

**THE IMPACT OF HIV/AIDS ON PRIMARY AND SECONDARY EDUCATION IN  
MOHALE'S HOEK IN LESOTHO**

**by  
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## **DEDICATION**

I dedicated this study to my husband Mokuena for his love and forbearance in this undertaking. As time has progressed I have been indeed blessed to have him on my side and as a silent partner in this labour.

My little brothers Relebohile and Thoto also continually show the patience, understanding and love that they give so unselfishly.

Finally, thoughts of my brother Tefo, who before his death was very close to me during this undertaking. This book is a commemoration of his loss to me and for others, who lost their own loved ones to the HIV/AIDS pandemic.

**MAKHALA MOPELI**

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There are also other people who have, in one way or another, contributed towards the success of this study. The fact that their names have not been mentioned here does not mean that their contribution was less important. I thank them all.

## DECLARATION

I, **Makhala Mopeli**, Student No. 20230109, hereby declare that the dissertation entitled:

***The Impact of HIV/AIDS on Primary and Secondary education in Mohale's Hoek in Lesotho***

submitted by me at the Central University of Technology, Free State, for the degree of Magister Technologiae, is my own independent work and that all the sources quoted have been acknowledged by means of references. It has not been submitted previously by me to any other university/faculty. I furthermore cede copyright of the dissertation in favour of the Central University of Technology, Free State. in fulfillment of the requirements for the attainment of any qualification.

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**MAKHALA MOPELI**

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Date

## **ABSTRACT**

The main purpose of this study is to investigate different attributing factors that contribute to the impact of HIV/AIDS on Primary and Secondary education at Mophale's Hoek in Lesotho.

The fact that about 30% of teachers and close to 170 000 children are shown to be HIV positive, demonstrates the urgent need for an educational based study. This study strives towards elaborating on these key elements by providing recent statistical evidence.

Quantitative research and qualitative research were used in the study. The descriptive research survey method was utilised through the use of questionnaires and interviews, as well as additional data, which were obtained from contributions by school principals and interviews held with Heads of Departments, to portray a holistic view of the research problem.

The tests carried out demonstrate that the HIV/AIDS epidemic can lead to negative school population growth in some areas, a decline in school enrolment and an increase in the drop-out-rate. The literature reviewed also shows that Lesotho is seriously affected by the AIDS pandemic. It is probable that by the year 2010, 30-35% of children will have lost one or both parents and the ability of relatives to keep such children in school, will have become a critical issue.

The results of the statistical analysis indicate that the impact of HIV/AIDS has been a significant factor in primary and secondary enrolment patterns, as well as in the dwindling pool of qualified educators.

The findings of the ANOVA show statistically insignificant differences in all the independent variables; that is, age, gender, level of education and years of experience with respect to the impact of HIV/AIDS on education.

The limitations of the study have been indicated and recommendations have been made. Decisions on the research questions, research aim and objectives have been made, and decisions on the research hypotheses have been reported as well. Recommendations for further studies have been made.

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## LIST OF ABBREVIATIONS

|          |   |  |
|----------|---|--|
| AIDS     | = | Acquired Immune Deficiency Syndrome          |
| HIV      | = | Human Immunodeficiency Virus                 |
| H.S.R.C. | = | Human Sciences Research Council              |
| LECAWU   | = | Lesotho Clothing and Allied workers          |
| MoE      | = | Ministry of Education                        |
| MTCT     | = | Mother-to-child Transmission                 |
| SADTU    | = | The South African Democratic Teachers' Union |
| STI      | = | Sexually Transmitted Infections              |
| UNDP     | = | United Nations Development Plan              |
| WHO      | = | World Health Organization                    |
| UNAIDS   | = | United Nations HIV/AIDS                      |
| UNICEF   | = | United Nations Children's Fund               |

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 INTRODUCTION**

HIV/AIDS is rapidly becoming the single most serious threat of school going children and educators in Mphahle's Hoek, Lesotho. Different attributing factors are discussed in this article as to the contributing impact of HIV/AIDS on school enrolment. The study proposes to identify the various future impacts that this viral has, as a result of an assumed lower school enrolment figures. It aims to inform and plan strategies that can respond to the impact of HIV/AIDS on the sustainability of other vital resource needs in the education and training system.

This chapter provides the background of the study, significant of the study, statement of the problem, research questions, hypotheses tested, research objectives and aims and definition of terms. Methodology and theoretical rationale of the study are also briefly discussed. Lastly the chapter provides a summary and division of the study in chapters to follow.

#### **1.2 BACKGROUND OF THE STUDY**

The HIV/AIDS epidemic could lead to negative school population growth in many areas, a decline in school enrolment and increase in the drop-out-rate. Mphahle's Hoek is seriously affected by the AIDS epidemic; it is probable that by 2010, 30-35% of children will have lost one or both parents (Tshepo, 2001:22).

The UNDP (1999) Human Development Report, South Africa calculated that there were perhaps more than 258,000 HIV-positive learners over 18, in the



system that year. The entry-level cohort was already in decline; an average five percent per annum shrinkage was observed over the previous three years. Dropout rates due to poverty, HIV/AIDS illness, lack of motivation and trauma were expected to increase. Absenteeism among children who are caregivers or heads of households, those who help to supplement family income and those who are ill, is bound to rise (Van der Westhuizen 2002:96-97).

### **1.3 SIGNIFICANCE OF THE STUDY**

It is envisaged through the results of this study that young people of primary and secondary schools at Mohale's Hoek will try to refine on how to prevent HIV/AIDS. It is also envisaged that the research will determine why AIDS is spreading so fast especially amongst the teenagers.

### **1.4 STATEMENT OF THE PROBLEM**

The impact of HIV/AIDS appears to aggravate and to deteriorate the quality of education and life in primary and secondary schools in Mohale's Hoek district.

### **1.5 RESEARCH QUESTIONS**

The research was endeavor to answers the following questions:

- 1.5.1 What is the impact of HIV/AIDS on education in Mohale's Hoek, Lesotho?
- 1.5.2 What knowledge do learners possess about the dangers of HIV/AIDS?
- 1.5.3 Are Educators trained to educate learners about safe sex?
- 1.5.4 Does the government of Lesotho have policies in place about HIV/AIDS in education?

## **1.6 RESEARCH ASSUMPTIONS**

The research addressed the following assumptions:

1.6.1 School enrolments are declining since children are dying and others are orphaned by HIV/AIDS.

1.6.2 HIV/AIDS has an impact on educators and learners at primary and secondary schools in Mohale's Hoek, Lesotho

## **1.7 RESEARCH AIMS**

The aim of this research was to investigate the Impact of HIV/AIDS on education in Mohale's Hoek, Lesotho.

## **1.8 RESEARCH OBJECTIVES**

This study tried to achieve the following objectives:

- ◆ To suggest to the Ministry of Education the best possible way to educate scholars about the dangers of HIV/AIDS;
- ◆ To empower youths at Mohale's Hoek schools and all vulnerable and disadvantaged groups to protect themselves against HIV/AIDS;
- ◆ To ensure that every learner at Mohale's Hoek district is exposed to appropriate information on the danger of HIV/AIDS;

## **1.9 DEFINITION OF TERMS**

It was necessary that some terms used in this study be defined.

### **1.9.1 HIV – (Human Immunodeficiency Virus)**

HIV is defined as a virus that reduces the power of the body to defend itself against different forms of infections (immune system) (Paulins, 2002:24).

Van der Westhuizen (2002:96) defined HIV as one of a family of retroviruses that enters the blood stream and attacks the body's immune system, comprising its ability to fight infection.

### **1.9.2 AIDS- (Acquired Immune Deficiency Syndrome)**

According to Pauline [2001:34] AIDS is defined as a disease caused by HIV of the family of retrovirus. AIDS is also defined as a syndrome of opportunistic disease infections in a compromised system or a curse and punishment to a homosexuals and sexual deviants, visited by just vengeful God for their deviance (Crowther, 1999:9).

1.9.2.1 Acquired = when a person gains a virus, which enters the blood stream.

1.9.2.2 Immune = to secure or to be free.

1.9.2.3 Deficiency = the weakening of the body's defense system.

1.9.2.4 Syndrome = the number of symptoms, which shows the abnormal conditions of the body or mind (Pautines, 2001:3).

1.9.3 Impact: An effect or influence, especially when strong;

1.9.4 Primary and Secondary Education: The act or process of educating or being educated systematic instruction (Allen, 1990:273-275).

1.9.5 Orphans: Children whose parents are dead, both mother and father.

## **1.10 THEORETICAL RATIONALE**

The impact of HIV/AIDS on education is exacting a terrible toll not only in Maseru's townships, Lesotho, but to sub-Saharan Africa and to the whole world at large. By the year 2000 it was estimated that AIDS virus orphaned 500,000 of South African children but the figures could spiral to as high as one million, because HIV positive mothers die young with fewer progeny (Coombe 2000:16).

Lesotho is seriously affected by the AIDS pandemic; it is probable that by 2010, 30-35% of children will have lost one or both parents. The ability of relatives of such children to keep them in school will become a critical issue. In the context of widespread and deepening poverty, enrolment rather will decline and drop-out rates will rise. In some cases, there will be a negative school population "growth". UNDP's 1998 Human Development Report, Namibia suggests that by 2010 combined primary and secondary schools' enrolments are likely to be eight percent lower than total enrolment in 1998. An expected negative growth lack of adult guidance and lack of parents who pay fees for children contributes to the failure of many young people to continue schooling and to develop a personal moral and self-protective behaviour hence school enrolments deteriorate (Coombe 2000:17).

The UNDP 1999 Human Development Report, South Africa calculated that there were perhaps more than 280,000 HIV-positive learners over 18 years, in the system in that year. Then entry level cohort was already in decline; and average five percent per annum shrinkage was observed over the previous three years. Drop-out rates, due to poverty, illness, lack of motivation and

trauma were expected to increase. Absenteeism among children who are caregivers or heads of households, those who help to supplement family income, and those who are ill, is bound to rise (Van der Westhuizen 2002:2).

## **1.11 METHODOLOGY**

The following approach and methods were used for the study:

### **1.11.1 Research Approach**

The approach of this study was quantitative. The researcher chose this approach because it helps in the collecting, summarizing and describing our observation. With the quantitative approach, subjects can be examined and then the researcher can generalize what she/he found from a sample to a population [Ary and Jacobs, 1996:2].

### **1.11.2 Research Method**

The researcher used the descriptive method in this study because the descriptive method permits one to collect information from a large sample of people relatively quickly and cheaply. Instruments such as questionnaires and interview are used for gathering information from group of subjects. Questionnaire and interviews enable the researcher to come up with a summary of the characteristics of different groups or to measure their attitude and opinions towards some issues (Litheko 2002a:10).

Inferential statistics and descriptive statistics were used in order to organize, analyse and make inferences from numerical data. The descriptive statistics in particular are used for a convenient presentation of information while the inferential statistics are used for making inferences about the population from which the sample was taken (Litheko 2002a:10).

Since the descriptive method uses instruments such as questionnaires and interviews to gather information from the group of subjects, it permits researcher to summarize the characteristics of groups or measure their attitudes and opinions towards the Impact of HIV/AIDS at schools in Mohale's Hoek, Lesotho (Ary et al 1996:22).

### **1.11.3 Population and Sample**

#### **1.11.3.1 Population**

Population is described as a group about which the generation is made; it includes all members of well defined class of people, event or object [Ary et al 1996:76]. The population of this study consisted of primary and secondary schools in Mohale's Hoek.

#### **1.11.3.2 Sample**

The sample of this study consisted of 10 learners, 10 educators and 2 principals in primary and secondary schools situated in Mohale's Hoek.

#### **1.11.3.3 Sampling Technique**

A sampling technique called stratified random sampling was used to identify primary and secondary schools within Mohale's Hoek district from which to draw the sample.

The sample of the study was composed of 4 schools in Mohale's Hoek; two primary and two high schools. The reason for choosing these schools is that they were easily accessible. A sample of educators, learners and principals will be selected from the 4 selected schools to form part of the study. A statistical sampling called *stratified random sampling* was used to identify the sample for the study. To identify the number of schools in the lowlands and

highlands of Mohale's Hoek where they are located, and how many educators and learners they have, the Department of Education provided all the necessary information needed for the study.

According to Blaxter et al (1996:76) this strategy allows the researcher to sample within a group of population. This technique is a variable of random sampling as it identified the sample of the study. This random sampling according to Bowling (1997:163) gives each of the units in the population targeted a calculable probability of being selected. The representative of this study population will be enhanced by the use of random sampling methods. This method relates to the method of sampling, not to the resulting sample.

#### **1.11.4 Instrumentation**

A research instrument is a measuring device to evaluate more precisely the behaviour that is being studied (Litheko 2002a:11). Ary et al (2002:861) define an instrument as a device for operationally defining a variable. The measuring instruments used in this study, were questionnaires and interviews.

A four page questionnaire, consisted of two sections, was administered. The first section comprised a subsection on demographic variables and the second section was composed of a two-page impact of HIV/AIDS on education for this study. The description of each section follows.

##### **1.11.4.1 Questionnaire**

A questionnaire is defined as an instrument in which respondents provide written responses to questions or mark items that indicate their response (Ary et al 2002:566).

For this study, a questionnaire was developed to measure the educators and learners attitudes towards the Impact of HIV/AIDS on education.

#### 1.11.4.2 Demographics

Demographics are descriptive information about an individual's personal background as well as experience (Litheko 2002a:12). The information includes age, gender, years of teaching experience and the level of education.

Robins (1996:82-83) defines demographic variables as biographical characteristics of an individual that has an impact on the individual's productivity, turnover and satisfaction. Many of such variables are difficult to assess, but variables such as an individual's gender, age and level of education are definable and readily available. For the purpose of this study, these variables were selected for assessment with regards to the Impact of HIV/AIDS on education in Mohale's Hoek..

#### 1.11.4.3 Interviews

The interview is the specialized pattern of pre-planned interpersonal verbal or non-verbal communication between two or more people regarding a matter of mutual interest. The interviews can be short and factual, lasting for a few minutes or they can last for an hour or more (Van Schalkwyk 1997:84).

Cohen (2000:11) defines a research interview as a two-person conversation initiated by the interviewer for the specific purpose of obtaining information that is relevant to her/his research. An open ended interview schedule was devised so that teachers and learners could speak at length their feelings towards the impact of HIV/AIDS in schools. Teachers, principals and learners were interviewed individually.

#### 1.11.4.4 Data Analysis

Data was analyzed using the SPSS for Unix. It was analyzed by constructing a table from the responses from the questions which indicated the attitude towards the model frequency and percentages of the attitude. The median and the mean were found for the total group as a basis for comparison. Thereafter, graphs were constructed to show the results.



The independent variables that influence the differences in the study are age, gender, years of experience as a teacher and the level of education of educators. The dependent variable is the Impact of HIV/AIDS on education.

### **1.12 DELIMITATION OF THE STUDY**

The results of this study cannot be generalized beyond COSC level because these levels were not represented during the study.

The results of the study cannot be applicable outside Lesotho. The reason is that HIV/AIDS conditions in other countries might not be the same as those found in Lesotho.

### **1.13 SUMMARY**

The HIV/AIDS situation in Lesotho and its impact on school going children cannot be emphasized since emotional and social handicaps are serious causes of learning difficulties to deal with. Chapter one presented an overview of the study, significance of the study, statement of the problem research questions, hypothesis, aims and objectives, definition of terms and briefly the discussion of methodology is also presented. The next chapter will deal with review of literature.

### **1.14 DIVISION OF CHAPTERS**

The rest of the chapters that follow chapter 1 deals with the following:

Chapter 2: Literature review.

Chapter 3: Impact of HIV/AIDS on students' living with it in Moleleke's Hoek, Lesotho.

Chapter 4: Methodology

Chapter 5: Result of the study

Chapter 6: Summary, discussion, conclusion, recommendation and suggestions for future research.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

A review of related literature and research on the impact of HIV/AIDS, as a contributing factor in primary and secondary school enrolments in Lesotho will be discussed in this chapter. The fact that 27,000 children in primary schools and 15,000 in secondary schools are reported to be HIV positive and 73,000 to be orphaned as a result of HIV/AIDS, demonstrates the need to further elaborate on the current tendency of school enrolment and other possible trends related to HIV/AIDS in education (Kirby, 1995:87).

The future impact of HIV/AIDS on physical resource availability will be identified. The related history of HIV/AIDS in Lesotho, risk factors for HIV infection and the means of preventing AIDS to spread, will be considered in this chapter as well. The chapter aims to inform primary and secondary learners at Mohale's Hoek schools about the risk factors of HIV/AIDS infection amongst learners. It strives to outline pro-active strategies to combat resulting tendencies from HIV/AIDS.

In this chapter, recent statistical evidence as well as the consequences of HIV/AIDS will be provided.

#### **2.2 HIV/AIDS IN THE GLOBAL CONTEXT**

Globally, AIDS deaths in 2001 reached three million (UNAIDS 2002). The statistics on HIV infection clearly indicate that the epidemic is still spreading rapidly. More people are becoming infected from the disease than they are dying from it, which means that more are living with the disease everyday (Kirby, 1995).

UNAIDS (2000) found that in the year 2001, about 14 000 new HIV infections occurred world wide, per day. Almost 50% of those were women: about 50% are in the age group of 15 – 25 years. This age factor makes AIDS uniquely threatening to children. By the end of 2001, the epidemic had left over 11 million AIDS orphans, that is as those having lost their mothers and fathers before reaching the age of fifteen (UNAIDS, 2000:102).

Twenty years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become the most devastating disease human-kind has ever faced. This is the sobering statement made by the World Health Organization in the AIDS epidemic (Update, 2001). Statistics provided by UNAIDS supports the statement. It is against this background that different countries across the globe have responded differently to HIV/AIDS. The following table illustrates the estimated global summary of the epidemic in December 2000.

**Table 1 Global summary of the HIV/AIDS epidemic, December 2000**

|   |  |   |
|---|--|---|
| People newly infected with HIV in 2000                          | Total<br>Adults<br>Women<br>Children <15 years | 5.3 million<br>4.7 million<br>2.27 million<br>600 000       |
| Number of people living with HIV/AIDS                           | Total<br>Adults<br>Women<br>Children <15 years | 36.1 million<br>34.7 million<br>16.7 million<br>1.4 million |
| AIDS deaths in 2000   | Total<br>Adults<br>Women<br>Children <15 years | 3 million<br>2.5 million<br>1.3 million<br>500 000          |
| Total number of AIDS deaths since the beginning of the epidemic | Total<br>Adults<br>Women<br>Children <15 years | 21.8 million<br>17.5 million<br>9 million<br>4.3 million    |

Source: UNAIDS files, 2000.

