

EDUCATORS' ATTITUDES TOWARDS HIV/AIDS

by

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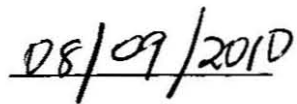
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DECLARATION

I, Protasia Lily Bathelile Shazi-Mweli, (Student number 011162) do hereby declare that this mini-dissertation, which is submitted in partial fulfillment of the requirements of the degree of Master of Educational Psychology to the University of Zululand, is my own work in design and execution and has not been previously submitted by me for a degree at any other university, and that all sources I have used or quoted have been indicated and acknowledged by means of a complete reference.



Protasia Lily Bathelile Shazi-Mweli



Date

ACKNOWLEDGEMENTS

I express my sincere gratitude to:

- **God for giving me strength, wisdom and motivation to complete this study.**
- **My parents for instilling in me the desire to study despite all the odds. May their souls rest in peace.**
- **My husband and my children for their sacrifice and understanding.**
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DEDICATION

This study is dedicated to

**My late parents Catherine and Paulos,
my husband Victor and our children
Lihle, Sabelo, Nondumiso and Unami**

ABSTRACT

Title of dissertation: Educators' Attitudes towards HIV/AIDS at Rural Schools

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One of the most devastating diseases in modern history as measured in terms of loss of human life is the HIV/AIDS pandemic – approximately 200 million people have already died. Sub-Saharan Africa is the most affected with South Africa severely affected with an estimated 6 million HIV positive South Africans and 2.5 million already dead from AIDS or related illnesses.

This study, located at several primary and secondary schools in the deep rural areas of the Scottburgh circuit, KwaZulu-Natal, South Africa, was undertaken to investigate the trend that, despite a higher level of knowledge and exposure to information about HIV/AIDS amongst educators and despite comprehensive campaigns to fight HIV/AIDS, an increasing number of educators are still dying from the disease. In this study it is assumed that knowledge alone is not enough and that attitude change is central to HIV/AIDS prevention since attitudes influence the way in which persons behave. The following research questions are asked: What is the nature of educators' attitudes towards HIV/AIDS, and, are the educators' attitudes towards HIV/AIDS influenced by variables such as age, gender, religion, experience and qualification? Thus the study aims to: determine the nature of educators' attitudes towards HIV/AIDS, and find out whether or not educators' attitudes towards HIV/AIDS are influenced by characteristics such as, gender, age, experience, religion, and qualification. To determine this, a quantitative study was

conducted with 71 secondary and primary school educators in the rural area of KwaZulu Natal, Scottburgh district. The survey, a cross sectional design, involved administering a fixed response questionnaire (Likert scale type) categorized into five scales, which described the nature of educators' attitudes towards HIV/AIDS.

The study revealed that there was no significant difference amongst the sampled educators' attitudes towards HIV/ADS, and that these attitudes were mostly negative. This difference was also not influenced by educators' age, gender, qualification, experience or religion. The study found that educators were still discriminating, reluctant to test themselves and disclose their HIV/AIDS status, which may be related to the failure of HIV/AIDS prevention strategies. The campaign to stop the spread of HIV/AIDS in schools and in communities appears to be jeopardized by such attitudes of educators.

The following was recommended: the cascading system of training educators did not work and therefore the Department of Education must ensure that every educator has an opportunity to receive training in HIV/AIDS information; that support systems (emotional, psychological, medical) for those educators infected and affected by HIV/AIDS be made available; financial allocations to HIV/AIDS prevention programmes should be increased but with better financial control; employment of full-time co-ordinators who are knowledgeable; provision of incentives to encourage educators to test for HIV/AIDS and programmes that provide social skills training needed for behavioural change, as well as those that aim at reducing stigmatization, ostracism and discrimination of individuals infected. The researcher suggests that an immediate, urgent strategy to address educator attitudes towards the disease is required from the relevant

government departments.

KEY CONCEPTS

The following are the key concepts of the study:

- Educators
- Attitudes
- HIV
- AIDS

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CHAPTER 1

Introduction: Orientation and Background to the Study

1.1 Introduction

Voluminous studies testify that one of the most devastating diseases in modern history as measured in terms of loss of human life is the HIV/AIDS pandemic (Bateman 2003; Matyu, 2003; Mannah, 2002; Hernes, 2002; Morrel, Unterhalter, Moletsane and Epstein, 2001; Piot and Kelly, 2001; UNAIDS, 2000; Whiteside and Sunter, 2000). Approximately 200 million people have already died, and an estimated 60 million have already been infected, one third of whom are between 15 and 24 years of age. Sub-Saharan Africa is the most affected (Morrel, Unterhalter, Moletsane and Epstein, 2001). South Africa is severely affected by HIV/AIDS with an estimated 6 million South Africans HIV positive and 2.5 million already dead from AIDS or related illnesses. Mortality rate is expected to rise by 2010 and life expectancy to drop from 68 to 40 years (Mannah, 2002; Whiteside and Sunter, 2000).

According to Mannah (2002), government employees in South Africa are second only to mining employees who have the highest HIV/AIDS infection rate. A significant number of government employees are educators and they form one of the largest occupational groups in the country. Since the education system is extensively human resourced, South African educators fall into a population category especially at risk of HIV/AIDS. It is estimated that 26% of employees in the government sector will be infected by 2010 and that 17% are already infected. This has serious negative implications for the teaching profession.

Research conducted by the South African Democratic Teachers Union (SADTU) on membership diseases indicated that two educators die daily from AIDS related diseases at an average age of 38.95 years, and more female educators are dying compared to male educators in the same age

level (Mannah, 2002). Despite a comprehensive campaign to fight HIV/AIDS, more and more educators are still dying from the disease. This study, located at several primary and secondary schools in the deep rural areas of the Scottburgh circuit¹, is a quantitative study that intends to describe the nature of educators' attitudes towards HIV/AIDS, as well as whether these attitudes towards HIV/AIDS are influenced by variables such as age, gender, religion, experience and qualification.

1.2 Motivation for the study

This study, motivated by a personal imperative, derives from a concern that despite comprehensive campaigns in South Africa to fight against HIV/AIDS, an increasing number of educators are still dying from the disease. The rising prevalence of HIV/AIDS infection rates indicates that most strategies to contain the disease had not been effective (Walters, Desmond, Wilson and Heard, 2001). This study focuses on the attitudes of educators towards HIV/AIDS, since educators play an important role in society as information and knowledge disseminators, and are regarded as role models. Attitudes are central to change of HIV/AIDS risk behaviour. It was envisaged that by changing educators' attitudes towards HIV/AIDS, behaviour that increases their risk to HIV infection, could also be changed. Therefore the primary aim of the study was to investigate the attitudes of educators towards HIV/AIDS. It was based on the assumption that negative attitudes of educators towards HIV/AIDS could result in their avoidance of the necessary precautions, as well as a failure to impart necessary information to learners. This might lead to many the infection of many educators and learner. Educators play an important role in learners' lives and in the community. As the HIV/AIDS epidemic increases, there is a growing number of learners being orphaned. This results in an increasing number of children and youth heading households. Educators have a greater responsibility of teaching skills needed to help learners

¹ a coastal town in KwaZulu Natal, on the east coast of South Africa

make healthy lifestyle choices, resist negative pressures and minimize harmful behaviours.

According to UNAIDS (2000), schools are the primary institutions that are able to reach the majority of learners while also having an impact in the community. UNAIDS (2002) maintains that education has a key role to play both in preventing HIV/AIDS and in mitigating its effect on individuals, families, communities and society. Whiteside and Sunter (2000) found that there are two crucial areas where more attention is needed. Firstly, schools need to be used for HIV/AIDS education, and secondly, the programme should start at a very early age, probably when the learner is six years old. This is valid since learners spend most of their time at school. All provinces in South Africa have mandated that AIDS education be included in their school curriculum. According to Peltzer (2000), learners continue to have many fears and questions about HIV/AIDS arising from lack of understanding and education. Learners, especially the younger ones, value educators' opinions. Since some learners are orphans and others have working parents, there is not enough time to share HIV/AIDS information. Information from well informed educators with positive attitudes can play an important role in preventing HIV infection in learners as well as the parents and the community. This will enable learners to initiate family discussions about HIV/ AIDS – topics that are often forbidden in many families.

Piot and Kelly (2001) maintain that HIV/AIDS is unequivocally the most devastating disease the world has ever faced and it will get worse before the situation improves. These authors argue convincingly that the cross-sectional strategies must be adopted to fight HIV/AIDS, one that will take full advantage of the benefit of education and help to create healthy, cohesive societies.

Bateman (2003) asserts that South African educators have a higher HIV/AIDS incidence than the general population. His study of 38 educators carried out in KwaZulu-Natal in the year 2001 indicated that only four educators would remain by the year 2010. Beyond the loss of trained and

experienced human resources, teaching and learning will become an increasingly stressed process, located in a more and more traumatized social environment.

Walters et al. (2003), in their study on in-service educators in KwaZulu Natal, found that educator mortality had risen from 8% in 1999 to 11% in 2000. The population age group mostly affected was 49 years and younger, and the male-female ratio was 1:2. Mortality rate is expected to rise to around 5% by 2010. From this study it became clear that HIV/AIDS was affecting most active and productive members of the educator population.

According to Piot and Kelly (2001), HIV/AIDS prevalence among young people is high and rapidly rising. Thirty percent of people living with HIV/AIDS are under the age of 24. Education can reduce the risk and vulnerability to HIV/AIDS by providing information and skills, access to trusted adults and increasing literacy. According to the South African Democratic Teachers' Union regional secretary Herald (2003), the Department of Education needs to play an important role in assisting AIDS orphans. He further stated that there were many educators identified in the region as living with HIV/AIDS and that both educators and learners would benefit from counselling. This means that educators need to be equipped with skills to teach HIV/AIDS education since infection rates tend to increase. However the strategies that are used are not effective enough. Learners are infected with HIV/AIDS while they are still at school, and girls are especially at risk. Girls, who are orphans, have no adult supervision and some enter into relationships with older men. Therefore the attitudes of educators need to change in order to carry out this vital task of preventing HIV/AIDS infection for themselves and learners.

Kelly (2000) asserts that if educators can have positive attitudes towards HIV/AIDS and serve as role models, many of the educators and learners can be prevented from contracting HIV/AIDS. This is particularly relevant in the primary schools since attitudes and beliefs are formed early in

life.

Educators need to be properly prepared, trained, supervised and monitored to teach HIV/AIDS education. For example, it cannot be assumed that educators who were trained to teach science or religious education, possess the competency to teach learners about sexuality education, relationships and health. Educators require training and support, good knowledge and attitudes as well as skills to protect themselves and others from HIV infections (UNIADS, 2002).

1.3 Statement of the problem

Although educators are an educated segment of society, and despite a comprehensive campaign to fight HIV/AIDS, an increasing number of educators are still dying from the disease. In relation to educators' levels of education, it is expected that they are knowledgeable, and exposed to information about the dangers of sexually risky behaviour, as well as methods of prevention of the spread of HIV. In this study it is assumed therefore, that knowledge is not enough; attitude change is central to HIV/AIDS prevention since attitudes influence the way in which persons behave. The following questions address the problem:

1.3.1 What is the nature of educators' attitudes towards HIV/AIDS?

1.3.2 Are the educators' attitudes towards HIV/AIDS influenced by variables such as age, gender, religion, experience and qualification?

1.4 Aims of the study

1.4.1 To determine the nature of educators' attitudes towards HIV/AIDS.

1.4.2 To find out whether or not educators' attitudes towards HIV/AIDS are influenced by characteristics such as:

- Gender
- Age
- Experience

- Religion
- Qualification

1.5 Hypotheses

1.5.1 Educators do not differ significantly in their attitudes towards HIV/AIDS.

1.5.2 The educators' attitudes towards HIV/AIDS are not influenced by variables such as gender, age, experience, religion, qualification and the nature of their attitudes.

1.6. Delimitation of the Study

This study was conducted at 8 primary and secondary schools in the rural areas of KwaZulu Natal south in the Scottburgh circuit². Seventy-one educators were sampled by means of a questionnaire.

1.7 Key Concepts

1.7.1 Attitudes

Attitudes refer to a collective set of beliefs or a way of thinking of a particular individual. In this study "attitudes" refers to the educators' feelings, opinions, and views about HIV/AIDS as measured by the scores obtained in attitude scale.

1.7.2 Educators

The traditional term is "teacher". In the context of the new South African curriculum, the term "teacher" has been replaced by "educator". In this study the sample consists of educators from the population of secondary and primary schools teacher/educators clustered in the district.

² For administration purposes, the Department of Education groups a cluster of school into "circuits", which fall into different geographical areas or regions.

1.7.3 HIV/AIDS

HIV is an acronym for “human immune-deficiency virus” and AIDS stands for “acquired immune-deficiency syndrome”. People who are initially infected with the virus, suffer from a progressively declining immune systems, until the immune system totally collapses causing the person to die from a host of opportunistic infections.

1.8 Research Design and Methodology

1.8.1 The Research Instrument

According to Brucker and Hall (1996) the questionnaire using items presented in a Likert scale is used in most studies of attitudes. The present study followed the same procedure.

The questionnaire was divided into two subsections – A and B. In Section A, the *Biographical data*, participants were required to provide information such as *age, gender, academic qualifications, experience and religion*. In Section B, participants were required to respond to attitudinal statements formulated as a Likert scale. The Likert Scale is an ordinal ranking scale since it indicates the difference among categories which can be ranked or ordered. The Likert scale is called a summated rating or additive scale because the respondents score on the scale is computed by summing the number of responses the respondents give (Neuman, 2000). For the purpose of this research answers were ranked in descending order from 5-strongly agree, 4-agree, 3-undecided, 2-disagree, to 1- strongly disagree. Respondents were required to mark the scale with an “X”.

1.8.2 Research design

Survey studies are research studies in which self-report data are collected from the sample in order to determine the characteristics of a population. The researcher merely searches for accurate

information about the characteristics of particular subjects or the frequency of a phenomenon's occurrence. The simple survey design was chosen for this study because it describes certain characteristics of the population, namely, attitudes.

The research design that was used in this study was the quantitative, non-experimental descriptive type. This design is descriptive since it provides descriptions of variables in order to answer the research questions. Quantitative research focuses on measurable aspects of human behaviour, that is, numerical descriptions are attributed to responses of participants. It would be unethical to manipulate variables such as illness (HIV/AIDS) in the human population. Thus, this study was carried out in the natural setting, namely, the schools, and the phenomena were observed as they occurred.

1.8.3 Population

The survey was conducted with 71 secondary and primary school educators as units of analysis. The survey was a cross-sectional design, since it involved data collected at one point in time from the sample of school educators in the Scottsburgh district.

1.8.4 Sampling

Cluster random sampling was used. Wiersma (1991) states that cluster sampling involves the random selection of clusters from a large population of clusters. All population members of a selected cluster are included in the sample. In this study the cluster was the selected schools in the district. Cluster sampling was selected for its convenience since it was not feasible to make up a list of every educator in the district. The schools were selected by random sampling from the list of all the schools in the district.

1.8.5 The Pilot study

The pilot study is the pretest that is done on few respondents who are not part of the study in order to identify any problems with the instrument used. In this study, the pilot study was done on three educators. The problems identified in the questionnaire were attended to before it was administered to the participants (Wiersma, 1991).

1.8.6. Reliability and validity

Reliability of the questionnaire was assessed using Cronbach Alpha test. The test measure indicated that there was medium internal consistency and reliability. To establish validity, the pilot study was done on three educators who were not part of the study. to test for clarity and precision of the questions in terms of the ability to extract information relevant to the questions guiding the research.

1.8.7 Ethical considerations

An important aspect of conducting this research was to obtain informed consent. The district manager was informed in writing and permission obtained to conduct the research. The schools were selected by random sampling from the list of all the schools in the district. The researcher requested permission from the principal of each selected school telephonically. When the permission had been granted the researcher visited the school on the pre-arranged date and time. The purpose of research, informed consent and issues of confidentiality were discussed with educators. The researcher moved around as the educators were filling the questionnaire to attend to queries immediately.

1.8.8 Method of data analysis

The data was captured on an Excel spread sheet and was computer analyzed using the statistic package SPSS (2005 version). The results were presented in two sections – A and B. Section A dealt with descriptive statistics which included the bar graphs and the measure of central tendency

statistics, namely, the mean to indicate the average score and the standard deviation to indicate the variability of scores for the sample. In section B, inferential statistics were conducted, namely, the t-test and the ANOVA test to make inferences about the population and to accept or reject the null hypothesis. The t-test was used to find the difference between two groups, in this case gender. The ANOVA was used for several groups, namely, age, qualification, and experience.

1.9 Conclusion

HIV/AIDS is the most devastating disease in recorded history. If nothing is done to curb the pandemic, many children will be left without parents and adults to guide them and provide supervision. The impact of HIV/AIDS in our country is great. It calls for a renewed commitment from all South Africans to make lifestyle changes. Numerous strategies had been adopted to fight the disease, but nothing seems to work. The high rate of death among educators from HIV/AIDS related illnesses indicate that they are not taking precautionary measures or not taking the disease seriously. An urgent strategy that attempts to facilitate a change in attitudes is needed. Life skills through education can help to contain the disease if the educators have positive attitudes and possess relevant information to teach their learners. Educators are the custodians of our education and greater emphasis should be placed on changing educators' attitudes and educating them about the disease. The high incidence of pregnancy among learners indicates that they are not getting the clear message about the HIV/AIDS prevention.

Therefore this quantitative study intends to describe the nature of educators' attitudes towards HIV/AIDS, as well as whether these attitudes towards HIV/AIDS are influenced by variables such as age, gender, religion, experience and qualification.

1.10 Structure of the Thesis

In this *Chapter One*, the study was contextualized by describing the background and motivation for the study, and the critical questions and aims of the study. The hypotheses statement was formulated, some of the salient concepts were summarized and the research methodology and design were introduced.

In *Chapter Two* the review of literature on the nature of educators' attitudes towards HIV/AIDS is discussed. Previous research on the influence of characteristics such as gender, age, religion, experience and qualification on the nature of educators' attitudes towards HIV/AIDS is reviewed. Finally, the theoretical approaches to individual level change in HIV/AIDS risk behaviours are also discussed.

Chapter Three describes the sample, the rationale for the control of variables, the reasons for the choice of the measuring instruments, the validity and reliability of the measuring instruments, the scales of measurement, the procedure for data collection, the method of statistical analysis and ethical considerations.

In *Chapter Four* the analysis and interpretation of data is presented. The elicited data is presented in the sequence of the research questions as listed in the questionnaire and graphs are used to validate the data. The presentation begins with the descriptive statistics that describe the results, and then the inferential statistics which includes the t-test and ANOVA test, which are used to test the hypotheses.

Chapter Five focuses on crystallizing and developing findings based on the data that was discussed in the previous chapter. The themes that have emerged from the analysis provide an understanding of educator attitudes and influencing variables. The chapter concludes with a discussion of the limitations of the study, recommendations and a final conclusion.

1.11 SIGNIFICANCE OF THE STUDY

The study of this nature is significant for Department of education to reduce the number of educators and learners being infected with HIV/AIDS.

