal settlements”, for example, HIV rates are reported to be twice the national average appears to substantiate the above postulation.

HIV historians have rightly argued that the HIV/AIDS epidemics in southern Africa are rooted in the late 19th century and in the violent imposition of labour markets that turned tens of millions men into powerless impoverished proletarians within systems of circular migration. The ensuing outcomes dismantled family units, and normative regulation helped create an ideal social and ideological terrain that strongly favoured the spread of socially transmitted
infections (Hargrove, 2008; Walker, Reid & Cornell, 2004; Kark, 1999).

The HSRC study conducted by Phaswana-Mafuya et al (2010) has reviewed recent studies from South Africa, which focus on sexuality in the late apartheid and early post-apartheid periods. These studies have expanded on sexuality in the late apartheid and early post-apartheid periods and identified three interlinked dynamics critical to understanding the scale of HIV epidemic in South Africa and by implication other southern African countries with similar economic and social developments. Phaswana-Mafuya (2010, pp.42) have described the three dynamics as follow: “(1) rising unemployment and social inequalities that have some groups, especially poor women, extremely vulnerable; (2) greatly reduced marital rates and subsequent increase of one person households; (3) rising levels of women’s migration, especially through circular movements between rural areas and informal settlements/urban areas (Hunter, 2007)”

Several studies documented the increasing numbers of migration that involved female entrants into the labour market. Commenting on this phenomenon, Crush (2001) reported that in South Africa migration has intensified and increasingly involves young women. Casale (2004) re-affirms the view expressed above when he observes that female entrants into the labour market rose by two millions during the period 1995-1999. During the same period and simultaneously median wages for women fell sharply against a backdrop of collapsing agrarian and wage livelihoods generally – a situation that led to a new pattern of household formation, marriage, sexual networking patterns (Hunter, 2007) and HIV risks. A KwaZulu-Natal study by Coffee et al (2007) revealed choking levels of HIV infections among migrating young women. The study found that 23% of sexually active young girls aged 17-18 years were infected and 65% of women aged 22-24 years were also infected with HIV/AIDS.
Many studies have suggested that role played by labour-related migration in fuelling the spread of HIV/AIDS in South Africa has been widely accepted (Jochelson et al, 1991; Okee-Obeng, 2001). According to Lurie (2000) and Lurie et al (1997), owing to the fact that migrant workers are more likely than non-migrants to have additional partners migration has been identified as a risk factor for HIV infection. This is particularly so within the context of circular migration between the mines and migrant workers’ places of residence has promoted the spread of HIV infection in rural areas (Lurie et al, 2003a, 2003b; Schoofs, 1999a, 1999b; Zuma et al, 2003, 2005). Shisana et al (2005) have reported that migration of educators has also been identified to be a major risk factor for HIV infection. How does this determinant impact Eastern Cape HIV/AIDS prevalence and incidence? Research suggests that owing to lack of job opportunities in the absence of industries and the resultant high unemployment, the Eastern Cape continues to be a feeder area for rural-urban migration and this is therefore likely to be another factor contributing to the HIV epidemic in the province.

3.4.9 Transactional Liaisons

Closely interlinked with labour-related migration determinant as a factor fuelling the HIV infection in South Africa is transactional liaisons. According to Hallman (2004), exchanging sex for favours, goods or services, which is often termed “transactional sex”, is not sexual practice unique to southern Africa. This sexual phenomenon appears to be relatively common in many of the countries UNAIDS classified as hyper-endemic (Chatterj et al, 2005; Gregson et al, 2002; Luke & Kurtz, 2002; Population Reference Bureau, 2001; Machel, 2001; Meekers & Claveés, 1997).

Research cautions that transactional sex must not be confused with prostitution. According to Hunter (2007), transactional sexual practices are not strictly commercial. Transactional liaisons can involve complex reciprocal arrangements and varied forms of
emotional attachment, and are often used to promote kinship ties. The study by Phaswana-Mafuya et al (2010, pp.43) observe: “The evidence [produced by extant literature] does not consistently bear out the stereotype of ‘powerless’ women exploited by ‘venal’ men”.

Hunter (2007), however, reports that the transactional sex networking does involve the financing of a mix subsistence needs and consumptive desires. Hence, the transactional sex functions as a vital mechanism for redistributing formal and informal earnings from men to women. The transactional sex networking is not only fed by gender inequalities, but also draws our attention to the fact that sexuality, survival and consumption have become closely intertwined in southern Africa (Delius & Walker, 2002) after more than a century of systemic, violent and highly unequal massification of impoverished Black workers into the labour market.

3.4.10 Poverty
How poverty impacted on the HIV/AIDS epidemic in South Africa and in the Eastern Cape Province is the next focus of the analysis. Although poverty is sometimes postulated to be a key factor in the spread of HIV, data from eight country-wide surveys in Sub-Saharan Africa conducted by Mishra et al (2007) did not prove the thesis that poverty increases HIV risk. This study suggests that the impact varies in different countries. Poverty enhances the HIV spread in South Africa. But this not true in Tanzania where opposite is true whilst in Kenya it is in between. Research studies carried out in three South African townships, for example, revealed that HIV risk was embedded in various ‘social ills’ that included poor education, unemployment, discrimination, crime and violence (Kalichman et al, 2006). On the question of the link between poverty and HIV spread, Phaswana-Mafuya et al (2010, pp.43) argue:

Overall, though, the available evidence currently does not support the contention that a consistent relationship exists between poverty and HIV risk. Global evidence suggests that the relationship between poverty and HIV risk is complex, and that
poverty on its own cannot be viewed simplistically as a driver of the HIV epidemic.

Research suggests that the social and cultural norms governing sexual liaisons are moulded by experiences of colonialism and the legacy of apartheid in the hyper-endemic countries that, to varying degrees, have been interlinked economically for several generations. Migrant workers from Botswana, Lesotho, Mozambique and Swaziland in particular were incorporated into the circular migratory patterns established in their internal labour markets as well as in those of neighbours (notably South Africa, Zambia and Zimbabwe).

The complex impact of poverty on HIV epidemic has been discussed by several studies. Research argues that poverty works through countless interrelations, including unequal economic distributions (Gie et al, 1999), economic inequalities between men and women, which promotes transactional sex (Halperin & Allen, 2001), relatively poor public health education and inadequate public health systems (Mitton, 2000). Kalichman et al (2006) conclude that poverty-related stressors derived distilled from descriptions of poverty in townships such as housing, transportation, sanitation, insufficient food, HIV/AIDS, unemployment, discrimination, poor education, violence, and crime have also been shown to be associated with HIV risks.

The literature analysed above suggests that, as the Eastern Cape is one of the poorest provinces, it is more likely to experience a considerable burden of poverty-related HIV exacerbating factors

3.4.11 Stigma and Denial
How do stigma and denial influence the HIV/AIDS spread across South Africa and the Eastern Cape? Phaswana-Mafuya et al (2010, pp.44) observe that “HIV infection and AIDS” as “the most stigmatised medical conditions”. According to UNAIDS (2006), stigmas interfere with HIV prevention, diagnosis, and treatment and can become internalized by people living with HIV and AIDS. It is
argued that although stigma is still prevalent, at a national level, AIDS stigma appears to be declining in South Africa. The findings of the 2005 national HIV household survey (Shisana, et al, 2005a) confirm the decline if HIV/AIDS stigma. The responses to questions aimed at measuring general attitudes to HIV and AIDS in the Eastern Cape were similar to the national average and the majority of respondents (74%) professed positive attitudes to those affected by HIV. The responses were based upon two sets of questionnaires are:

**Table 3.4.11.1:** Questionnaire (2008) questions on attitudes of respondents aged 15 years and older to people infected with HIV and AIDS: Affirmative responses (adapted from table 16, Phaswana-Mafuya et al, 2010, pp.45)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you know that a food seller had HIV, I would still buy food from him or her.</td>
<td>True</td>
</tr>
<tr>
<td>2. I would be willing to care for a family member with AIDS.</td>
<td>True</td>
</tr>
<tr>
<td>3. If a teacher has HIV but is not sick, he or she should be allowed to continue teaching.</td>
<td>True</td>
</tr>
<tr>
<td>4. It is not a waste of money to train or give a promotion to someone with HIV/AIDS.</td>
<td>True</td>
</tr>
<tr>
<td>5. I would not want to keep secret the HIV positive status of a family member.</td>
<td>True</td>
</tr>
<tr>
<td>6. It is not foolish to marry a person who is living with HIV/AIDS.</td>
<td>True</td>
</tr>
<tr>
<td>7. It is not acceptable for a man to have more than one girlfriend at the same time.</td>
<td>True</td>
</tr>
</tbody>
</table>

**Table 3.4.11.2:** Questionnaire (2008) questions on myths & misconceptions for respondents aged 15 years and older about HIV and AIDS (adapted from table 17, Phaswana-Mafuya et al, 2010, pp.46).
### AGREE

1. HIV causes AIDS.

2. To prevent HIV infection, a condom must be used every time you have sex.

3. One can reduce the risk if HIV by having fewer sexual partners.

4. If a person has two or more sexual partners at the same time they are more likely to get HIV.

5. It is against the law for a girl younger than 16 to have sex with much older man even if she agrees.

### DISAGREE

1. Christian healers can cure AIDS.

2. HIV/AIDS is God’s punishment on sinners.

3. AIDS is cured by having sex with a virgin.

4. There is a cure for AIDS.

5. AIDS is caused by witchcraft.

Phaswana-Mafuya et al (2010, pp.44) reported that a recent large survey conducted by Simbayi et al (2007) among 1054 HIV positive individuals in Cape Town found that high levels of internalized stigma, with a large number of study participants not disclosing their HIV-positive status for fear of stigma and discrimination. According to Johnson (2001), the internalized HIV stigma stemmed mostly from the fact that, although HIV is transmitted during normal sexual acts, HIV infection is widely perceived as an outcome of sexual excess and low moral character, with a consequent strong culture of silence by people living with HIV and AIDS because of the fear of rejection and isolation by close relatives and the community at large. Research (Gupta cited in NGLS, 2002, pp.2; Kalichman & Simbayi, 2004a) has consistently shown that stigma is more severe for women that for men. AIDS stigma has also been shown to be
associated with traditional beliefs that AIDS is caused by spirits and supernatural forces (Kalichman & Simbayi, 2004a).

The research studies reviewed in this section have suggested that one of the consequences of stigma is denial. The fear of exclusion and discrimination forces people living with HIV and AIDS to hide their condition. The silence and the denial about HIV/AIDS are deadly because they prevent infected people from accessing and accepting their role in infecting their sexual partners (Qwana et al, 2000; Strydom, 2000). The assessment of knowledge of respondents aged 15 years and older about HIV and AIDS during the period 2005-2008 indicated that: “Significant declines in correct knowledge over time, as found in the Eastern Cape between 2005 and 2008, are cause for concern” (Phaswana-Mafuya et al (2010, pp.48).

3.4.12 Culture and Social Norms
In a recent research conference held in the Eastern Cape entitled The Political Economy of HIV/AIDS in the Eastern Cape (7-9 March 2010), it was observed that “The Eastern Cape province has a multitude of cultural patterns” (Eastern Cape Research Conference, 2010, pp.30). The following cultural practices that are perceived to threaten the efforts aimed at fighting against the HIV/AIDS epidemic are:

3.4.12.1 “Circumcision Practices

■ Umgubho – where girls are divided amongst the men attending the function.

■ Ukuqiniswa – the same instrument (blade) may be used on all boys in the ritual

they undergo before circumcision, to make them strong and protect them from evil spirits.

■ Umdlanga – sometimes the single instrument used to circumcise boys is not sterilised and is used on all boys.
The ingcibi (traditional surgeon) asks the boys to swallow the foreskin to prevent Thikoloshes from getting hold of it.

Okusula – new initiates sleep with any woman other than their own usual sexual partner (usually without a condom), ‘cleanse’ themselves.

3.4.12.2 Other Cultural Practices

Ukuthwala – a young girl is abducted and forcibly married to an older man of an unknown HIV status.

Ukungenwa – when a husband passes away, his brother or even his father takes over as a husband.

Ukuphutshwa – single women in certain religions are encouraged to marry men who claimed to have dreamed about them.

Ukuqutyulwa – traditional healers bite off a piece of flesh from a client under the pretext of healing them.

Abathandazeli – spiritual healers pray for HIV+ clients and then tell them they have been healed (Eastern Cape Research Conference, 2010, pp.30).