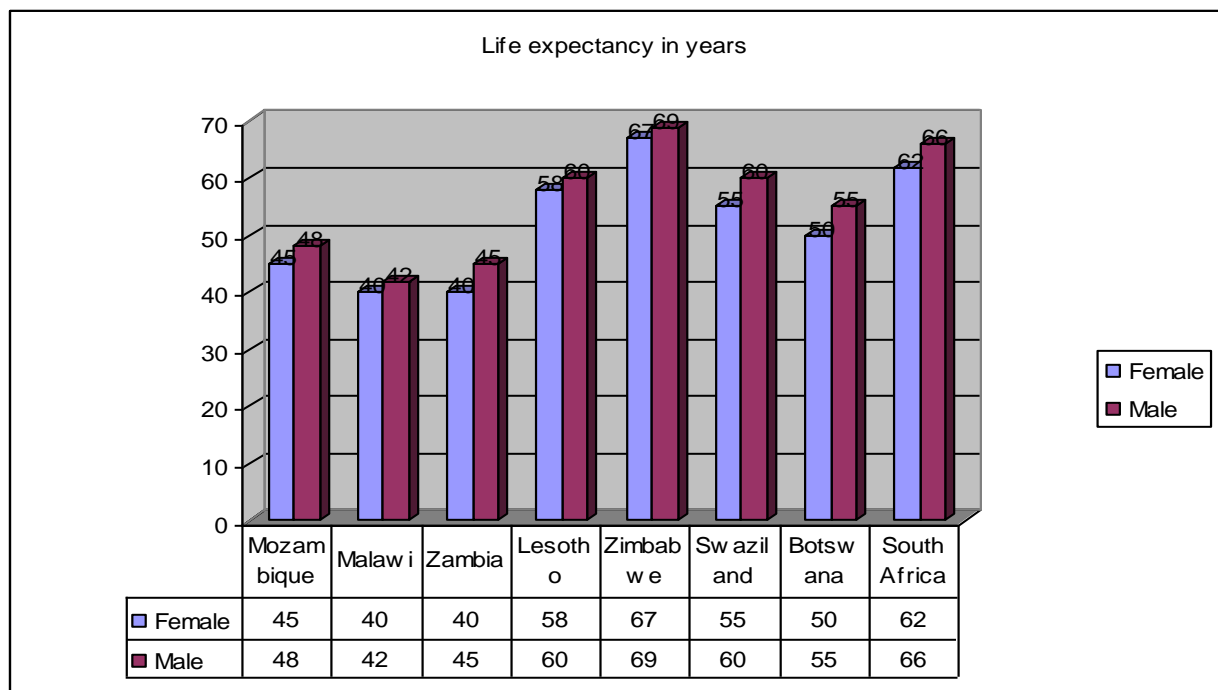
Table 1 focuses on the global summary of HIV/AIDS epidemic in December 2000. In the year 2000, the total number of people who are newly infected with HIV/AIDS was 5.3 million and out of a total of 5.3 million, 4.7 million were adults, 2.27 million were women and 600,000 were children who were below 15 years of age. The total number of people living with HIV/AIDS in 2000 was 36.1 million, with 34.7 million as adults and 16.7 million women, while children who are below 15 years of age, were 1.4 million. Out of a total of 3 million people who died as a result of HIV/AIDS, 2.5 million were adults and 1.3 million were women, while 500,000 were children below the age of 15. Globally the total number of AIDS deaths since the beginning of the epidemic is 21.8 million and 17.5 million were adults; 9 million were women and 4.3 million were children below the age of 15. This situation of the HIV/AIDS epidemic is quite stressful and can have long term disruption on learners.

### **2.2.1 HIV/AIDS on educators in South Africa**

In Africa, a number of countries have been hardest hit by HIV/AIDS. Stayton and Way (2003) note that repeated HIV sero-prevalence studies of pregnant women conducted in African countries generally show a consistent and rapid increase in HIV sero-prevalence. The following figures shows that life expectancy in the sub Saharan countries has significantly dropped. HIV/AIDS is the leading cause of dropping in life expectancy.

South Africa is especially hard hit by the epidemic with over 5 million people estimated to be infected with HIV at mid-2004. The Government of South Africa has adopted the provision of antiretroviral therapy as a key strategy to confront the disease. The Department of Health of South Africa has recently released national guidelines for antiretroviral treatment (Department of Health, 2004). The national treatment plan has two goals. Firstly to provide comprehensive care and treatment for people living with HIC and AIDS; and secondly, to help strengthen the country's national health system (Thomas and Thabo 2005).

**Fig. 1 Life expectancy by gender, 1997 in Sub-Sharan countries**



**Source: UNDP (1997)**

Figure 1 above shows life expectancy by gender in 1997 in Sub-Saharan Countries. In Mozambique life expectancy amongst females was 45 years and 48 years by males; Malawi had 40 years. In Zambia, life expectancy amongst females was 40 and 45 by males. The life expectancy of females in Lesotho, in 1997, was 58 years and that of males 60 years. Zimbabwe had the highest life expectancy in the same year, with 67 years by females and 69 years by males. That is followed by South Africa with 62 years life expectancy amongst females and 66 years by males. Malawi had the lowest life expectancy of 40 years amongst females and 42 years by males.

These show that males live longer than females because the prevalence rate of HIV/AIDS in females went up to those to four times higher than in males of the same age in 1997 (UNDP, 1997:19).

## **2.2.2 HIV/AIDS in the Regional Context**

Angola, probably the worst off of the African countries, spent 10% of its budget on education in 1997 because of the death-rate caused by HIV/AIDS. Over the past decade enrolments have fallen sharply. In 1996, school enrolment was estimated to be about 53% of children in the age group of 5 – 14, with average dropout and failure rates estimated at 50% (van der Westhuizen, 2002:7).

Tanzania has the lowest rate of secondary school enrolment in Eastern and South Africa – only 5% of the relevant age group. HIV/AIDS has been a significant factor in primary and secondary enrolment patterns, as well as in the dwindling pool of qualified teachers. In Botswana, one of the most prosperous and stable countries in Africa, 90% of primary school aged children were enrolled at primary school in 1997 and in 1998; there was an 80% progression from primary to junior secondary schools. (Robins, 1996:7)

### **2.2.2.1 *HIV/AIDS situation in Namibia***

The first cases of HIV infection in Namibia was recorded in 1986. Ever since, the numbers of HIV/AIDS cases and related deaths have increased at an alarming rate. By 31 December, 1997, a cumulative number of 40 629 HIV confirmed cases and 2 926 AIDS related deaths were recorded. In 1997 a total of 3 645 patients were hospitalized owing to AIDS related illnesses. More reliable information on the magnitude of HIV infection among the general population is obtained through regular surveys among pregnant woman. In 1996, the HIV prevalence among pregnant women was 15.4%. (Gwai, 2005:21)

In response to the increasing number of HIV/AIDS cases, the newly independent Namibia established the National AIDS Control Programme (NACP) in the Ministry of Health and Social Services. The NACP, as reflected by the External Review, was largely unsuccessful in reducing the spread of HIV infection owing

to deficiencies within the management structure and its relatively low placement in the structure of the Ministry of Health and social Services (Gwai, 2005:21).

The National Aids Committee, which was supposed to provide support to the NACP, did not function at all. The Ministry of Health and Social Services also took cognizance of the fact that the major determinants of HIV transmission lie outside the health sector. It was therefore decided to formulate a national response to the HIV epidemic to Mphahle's Hoek. The establishment of the new National AIDS Co-ordination Programme (NACOP) is a concrete expression of this national response. The goal of this programme is to reduce the HIV infection (Gwai, 2005:127).

### **2.3 HISTORY OF HIV/AIDS IN LESOTHO**

In Lesotho, according to Tsepo (1996:5), the first case of HIV/AIDS was reported in 1986. Since that time the disease has spread rapidly throughout the population. By December 1999, 10880 cases of full-blown HIV/AIDS victims had been officially reported. It is estimated that these reported cases represent less than a quarter of all HIV/AIDS cases in the country. Sentinel surveillance carried out on six sites, Maseru, Mafeteng, Mphahle's Hoek, Leribe, Quthing and Maluti identified that over the years, there has been a steady upward trend in the proportion of individuals testing HIV positive among pregnant women aged 20-24 years and among teenagers in schools. The zero prevalence has risen from 3.9% in 1992 to 51% in 2001.

The number of newly diagnosed AIDS cases have increased dramatically amongst young people since 1992, by four fold comparison to previous years and the rate of increase has continued in 2000, a total of 3760 new cases were reported. It is likely that reported cases vastly underestimate the actual magnitude of the epidemic. The total cumulative number of reported AIDS cases in Lesotho as of 31 December 2000 was 14, 640 cases and 2,233,251 in 2002 (Coll, 1996:12).

According to Frederick (2002:3), it is estimated that half of the population of Lesotho live below the poverty line, and the impact of HIV/AIDS has increased the poverty in that 54% of the rural households being poor has increased to 63% and 29% of ultra poor to 31%. The poorest families are in the highland, but urban poverty is also on the increase because of HIV/AIDS.. The gross national per capita income is M3133. Furthermore, income distribution is extremely skewed with 10% of the households receiving 44% of the national income whilst the poorest 40% have to be satisfied with only 8% of the annual national cake; most of the people cannot afford to take their children to school, hence children resort to being street kids.

Lesotho has a young population structure. The population of about 39.2% is below 15 years of age, with a male/female sex ratio of 96/100. This means that because of Lesotho's under low growth assumptions as a result of HIV/AIDS it will have 37% below 15 years of age, with 49.6% persons within the productive and reproductive age group of 15-49 years of age and 11% persons above 50 years of age in 2005 (Frederick, 2002:3).

It is expected that there will be a rapid downturn in life expectancy as more people in the productive age group are infected by HIV/AIDS and eventually die. This situation will have a negative effect on the school enrolments (Frederick 2002:4).

According to Stanley (2001:2), it was estimated that there were 40,000 adult Basotho aged 15 to 49, living with HIV/AIDS in 1994. This had increased to 79,000 by 1997 and 92,000 by 1998, representing a sero-prevalence of 9.8% of all adults in this age group.

The rate of HIV infection in sexually active adults and teenagers continue to rise. It is clear those population mobility patterns of sexual behaviour and other social factors contribute to the doubling of newly reported HIV/AIDS cases every two years. As HIV rates increase in the general population, new infections are



increasingly concentrated in young people, with more female HIV/AIDS cases than males and the rate of HIV infection progression to HIV/AIDS being faster in females (Schoteich, M. 2000:5).

Most of the HIV infections in 15 to 19 year-olds are females. The reasons for the disproportionate risk of young women acquiring HIV infection early are: early age of sex debut for girls; the patterns of sexual mixing where young girls at schools tend to have sex with older men in exchange for money or other advantages, another biological reason why girls and women in Lesotho are so vulnerable to HIV/AIDS infection is because a woman is the receptive partner during sex. Infected semen is deposited in the women's vagina and remains there for some time, which gives the virus an opportunity to gain entry into the body; inflaming or damaging to the vaginal walls. This is usually from STD's or from the use of herbal and other substances used in the vagina, because of "dry" sex. Menstruation also results in a large, raw, exposed area of the inner uterine lining which may make the transmission of HIV/AIDS easier just before, during or after menstruation (Moe, 2000:4).

From reviewing statistical figures obtained from the Ministry of Health, Lesotho, it is evident that certain population groups are at a disproportionately higher risk of being infected with the virus. These include children, girls, women, youth, migrants and people already infected with sexually transmitted infections. Statistics also shows that HIV/AIDS is concentrated in urban areas although the prevalence rate is very high across the country.

Women: UNAIDS estimates that by the end of 2002, at least 180,000 of the estimated 330,000 adults, living with HIV/AIDS, were women from a total population of 2.2 million, while in the year 2000, out of a total of 37,600, 20,640 were women and 16,960 men as shown in Table 2. This is 55% of the total number of adults infected with HIV. Similarly, nearly 4,000 new cases reported in 2001, were women. Young women between the age of 15 to 29 years are particularly affected as they constitute almost 75% of all reported AIDS cases in this age group (Moe, 2000:6-7).

**Table 2 Reported AIDS cases by Gender in Lesotho**

| <b>Gender</b> | <b>Number of people</b> |               |               |                |
|---------------|-------------------------|---------------|---------------|----------------|
|               | <b>Year =</b>           | <b>2000</b>   | <b>2001</b>   | <b>2002</b>    |
| Male          |                         | 16,960        | 20,000        | 150,000        |
| Female        |                         | 20,640        | 21,700        | 180,000        |
| <b>TOTAL</b>  |                         | <b>37,600</b> | <b>41,700</b> | <b>330,000</b> |

**Sources: Ministry of Health, 2000.**

Young Adults: The majority of Basotho infected with HIV are between 15 and 49. It is estimated that one out of three Basotho's in this age, is living with HIV/AIDS. By June 1999, over 80% of AIDS deaths came from this age group.

Infants, Children & Youths: According to UNAIDS (2002:10), about 27,000 Basotho children between 0-14 years were living with HIV/AIDS in 2002. Nearly 10% of all new HIV/AIDS cases in 2001 were among children less than 4 years of age, who had contracted the virus through mother-to-child transmission (MTCT).

### **2.3.1 HIV/AIDS in Lesotho districts**

According to Schoteich (2000:15), all districts of Lesotho have reported AIDS cases, The lowlands where most of the population live are more affected than the mountain areas. In 2000 the geographic distribution of new cases shows that Maseru is probably the worst of these districts in Lesotho. It has the highest number of adults and children dying of AIDS (1429). Mohale's Hoek and Quthing have the highest number of cases (299) in the mountain areas, followed by Thaba-Tseka District (232) and Qacha's Nek having the lowest cases of HIV/AIDS (95).

Among all these districts the majority of people with HIV/AIDS are housewives 498 (29%), followed by minors 392 (21%). Other groups are construction workers 108 (6%), factory workers 108 (6%) and students from both primary and secondary 102 schools (5%) (Ntsekhe, 2002:41).

### 2.3.1.1 HIV situation at seven Lesotho sites in 2000

Secondary data has been used to establish future historical trends of the HIV/AIDS situation in Lesotho. Table 3 below shows the HIV/AIDS situation in seven Lesotho sites in 2000:

**Table 3 HIV situation at seven Lesotho sites in 2000**

| <b>SITES</b>  | <b>1991</b> | <b>1994</b> | <b>2000</b> |
|---------------|-------------|-------------|-------------|
| Maseru        | 5.5%        | 31.3%       | 42.2%       |
| Mafeteng      | 3.5%        | 10.8%       | 18.98%      |
| Leribe        | 2.2%        | 8.7%        | 26.03%      |
| Quthing       | 0.7%        | 9.1%        | 22.81%      |
| Maluti        | 1.8%        | 5.0%        | 19.04%      |
| Mokhotlong    | 0%          | 0%          | 12.29%      |
| Mohale's Hoek | 2.8%        | 7.8%        | 28.9%       |

Source: Ministry of Health and Social Welfare, HIV/AIDS and STD situation in Lesotho, 2004.

The rates rose dramatically from 5.5% in 1991 at Maseru to 42.2% in 2000. For the other sites, Leribe, Maluti, Mafeteng and Quthing, HIV infection rates increased from 0.7% - 3.5% in 1991 to between 18.98% – 26.03% in 2000. Mokhotlong is the new site for 2000 representing the mountain areas and in 2000 its rate started at 12.29%. In Mohale's Hoek only 2.8% AIDS cases were reported in 1991; it increased to 28.9% in 2000 as shown in Table 3 above. Therefore, these statistics shows that the HIV situation in Lesotho is increasing at an alarming rate.

From a 1999 Mphahle's Hoek hospital based survey, the adult HIV prevalence was estimated at 26.4% among the general population. This figure shows that the trend of HIV infection is increasing in Mphahle's Hoek at an alarming rate. In 1998, the adult HIV prevalence rate was estimated at 9.8%. UNAIDS and WHO estimate the adult HIV prevalence at 23.57% among 15 – 49 year-olds of the population in 1999, which is comparable to the World Bank figure. At the end of 1999, UNAIDS/WHO estimates shows that 240,000 people in Lesotho were living with HIV/AIDS by the end of 1999 of which 130,000 were women and 8200 were children (Ministry of Health and Social Welfare, 2004:8).

#### **2.4 EFFECTS OF HIV/AIDS ON PRIMARY AND SECONDARY ENROLMENTS IN LESOTHO EDUCATION**

According to Ntsekhe, (2002:40) there are no current statistics to accurately estimate the direct and indirect impact of HIV/AIDS in school attendance, but according to the statistics data sheet of 1996, there are 1,289 primary schools throughout Lesotho and 206 secondary schools. The total enrolments in primary schools was 261,982, predominantly females, while secondary schools had 180,099. Over the past decade enrolments have fallen sharply. In 1992, primary enrolment was estimated to be about 60% of children in the age-range 5 – 15, with average drop-out and failure rates estimated at 52%. Secondary enrolment was estimated to be 55% of children in the age-range 12 – 20, with average drop-out and failure rates estimated at 49.5%. HIV/AIDS has been a significant factor in primary and secondary enrolment patterns, as well as in the dwindling pool of qualified teachers, not only in Lesotho.

According to Frederick (1997:20) HIV/AIDS transforms generational relationships by placing heavy material and emotional burdens on both the sick and the caregivers. This has particularly compounded the challenges already faced by young people. HIV/AIDS is an issue for the entire society, including children who seem to pay the heaviest price. Learners, particularly, need assistance to cope. Unless adequately and professionally handled, the psychosocial effects of

HIV/AIDS on school-going children may overwhelm the society. It might even transform the very meaning of parenthood and childhood. Since HIV/AIDS is associated with eventual death, it should be noted that its trauma could affect a child for life, and those who are affected will drop out of school and school enrolments will decline eventually.

## **2.5 RISK FACTORS FOR HIV INFECTION IN LESOTHO**

According to Buckens (2002:8) most mineworkers live alone in single-sex dormitories, often hundreds of miles from families. They also have dangerous jobs but good wages. With the good wages comes all manners of goods and services, including of course, alcohol and sex, and with alcohol people become morally loose and have sex with different people without using condoms. The HIV dangers are not just restricted to the mineworkers themselves or their sex partners around the mining sites. Most migrant workers return home periodically. They carry the infection back to their wives and their communities. Moreover, one study found that sex outside the primary relationship is accepted as almost inevitable in the separated families, for both men and women.