CHAPTER 2

Literature Review:

Educator Perceptions and Attitudes towards HIV/AIDS

2.1 Introduction

Although much has been written about HIV/AIDS, for the purposes of this mini-thesis an annotated description of the disease is presented as a backdrop. The acronym AIDS stands for “acquired immune deficiency syndrome”, the first case being reported in 1981 in the USA by the Centres of Disease Control. People with HIV/AIDS suffer from a functionally and progressively declining immune system. The consequences of this are a greater likelihood of those infected to develop opportunistic infections. The majority of biomedical scientists agree that a retrovirus, a human-immune-deficiency virus (HIV) and an unknown number of its mutations cause AIDS (Schulken, 1998).

HIV/AIDS is the most fatal epidemic in modern history. It is estimated that more than 60 million people have already been infected; some 200 million have already died. About one third of those infected are between 15 and 24 years of age. Sub-Saharan Africa, which includes South Africa, is the most severely affected (Hernes, 2002). People in these areas are very poor and illiterate which could be the contributory factors to the high rate of infection. The statistics for South Africa are alarming. Morrel et al. (2001) assert that South Africa is one of the countries worst affected by HIV/AIDS. An estimated 6 million South Africans are HIV positive and 2.5 million have already died from AIDS or related illnesses. Mortality rate is expected to rise by 2010 and life expectancy to drop from 68 to 40 years (Mannah, 2002).

As HIV/AIDS spreads, individuals, families, communities and nations must learn to live with the disease. HIV/AIDS is no longer just a disease but a pandemic. The pandemic is a complex set of

related problems which together constitute a phenomenon. It needs to be understood in very broad geographic, demographic, environmental, psychological, cultural, economical and social terms (Coombe, 2002). With no cure or vaccine in sight, it is evident that AIDS represents a potential health catastrophe to the degree never previously experienced. The epidemic not only hampers development in many countries, it reverses it by destroying capacity, especially the capacity to cope and care. It means loss of productivity by the loss of the most productive individuals. It drains resources from development to maintenance by the need to tend to the sick and care for orphans. Not only the health of the whole society is at stake, but also their very survival is at risk (Diclemente, Crosby and Wingood, 2002). According to Coombe (2002) much still remains to be learnt about HIV/AIDS, but enough is known to act immediately, decisively and massively. HIV/AIDS is embedded in the most intimate lifestyle of communities and cultures. The implication here means that interventions must be local, community driven and appropriate to the context in which HIV/AIDS thrives.

Rising prevalence rates worldwide indicate that most strategies to contain the disease have not been effective (Coombe, 2002; Hemes, 2002; Morrel et al., 2001). The trend amongst South African educators bears a similar resemblance (Mannah, 2002; Walters, et al., 2001 ; Whiteside and Sunter, 2000; Franzini, Sideman, Dexter and Elder; 1990). Given the educated status of this sector of the professional population, the increasing mortality amongst such educators is both alarming and intriguing (from a research perspective). It is proposed that the attitudes of educators towards the HIV/AIDS pandemic are related to the observed trends. Therefore in this chapter the literature on the nature of educators' attitudes towards HIV/AIDS is reviewed, and research on the influence of characteristics such as gender, age, religion, experience and qualification on the nature of educators' attitudes towards HIV/AIDS is also examined. Finally, the theoretical approaches to individual level change in HIV/AIDS risk behaviours are appraised.

2.2 Education and HIV

According to Mannah (2002) the education system, which is extensively human resourced, is especially vulnerable to the pandemic. Educators are currently one of the largest occupational groups in the country. They are educated, mobile, and relatively affluent and thus fall into a population category shown to be especially at risk of HIV/AIDS. The incidence of infection among educators is likely to be above that of the population as a whole. Mannah (2002) further cites recent reports that government employees in South Africa (a significant number of which are educators) follow behind mining employees who register the highest infection rate. It is estimated that 26% of employees in the government sector will be infected by 2010 and that 17% are already infected. This has grave implications for the teaching profession as HIV/AIDS has long been understood to threaten the supply of educators.

In Zambia, for example, the mortality amongst educators in 1998 was 89 per 1000; 70% higher than that of the 15-49 age group in the general population. Death of educators in service was equivalent to the loss of about two thirds of the total annual output of the countries educator training college (Walter and Whiteside, 2002). The impact of HIV/AIDS on educators is of special concern to organised labour. Research conducted by the South African Democratic Teachers Union (SADTU) on membership diseases indicated that two educators are dying daily from AIDS related diseases at an average age of 38.95 years and more female educators are dying compared to male educators in the same age group (Mannah, 2002).

Franzini et al. (1990) and Hernes, (2002) argued that educators know about the virus and risks involved. Yet they do not adopt safer practices. They seem to ignore the risk or expose themselves to infections recklessly, and are not sufficiently motivated to adopt behavioural modifications. Hence prevention needs to address mentalities and cultures within which they are embedded in

order to generate attitudes to change behaviour. In many communities beliefs about causes of AIDS are wrong. Misconceptions lead to stigmatization, discrimination, exclusion and denial. Stigma remains a major feature of the HIV/AIDS pandemic that is making educators reluctant to be tested or disclose their infected status. Despite shocking statistics in the mortality of educators, research by Morrell et al. (2002) in two large township schools in Durban with a total of 60 educators, revealed that no one openly declares his or her status or actually knows it. Stigmatization, discrimination, fear, denial and ostracism make it hard for HIV/AIDS prevention to take place. Research evidence confirms that educators are as guilty of high-risk and discriminative behaviour, bias and conservative reactions to the fact of the pandemic, as their peers outside the system. It is imperative that educators act as role models and be proactive, honest campaigners in HIV/AIDS education (Walters et al. 2001 and Whitehead & Sunter, 2000).

To promote improved health seeking behavior and the adoption of safe sex practices, the government has implemented life skills education in all primary and secondary schools and has also produced and disseminated informational, educational and communication material to various stakeholders (Department of Health, 2000). Educators are at the driving seat of education, which is said to be the core, independent, strong and vital factor in preventing the spread of the virus. According to Alzubir, Nour and Ansari (1996) educators and learners constitute an active group in the society, both physically and mentally. Educators are an important source of HIV prevention information required by learners. At the same time both educators and learners can be relied upon to convey messages of prevention to the rest of the community. In the context of HIV/AIDS, education can no longer be business as usual. As the AIDS pandemic ravages, it becomes imperative for the country to rethink its education and education system in order to curb the onslaught of the disease (Mannah, 2002, p34). The school provides the most ideal setting for implementing health education. Educators have a capacity and responsibility to teach young people the actions they can take to prevent HIV/AIDS infections (Munodawafa, 1991). As

Walters and Whitehead (2002) put it, “Nowhere else in society is there such a concentration of impressionable minds, assembled for so long in the control of educators’ role models and information providers. Nowhere else does such an opportunity exist to counter the attitudinal and physical threat of the pandemic”. In order to perform such vital roles, educators need to change their attitudes and therefore behaviour.

2.3 Review of previous studies on educators attitudes toward HIV/AIDS

Educators have a strong influence on their learners and the attitudes they convey to these learners will set the stage for future generations to come. A study by Bruker and Hall (1991) showed that educators’ attitudes are changing from being negative to being positive. This could be attributed to the fact that the general public, including educators, have become more educated and knowledgeable on HIV/AIDS related issues. Numerous television programmes have been broadcast in an attempt to educate society about the AIDS epidemic. According to Cilliers (1988) almost all school districts have now adopted a parent and school board approved AIDS curriculum. Numerous educators have been trained or have been required to attend at least one in-service session on AIDS. Chifunyise, Benoy and Mukubi (2002) found that about 83 % of student-educators had negative attitudes towards people with AIDS, especially those who know that they are positive and have unprotected sex.

In a study by Visser, Roos and Korf (1995) student-educators continued to engage in HIV/AIDS risk behaviours regardless of having basic knowledge about AIDS. Research indicates that educators’ attitudes towards people with HIV/AIDS remains largely hostile and many misconceptions persisted besides their improved knowledge of transmission, prevention and course of the disease (Kuhn, Steinberg & Matthews, 1994). Research evidence gives a clear indication of the need to change attitudes in combating AIDS.

According to Gingiss and Basen-Engquist (1994), educators’ attitudes influence both the scope

and emphasis of health instruction. The educators' attitudes also influence the effectiveness of a sexual education programme in promoting the health of learners. Furthermore, learners with chronic illnesses including HIV/AIDS spend most of their day at school. Therefore educators need to have positive attitudes towards these learners since the complexity of illness management and disease sequel can alter their school experiences (Olson, Seilder, Goodman, Gaelic and Nordgren, 2004). A research by Dowson, Smith and Carboni (2001) showed that educators' attitudes towards HIV/AIDS and those who are HIV positive may affect learners' interactions as well as instructions. Research conducted in Israel found that one third of the educators' studied held negative attitudes towards AIDS and learners with AIDS. Research by Ballard, White and Gasscoff (1990) found that 44% of their participants, college students preparing to become educators, were scared by the prospect of having an HIV positive learner in their classroom, and 20% believed that they had the right to refuse to teach an HIV positive learner.

2.4 Educator characteristics

In this section the importance of the contributing factors to the spread of HIV/AIDS is reviewed, namely, age, gender, experience, religion and qualification.

2.4.1 Age

With the senior and older educators having taken packages, it means that only the young and very vulnerable age groups remain in the teaching profession. According to Walters, Desmond, Wilson and Heard (2001) 90% of all educators who died in 1998, were below the age of 49 years. This percentage rose to 93% in 1999 and 2000, and declined slightly to 92 % in 2001. This mortality rate was estimated as three times higher than it might be expected in this age band of healthy people. Research on the influence of age and attitudes towards HIV/AIDS showed no age group difference (Bucker and Hall, 1996; Peltzer, 2000).

2.4.2 Gender

Research on gender indicates that more female educators are dying as compared to male educators in the same age range (Mannah, 2002). Female educators have infection rates previously seen only in high risk sex worker population (MRC News, 1999). This could be attributed to the fact that women lack negotiation skills to practice safe sex. They maybe fearful that if they insist on safe sex they may lose their men. Promiscuity in men is regarded as normal and good practice. The greater gender discrimination and the lower position of women in society make them more negatively affected by HIV/AIDS.

Walters et al. (2001) assert that it is important to understand the contributing factors to the spread of HIV/AIDS and the manner in which educators are grappling with the issue at personal and professional levels. In most societies in Eastern and Southern Africa, women lack control over their lives. They have been socialized from an early age to be subordinates and submissive to men. They lack assertiveness to aid in coping with pressure to engage in intercourse. Some women get infected whilst taking care of the sick. Research by Morrell et al. (2002) confirms that unequal gender relations and extensive sexual violence make it impossible for women to insist on condom use, and this exposes themselves to increased risks of infections because of coerced sex. Research on in-service educator mortality in KwaZulu Natal indicates that mortality rates are significantly higher for male educators (14 % versus 0.76% females) and tend to peak later than those of females. Research on gender and attitudes are contradictory. According to Connors and Heavens (1990), female educators have more positive attitudes towards people living with HIV/AIDS than males. The studies by Brucker and Hall (1991) and Brucker and Hall (1995) indicate similar results. Dowson, Chunis, Smith, and Carboni, (2001) found that educators' attitudes towards HIV/AIDS were generally positive with female educators holding more positive attitudes than did male educators. In a study of sample student-educators in South Africa, Peltzer

(2000) challenged the findings of the above studies by arguing that the mean difference in attitudes for men and women were not significantly different.

2.4.3. Teaching Experience

Research on teaching experience found no correlation between the length of teaching experience and attitudes (Peltzer, 2000; Dowson et al, 2001). Boscarení and Disclemente (1996) also found no correlation between years of teaching and AIDS knowledge.

2.4.4. Religion

Research on religion shows that one of the sources of HIV/AIDS stigmatization, denial and discrimination, is religious and moral beliefs that lead some people to conclude that having HIV/AIDS is a result of faults such as promiscuity that deserve punishment (UNAIDS, 2002). Religion is supposed to make people supportive and caring towards those affected and infected with HIV/AIDS. This understanding would transform people who live with HIV/AIDS and those close to them. According to Mannah (2002), traditional views are much more influential in the way that disease is interpreted. In some communities the cause of the disease is understood in terms of the cultural world taboos and sorcery. It is seen as some kind of spell that has been done by the enemy. Others believe that ancestral spirits are angry and are punishing them. Van Dyk (2001) viewed the African belief in witchcraft as helping the bereaved family to avoid feeling stigmatized by their communities. Furthermore, people who believe that AIDS is caused by witches are more likely to be supportive, caring and have positive attitudes towards HIV/AIDS. Their understanding is that the patient has become infected with the virus through agents beyond their control. Though no research had been done on religion and attitudes, it seems as if people of different religions have positive attitudes towards HIV/AIDS.

2.4.5 Academic Qualifications

Research on educator qualifications found little difference in attitudes among educators of

different educational status (Brucker et al. 1991). Thus the qualification the educator holds would not determine the nature of his or her attitudes.

In the following section the theoretical and conceptual framework used in this study are described.

2.5 Theoretical and conceptual framework of attitudes towards HIV/AIDS prevention

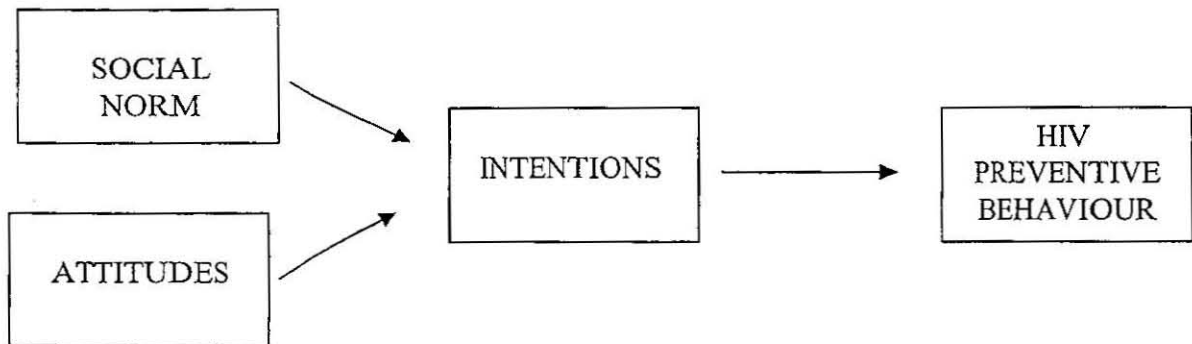
In this section I discuss the theoretical and conceptual framework that underpins my study. The theoretical framework is a thread that runs throughout the study, while theories actually support a particular point of view. The following theories are described namely; *Theories of a Reasoned Action* (TRA), *Theories of Planned Behaviour* (TPB) and *Information-motivation-behavioural skills* model (IMB).

Attitudes can be viewed as self-description which is partially based on the individual's observation of his/her internal affective responses and beliefs. Schiebusch, Bedford, Bosch and Du Preez (1991) maintain that it has always been well established that effective change of health risk behaviour requires a multiple-determined intervention strategy. Attitudes need to be taken into account in such a strategy. The unsubstantiated dissemination of knowledge about HIV/AIDS is shown to have minimal impact on the level of changing attitudes or health risk behaviours. HIV/AIDS education needs to go beyond the factual understanding of the disease to changing attitudes. Therefore, any attempt to educate people about HIV/AIDS without considering attitudes that lead to prejudice, stigmatization and victimization of people with the disease, means to misunderstand its complex nature and to misdirect combative efforts. A major current alternative available for altering the progressions of this global pandemic remains effective education. One main focus therefore constitutes changing behaviour that facilitates the spread of AIDS. A need for behavioural change to combat HIV/AIDS cuts across the entire behaviour spectrum, including

attitudes (Schlebusch et al., 1991). To get learners and communities to change their behaviour in order to avoid the risks of contracting HIV/AIDS, educators need to consider their own attitudes. Attitudes are the major component of the *Theories of Reasoned Action* (TRA) and the *Theories of Planned behaviour* (TPB) which are theoretical approaches to individual level change in HIV/AIDS risk behaviour (Fisher and Fisher, 2000; Azjen 1988). These theories including the *Information-motivation-behavioural skills* model (IMB) have been thoroughly tested as integrative multivariate models. Each has achieved a considerable degree of support and each explains considerable variance in HIV preventative behaviours across population at risk. The TRA, TPB and IMB models specify elicitation research procedures that can readily be applied to create a conceptual based and empirically identified roster of targets for focused intervention attempts. They are applied to the risk reduction behaviour change under the assumption that changing the proposed determinants of behaviour will be an effective means of changing behaviour.

2.5.1 The Theory of Reasoned Action (TRA)

According to the TRA, preventative behaviour would be performed by the individual who has an intention of performing the preventative act. The intention in turn is determined by the individual's attitude and subjective norms, or perception of referent support for performances of that act. The individual with positive attitudes and social support is likely to have intentions of performing HIV/AIDS preventative behaviour. It also asserts that personality, demographic and other variables external to the model may influence behaviour indirectly. The TRA holds that it is necessary to strengthen prevention intentions in order to increase preventative behaviour. To strengthen intentions, it is necessary to enhance the individual's attitudes towards preventative act and the individual's subjective norm concerning these acts (Fisher and Fisher, 2000).

Table 1: The Theory of Reasoned Action.

Source: Fisher and Fisher (2000: 30)

The TRA has been applied widely and successfully in efforts to change HIV preventative behaviour with success. The TRA investigations have provided critical information about attitudinal and normative determinants of intentions of practicing safer sex. Across a large number of studies of the determinants of safer sex intentions, it is generally found that attitudes towards safer sex behaviours and subjective norms contribute significantly to the determination of safer sex intention.

Research by Fishbein found that among gay men, both personal attitudes and perceptions of social support were significantly associated with intentions to use a condom during anal intercourse (Fisher and Fisher, 2000). It therefore follows that HIV preventative intentions in this population should focus on changing perceptions referent support of these practices. In contrast it was found that heterosexual high school and university males' intentions to use condoms during sexual intercourse were solely under control of personal attitudes and were not influenced by perceptions of social support. It therefore follows that HIV preventative intervention directed towards these

populations should focus mostly on modification of attitudes towards personal use of condoms during sexual intercourse. At an immediate post intervention assessment, it was found that TRA interventions were effective in changing attitudes towards risky sexual behaviours and intentions to engage in them, a study which confirmed that change persisted at a 3-month follow up (Fisher and Fisher, 2000).

Moreover participants in the TRA-inspired HIV/AIDS prevention intervention reported engaging in significantly less risky sexual behaviour 3-months following the intervention. Furthermore, Fisher and Fisher (2000) reports that a single 45 minutes HIV/AIDS preventions intervention was successful in modifying university students' beliefs about the health consequences of using condoms, their attitudes towards condom use and their self reported condom use behaviour. Their changes in HIV/AIDS risk behaviour were associated with changes in attitudes.