Some of the cultural and social norms the Eastern Cape Research Conference identified as key drivers that fuel HIV/AIDS infections particularly among women and girls have been highlighted by many studies. Firstly, Meyer-Weitz et al (1998) argue that gender inequalities inherent in many societies where women are accorded a lower status than men have serious implications for choices that women make in their lives especially with regards to when, with whom and how sexual intercourse takes place. A study undertaken by Leclerc-Madlala (2003) made the following conclusions regarding how women are treated in male-dominated sexual relationships:

That decisions are frequently marred by coercion and violence in the women’s relationships with men;
That male partners tend to either have sex with sex workers or engage in multiple relationships;

That their female partners or spouses are unable to insist on the use of condoms during sexual intercourse;

That the female partners’ failure to insist on the use of condoms often stems from the fear of losing their main source of livelihood;

That as a result of this fear, many women are left unprotected and exposed to HIV infection from their male sexual partners;

That in line with global trends for greater gender equality, young women in South Africa are increasingly eager to assert themselves, minimise their interests and forge new identities as modern women;

That doing this within the confines of existing cultural perceptions for gender, often leads young women to manipulate or exploit their relationships with men in ways that increase their vulnerability and exposure to HIV.

Secondly, a study by Shisana and Simbayi (2002) listed sex-related cultural beliefs and behavioural practices that compound HIV risk factors and fuel HIV spread and rates of prevalence and incidence. These include rites of marriage including premarital sex, virginity testing, fertility and virility testing, fertility obligations, polygamy, and prohibition of post-partum sex and also during breastfeeding, rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of an infertile woman marries his wife’s sister), or still prevailing beliefs that sex with a virgin can cure AIDS. Shisana and Simbayi (2002) concluded that although these cultural and social practices may have served a valuable social purpose in the past, today they fuel the spread of HIV.
3.5 CONCLUSION
The key drivers that fuel the HIV/AIDS spread and prevalence outlined in this subsection provide indications on the types of HIV prevention information to be provided by HIV/AIDS Health Advisory Communities to school learners and the cultural and social norms to be targeted in different age groups on HIV/AIDS health education. The most important determinants of HIV/AIDS spread are (1) lack of knowledge on myths and misconceptions, (2) sexual debut, (3) multiple sexual partners, (4) condom use, (5) awareness of HIV status, (6) teenage pregnancy, (7) intergenerational sex, (8) gender-based violence, (9) labour-related migration, (10) transactional liaisons, (11) poverty, (12) stigma and denial and (13) culture and social norms.
CHAPTER 4
RESEARCH METHODOLOGY

4.1 INTRODUCTION

The main purpose of this chapter is to review the scientific research process followed in this chapter. Cohen and Manion (1994) observe that the aim of research methodology is to help researchers to understand not only the product of scientific enquiry, but also the process itself. Anderson (1990) observes that a research method is an approach devoted to addressing a research question or problem – a view that re-affirms that of Cohen and Manion (1994). Cohen and Manion (1994, pp.38-39) perceive methods as the range of approaches used in research to gather data which are to be used as a basis for inference and interpretation, explanations and prediction.

Studies on research methodology have established a distinction between a “research design” and “research methodology”. “[R]esearch design” is defined as “a plan or blueprint of how” researchers conduct the research studies. According to Babbie and Mouton (2001, pp.74), “Research methodology” consists of the methods, techniques and procedures deployed in the implementation process of the research design in order to solve the research problem. Research methodology may, therefore, be defined as “the methods, techniques, and procedures that are employed in the process of implementing the research design or research plan, as well as the underlying principles and assumptions that underlie their use” (Babbie & Mouton, 2001, pp.647).
4.2 RESEARCH DESIGN

This is a quantitative research design. According to Babbie and Mouton (2001, pp.646), the following three features characterise quantitative paradigm:

(1) An emphasis on the quantification of constructs. The quantitative researcher believes that the best or the only way of measuring the properties of phenomena ... is through quantitative measurement, i.e. assigning numbers to the perceived qualities of things. (2) The emphasis placed on variables in describing and analyzing human behaviour. [...] (3) The central role afforded to control for sources of error in the research process. The nature of control is either through experimental control (in experimental design) or through statistical controls (in multivariate analysers).

The emphasis of the above quotation is on quantitative research or on what Blaikie (1993) and Neuman (1997) refer to as positivism/objectivism. Blaikie (1993) and Neuman (1997) suggest that there are three distinct approaches to social science research: positivism (or objectivism), interpretive and critical, each of which is treated as a model or a paradigm for research. Wimmer and Dominick (2000, pp.103) explain the distinction between a positive paradigm and an interpretivist paradigm. “The positive paradigm involves such concepts as quantification, hypotheses, and objective measures”. For example a survey method of inquiry falls under positivism.

4.3 RESEARCH METHODS APPLICABLE TO THIS STUDY

4.3.1 Survey Research

A descriptive self-directed small scale survey, was employed to collect relevant data from all eighteen high schools in Idutywa education district area.

Leedy (1980), view descriptive method of research as the method of research that looks with intense accuracy at the phenomenon and then describes possibly what the researcher sees. The
researcher chose to use a descriptive survey design because of the accuracy with which it produces research results. This is probably among the best designs for collecting original and authentic data.

Cohen and Manion (1984), suggest that surveys are excellent vehicle for the measurement of attitude behaviours and orientation prevalent in large population. The survey design method, therefore, was suitable for this study since the study aimed to find out the existence and role of HIV/AIDS health advisory committees in senior secondary schools in accordance with the education policy in South Africa.

According to Borg and Gall (1989), a descriptive survey method is considered as a method of systematic data collection that can be used in collecting original data from sampled population. The survey method, the two authors argue, gives the respondents the freedom to express their views without the researcher’s influence through the use of questionnaires.

However, Leedy (1980) observes the descriptive research method has few limitations. For example, if care is not exercised, all the acquired results may be invalid. Best and Khan (1993) also caution that descriptive survey must not be confused with mere clerical routine of gathering and tabulating figures but must involve clearly defined problems and objectives.

To overcome the weakness attributed to descriptive surveys, the researcher followed the measures suggested by research in order to produce quality descriptive surveys. These were (1) defining the research objectives before carrying out the research; (2) designing a clear and precise questionnaire to collect primary data; (3) making use of the research objectives; (3) ensuring logical data presentation and analysis techniques so as to deduce meanings from the data collected.
Survey research is the method of collecting information by asking a set of pre-formulated questions in a predetermined sequence in a structured questionnaire to a sample of individuals drawn so as to be representative of a defined population (Briggs and Coleman, 2007, pp.125).

According to Cohen and Manion (1995), surveys gather data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared, or determining the relationships that exist between specific events. Thus, surveys may vary in their levels of complexity from those which provide simple frequency counts to those which present relational analysis.

A researcher using the various types of survey will be seeking to gather large scale data from as representative a sample population as possible in order to say with a measure of statistical confidence that certain observed characteristics occur with a degree of regularity.

In order to critically analyse operations of schools in Idutywa district schools, the researcher used a small scale survey that employed mixed-methods triangulation approach. Babbie and Mouton (2001, pp.232) stated that survey is the best method available to social scientists interested in collecting data, for describing a population which is too large to observe directly. It would be impossible for this study to critically and analyse parents, teachers and learners’ inputs on the existence of the HAC in all the Amathole mega district schools thus the need for a survey. According to Maykut and Morehouse (1985, pp.125), a survey is a form of study where subjects’ attitudes, beliefs, opinions and other types of information about a particular phenomenon under study are described in educational research.
The study systematically used mostly the questionnaires and interviews to elicit views from the respondents.

Babbie and Mouton (2001, pp.231) explain the use of survey research as follows: “In a typical survey, the researcher selects a sample of respondents and administers a standardized questionnaire to them”. Du Plooy (1995, pp.127) observes that: A survey has several characteristics and several claimed attractions; typically it is used to scan a wide field of issues, populations, programmes etc, in order to measure or describe any generalised features. It is useful (Morrison, 1993, pp.38-40) in that it usually:

- Gathers data on a one-short basis and hence is economical and efficient;
- Represent a wide target population;
- Generates numerical data;
- Provides descriptive, inferential and explanatory information;
- Manipulates key factors and variables to derive frequencies;
- Gathers standardised information;
- Makes generalisations about, and observes patterns of response in, the targets of focus;
- Gathers data which can be processed statistically;

Research reveals that usually a survey research relies on a large scale data gathering from a wide population in order to enable generalisation to be made about given factors or variables. According to Du Plooy (1995, pp.127): “Generally the purpose of using survey … is to explore and describe what is; rather than to evaluate why an observed distribution (e.g. of attitudes) exists. Accordingly, we may refer to exploratory survey research or descriptive survey research, which simultaneously point to the purpose of the survey. If, however, a survey is undertaken with explanatory purpose in mind, we would be examining the relationships among two or more variables” (for example, to explain why some high school management teams have
established HACs as requested by legislation and why some have not and also to explain why some existing established HACs are better managed than others.

According to research there are four basic ways to collect survey data – “mail-surveys, telephone surveys, personal interviews and group administration” (Wimmer & Dominick, 2000, pp.175; Du Plooy, 1995, pp.129). Babbie and Mouton (2001, pp.229), however, have listed three basic ways of collecting survey information together with their sub-categories. These are (1) “face-to-face interviews”; (2) “telephone surveys” and its sub-category, the “computer-assisted telephone interview (CATI) and (3) “self-administered questionnaires”, with the following sub-categories – “mail distribution and return and electronic surveys”.

Research studies have stated that although surveys may be used for descriptive, explanatory and exploratory purposes they are chiefly used in studies that have individual people as units of analysis Babbie & Mouton, 2001; Wimmer & Dominick, 2000; Du Plooy, 1995). For example in this study 18 Senior Secondary Schools (SMTs) were selected from the Amathole mega district schools for the investigation. But the sampled survey respondents were SGB parent members, educators and learners, not the 18 schools or entities.

Du Plooy (1995, pp.129) describes the process of the mail surveys:

In a mail survey, we send a questionnaire to individuals in the sample, which they fill in at their leisure and return by a given date. As each respondent personally completes his or her own questionnaire, this is usually called self-administered questionnaire (Babbie, 1983, pp.223-228)...The advantages of using a mail survey as a method of collecting data are numerous. It is relatively inexpensive and one researcher, with one or two assistants, can undertake the research. It also enables us to reach respondents whom we might not be able to visit personally or reach by telephone. When compared with the other three methods of collecting survey
data, a mail survey is the best method to use when investigating responses to sensitive topics.

The obvious disadvantage of mail surveys is that response rate tends to be poor. The next method applicable to this study is evaluation research method. This methodological component stems from the fact that HAC study does not only involve measuring the existence of HIV/AIDS Advisory Health Committees but also determining whether those that had been established are being effectively managed by SMTs.

4.4 SAMPLING
This subsection deals with what sampling means and the type of sampling technique chosen for the study. According Fox and Bayat (2007, pp.54), “a sample is any subset of the elements of the population that is obtained (by some process) for the purpose of being studied”. The process by which elements are drawn from the population is known as sampling. The study used two main sources of data: primary and secondary existing textual data.

The two major types of samples are probability and non-probability samples (Wimmer & Dominick, 2000; Babbie & Mouton, 2003). According to Wimmer and Dominick (2000, pp.82):

A probability sample is selected according to mathematical guidelines whereby each unit’s choice for selection is known. A nonprobability sample does not follow the guidelines of mathematical probability. However, the most significant characteristic distinguishing the two types of samples is that probability sampling allows researchers to calculate the amount of sampling error present in research study; nonprobability sampling does not.

Sampling is “a process of selecting people or things that have been selected as a source of data” (Charles, 1998, pp.119). Vockell (1983, pp.103) defines sampling as “strategies, which enable researchers to pick a subgroup from a large group and then use that subgroup on a large basis for making judgements about the larger group”. To Bless
and Higson-Smith (1995, pp.86), sampling is a process of selecting a “subset of the whole population which is actually investigated by the researcher. The characteristics of the subset will be generalized to the entire population”.

Sample size and sampling are determined by five important procedures. These are: Random Sampling, Stratified Random sampling, Cluster sampling and Systematic or Purposive/Purposeful sampling and Snowball sampling.

4.4.1 Sampling Strategy Used
The sampling methods that were used in this study were the simple random sampling method for collecting data. The research used a non-probability sample. The non-probability sample selected and used was the convenience sample that targeted all senior secondary schools in the Idutywa area. According to Cohen (2000, pp.99) in a non-probability sample, the chances of members of the wider population being selected for the sample are unknown. Some members of the wider population definitely will be excluded and others will definitely be included (i.e. every member of the wider population does not have an equal chance of being included in the sample.

In his conclusion, Cohen (2000, pp.102) stated that convenience sampling or as it is sometimes called, accidental or opportunity sampling – involves choosing the nearest individual to serve as the respondents and continuing that process until the required sample size has been obtained. Captive audiences such as students or teacher soften serve as respondents based on convenience sampling. The researcher simply chooses the sample from those to whom she has easy access. As it does not represent any group apart from itself, it does not seek to generalise about wider population. Generalization from the wider population is totally irrelevant in convenience sampling technique. The researcher, of course must take pains to report
this point – the parameters of generalisability in this type of sample are negligible. A convenient sample may be the sampling method selected for a case study or a series of case studies.