Rapid urbanization, with an increasing number of unemployed people moving from remote mountain villages to towns seeking employment, contributes another risk group for the acquisition and spreading of sexually transmitted infections (STIs) and HIV infection (Frederick 2002:6).

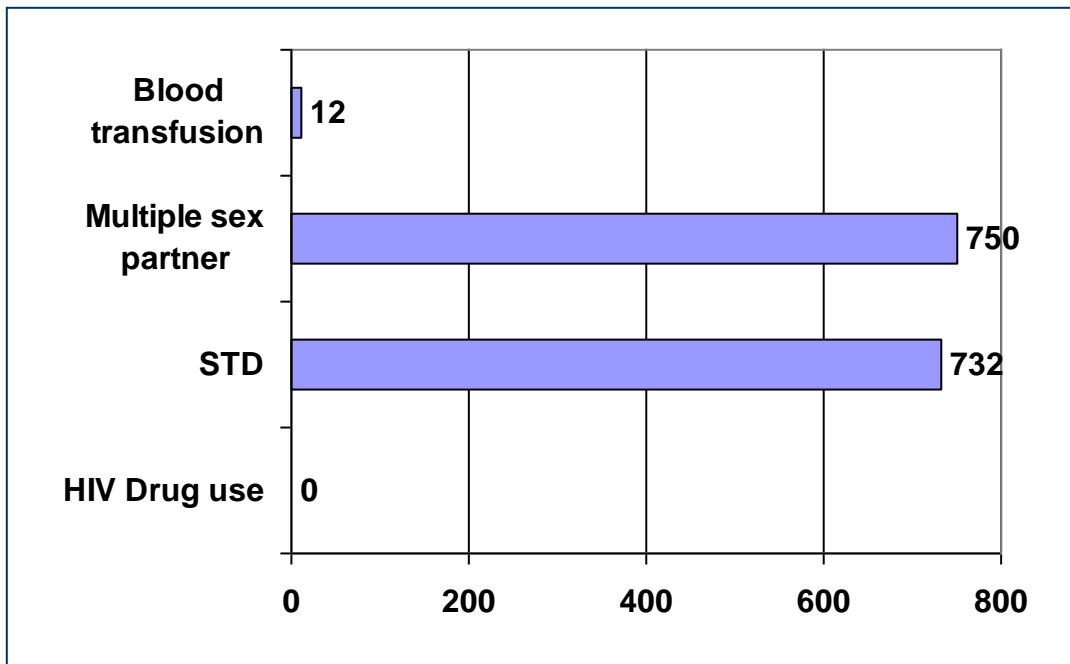
Students do not know about HIV or STIs, while others know about them but do not know how to avoid infection. Those with the information may be unable to get hold of condoms, or may feel unable to discuss condom usage with their partners. Young girls are unable to defend themselves against unwanted sex because boys naturally are more powerful than girls. They also sell sex to older men to get money for their uniforms and books, which their parents cannot afford to buy. Learners at primary and secondary schools often drink too much alcohol, smoke dagga or even use drugs to escape from everyday hardships. This also encourages learners to become morally loose to and have sex with different

people; that is why they get infected with HIV/AIDS (Department of Education, 2002:191).

According to Frederick (1997:1) another risk factor for HIV is the social norm that accepts or encourages a high number of sexual partners. Women are often exploited and have more inferior status than men. In many communities women have very little control over their sexual lives and ways to prevent STIs. Poverty often makes the sexual exploitation worse; and the legacy of apartheid resistance to the use of condoms allows the spread of HIV/AIDS. (Frederick)

The graph below shows the risk factors of HIV infection in AIDS cases in Lesotho:

**Fig. 2 Risk factors of HIV infection in AIDS cases 2003**



( Evans, 2003:20)

The risk factors for HIV infection in AIDS cases is shown in figure above. 750 Adult AIDS patients have a history of multiple sex partners and 732 have a history of sexually transmitted diseases in 2003. In contrast, 12 AIDS cases

have had a history of blood transfusion which took place after the HIV screening of donated blood has been established (by April 1987, all blood products were screened for HIV). None of the AIDS cases have a history of illegal intravenous drug usage (Evans 2003:20).

### **2.5.1 Risk factors for HIV infection amongst teenage girls in schools at Mohale's Hoek**

The high rate of sexual violence against girls in Lesotho is compounding the county's rapidly accelerating rate of HIV/AIDS infection. Rape and other forms of sexual violence place girls at risk of contracting not only sexually transmitted infections, but also HIV. Some researchers attribute the increase in sexual violence against girls to be a belief gaining credence in some communities that sexual intercourse with young virgin can "cleanse" HIV positive men or cure men with AIDS (Stanley, 2001:21). Rape of young girls is also committed as a preventive measure to avoid contracting the virus from older women. Young girls have become increasingly attractive to older men as sexual partners, whether willing or unwilling, because young girls are commonly believed to be less likely to be infected and, as such, they run an increased risk of being sexually violated. Young girls have been abducted and sexually assaulted on their way to school (Kelly, 2000:3).

The statistics show that 60% of new HIV/AIDS infections worldwide occur among girls and young women aged 15 – 24. Girls risk becoming infected at a much younger age than boys do. At the end of 2000, 47% of 36.1 million people living with HIV were women and this proportion is growing (Tsepo, 2001:16).

In Sub-Saharan Africa alone, an estimated 12.2 million women carry the virus, compared with 10.1 million men. Women constitute 55% of all infections, the HIV infection rates among young women being more than five times higher than those in young men. Lesotho health officials say that teenage girls at schools are twice as likely to become infected with HIV as boys. Their increased sexual

activity, often coerced, is with older men who have had longer exposure to the virus (Tsepo, 2001:17).

## **2.6 RESULTS**

According to the Department of Education (DoE), Lesotho (2002:2), most educator and school principals in Mohale's Hoek believe that, the direct impact of HIV/AIDS in school enrolments would not be clearly visible, as learners and their parents do not disclose information as to why children are removed from schools. They admitted that there is an alarming increase rate in absenteeism of school learners as a result of medical reasons. One principal at St Stephen High School in Mohale's Hoek said he had 1092 learners at school in January 2002, but in November 2002 he had only 998 learners. Some dropped out because of medical reasons while others have no fees because their parents have died of HIV/AIDS.

HIV/AIDS reduces population growth in Mohale's Hoek by killing adults and children and by reducing fertility among women who are HIV infected. By 2005, 61 out of every 1000 births in Mohale's Hoek will result in infant deaths in their first year. Currently 130 HIV positive babies are born per year (Dr Simelela, 2001:28).

By the year 2002 it was estimated that the AIDS virus would orphan 2,000 Mohale's Hoek children, but the figures could spiral to as high as 10,000 because the HIV mothers die young with fewer children. As the proportion of potential parents between 20 – 40 years declines, the number of orphaned children increases, poverty deepens and dropout rates as a result of illness, lack of motivation and trauma, are clearly on the increase. There may be negative school population growth in places, according to the National Development Plan (1998:14).

Care of AIDS orphans will become the greatest challenge in Mohale's Hoek and the Department of Education (Motsoari, 2001:5). The projected number of



children requiring education will decline. Firstly, the birth rate will decline, following the premature death of potential mothers and possibly, increased use of condoms and empowerment of women. Secondly, prenatal transmission and orphanage will increase infant and child mortality. Absolute numbers in any cohort will not decline, but rather the rate of increase will be reduced. No current quantifiable evidence of anti-retroviral success for pregnant mothers can be concluded, as political discourse still exist over the release of these drugs. If the infection rate can be reduced to infects, hypothetically, the result will have a bearing on future enrolments. There is a real danger that families affected by AIDS will be forced to keep children out of school to care for the sick, work the land, or earn an income. These children may also feel discriminated against or ostracised. Orphans may be totally occupied by the struggle for survival and education may not be an option for them. This is likely to lead to children never enrolling or dropping out. In some settings attendance at school requires a cash outlay for fees, uniforms and school books. AIDS may result in exclusion of children from schooling because family income decreasing as a result of death and illness or because of taking in orphans per capita which reduces the family income. A gap in the educational needs of the child will result because of his or her exclusion from basic educational rights, according to Van der Westhuizen (2002:101).

In Mohale's Hoek many learners do not have any choice when their parents succumb to AIDS. They simply do not have the opportunity to complete their education. Physical resources have to be in place to cater for those who were restricted in any way or means from personal development. The Department of Education (DoE) indicated that little provision could be made for children to attend school, if their legal guardian has decided against it (Motsoari, 2002:14).

According to Coombe (2000:18), infected teachers will not be able to fulfil their duties, which will result in high absenteeism. This largely impacts on the learning environment of the child and the quality of education which he/she could receive. It will worsen the projected shortage of teachers, affecting their ability to teach, increasing infection rates among pupils, changing enrolment patterns and

generally disrupting schooling because of erratic attendance rates as teachers and pupils take time to care for family members with AIDS (Piot, 2001:43).

According to Van der Westhuizen (2002:103) the resulting shortages will culminate in a subsequent reshuffling of physical resources at educational facilities, as learners will now be condensed into single classrooms to be able to receive classes where the respective educators are absent.

The work of educators who are HIV positive will be compromised by periods of illness. Once they know they are HIV positive, many are likely to lose interest in continuing their professional development. The United National Development Plan (1998:15) suggested, that 12% of educators are infected, and that over 530 educators will have died by the year 2010. Infection rates of 20-30% means between 880 to 1,330 educators who are ill absent and dying or preoccupied with family crises. In many cases professional educators will be required to take responsibility for the orphans of the extended family. Teachers, in particular, are educated, mobile and relatively affluent, and thus falling into a population category that has been shown to be especially at risk. The incidence of HIV infection among educators is likely to be above that of the population as a whole (Crowther, 1999:14).

According to Motsoari (2000:6), educational management capacity is very fragile in Lesotho and its ten districts. At school level, many principals have not received sufficient support or training to enable them to be creative about the local management of education. HIV/AIDS is making it more difficult to sustain the structures necessary to provide formal education of the scope and quality envisioned by democratic government policies. The situation will become worse as the pandemic takes hold. In the private sector, some companies already training replacements for technical and management personnel they expect to lose to HIV/AIDS. Strategies will be required to do the same in the education sector.

Teacher mentors and teacher educators at the Universities, Colleges and Technikons (now technological universities) will also be lost to HIV/AIDS. Younger and less experienced educators will take their place. As a result, the quality of teacher education will decline (Hein, 2000:16).

The cost of burials and death benefits are rising along with additional costs for teacher training. However financial contributions from parents and the community will decline as poverty increases and many households will no longer be able to keep children at schools. Demand on the country to increase education budgets will increase. Incalculable psychosocial trauma will overwhelm teachers, children and their parents. Therefore there will be a reverse of development gains, further development will be more difficult and current education development goals will be unattainable within the foreseeable future (Coombe, 2000:17).

Taken from Coombe's statistics indicate that orphan rates will project a need for low budget schooling and school facilities. An increase in AIDS Counselling Centres and medical institutions specialising in AIDS-treatment, more specifically, paediatric services is the inevitable for part-time secondary education is foreseen, as fewer learners have the social support system to attend full time classes, owing to financial obligations.

**Table 4 The consequences of HIV/AIDS in Mohale's Hoek (1999 & 2005):**  
Projections to 2010 on resources

|   | <b>1999</b> | <b>2005</b> | <b>2010</b> |
|---|-------------|-------------|-------------|
| % of Mohale's Hoek teachers that is HIV+          | 27%         | 30%         | 43%         |
| % of minors that is HIV+                          | 58%         | 58%         | 61%         |
| % of students living with AIDS                    | 34%         | 37%         | 45%         |
| Life expectancy of people living without HIV/AIDS | 65          | 65          | 37          |
| Life expectancy of people living with HIV/AIDS    | 45          | 37          | 38          |
| Number of AIDS orphans                            | 98          | 2,980       | 10,000      |

|                                |     |       |       |
|--------------------------------|-----|-------|-------|
| % of infants infected with HIV | 20% | 34%   | 50%   |
| Adults living with HIV/AIDS    | 231 | 1,851 | 3,000 |

Source: Ministry of Health and Social Welfare, HIV/AIDS and STD situation in Mohale's Hoek 2004.

## **2.7 SUMMARY**

Chapter two dealt with the literature review on HIV/AIDS in different context i.e. global, regional and in Lesotho. Further, the researcher touched on the effects of HIV/AIDS ON PRIMARY AND SECONDARY ENROLMENTS IN Mohale's Hoek education, risk factors for HIV infection in Mohale's Hoek among teenagers at school. The purpose of this chapter was not only to highlight the HIV/AIDS pandemic, but also to acquaint the readers with its impact globally and regionally.

Chapter three deals with the Impact of HIV/AIDS in Mohale's Hoek, Lesotho.

## **CHAPTER THREE**

### **THE IMPACT OF HIV/AIDS ON STUDENTS LIVING WITH HIV/AIDS IN MOHALE'S HOEK**

#### **3.1 INTRODUCTION**

Different contributing factors on the impact of HIV/AIDS on students living with HIV/AIDS in Mohale's Hoek, Lesotho will be discussed in this chapter. With the escalating number of HIV/AIDS orphans, it is inferred that education will be affected; therefore the purpose of this chapter is to present the impact of HIV/AIDS on school going children. People living with HIV/AIDS are stigmatized and experience many forms of discrimination. This chapter also discusses the impact of HIV/AIDS on students' families living with HIV/AIDS. This deadly disease is eradicating the active population of the country. In this chapter the effect of HIV/AIDS and health on population and development will be discussed critically. The impact of this killer disease in Mohale's Hoek's resources in general, sports and economic development shall be discussed as well.

Lesotho, with the population of 2.2 million people, is said to be among the countries in the sub-continent where the HIV/AIDS pandemic is increasing at an alarming rate. The percentage which stood at 2% in 2001 has increased by 2% to 31% to date. This figure covers only people who have revealed their own status. According to the UNAIDS (2000) report on the global AIDS epidemic, about 40 million people are currently living with HIV/AIDS worldwide. Since the virus was discovered 20 years ago, 60 million people have been infected and each year five million people fall or die because of HIV/AIDS. The United Nations Organization reports that the death toll already stands at 30 million. Although no country is unaffected, it is the African countries that are paying an increasingly heavy price (Lewis, 2003:4).

## **3.2 IMPACT OF HIV/AIDS ON SCHOOL GOING CHILDREN IN MOHALE'S HOEK**

Children and learners at the higher levels of education in Mohale's Hoek are becoming sexually active. It does not mean that they are not immune to infection. This is especially true of females and means that HIV-infected, ill scholars and students are emerging in the educational system. An increase in secondary dropout rate has increased by 6% from 2000 to the final headcount in 2001 (Lewis 2003:4).

According to Lewis (2003:3), there are two major perspectives in education planning in the context of HIV/AIDS. The first is the role of education in reducing the spread of diseases; the second is the impact the AIDS pandemic has had on the education system. HIV and AIDS affects demand for education; potential clientele for education; process of education; organization of schools; role of schools; availability of funds for education; AIDS agency education; and the planning and management of the education system.

AIDS has the long-term effect on populations of being significantly smaller than they would have been in the absence of AIDS. In Mohale's Hoek, one outcome of the pandemic is that their population projection for 2010 is about 25% smaller than it would have been. This demographic change will result in the number of school-going aged children being smaller than it otherwise would have been. An AIDS assessment and planning study for Lesotho projectes that the worst case scenario is at secondary level where the number of children will be reduced by about 14% (Lewis 2003:5).

### **3.2.1 Loss of childhood**

According to Lewis (2003:3) it is clear that HIV/AIDS is taking so many lives of young woman aged 15 - 21 years, which will result in many children being

orphaned. For many older children, the illness of a parent means loss of childhood. They enter into reversed roles, caring for their sick parents while they themselves need to be cared for. The loss of childhood is also associated with the fact that older children have to care for younger siblings. It forces children to grow up prematurely, skipping some stages of development. It is evident that some children may even fail to cope with this role due to lack of appropriate preparation, knowledge of parental skills and attitudes. They may even be exposed to risky situations.

According to Mabote [1999:16], the adverse impact of HIV/AIDS on children survival that is evident in most of the 30-40 percent of babies who become infected with HIV, will develop AIDS and die within two years. Many children have been and are being orphaned by HIV/AIDS. These children are often turned away by extended families and have no place to live. Several non-Governmental organizations care for both HIV infected children and orphans, but the need is much greater than available services. Non-Governmental organizations report that many of these children live alone or are taken in by elderly woman, grandmothers and aunts. Many of these children do not go to school; they do not receive adequate medical care and do not eat nutritious food. The long-term impact will be devastating if Lesotho does not plan for and care for these children.

### **3.2.2 Dropping out of school and trauma**

As the proportion of the potential parents increases between 20-40 years declines, the number of orphaned children and poverty deepens, drop out rates owing to illness, lack of motivation and trauma are clearly set to increase. Absenteeism of children who are care givers or heads of households, who help supplement family income and who are ill, is bound to rise. There may be a negative school population growth in place [United Nations Development Plan 1998:14].

According to Mabote [1999:3], children, while caring for the family, children end up with long school absenteeism. This makes it difficult to catch up with the rest of the students. Since poor performance is displeasing, children start playing truant or staying away. In some instances, they are withdrawn from school since they are the only ones keeping the family going. When children combine school with such stressful and strenuous home responsibilities, it is not easy and many children leave school since they are unable to cope with multiple roles. Emotionally it makes it difficult for children, let alone adults, to focus. This is because their minds are pre-occupied and they are prone to forgetfulness and day dreaming.

Affected children go through much of stress and depression, which are related to the illness or death of the family member. The Fear devastates a child as he/she worries, not only about the death or illness of the parent, but whether they themselves are not infected. When they witness the undignified illness of parents, is highly traumatic for them since they are aware of the ultimate break up of households. It is one of the most stressful situations for children to be split among members of the family without even having been consulted or prepared for the separation. This situation compounds their already traumatic situation of having lost a parent. This situation in most cases leads to them being uprooted from the family home and the community and migrating to a completely new environment, which is associated with a great deal of uncertainty and stress. Situations such as these result in girls opting for early marriages, or the children running away from home or acting out so that the future family gives up on them or drops the idea of moving them. In situations where there is no one to take over, there is also complete devastation when children are scattered [the Department of Public Information and the United Nations 1992:70].