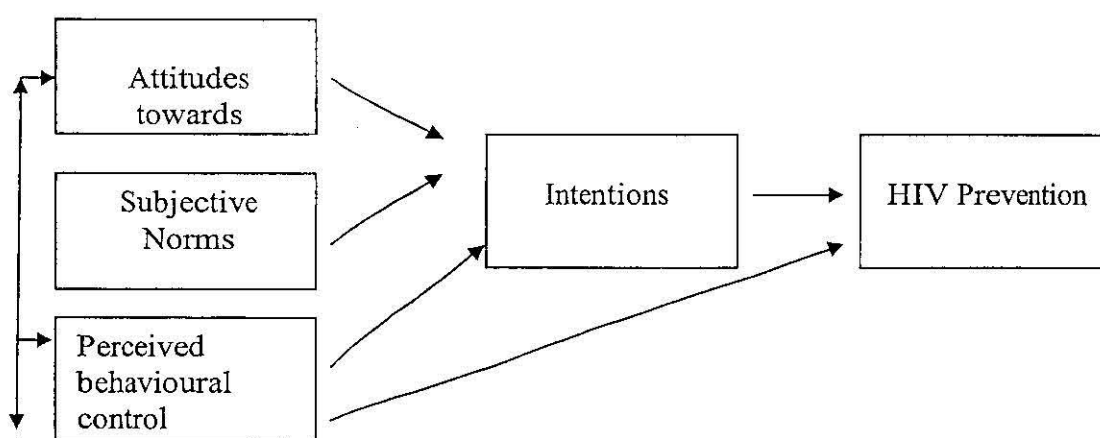
2.5.2 The Theory of Planned Behaviour (TPB)

The Theory of Planned Behaviour (TPB) is the extension of the TRA that adds the construct of perceived behavioural control to the model's original assertions concerning intentions, attitudes and norms as determinants of behaviour. According to Fisher and Fisher (2000), perceived control is an individual's assessment of the ease or difficulty of performing a given preventative behaviour. It reflects an individual's control belief or assessment of the degree to which s/he possesses the resources and opportunities necessary for performing the preventative behaviour in question.

TPB argues that an individual who has positive attitudes towards HIV/AIDS prevention, positive norms concerning performance of the act, and perception of control over the performance should intend to practice the HIV/AIDS preventative behaviour in question. In contrast an individual who

has positive attitudes towards HIV/AIDS preventative act and positive norms in this regard but who perceives performance of behaviour to be entirely out of his or her control due, for example, intractable partner resistance, should be less inclined to intend to practice the preventative behaviour. TPB's assertion that perceived control over behavioural performance adds significantly to the influence of attitudes and norms in the formation of behavioural intentions has been confirmed consistently in research conducted in HIV/AIDS prevention.

Table 2-The Theory of Planned Behaviour



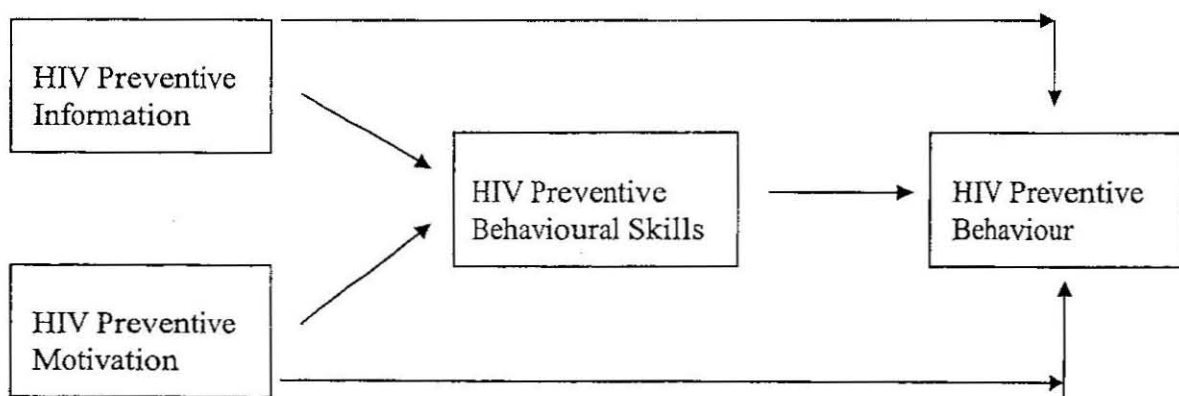
Source: Fisher and Fisher (2000:36)

2.5.3 The Information-motivation-behavioural (IMB) skills model

Fisher and Fisher (2000) describe the IMB as based on the assumption that HIV preventative information, HIV preventative motivation and HIV preventative behavioural skills are fundamental determinants of HIV preventative behaviour. To the extent that individuals are well informed, motivated and possess the behavioural skills required to act effectively, to that extent they will be likely to initiate and maintain patterns of HIV preventative behaviour. The HIV preventative information refers to specific facts about HIV transmission and HIV prevention that serve as a guide for personal preventative actions. Motivation to engage in HIV prevention is an

additional determinant and influence as to whether well informed individuals would be inclined to act what they know about prevention. Motivation includes the individual's attitudes towards practicing specific preventative acts, and social motivation, which includes perception of social support for performing such acts and perceptions of vulnerability to HIV infection. Behavioural skills are additional prerequisites of HIV preventative behaviour that determines whether well-informed and well-motivated individuals are capable of practicing prevention effectively. The behavioural skill component of the IMB is composed of an individual's objective ability and his/her perceived self-efficacy concerning performance of the sequence of HIV preventative behaviours (Fisher and Fisher ,2000).

Table 3: The IMB model of preventive behaviour



Source: Fisher and Fisher (2000:39)

2.6 Conclusion

This chapter provided a theoretical background to the study. The emotional, physical and social impact of HIV/AIDS worldwide especially in Sub-Saharan Africa with special reference to South Africa was discussed. The discussion was extended to include the impact of HIV/AIDS on education, and educator attitudes, which are the fundamental thrusts of this study. Research indicates that the South African educational environment is severely impacted by HIV/ADS (Mannah, 2002; Walters, Desmond, Wilson and Heard, 2001 and Whiteside et al, 2000; Franzini,

Sideman, Dexter and Elder; 1990), which debilitates service delivery and is a huge cause of concern since this is the arena in which HIV/AIDS prevention through education is regarded as the hope to change attitudes and risky behaviour. The influence that educators' characteristics such as age, gender, experience, religion and qualification have on the way they perceive HIV/AIDS was reviewed.

Finally, the three theories of attitudes towards HIV/AIDS prevention namely TRA, TPB and IMB were briefly discussed. The TRA states that the social norms and attitudes influence the intentions of performing the HIV/AIDS preventive behavior. The TPB adds the construct of perceived behavioral control to the norms and attitudes as the determinants of preventive behavior. The IMB on the other hand assumes that information, motivation and behavioral skills are the most important determinants of HIV/AIDS preventive behavior. In the next chapter the details of the research design and methodology of the study will be discussed.

CHAPTER 3

Research Design and Methodology

3.1 Introduction

This study, which was located at primary and secondary schools in the deep rural areas of the Scottburgh circuit¹, sought to determine the nature of educators' attitudes towards HIV/AIDS, and whether educators' attitudes towards HIV/AIDS are influenced by variables such as age, gender, religion, experience and qualification.

3.2 Methodology

The function of the research design is to ensure that evidence obtained enables the researcher to answer the initial question as unambiguously as possible (de Vaus, 2002), as well as to test the formulated hypotheses, and enable the researcher to make generalizations, predictions and causal explanations. In this study the research design that was used, was the quantitative, non-experimental descriptive type. Quantitative research collects data in the form of numbers and statistical types of data analysis (Terre Blanche, Durrheim and Painter, 2006). Descriptive research provided the researcher with information on attitudes of educators. It involved collecting data in order to test hypotheses and answer questions concerning the current status of the subjects of the study. The purpose of the quantitative study is to make generalizations, predictions and causal explanations. The researcher in this study wanted to make generalizations to the population of educators. The quantitative research emphasized the numerical measurement of variables to quantify the extent to which a target population is aware of things and inclined to behave in a certain way. A survey, in the form of a fixed response questionnaire was used. Survey studies are research studies in which self-report data are collected from the sample in order to determine the characteristics of a population. The researcher merely searches for accurate information about the

¹ A small town on the South coast of KwaZulu Natal, a province on the east coast of South Africa.

characteristics of particular subjects or the frequency of a phenomenon's occurrence. The simple survey design was chosen for this study because it describes certain characteristics of the population, namely, attitudes. As it is unethical to manipulate variables such as illness (HIV/AIDS) in the human population, this study was carried out in the natural setting, namely, the schools, and the phenomena were observed as they occurred.

3.3 The Sampling Process

3.3.1. Population

According to Sowell and Casey (1982:40), the population is simply a group that has one or more characteristics in common. The target population for this study was the primary and secondary school educators in the Scottburgh circuit. The samples are drawn from the educator population in the rural areas of KwaZulu Natal south coast. IsiZulu was the mother tongue of all the educators sampled. The survey was conducted with 71 secondary and primary school educators as units of analysis.

3.3.2. Sample

Sampling means selecting some of the elements of the population with the intention of drawing inferences about the entire population (Wiersma, 1991). Cluster sampling involves the random selection of clusters from a large population of clusters. It is hoped that what is found out about the sample is true of the population as the whole. The sampling method used in this study was random cluster sampling. According to Ary, Jacobs and Razavieh (1985) cluster sampling is when the unit chosen is not an individual, but a group of individuals who are naturally together. Schools in this study are a good example of clusters. The members of the sample were selected on probability bases. Probability sampling is the kind of sampling in which every element in the

population has a non-zero chance of being selected (Ary et al. 1985). The possible inclusion of each population element in this kind of sampling takes place by chance and is attained through randomization.

In this study the cluster was the selected schools in the district. Cluster sampling was selected for its convenience since it was not feasible to make up a list of every educator in the district. The cluster random sample was drawn from the list of schools obtained from the district manager. To prepare the number of participating schools, the school names of number of schools in the district were written down separately. All these names were placed into a box and mixed thoroughly. These names were then picked out one at a time until a desired sample of 12 schools was obtained. Of the 12 schools 8 agreed to participate in the research. There were 4 primary and 4 secondary schools.

3.4 The Research Instrument

According to Brucker and Hall (1996), the questionnaire using items presented in a Likert scale is used in most studies of attitudes. The Likert scale is called a summated rating or additive scale because the respondents score on the scale is computed by summing the number of responses the respondents give (Neuman, 2000). A fixed response type questionnaire using five scales was used in this study to elicit data. Using a questionnaire was an efficient and economical way of gathering primary data. The major weakness of questionnaire is that the quality and the quantity of information secured depend heavily on the ability and willingness of respondents to co-operate (de Vaus, 1986). The questionnaire used in this study was obtained from pre-existing questionnaires, utilized by Brucker and Hall (1991)² and applied with a few alterations, for example, grades were omitted because in the present study grades were not specified. The Likert

² The questionnaire appeared in an article by Brucker and Hall (1991) *AIDS in the classroom: Are teachers' attitudes changing?* based on an American study that interrogated attitudes of teachers towards HIV/AIDS.

style questionnaire was chosen for this study as it has been found to be the best of the attitudes measurements. Its reliability has been already established and it has received support from several researchers (Brucker & Hall 1996; Diclemente et al, 1990; Peltzer, 2000; and Schiebueh et al. 1991). No major shortcomings have been identified. Secondly, this questionnaire was subjected to Cronbach Alpha test of reliability. The Cronbach Alpha value was 0,5 which indicated that the questionnaire's continuous study variables had medium internal consistency and reliability. Validity was established by administering the questionnaire to three educators before being given to the target population. From this it was assumed that questionnaire used was an efficient method to use in the execution of this study.

The questionnaire was divided into two subsections – A and B. In Section A, the *Biographical data*, participants were required to provide information such as *age, gender, academic qualifications, experience and religion*. The second part contained 13 attitudinal questions that are rated on the five point Likert Scale ranging from strongly disagree, disagree, no opinion, agree and strongly agree. All the questions were closed ended. The purpose of these questions was to ascertain the respondents' attitudes towards HIV/AIDS. Anonymity and confidentiality was maintained as no names of respondents and schools had to be mentioned. The attitudinal questions were based on the attitudes of educators towards the five major themes described below.

3.4.1 HIV/AIDS testing

There were three statements on testing, namely:

Statement 1. All educators should be required to test for HIV/AIDS,

Statement 2. All beginning educators should be required to test for HIV/AIDS antibody as requirement for certification

Statement 5. Mandatory testing of learners for the HIV/AIDS antibody should be required for all learners as a condition of his or her attending class.

These questions aimed at finding out about the perceptions and feelings of the educators regarding testing for HIV/AIDS.

3.4.2 Continuation of an HIV positive individual in an educational institution

3. If the educator test positive for HIV/AIDS, s/he should not be allowed to teach.
4. If the educator test indicates that s/he has been infected with HIV/AIDS but shows no outward signs, s/he should be issued a teaching certificate.
6. Learners who have been infected with HIV/AIDS should not be allowed to attend class
8. Learners who have been infected with HIV/AIDS but who display no outward signs should be allowed to attend classes

These statements were based on the above attitude and they attempt to find out whether educators thought that an HIV positive individual should be allowed to continuation in a school setting or not.

3.4.3 Contact with or inclusion in educational activities of an individual infected with HIV/AIDS

The responses to the following questions showed how educators would act towards an HIV positive individual on contact.

7. Learners who have been infected with HIV/AIDS should not be allowed to participate in school activities with other learners,
9. Learners who have been infected with HIV/AIDS but display no outward signs should be allowed to participate in school activities with other learners,

3.4.4 The responsibility of school system to provide an academic programme for those infected with HIV/AIDS

10. School districts should take appropriate steps to educate school employees regarding HIV/AIDS and its transmission,
13. Public school districts have a responsibility to provide an educational programme for those learners who are infected with HIV/AIDS,

The above statements attempted to determine who educators thought was responsible for providing HIV/AIDS education.

3.4.5 Should educators be required to teach learners infected with HIV/AIDS

11. Educators should not be required to teach learners infected with HIV/AIDS
12. Educators should be required to teach learners infected with HIV/AIDS only if the learner displays no outward signs,

These statements were to determine how the educators feel about teaching an HIV positive learner.

It was important for the questionnaire to be initially developed and tested in a pilot study

3.5 The Pilot study

A pilot study is the preliminary study on small samples that help to identify potential problems with the design, particularly the research instrument (Terre Blanche et al, 2006). In order to assess clarity and minimize ambiguity in the questionnaire a pilot study was conducted on the three non-participating educators. They were asked to comment on the following:

- Sources of confusion and vagueness
- Any ambiguity in the questions

- Time taken to complete the questionnaire
- Relevance to South African context

The pilot study helped to ascertain certain areas that needed to be clarified. The educator's comments and feedback assisted in rephrasing certain questions and contextualizing the questionnaire. Bibliographical data was also included. It also helped the researcher to be sensitive to the research process and aware of the need to treat respondents with respect and dignity.

3.6 Reliability and validity

3.6.1 Reliability

Reliability refers to the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time on the same person, or if used by two different investigators. The reliability of an instrument is indicated by a correlation measure which varies between 0 and 1. The nearer the measure is to 1, the higher the correlation (Brink, 2003). To establish the reliability of the questionnaire in this study, the researcher measured the internal consistency by using the Cronbach's alpha co-efficient. Internal consistency addresses the extent to which all items on an instrument measure the same variable. The Cronbach's Alpha test for this questionnaire was 0.49 which indicates medium internal consistency and reliability.

3.6.2. Validity

Validity of the measuring instrument refers to whether an instrument accurately measures what it is suppose to measure, given the context in which it is applied (Brink, 2003). The type of validity used in this study was content validity. Content validity is an assessment of how well the instrument represents all the different components of the variable to be measured. To establish validity, a pilot study was done on three educators who were not part of the study – to test for

clarity and precision of the questions in terms of the ability to elicit information relevant to the questions guiding the research.

3.7 Ethical considerations

The aim of ethics is to ensure that no one suffers any adverse effect of the research activity. An important aspect of conducting this research was also to obtain informed consent. To ensure the protection of the research participants the researcher did the following prior to administering the questionnaire:

- Obtained the informed consent to conduct research from the District manager
- Obtained the informed consent from the school principals and educators of the participating schools
- Ensured confidentiality of the participants as they were not required to write their names and schools
- Informed participants that participation in the research study was voluntarily and that they could withdraw at any time if they felt like, without obligation.

3.8 Administration

The questionnaire was administered to 71 educators from 8 schools who agreed to participate. It should be borne in mind that deep rural areas are sparsely populated, so the number of educators per school is low due to low enrollment. The researcher visited the schools during the pre-arranged dates and times. The aim of the study and the method of filling in the questionnaire was explained to educators. The researcher monitored the completion of the questionnaire, attending to queries immediately to ensure minimal time consumption.

3.9 Data analysis

Data are the basic material with which the researcher works. Data analysis refers to transforming

the data or information obtained into an answer to the original research question (Terre Blanche et al, 2006). In this study the data was captured on an Excel spread sheet and was computer analyzed using the statistic package SPSS (2005 version). The results were presented in two sections – A and B. Section A dealt with descriptive statistics which included the bar graphs and the measure of central tendency statistics, namely, the mean to indicate the average score and the standard deviation to indicate the variability of scores for the sample. In Section B, inferential statistics were conducted, namely, the t-test and the ANOVA test to make inferences about the population and to accept or reject the null hypothesis. The t-test was used to find the difference between two groups, in this case gender. The ANOVA was used for several groups, namely, age, qualification, and experience.

3.10 Limitations

Owing to time limitations and lack of finance, the researcher could not extend the investigation to a large number of schools. The investigation was confined to the sample of 8 schools. Most principals saw the research as a waste of time. Most of the schools that did not participate in the study first asked whether the questionnaire was from the Department of education. Once they were told that it was for personal use, they refused. It seemed as if they were expecting only people from the Department to conduct such research in school. This limited the number of participating school to 8.

Some of the educators seemed not interested in answering the questionnaire. They were filling it simply because the school management had requested them to do so. This is in concordance with de Vaus' (1986) assertion that the quality and the quantity of information obtained by the fixed response questionnaire depended heavily on the ability and willingness of respondents to co-operate. The lack of interest by some participants as described could have influenced the data collected.

3.11 Conclusion

This chapter began with a reiteration of the aims of the study, a description of the research method

employed, and the rationale for its choice. The chapter unfolds by describing the research design, the sampling process, and the reasons for the choice of the measuring instruments, the description of the sample, methods of data collection, a description of the questionnaire, the validity and reliability of the measuring instruments, data analysis, ethical considerations and limitations involved in the data collection. In the next chapter the data will be analyzed, presented and interpreted and the results will be discussed

In the next chapter the collected data will be analyzed, presented and interpreted and the results will be discussed.

CHAPTER 4

Data Analysis and Interpretation

4.1 Introduction

In this chapter the survey results will be analyzed and interpreted. The elicited data will be presented in the sequence of the research questions as listed in the questionnaire. Graphs are used to validate the data and systematically arranged to answer the research questions at hand. The sequence of presentation begins with the descriptive statistics and then the inferential statistics. The descriptive statistics will describe the results, while the inferential statistics which includes the t-test and ANOVA test, are used to test the hypotheses.

4.2 Descriptive statistics

4.2.1 Descriptive frequency statistics

The results represent percentages of respondents' socio-demographic characteristics.