Creswell (2006, pp.116) observes that:

It is essential to know the general procedures of collecting data in qualitative and quantitative research because mixed methods research involves collecting both forms of data ... The data collection procedures will vary depending on the type of mixed methods design. A helpful way was to conceptualize data collection among the designs is to consider data collection as occurring concurrently or sequentially. In concurrent data collection, the quantitative and qualitative data are collected a roughly at same time (as in the Triangulation or Embedded Designs). In the sequential approach, the quantitative (or qualitative) data is collected first, and the results inform the second (quantitative or qualitative) form of data collection....

In the HAC study the researcher randomly selected learners from the 18 high schools from at the beginning of the school year in 2010 to determine whether the learner-teacher ratio conform to the official recommended ratio or too low or normal. At the end of a school year, the researcher measured each student’s achievement via the state assessment and compared the average achievement of the two sizes of classes. The purpose of this randomized phase of this was to collect numeral data that would reveal the variables that influence learner performance (Lauer, 2006, pp.16). The closed-ended and open-ended questionnaires mailed to convenience or purposefully sampled parents (108) also generated quantitative data that was quantitatively analysed (tables, flowcharts, statistical inferences), suggesting that qualitative data served only a secondary role in the study.

According to Cohen, Manion and Morrison (2003), in simple random sampling each member of the population under the study has an equal chance of being selected and the probability of the
member of the population being selected is unaffected by the selection of other members of the population, i.e. each selection is entirely independent of the next.

The method involves selecting at random from a list of the population the required number of subject for the sample. This can be done by drawing names out of a hat until the required number is reached, or by using a table of random numbers set out in the matrix form, and allocating these random numbers to the participants or cases. Because of probability and chance, the sample should contain subjects with characteristics similar to the population as a whole; some old, some young, some tall, some short etc. One problem associated with this particular sampling method is that a complete list of the population is needed and this is not always readily available (Cohen et al, 2003, pp.100).

4.4.2 Research Instruments

The primary sources of information were collected by standardized questionnaires and documents that were provided by the schools. Questionnaires can be described as a set of, or statements that assess attitudes, opinions, beliefs and bibliographical information (Kuhn 1961, pp.172). Other researchers further defined questionnaires as a research instrument consisting of a series of systematically structured questions for the purpose of obtaining specific information from the respondents.

Questionnaires were used in this study to collect data from the respondents. According to Merrian (1984), a questionnaire is a research instrument consisting of a series of questions and other prompts for the purpose of gathering information from respondents. The questionnaires were used because they give standardized answers and make it simple to compile data. He added that they are easy to administer and data collected from questionnaires is easy to analyze. With the use of questionnaires the respondents had the chance to carefully study the
questionnaire and respond at their own pace. The questionnaires also facilitated the confidentiality thereby allowing respondents to freely express their views. The questionnaires were relatively cheap to extract data.

However, Borg (1996, pp.55) mentioned the following limitations of the use of questionnaires. The weaknesses include inflexibility with regards to new variables that were not catered for. At some time other respondents were less cooperative and this caused delays to the researcher. In a bid to overcome these problems, the researcher distributed the questionnaires personally to the respondents. Apart from oral explanation, the researcher also concluded a note explaining the importance of the study, stressing the need of the respondents to cooperate. The researcher also assured the respondents that the research findings were kept confidential and that the respondents would remain anonymous.

The researcher decided to use the questionnaires because they helped in gathering a sufficient amount of primary data needed in the study. With this research tool the researcher was able to gather sufficient data on the existence of HIV/AIDS health advisory committees in selected senior secondary schools. Wilson and Mcean (1994) quoted by Cohen (2000, pp.245) also stated that the questionnaire is a widely used and useful instrument for collecting survey information, producing structured, often numerical data, being able to be administered without the presence of the researcher, and often being comparatively straightforward to analyse.

According to Cohen (2000, pp.245), the questionnaire will always be an intrusion into the life of the respondent, be it in terms of time taken to complete the questionnaire, the level of threat or sensitivity of the questionnaire or possible invasion of privacy. Questionnaire respondents are not passive data providers for researchers; they are subjects not objects of research. There are
several requisites that flow from this. Research ethical considerations implore all researchers to ensure that respondents are not coerced into completing a questionnaire. They might be strongly encouraged, but the decision to whether to become involved and when to withdraw from the research is entirely theirs.

Their involvement in the research must be governed by the following conditions:

- Their informed consent
- Their rights to withdraw at any stage or not to complete particular items in the questionnaire.
- The potential of the research to improve their situation
- The guarantees that the research will not harm them
- The guarantees of confidentiality, anonymity and non-traceability in the research
- The degree of threat or sensitivity of the questions (which may lead to respondents’ over-reporting or under-reporting (Sudman and Bradburn, 1982, pp.32)
- Factors in the questionnaire itself i.e. the avoidance of bias and assurance of validity and reliability in the questionnaire.
- The reaction of the respondent.

Wilson and Mcean (1994) quoted by Cohen (2000, pp.245) also has listed the usefulness of the questionnaire. The questionnaire is a widely used and a useful instrument for collecting survey information, producing structured, often numerical data. Besides these, the questionnaire is capable of being administered without the presence of the researcher, and often capable of being submitted to a straightforward comparative analysis.
4.4.3 Validity and Reliability

For a research study to be credible and successful it must be reliable and valid. Cohen (2000, pp.105) stated that validity is an important key to effective research. If a piece research is invalid then it is worthless. Validity is thus a requirement for both quantitative and qualitative or naturalistic research. Whilst earlier version of validity were based on the view that it was essentially a demonstration that a particular instrument in fact measures what it purports to measure, more recently validity has taken may forms. For example, in qualitative data validity might addressed through the honesty depth, richness and scope of the data achieved, the participants approached, the disinterestedness or objectivity of the researcher. In quantitative data validity might be improved through careful sampling, appropriate statistical treatments of the data.

Reliability is essentially a synonym consistency and replicability over time, over instruments and over groups of respondents. It is concerned with precision and accuracy. For the research to be reliable it must demonstrate that if it were to be carried out on a similar group of respondents in a similar context (however defined) then similar results would be found (Cohen 2000, pp.117).

4.4.4 Validity and Reliability of Questionnaires

According to Cohen (2000, pp.129), the advantages of the questionnaires over interviews, for instance are: it tends to be more reliable, because it is anonymous, it encourages greater honesty. It is more economical than the interview in terms of time and money and there is the possibility that it can be mailed. Its disadvantages on the other hand are: there is often too low a percentage of returns, the interviewer is able to answer questions concerning both the purpose of the interview and any misunderstandings experienced by the interviewee for it sometimes happens in the case of the latter
that the same questions have different meanings for different people, if only closed items are used, the questionnaire may lack coverage or authenticity. If only open items are used respondents may be unwilling to write their answers for one reason or the other. Questionnaires present problems to people of limited literacy and an interview can be conducted at an appropriate speed whereas questionnaires are often filled in hurriedly.

Morrison (1993) in Cohen et al (2000, pp.129) said that there is a need to pilot questionnaires and refine their contents, wording, length, e.t.c as appropriate for the sample being targeted. One central issue is considering reliability and validity of questionnaire surveys is that of sampling. An unrepresentative, skewed sample, one that is too small or too large, can easily distort the data, and indeed in the case of very small sample, prohibit statistical analysis.

4.5 DATA ANALYSIS PROCEDURES
The researcher used descriptive statistical analysis consisting of number and corresponding percentages of respondents. To achieve this, tables and graphs will be used to organize data. This approach makes it easy for the researcher to arrange data more systematically and to reduce it to the same units of measurements. Comparison among and between responses becomes easy. In addition, tables and graphs will be manipulated to reveal trends that are normally difficult to observe or to reduce to narrative patterning. According to Bell (1995), data collected is not useful until it is analyzed, data collected by means of questionnaires, interviews or other methods mean very little until analysed.

Cohen et al (2000, pp.147) states that data analysis involves organising, accounting for, and explaining the data; in short making sense of the data in terms of the participants’ definitions of the situation, noting patterns, themes, categories and regularities. According to Cohen et al (2000, pp.77), the
researcher will need to consider mode of data analysis to be employed. In some cases this is very important as it has a very specific bearing on the form of instrumentation.

The planning of data analysis will need to consider the following: what needs to be done with the data when they have been collected – how will they be processed and analysed. How will the results of the analysis be verified, cross-checked and validated?

Cohen et al (2000, pp.77) also emphasised the decisions that needed to be taken with regard to the statistical tests that would be used in data analysis as they will affect layout of research items (for example in a questionnaire) and the computer packages that are available for processing quantitative and qualitative data e.g. SPSS and NUD respectively. Statistical processing demands that the researcher ascertains the level of data being processed—nominal, interval or ratio. Questionnaires that yielded nominal or word-based data can be analysed using a computer programmes (for example SPSS, Sphinx survey or ethnography respectively). If the researcher intends to process the data using a computer package, it is essential that the layout and coding system of the questionnaire is appropriate for the computer package.

4.6 SUMMARY
This chapter has provided a detailed overview of research design and methodology, focusing on the general characteristics of scientific research process. The general outline of what constitutes scientific research enquiry is followed by the major components of research and methodology. The distinction by research design and methodological process has been established, followed quantitative research designs.
CHAPTER 5
DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

The research study used quantitative data source. This means that only the quantitative data analysis strategy receives full treatment of data analysis and interpretation in this chapter. Quantitative data refers to numeric facts and figures while qualitative data “refers to opinions” that tend to be very subjective (Remenyi, 1996, pp.32).

Data analysis is perceived as a process of inspecting, cleaning, transforming and modelling data with the goal of highlighting useful information, suggesting conclusions and supporting decision making. Jorgensen (1989, pp.107) explains what the researcher does during a data analysis process: “the researcher sorts and shifts them, searching for types, classes, sequences, processes, patterns or wholes”.

Chapter 5 deals with the analysis of data and presentation of findings. According to Wikipedia, analysis of data is a process of inspecting, cleaning, transforming, and modelling data with the goal of highlighting useful information, suggesting conclusions, recommendations and supporting decision making. Data analysis has multiple facets and approaches, encompassing diverse techniques under a variety of names, in different business, science, and social science domains. Data can be quantitative or qualitative. In this study, the researcher used both quantitative and qualitative approaches to develop the questionnaire. Statistical Program for Social Sciences (SPSS) was used to analyse data, that is to say the responses in the questionnaires from the participants. SPSS is a widely used computer program in research for survey authoring, data mining and statistical analysis.
To analyse the quantitative (closed-ended) data/responses in the questionnaire, the researcher coded, labelled and gave variables to the responses from participants in order to produce frequencies and percentages presented in tabular format. To analyse the qualitative (open-ended) data/responses, the researcher performed sentence analysis of each response in the questionnaire in order to produce themes.

Themes were further classified according their meanings in order to generate patterns. The patterns were further analysed into tally marks in order to produce frequency counts and percentages, which were presented in tabular format.
### 5.2 RESPONSES FROM EDUCATORS

**Table 5.2.1: The existence / none-existence of HIV/AIDS HACs and the composition of HIV/AIDS HAC and / or none HIV/AIDS HACs**

<table>
<thead>
<tr>
<th>Does your school have HIV/AIDS HAC?</th>
<th>What is it committee composed of?</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>YES</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One Educator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents, Educators, Learners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chairperson(Coordinator SMT), Community Leader, Traditional Leader, Community Policing Forum, Two learners, and SGB members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educator, Principal, Parent (SGB) and Learner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coordinator, Secretary, and Traditional</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

108
<table>
<thead>
<tr>
<th>NO</th>
<th>What committee or structure is existing to attend to health related matters?</th>
<th>members</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Health Promoting Schools</td>
<td>4 2</td>
</tr>
<tr>
<td>3</td>
<td>Parents, Educators, Learners</td>
<td>5</td>
</tr>
<tr>
<td>6.2</td>
<td>Three (3) L.O. Teachers and SCO co-ordinator</td>
<td>1</td>
</tr>
<tr>
<td>6.2</td>
<td>Clinic staff and teachers</td>
<td>1 6</td>
</tr>
<tr>
<td>6.2</td>
<td>Educators, PGT, Co-ordinator and Learners</td>
<td>1 2</td>
</tr>
<tr>
<td>6.2</td>
<td>Assistant Pastor, Deputy Principal, Learner</td>
<td>2 6</td>
</tr>
</tbody>
</table>

<p>| 56 | Partnership with local clinic                                         |         |
| 7  | 44                                                                     |         |</p>
<table>
<thead>
<tr>
<th>Peer Education Programme</th>
<th>School Counselling Committee</th>
<th>Support</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>School staff help promote healthy standards</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>56</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>
Forty four (44) percent (%) of educators reported that HIV/AIDS HAC existed in their schools, while 56% reported the existence of other Committees / Structures to attend to health related matters. In terms of HIV/AIDS HAC, it was encouraging to note that this committee was composed of the key school stakeholders and community, i.e. parents, educators and learners, as indicated by 19% and 6.3%.