### **3.2.3 Behavioural problems**

Some children may for a long time deny the fact that someone in their family is infected. This is because parents and family are a child's whole world and the idea of losing parents can be impossible for them to imagine. That is why some children, when confronted by this situation, may start acting out or reverting to behaviour that they have outgrown. For instance, younger children may revert to bedwetting, nail biting etcetera, while older ones may become aggressive, sullen or resort to drugs. In some cases they withdraw or escape to by means of computers, television and friends, which provide buffers for the child against matters too difficult and painful for him/her to face. The situation compels them to focus on themselves rather than the external world [Pauline 2001: 12].

According to Mabote [1999:4] to most children HIV/AIDS related illnesses provoke feelings of humiliation, embarrassment and shame. This is particularly because of society's negative attitude towards the situation. Consequently, children may start playing truant or avoid peer contact in fear of being victimized. The children start feeling helpless, hopeless and eventually view life as worthless. The situation brings their world to a standstill, with a complete loss of hope in life. The illness of a parent, significant family member or the individual child may also provoke fear of abandonment and rejection. This may even result in children choosing to stay away from school to ensure that the parent does not die in their absence. In some cases this may even lead to ideas of suicidal intentions.

### **3.3 THE IMPACT OF HIV/AIDS ON FAMILIES OF LEARNERS IN MOHALE'S HOEK**

According to Lewis [2003:15], in many localities in Mohale's Hoek, people living with HIV/AIDS are stigmatized and experience some form of discrimination. This stigma is extended even to the family members, friends and caretakers. It is also associated with misconceptions about how HIV/AIDS is acquired.

The consequences of such stigma include, but are not limited to: an increased burden and suffering among those living with AIDS; a reluctance of individuals to know their HIV status; delay in seeking health care; and a delay by communities to respond to HIV/AIDS prevention.

As their health deteriorates, people living with HIV/AIDS lose income because they are unable to work regularly. While they are treating associated opportunistic infections by means of folk remedies presumed to cure AIDS, they find themselves in poverty. It is not uncommon for people with HIV/AIDS to be abandoned by their relatives and/or expelled from their family, and left being in destitute.

Some of the psychological consequences experienced include loss of self esteem, grief, demoralization and a feeling of rejection more especially by learners. As stipulated by Lewis [2003:6], Lesotho was doing herself a disservice by keeping silent on HIV/AIDS. Lewis [2003:14], pointed out that in some instances people living with AIDS, were denied food, jobs and education, conveniently forgetting that they are also entitled to the same rights as those not infected.

On his arrival in Lesotho the secretary general special envoy was flown to Moleleke's Hoek with the Minister of Health to witness the plight of the people whose families were claimed to have HIV/AIDS.

Ntlo Matela who is living with HIV/AIDS pleaded with the Ministry of Health to provide home based care to students and people living with HIV/AIDS because it would end the stigma. Matela also called on the Prime Minister, Mr. Pakalitha Mosisili, who noted that according to the current statistics available, out of a population of 2.2 million people, 31% is said to be HIV positive and are stigmatized. From the increase of 26% in 2001, experts indicated that the

situation had worsened.

According to the National AIDS Strategic Plan [2002:16], AIDS primarily affects adults between the ages of 20-49, the most productive members of the family and the impact of HIV/AIDS, which is more rapidly visible and worrying to households, specifically when the person affected by the disease is the family income generator. Drop in family revenue is affecting all. The impact of the disease on households varies according to the level of income and the state of the disease. There are problems in meeting the basic needs, the composition of the households change since they are headed by children withdrawn from school. The main impact on households can be summarized as problems in meeting basic needs, changes in household structure and composition, withdrawal of children from school, fear of stigma and exclusion, and worries about the future for the children.

### **3.4 IMPACT OF HIV AND AIDS ON THE ECONOMY IN MOHALE'S HOEK, LESOTHO**

According to the Secretary General Daniel Maraisane of the Lesotho Clothing and Allied Workers' Union [LECAWU] [2003:20], HIV/AIDS affects women with household responsibilities and economically active people: the epidemic has had an impact on production and economic growth. He states that: "Adding to the pandemic is already putting an unbearable burden on social services and reversing hard-worn development gains".

The HIV/AIDS pandemic represents an immense obstacle in reaching the national poverty reduction targets and development goals agreed upon at the United Nations millennium summit. (Daniel, 2003:21)

HIV and AIDS hold more serious implications for the economy than other

diseases, which are prevailing in Mohale's Hoek. One could state that, the fact that there is no cure for HIV and AIDS, puts added pressure on the country's economy. Another thing one may point out is that HIV and AIDS primary affect adults in their most economically productive years.

The National AIDS Strategic Plan [2002:17] states that it is difficult to establish a direct relationship between the HIV/AIDS epidemic and future economic growth because of the multitude of other intervening factors. Given that AIDS will disproportionately affect the working age population, the quantity and quality of the labour force will be negatively affected. The cost of overall production is likely to increase. An indirect effect on all sectors is the drop in consumer spending as the economic effects of AIDS spread through society.

According to the Community Home Based Care Reference Manual Lesotho [2002:67], HIV/AIDS is a threat to development since economic growth is reduced because the size, composition and quality of labour are falling significantly. Two-thirds of those affected world- wide are Africans and 96% in the productive group are 15-20 years of age. The pandemic is devastating for Lesotho economy, Mohale's Hoek included.

The medium sized enterprises, in particular the farming and informal sectors, the transport and mining sectors, are vulnerable to HIV and AIDS. The impact on enterprises include lose of skilled workers and professionals owing to death or early retirement, reduced production capacity because of absenteeism related to illness and attending funerals caused by HIV/AIDS, high staff turnover, high retraining and replacement costs, high employee care costs, and falling agricultural capacity (Coombe, 2000:2). All those affect children who are still schooling.

HIV/AIDS has become the major cause of adult mortality, leaving many of the economically dependent uncared for. These economically dependent are mainly

children and elderly people. In this discussion of the impact of HIV and AIDS on the economy, it is also important to mention the direct and indirect cost of HIV/AIDS. The direct cost is linked to the treatment of an infected person which is highly speculative. This is justified by Cross and Whiteside (Stayton and Way, 2003:17-20) in their argument that the direct cost is high and a liability on an already burdened economy.

### **3.5 THE FINANCIAL IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR**

According to the World Bank report (2002:16), on the impact of HIV/AIDS on the education sector costs, HIV/AIDS is costing the education sector tremendously because education budgets have to accommodate higher teacher recruitment and training costs. This is to replace the growing numbers of teachers who are dying because of the epidemic. Other costs include salary payments to absent teachers, and salary and training costs for substitute teachers.

HIV/AIDS will cost the Lesotho education sector about US\$25 million between 2000 and 2010, which include the cost of increasing the supply of teacher and absenteeism. In Mozambique, the estimate is twice that of Zambia. In both countries the costs of salaries for absent teachers consume a large portion of the estimated amounts. Teacher absenteeism because of attendance of funerals, illness and family, is becoming an escalating and major problem in Lesotho (Kelly, 2000:12-13).

Swaziland, on the other hand, has estimated about US\$233 million for recruitment and training costs by 2016. Other costs to the education system include placements of sick teachers near towns in hospitals and clinics at the expense of remote rural areas. The likely scenario for high-infected countries is that already limited resources, financial or otherwise, will be decreased because of the demands of replacing infected staff, health benefits and teacher training. A rise in the cost of rural education owing to placement of teaching staff near towns

is another likely scenario (Kelly, 2000:16).

In South Africa, an analysis of the financial impact of HIV/AIDS on the education sector will also have to measure other costs in addition to the substitute teachers system. For instance, the financial implications of large class sizes for the education sector needs to be studied.

### **3.6 IMPACT OF HIV AND AIDS ON EDUCATORS AND TEACHERS**

The available information shows that current teachers are a high risk group in several countries. In the early 1990's, HIV testing of teachers in Zambia determined high levels of infection amongst this group, compared to other groups in the population. Seven years later, teacher mortality in Zambia was 39 per thousand, which is 70% higher than the 15-10 age cohort in the general population. In 1996, 680 teachers died in Zambia. Teacher deaths in Kenya increased from 450 in 1995 to 1500 in 1999 with AIDS being the major contributor to the increase. One of Kenya's eight provinces reported deaths of 20-30 teachers a month because of AIDS.(UNICEF 1999:20).

In Malawi and Uganda, more than 30% of teachers are estimated to be HIV positive, and in South Africa, estimates based on antenatal sero-prevalence data put the figure at 12%. A preliminary study conducted by the South African Democratic Teachers Union (SADTU) into the mortality of its members revealed that out of 701 deaths from August 1999 to May 2000, a significant number are considered to be AIDS related. Gwai (2005:9) found that around one third of teachers are likely to be HIV positive. Loss of teachers in Zimbabwe resulting from illness and death was around 2% in 2001.

It is estimated that the level of HIV-infection in Namibia could be above that of the population, as a whole, which stood at 20% and 25% a few years ago. However, three interrelated studies conducted in three countries with high HIV

prevalence rate (Malawi, Uganda and Botswana), gave an alternative analysis of teacher attrition and mortality. A study was a survey of 41 schools across the three countries. According to the results of the survey, in most HIV high prevalence countries, with the exception of Zambia and Malawi, teacher mortality rates are under 1%. The authors of the preceding study attributes teacher attrition to low morale and low pay, and as a result, teacher deaths make up less than 20% of all attrition in high prevalence countries, including Lesotho, South Africa and Uganda (UNICEF 1999:17).

In a report of ABT Associates (2002) on the Impact of HIV/AIDS on the South African Departments of Education (DoEs), HIV-infection prevalence was estimated to be within the range of 5%-10% ( $\pm 1$  in 10 employees) in 2000 for education sector employees. It was expected to rise to 18%-21% by 2005 and even higher later, if prevention did not become effective. The study utilized a calibrated version of the Metropolitan Life/Doyle model for projecting demographic impacts of the HIV/AIDS epidemic. Socio-demographic characteristics of the education sector were extracted from the PERSAL database for the month of December 1999, and information for a total of 427 228 employees was obtained. According to this report, prevalence of HIV is expected to reach 25% (1 in 4) among educators and 15% for non-educators by 2010 (ABT Associates 2001).

HIV and AIDS hold more serious implications for the economy than other diseases which are still prevailing in Maseru, Lesotho. It also affects the elite, well educated and qualified teachers, and educators and officials. They are lost to education due to death, HIV/AIDS illness, or departure for other jobs. The capacity of teachers to keep up with attrition will be undermined by their own staff losses.

Enrolments in post secondary institutions will decline as secondary school output quality goes down and higher education institutions lose academic staff. The

work of educators who are HIV positive will be compromised by periods of illness. Once they know they are HIV positive many are likely to lose interest in continuing their professional development [National AIDS Strategic Plan 2002:32].

According to Coombe (2000:17), the impact of HIV/AIDS on morale will extend to both the infected and affected in schools. Issues of declining health and increased rate of absenteeism will impact on ability to teach. An assessment of the Impact of AIDS in Education in Zimbabwe found that the epidemic is causing anxiety and stress to infected and affected staff, posing a challenge to morale.(Coombe, 2000:18)

Educators who are HIV-positive, but who have not developed full blown AIDS, will not always work to their full potential. In fact, it is estimated that repeated sickness could lead to such educators losing about six months' of teaching time during the infection period, before terminal illness. However, this estimate does not consider availability and provision of appropriate medication. On average, an HIV positive person who has no access to antiretroviral medication could die within seven years of infection (Kelly 2002:22).

According to the Department of Health,[2001:21], even among the educators who believe they are not infected, morale is likely to fall significantly as they cope emotionally with sickness and deaths among relatives, friends and colleagues, and wrestle with uncertainty about their own future and that of their dependants. On the other hand, other additional responsibility will include counseling and caring for learners who are either HIV-positive, or affected by HIV/AIDS through a sick parent or relatives. These additional stresses that teachers experience because of HIV/AIDS need to be incorporated in initial and continuous teacher training and development (Coombe 2000:26).

A study in Zambia found that primary school teachers who received training on



stress management, felt incapable to adequately counsel learners who were affected by the impact of HIV on poverty, death and illness of parents and fellow learners and teachers. The primary school teachers were in need of ongoing support and training to enhance their ability to cope with counselling and providing support to affected learners. The impact of HIV/AIDS will be all encompassing on schools, including operations of the education sector (Baggaley 1999:220).

Delivery outputs and organizational performance is likely to be compromised. AIDS in Africa will weaken the already fragile management, administration and financial control of the education system. Rising AIDS mortality rates will increase attrition in ranks of the education system's planners and administrators. Replacement of these personnel is going to be costly and the loss of their experience could affect the functioning of the education system. Simply put, increased mortality and morbidity rate could impact the running of the education system – it will not be “business as usual” (Coombe 2000:27).

According to UNESCEF (1999:5), the impact of HIV/AIDS on the operations of the education system will include entry age of learners, school calendar and timetable, school and classroom size, and venue of schooling. For instance, school calendar and timetables might have to become accommodating to learners who have additional responsibilities at home, especially learners generating income for their families. The AIDS crisis demands greater flexibility in the delivery of education – it will have to serve the needs of its learners – particularly learners affected and infected by HIV/AIDS. In Burkina Faso and Zambia, community schools have less rigid timetables and accommodate the special needs of orphans, street children and those that AIDS has forced them to abandon school (Kelly 2000:12).

The United National Development Plan [1998:15], suggested that 12% of educators are infected with over 53000 educators dying by the year 2010.

Infection rates of 20-30% mean that between 88,000- 133,000 who are ill, absent, dying or preoccupied with family crises. Professionals educators will often be required to take responsibility for orphans in the extended family. The incidence of HIV infection among educators is likely to be above that of the population as a whole.

Daniel [2000:6] states that education management capacity is very fragile in Lesotho. AIDS is making it more difficult to sustain the structures necessary to provide formal education of the scope and quality envisioned by democratic government policies. The situation will become worse as the pandemic takes holds. In the private sector, some companies are already training replacements for technical and managerial workers they expect to lose to HIV/AIDS.

According to Coombe [2000:92], studies in several African countries indicate that educators are after at higher risk of HIV infection than other adults in their communities, owing to, amongst others, a relatively high socio-economic status which creates more opportunities for high-risk sexual behaviour. An estimated 14 – 16% of educators would have been infected by the end of 2000. In countries such as Malawi and Uganda almost 40% of the teaching corps is infected. The South African Democratic Educator Union's funeral scheme indicated that 1011 educators (average age 39) died in the 12-month period June 2000 to May 2001 of HIV/AIDS related diseases.

A decrease in quality and quantity contact time can be expected because of absenteeism, ill health, time lost to funerals and family trauma. Permanent loss of educators resulting from death, job change, chronic illnesses and natural attrition will also occur (Coombe, 2000:92).

Demand on the country to increase education budgets will increase. Incalculable psychosocial trauma will overwhelm teachers, children and their parents. Therefore there will be more difficulties and current education development goals

will be unattainable within the foreseeable future (Daniel, 2000:6).

### **3.7 IMPACT OF HIV AND AIDS ON HEALTH SECTOR IN MOHALE'S HOEK**

The impact of HIV and AIDS on the health sector in Mohale's Hoek continues to be of much concern given the consequent astronomical costs it will have to bear. One of the intents of decentralization in the context of health sector reform is to increase community access to health, through the transfer of services and applicable resources and tertiary health facilities to primary health facilities, such as rural health centres.

Available information on health seeking behaviour suggests that people continue to bypass the primary level health facilities and go to secondary and tertiary level facilities in contradiction to the expected outcomes of the reform process. Therefore the main burden of providing care still falls on hospitals, and on the families themselves. Another impact on the health sector is the trend of rising mortality rates among health workers [Dilly and Helquist 1998:9].

The cost of training the service providers is not recovered, as they are affected by HIV/AIDS. Service delivery for people, including those with HIV/AIDS, is compromised [Davis et al 1995:20].

With reference to *Methew* September [2002: 6], it is true that HIV/AIDS affect health care, this is because an increasing number of people becoming HIV positive have placed a heavy burden on health services, since treatment is needed for the opportunistic illness occurring on account of the HIV infection. This leads to an increase in bed occupancy, up to the point that many hospitals are unable to cope with the increasing demand. This means that the demands for health services are higher and the supply is influenced because health

services have to support and care for more people than previously. The result of this is a higher demand on already burdened health services in the country, which might lead to a discontinued treatment of patient from hospitals. This growing demand in terms of both the quality and quantity of health care for AIDS-related illnesses is likely to negatively affect provision of treatment for other diseases or injuries. All these affect learners at schools because they will be forced to leave school and care for their parents who are suffering from HIV/AIDS.

### **3.8 IMPACT OF HIV AND AIDS ON LAND AND AGRICULTURE**

According to the National AIDS Strategic Plan [2002:18], AIDS in Mohale's Hoek is wiping out gains made in progress and development. HIV and AIDS result in and enhance poverty as bread winners die and family resources are rapidly consumed to care of the sick and dying. It affects food security as tillers of the land are no longer there to grow food crops, or are too feeble to toil on the land. It is indicated in this plan that HIV/AIDS has a negative effect on families across the country.

A new, decidedly unorthodox system implies that if a person has been buried for over ten years, the Burial council can re-use the grave to bury someone else to alleviate the chronic shortage of burial land or sites. Research commissioned by Durban Metros' Town and Regional Planning Department shows that Kwazulu-Natal will require 1620 hectares, the equivalent of 3240 football fields to bury the dead in the next ten years [Drum, September 2002].

Drum September (2002:10), points out that if the toll taken by HIV/AIDS continues, 9 million bodies will need to be buried in the next fifty years, which will require 4770 hectares of land. Under such circumstances one could point out that if this much land is needed for burial sites what of farming sites, school sites

as well as residential sites, a problematic issue [Drum September 2002:10].

The United Nations resident representative, Scholastic Kimaryo [2003:5], informed a meeting attended by donors and officials of World Food Programmes including those from the Ministry of Agriculture, that the serious food shortage in the Mohale's Hoek would not go away easily as young and able-bodied people who should be engaged in agriculture were either sick or dying of HIV/AIDS.

The large proportion estimated at 30% of inhabitants infected with HIV/AIDS, are young people who face the threat of dying in the next 5-10 years, leaving young orphans to become heads of households [Scholastic Kimaryo, 2003:April-June].