4.2.1.1 Socio-demographic characteristics of the sample

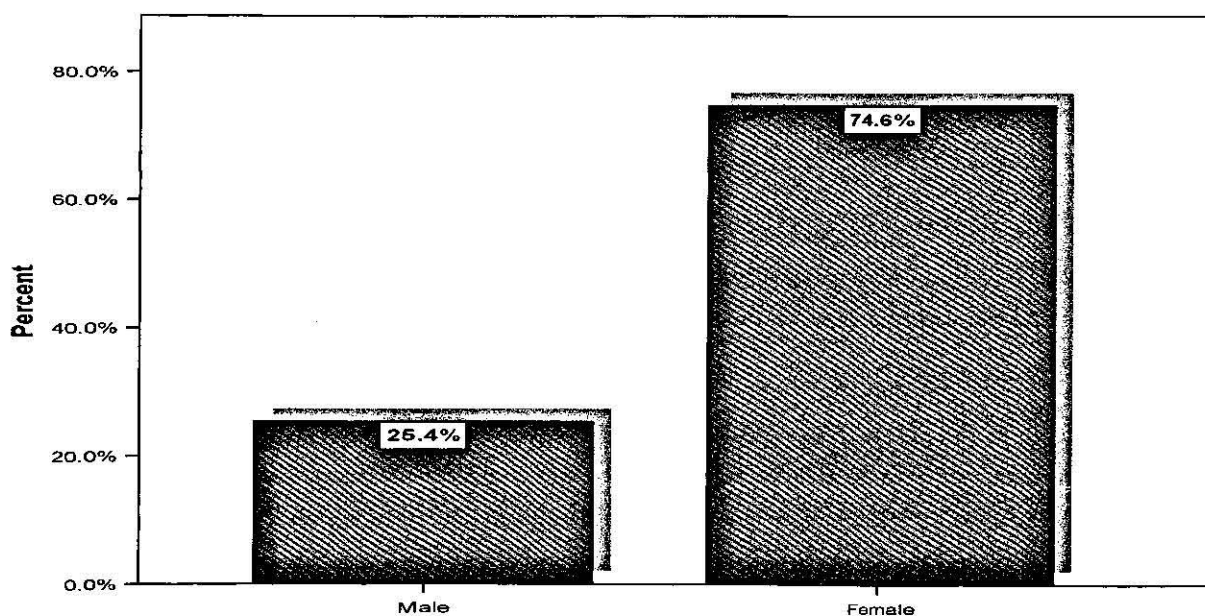


Figure 4.1: Gender

Interpretation

The above graph results reveal gender dispersion of respondents in this project. The participating respondents in this study were 25.4 % males and 74.6 % females. This difference could be attributed to the fact that the teaching profession is dominated by females. This also has implications for HIV/AIDS prevention since women are mostly at risk of contracting the disease. In many developing countries like South Africa, women are economically, culturally and socially disadvantaged. Being outside the structures of power and decision-making, they may be denied the opportunity to participate equally within the community and may be subjected to punitive laws, norms and practices exercising control over their bodies and sexual relations (UNAIDS, 2000).

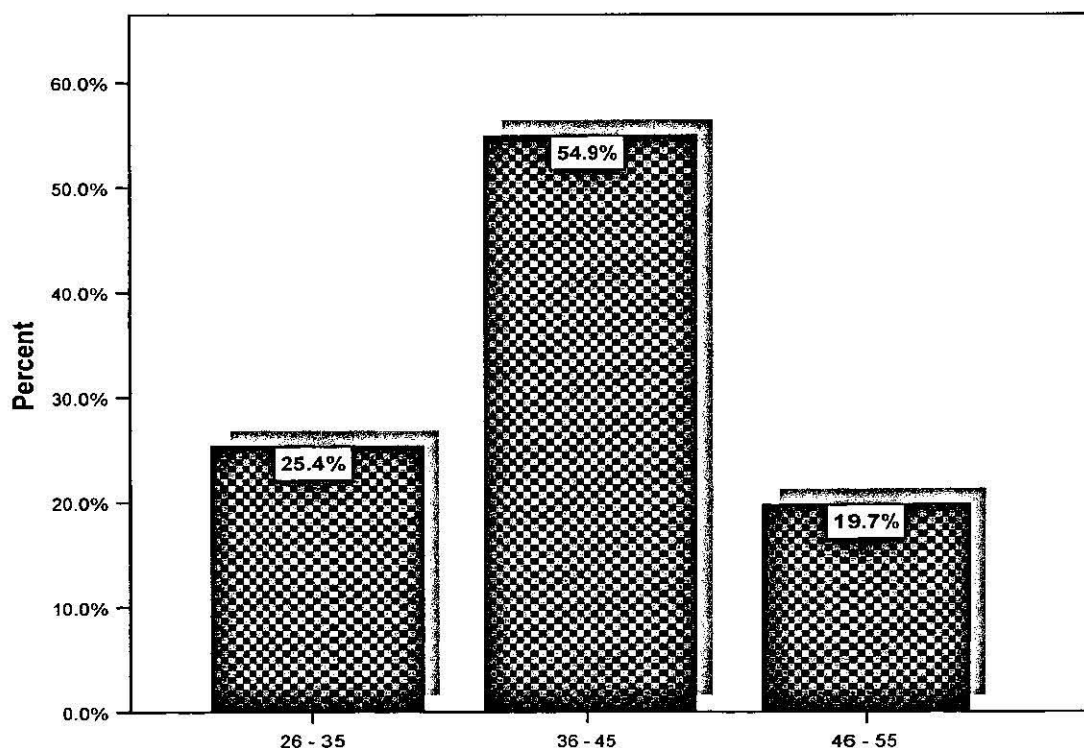


Figure 4.2: Age group

Interpretation

The above graph reveals the age group dispersion of respondents in this project. The majority of

educators were between the ages of 35 and 45. About 80.3% of educators were below the age of 45. People in this age band are most at risk. This may be due to the fact that older educators had taken severance packages¹; others might have left the profession for more rewarding jobs. There were no educators younger than 25 years. According to Walters et al. (2001) a limited numbers of these professionals were entering the service and it was confirmed that educators were ‘getting older’. The pattern observed in this study concurs with the research conducted by Walters et al. (2001).

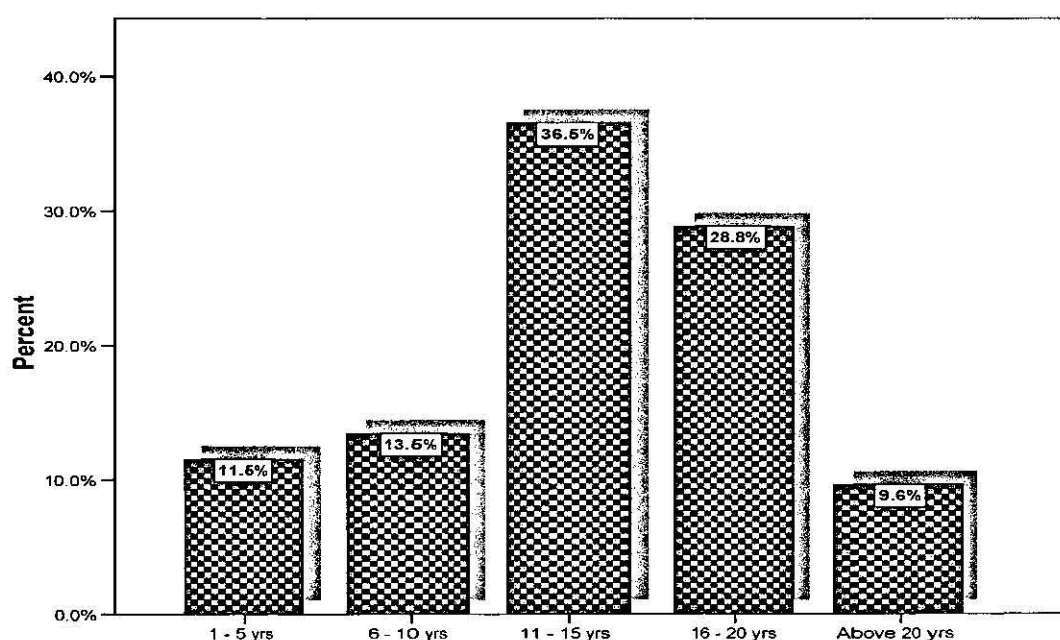


Figure 4.3: Number of years teaching experience

Interpretation

The above graph displays the years of teaching experience dispersion of participated respondents in this research. The majority of educators had experience in the interval of 11-20 years. There were few new educators with experience of less than 10 years with even fewer with experience of more than 20 years. About 26, 8% of educators did not include their years of experience. The possible explanation would be that some educators were not permanently employed.

¹ This refers to the government’s offer of an early retirement package called a “severance package”.

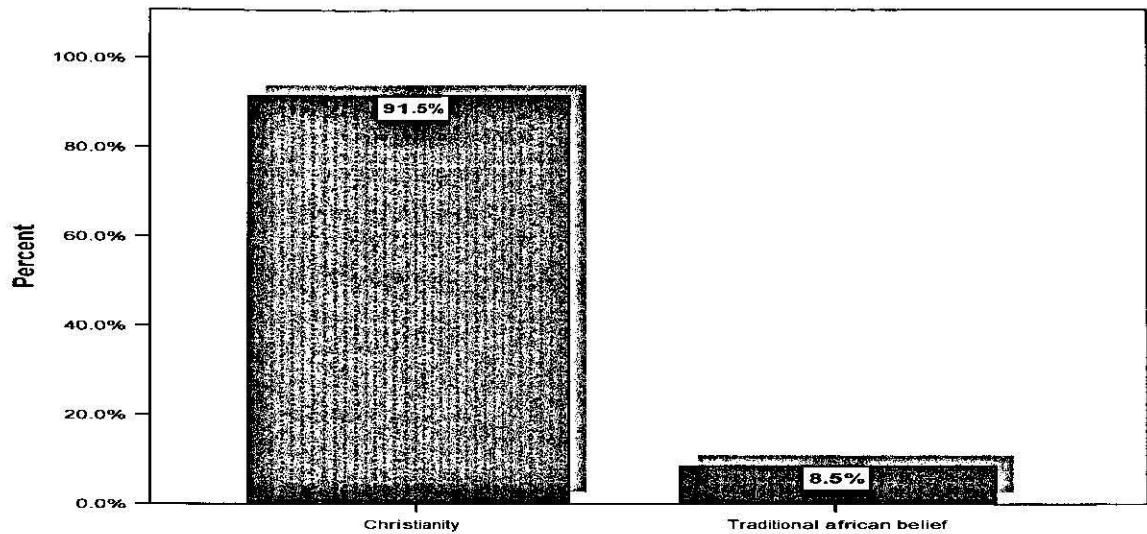


Figure 4.4: Religion

Interpretation

The above graph shows religious membership of respondents in this research. There were 91,5% Christians and 8,5% other traditional believers. The reason would be that Christianity is a dominant religion among black South Africans. According to UNAIDS (2000), Christianity is the major religion in the world hence in South Africa.

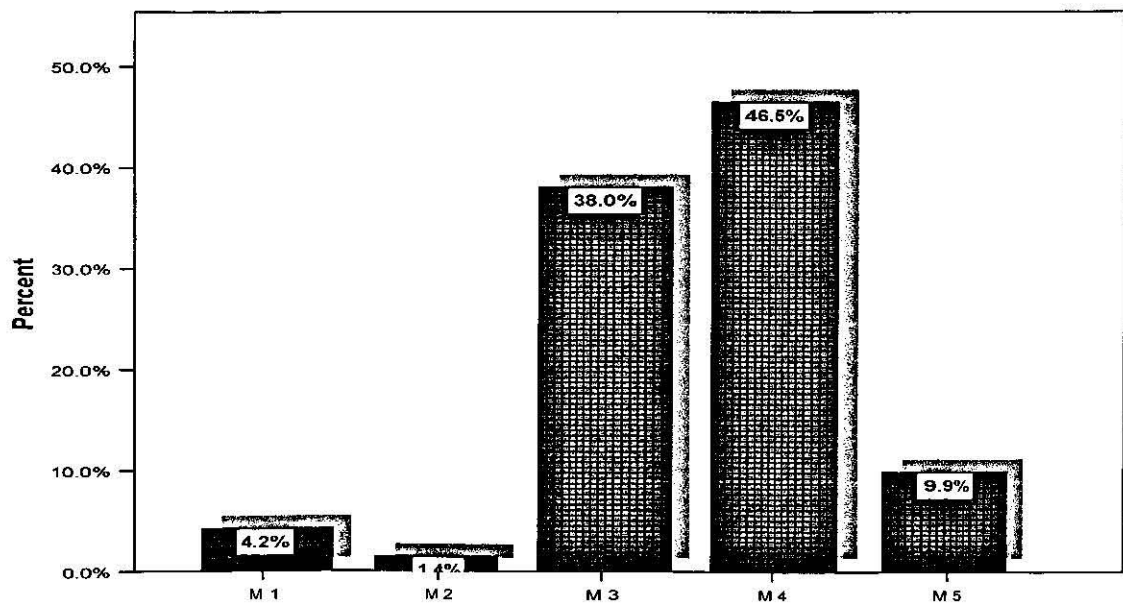


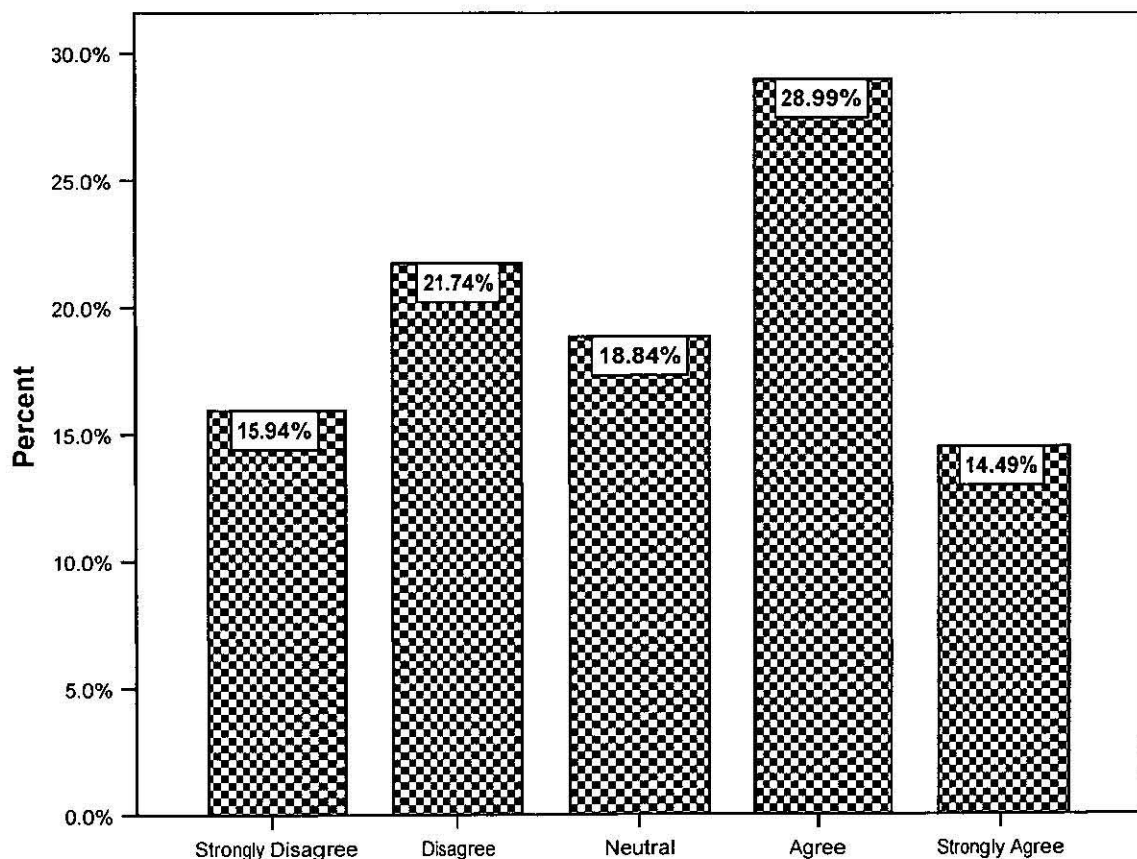
Figure 5.5: Qualifications

Interpretation

The above graph displays qualification dispersion results of participants in this research. The majority of educators (about 94%) have qualifications ranging between Matriculation plus Diploma (M+3) to Matriculation plus Degree (M+4²). That means that the majority of educators sampled were well educated which assisted them in understanding the questionnaire.

4.2.1.2 Attitudinal questions

The following reveals the percentage of educators in each of the study variables (SV).

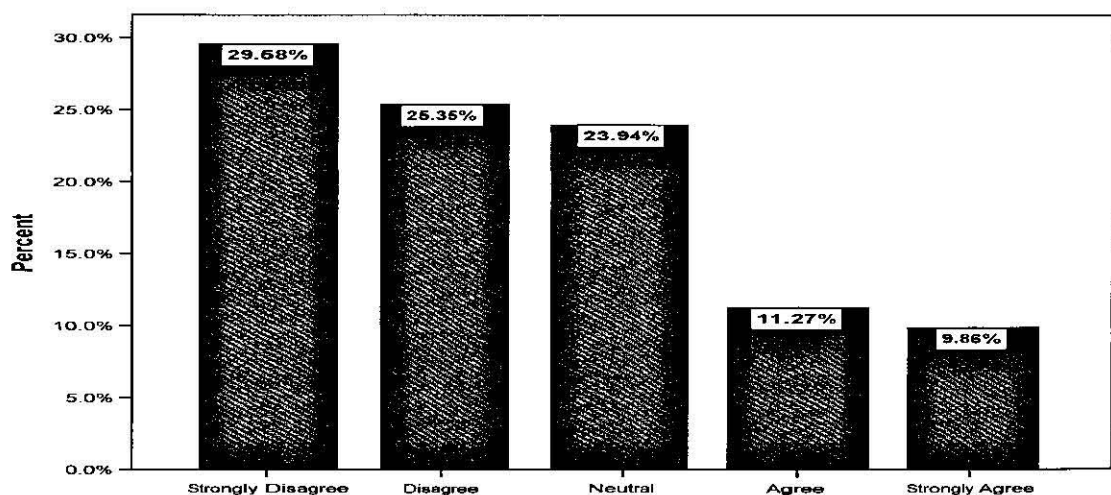


SV 1: All educators should be required to test for AIDS

² M+3 or M+4 refers to the numbers of years the educator has studied to become an educator, M+3 will be equivalent to three years of study, usually an education diploma; M+4 would be equivalent to four years of study, e.g. a four year Bachelor of Education degree, or a three year degree and a one year professional educator's qualification. .

Interpretation

The above graph reveals the attitudes of respondents towards mandatory testing educators for HIV/AIDS. About 18.8 % responded neutrally and 2.8 % did not respond towards the above statement. The responses of the respondents vary a lot. There is a large number of educators who are against testing with only about 6% lower than those who are for testing. This seems to be sending a very serious message. It suggests that there is still much that needs to be done for HIV/AIDS prevention. These educators may be lacking information which can change their perceptions about testing. They do not know that by knowing their status they might be able to live long productive lives. This means that the majority of educators are not well informed about HIV/AIDS. They may be likely to spread the disease and unable to educate learners and community about the virus. This is in line with the research by Morrel et al.(2001) and Walters et al.(2001) where educator were found to be scared of testing due to the stigma involved when one is found to have the HIV/AIDS.