The researcher also noted that other existing committees / structures (Health Promoting Schools, HIV/AIDS Committee, First Aid Co-ordinator, L.O. teachers and SCO co-ordinator, Partnership with local clinic, Peer Education Programme, School Counselling Committee, School staff help promote healthy standards) at schools were also composed of key school stakeholders (parents, educators and learners), as indicated by 25%. However, these committees / structures have fewer parents in these structures/committees. The reduction in number of parents present in these might be due to the schools’ deliberate actions (educators and principal) aimed at arrogating themselves who should be members of the HIV/AIDS health committees / structures.

From the above analysis, it can be argued that the selected schools have committees/structures that take care of health related matters; however, not all schools have HIV/AIDS HAC as stipulated by DoE policy.

**Table 5.2.2: Parents’ Involvement in HIV/AIDS HAC and / or none HIV/AIDS HAC**

<table>
<thead>
<tr>
<th>Are parents fully involved?</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
</tr>
<tr>
<td>YES</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td>NO RESPONSE</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
In some HIV/AIDS HACs and other committees / structures, parents were fully involved (as indicted by 50%). This could mean that some schools had no problem allowing parents to become members of the HACs and to participate freely in HIV/AIDS HACs and other committees / structures. The evidence from this school suggested that parents were also interested in participating in HIV/AIDS HACs and other committees / structures.

It was equally encouraging to observe that committees/structures that had not previously fully involved parents (44%) were taking steps to improve parents’ involvement (as indicated by 6.2%, 13%, 6.2%, 13%, 6.2% and 6.2%).

In some HIV/AIDS HACs and other committees / structures, parents were fully involved (as indicted by 50%). This could mean that some schools had no problem allowing parents to become members of the HACs and to participate freely in HIV/AIDS HACs and other committees / structures. The evidence from this school suggested that parents were also interested in participating in HIV/AIDS HACs and other committees / structures.

It was equally encouraging to observe that committees/structures that had not previously fully involved parents (44%) were taking steps to improve parents’ involvement (as indicated by 6.2%, 13%, 6.2%, 13%, 6.2% and 6.2%).
From the above analysis and the participation rates, it could be suggested that not all parents were fully involved. The lack full participation might be attributed to socio-economic factors such as parents’ low level of education, inferiority complex and family commitments.

**Table 5.2.3: Knowledge of the committee about HIV/AIDS and related diseases**

<table>
<thead>
<tr>
<th>Does the committee have enough knowledge about HIV/AIDS and related diseases?</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
</tr>
<tr>
<td>YES</td>
<td>1 1</td>
</tr>
<tr>
<td><strong>Motivate your answer</strong></td>
<td>1 1 5 1 2 1</td>
</tr>
<tr>
<td>Committee preaches abstinence and condomising</td>
<td>1 1</td>
</tr>
<tr>
<td>Pastor is a well trained member and qualified, though need to be supplemented</td>
<td>5 1 2 1</td>
</tr>
<tr>
<td>Staff have knowledge about HIV/AIDS and related diseases / Teachers know very well, they are able to advise the learners at school</td>
<td></td>
</tr>
<tr>
<td>There is HIV/AIDS policy drafted. Dept of health visits the school to educate the school community</td>
<td></td>
</tr>
<tr>
<td>Use of magazines, Radio &amp; TV. Nurses and NGOs involvement</td>
<td></td>
</tr>
<tr>
<td>Workshops about HIV are conducted once in a month/quarterly</td>
<td>11 69</td>
</tr>
</tbody>
</table>

113
**Motivate your answer**

Educator who is in this committee does not have course in/on HIV/AIDS

Knowledge insufficient more especially on the side of parents, only the school is knowledgeable since health official pay regular visit to the school in the absence of other HAC components.

Parents may not have enough knowledge, learners may have little knowledge acquired from L.O.

No response

<table>
<thead>
<tr>
<th></th>
<th>5</th>
<th>31</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>6.2</td>
</tr>
<tr>
<td>2</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>6.2</td>
<td></td>
</tr>
</tbody>
</table>

The majority of educators (69%) believed that HIV/AIDS HACs and other committees / structures being run in their schools had enough knowledge about HIV/AIDS and related diseases, while 31% thought that HIV/AIDS HACs and other committees / structures operating in their schools had not enough knowledge about HIV/AIDS and related diseases.

The educators who indicated “enough knowledge” further motivated their answers as follows:
- Some committee members have undergone training and are qualified.
- There are policy documents to refer to.
- There is educational material to refer to.
- Health officials from the health department visit the schools to conduct workshops on health-related matters.
- The educators who indicated "no enough knowledge" (31%) further cited the following challenges:
  - Many parents may be lacking knowledge about HIV/AIDS and health-related matters due to illiteracy.
  - Learners may be having insufficient knowledge about HIV/AIDS and health-related matters.
Table 5.2.4: Challenges faced by schools that had HCs & challenges faced by schools that had no HACs

<table>
<thead>
<tr>
<th>When there is HAC</th>
<th>F</th>
<th>%</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Absenteeism, Drop-out and Poor Performance</strong></td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Learners are not confident enough to talk about their status / Learners</td>
<td>1</td>
<td>.</td>
<td></td>
</tr>
<tr>
<td>are not free to present their health related matters</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Learners expect us to help them heal immediately with serious problems like rape</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Learners go to clinics during school hours even for minor illness</td>
<td>2</td>
<td>.</td>
<td></td>
</tr>
<tr>
<td>No challenges as we have HAC / No serious challenges</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>poorly or misinformed of the health related matters</td>
<td>2</td>
<td>.</td>
<td></td>
</tr>
</tbody>
</table>
When there is no HAC

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism, Drop-out and Poor Performance</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>As teachers, we are unable to identify the affected /infected with</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS and to deal with them accordingly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Funding Challenges. Skills Shortage</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Learners and community become victims of deadly and spreading</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>diseases which could have been prevented if the committee was existing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learners are not confident enough to talk about their status / Learners are not free to present their health related matters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learners involve themselves in unhealthy risk behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Since there is no HAC, we do not have workshops to motivate learners and community on health matters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 \cdot 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-------</td>
<td>-----------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is alarming to note that the absence of HAC has a negative impact on teaching and learning (as indicated by high percentage (19%) of absenteeism, drop-out and poor academic performance. Some educators indicated that there were no serious challenges in the schools that undermined teaching and learning when the school had a HAC.

Table 5.2.5 Resource issue

<table>
<thead>
<tr>
<th>Does the committee have enough resources at its disposal?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

All educators who responded to the questionnaire indicated that committees at their schools did not have enough resources, as evidently shown by 100%. Lack of / limited resources such as first-aid kits, books, equipment and limited access to health centres due to the fact that school was very far away urban centres with quality health facilities posed serious challenges in the schools.

Table 5.2.6: Comments on the existence or absence of HIV/AIDS Health Advisory Committee

<table>
<thead>
<tr>
<th>Comments on existence of HIV/AIDS Health Advisory Committee</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference is not noticeable</td>
<td>1</td>
</tr>
<tr>
<td>HAC is good to help learners and teachers / It is important as it improves the quality of life on health matters / Its existence is very important/ Promotes</td>
<td>5</td>
</tr>
</tbody>
</table>
health living style

It is not easy to talk

Not functioning well

With HAC being vibrant, learner dropout due to HIV/AIDS related diseases has been reduced

No response

Comments on absence of HIV/AIDS Health Advisory Committee

Not fully supported as there is no fulltime employees

Not well structured

Since there is no HIV/AIDS HAC, there is teenage pregnancy among learners.

The absence of this committee makes communication with the affected parities difficult

The existence of the committee would help us dealt with health matters accordingly / the existence of the committee would improve the understanding of HIV/AIDS related sickness, thus improve the health of the people
The result suggested that the existence of HIV/AIDS HAC in the school helped learners and teachers by promoting healthy living style (as indicated by 32% from educators’ responses). Even though 12.5% of educators’ responses showed that HIV/AIDS HACs existed in some schools, these HIV/AIDS HACs were not functioning well or were not well managed.

The prevalence and incidence of teenage pregnancy and STIs among learners (6.2%) confirmed the view that the absence of HIV/AIDS pose serious health related challenges. The 6.2% of the respondents reported that the absence of HIV/AIDS HAC made communication about health related matters difficult among school stakeholders. The lack of communication generated by the absence of HIV/AIDS HAC might lead to serious socio-psychological problems such stress, depression, poor memory and loss of concentration, and these might ultimately resulted into serious illness that could negatively affect teaching and learning.

Table 5.2.7: Informativeness of Health Advisory Committee at School

<table>
<thead>
<tr>
<th>How informative do you consider the Health Advisory Committee at your school?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useful</td>
<td>11</td>
<td>68.8</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>N/A</td>
<td>4</td>
<td>25.0</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
</tr>
<tr>
<td>How informative do you consider the Health Advisory Committee at your school?</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Useful</td>
<td>11</td>
<td>68.8</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>N/A</td>
<td>4</td>
<td>25.0</td>
</tr>
</tbody>
</table>

The research results indicated that the majority of educators (68.8%) believed that the HACs / committees / structures that were established in their schools were useful. This usefulness might be attributed to good advisory and relevant information disseminated by HACs / committees / structures to the school stakeholders.
Table 5.2.8: Year of Formation of the Committee and the Reasons for the Formation

<table>
<thead>
<tr>
<th>When was the committee formed?</th>
<th>F</th>
<th>%</th>
<th>Reasons for the formation</th>
<th>F</th>
<th>%</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>1</td>
<td>6.3</td>
<td>To reduce the chances of contracting HIV/AIDS</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>2</td>
<td>12.5</td>
<td>To help learners</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No response</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>3</td>
<td>18.8</td>
<td>To ensure/promote a better healthy living/environment in the school</td>
<td>2</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No response</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>4</td>
<td>25</td>
<td>To improve health conditions in the school/ To ensure/promote a better healthy living/environment in the school</td>
<td>2</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>To reduce teenage pregnancy rate and absenteeism at school</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No response</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>2</td>
<td>12.5</td>
<td>To ensure/promote a better healthy living/environment in the school</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Value</td>
<td>Description</td>
<td>Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------</td>
<td>--------------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not formed yet (No yet in existence)</td>
<td>2</td>
<td>Desirable to form it</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>No response</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>No response</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>100</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

124
The analysis and the interpretation of data collected from all the 18 selected schools indicated that formed their HACs or committees / structures 5 years, 8 years, 11 years and 13 years after 1997. It should be pointed out that the Department of Education endorsed the government HIV/AIDS policy that stipulated that all schools in South Africa should establish HIV/AIDS HACs. Why South African schools took so long to comply with the national policy on the establishment HIV/AIDS Health Advisory Committees is difficult to understand. The data analysis suggests that the long delays might stem from the fact that not all schools were ready immediately after 1997 to form the HACs. The data analysis also has also suggested that there might be some schools which have not yet established HACs or committees / structures.

The participant responses to the question why HACs were established in schools, 12.5% of the response indicated that the HACs were formed to address health related matters at schools.

Table 5.2.9: Challenges that occur / would occur in the absence of the committee at school

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious illness, high failure rate / High death rate, TB and other related diseases</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>HIV/AIDS as a socio-economic issue</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>In its absence – there would be health related problems high rate of absenteeism, drop-out, poor performance</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Involvement of learners in unhealthy risky behaviours</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Lack of knowledge about diseases</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Learners go back to traditional healers for diseases that need convectional medicine</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Learners would not be able to express themselves to the educators</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Not at present</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>School community would be unable to deal with diseases like HIV/AIDS</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Situation would be worse than what it is now.</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Spread of infectious diseases/Exposure of learners and teacher to various diseases</td>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>Teenage Pregnancy</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The educators who responded to the questionnaires indicated the serious challenges that would occur in the absence of HAC at schools and these challenges included the following:

- There would be spread of infectious diseases (12.5%), teenage pregnancy (18.8%) and HIV/AIDS related illnesses (6.3%).
- Learners would involve themselves in unhealthy and risk behaviour (6.3%)
- There would be lack of knowledge among school stakeholders on health matters (6.3% and 6.3%).
- Teaching and learning would negatively affected; learner drop-out, poor academic performance (12.5%)
The outcomes that would result from the absence HCs in schools, which are listed above clearly confirm the important role played by HAC in schools.