### **3.9 IMPACT OF HIV AND AIDS ON SPORTS**

As it has been indicated earlier that AIDS is not bias of sex and status, it has threatened the future of Mohale's Hoek sports. Drum (September 2002:24), states that the spread of HIV and AIDS has led the sporting community to take stringent measures in a bid to half the pandemic. It is indicated that in Lesotho a quarter of the population is estimated to be HIV positive, making 25% of our potential champions of sports are lost (Scholastic Kimaryo, 2003:April-June).

Since sports is very weak in Mohale's Hoek, the downward spiral increase and Mohale's Hoek might become a vague weakened shadow of it former self. The future looks bleak for sports as the runaway AIDS pandemic swarms over Africa. Even South Africa's sport is in danger of losing the international stature it now enjoys and sport plays a vital role in the country's gross national products [Davis, 1995: 8].

### **3.10 SUMMARY**

Chapter 3 deals with the Impact of HIV/AIDS on learners living with HIV/AIDS in Mohale's Hoek, Lesotho. Losses of childhood, dropping out of school, and trauma as well as behavioral problems of learners at schools in Mohale's Hoek are discussed. A discussion of the impact of HIV/AIDS on families of learners, impact of HIV/AIDS on economy, the financial impact of HIV/AIDS on the education sector, as well as on educators and teachers, the impact of HIV/AIDS on the Health sector, the impact on Land & Agriculture as well as Sports in Mohale's Hoek, has followed.

Chapter 4 presents research methodology.

## **CHAPTER FOUR**

### **METHODOLOGY**

#### **4.1 INTRODUCTION**

The description of the methodological procedures, methods and logical assumptions used in this study follows. The population, sample and research design are described, followed by a section on data collection procedures. Research design and pilot study as they apply to the development of instruments, and characteristics of the sample are discussed. Data processing analysis and limitations of the study will also be included in this chapter. The section on instrumentation reviews on the impact of HIV/AIDS on primary and secondary education at Mphahle's Hoek in Lesotho.

#### **4.2 RESEARCH METHODOLOGY**

For the purpose of this study, the researcher has implemented both qualitative and quantitative approaches for collecting data.

##### **4.2.1 Research Approach**

Quantitative approach deals with quantities and relationships between attributes. It involves data collection methods (for example, the survey questionnaire), by which it aims to document prevalence or test hypothesis. Qualitative approach represents facts in narration with work [Bowling, 1997:173].

According to Ary & Jacobs (1996:565), quantitative approach study phenomena occur in their natural settings without predetermined assumptions. The approach begins with a theory of the phenomenon to be investigated. The flexibility of the quantitative approach allowed the researcher to examine the impact of HIV/AIDS on education, learners and educators. The researcher has been able to discover ideas, give insight and finally formulate a problem for further investigation (Monsen, 1992:7).

It was not difficult for the researcher to use the qualitative approach. That is, it was not a major task to prepare and administer the questionnaire that was handed out to the respondents. It was also not too demanding for the researcher to follow up the results after the questionnaires had been completed in schools.

The quantitative approach has been used because one had to establish the assumptions. The assumptions were later tested using a predetermined procedure such as questionnaires (Ary et al. 2002:422).

#### **4.3 RESEARCH METHOD**

A descriptive survey technique has been used in this study because of its flexibility. The survey is a method of collecting information, from a sample of the population of interest, usually by personal interviews [face to face or telephone, postal or other self completion questionnaire methods] in order to determine opinions, attitudes, preferences and perceptions [Gillman, 2000 :59].

A descriptive survey cannot provide robust evidence about the direction of cause and effect relationships. However the increasing sophistication of statistical technique can help to minimize this limitation. The survey method is the most widely used technique because it can “describe the nature of current conditions, identify problems in existing situations, assess the needs or goals in



order to analyze trends, and generally to describe what exist in context” [Litheko. 2002:102].

Since survey research uses instruments such as questionnaires to gather information from the group of subjects, it permits the researcher to summarize the characteristics of groups or measure their attitudes and opinions towards the impact of HIV/AIDS in schools Lesotho [Ary et al 1996: 22]. The results of the questionnaire were further complemented by selective probing interviews to allow in-depth analyses of attitudes towards HIV/AIDS.

#### **4.4 POPULATION AND SAMPLE**

##### **4.4.1 Population**

Population is described as a group that comprises the generation; it includes all members of well defined class of people, event or object (Ary et al. 1995:76).

The population of this study consists of all the primary and secondary school learners and educators at Mohale’s Hoek, Lesotho.

##### **4.4.2 Sample**

According to Ary et al (1996:76), sample is a large selection of the population for observation in a study. It is also defined as a subset of the population (Rosnow, 1996:413).

The sample of this study consists of 10 learners, 10 educators and 2 principals in primary and secondary schools at Mohale’s Hoek, Lesotho. The principals, teachers and learners were targeted from two primary schools and two

secondary schools from the highlands and the lowlands of Mohale's Hoek, District of Lesotho.

The schools in the sample include the following:

- ◆ Good Shepherd Primary School
- ◆ St. Stephens Primary School
- ◆ Bonhomme High School
- ◆ Mohale's Hoek High School

In random sampling, the researcher identified schools in Mohale's Hoek from which to draw the sample. This helps build-up a sample satisfactory to their specific need. It also gives each of the units in the population targeted a calculable probability of being selected (Bowling, 1997:163).

The primary and secondary schools in Mohale's Hoek are far apart from one another. Other schools are situated in the highlands, while others in the lowlands of Mohale's Hoek district. The schools to be used for the study had to have some characteristics to be selected for the sample. Therefore, the schools in the lowlands of Mohale's Hoek were selected because it was easy for the researcher to reach those schools in time because of availability of transport. Once a school becomes a sample, then all educators in that school are eligible to become participants in the study as they form part of the sample.

It needs to be mentioned that there is a good geographic spread of the schools selected in the lowlands of Mohale's Hoek, and a number of respondents participated voluntarily. The interviews were voluntary as well. Therefore it was from this sample that the descriptive statistics shown in chapter 5, were accomplished.

## **4.5 SAMPLING TECHNIQUE AND RESEARCH DESIGN**

The sampling techniques and the research procedures employed in this study are explained below.

### **4.5.1 Sampling Techniques**

A statistical sampling technique called stratified random sampling was used to identify primary and secondary schools in the Mofhele's Hoek district from which to draw the sample. According to Blaxter [1996:79] this strategy allows the researcher to sample within a group of the population. This technique is a variation of random sampling as it identifies the sample of the study. This random sampling according to Bowling [1997: 163] gives each of the units in the population targeted a calculable probability of being selected. The representativeness of the study population is enhanced by the use of methods of random sampling. This method relates to the method of sampling not to the resulting sample.

A stratified random sampling method is commonly used. It has been implemented here to guard against obtaining an unrepresentative sample, which represents certain groups of the population [for example, teachers]. This is a method of increasing the precision of the sample by dividing the population into strata and sampling from each stratum. The population of interest is divided into layers of strata, for example, principals, teachers and students, and sampling from the strata is carried out using simple random sampling.

If a convenience sample is used the researcher can minimise the inference process by providing a careful description of the sample as indicated in this study. Inferential statistics are often used to analyze data collected from convenience sample, even though the logic of inferential statistics requires that

the sample be randomly drawn from a defined population. Coll [1996: 229] states that inferential statistics can be used with data collected from a convenience sample if the sample is carefully conceptualized to represent a particular population [primary and secondary schools]. Litheko [2002a: 90] states that “used with reasonable knowledge and care, it is probably not as bad as it has been said to be, if you use it, use extreme circumspection in analysis and interpretation of data”. The results of the descriptive and inferential statistics of the study sample are presented in chapter 5.

## **4.5.2 Research Design**

### ***4.5.2.1 The Pilot Study***

Ideas and topics should be tested on colleagues and then pre-piloted with a small number of in-depth interviews with the population of interest. In order to ensure the validity of the coverage, the investigator should hold meetings with ‘experts’ in the field and group discussions with members of the target group. Respondents should be informed that they are being interviewed for a pilot study. Pilot study acts as a check on potential interviewer errors [Bowling, 1997: 247].

In a pilot study the entire research procedure is carried out, including analysis of the data collected, by following the procedures planned for the main study closely. A pilot study helps to improve data collecting routines, tries scoring techniques and checks the appropriateness of standard measures. It also provides additional knowledge that helps to determine the feasibility of the investigation. This implies that the validity and feasibility of the investigation are dependent on the pilot study. A pilot study also reduces number of data gathering difficulties owing to unforeseen problems revealed in the pilot study which may be overcome in readdressing the main study [H.S.R.C 1997: 39].

According to Allison [1996: 51], it is imperative for a pilot study to precede the main investigation for the purpose of providing information to assess the effectiveness of the research instruments.

Pilot testing of the questionnaires was carried out on 16 educators and 12 learners at Bonhomme High School in Mohale's Hoek. The pilot study showed some weaknesses regarding some questions and ambiguity in others that needed clarification. The original questionnaire had 26 items for the educators and 32 items for the learners to complete. Ten other items from the questionnaire of educators were removed and twelve items from the questionnaire of learners. The final questionnaire of educators had 16 items while that one of learners had 20 items. After the responses had been analysed to test the content validity and reliability of the research instruments, the ambiguities were eliminated. The revised questionnaires were then tested with 10 educators and 10 learners at St. Stephens High School in Mohale's Hoek. For the interview, the pilot testing was also done on five educators from the same school who were the heads of departments. This shows that the pilot study in this research was significant for testing the validity and reliability of the instrument (Litheko, 2002a:83). Appendix A and B shows the questionnaires after corrections had been made.

Data for the pilot study and the final sample were collected through a four-page questionnaire. The aim for designing this questionnaire was to investigate the attitude of learners towards the impact of HIV/AIDS. Each questionnaire contained a covering letter to explain the purpose of the study, who should respond and when to return the questionnaire as well as the contact address number of the researcher.

## **4.6 DATA COLLECTION PROCEDURES**

Whether the study is an analytic or descriptive survey, the method of collecting data needs to be addressed. For the purpose of this study, data was collected through the use of questionnaires. The procedures used for this technique are as follow;

### **4.6.1 The questionnaire**

A questionnaire is a pre-formulated written set of items to which respondents record their responses, usually within rather closely defined alternatives [Litheko, 2002a:200]. It is relatively economical, has standardized items, can ensure anonymity, and items can be written for specific purposes [McMillan & Schumaker, 1997; 228].

The researcher obtained permission to distribute questionnaires among the population of interest from the Department of Education at Mohale's Hoek. Letters requesting permission to distribute questionnaires among learners and teachers at the schools for research purposes were subsequently dispatched to the school principal at the selected schools. The aims and the objectives of the research study were outlined [letters of request to principals of the sampled primary and secondary schools, Appendix B; letters of request to heads of education departments, Appendix D]. Principals sent letters to grant permission based on support by their teachers. Heads of the Education Department expressed positive and enthusiastic response to the research being conducted in their schools.

At Bonhomme High School the researcher distributed fourteen [14] questionnaires personally, with the assistance of one teacher, and collected

them immediately after their completion by learners. Fourteen [14] questionnaires per school were distributed to each of the four [4] schools. The main focus of the questionnaires was the impact of HIV/AIDS on primary and secondary education in Mphahlele, Lesotho. A total of fifty six [56] questionnaires were distributed. Before completing the questionnaire, the researcher chose to go to the sampled schools to explain when questions could not be understood. The principals were requested to distribute the questionnaires to educators in their respective classes. The questionnaires were then collected from the sampled schools immediately. The researcher took two days to collect data.

After two days a total of fifty six [56] questionnaires were completed depicting a 100% response rate. The respondents were informed that this was part of a Master's Degree research project at the Central University of Technology in Bloemfontein. The researcher thanked the respondents for their cooperation, participation and assistance in this study.

#### **4.6.2 The interview**

The interview is a specialized pattern of pre-planned, interpersonal, verbal or non verbal communication between two or more people about a matter of mutual interest. The interviews can be short and factual, lasting for a few minutes or they can last for an hour or more [Kirby, 1995:84]. The purpose of the interview was to supplement data that had been collected through the use of other methods.

In this study the purpose of the interview was to complement the questionnaires. After having developed a questionnaire to gather information from students, the interview data was collected from teachers through an unstructured interview. Unstructured intervention aims to probe deep beneath

the surface of superficial responses to obtain the meanings that individuals assign to events, and the complexities of their attitudes, behaviours, and experiences. This method allows the respondents to tell in their own words, with prompting from the interviewer.

For this research 10 teachers from each of the four selected schools were interviewed. The teaching experience of teachers ranged from one to twenty years and above, twenty-four [24] of them were females and sixteen [16] were males. The interviews were therefore conducted with approximately 5% of the respondents, based on the analyses of the survey instrument, in order to acquire a more in-depth understanding of the priorities within each category.

The main purpose of this was to form a better impression of the interviewee by allowing him/her to do most of the talking. The interviewer did this by encouraging the interviewee to voice out his/her opinions, reveal attitudes and express feelings about HIV/AIDS in schools. A teacher's responsibility in terms of children living with HIV and AIDS and those orphaned by HIV/AIDS was considered. The interview took place in staff rooms, on Fridays after 13:00 or during free periods; the interview took approximately fifty minutes.

The interview allowed the researcher to examine fundamental questions about how teachers and principals perceived and interpreted the impact of HIV/AIDS on schools at Mphahle's Hoek, Lesotho. The procedures and questions asked are presented below.

#### **4.6.2.1 Procedure**

The initial introductions were made, and the interviewer presented herself as both researcher and teacher, and briefly described her background in teaching in order to establish rapport and trust with the interviewee.



- The researcher thanked the interviewee and expressed her appreciation for their invaluable participation in the study.
- She then continued to say: “I am going to ask you a variety of questions about the impact of HIV/AIDS on schools, about how HIV/AIDS can affect education at Mohale’s Hoek”.
- The questions were asked in a predetermined order.

#### **4.6.2.2 Questions**

1. Has HIV/AIDS had an impact on this school?
  - If yes
    - How does it affect the school?
2. How many children left school due to HIV/AIDS problems? Many/None
3. If many
  - As a teacher how do you feel about it? Bad or Good?
4. If you feel bad about it, what actions do you, as a teacher, take to see to it that the affected children go to school?
5. If there is no action
  - Who takes the responsibility of these affected children:
  - The principals?
  - The Heads of Department?
  - Board of Governors?
  - The Department of Education?

- Or Government?
6. Should children with HIV/AIDS be served under special education?
  7. If yes, how can the procedures be adapted to meet children's needs?
  8. Do you teach learners about HIV/AIDS at your school?
  9. If No, do you think it is necessary to teach learners about HIV/AIDS?
  10. If yes, are you going to teach them about HIV/AIDS in class or individually?
  11. Do students seem to be exposed to appropriate information on HIV/AIDS on the danger of unprotected sex?
  12. If yes, do you encourage them:
    - to use condoms?
    - to abstain from sex?
    - or what?
  13. Do you improve coordination of HIV/AIDS prevention and control activities in your school?
  14. Does HIV/AIDS lead to deterioration in school enrolment?
  15. If yes, How?
  16. Do you as a teacher encourage parents to talk about sexuality which may lead to HIV/AIDS discussions with their children?

17. As a teacher, are you also affected by HIV/AIDS?

18. If yes, how does it affect you?

The data analyses, techniques of asking the questions and the results of these questions are presented in chapter four.

## **4.7 INSTRUMENTATION**

A four-page questionnaire was administered to the teachers of the four selected schools.

The first section comprised of a subsection on demographic variables. The second section was composed of attitudes of teachers and learners towards the impact of HIV/AIDS. The two sections can be found on Appendix A & B. The description of each section follows:

### **4.7.1 Demographics**

This section was included to obtain data about research subjects. Demographic variables are defined as biographical characteristics of an individual that have an impact on individual's productivity, turnover, and satisfaction [Bowling 1997:247]. It provides information on the demographic characteristics of populations. This information can be analyzed in relation to mortality patterns on any existing data on the morbidity of the population of interest and service allocation. Many of such variables are difficult to assess, but variables such as an individual's gender, age and qualifications are definable and readily available.

For the purpose of this study the variables selected by the researcher for assessment of the response of teachers and learners are age, marital status, gender, qualifications, experience, grade and learning areas (Bowling, 1997:247).

#### **4.7.2 The Impact of HIV/AIDS on school enrolment scale**

This section begins with the summary of how HIV/AIDS impacts on school enrolment, the final scale is described and validity/reliability issues are discussed.

##### **4.7.2.1 *Rationale behind the impact of HIV/AIDS on education***

Other than the direct educational impact and the following socio-economic implications to youth have been identified for future studies:

- ◆ Household incomes decline as family members become less productive, lose jobs or have to stay at home to care for sick members.
- ◆ Children are removed from school and sent to work to support families where breadwinning adults have lost jobs or are too ill to work or have died.
- ◆ Destruction of young lives no education.

In a review of statistical figures obtained from the National Health Department (2001:2), it is evident that the estimated population figure is regressing to a negation growth figure if current trends continue. In 2002, it was projected that 300000 AIDS deaths occurred. HIV/AIDS reduces population growth by killing adults and children.

Schools are now dealing with a significant number of infected children and also sexually active teenagers. The Department of Education (2000:22) estimate that a quarter of million learners are already HIV positive. Many thousands of children will need the school structure for support and psychological assistance.

Lesotho welfare will have to provide extensively to those in need of government help, educational assistance for those lacking in basic training and supply support structures to remedy already failing family-based educational foundations.

Another important study was conducted by Cull [1992] entitled “Future trends of enrolments” comprised of a survey by means of questionnaires and interviews of the opinions of teachers, principals and learners. Consent was obtained from teachers or educators for interviews on HIV/AIDS and its specific contributions to school enrolment figures. These education facilities were randomly selected according to a probability method and represented at primary and secondary schools in Lesotho. Information relevant to the study was applied to the interpretation and discussion of the research topic.

One of the studies which were conducted by the principal of Mafeteng High School, Mr. Mofosi [1998] entitled “HIV infection growth rate among school children”. He assisted in assessing teachers’ views about the HIV infection rate by developing a questionnaire consisting of fifteen items and distributing them to a random sample of assistant teachers from Mohale’s Hoek secondary schools. Participants were requested to evaluate each of the items. According to their views, the increased rate of absenteeism in schools as a result of medical reasons is alarming. In this study, data will be presented to substantiate a trend in this regard.