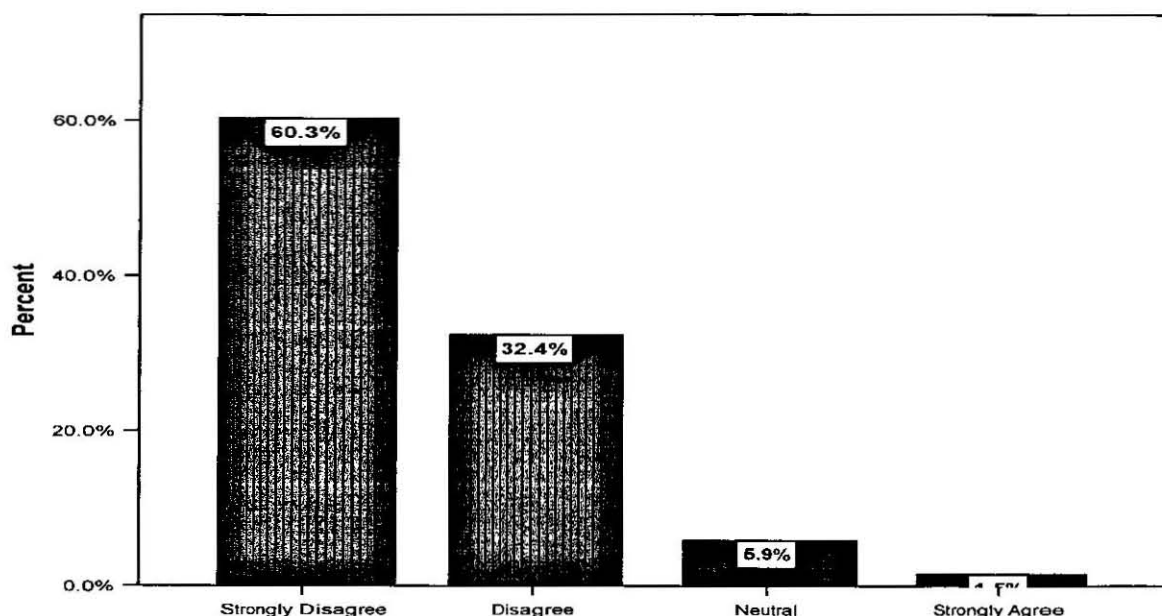


SV 2: All beginning educators should be tested for HIV/AIDS antibody as a requirement for certification

Interpretation

The graph reveals attitudes of respondents in this research towards testing beginner educators for HIV/AIDS as a requirement for certification. It can be seen that there is still the majority of educators who are against testing and also the large number of those who are neutral is the cause for alarm. Testing is at the centre of HIV/AIDS prevention. Testing has possible benefits to both

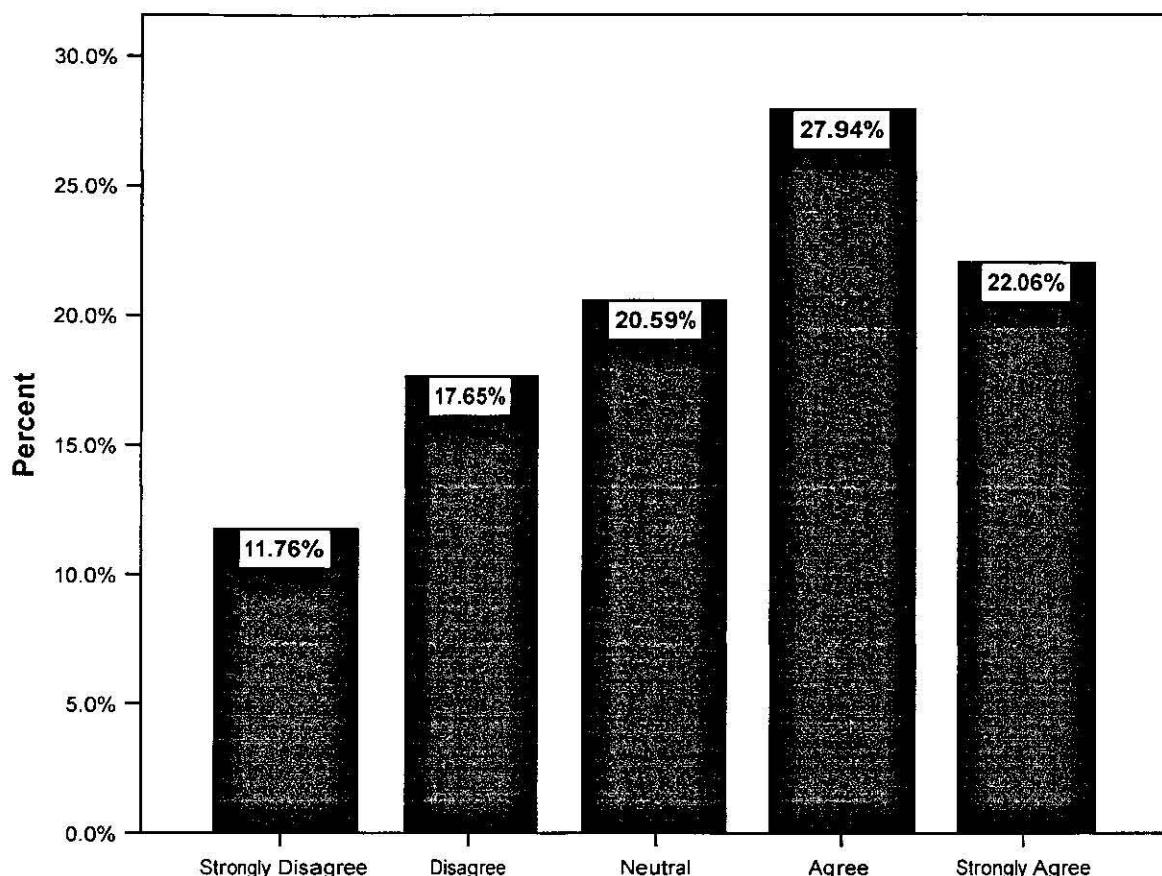
HIV positive and HIV negative individuals. According to UNAIDS (2000) for those who are HIV positive the benefits include closer medical follow up, earlier use of retrovirals which improves and prolongs health, protection of loved ones and reduction of mother to child transmission. For the HIV negative the benefits include the protection of an individual from infection and staying uninfected.



SV 3: If the educator test positive for the AIDS virus he / she should not be allowed to Teach.

Interpretation

The above graph displays the attitudes of respondents in this research towards not allowing educators who test positive for HIV/AIDS to teach. According to the response to the above statement the majority of educators feel that HIV positive educators should be allowed to teach. However there are few who would not allow the HIV positive educator to teach. However a research by Olson et al. (2004) showed that educators are scared of the risks involved and are uncomfortable at having a child with chronic illness in their classroom.

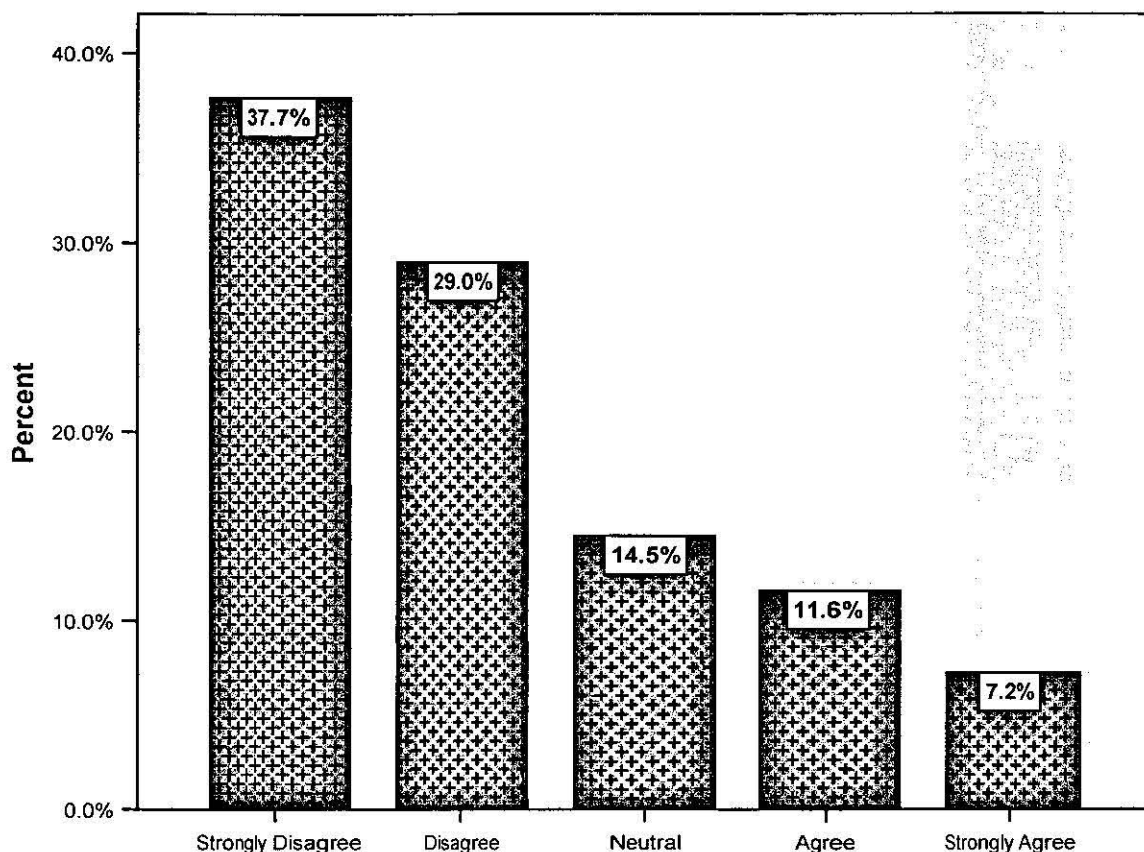


SV 4: If the educators test that he/she has been infected with the aids virus but shows 'no outward signs' he/she should be issued a teaching certificate.

Interpretation

The above graph reveals attitudes of the participants towards issuing a teaching certificate to educators infected with HIV. It is evident that the responses of educator vary greatly around this issue. There are still a large number of neutral responses. This could be an indication that educators do not know much about HIV/AIDS and they do not want anything to do with it. It is also surprising that after so many campaigns against HIV/AIDS there are still such a large number of people who are well educated, but cannot issue an HIV positive individual with the teaching certificate. It shows that there is still a large amount of work that need to be done in educating educator about HIV/AIDS and its transmission. This is in line with the research by Morrel et al.

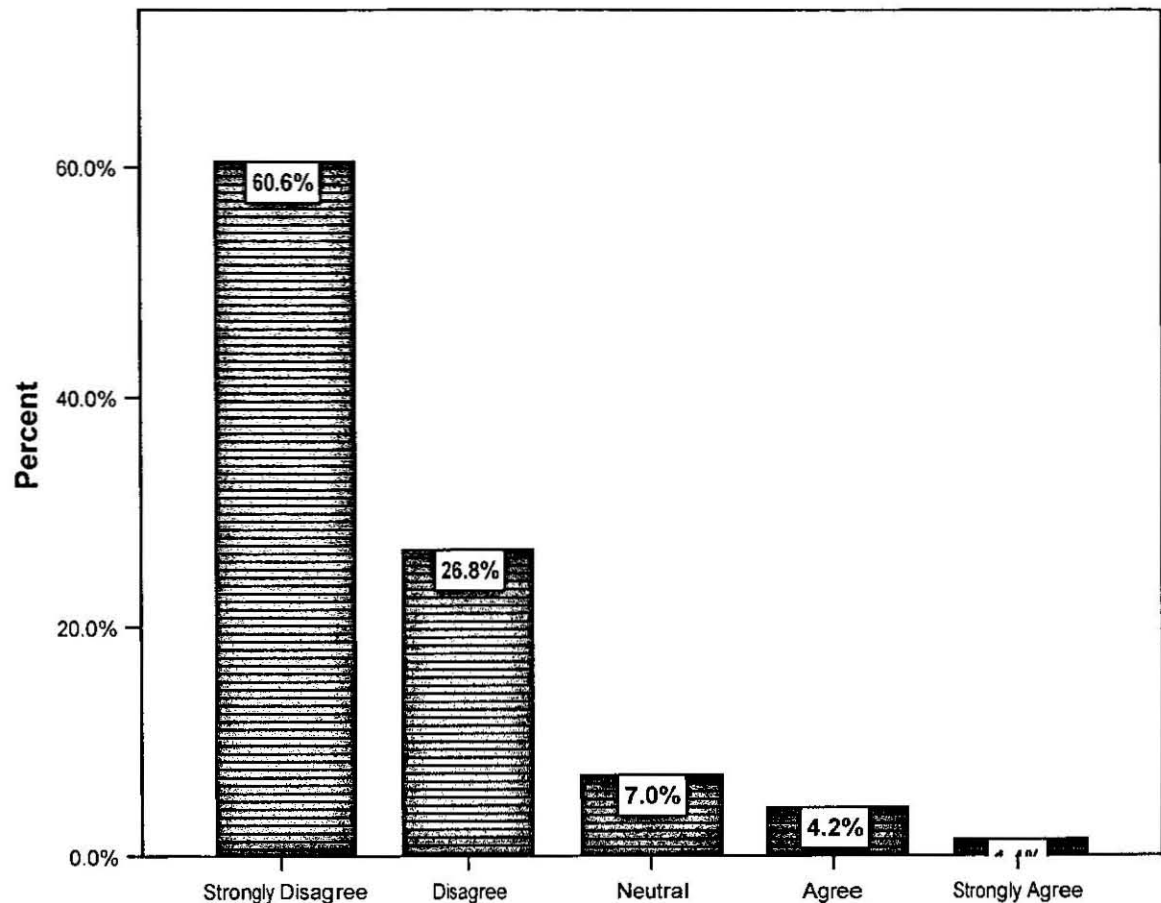
(2001) which showed that educators are guilty of high – risk and discriminative behaviour.



SV 5: Mandatory testing of learners for HIV/AIDS antibody should be required for all learners as a condition of his/ her attending classes

Interpretation

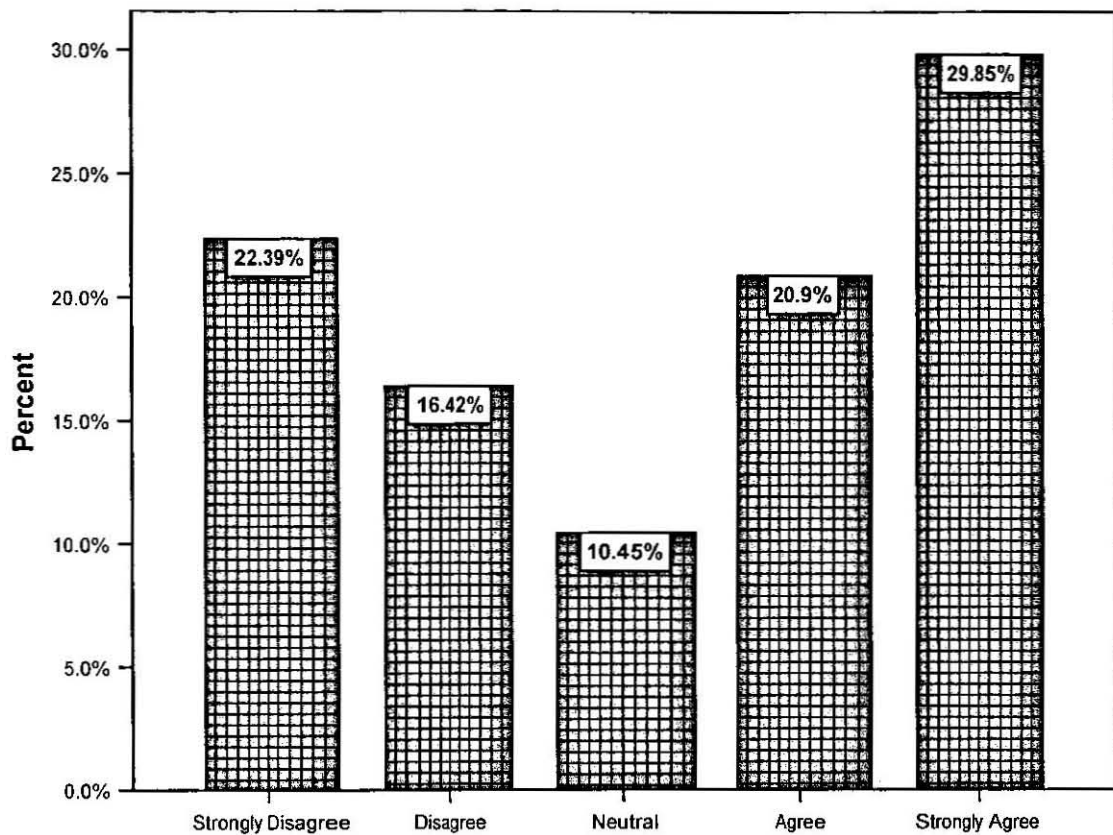
In this graph, the attitudes of respondents towards mandatory testing of learners for HIV/AIDS as a pre-condition for attending class, is shown. About 18% of educators are of the opinion that mandatory testing should be done. The majority of educators participated in this research are against mandatory testing for HIV. Research (Bowd, 1987; Brucker and Hall, 1996; Dowson et al, 2001) indicate a smaller number of educators agree with mandatory testing, which is in line with the data obtained in this study.