**Table 5.2.10: Steps / Procedures taken when one is sick during teaching-learning hours**

<table>
<thead>
<tr>
<th>Step Description</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice the affected / infected to go and do VCT in the near health centre. Encourage the counselling</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Application of First Aid by HAC members</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Apply first aid, Inform parents, take the learner to the health centre or home</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Inform class teachers, inform HAC</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Inform parents, take the learner to the health centre or home immediately / Take the learner to the health centre/ clinic / home immediately (involve parents)</td>
<td>5</td>
<td>31.3</td>
</tr>
<tr>
<td>Learner approach subject/class teacher, learner granted permission to go to the clinic</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Learners are given medication relevant to their illness, sometimes referred to the clinic and doctor and the parent is informed</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Refer one to the first-aid coordinator, then release to the nearest clinic</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Take the learner to the health centre/home immediately, Provide counselling to the learner</td>
<td>1</td>
<td>6.3</td>
</tr>
</tbody>
</table>
In this theme analysis the researcher sought to investigate how schools responded/reacted to a situation / scenario when a learner got sick during the teaching-learning hours.

The majority of educators (31.3%) indicated that the learner’s parents were informed and the sick learner was either sent home or taken to nearby healthcare centre. From steps / procedures listed in Table 5.2.10, it was pleasing to note that some schools had established health safety interventionist procedures or took actions when a learner became sick in school.
Table 5.2.11: Precautions taken by the committee to ensure a disease free environment

<table>
<thead>
<tr>
<th>Are there any precautions taken by the committee to ensure a disease free environment?</th>
<th>If YES, which are those precautions? / If NO, how does the committee promote a disease free environment?</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>Cleaning the classrooms and toilets regularly. Identifying the infected learners and allowing them to stay at home</td>
<td>F: 15</td>
</tr>
<tr>
<td></td>
<td>Health Awareness Programme</td>
<td>F: 2</td>
</tr>
<tr>
<td></td>
<td>Counselling is done to those infected, promote safe sex and abstinence</td>
<td>F: 2</td>
</tr>
<tr>
<td></td>
<td>Invite health practitioners from the nearby health centre / Inviting external organisations to counsel the learners</td>
<td>F: 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F: 1</td>
</tr>
</tbody>
</table>

129
Learners and teachers are advised to visit the nearest clinic/doctor

Learners are advised to wash hands before eating, to close their mouth when coughing, to use gloves when helping bleeding person

No littering, there is Clean water, neatness

Toilets are cleaned fortnightly, learners are taught about lifestyle diseases and Life Orientation

Use of chemicals/disinfectants when cleaning. Cleaning Campaigns.

We built toilets, bought water tanks for the school

<p>| | | | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>1</td>
<td>6.3</td>
<td>No response</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>100</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is good to note 93.7 % of educators who responded to the questionnaire reported that there were precautions taken by committees to ensure a disease free environment. The most common health precautionary measure was cleanliness and basic hygiene, preventive health safety procedures indicated by the following response scores: 12.5%, 6.3%, 12.5%, 6.3%, 12.5% and 6.3%. The above data analysis proved that some of the selected schools looked after the school environment and took care of the school stakeholders.

The researcher also discovered that there were few schools that might or did not take precautionary measures to ensure a diseases free environment as indicated by 6.3% response by participants. The reason behind this non-involvement in ensuring clean school environment was difficult to unravel. Such schools need serious intervention by educational authorities to bring change.

**Table 5.2.12: The effect of poor health on the learner performance at school**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism. Performance decreases / high failure rate. Drop-out</td>
<td>10</td>
<td>62.5</td>
</tr>
<tr>
<td>Learner are always dull, not participate in classroom activities</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Learner will not respond to the educator as expected</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Learners are easily infected by diseases</td>
<td>1</td>
<td>6.3</td>
</tr>
</tbody>
</table>
Learners are taught about short term and long term substance abuse, community is asked not to sell drugs to learners.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough time to study, therefore poor performance</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Not much</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

The educators cited various poor health effects on learner performance; these are presented as follows:

- The majority of educators (62.5%) cited absenteeism, decrease in performance, high failure rate and drop-out.
- Learner participation in classroom is negatively affected; learner loss of focus and concentration (6.3%).

The poor health experienced by educators and learners had had drastic effects on teaching and learning.

**Table 5.2.13: Extra effort put by the schools to improve health standards / conditions of the school community**

<table>
<thead>
<tr>
<th>What Extra effort does your school put to improve health standards / conditions of the school community?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bringing sanitary material and ensure that sanitary measures are followed</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Educate everybody in the community</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Everyone is involved in cleaning of the school</td>
<td>1</td>
<td>6.3</td>
</tr>
</tbody>
</table>
Some of the educators (37.5%) indicated that their schools invited / involved health institutions / organisation to do workshops and awareness campaigns in their schools.

Some of the educator respondents (6.3%) reported that their schools organised workshops which aimed at knowledge and skills acquisition and enhancing teaching and learning in schools. The responses also indicated that some schools regularly clean the school environment (6.3%) and followed hygienic practices (6.3%) in order to promote healthy lifestyle.

The responses also indicated 6.3% of the participants reported schools that in order to ensure safe school environment and vandalism and promote food security school made extra efforts to initiate programmes such fencing the school and establishing vegetable gardens.
The questions directed at investigating whether schools self-consciously made the extra efforts to improve health standards / conditions of the school community revealed that 6.3% of the participants responded positively to this question.

5.3 SUMMARY OF FINDINGS FROM THE INTERPRETATION OF ANALYSED EDUCATORS’ RESPONSES

- There were HIV/AIDS HACs in some schools under the Amathole District Municipality. The results indicated that some schools did not have health advisory committees or non-HAC-committees / structures. The alternative HIV/Aids health promotion committees and structures -- Health Promoting Schools, First Aid Co-ordinator, L.O. Teachers and SCO Co-ordinator, Partnerships with local clinic, Peer Education Programme, School Counselling Committee, School staff Promotion of Healthy Standards – which were aimed at attending to health related matters, were never established and were not available in some schools. This research evidence or result confirms that although HACs and related committees and structures had been operating in country since 1997 or for almost 14 years, HACs do not exist in some schools today.

The following responses from the participants confirm HAC existence and participation indicators gleaned from the research data analysis:

- The average percentage (50%) of involvement of parents in committees / structures is not satisfactory. This result suggests that parents are not 100% (fully) involved in the committees / structures.

- Although 68% of educators indicated that HIV/AIDS HACs / committees / structures in their schools had enough knowledge
about HIV/AIDS and health related matters, the remaining 32% negative responses constituted a major concern.

- The absence of HACs or alternative HIV/AIDS committees and structures created serious health related challenges that undermined all levels of educational activities and the lives of learners and educators and non-teaching staff members in schools that had no HIV/AIDS health committees. The problems created by the non-existence of HACs included high rate of teenage pregnancy, learner poor academic performance, learner drop-out and drastic effects on teaching and learning in general.

- The lack of resources to deal with health matters constituted another dimension of constraints facing HIV/AIDS HAC / committee / structure in many schools.

- The results highlighted the important role played by HAC/AIDS / committees / structures in schools: namely the provision of disease free school environment; putting in place health interventionist procedures that attain to learners who fell sick at school during teaching and learning hours; creating precautionary measures and making extra efforts to address health related issues at schools and to improve health standards / conditions of the school community.

- The research data and analysis also indicated that the existence of HACs within the schools induced some school authorities to respond to HIV/AIDS related problems by inviting external organisations / institutions such as health officials to come to schools and conduct workshops on HIV/AIDS health related matters.
5.4 RESPONSES FROM LEARNERS

Table 5.4.1: Existence / none-existence of HIV/AIDS HAC and the composition of HIV/AIDS HAC and / or none HIV/AIDS HAC

<table>
<thead>
<tr>
<th>Does your school have HIV/AIDS HAC?</th>
<th>What is it committee composed of?</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES 8</td>
<td>Teachers, Learners and Parents</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Parents, Educators, Learners and some people from health department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Educators, Principal, Parents and Learners</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>S.M.T, Learners, S.G.B and Community Policing Forum Coordinator.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>NO</td>
<td>What committ ee or structur e is existing to attend to health related matters?</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>One Member Committee</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Health Promoting Schools</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>There is a community group</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>6.25</th>
<th>3</th>
<th>18.75</th>
<th>1</th>
<th>6.25</th>
<th>1</th>
<th>6.25</th>
<th>1</th>
<th>6.25</th>
</tr>
</thead>
<tbody>
<tr>
<td>One educator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>6.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents, Educators, Learners / Teachers and Learners</td>
<td></td>
<td></td>
<td>3</td>
<td>18.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community group</td>
<td></td>
<td></td>
<td>1</td>
<td>6.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L.O. Teachers and SCO co-ordinator</td>
<td></td>
<td></td>
<td>1</td>
<td>6.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educators, PGT, Co-ordinator and Learners</td>
<td></td>
<td></td>
<td>1</td>
<td>6.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses and Volunteers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
that comes to the school some months to advise learners about HIV/AIDS and health related matters

Peer Education Programme

HIV/AIDS Committee, First
| Aid Coordinator |  |  |  |  | 8 | 50 |
| Attend­ing at clinic for the health care |  |  |  |  | 16 | 100 |
Fifty percent (50%) of learners reported that there were HIV/AIDS HACs in their schools, while the other 50% reported that instead of Health Advisory Committees their schools had other committees / structures that performed the same functions allocated to HACs by legislation. The educators’ responses to the same question indicated that 44% of educators reported the existence of HIV/AIDS HACs while 56% reported other committees / structures that existed in their schools (in Table 5.2.1).

The data gleaned from participant responses (31.25% and 6.25%) indicated the key school stakeholders (parents, educators and learners) constituted the integral parts of the HIV/AIDS HACs in schools where HIV/AIDS HACs existed. However, the data suggested that it seemed not all school stakeholders were members of non-HIV/AIDS HAC committees / structures. This conclusion is based on the fact that research evidence supported the view that only few parents were members of non-HIV/AIDS HAC committees / structures. This situation intimates that some schools do have confidence in parents or do not believe that parents are capable of making any important contribution to the successful management of HIV/AIDS health committees / structures.
<table>
<thead>
<tr>
<th>Do you think it is necessary for your school to have HIV/AIDS HAC?</th>
<th>Motivate your answer</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES 16 100</td>
<td>To advise/teach us and the community on health related matters</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>Learners will be safe in many things like getting STI, HIV and teenage pregnancy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promote healthy leaving</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>Through Committee there is a great link between parents, teachers and learners; discuss freely on HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It can help for those who are injured and HIV/ADIS infected.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>To obtain more knowledge facts about the various disease related to HIV/AIDS</td>
<td></td>
</tr>
</tbody>
</table>
It helps us

HIV/AIDS should not be treated in isolation, i.e. in clinics only, but also in schools.
All the learners, who respondent to the questionnaires, valued the necessity of having HIV/AIDS HAC in schools. This view is unanimously endorsed by the fact all the learners (100%) responded “YES” to this question. Some of the learners further indicated how HACs could enhance the fight against HIV/AIDS spread and reduce the rates of infections in schools as follows:

- Teenage pregnancy can be reduced as reported by 6.3% of the respondents.
- There is education and knowledge acquisition about HIV/AIDS, diseases and health related matters (endorsed by response rates of 43.8% and 6.3%).
- Promotion of healthy living style for the school community is important (as indicated by 12.5% of the participants).
- Collaboration with community health centres, such as clinics, health officials is possible (confirmed by 6.3% of the responses)

The participants’ responses outlined above suggest that respondents believed that there was a need for HIV/AIDS HAC in schools to deal with HIV/AIDS, diseases and other health related matters.
Table 5.4.3: Involvement of parents in the committees

<table>
<thead>
<tr>
<th>Are your parents fully involved in this committee?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

Fifty percent (50%) of the learner respondents reported that parents were involved in the committees, while the other 50% indicated that parents were not involved in the committees. This result suggests that the involvement of the parents in the HIV/AIDS HAC or committees/structures is not taken seriously by either the parents themselves or the school authorities. If parents do not or are not allowed to be represented fully or involved in HIV/AIDS HAC or committees/structures in schools, the parents’ lack of knowledge in HIV/AIDS health-related issues will both impact negatively on learners’ ability to apply HIV/AIDS knowledge learned at school to protect themselves against the epidemic due to the clash between what they are taught at school and the lack of knowledge displayed by their parents at home.
Table 5.4.4: The importance of the task performed by HAC

<table>
<thead>
<tr>
<th>How important is task performed by HAC?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Very important</td>
<td>10</td>
<td>62.5</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>18.75</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of learners (63%) indicated that tasks performed by HACs in the schools were “VERY IMPORTANT”. This majority view on the vital role played by HACs in schools re-affirms the need for the establishment of and existence of HACs in all schools across the country.