In comparing and evaluating gathered data, projected against published national statistics, the research strives to prove the validity of its findings relevant to the research topic. All the cited studies provide the framework and the development of the instrument used in this study. They enabled the design of the questionnaire and its validation ensured its relevancy in total context.

#### **4.7.2.2      *Attitude of teachers and learners towards HIV/AIDS***

In this study the construct to be measured is the impact of HIV/AIDS. Therefore the impact of HIV/AIDS is the dependent variable in this study. The instrument used is an adapted Likert scale, 1 [strongly agree], 2 [agree], 3 [disagree] and 4 [strongly disagree].

The assumption in a Likert scale is that the interval between each point on the scale determines the way in which educators and learners respond towards the impact of HIV/AIDS on schools. The higher the scale the more information the researcher could gather. Respondents were instructed to make a cross in the appropriate box representing the level of agreement.

The items were independent; so that no answer to an item is dependent on the responses to any other items. Respondents were also requested to comment on the ways of preventing HIV/AIDS. These open ended responses were also summarized and presented.

The measures taken to ascertain the validity and reliability of the impact of HIV/AIDS on schools at this stage are discussed below.

## **Validity**

Validity is an assessment of whether an instrument measures what it aims to measure. It should have face, content, concurrent, criterion, construct and predictive validity. It should also be responsive to actual changes. An instrument is assigned validity after it has been satisfactorily tested repeatedly in the populations for which it was designed. It also refers to the generality of the research findings to the wider population of interest [Bowling, 1997: 131]

McMillan et al [1997: 235] also describes validity as appropriateness, meaningfulness of the specific inferences made from test scores. It is an integrated evaluative judgment of the degree to which empirical evidence and theoretical rationales support the adequacy and appropriateness of inferences and actions based on test scores or other modes of assessment.

The two types of validity addressed in this study are content validity and construct validity. Content validity refers to a theoretical concept.

It refers to judgment [usually made by a panel] about the extent to which the content of the instrument appears logically to examine and comprehensively include, in a balanced way, the full scope of the characteristic or domain it is intended to measure [Bowling, 1997: 133]. In establishing content validity, expert judges typically examine the test item and indicate whether the items measure pre-determined criteria, objectives or content.

Construct validity was addressed by reference to research studies on the impact of HIV/AIDS on education. Construct validity is the extent to which the results support the theory behind the research, that is, the theoretical meaning on the instruments [Litheko, 2002a:109]. It is the extent to which the instrument tests the hypothesis for its measuring [Bowling, 1997:133].

It is demonstrated by placing the trait that is measured within the context of a clear and compelling theoretical framework. This framework is helpful in showing how the trait is different in definition from similar traits [McMillan 1997: 237]. The literature of the impact of HIV/AIDS was reviewed.

## **Reliability**

Reliability refers to the reproducibility and consistency of the instrument.

It refers to the homogeneity of the instrument and the degree to which it is free from random error [Bowling 1997:130], the extent to which the results are similar over different forms of the same instrument or occasion of collecting data. A reliable measure is the one that has a small error component and does not fluctuate from one moment to the next [Litheko, 2002a: 10]. It tells the same story from one measure instance to the next. Litheko [2002a:10], states that the reliability and validity of the instrument correspondingly increases with the age of an individual. The older the individual who is being assessed, the better his/her attention span and stability and consistency in his/her answer. Additionally are the reliability of self-understanding, the willingness to introspection and comprehension of the importance of honest responses. All three requirements have been honored in this study. Further it is stated that comparing the data from the same subjects gathered can assess the reliability of the observable results of HIV/AIDS at schools. Then follow-up questionnaires should be administered to a subject of the sample. So the questions were tested with 10 educators and 10 learners as already indicated. The questions were refined and prepared for the study afterwards.



## **4.8 SUMMARY**

Chapter four describes the method of research used in this study. The research design has been explained. The explanation of the data collection procedures followed. The chapter also includes methodology, with an explanation of the instrumentation used in which a rationale for, and a detailed description of the procedure employed, in the investigation of the impact of HIV/AIDS on education, were given. Chapter five presents the results of the study.

## **CHAPTER FIVE**

### **RESULTS OF THE STUDY**

#### **5.1 INTRODUCTION**

According to the findings of the study, there will be a reduced flow of learners from primary to secondary schools in Mphahle's Hoek, due to the reduction of primary enrolment, increased dropout rates, as well as reduced quality and performance because of learner absenteeism and bad health.

The purpose of this chapter is to present the results of the data analysis carried out to assess the teachers and learners' attitudes toward the Impact of HIV/AIDS on education in Lesotho districts. This chapter is divided into three sections. The first section, descriptive statistics, describes the sample characteristic and data cleansing procedures that preceded analysis. The section presents a report on the reliability of the impact of HIV/AIDS on education at Mphahle's Hoek.

The second section, inferential statistics, reports the results of a 2x2x2 analysis of variance computed for testing the main effects and interactions associated with age, gender and experience as independent variables, with HIV/AIDS on education as a dependent variable. The results of the statistical analyses for each testing of the hypotheses investigated are also presented in this section. The section concludes with the decisions made on testing the hypotheses. The third and final section deals with the interpretation of the results of the questionnaires.

## **5.2 DESCRIPTIVE STATISTICS**

This section provides a demographic profile of the subjects where data was obtained. The statistical descriptions arise from responses to the items on the questionnaire, to be found in appendix D.

### **5.2.1 Sample characteristics and data cleansing procedures**

The initial size of the sample had been 50 teachers from the selected primary and secondary schools at Mohale's Hoek., Lesotho, while the initial size of learners from both primary and secondary had been 60 from selected secondary and primary schools. After the first administration of the questionnaire, the low response rate necessitated two follow-up on non-respondents. Eventually, a total return rate of 48 (96%) responses was obtained from teachers and 60 (100%) responses were obtained from learners. After administration of the questionnaires, data was examined for accuracy by checking the raw errors. Subjects with large amounts of missing data or responses were eliminated from the study. Eight (16.6%) such cases were eliminated from teachers' questionnaires. As a result, statistical analyses for this study were based on responses from 40 (80%) subjects (teachers) and 57 (95%) subjects (learners). Total non-respondents were jettisoned from the study. McMillan and Schumacher (1993:202) state that a total response rate of 75% is satisfactory enough to justify abandonment of those who do not respond at all.

Frequency data was also checked for minimum and maximum values as well as means and standard deviations to detect out-of-range or inconsistent scores. After these initial checks, group means and standard deviations were obtained for the total sample. These descriptive statistics were obtained for the total sample; they revealed no out-of-range or alarming means and standard deviations.

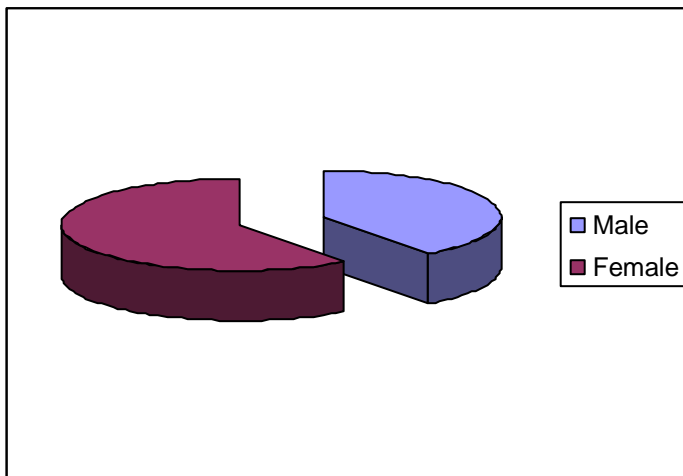
## 5.2.2 Biographic information of respondents and graphical representation (Teachers)

The questionnaire entitled “The Impact of HIV/AIDS on Education” consists of several sections. Firstly, respondents were asked for some personal details, namely their age, gender, years of experience, level of education and whether HIV/AIDS prevention and control system was in place in their respective schools. Secondly, respondents were asked to indicate their opinion by answering *yes*, *not sure* or *no*, to the sixteen items relating to various aspects of the impact of HIV/AIDS on education.

The frequencies of the responses in the four categories to each of the seventeen items are shown in table 5.1 to 5.39. For the statistical analysis described later in this chapter, *not sure* and *no* were combined as *Disagree* and *Yes* as *agree*. A summarized picture of the scores is obtained by means of graphical representation so that the results can be easily and correctly interpreted.

### 5.2.2.1 Responses according to gender

Figure 5.1 Responses according to gender



Out of a total of forty (40) responses, 16 (40%) were male, while 24 (60%) were females, with no missing cases. There were more female respondents than male respondents, as shown in Fig. 5.1. The reasons for this finding are not immediately apparent given the concerns on equity, affirmative action and gender equality.

### 5.2.2.2 Responses According to Age.

**Table 5.1 Responses according to age**

| <b>AGE</b>     | <b>NUMBER OF TEACHERS</b> | <b>PERCENTAGE (%)</b> |
|----------------|---------------------------|-----------------------|
| Below 30 years | 16                        | 40%                   |
| Above 30 years | 24                        | 60%                   |
| Missing Cases  | 0                         | 0%                    |
| <b>TOTAL</b>   | <b>40</b>                 | <b>100%</b>           |

The biographical information indicates that most of the teachers at the selected schools were over the age of 30, as presented in table 5.1. Out of 40 respondents, 24 (60%) were above the age of 30 years, while 16 (40%) were below the age of 30 years. This situation indicates that the level of maturity in age at these schools is high.

### 5.2.2.3 Responses according to years of experience in teaching

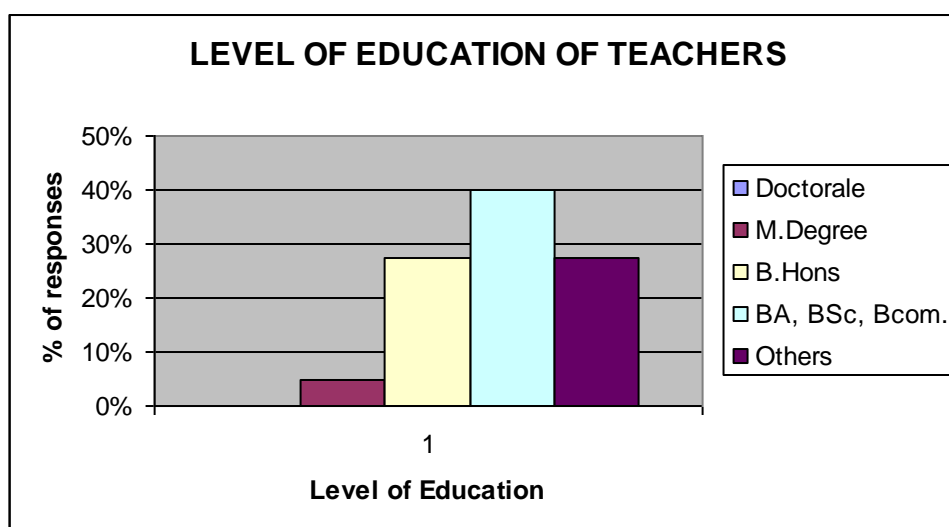
**Table 5.2 Responses according to years' of experience**

| Years' of Experience | Number of Teachers | Percentage (%) |
|----------------------|--------------------|----------------|
| 0-3                  | 14                 | 35%            |
| 4-10                 | 9                  | 22.5%          |
| 11-20                | 9                  | 22.5%          |
| 20-Above             | 8                  | 20%            |
| <b>TOTAL</b>         | <b>40</b>          | <b>100%</b>    |

Out of a total of 40, 14(35%) had 0 to 3 years of experience, 9(22.5%) had 4 to 10 years of experience, 9(22.5) had 11 to 20 years of experience and 8(20%) had above 20 years of teaching. The respondents were asked to indicate their teaching experience at other schools, such as primary and secondary schools. Teachers with experience of 0 to 3 years are in the majority. It shows that younger generation is more aware of the disease than the older generation who are probably sticking to the past.

### 5.2.2.4 Level of Education of Respondents

**Figure 5.2 Level of Education of Teachers**



Qualification of the respondents: out of a total of 40 responses, only 2 (5%) had Masters or an equivalent, 11 (27.5%) had B. Hons Degree, 16 (40%) had a BA, BSc, B.Com, while 11 (27.5%) had other certificates. None of the respondents had a Doctoral degree. Most of the educators at both Primary and Secondary schools have BA, BSc, B.Com and many other qualifications. Educators with BA, B.Sc. and B.Com are more aware of the disease and its impact on education than any other groups.

### **5.2.2.5 HIV/AIDS prevention and control system**

The question asked is whether HIV/AIDS prevention and control system is in place at the selected schools.

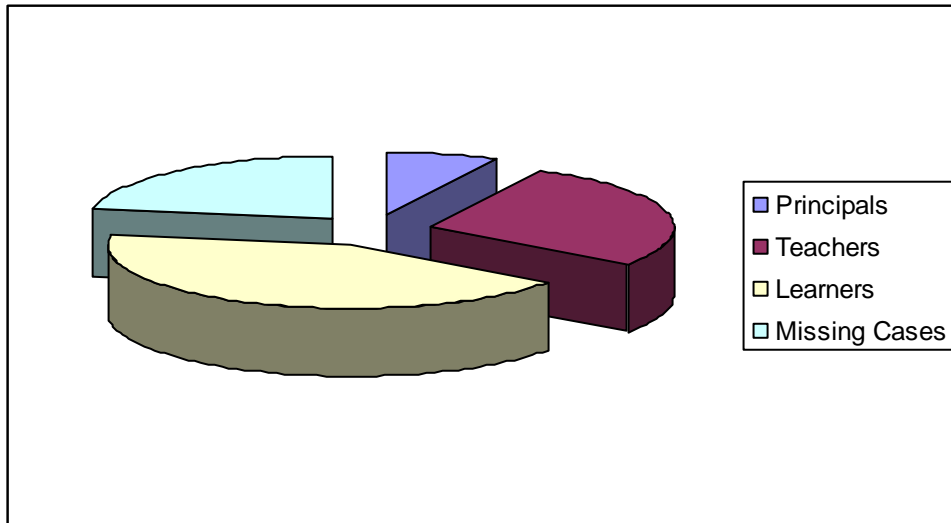
**Table 5.3 Responses according to the above question**

|                    | <b>Agree</b> | <b>%</b> | <b>Disagree</b> | <b>%</b> |
|--------------------|--------------|----------|-----------------|----------|
| Number of Teachers | 27           | 67.5     | 13              | 32.5     |

Respondents were asked whether HIV/AIDS prevention and control is in place at their schools. Out of 40 respondents 27 (67.5%) said a HIV/AIDS prevention and control system is in place at their schools, while 13 (32.5%) said they had not yet started the system of controlling and preventing HIV/AIDS. Most of the respondents agreed with the statement, which demonstrates that most of the schools have HIV/AIDS prevention and control system.

### 5.2.2.6 Who is in Charge of HIV/AIDS prevention and control at your school?

Figure 5.3 People in charge of HIV/AIDS prevention



Out of 40 (100%) only 3 (7.5%) were Principals who seemed to be interested in the HIV/AIDS prevention while 11 (27.5%) were teachers and 17 (42.5%) were learners with 9 (22.5%) missing cases. Fig. 5.3 above shows these findings. The devastating impact of HIV/AIDS necessitates education in schools to pursue the methods of prevention care.

### 5.2.3 Results of responses of educators according to each item

The following section shows how educators responded to each item on the questionnaire. The respondents were asked to indicate their opinions by answering “yes”, “not sure” and “no” (where “yes” = *agree* and “not sure” and “no” indicated *disagree*) to the sixteen items relating to various aspects of HIV/AIDS on education.



### 5.2.3.1 Item 1 asked whether HIV/AIDS leads to loss of childhood

**Table 5.4 Responses according to Item 1**

| <b>Item 1</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 37                        | 1.08        | 97.5                  |
| Disagree      | 3                         | 0.042       | 7.5                   |

Table 5.4 above arranges and separates the responses of teachers to the first item in order of agreeing and disagreeing. Out of a total of 40 people 37(97.5%), with a mean of 1.08, agreed that HIV/AIDS leads to loss of childhood while only 3(7.5%) with a mean of 0.042 disagreed. This shows that most of the children lose their childhood and tend to care for their siblings because of HIV/AIDS.

### 5.2.3.2 Item 2 asked whether HIV/AIDS leads to drop-out at school

**Table 5.5 Responses according to Item 2**

| <b>Item 2</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 38                        | 1.05        | 95                    |
| Disagree      | 2                         | 0.035       | 5.0                   |

Table 5.5 shows the responses of teachers according to the second item. Out of 40 people, 38(95.0%) with a mean of 1.05 agreed with the statement while 2 (5.0%) with a mean of 0.035 disagreed. This shows that most of the children leave schools because of HIV/AIDS problems.

**5.2.3.2 Item 3 asked whether affected children go through much stress and depression**

**Table 5.6 Responses according to Item 3**

| <b>Item 3</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 30                        | 1.25        | 75%                   |
| Disagree      | 10                        | 0.069       | 25%                   |

Out of a total of 40, 30 (75%) with a mean of 1.25 agreed and 10 (25%) with a mean of 0.069 disagreed with item 3. The mean of “Agree” is 1.25. This is higher than the mean of “Disagree”. This shows that most children at school go through much stress and depression owing to HIV/AIDS problems or other problems.

**5.2.3.3 Item 4 asked whether teachers know of any learners who left school because of HIV/AIDS**

**Table 5.7 Responses according to Item 4**

| <b>Item 4</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 11                        | 0.071       | 27.5                  |
| Disagree      | 29                        | 1.73        | 72.5                  |

As shown in Table 5.7 above, only 11 (27.5%) with a mean of 0.071 agreed that they know learners who left school because of HIV/AIDS, and 29 (72.5%) with a mean of 1.73 said they do not know about learners who have left school because of HIV/AIDS. However, the fact is that most learners are leaving school at an alarming rate. This shows that most teachers do not know the real reason why pupils leave schools. Teachers should investigate the matter.

**5.2.3.4 Item 5 asked whether children with HIV/AIDS should be regarded under special education**

**Table 5.8 Responses according to Item 5**

| <b>Item 5</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 11                        | 0.073       | 27.5                  |
| Disagree      | 28                        | 1.72        | 70.0                  |
| Missing       | 1                         |             | 2.5                   |

Table 5.8 shows that only 11 (27.5%) with a mean of 0.073 teachers agreed that children with HIV/AIDS should be regarded under special education, while 28 (70.0%) with a mean of 1.72 disagreed with 1 (2.5%) missing case. This shows that most teachers do not like the issue of teaching HIV/AIDS children under special education.