SV 6: Learners who have been infected with the AIDS virus should not be allowed to attend classes

Interpretation

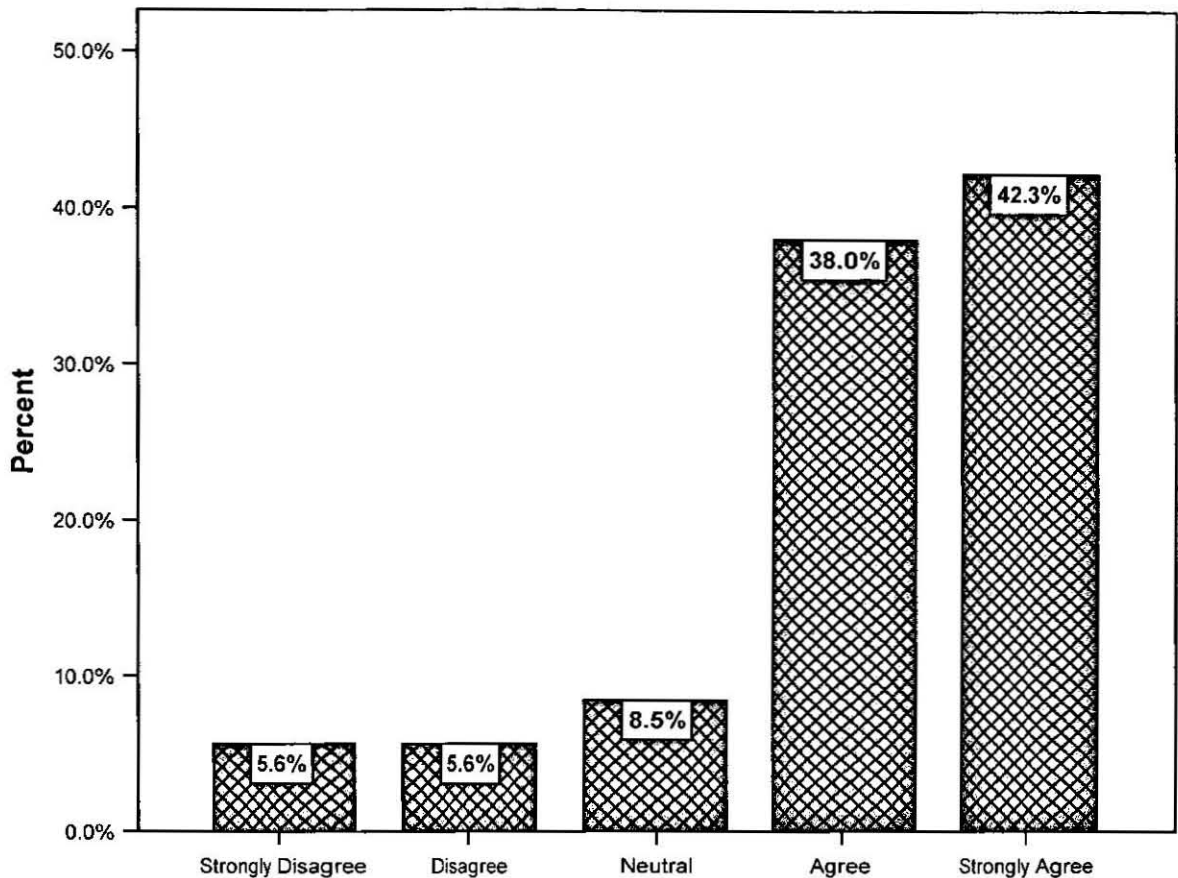
The above graph shows the perceptions of respondents towards whether learners who have been infected with the HIV virus should be allowed to attend classes or not. The majority of educators are willing to accommodate HIV positive learners in their classes. The study by Olson et al. (2004) found that educators have positive attitudes about learners with chronic health conditions including HIV/AIDS in the classroom.



SV 7: Learners who have been infected with the AIDS virus should not be allowed to participate in school activities with other learners

Interpretation

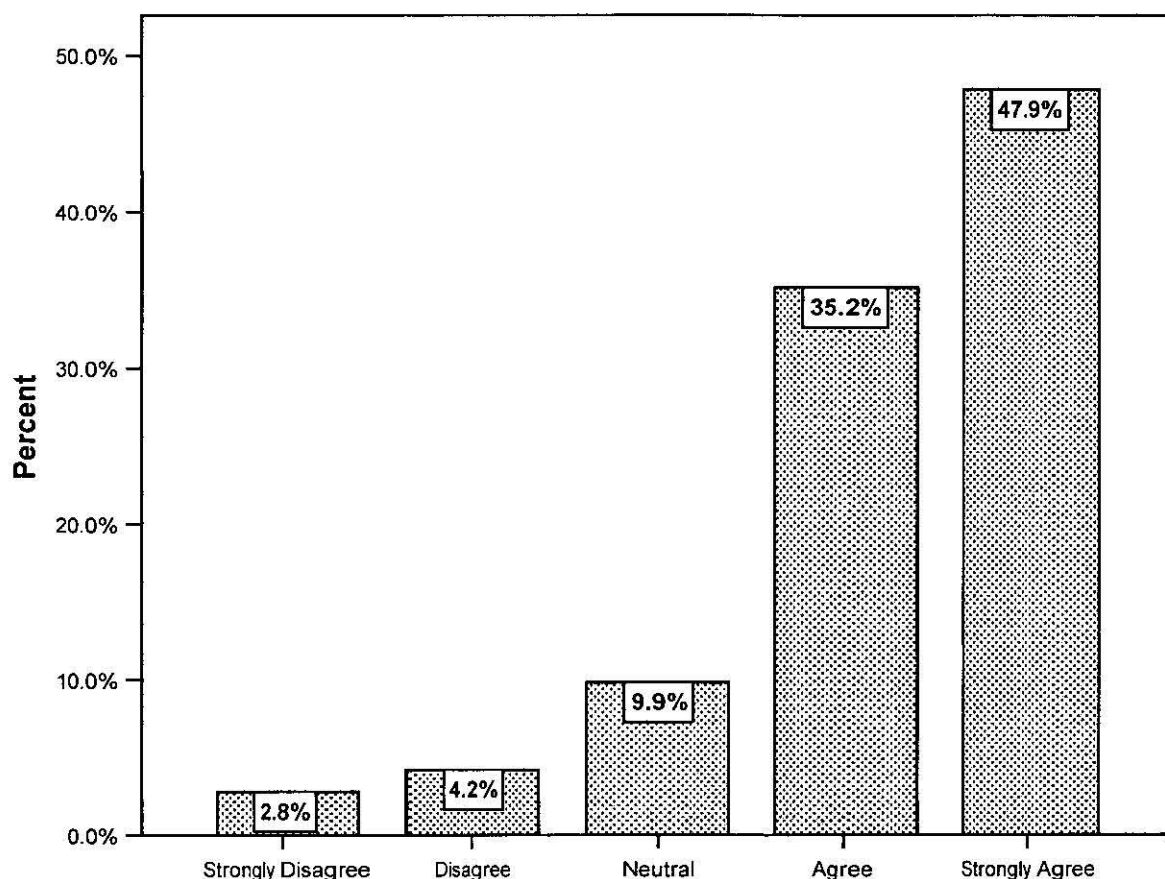
The above graph shows the perceptions of respondents in this research as to whether learners who have been infected with the HIV virus should be allowed to participate in school activities with other learners or not. The respondents' attitudes towards the above statement vary considerable. There are still a large number of educators who would not allow the HIV positive learner to participate in school activities even though they are willing to accommodate them in their classes. This attitude could also lead to discrimination, stigmatisation and exclusion of the individuals with HIV/AIDS which according to Franzini et al. (1990) and Hernes(2002) are the factors that lead educators to HIV/AIDS risky behaviours.



SV 8: Learners who have been infected with the AIDS virus but who display 'no outward signs' should be allowed to attend classes

Interpretation

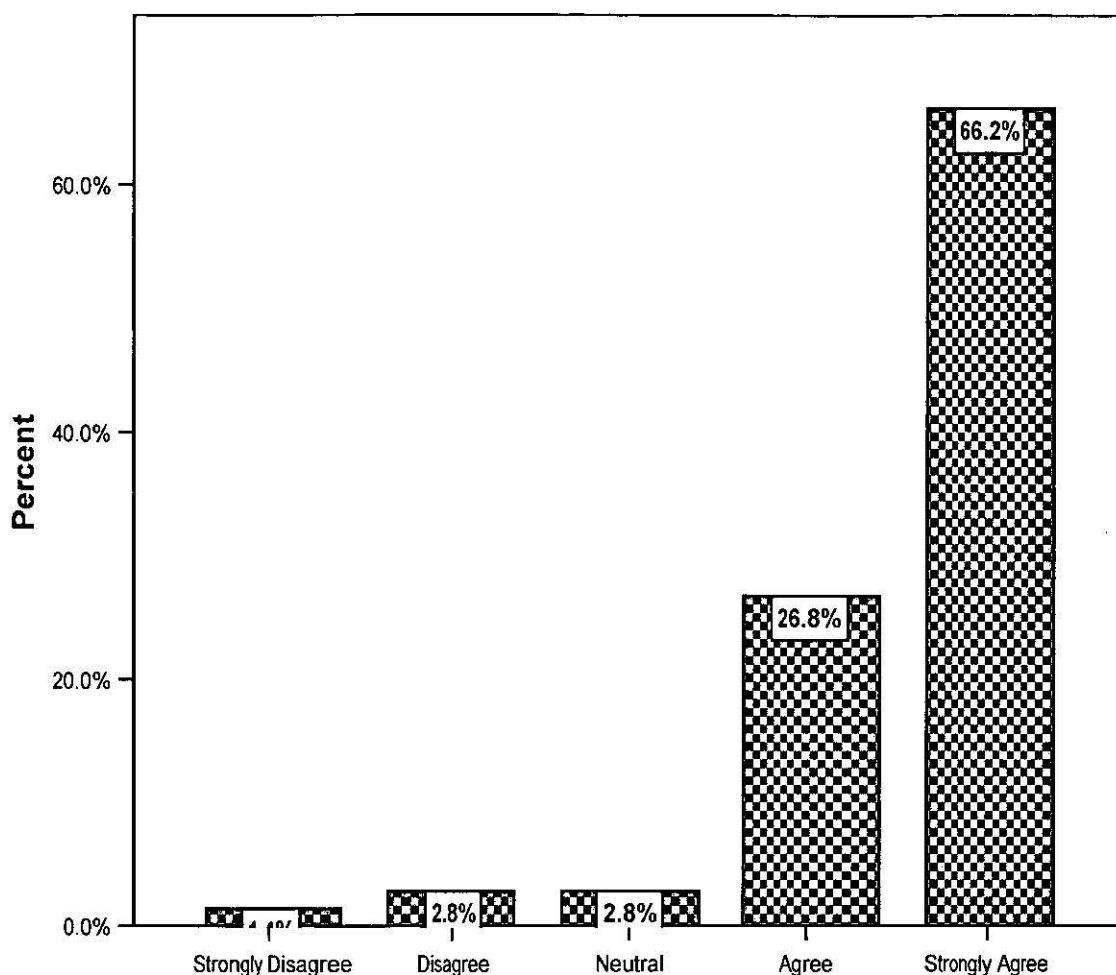
The above graph displays attitudes of respondents as to whether infected learners who do not display outward symptoms of HIV/AIDS should be allowed to attend classes or not. The majority of educators seem to be willing to allow the HIV positive learner into class, provided s/he shows no outward sign. This shows that educators may be concerned about an emergency occurring with such a learner in the class and safety of themselves and other learners Olson et al. (2004). Variables such as incurability of the disease and risk of infection may explain such reaction to people with AIDS. There are still a few who educators want nothing to do with HIV. Diclemente et al. (2002) found that even in highly educated population the scientific debate about HIV/AIDS engendered the feeling of confusion, apprehensive and distrust.



SV 9: Learners who have been infected with the AIDS virus but who display 'no ward signs' should be allowed to participate in school activities with other learners

Interpretation

In the above graph the attitudes of the respondents towards whether infected learners who have no visible symptoms should be allowed to participate in school activities with other learners or not, is shown. The majority of respondents feel strongly that these infected learners should be allowed to participate in school activities with other learners. About 8% of educators still disagree. This shows that some educators are still negative about HIV/AIDS.

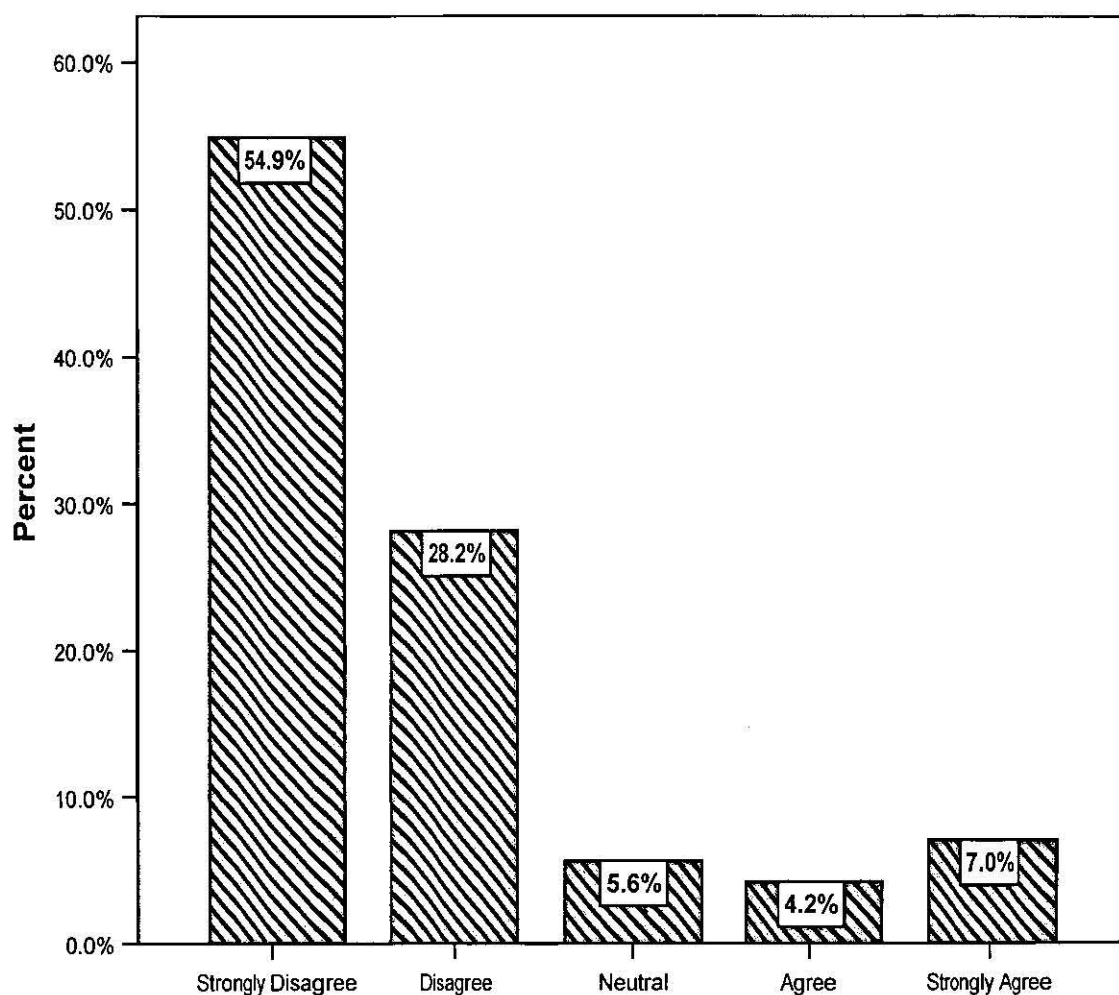


SV 10: School districts should take appropriate steps to educate learners, parents and school employees regarding HIV/AIDS and its transmission

Interpretation

The above graph shows the attitudes of participants towards the involvement of school districts in educating the learners, parents and school employees about HIV/AIDS. The majority of educators seem to support the above statement. They feel that there is a need for more education about HIV/AIDS. This means that they acknowledge the fact that they do not know much about the disease and its transmission. According to Coomber (2002) education in the context of HIV/AIDS can no longer be business as usual. There is a need for paradigm shift. The education sector has a special responsibility with regard to the HIV/AIDS pandemic, namely providing care and support

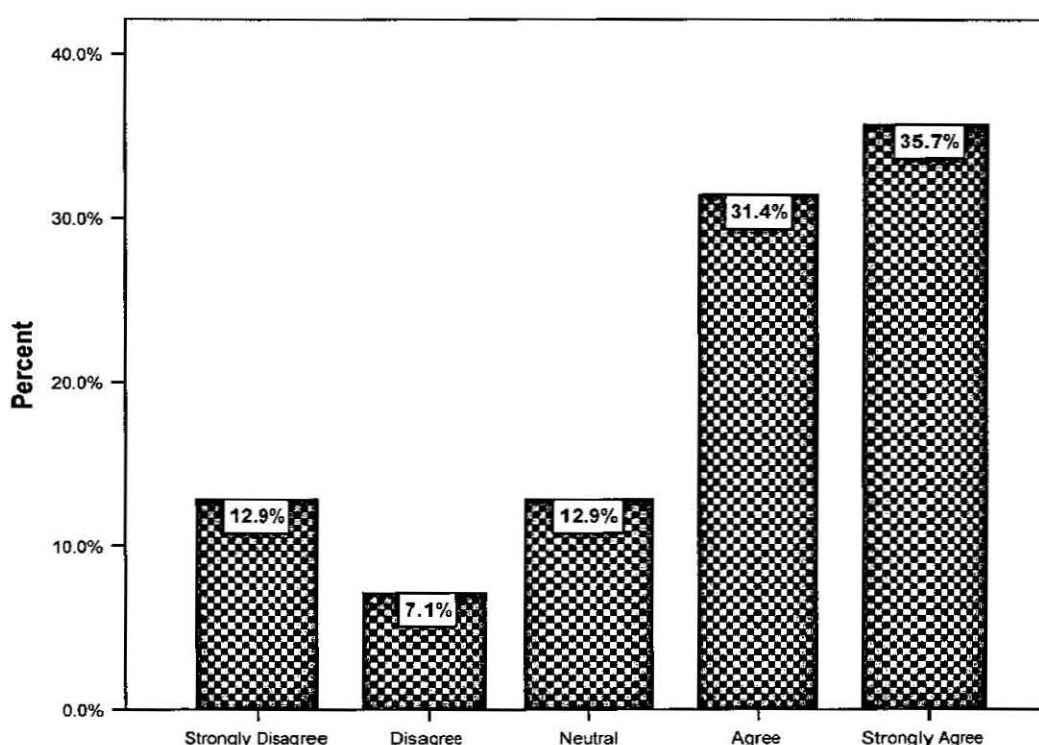
to educators and learners, protecting the education sector's capacity by stabilising teaching service and improve educator skills and finally acquiring and developing the capacity to manage the sector's response to this crisis.



SV 11: Educators should not be required to teach learners infected with HIV/AIDS.

Interpretation

The above graph shows attitudes of respondents towards teaching infected learners. About 82% of educators support the idea that educators should be required to teach learners infected with HIV/AIDS. While 11% agree. This confirms that educators have positive attitudes about learners with HIV/AIDS in their classroom. Research by Olson et al. (2004) also confirms that educators do have positive attitudes about learners with chronic health conditions including HIV/AIDS in the classroom.