Table 5.4.5: The existence or absence of the committee
<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>About the existence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very important, very useful, as it helps people and community. Many learners have changed their behaviour</td>
<td>7</td>
<td>43.75</td>
</tr>
<tr>
<td>Important, as it allows one to express his/her views. Keeps school community informed about health related matters</td>
<td>3</td>
<td>18.75</td>
</tr>
<tr>
<td>Committee is informed about how to take care of the infected and affected with HIV/AIDS victims</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Lacking people to advise on treatment at school</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td><strong>About the absence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not knowing about the diseases, we can get easily infected and affected.</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>A proper structure involving all the stakeholder has to be formed to promote good health standards.</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>About the existence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It has to be there to advise the learners and community</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

The data analysis suggests that the existence of the committees in schools is very important. This importance can be attributed to the fact that the HIV/AIDS health committees help the learners and the school community in general – a conclusion confirmed by 43.4% of learner responses. Another benefit derived from the existence of committees in schools is the fact that they have transformed the African traditional attitudes that shun discussing sex related matters with young adults. The new atmosphere makes it possible for learners to freely express themselves about health related and sexual matters imposed by HIV/AIDS epidemic – a situation as indicated by 18.8% response rate. Despite the existence of the committees there are challenges such as lack of human capacity to seek advice from HACs on treatment.
Some learner respondents (6.25%) indicated that the absence of the committees in schools could lead to lack of or limited education/knowledge about HIV/AIDS related diseases and health related matters that could put learners at greater risk. Lack of knowledge and awareness about diseases could also lead to high number of HIV/AIDS victims and teenage pregnancy in school communities. The 12.5% and 6.3% of learners reported there was a need for the existence of committees that should involve all school stakeholders in schools.

**Table 5.4.6: Year of formation of the committee and the reasons for the formation**

<table>
<thead>
<tr>
<th>When was the committee formed?</th>
<th>Reasons for the formation</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>2002</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To reduce the chances of contracting HIV/AIDS</td>
</tr>
<tr>
<td>2005</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For health in schools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To change learner behaviour</td>
</tr>
<tr>
<td>2008</td>
<td>4</td>
<td>18.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To ensure/promote a better healthy living/environment in the school</td>
</tr>
<tr>
<td>Year</td>
<td>Code</td>
<td>Percentage</td>
</tr>
<tr>
<td>--------------</td>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>2009</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Not formed yet (No yet in existence)</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

150
The educators’ responses to the question on when and why the HACs were formed in schools (Table 5.2.8) were re-affirmed by learners’ responses. Thus, according to learners’ responses, not all the selected schools formed their HACs or committees / structures 5 years, 8 years, 11 years, 13 years after 1997 – the year the Department of Education endorsed the HIV/AIDS policy that stipulated that all schools in South Africa must have HIV/AIDS HAC. The varying periods of delay in formation of HACs in the selected schools suggest that not all schools were ready immediately after 1997 to form the HAC. The data and the analysis reveal that there might be some schools which have not yet established HACs or committees / structures.

The majority of the participants identified the need to address health related matters at schools as the motivation for establishing and running HACs in schools.

Table 5.4.7 Source of information of knowledge based on health related matters

<table>
<thead>
<tr>
<th>Source of information</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Clinics, Love Life, Generation Groups, Workshops, Peer Education</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Teachers, Nurses from Health Department, and HAC members</td>
<td>3</td>
<td>18.75</td>
</tr>
<tr>
<td>Teachers, Parents, L.O. Teachers Media (TV, Radios, Magazines)</td>
<td>5</td>
<td>31.25</td>
</tr>
<tr>
<td>Education officers, Community Clinics / Healthcare Centres</td>
<td>3</td>
<td>18.75</td>
</tr>
<tr>
<td>HIV/AIDS Committee</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>In school and the community</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Department of Health</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Teachers and Learners</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

About a third (31.3%) of learners reported that their main sources of information / knowledge based on health related matters for learners are (1) teachers, (2) parents and (3) the media (Radio, TV and print-media) followed by (4) community clinics, and (5) HACs (12.5%). Learner respondents (6.3%) also stated that they acquired information / knowledge based on health related matters from clinics, love life
relationships, generation groups, workshops, peer education. The statistical inferences and descriptive analysis suggest that HACs and other committees / structures in schools still have much to do in terms of being the information / knowledge reservoirs and providers for mitigating the HIV/AIDS epidemic.

Table 5.4.8: Frequency of absence at school due serious illness

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 times</td>
<td>3</td>
<td>18.75</td>
</tr>
<tr>
<td>Once</td>
<td>6</td>
<td>37.5</td>
</tr>
<tr>
<td>Twice</td>
<td>5</td>
<td>31.25</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>
The data and the research results indicated the high percentage of learners who were absent from schools once (37.5%) and twice (31.3%) in quarter due to serious illness. This analysis suggests that there are serious cases of illness in schools; these cases of illness might have contributed to learners’ poor attendance, poor academic performance and high drop-out rates. These challenges demand that HACs / committees / structures have to work hard in advising the learners about the diseases and health related matters.

5.5 SUMMARY OF FINDINGS FROM THE INTERPRETATION OF ANALYSED LEARNERS` RESPONSES

- Fifty percent (50%) of respondents reported that there were HIV/AIDS HACs in some schools under the Amathole District Municipality. The other fifty percent of the schools which did not have HIV/AIDS HAC in existence had other forms of committees / structures that performed the functions of the HACs. The non-HAC committees and structures included (1) One Member Committee, (2) Health Promoting Schools (community group that comes to the school some months to advise learners about HIV/AIDS and health related matters), (3) Peer Education Programme, (4) HIV/AIDS Committee, (5) First Aid Co-ordinator and (6) Health Care Clinics. The listed health committees and structures, the data and analysis indicated attended to health related matters of learners and educators. It must be reiterated that the data extracted from the years the HIV/AIDS HACs and non-HAC committees / structures were formed suggest that some schools had not yet established or formed HIV/AIDS HACs nor any other committees / structures.
The average percentage (50%) of involvement of parents in committees / structures has not achieved the intended objectives of the HAC policy. The intended goal of the policy-makers would only be deemed to have been achieved when parents’ involvement in the HACs and non-HAC committees and structures have achieved 100% participation.

The hundred percent learner response (100%) and sixty-three percent (63%) educators’ response to whether tasks performed by HACs were “very important” undoubtedly confirm the learner/educator views that there role mapped out by policy for HIV/AIDS HAC was crucial for health and educational wellbeing of schools. This finding underscores the important role of the existence of HIV/AIDS HAC within school communities. Because the HACs, the results have re-confirmed, are capable of addressing health related challenges / problems such as teenage pregnancy, HIV/AIDS related diseases, hygiene and healthy living style among school stakeholders.

The findings have suggested that the majority of learners acquire information / knowledge based on health related matters from parents, teachers and media (Radio, TV and print-media). This conclusion re-affirms the overwhelming numbers of responses that confirm that HIV/AIDS HACs or committees / structures have a big role to play as information / knowledge providers.

The high frequency / percentage of learners who reported being absent from school due to serious illness constitutes a major concern to all school stakeholders.
### 5.6 RESPONSES FROM PARENTS

Table 5.5.1 The existence / none-existence of HIV/AIDS HAC and the composition of HIV/AIDS HAC and / or none HIV/AIDS HAC

<table>
<thead>
<tr>
<th>Does your school have HIV/AIDS HAC?</th>
<th>What is it committee composed of?</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>YES</td>
<td>6</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 37.5
<table>
<thead>
<tr>
<th>NO</th>
<th>What committee or structure is existing to attend to health related matters?</th>
<th>10</th>
<th>62.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Learner Support Services – Counselling</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>5</td>
<td>None</td>
<td>5</td>
<td>31.2</td>
</tr>
<tr>
<td>1</td>
<td>Peer Education Programme</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>1</td>
<td>HIV Committee</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>1</td>
<td>Life Orientation as subject, as it related Health and Awareness</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>1</td>
<td>One member committee</td>
<td>1</td>
<td>6.25</td>
</tr>
</tbody>
</table>

<p>|  | Deputy Principal, Educator and LRC | 1 | 6.25 |
|  | N/A, Educator, PGT, Co-ordinator and Learners | 5 | 31.25 |
|  | Staff members, learners and parents | 1 | 6.25 |
|  | Two teachers | 1 | 6.25 |
|  | One educator | 1 | 6.25 |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th>10</th>
<th>62.5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The majority of parents (62.5%) reported that there were no HIV/AIDS HACs in their schools. Furthermore, 31.3% of parents who reported the non-existence of HIV/AIDS HACs also reported that there were no committees / structures to deal with health related matters in their schools. Fifty percent of learners reported that they had HACs in their schools and the other fifty percent reported that there were no HACs in their schools. These learner percentage figures on existence of HACs in schools do not confirm the percentages (62.5% for non-existence of HACs and 31.3% for non-existence of other committees/structures in the schools. The study does not have an explanation for the conflicting data reported by learners and parents. The findings also indicate the low percentage (6.3%) of parents` participation in committees / structures.

A number of parents (37.5%) reported the existence of HIV/AIDS HAC in their schools.

Table 5.5.2: The necessity of having HIV/AIDS HAC in schools

<table>
<thead>
<tr>
<th>Do you think it is necessary for your school to have HIV/AIDS HAC?</th>
<th>Motivate your answer</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F %</td>
<td>F %</td>
<td>F %</td>
</tr>
<tr>
<td>16 10 0</td>
<td>1 3</td>
<td>81.3</td>
</tr>
</tbody>
</table>

To educate / advise the community about HIV/AIDS, other diseases, healthy living style,
Similar to learners’ response to the above questions, parents also valued the need or the necessity for HIV/AIDS HAC in schools; all parents indicated “YES”, translates to 100%. This need and necessity for HIV/AIDS within the school context were further motivated by the following answers from the parents:
The majority of the parents (81.3%) reported that HIV/AIDS HAC was crucial for educating / advising the school community about HIV/AIDS and health related matters.

Few of the parent participants (6.3%) stated that HIV/AIDS HAC should treat sick learners first before they were sent home / clinic.

A small percentage of parent respondents (12.5%) believed that HIV/AIDS HAC would promote good relationship among schools stakeholders and created an enabling environment for learners to talk freely about HIV/AIDS and health related matters.

Table 5.5.3: Operational effectiveness of the committee according to the policy stipulation

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>37.5</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>31.25</td>
</tr>
<tr>
<td>Do not know / NA</td>
<td>5</td>
<td>31.25</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

Some parents (37.5%) believed that the committee was operating according to the policy stipulations, while some parents (31.3%) did not. The other 31.3% of parents stated that they did not know; the challenge could that these parents did not know the HIV/AIDS HAC policy stipulations.
Table 5.5.4: Comments / Suggestions on the existence or absence of HIV/AIDS HAC

<table>
<thead>
<tr>
<th>About the existence</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children could now have a home to have self awareness and confidence</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>It is important for the committee to be available to guide the learners and community. Committee improves the quality of life.</td>
<td>5</td>
<td>31.25</td>
</tr>
<tr>
<td>Through the committee, advises on HIV/AIDS can be obtained. The spread of HIV/AIDS can be minimised.</td>
<td>3</td>
<td>18.75</td>
</tr>
<tr>
<td>More Training and Workshops are needed</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>About the absence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of HAC is an unfortunate situation which needs to be addressed immediately</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>Parents should educate learners during meetings at schools</td>
<td>1</td>
<td>6.25</td>
</tr>
<tr>
<td>There should HAC in every school, so that learners can express themselves freely about health related matters. HAC should be supported by the Department.</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

The parent respondents (31.3%, 18.8 and 6.3%) believed that the existence of the HIV/AIDS Health Advisory Committees in schools
were very beneficial to learners because committees would provide learners and the school community vital knowledge and information about health matters, advice on HIV/AIDS, and promote self-awareness and confidence among learners. Some parents (6.3%) suggested that more training and workshops might be needed to provide a thorough HIV/AIDS prevention and treatment strategies for all stakeholders.

The data suggested that the absence of the HIV/AIDS health committees in schools would create unfortunate situations in the school communities in general – an observation supported by 6.3% of parents’ responses. Twenty-five percent of parent respondents (25%) suggested that there should be a HAC in every school to deal with health matters.

5.7 SUMMARY OF FINDINGS FROM THE INTERPRETATION OF ANALYSED PARENTS` RESPONSES

- There huge difference between the learners’, educators’ and the parents’ responses to the questions regarding the existence of HACs and non-HAC committees and structures in the sampled schools is rather surprising and the factor responsible for this data variation is difficult to determine. The majority of parents (62.5%) reported that there is no HIV/AIDS HAC in existence in their schools, whereas learners (50%) and educators (44%) reported the existence of HIV/AIDS HACs in the selected schools studied. The second inconsistency in data and findings stemmed from the fact that 31.3% of parents reported that there was no committees / structures in their schools to deal with health related matters. This evidence suggested that some schools in Amatole District Municipality had not yet established HIV/AIDS HAC nor committees / structures.