**5.2.3.5 Item 6 asked whether teachers know of any learner infected with HIV/AIDS**

**Table 5.9 Responses according to Item 6**

| <b>Item 6</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 11                        | 0.071       | 27.5                  |
| Disagree      | 29                        | 1.73        | 72.5                  |

Table 5.9 above shows that 11 (27.5%) with a mean of 0.071 respondents said they know learners are infected with HIV/AIDS, while 29 (72.5%) said they do not know about infected learners but most of the learners leave school because of sickness. Therefore it is not clear to them whether learners are infected with HIV/AIDS or not.

**5.2.3.6** *Item 7 asked whether learners are exposed to appropriate information on HIV/AIDS or the danger of unprotected sex*

**Table 5.10** Responses according to item 7

| <b>Item 7</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 13                        | 0.075       | 32.5                  |
| Disagree      | 27                        | 1.68        | 67.5                  |

Out of 40 respondents, 13 (32.5%) with a mean of 0.075 agreed that learners are exposed to appropriate information on HIV/AIDS or the dangers of unprotected sex, while 27 (67.5%) with a mean of 1.68 disagreed; they said their learners are not exposed to appropriate information on HIV/AIDS and unprotected sex.

**5.2.3.7** *Item 8 asked whether HIV/AIDS affects school enrolment*

**Table 5.11** Responses according to item 8

| <b>Item 8</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 36                        | 1.10        | 90%                   |
| Disagree      | 4                         | 0.048       | 10%                   |

As shown in Table 5.11, 36 (90%) respondents agreed with the statement while only 4 (10%) disagreed. This shows that school enrolment is affected by HIV/AIDS because most learners leave school owing to HIV/AIDS problems and most teachers die because of HIV/AIDS.

**5.2.3.8 Item 9 asked whether teachers encourage parents to talk about sex issues to their children**

**Table 5.12 Responses according to Item 9**

| <b>Item 9</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-------------|-----------------------|
| Agree         | 38                        | 1.05        | 95%                   |
| Disagree      | 2                         | 0.035       | 5%                    |

Out of 40 respondents, 38 (95%) agreed while 2 (5%) disagreed with item 9. Most respondents (95%) said they always encourage parents to talk about sex issues to their children, though it is very difficult for the parents, especially for those who are living in rural areas, to expect them to talk about sex issues with their children. Only 5% of the respondents said they do not encourage parents to talk about sex issues with their children because parents think it is not good to discuss sex issues with children.

**5.2.3.9 Item 10 asked whether respondents know of any of their colleagues infected with HIV/AIDS**

**Table 5.13 Responses according to Item 10**

| <b>Item 10</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 10                        | 1.75        | 25%                   |
| Disagree       | 30                        | 0.069       | 75%                   |

As shown in Table 5.13, only 10 (25%) out of 40 respondents agreed that they know of any of their colleagues infected with HIV/AIDS, while 30 (75%) said they do not know of any of their colleagues infected with HIV/AIDS. This shows that most infected people are afraid to tell other people about their HIV/AIDS status as they fear discrimination.

**5.2.3.10 Item 11 asked whether affected children were ostracized by their peers**

**Table 5.14 Responses according to Item 11**

| <b>Item 11</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 25                        | 1.38        | 62.5%                 |
| Disagree       | 15                        | 0.078       | 37.5%                 |

The percentage of the respondents who agreed is 62.5%. This is higher than 37.5% respondents who disagreed with item 11. This shows that affected children are being rejected by their peers; this is particularly so because of society's negative attitude towards HIV/AIDS, and owing to such feelings as embarrassment, humiliation and shame. Children may even play truant or avoid peer contact in fear of being victimized.

**5.2.3.11 Item 12 asked whether learners display signs of low self-esteem**

**Table 5.15 Responses according to Item 12**

| <b>Item 12</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 31                        | 1.23        | 77.5%                 |
| Disagree       | 9                         | 0.067       | 22.5%                 |

Most respondents (77.5%) agreed, while 9 (22.5%) disagreed. This shows that most affected children display signs of low self-esteem, owing to the stigma, discrimination and negative attitudes towards HIV/AIDS related illness.

**5.2.3.12 Item 13 asked whether HIV/AIDS increases the number of orphans and increase incidents of child labour**

**Table 5.16 Responses according to Item 13**

| <b>Item 13</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 39                        | 1.02        | 97.5%                 |
| Disagree       | 1                         | 0.025       | 2.5%                  |

Out of 40 respondents, 39 (97.5%) agreed with the item while only 1 (2.5%) disagreed. This shows that most children have lost their parents because of HIV/AIDS problems. The high the percentage in “Agree” is consistent with the reviewed literature that HIV/AIDS increases a number of orphans and increase incidents of child labour (Davis, 1995:8).

**5.2.3.13 Item 14 asked whether HIV/AIDS orphans eventually resort to being street children**

**Table 5.17 Responses according to Item 14**

| <b>Item 14</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 36                        | 1.10        | 90%                   |
| Disagree       | 4                         | 0.048       | 10%                   |

The percentage of the respondents who agreed is 90%. This is higher than the 10% of respondents who disagreed with item 14. This shows that HIV/AIDS orphans face many challenges, find themselves in very painful circumstances and eventually resort to being street children. The high percentage of the respondents who agreed, is consistent with the reviewed literature of this study.

**5.2.3.14 Item 15 asked whether HIV/AIDS provoke feelings of embarrassment and shame**

**Table 5.18 Responses according to Item 15**

| <b>Item 15</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 36                        | 1.10        | 90%                   |
| Disagree       | 4                         | 0.048       | 10%                   |

As shown in Table 5.18, 36 (90%) of respondents agreed while only 4 (10%) of respondents disagreed with statement 15. This shows that it is true for most people, including children, HIV/AIDS related illness provoke feelings of humiliation, embarrassment, shame and children start feeling helpless, hopeless and eventually, view life as worthless. The high the percentage of respondents who agreed is consistent with the reviewed literature of this study.

**5.2.3.15 Item 16 asked education whether HIV/AIDS orphans become aggressive, sullen or revert to drugs**

**Table 5.19 Responses according to Item 16**

| <b>Item 16</b> | <b>No. of Respondents</b> | <b>Mean</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-------------|-----------------------|
| Agree          | 36                        | 1.10        | 90%                   |
| Disagree       | 4                         | 0.048       | 10%                   |

The percentage of the respondents who agreed is 90% while the percentage of the respondents who disagreed is only 10%. This shows that HIV/AIDS orphans are being uprooted from the family home and the community, migrating to a completing new environment, which is associated with much uncertainty and stress. The high the percentage of the respondents who agreed is consistent with the reviewed literature that HIV/AIDS orphans become aggressive, sullen or revert to drugs (Davis, 1995:4).



#### **5.2.4 Summary**

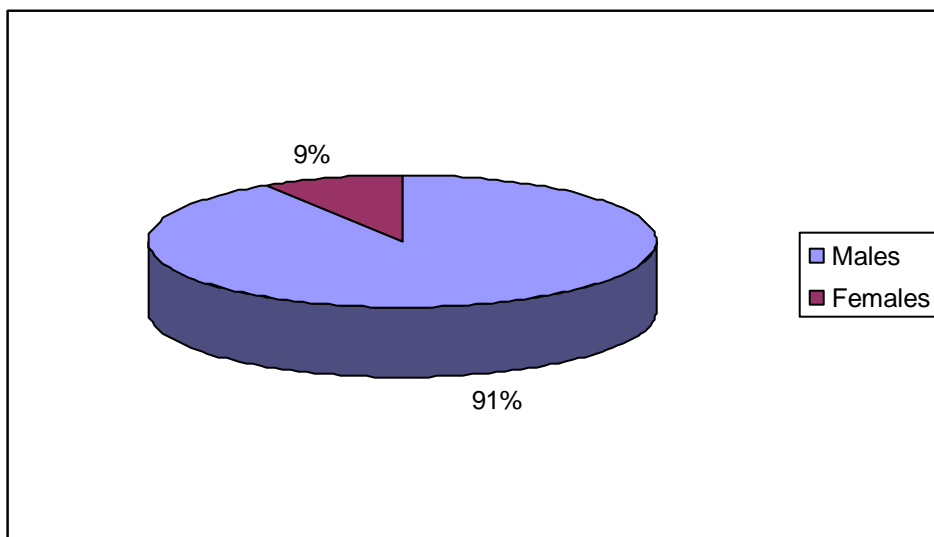
The items from 1-16 were found to be reliable for this study. The internal consistency reliability was consistent with previously reported statistics of very good reliability in research studies, with the exception of a few instances where impact can be regarded as negligible.

#### **5.2.5 BIOGRAPHICAL INFORMATION OF RESPONDENTS (LEARNERS) AND GRAPHICAL REPRESENTATION**

The questionnaires entitled “The Impact of HIV/AIDS on education at Mohale’s Hoek, Lesotho” was composed of 2 sections. The first section concentrated on the respondents’ biographical information. The information sought was about gender and the age of learners. The second part was composed of 20 items seeking various possible factors that contributed to the impact of HIV/AIDS on education in Mohale’s Hoek, Lesotho. The item was to be answered using a 3-point scale. The scale used the following categories: *Agree* (1); *Not sure* (2); and *Disagree* (3). The questions sought information that answer the hypotheses of the study. Respondents were asked for some personal details, their age, gender and their Grade or Class. They were also asked to indicate their opinion by answering *agree*, *not sure* and *disagree*, where *not sure* and *disagree* were combined as *disagree*.

### 5.2.5.1 Responses according to gender (learners)

Figure 5.4 Responses to gender (learners)



There were 57 learners who responded in selected schools, 52 (91.2%) were males while 5 (8.8%) were females. The biographical information indicated that most of the learners who responded to the questionnaire were boys because it was during technical subject lessons. Technical subjects at selected schools were done mostly by boys and very few girls.

### 5.2.5.2 Responses according to age

Table 5.20 Responses According to Age

| AGE      | NO. OF LEARNERS | PERCENTAGE % |
|----------|-----------------|--------------|
| BELOW 12 | 0               | 0%           |
| ABOVE 12 | 57              | 100%         |
| TOTAL    | 57              | 100%         |

The biographical information indicated that all the learners who responded to the questionnaire were over the age of 12 years as presented in table 5.18. Out of a total of 57 (100%) were above 12 years; none of the respondents were below 12 years.

### **5.2.6 Attitude of learners to the Impact of HIV/AIDS on education in Lesotho**

The following section shows how learners responded to each item on the questionnaire. The respondents were asked to indicate their opinion on a 1 to 3 scale where 1=agree, 2=not sure, 3=disagree of the twenty items relating to various aspects of HIV/AIDS.

#### **5.2.6.1 Item 1 asked learners whether the number of learners decreases of HIV/AIDS problems**

**Table 5.21 Responses according to Item 1**

| <b>Item 1</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 33                        | 66.7%                 |
| Disagree      | 19                        | 33.3%                 |

The percentage of the learners who agreed is 66.7%. This is slightly higher than the 33.3% who disagreed. This shows that the number of learners decreases because of the HIV/AIDS problem.

#### **5.2.6.2 Item 2 asked learners whether the number of educators decreases because of HIV/AIDS**

**Table 5.22 Responses according to Item 2**

| <b>Item 2</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 34                        | 59.6%                 |
| Disagree      | 23                        | 40.4%                 |

As shown in Table 5.22, 34 (59.6%) of respondents agreed while 23 (40.4%) of respondents disagreed that the number of educators decreases because of HIV/AIDS problems. This shows that most of educators leave schools or die because of HIV/AIDS.

**5.2.6.3 Item 3 asked learners whether HIV/AIDS orphans are able to continue schooling**

**Table 5.23 Responses according to Item 3**

| Item 3   | No. of Respondents | Percentage (%) |
|----------|--------------------|----------------|
| Agree    | 19                 | 33.3%          |
| Disagree | 37                 | 64.9%          |
| Missing  | 1                  | 1.8%           |
| TOTAL    | 57                 | 100%           |

There was 1 missing case in item 3. The percentage respondents who agreed is 33.3% while the respondents who disagreed is 64.9%. The percentage in *disagree* is higher than the percentage in *agree*. This shows that HIV/AIDS orphans are not able to continue schooling.

**5.2.6.4 Item 4 asked learners whether HIV/AIDS orphans are able to pay school fees**

**Table 5.24 Responses according to Item 4**

| Item 4   | No. of Respondents | Percentage (%) |
|----------|--------------------|----------------|
| Agree    | 12                 | 21.1%          |
| Disagree | 45                 | 78.9%          |

According to the table above, most respondents (78.9%) disagreed that HIV/AIDS orphans are able to continue schooling and even to pay school fees, while 21.1% agreed that they are able to pay school fees; they said HIV/AIDS orphans are being helped by the government to pay their school fees.

**5.2.6.5 Item 5 asked learners whether HIV/AIDS orphans resort to being street children**

**Table 5.25 Responses according to Item 5**

| <b>Item 5</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 40                        | 70.2%                 |
| Disagree      | 17                        | 29.8%                 |

Table 5.25 shows responses according to item 5. Out of 57, 17 (29.8%) of respondents disagreed, while 40 (70.2%) of respondents agreed. Most of the learners agreed that HIV/AIDS orphans resort to being street children because they are unable to continue schooling.

**5.2.6.6 Item 6 asked learners whether HIV/AIDS orphans become aggressive, sullen or revert to drugs**

**Table 5.26 Responses according to Item 6**

| <b>Item 6</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 35                        | 61.4%                 |
| Disagree      | 22                        | 38.6%                 |

The percentage of the respondents who agreed with question 6 is 61.4%. This is higher than the percentage of the respondents who disagreed (38.6%) with the question. This shows that it is very easy for HIV/AIDS learners to become aggressive, sullen or revert to drugs to avoid matters that are too difficult and painful for them to face (Drum September, 2002:29).

**5.2.6.7** *Item 7 asked learners whether they know of any learners who left school because of HIV/AIDS*

**Table 5.27** Responses according to Item 7

| <b>Item 7</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 17                        | 29.8%                 |
| Disagree      | 40                        | 70.2%                 |

Out of the total of 57, 17 (29.8%) agreed while 40 (70.2%) disagreed with item 7. This shows that owing to stigma, discrimination and negative attitudes towards HIV/AIDS related illnesses, children just leave school without saying anything to anybody.

**5.2.6.8** *Item 8 asked learners whether affected and infected children are criticized by their peers*

**Table 5.28** Responses according to Item 8

| <b>Item 8</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 22                        | 38.6%                 |
| Disagree      | 35                        | 61.4%                 |

As shown in table 5.28 above, the percentage of the respondents who agreed is 38.6% while the percentage of the respondents who disagreed is 61.4%. Most of the respondents disagreed that affected and infected children are being criticized by their peers because affected children hide their problems which are caused by HIV/AIDS. This is consistent with the reviewed literature of this study.

**5.2.6.9** *Item 9 asked whether affected learners show signs of low self-esteem*

**Table 5.29** Responses according to Item 9

| <b>Item 9</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|---------------|---------------------------|-----------------------|
| Agree         | 32                        | 56.1%                 |
| Disagree      | 25                        | 43.9%                 |

As shown in Table 5.29 above, the percentage of respondents who agreed is 56.1%. This is slightly higher than the 43.9% respondents who disagreed. This shows that affected learners show signs of low self-esteem; this is owing to stigma, discrimination and negative attitudes towards HIV/AIDS related illness. This is consistent with the reviewed literature of this study.

**5.2.6.1** *Item 10 asked learners whether HIV/AIDS provokes feelings of embarrassment and shame*

**Table 5.30** Responses according to Item 10

| <b>Item 10</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 34                        | 59.6%                 |
| Disagree       | 23                        | 40.4%                 |

The percentage of the respondents who agreed with question 10 is 59.6% while the percentage of those who disagreed is 40.4%; this is slightly lower than the percentage of those who agreed. This means that it is true that HIV/AIDS provokes feelings of embarrassment and shame. This is particularly because of society's negative attitude towards the situation (Davis 1995:7). This is consistent with the reviewed literature of this study.

**5.2.6.11 Item 11 asked learners whether affected young girls tend to sell sex for their school fees**

**Table 5.31 Responses according to Item 11**

| <b>Item 11</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 23                        | 40.4%                 |
| Disagree       | 33                        | 57.9%                 |
| Missing        | 1                         | 1.8%                  |
| TOTAL          | 57                        | 100%                  |

There was 1 missing case with a percentage of 1.8%. The percentage of the respondents who agreed with statement 11 is 40.4%, while the percentage of those who disagreed is 57.9%; this is slightly higher than the percentage of the respondents who agreed with statement 11. This shows that most learners disagree that young girls tend to sell sex for their school fees.

**5.2.6.12 Item 12 asked learners whether affected children go through much stress and depression**

**Table 5.32 Responses according to Item 12**

| <b>Item 12</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 31                        | 54.4%                 |
| Disagree       | 26                        | 45.6%                 |

As shown in Table 5.32 above, out of 57 respondents, 31 (54.4%) agreed that affected children go through much stress and depression, while 26 (45.6%) disagreed. The high the percentage of the respondents who agreed is consistent with the reviewed literature of this study.



**5.2.6.13 Item 13 asked learners whether they discuss sex issues with their parents**

**Table 5.33 Responses according to Item 13**

| <b>Item 13</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 26                        | 45.6%                 |
| Disagree       | 31                        | 54.4%                 |

The percentage of the respondents who agreed is 45.6% and the percentage of the respondents who disagreed is 54.4%. This is slightly higher than the percentage of those who agreed that they talk about sex issues with their parents. This shows that it is not possible for parents to talk about sex issues with their children. This is consistent with the reviewed literature of this study.

**5.2.6.14 Item 14 asked learners whether they have sex without using condoms**

**Table 5.34 Responses according to Item 14**

| <b>Item 14</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 19                        | 33.3%                 |
| Disagree       | 38                        | 66.7%                 |

As shown in Table 5.34 above, most respondents (66.7%) disagreed that they have sex without using condoms while 19 (33.3%) agreed that they have sex without condoms.

**5.2.6.15 Item 15 asked learners whether they abstain from sex**

**Table 5.35 Responses according to Item 15**

| <b>Item 15</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 31                        | 54.4%                 |
| Disagree       | 25                        | 43.9%                 |
| Missing case   | 1                         | 1.8%                  |

There was one missing case in item 15. The percentage of the respondents who agreed that they abstain from sex is 54.4% while the percentage of those who disagreed is 43.9%. This shows that most learners abstain from sex and this is consistent with the reviewed literature of this study.