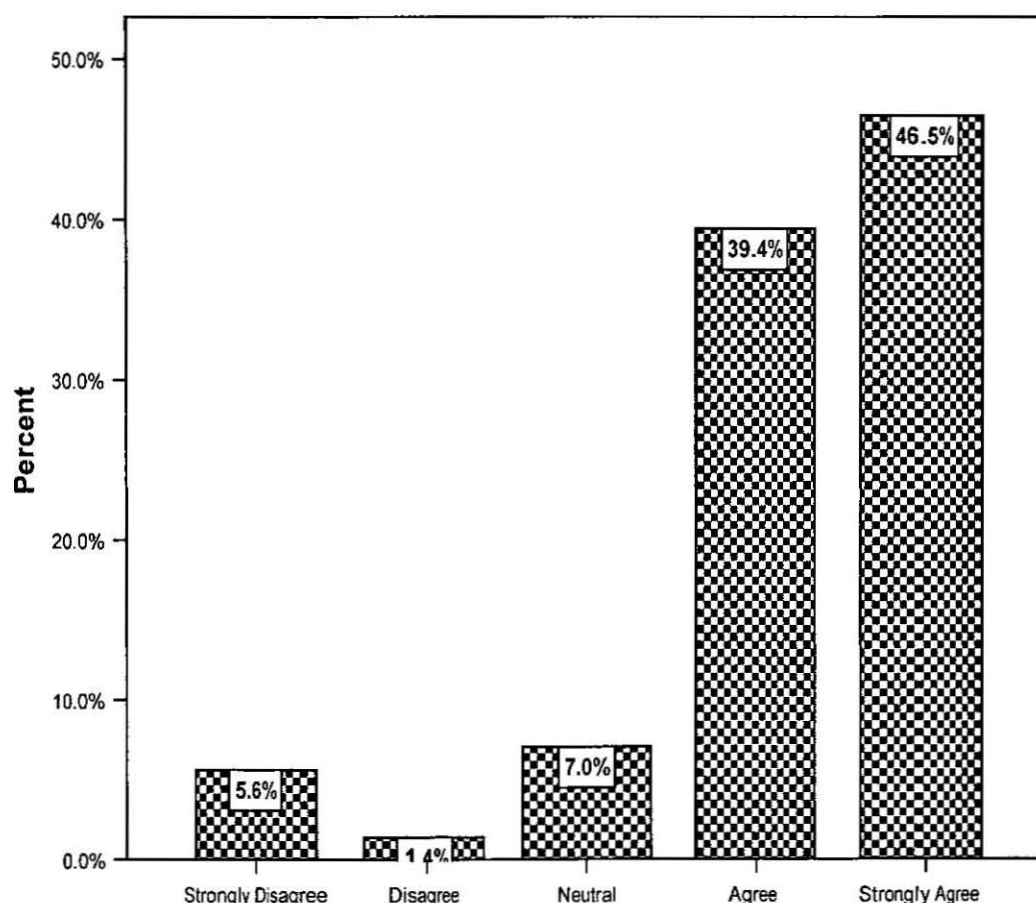


SV 12: Educators should be required to teach learners infected with HIV/AIDS only if the learner displays 'no outward sign'.

Interpretation

The responses of the research participants towards infected learners who display 'no outward signs' are shown above. The responses of educators vary but the majority strongly agree. This also indicates that they do not understand much about HIV/AIDS. How would they distinguish HIV related illnesses from other sicknesses without testing of which they are very much against!

Research by Olson et al. (2004) found that the aspects of relatively more concern for educators are not the academic issues but the extra burdens and feeling personally at risk of having a learner with HIV/AIDS in their classrooms.



SV 13: Public school districts have a responsibility to provide an educational programme for those learners who are infected with the HIV/AIDS virus

Interpretation

In the above graph it is visible that the majority of educators agree that the school district should provide programmes for learners infected with AIDS virus. The programmes that emphasize personalizing the risk of HIV infection may be more potent motivator of health-promoting behaviour change (Diclemente, et al. 2002). Such programmes need to address attitudes that cause

discrimination, stigmatisation and denial. They should be aimed at introducing voluntary testing and support for educators infected and affected by HIV/AIDS.

4.2.2 Central tendency and variability measures

Central tendency

The mean was used as the central tendency measure. The mean gives the average score obtained by the group of participated respondents. The study variables (SV) 1, 2, 4 and 7 had the mean value of 3. This revealed that the respondents participated in this survey had articulated an average perception of *Neutral* towards the above mentioned study variables.

The SV 3, SV 6 and SV 11 had the mean value of 2. This revealed that the respondents that participated in the survey had articulated an average perception of *Disagree* towards the above mentioned study variables.

SV 8, SV 9, SV 12 and SV 13 had a mean value of 4. This revealed that the respondents that participated in this survey had articulated an average perception of *Agree* towards the above mentioned study variables.

The average mean of all the variables was 3. This revealed that the overall perception of the respondents participated in this research was *Neutral*.

Although the measure of central tendency was a very useful statistic for describing a set of data they were not sufficient. There was a need for a measure that indicated the way the scores were spread (Gay, 1992). For this purpose, the standard deviation was used. The standard deviation is the most stable measure of variability that takes into account each and every score. For all the

study variables the standard deviation ranged from 0,743 to 1,567. This revealed that the study variables differed according to respondents' perceptions. This means that the educators' attitudes towards HIV/AIDS differ significantly. Therefore, the null hypothesis which states that educators do not differ significantly in their attitude towards HIV/AIDS was rejected.

4.3 Inferential statistics

Inferential statistics dealt with inferences about the population based on the behaviour of the sample. The inferential statistics used were the t-test and analysis of variance (ANOVA).

4.3.1 The t-test

4.3.1.1. Gender

A t-test was conducted on each of the 13 statements to determine whether there was a significant difference in response to the statements relative to the gender of educators. The analysis showed that only three statements, namely 2 (All beginning educators should be required to test for HIV/AIDS antibody as requirement for certification), 3 (If the educator test positive for HIV/AIDS, he/she should not be allowed to teach) and 4 (If the educator 's indicates that he/she has been infected with HIV/AIDS but shows 'no outward signs' he/she should be issued a teaching certificate), showed values below 0,05 level of significance. Therefore the null hypothesis was rejected in only three statements. As it can be seen these statement are about issuing a certificate to HIV positive educator, so as far as gender is concerned the educators differ only in this regard. For statements 1, 5 and 6 to 13 the p significance values was above 0.05 level of significance. Therefore the null hypothesis was retained. This reveals that there was no significant difference between male and female attitudes towards HIV/AIDS.

4.3.2 Analysis of variance (ANOVA) tests

4.3.2.1 Age groups

An analysis of variance (ANOVA) was conducted for each of the 13 statements in an attempt to determine whether there was any difference in the responses among the different age groups. For all the 13 statements the test results revealed no statistical significance difference in attitudes of different age group respondents. The p values ranged between 0,72 to 0,87 which were above 0,05. Therefore the null was retained.

4.3.2.2 Experience

An ANOVA was conducted for each of the 13 statements in an attempt to determine whether there were differences in responses among educators with different years of experiences. In all the 13 statements the p significant values ranged between 0,204 and 0,72 which were above 0,05. This means that there was no statistical significance in difference in attitudes of respondents with different years of experience. So the null hypothesis was retained.

4.3.2.3 Religion

AS far as religion was concerned, there was a huge difference in the number of respondents between the two groups which made it impossible to make comparisons.

4.3.2.4 Qualification

The ANOVA was conducted for each of the 13 statements in an attempt to determine if there was any difference in the responses among educators with different qualification. The ANOVA test results for qualification revealed that there was no statistical significant difference in attitudes of

respondents with different qualification status. In all the 13 statements the p significance values ranged between 0,30 to 0,89 which were above 0.05. Therefore the null hypothesis was retained.

In conclusion, there was no statistically significant difference in educators' attitudes. This means that educators' attitudes do not differ except for the three statements in gender. Their attitudes are not influenced by variables such as gender, age, religion, qualification and experience. The null hypotheses were not rejected.

4.4. The Null Hypothesis

The following null hypotheses are stated:

4.4.1. Educators do not differ significantly in their attitudes towards HIV/AIDS.

4.4.2. Educators attitudes are not influenced by variables such as age, gender, teaching experience, academic qualifications, and religion.

The t-test for the majority of the attitudinal questions produced a value above 0,05, which means that the null hypothesis was retained – that is, educators do not differ significantly in their attitudes towards HIV/AIDS.

The second null hypothesis was also retained since the t-test and ANOVA produced values above 0,05. Thus, educators' attitudes are not influenced by variables such as age, gender, teaching experience, academic qualifications, and religion

4.5 Conclusion

The aim of this study was to determine the nature of educators' attitudes towards HIV/AIDS and whether or not that difference, if it does exist, is influenced by characteristics such as gender, age, experience, religion and qualification. From the analysis of socio-demographic data it was evident that the majority of educators in the sample are women below the age of 45. Their age band and the fact that they are women place them at greater risk of contracting HIV. The majority of them are well educated.

The analysis of their responses to the questionnaire revealed that the majority of them have negative attitudes towards testing for HIV/AIDS. Testing is believed to be the basis of HIV prevention. People who know their HIV statuses are believed to be able to live longer, productive lives and they are able to accept other people who are infected and affected by the virus. They will also be able to educate others about HIV/ AIDS prevention. There were also a large number of neutral responses in almost all the questions which might be interpreted as negative attitude. Inferential statistics test results indicated that there was no significant difference in educators' attitudes towards HIV/AIDS. It also showed that educators' attitudes are not influenced by variables such as gender, age, experience, religion and qualification with the exception of only three questions in the case of gender. So the null hypotheses were retained.

In the following chapter the detailed discussions of the findings in respect of the aims of the study will be presented as well as a discussion of the limitations and recommendations.

CHAPTER 5

Summary, Conclusions and Recommendations

5.1. Introduction

This study sought to determine the nature of educators' attitudes towards HIV/AIDS, and whether such attitudes are influenced by variables such as age, gender, religion, experience and qualification. This chapter focuses on crystallizing and developing findings based on the data that has been presented in the previous chapter. The themes that have emerged from the analysis provide an understanding of educator attitudes and influencing variables. The findings are discussed in relation to the aims of the study outlined in Chapter 1. This is followed by the recommendations, limitations of the study and conclusion.

5.2 Reiteration of the study aims.

5.2.1 Aim 1: To determine the nature of educators' attitudes towards HIV/AIDS.

In order to determine the nature of educators' attitudes towards HIV/AIDS, thirteen attitudinal questions were used. The questions focused on five major issues as outlined below.

5.2.1.1 Testing for HIV/AIDS

Testing for HIV/AIDS is the core to HIV/AIDS treatment and prevention. It is assumed that by knowing one's status one can be able to live longer by getting treatment early, eating healthy and protecting oneself and others from further infections. However, the findings of this study indicated that educators are still strongly against testing for HIV/AIDS. This perception of educators could be due to the fact that educators may have seen the discrimination and ostracism that people known to have the virus have been subjected to. Some people have been killed for

disclosing their status while others have been disowned by their families. Another answer to this could be that educators themselves have limited knowledge of the disease or are pretending not to know for the fear of stigmatization. Denial can discourage voluntary testing among people and may increase the potential risks of HIV transmission. This negative attitude of educators towards testing could have devastating effects on HIV/AIDS prevention since schools provide the most ideal setting for implementing HIV/AIDS education. Educators seem not to know much about HIV/AIDS. They fear that being HIV positive means that one is going to die so they prefer not to know their status. HIV/AIDS is seen by many as death, some form of punishment for immoral behavior, as horror, as a result of personal irresponsibility, shameful and as 'otherness'. These stereotypes enable some people to deny that they are personally likely to be affected or infected (UNAIDS: 2000).

5.2.1.2 Continuation in an education institution of an individual infected with HIV/AIDS

The majority of educators feel that an individual infected with HIV/AIDS should continue to teach or attend classes even though infected. This is in contradictory to the study by Visser and Antoni (1994) which showed that more than 40% of educators answered that HIV infected individual should keep away from school. This could be due to the fact that educators in this study understand that the HIV/AIDS takes long to actually interfere with the person's daily living. During this period, the individual needs to live like everybody else and be able to get treatment. This positive attitude in the case of learners could have been influenced by the Post Provision Norm (PPN) policy. According to this policy if the enrolment decreases the excess educators must be transferred to schools with higher enrolment, that is, the number of educators assigned to the school is determined by the number of learners. If so, that would mean that the educators are prepared to teach even HIV positive learners to secure their jobs.

5.2.1.3 Contact with or inclusion in education activities of an individual infected with HIV/AIDS

The majority of educators were against contact with or inclusion in educational activities of an individual infected with HIV/AIDS. The educators seemed to lack knowledge of the ways in which HIV/AIDS can be passed from one individual to another. The other reason could be that they do not know what to do with the infected person in the case where the individual can get hurt, since HIV/AIDS is transmitted through contact with the infected blood. Most of the schools do not have first aid kits and where it is available educators do not know how to use it. Learners spend half of their waking hours with their educators. Yet most of the educators have had little information about the learners with medical conditions in the classroom. This negative attitude shows that educators themselves are discriminating against people living with HIV/AIDS and are ignorant to the fact that everyone could be infected by the virus. Stigmatization and discrimination prevent people to be open about HIV and undermine the ability of individuals, families and societies to protect themselves and provide support and reassurance to those infected (UNAIDS:2000). Visibility and openness are the prerequisites for successful mobilization of government and community resources to respond to epidemic. The research by Olson et al (2004) found that educators who had been in contact with individuals with AIDS had more positive attitudes towards HIV/AIDS.

5.2.1.4 Responsibility of the school system to provide an academic programme to those infected with HIV/AIDS.

Educators have a strong feeling that it is a duty of the school system to provide an academic programme for those infected with HIV/AIDS. They feel so because they think that they have limited resources and lack expertise to render such programmes. The educators are not well

equipped and do not possess relevant knowledge and therefore not ready to provide intervention. When the Department of Education renders in-service courses for educators on HIV/AIDS, one educator per school is allowed to attend and is supposed to return and cascade the information to others. In most cases there is no time for that, and the training is insufficient, so the rest of the educators remain ignorant. HIV/AIDS education needs to go beyond the factual understanding of the disease and address the attitudes. From the findings of this study educators do not only have negative attitudes but they also lack understanding of the disease. According to the study by Diclemente et al (2002) even in highly educated population, the scientific debate about AIDS may inadvertently engender feelings of confusion, apprehensiveness and distrust. This suggests that AIDS prevention programmes need to address misconceptions as a distinctively separate issue and should not assume that providing accurate information about identified mode of transmission supplant misinformation. At the present time education is the only social vaccine available against HIV infection. The school system has a special responsibility with regard to the HIV/AIDS pandemic. Learning institutions need to have a paradigm shift. It is necessary to change education planning and management principles, curriculum development goals as well as the way education is done (Coombe: 2002).

5.1.2.5 The requirement to teach learners infected with HIV/AIDS.

Educators are willing to teach HIV infected learners provided they do not show outward signs. The problem here is how educators would be able to see that the symptoms displayed by the learner are for HIV/AIDS. It seems that educators do not understand that the diseases that affect HIV positive individuals are the same as those that can affect HIV negative individuals. They think that there are specific symptoms defining HIV positive individuals. This idea can lead to discrimination of sick people irrespective of their status.

The findings of this study indicate that the educators' attitudes are still negative despite numerous campaigns against HIV/AIDS.

5.2.2 Aim 2: To find out whether educators' attitudes towards HIV/AIDS are associated with educators' characteristic such as gender, age, experience, religion and qualification.

The findings show that there is no significance difference in terms of gender, age, experience, religion and qualification except for three statements in the case of gender. Males and females tended to differ only on three statements in the questionnaire, namely, whether an HIV positive educator should be allowed to teach or not; whether s/he should be issued with teaching certificate irrespective of the progression of the disease; all beginner educators should be required to test as a requirement for certification. An overall conclusion therefore indicates that there is no significant relationship between educator characteristics such as age, experience, religion, qualification and the nature of their attitude.

5.3 Limitations of the study

The following are several limitations of this study. Due to time and financial constraints the study was confined to only a few schools. Furthermore, of the 12 schools sampled, only 8 chose to participate. The number of male respondents was fewer than that of females. To obtain the true difference in opinion the number of males and females should be equal. Further studies could perhaps use a purposive sample to ensure an equal number of males and females. Only two religions were used in the study and the second one had very few respondents. South Africa is a multi-religion country and that should be reflected in the sample. The majority of the respondents come from one age group. An ideal situation would be equal number of participants coming from all the age groups. The participants come from one racial group since most schools

in the rural areas are dominated by black teachers. That does not represent the multiracial nature of the country. The results obtained in this study may differ in urban schools. Therefore future studies must include educators both in urban and rural environments. It is the researcher's suggestion that future studies must include a sample that balances race, religion, age and gender characteristics

5.4 Recommendations

From the results of this study, the following is recommended:

- The Department of Education must ensure that every educator has an opportunity to receive training in HIV/AIDS information. The usual practice of the Department of Education is to take only a few educators per school to attend a HIV/AIDS workshop. That educator is expected to cascade the information to others in his staff, which is difficult because there is no time allocated for such feedback sessions. The short period given to training cannot ensure that the educators will be proficient enough to disseminate all the information given to them to their staff members.
- The Department of Education needs to devise educational strategies to change educators' attitudes, since attitudes are the basis of behavioral change. Campaigns against HIV/AIDS should aim at changing attitudes first. HIV/AIDS is still seen by many educators as taboo. Initiatives by the Department to step up its efforts to communicate the terrible reality of the dangers of HIV/AIDS will help.
- There must be support systems (emotional, psychological, medical) for those educators infected and affected by HIV/AIDS.
- The government needs to increase financial allocations to HIV/AIDS prevention programmes.
- The Department of Education must ensure that funds should be spent productively.

Officials in charge of budgets should not wait until the end of the year to spend on allocated projects as they engage in unnecessary wastage just to exhaust the budget. Sometimes HIV/AIDS budgets go unspent¹ due to lack of resources and capacity yet a large number of educators and learners are dying everyday.

- Full-time co-ordinators who are knowledgeable, should be employed to co-ordinate HIV/AIDS programmes.
- The Department of Education needs to encourage educators to test for HIV/AIDS by even giving incentives if there is no other way. That can also save a large amount of money that is spent on educator sick leave.
- Programmes should aim at personalizing the risk of HIV infection by encouraging the self appraisal of risk taking behaviours and provide social skills training needed for behavioural change.
- Programmes should aim at reducing stigmatization, ostracism and discrimination of individuals infected as well as developing values and attitudes that respect the right of all individuals.

5.5 Conclusion

The study reveals that there is no significant difference in the nature of educators' attitudes sampled towards HIV/ADS, and that these attitudes are mostly negative. This difference is also not influenced by educators' characteristics such as age, gender, qualification, experience or religion. Such findings give indications as to why educators are dying in such numbers of a preventable disease. This suggests that the campaign to educate about HIV/AIDS is not working. If the educated and well informed educators after so many awareness campaigns still show such

¹ Informal interview with Department official who volunteered information only on conditions of anonymity

results, it means that the message is not getting through or is not being believed. Educators perform one of society's most important functions and are custodians of our children's education. Therefore everybody, especially the Department of Education should be worried about these results.

Educators form an important source of HIV/AIDS prevention information required by learners and community. If educators are still discriminating, reluctant to test themselves and disclose their HIV/AIDS status, HIV/AIDS prevention strategies will fail. The campaign to stop the spread of AIDS in schools and in communities appears to be jeopardized by such attitudes of educators. The large number of neutral responses shows that educators do not care about the disease or they pretend not to care. The system of cascading preventive information to colleagues by a few educators will not be effective in an environment where negative attitudes towards HIV/AIDS prevail. An immediate, urgent strategy to address educator attitudes towards the disease is required from the relevant government departments.