- All the parents who responded to the questionnaire believed that the existence and the running of HIV/AIDS HACs in schools were
of paramount importance for the wellbeing of all school stakeholders. This above statement was unanimously re-affirmed by all parent respondents (100%), who responded “YES” to this question. Based upon this finding, it could be asserted that the existence of HIV/AIDS HACs within school communities made it possible for schools to deal with health related challenges / problems such as teenage pregnancy, HIV/AIDS, diseases, hygiene and healthy living style among all school stakeholders.

One of the major policy-related problems that emerged from the study was respondents’ failure to interpret the policy guides that govern the operation of HACs. There is evidence to suggest that majority of parents do not understand the policy stipulations that guide the operational effectiveness of the running the committees – the performance framework that benchmarks the operation against the policy. The parents’ response – “do not know” – appeared to have confirmed this conclusion.

5.8 SUMMARY OF CHAPTER 5

Chapter 5 dealt with the analysis of data (educators’, learners’ and parents’ responses to questionnaire questions), interpretation and presentation of findings. The researcher used tables to present the analysis. The interpretation was distilled from the data and data analysis. The final findings based on the quantitative data were summarized and presented in bulleted-format. The next chapter (Chapter 6) deals with discussion of findings, recommendations and conclusion.
CHAPTER 6
DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION
In this chapter discusses the findings of the research. The discussion of findings of this research is based on the analysis and interpretation that have been dealt with in Chapter 5 of the study. The discussion of the findings is informed and shaped by the research questions of the study. The discussion of the findings will be followed by drawing conclusions from the findings and finally making recommendations.

6.2 HIV/AIDS HAC AND ITS COMPOSITION
The National Education Policy Act (NEPA) 27 of 1996, pp.20 of South Africa on HIV/AIDS recommended that where community resources make this possible, each school and institution in South Africa should establish its own Health Advisory Committee (HAC) of the governing body or council. Where the establishment of such a committee is not possible, the school or institution should draw on expertise available to it within the education and health systems.

This policy also stated that where it is possible to establish a Health Advisory Committee, the committee should be set up by the governing body or council and should consist of educators and the staff, representatives of the parents of learners at the school and the representatives of learners or students, and representatives from medical or health care professions.
6.3 Findings
The findings that emerged from the data analysis revealed that some schools (44%) had established HIV/AIDS HACs. Their membership compositions were neither the same as those in Chapter 5 nor the membership composition stipulated by (NEPA).

The following are the details of membership compositions of the Health Advisory Committees from the 18 sampled schools: 6.3% of the HACs had 1 educator; 19% had parents, educators and learners; 6.3% had chairperson, community leader, traditional leader, community policing forum, 2 learners and SGB members, and the remaining ones have their own composition which was also different and did not comply with government policy stipulations governing the establishment of HACs.

Some schools (56%) had no HIV/AIDS HACs; instead of HACs they had other committees/structures with unique membership compositions. For example 19% non-HAC committees/structures were composed of parents, educators and learners. Few of the structures/committees (6.2%) had membership composed of Life Orientation teachers and SCO coordinators, and others had different membership composition combinations which were totally different, e.g. Pastors, PGT, etc.

6.4 THE ROLE OF THE HIV/AIDS HAC
According to the National Education Policy Act 27 of 1996 Pa-20, the role of the HAC is to:

- Elect its own chairperson who should preferably be a person with knowledge in the field of health care.
- Advise the governing body on all health matters, including HIV/AIDS.
Be responsible for developing and promoting a school plan of implementation on HIV/AIDS and review the plan from time to time, especially a new scientific knowledge about HIV/AIDS becomes available, and be consulted on provisions related to the prevention of HIV transmission in the code of conduct.

6.5 Findings
The findings revealed that the main role played by the HIV/AIDS HACs and other school health facilities that exist in different schools include the following, although it may differ from one to another school.

- The committee/structures convene meetings to discuss about the health related matters that also involve the parents.
- They have knowledge about HIV/AIDS and related matters, and they preach abstinence and condomissing among learners.
- They advise the learners at school about healthy living style as they are knowledgeable about diseases including the HIV/AIDS; for example, visiting the nearest health centre for check-ups, follow sanitary measures every time and everywhere etc.
- They also ensure that the knowledge is provided through the media (magazines, radios and televisions).
- They conduct workshops which deliver most recent scientific data on HIV/AIDS (i.e. updates).
- They make sure that at the right time they apply first aid from the nearest medical health centre.
- They take precautions to ensure a disease free-environment through regular supervision of cleaning the schools and
identifying the infected learners and referring them to the nearest health centres.

The data collected and analysed seem to suggest that the present health committees/structures are doing their best despite the challenges they face e.g. little support and high rate illiterate among parents rate in some communities especially in rural areas.

6.6 THE INVOLVEMENT AND PARTICIPATION OF THE SCHOOL STAKEHOLDERS IN HIV/AIDS HAC

The involvement and participation of the school stakeholders in the HIV/AIDS HAC plays a significant role as it promotes the health living standard in the school community through education. The National Education Policy Act 27 of 1996 on HIV/AIDS Pa-20 recommended that each school's HAC should consist of educators other staff, parents of learners, learners and health care professions. A special attention had to be paid to the current membership compositions of HACs and non-HAC committees/structures performing the functions and tasks HACs, which were mandated by the National Education Policy to perform in schools.

Involvement and participation of schools stakeholders (especially parents) in the HIV/AIDS HAC is not 100% in many schools and this may lead to unsatisfactory results. The major cause of this unsatisfactory and under-representation of parents in these committees might stem from poor communication and relationships between parents and other school stakeholders. Research, however, identifies illiteracy amongst parents as the major contributory factor responsible for the low participation and involvement of parents especially in rural areas. The findings indicated the involvement and participation of the SGB members, teachers and learners in some schools were quite good.
6.7 Findings

- According to the findings, the involvement of parents in HIV/AIDS HAC or other structures was 50% “yes” and 6% “no response” while 44% responded “no”. This findings suggests that some schools genuinely welcome parents’ involvement in their Health Advisory Committees.

- Not all parents were fully involved; this might be due to socio-economic factors such as parents’ low level of education, inferiority complex and family commitments.

- The researcher had noted that those committees/structures (44%) with no or poor parental involvement were currently taking steps to improve parents’ involvement e.g. local chiefs convened meetings 6.2%, 13%, 6.2% and 6.2%) aimed at improving full involvement of all school stakeholders.

- On the other hand, the findings revealed that 50% of learners believed that parents were involved in the committees, while other 50% did not believe that parents were involved in the committees.

The inconsistencies indicated by conflicting reports on data appear to confirm the view that parents were not fully involved in the HACs or other structures in schools and that their lack of full presentation appeared to render them invisible.

6.8 KNOWLEDGE OF HIV/AIDS HAC

According to Sharma (2006, pp. 47-48), education systems in many countries must undergo substantial charge if they are to survive the impact of HIV/AIDS and play an effective role in the provision of education for prevention of HIV. In particular teacher educational institutions may require re-designing so as to meet radically changed circumstance. Beyond the education system the HIV/AIDS epidemic is undermining the institutions and human resources on which future
health security and progress depend. These include both formal and non-formal systems of care and support.

In addition, Sharma (2006, pp. 47-48) stated that while education alone cannot provide the answers to all these problems, action to strengthen the education system and to ensure that both schools and out of school education contribute more effectively to HIV/AIDS prevention can help communities and nations respond more effectively. The provision of more flexible forms of education is essential for reaching vulnerable children and young people and to ensure that they do not lose out on the knowledge and skills they will need in the future (Sharma 2006, pp.47-48).

According to the National Education Policy Act 27 of 1997 on HIV/AIDS PA-20 the HAC may as far as possible use the assistance of community health workers led by a nurse or local clinics. The Act (1996) recommends that one representative from medical or health care profession must be a member of HAC. Another policy stipulation stated that HIV/AIDS education programme, which incorporates life-skills, must be implemented at all schools and institutions for all learners, students, educators and other staff members. These HIV/AIDS-cum-life-skills measures must also be implemented at school hostels. Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students and should be integrated into the life-skills education programme for pre-primary, primary and secondary school learners.

The policy states that education and information regarding HIV/AIDS must be given in accurate and scientific manner and in language and in terms that are understandable. Parents of learners and students must be informed about all life skills and HIV/AIDS education offered at all schools and institutions. This procedure should become the learning content and the methodology to be used as well as values
that must be followed in schools and institutions. Parents, the ACT insists, should be invited to participate in the parental guidance sessions and should be made aware of their role as sexuality educators and imparters of values home.

6.9 Findings

In Chapter 5 the findings revealed that the majority of educators (69%) believed that HIV/AIDS HACs and other committee/structures in their schools had enough knowledge about HIV/AIDS and related diseases while 31% thought that HIV/AIDS HACs and other committee/structure in their schools did not have enough knowledge about HIV/AIDS and related diseases.

The 61% of educators who indicated that there was “enough knowledge“ resources stored in their HACs further motivated their answers by stating that the availability of the knowledge stemmed from the presence of the following:

- Some trained and qualified committee members
- Policy document to refer to
- Educational material to refer to
- Health officials visit their schools

The educators who indicated “no enough knowledge (31%)” further cited the following challenges which hinder the necessary knowledge to the committee and school community at large:

- Many parents may be lacking knowledge about HIV/AIDS and health related matters due to illiteracy and their cultural background.
- Learners may be having insufficient knowledge about HIV/AIDS and health related matters.
6.10 THE STRATEGIES/ PROCEDURES EMPLOYED BY SCHOOLS TO PROMOTE A DISEASE-FREE ENVIRONMENT AND TO IMPROVE HEALTHY STANDARD/ CONDITIONS

According to the National Education Policy Act (NEPA) 27 of 1996 on HIV/AIDS (Pa-20) under the subtopic, School and Institution Implementation Plans, the terms of its functions under the South African Schools Act, 1996 the Further Education and Training Act 1998, or an applicable provincial law, the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the National Policy.

On preventing HIV/AIDS, Sharma (2006, pp.84) stated that infection can be prevented by never sharing needles and abstaining or having oral, virginal or and sex. Risk can be substantially reduced by latex condoms for all types of sexual intercourse, and avoiding contact with blood, semen, vaginal fluids and breast milk of an infected person. Sharma (2006, pp. 84) also added that avoidance of alcohol and drugs is also a key to the prevention of spread of HIV not because a person can get HIV from drinking and doing drugs but drinking and drug use often leads to risky behaviours that are associated with an increased risk of infection.

In his conclusion Sharma (2006, pp.84) states that doctors and counsellors suggest that becoming knowledgeable and discussing sex and other difficult issues earlier on, even before the teen years is important. After all the issues involved understanding the body and sexuality, adopting health behaviours, respecting others and dealing with feelings are topics that have meanings at all ages. Open communication and good listening skills are vital for parents and children.
6.11 Findings

The findings revealed that most schools are engaged in concerted efforts aimed at improving health standards/ conditions of the school community. For example the following points highlight the extra efforts being made by the schools to promote a disease-free environment and to improve healthy standards/ conditions. The listed findings together with percentages of response rates convey participants’ views:

- Bringing sanitary material and ensuring that sanitary measures are followed (6.3%).
- Educate everybody in the community (6.3%)
- Everyone is involved in cleaning the school (6.3%)
- Schools invite health workers to conduct to workshop health-awareness campaigns/ programme (37.5%)
- School cleaning is done regularly (6.3%)
- School fencing programme is carried out (a plan to have a vegetable garden)
- Everyone (learners and teachers) are advised to visit the nearest clinic/ doctor for check-up
- Counselling is done to the infected ones continuously, and the safe sex and abstinence is promoted (6.3%)
- Building of toilets and provision of water tanks to promote hygiene has taken place in some schools (6.3%)

The findings also have suggested the following incidence of poor performance schools in discharging their duties effectively:
There are schools that do care about making concerted extra efforts to improve health standards/ conditions of the school community reported (6.3%).

6.12 CHALLENGES FACED BY HIV/AIDS HEALTH ADVISORY COMMITTEE IN SCHOOL

The findings under this theme revealed that all schools with or without HIV/AIDS HAC were still plagued by problems that appeared to defy solutions. The following are the problems that faced schools that had established HACs. The HAC-related problems prevented the committees/ structures from performing their functions in accordance with the National Education Policy Act 27 of 1996 on HIV/AIDS:

- Absenteeism, dropping-out of school and poor academic performance (6.2%)

- Learners’ lack of confidence and moral courage to talk about their HIV status or learners’ failure to summon courage to talk freely in presenting their health related matters (6.2%).

6.13 Schools with Non-HAC Structures: Their Challenges Include the Following:

- High rate of absenteeism, massive drop-out rates and poor performance (19%)

- School stakeholders (parents, teachers and learners) were incapable of identifying the HIV/AIDS infected learners and dealing with them accordingly (6.2%)

- Learners were not confident enough to talk about their HIV status (6.2%).

- The members of the committees received no formal training hence some of them lacked the necessary confidence and ultimately lost interest.
Advice from the committees/structures was not regular in some communities, especially in the rural communities.

Many schools had no access to assistance from the community health workers led by a nurse, or local clinics, as indicated in the data collected.

The realities on the ground suggested that no time allocated for the HIV/AIDS HACs to organise workshop/programmes that aimed at improving effective management of the HACs and committees/structures. All these HAC activities aimed at enhancing the performance of the HACs and structures outlined research data and extant literature were not deemed to be important and therefore, not enforced by the school management-decision-makers.

6.14 RESOURCE ISSUES

The findings suggest that most schools do not have enough resources to cater for HAC or Health Advisory activities. This could be simply because schools do not have specific budget allocated for HAC activities, first-aid-tools and equipment.

It has been observed that some schools that have financial resources do not very often spend all the funds allocated because those in charge of managing the committees do not have necessary special training offered the Department of Health, which provides the skills for running the HACs.

The available equipment (tables, chairs, cupboards, stationary, first aid kit television etc) has a little value to some parents and learners as they tend to use them for some other purposes e.g. community, youth concert.
In schools that do not have secured working environment the resources – cleaning materials etc – are easily lost or stolen by some poor community members and sold elsewhere.

These findings mean that schools have to work very hard to change the mindset of the communities in relation to the attitude they have on the available health resources.

6.15 SUMMARY OF FINDINGS

The majority of schools which participated in this research study formed/ established their HACs or other health committees in their schools 4, 5 or even 6 years after DoE endorsement of the policy in 1997. The National Education Policy Act 27 of 1996 which recommended the establishment of HAC in schools was endorsed in 1997 by South African government. This finding revealed that many schools were not ready immediately after 1997. It is possible to conclude that some schools in the Amathole District Municipality have not yet implemented HAC policy.

Data and the findings indicated that some schools in the Amathole District do not have HAC. Instead of HACs, they have other health advisory structures.

The involvement of parents in HAC or other health structures, what translated into about 43.8% ([50% + 44% + 37.5%] ÷ 3)) average could be described as unsatisfactory.

Parents believed that there was the need for HIV/AIDS HACs in their school communities as they were considered capable of addressing health related challenges/ problems such as teenage pregnancy HIV/AIDS diseases, hygiene and healthy living style among the school stakeholders.
The data indicated that the schools displayed lack of seriousness towards policy implementation dealing with health related matters.

The extant literature suggested that cultural and social norms impacted negatively on the practical performance of the HIV/AIDS structures and committees that were working on the health related matters.

Other stakeholders (parents and learners) were not well informed about education policies that affected their own lives within the school landscape.

Inferiority complex and inadequate education among the parents undermined their participation and involvement in school matters.

The pressure on Department of Education in schools for the good matric results turned the focus to the grade 12 classes. The preoccupation with matric classes derailed the programmes aimed at implementing HAC-related activities in schools. The shortage of committed and dedicated staff in some schools also had a negative impact on the establishment of such committees that might have improved the health of school communities.

The data collected and the existing literature has also suggested that school stakeholders (some members in the SGBs) were disinterested in the establishment of HIV/AIDS health advisory committees in their schools.

The research has also suggested that willingness and readiness to implement the education policies differs from one school to another, and is also determined by the attitude of the stakeholders (SMT and SGB) towards the policies. 6.17. Based on
the findings of this study there are various suggestions that I recommend below.

6.16 RECOMMENDATIONS

Just like any other research study recommendations are crucial as they suggest the remedial measures that address the challenges highlighted by the research findings. The recommendations for this study include the following:

- **Schools** which are part of this study need to be provided with adequate guidance concerning educational policies on mainstreaming HIV/AIDS into the school curriculum so that the quality of education as well HIV/AIDS prevention programmes could be improved in our country.

- **A close supervision** by the Department of Education on the implementation of its policies is necessary.

- **Training workshops** by Department of Health and Department of Education have to be continuously conducted in schools to equip the committee/structures and to enable all members to understand and comply with valid policy stipulations.

- **Only people** who are committed, dedicated and show interest have to be elected into the school committees/structures e.g. (HIV/AIDS HAC)

- **Challenges and problems** have to be tackled immediately or reported to the relevant section in the Department of Education.

- **Quarterly reports** on the efficient functioning of the HACs should be submitted to the relevant section in the Department of Education, so that Department of Education could provide early intervention where necessary.
There must be a special budget allocated for the effective management of HIV/AIDS HAC in all schools in South Africa.

Schools and wider communities ought to be updated on the health matters by the Department of Health.

Regular visit by the Department of Education is essential for effective management of these committees.

6.17 CONCLUSION OF THE STUDY

The study concludes that the existence of the HIV/AIDS HAC is essential and necessary in all schools as it ensures a healthy living in the school communities as suggest by the findings of this study. The absence of HIV/AIDS Health Advisory committee impacts on the performance of teachers and learners as the committee is not working in schools that this study was conducted on. Furthermore, the continuous training of the committee members has to be conducted in all schools and in communities to narrow the gap between literate and illiterate members of the HACs. It will also be of importance if home visits by the health workers could be done on a regular basis as this might also bring about change in the attitude of some people in the school community. Finally, study suggests that if the Department of Health and Education Department work closely together and adopt collaborative relationship the challenges that face the effective implementation of the HIV/AIDS Health Advisory Committees implementation could addressed.
7. REFERENCES


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8. LIST OF APPENDICES

Appendix A: Questionnaires

QUESTIONNAIRE FOR EDUCATORS

This research seeks your opinion on the existence of HIV/AIDS Health Advisory Committee or any other relevant committee which is promoting or improving the health standards amongst the school community members. Please give us your honest opinion regarding this committee. Please tick the appropriate box.

1.1 Does your school have the HIV/AIDS Advisory Committee (HAC)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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1.2 If your answer is No what kind committee or structure is existing and attend the health related matters in the school?

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1.3 What is the composition of the committee?

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1.4 Are parents and learners fully involved?

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<tr>
<th>Yes</th>
<th>No</th>
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1.5 If No what steps are you taking to improve their involvement?
1.6 Does the committee have enough knowledge about HIV/AIDS?

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<th>Yes</th>
<th>No</th>
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1.7 Motivate your answer

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1.8 What challenges do you experience if there is or there is no Advisory committee at your school?

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1.9 Does the committee have enough resources at their disposal?

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<th>Yes</th>
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1.10 Give commends on the existence or absence of the HIV/AIDS Health Advisory Committee.

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1.11 How informative do you consider the Health Advisory Committee at your school?

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Useless</th>
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**QUESTIONNAIRE FOR LEARNERS**

This research seeks your opinion on the existence of HIV/AIDS Health Advisory Committee or any other relevant committee which is promoting or improving the health standards amongst the school community members. Please give us your honest opinion regarding this committee. Please tick the appropriate box.

1.1 Does your school have the HIV/AIDS Advisory Committee (HAC)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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1.2 If your answer is No what kind committee or structure is existing and attend the health related matters in the school?

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1.3 What is the composition of the committee?

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1.4 Do you think it is necessary for your school to have it?

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1.5 Motivate your answer you gave above.

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207
1.6 Are your parents fully involved in this committee?

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<th>Yes</th>
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<tr>
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1.7 Why do you think that this committee is necessary or not necessary at your school?

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1.8 How important do you consider the task performed or would be performed by the HAC at your school?

(1) not at all (2) very little (3) a little (4) a lot (5) a very great deal

1.9 What can you say about the existence or absence of this committee at your school?

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QUESTIONNAIRE FOR PARENTS

This research seeks your opinion on the existence of HIV/AIDS Health Advisory Committee or any other relevant committee which is promoting or improving the health standards amongst the school community members. Please give us your honest opinion regarding this committee. Please tick the appropriate box.

1.1 Does your school have the HIV/AIDS Advisory Committee (HAC)?

| Yes | No |

1.2 If your answer is No what kind committee or structure is existing and attend the health related matters in the school?

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1.3 What is the composition of the committee?

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1.4 Do you think it is necessary for your school to have it?

| Yes | No |

1.5 Motivate your answer you gave above.

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1.6 Is the committee operating effectively according to the policy stipulation?

Yes [ ]
No [ ]

1.7 Why do you think that this committee is necessary or not necessary at your school?

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1.8 Give comments / suggestions on the existence or absence of the HIV/AIDS Health Advisory Committee.

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210
THE CIRCUIT MANAGER
DUTYWA EDUCATION DISTRICT
DUTYWA
5000

SIR / MADAM

RE-REQUEST FOR PERMISSION TO CONDUCT AN
EDUCATIONAL RESEARCH

I am a part-time student at WSU who is doing M.Ed. level 2. I therefore humbly request your permission to conduct a research on the existence of the HIV and AIDS Health Advisory Committee (HAC) in all Senior Secondary Schools in the Dutywa Education District.

This is an investigation task towards my studies which aimed at promoting the health standards in all schools.

I will appreciate your positive response on this matter.

Thank you,

Yours truly

S.M. Mbayeka (0731590048)
Appendix C: Letter from the Circuit Manager

Province of the
EASTERN CAPE
DEPARTMENT OF EDUCATION
Private Bag X 1203 "Dutywa" 5000* REPUBLIC OF SOUTH AFRICA
Enquiries: N.Jadezweni  Tel No. 0474891147  Cell No. 0820911242  Fax No. 0474891028  IDS&G Section

Mbashie Circuit

Permission to Conduct an Educational Research

Dear Principals

Please, be advised that permission has been granted for Mr S.M. Mbayeka to gain access to your institutions to conduct research for his M.Ed studies. As scholars yourselves and therefore appreciative of the undertaking, it is my confident anticipation that you will welcome and give him all the support necessary for his project. Additionally, Mr Mbayeka is one of our own as he currently teaches at Bashee C.H.S.

Yours in education service
N.Jadezweni – EDO – Mbashie Circuit  30/03/2011
Appendix D : Letter from District Director : Department of Education

Province of the
EASTERN CAPE
DEPARTMENT OF EDUCATION

TO : Mr M. Mbayeka
FROM : District Director: Dutywa
SUBJECT : Permission to Conduct Research
DATE : 23 March 2011

Kindly be advised that Mr S.M. Mbekela has been permitted to conduct research in your school in pursuit of her studies M.Ed level 2, towards Health Advisory Committee (HAC) at WSU.

Yours truly

DISTRICT DIRECTOR
A.M. DWANGU

DISTRICT DIRECTOR
DUTYWA EDUCATION DISTRICT
F/BAG X1203
TEL: 047 489 2247
FAX: 047 489 1148

"STRIVING TO TURN THE SITUATION AROUND"
APPENDIX K

WALTER SISULU UNIVERSITY
DIRECTORATE OF POSTGRADUATE STUDIES
MANDATORY CONSENT FORM: ELECTRONIC Theses & DISSERTATIONS (ETD) AND PLAGIARISM REQUIREMENT (For postgraduate research outputs from 2009 September)
TEMPLATE FOR THE STUDENT AND SUPERVISOR CONSENT FOR PUBLICATION OF ELECTRONIC RESEARCH OUTPUT ON INTERNET AND WSU INTRANET

FACULTY:

QUALIFICATION NAME: ___________________________ ABBREVIATION: _______ YEAR: ____________

STUDENT'S FULL NAME: ________________________ STUDENT NUMBER: ______________________

TYPE OF RESEARCH OUTPUT: RESEARCH PAPER/MINI-DISSERTATION/DISSERTATION/THESIS (TICK ONE)

TITLE OF THE RESEARCH OUTPUT:

CONSENT: I HEREBY GIVE MY CONSENT TO WALTER SISULU UNIVERSITY TO PUBLISH MY RESEARCH OUTPUT FOR THE QUALIFICATION ABOVE ON THE WSU INTRANET AND INTERNET. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THERE IS NO PLAGIARISM IN THE RESEARCH OUTPUT AS SUBMITTED. I HAVE TAKEN REASONABLE CARE TO ENSURE THAT THE RESEARCH OUTPUT MEETS THE QUALITY LEVEL EXPECTED FOR THE PRESENT QUALIFICATION LEVEL BOTH IN TERMS OF CONTENT AND TECHNICAL REQUIREMENTS. I FULLY UNDERSTAND THE CONTENTS OF THIS DECLARATION.

SIGNATURE OF STUDENT: ___________________________ DATE: ____________

ENDORSEMENTS BY:

SUPERVISOR:
FULL NAME: ___________________________ SIGNATURE: ___________________________ DATE: ____________

CO-SUPERVISOR(S):

1. FULL NAME: ___________________________ SIGNATURE: ___________________________ DATE: ____________

2. FULL NAME: ___________________________ SIGNATURE: ___________________________ DATE: ____________