References

- Ajzen, I. (1988). *Attitudes, Personality and Behaviour*. Chicago: The Dorsey Press
- Alzubir, A.G., El Nour, M.H. and Ansari, E.H.H. (1996) AIDS related knowledge and misconceptions among high secondary school educators in Kassola, Sudan. *East African Medical Journal*, 75 (5), 295-297.
- Ary, D., Jacobs, I.C. and Razavich, A. (1985). *Introduction to Research in Education*. 3rd Ed. CBS College Publishing, Holt, New York.
- Ballard, D.J., White, D.M. and Glascoff, M.A. (1990). AIDS /HIV education for preserves elementary educator, *Journal of School Health*, 60, 262-265
- Boscareni, J.A. and Diclemante, J.R. (1996). AIDS Knowledge, Teaching, Comfort and support for Aids Education among school educators. A state-wide survey. *AIDS education and prevention*, 8 (3), 267-277.
- Bateman, C. (2003). KwaZulu Natal AIDS slashes educator numbers. *South African Medical Journal*, 93(5), 313-314.
- Bogdan, R.C., and Biklen, S.K., (1992). *Qualitative Research for Education An Introduction to Theory and Methods*. 2nd Ed. Allyn and Bacon, Boston.

Brink, H. (2003). Fundamentals of research methodology for health care professionals. 6th Ed. Creda Communications, Cape Town.

Brucker, W.B. and Hall, W.H. (1991) AIDS in the classroom: Are educators' attitudes changing? *Early child development and care*, 77, 137-147.

Brucker, W.B. and Hall, W.H. (1996) AIDS in the classroom: A survey of teacher attitudes. *Early child development and care*, 43, 61-64.

Brucker, B.W. and Hall, W.H (1995) Educators' attitudes towards HIV/AIDS: An American National Assessment. *Early child development and care*, 115, 85-95.

Chifunyise, T., Benoy, H. and Mukiubi, B. (2002). An impact evaluation of student teachers training in HIV/AIDS education in Zimbabwe. *Evaluation Progress Planning*, 25 (2002), 377-385.

Cilliers, C.D. (1988). The role of the school in the Republic of South Africa in the prevention of AIDS-a situation analysis. *South African Journal of Education*, 1 (9), 1-6.

Coombe, C. (2002). Editorial: HIV/AIDS in education. *Perspectives in education*, 20(2), vii-x.

Connors, J., Heaven, P.C.L. (1990). Belief in the just world and attitudes toward AIDS sufferers. *Journal of Social Psychology*, 130, 559-560.

Disclemente, R.J., Crosby, R.A. and Wingood, G.M. (2002) HIV prevention for adolescents: Identified gaps and emerging approaches. *Prospects*, XXX11 (2), 13-32.

Department of health,(2000). HIV/AIDS/STD strategic plan for South Africa 2000-2005: Republic of South Africa.

De Vaus D.A.,(1986).Survey in social research. Gorge Allen and Unwin Publishers LTD. UK.

Dowson, L. J., Chunis, M. L., Smith, D. M. and Carboni, A.A. (2001) The role of Academic Discipline and Gender in High Schools teachers' AIDS-Related Knowledge and Attitudes. *The Journal of school health*, 171, 3-8.

Fisher, J.D. and Fisher, W.A. (2000). The Theoretical approaches to individual level change in HIV risk behaviour. In Peterson and Diclemente. *Handbook of HIV Prevention*. New York: Kluwer Academic/Plenum Publishers.

Franzini, L.R., Sideman, L.M, Dexter, K.E. and Elder J.P. (1990). Promoting AIDS risk reduction via behavioural training. *AIDS Education and Prevention*, 2(4), 313-321.

Gay, L.R. (1992). *Educational Research Competencies for Analysis and Application*. 4th ed. MacMillan Publishing Company. New York.

Gingiss, P. and Basen-Enquist, K. (1994). HIV Education practises and training needs of middle

school and high school educators. *Journal of School Health*, 64 (70), 290-295.

Hernes, G. (2002). UNESCO versus HIV/AIDS: the history and ten lessons. *Prospects*, XXX11 (2), 5-12.

Kelly, M.J (2000). *Planning for Education in the content of HIV/AIDS*. UNESCO, PANS, SAGIM printers.

Kuhn, L., Steinberg, M. and Matthews, C. (1994). Participants of School Community in AIDS Education of a high school programme in South Africa. *AIDS Care*, 6 (2), 161-171.

Mannah, S. (2002) South Africa: The Complex role of educating about HIV/AIDS in schools. *Prospects*, XXX11 (2), 33-48.

Matyu, J. (30 May 2003). SADTU's plea for AIDS orphans, *Herald*.

McQuire, M.J. (1968). Personality and attitude changes. An information processing theory. In Greenwald, A.G. Brock, T.C and Osborn, T.M (Eds). *Psychological Foundation of Attitudes*. New York: Academic Press

Morell, R., Unterhatter, E., Molefsane, L. and Epstein. (2001). HIV/AIDS, Policies, schools and gender identities. *Indicators South Africa*, 18 (2), 51-57.

Schuklenk, V. (1998). AIDS: Individual and public interests, In Kuhse, H. and Singer, P.A. *Comparison of Bioethics*. Oxford: Blackwell, 343-354.

Sowell, E.J. and Casey, R.J. (1982). *Research Methods in Education*. Wadsworth Publishing Company, Belmont, California.

Terre Blanche, M., Durrheim, K. and Painter, D (2006). Research in practice. Applied methods for the social sciences. 2Ed. UCT Press. South Africa

UNAIDS (2000). HIV and AIDS Related stigmatization, Discrimination and Denial: Forms, content and determinants. *Research Studies from Uganda and India*. Geneva, Switzerland.

UNAIDS. (2002). *HIV/AIDS and Education Strategic Approach*. World Bank group.

Van Dyk, A. (2001). *HIV/AIDS care and counselling: A Multidisciplinary Approach*. Cape Town: CTP Book Punters.

Visser, A. and Antoni, M. (1994). Current perspectives on AIDS/HIV education and counseling. *Patient education and counselling*, 24 (1994) 191-198.

Visser, M.J., Roos, J.L. and Kort, L. (1995). AIDS Prevention on the campus. *South African Journal of Higher Education*, 9 (2D), 165-173.

Walters, P.B., Desmond, C., Wilson, D. and Heard, W. (2001). Educational Morality in service in KwaZulu Natal. *Heard*, University of Natal.

Whiteside, A. and Sunter, C. (2000). *AIDS, the challenge for South Africa*. Tafelberg: Human

References:

P L B Shazi-Mweli

and Rousseau.

Wiersma, W. (1991). *Research methods in education. An introduction*. 5th Ed. Boston: Allyn and Bacon.

ANNEXURE A

Central Tendency Stats

Central Tendency Stats

		sv1	sv2	sv3	sv4	sv5	sv6	sv7	sv8	sv9	sv10	sv 11	sv12	sv13
N	Valid	69	71	68	68	71	67	71	71	71	71	70	71	69
	Missing	2	0	3	3	0	4	0	0	0	0	1	0	2
Mean		3.00	3.00	2.00	3.00	2.00	2.00	3.00	4.00	4.00	5.00	2.00	4.00	4.00
Median		3.00	2.00	1.00	4.00	2.00	1.00	4.00	4.00	4.00	5.00	1.00	4.00	4.00
Mode		4	1	1	4	1	1	5	5	5	5	1	5	5
Std. Deviation		1.322	1.296	.743	1.319	1.270	.904	1.569	1.120	.984	.808	1.179	1.366	1.037
Variance		1.748	1.681	.552	1.739	1.614	.816	2.462	1.254	.969	.652	1.389	1.865	1.075
Range		4	4	4	4	4	4	4	4	4	4	4	4	4
Minimum		1	1	1	1	1	1	1	1	1	1	1	1	1
Maximum		5	5	5	5	5	5	5	5	5	5	5	5	5

Interpretation

The above table results reveal central tendency stats results of study statements SV1 to SV13

The measurement scale code interpreted as

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly Agree

ANNEXURE B

Cronbach Alpha test (Reliability test)

Interpretation Rules: 1) If Cronbach Alpha value is between 0.4 to 0.7, indicates of medium internal consistency and reliability.
2) If Cronbach Alpha value is between 0.7.1 to 1.0, indicates of High or good internal consistency and reliability

Case Processing Summary

		N	%
Cases	Valid	60	84.5
	Excluded	11	15.5
	Total	71	100.0

Reliability Statistics

Cronbach's Alpha	N of Items
.492	11

ANNEXURE C

T- Test: Gender

Interpretation Rule: 1. If p value is less than or equal $p \leq 0.05$, statistically there is Significance difference between Gender groups opinions.

2. If p value is greater than $p > 0.05$, statistically there is NO Significance difference between Gender groups opinions.

* p indicates probability value

		t-test		
		t	df	Sig. (2-tailed)
sv1	Equal variances assumed	1.083	67	.283
	Equal variances not assumed	1.103	30.885	.278
sv2	Equal variances assumed	2.305	69	.024
	Equal variances not assumed	1.886	22.221	.072
sv3	Equal variances assumed	2.288	66	.025
	Equal variances not assumed	2.161	27.222	.040
sv4	Equal variances assumed	2.012	66	.048
	Equal variances not assumed	2.105	32.841	.043

		t-test		
		t	df	Sig. (2-tailed)
sv5	Equal variances assumed	.504	67	.616
	Equal variances not assumed	.550	32.031	.586
sv6	Equal variances assumed	1.635	69	.107
	Equal variances not assumed	1.381	23.035	.181
sv7	Equal variances assumed	.388	65	.699
	Equal variances not assumed	.456	30.190	.651
sv8	Equal variances assumed	-1.478	69	.144
	Equal variances not assumed	-1.510	30.566	.141

		t-test		
		t	df	Sig. (2-tailed)
sv9	Equal variances assumed	-.221	69	.826
	Equal variances not assumed	-.255	39.138	.800
sv10	Equal variances assumed	-1.582	69	.118
	Equal variances not assumed	-1.463	25.971	.155
sv 11	Equal variances assumed	-.104	69	.918
	Equal variances not assumed	-.115	36.081	.909
sv12	Equal variances assumed	-.385	68	.701
	Equal variances not assumed	-.369	25.340	.715
sv13	Equal variances assumed	-1.472	69	.145
	Equal variances not assumed	-1.297	24.282	.207

ANNEXURE D

Anova test

Interpretation Rule: 1. If p value is less than or equal $p \leq 0.05$, statistically there is significance difference between groups opinions.

2. If p value is greater than $p > 0.05$, statistically there is **NO** significance difference between groups opinions.

Note: p indicates probability

1): A2: Age groups

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv1	Between Groups	2.870	2	1.435	.446
	Within Groups	116.000	66	1.758	
	Total	118.870	68		
sv2	Between Groups	.580	2	.290	.845
	Within Groups	117.082	68	1.722	
	Total	117.662	70		
sv3	Between Groups	.234	2	.117	.814
	Within Groups	36.766	65	.566	
	Total	37.000	67		
sv4	Between Groups	1.535	2	.768	.650
	Within Groups	114.980	65	1.769	
	Total	116.515	67		

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv5	Between Groups	4.009	2	2.005	.293
	Within Groups	105.730	66	1.602	
	Total	109.739	68		
sv6	Between Groups	2.359	2	1.179	.239
	Within Groups	54.796	68	.806	
	Total	57.155	70		
sv7	Between Groups	12.817	2	6.408	.072
	Within Groups	149.661	64	2.338	
	Total	162.478	66		
sv8	Between Groups	4.756	2	2.378	.150
	Within Groups	83.018	68	1.221	
	Total	87.775	70		

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv9	Between Groups	.273	2	.136	.872
	Within Groups	67.558	68	.993	
	Total	67.831	70		
sv10	Between Groups	1.012	2	.506	.467
	Within Groups	44.650	68	.657	
	Total	45.662	70		
sv 11	Between Groups	.705	2	.353	.781
	Within Groups	96.534	68	1.420	
	Total	97.239	70		
sv12	Between Groups	1.469	2	.735	.681
	Within Groups	127.231	67	1.899	
	Total	128.700	69		
sv13	Between Groups	2.017	2	1.008	.397
	Within Groups	73.223	68	1.077	
	Total	75.239	70		

2) A3: Qualifications

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv1	Between Groups	8.604	4	2.151	.300
	Within Groups	110.266	64	1.723	
	Total	118.870	68		
sv2	Between Groups	3.539	4	.885	.727
	Within Groups	114.123	66	1.729	
	Total	117.662	70		
sv3	Between Groups	2.298	4	.575	.392
	Within Groups	34.702	63	.551	
	Total	37.000	67		
sv4	Between Groups	9.676	4	2.419	.236
	Within Groups	106.839	63	1.696	
	Total	116.515	67		

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv5	Between Groups	9.225	4	2.306	.222
	Within Groups	100.514	64	1.571	
	Total	109.739	68		
sv6	Between Groups	2.195	4	.549	.623
	Within Groups	54.960	66	.833	
	Total	57.155	70		
sv7	Between Groups	7.644	4	1.911	.552
	Within Groups	154.833	62	2.497	
	Total	162.478	66		
sv8	Between Groups	9.212	4	2.303	.115
	Within Groups	78.563	66	1.190	
	Total	87.775	70		

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv9	Between Groups	10.900	4	2.725	.019
	Within Groups	56.931	66	.863	
	Total	67.831	70		
sv10	Between Groups	2.044	4	.511	.547
	Within Groups	43.618	66	.661	
	Total	45.662	70		
sv 11	Between Groups	1.646	4	.412	.887
	Within Groups	95.593	66	1.448	
	Total	97.239	70		
sv12	Between Groups	4.380	4	1.095	.684
	Within Groups	124.320	65	1.913	
	Total	128.700	69		
sv13	Between Groups	4.121	4	1.030	.438
	Within Groups	71.119	66	1.078	
	Total	75.239	70		

3) A4: Experience

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv1	Between Groups	5.428	4	1.357	.602
	Within Groups	90.258	46	1.962	
	Total	95.686	50		
sv2	Between Groups	7.256	4	1.814	.355
	Within Groups	75.571	47	1.608	
	Total	82.827	51		
sv3	Between Groups	1.931	4	.483	.550
	Within Groups	28.814	46	.626	
	Total	30.745	50		
sv4	Between Groups	8.857	4	2.214	.233
	Within Groups	67.143	44	1.526	
	Total	76.000	48		

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv5	Between Groups	8.720	4	2.180	.289
	Within Groups	77.868	46	1.693	
	Total	86.588	50		
sv6	Between Groups	1.800	4	.450	.662
	Within Groups	35.027	47	.745	
	Total	36.827	51		
sv7	Between Groups	7.756	4	1.939	.580
	Within Groups	123.225	46	2.679	
	Total	130.980	50		
sv8	Between Groups	9.072	4	2.268	.204
	Within Groups	68.928	47	1.467	
	Total	78.000	51		

ANOVA

		Sum of Squares	df	Mean Square	Sig.
sv9	Between Groups	2.936	4	.734	.640
	Within Groups	54.295	47	1.155	
	Total	57.231	51		
sv10	Between Groups	1.097	4	.274	.768
	Within Groups	28.345	47	.603	
	Total	29.442	51		
sv 11	Between Groups	1.608	4	.402	.872
	Within Groups	61.469	47	1.308	
	Total	63.077	51		
sv12	Between Groups	.858	4	.215	.983
	Within Groups	101.299	46	2.202	
	Total	102.157	50		
sv13	Between Groups	1.949	4	.487	.802
	Within Groups	56.128	47	1.194	
	Total	58.077	51		

ANNEXURE E

P.O. Box 625

SUMMERFIELDS

4162

13 October 2005

Scottburgh Circuit
Private Bag X 0515
UMZINTO
4200

Dear Sir/Madam

RE: PERMISSION TO DO A RESEARCH IN YOUR CIRCUIT

I kindly beg for permission to do research in your circuit. I am a MED student studying at the University of Zululand. My research topic is attitudes of Educators to circuits HIV/AIDS.

Thanking you in anticipation

Yours faithfully

.....
Mrs P.L.B Mveli



KZN EDUCATION
UMNYANGO WEZEMFUNDO
ISIFUNDAZWE SAKWAZULU-NATALI
SCOTTBURGH CIRCUIT



Address/Kheli/Adres : Private Bag X 0515, Umzinto, 4200
Telephone/Uncingo/Telefoon : 039-9740149 / 9740462/3



Fax/Isikhalamezi/Faks : 039-9740461
Physical Address: Vulamehlo, Dududu

14.10.2005

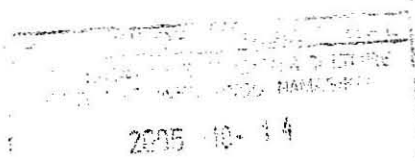
TO WHOM IT MAY CONCERN

Please be informed that Mrs P.L.B. Mveli has been granted permission to conduct research in the schools towards her M.Ed thesis. Kindly note that she can only conduct her research outside contact time

Any assistance to her will be appreciated.

Thank you

C.K. Ngcobo
SEM



Questionnaire

Dear Respondent

You are kindly requested to respond to the following questions. This questionnaire is for educational purpose and aims to obtain your views about HIV/AIDS. The true reflection of your views will help to make the study a success. There is no right or wrong answers. Your participation will remain anonymous and your response will be kept confidential. Your co-operation is greatly appreciated.

SECTION A

Biographic Data

Please write an 'X' on the relevant information about yourself on the space provided.

1. Gender

Male	
Female	

2. Age

< 25 yrs	
26- 35 yrs	
36-45 yrs	
46-55+ yrs	

3. Number of years of teaching experience

1-5 yrs	
6-10 yrs	
16-20 yrs	
Above 20 yrs	

4. Religion

Christian	
African traditional belief	

5. Qualifications

M1	
M2	
M3	
M4	
M5	

SECTION B

Close-ended questions

Please put 'X' below the best answer that describes your opinion.

1. All educators should be required to test for HIV/AIDS.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

2. All beginning educator should be required to test for HIV/AIDS antibody as requirement for certification.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

3. If the educator test positive for HIV/AIDS, he/she should not be allowed to teach.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

4. If the educator's test indicates that he/she has been infected with HIV/AIDS but shows "no outward signs" he/she should be issued a teaching certificate.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

5. Mandatory testing of learners for the HIV/AIDS antibody should be required for all learners as a condition of his or her attending class.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

6. Learners who have been infected with HIV/AIDS should not be allowed to attend class.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

7. Learners who have been infected with HIV/AIDS should not be allowed to participate in school activities with other learners.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

8. Learners who have been infected with HIV/AIDS but who display "no outward signs" should be allowed to attend classes.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

9. Learners who have been infected with HIV/AIDS but who display "no outward signs" should be allowed to participate in school with other learners.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

10. School districts should take appropriate steps to educate learners, parents and school employees regarding HIV/AIDS and its transmission.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

11. Educators should not be required to teach learners infected with HIV/AIDS.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

12. Educators should be required to teach learners infected with HIV/AIDS only if the learner display "no outward signs".

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

13. Public school districts have a responsibility to provide an educational program for those learners who are infected with HIV/AIDS.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Agree

List of Acronyms

HIV – Human - Immune -Deficiency Virus

AIDS – Acquired Immune Deficiency Syndrome

SPSS – Statistic Package for Social Sciences

TRA- Theory of Reason & Action

TPB – Theory of Planned Behavior

IMB – Information – Motivation-Behavior

Anova – Analysis of Variance

SV- Study Variable

PPN – Post Provisional Norm