**5.2.6.16 Item 16 asked learners whether they believe that condoms reduce the high risk of HIV/AIDS infection**

**Table 5.36 Responses according to Item 16**

| <b>Item 16</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 31                        | 54.4%                 |
| Disagree       | 25                        | 43.9%                 |
| Missing case   | 1                         | 1.8%                  |

There was one missing case with a percentage of 1.8%. The percentage of the respondents who agreed is 54.4% while the percentage of those who disagreed is 43.9%; this is slightly lower than the percentage of the respondents who agreed that condoms reduce the high risk of HIV/AIDS infection. This is consistent with the reviewed literature of this study.

**5.2.6.17 Item 17 asked learners whether there is any cure for HIV/AIDS**

**Table 5.37 Responses according to Item 17**

| <b>Item 17</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 5                         | 8.8%                  |
| Disagree       | 52                        | 91.2%                 |

The percentage of the respondents who agree is 8.8% while the percentage of those who disagreed is 91.2%. This is higher than the percentage of those who said HIV/AIDS can be cured. Most of the learners believe that there is no cure for HIV/AIDS. This is consistent with the reviewed literature of this study.

**5.2.6.18 Item 18 asked learners whether HIV/AIDS kills only young people**

**Table 5.38 Responses according to Item 18**

| <b>Item 18</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 1                         | 1.8%                  |
| Disagree       | 55                        | 96.5%                 |
| Missing case   | 1                         | 1.8%                  |

There was one missing case. Out of the total of 57, 1 respondent agreed with question 18 while 55 (96.5%) disagreed. Most of the learners disagreed that HIV/AIDS kills only young people; they said it also kills old people. This is consistent with the reviewed literature of this study.

**5.2.6.19 Item 19 asked learners whether affected children lose their childhood**

**Table 5.39 Responses according to Item 19**

| <b>Item 19</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 19                        | 33.3%                 |
| Disagree       | 38                        | 66.7%                 |

As shown in Table 5.39 above, the percentage of the respondents who agreed with question 19 is 33.3% while the percentage of the respondents who disagreed is 66.7%. This shows that most of the learners do not believe that affected children lose their childhood. This is not consistent with the reviewed literature of this study.

**5.2.6.20 Item 20 asked learners whether teenagers are sexually active**

**Table 5.40 Responses according to Item 20**

| <b>Item 20</b> | <b>No. of Respondents</b> | <b>Percentage (%)</b> |
|----------------|---------------------------|-----------------------|
| Agree          | 40                        | 70.2%                 |
| Disagree       | 16                        | 28.1%                 |
| Missing case   | 1                         | 1.8%                  |

There was one missing case with a percentage of 1.8%. The percentage of the respondents who agreed is 70.2% while the percentage of the respondents who disagreed is 28.1%. This shows that most of the learners do agree that teenagers are sexually active and that it leads to HIV/AIDS. This is consistent with the reviewed literature of this study.

### **5.2.7 Summary**

The items from 1 – 20 were found to be reliable for this study. The internal consistency reliability was consistent with previously reported statistics of very good reliability in research studies, with the exception of a few instances whose impact can be regarded as negligible.

## **5.3 INTERPRETATION OF THE INTERVIEWS**

There were 15 questions prepared for interviews with the Heads of Department and Principals. The first four questions sought biographical information. The questions were about gender, age, teaching qualifications and subjects, which educators had been trained in.

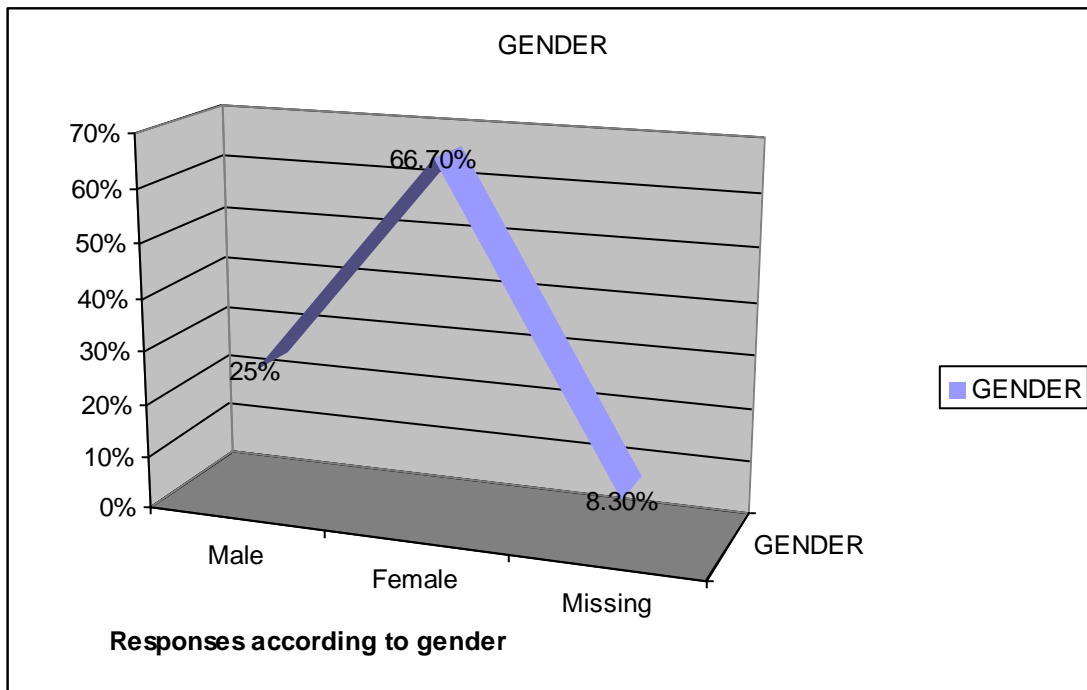
The other eleven questions sought information about how HIV/AIDS impacts on their education; how HIV/AIDS affects learners and educators; how the school system responds to the needs of children with HIV/AIDS; how other members of staff who perhaps suffer from HIV/AIDS have an effect on the Heads of Department and Principals' duties; and whether they receive any support in taking care of orphans and vulnerable children. Ten Heads of Department and two Principals were interviewed.

### **5.3.1 Biographical information about the Heads of Department and Principals**

This section describes the responses of the participants in relation to gender, age, teaching qualifications and subjects which educators had been trained in.

### 5.3.1.1 Responses according to gender

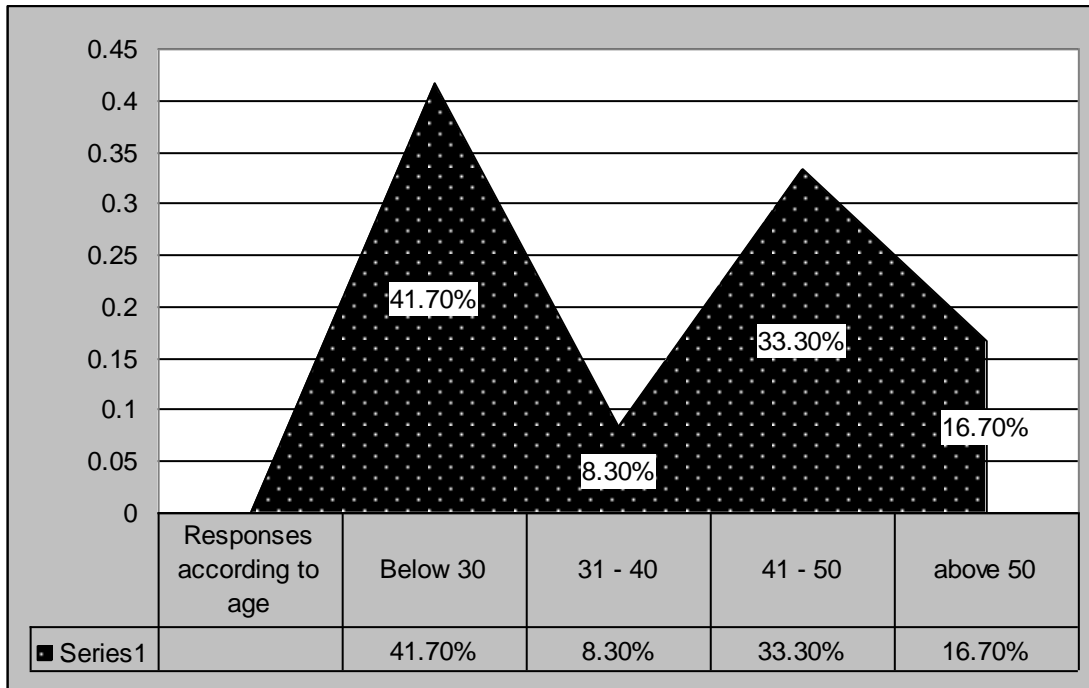
**Fig. 5.5 Responses according to gender (Heads of Department)**



There were more female respondents than male respondents as shown in Fig. 5.5 above. The reasons for this finding are not immediately apparent given the concerns on equity, affirmative action and gender equality. Out of a total of 12 responses, 8 (66.7%) were female while 3 (25%) were males, with 1 (8.3%) missing case who did not respond at all.

### 5.3.1.2 Responses according to age

**Fig. 5.6 Responses according to age (Heads of Department)**



Age distribution above shows that 5 (41.7%) were below the age of 30, while 1 (8.3%) were 31 to 40 years of age; 4 (33.3%) were 41 to 50 years of age, and 2 (16.7%) were above 50 years. This shows that most of the Heads of Department are above the age of 30. This situation at these schools is indicative of the level of maturity of the academic staff.

### 5.3.1.3 Responses according to level of education of Heads of Department

Figure 5.7 Level of Education

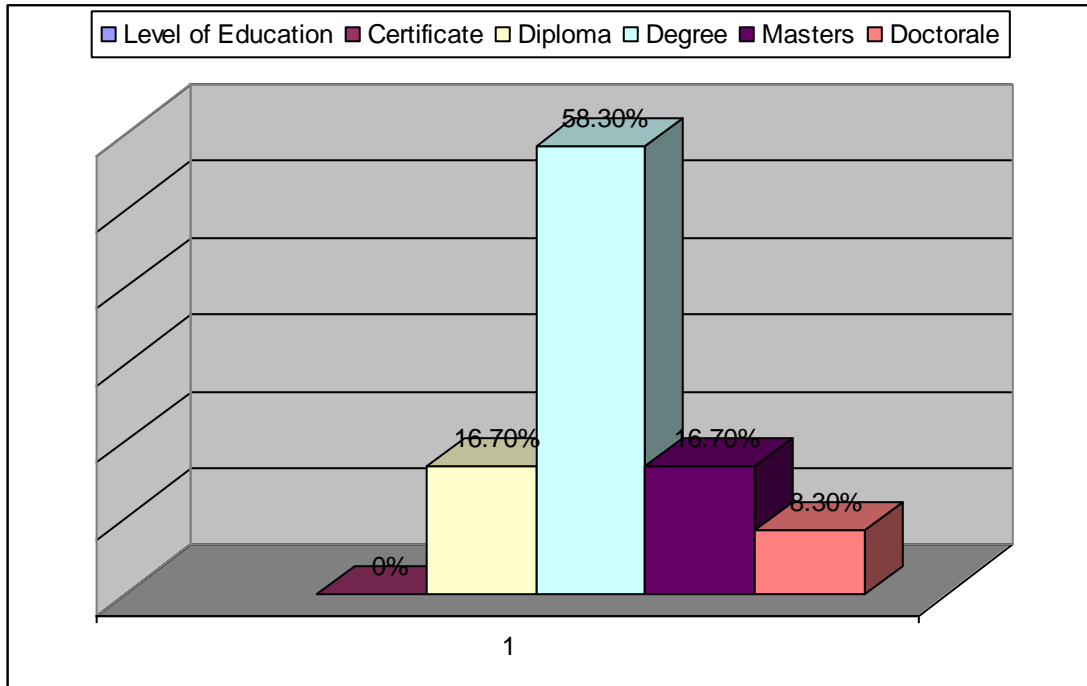
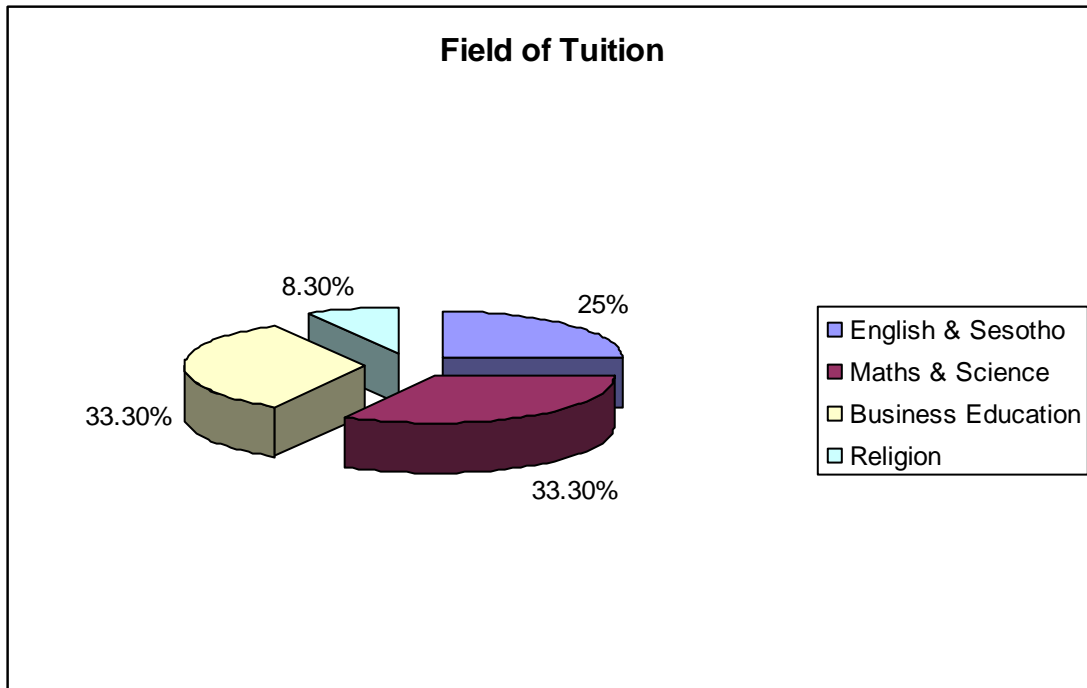


Figure 5.7 above shows the level of education of Heads of Department. The qualifications of the respondents are as follows: 2 (16.7%) had National Diploma; 7 (58.3%) had a Degree; 2 (16.7%) had Masters; and 1 (8.3%) had a Doctoral Degree. None of the respondents had a National certificate. For the purpose of this study, a qualified educator at primary and secondary schools is a person with a minimum of a National Certificate and above, with a teaching qualification.



### 5.3.1.4 Responses according to field of tuition

Fig. 5.8 Field of tuition of Heads of Department



As shown in Figure 5.8 above, 3 (25%) of Heads of Department were offering English and Sesotho; 4 (33.3%) were offering Mathematics and Science; 4 (33.3%) were offering Business Education; and 1 (8.3%) was offering Religious Knowledge. The Religious Knowledge is largely under represented by this sector with subjects' emphasis being English, Sesotho, Mathematics and Science.

## 5.4 THE STATISTICAL ANALYSIS

The purpose of the statistical analysis is to present the results of the analysis of variance used to test the hypotheses in the study (Litheko, 2002a:126).

The statistical analysis is conducted to determine whether the results of the study are consistent with the underlying null hypotheses. If the results do not demonstrate the presence of a difference or an effect, it is concluded that the data fail to refute the null hypothesis (Monsen, 1992:337).

The two hypotheses of the study state the following:

- ◆ School enrolments are declining since children are dying and others are orphaned by HIV/AIDS
- ◆ HIV/AIDS has an impact on educators and learners at primary and secondary schools at Mohale's Hoek, Lesotho

#### **5.4.1 Decisions on Assumptions**

This chapter presents the statistical results of the research. The focus is on the descriptive statistics and the statistical analysis of the items. The decisions taken are with respect to the four hypotheses.

Assumption 1: According to educators at Mohale's Hoek, the direct impact of HIV/AIDS is not clearly visible as learners and parents do not disclose information as to why children are removed from schools. About 92.5% of educators said dropout rates at schools increase at an alarming rate. Consent was obtained from 90% of educators who responded to the questionnaire on the contributory value of HIV/AIDS and its contribution to school enrolment figures. They said HIV/AIDS largely affects school enrolments, because most of the children orphaned by HIV/AIDS resort to being street kids; they leave school because they are not able to pay school fees.

Assumption 2: Based on the failure to reject the null assumption, by failing to reach statistical significance, HIV/AIDS has an impact on educators and learners at primary and secondary schools at Mohale's Hoek, Lesotho, with respect to age, gender, level of education and years of experience as a teacher.

#### **5.4.2 Decisions on research questions**

Research question 1: What is the impact of HIV/AIDS on education in Mohale's Hoek, Lesotho?

Decision on question 1: According to educators and learners in selected schools, it is clear that school enrolments deteriorate because of HIV/AIDS. About 90% of learners agreed that the number of learners and educators decreases because they may perhaps be suffering from HIV/AIDS.

Research question 2: What knowledge do learners possess about the dangers of HIV/AIDS?

Decision on question 2: Most of the learners, about 87%, know that most of the children are orphaned by HIV/AIDS; they know that HIV/AIDS does not kill only young people because most of the people (parents, educators and learners) are dying because of HIV/AIDS. It also provokes feelings of embarrassment and shame, and most infected and affected children are being criticized by their peers.

Research question 3: Are educators trained to educate learners about safe sex?

Decision on question 3: About 40.6% of educators are trained to educate learners about safe sex while most of the educators have not yet started to train to educate learners about safe sex.

Research question 4: Does the Government of Lesotho have policies in place about HIV/AIDS in education?

Decision on question 4: The Government of Lesotho has policies in place about HIV/AIDS in education. Most of HIV/AIDS orphans get free education; they are being helped by the government.

#### **5.4.3 Decisions on research aims and objectives**

Research aim: To investigate the Impact of HIV/AIDS on education at Mohale's Hoek, Lesotho.

Decision on research aim: The Impact of HIV/AIDS on education at Mohale's Hoek, Lesotho has been investigated. Most educators, about 97.5%, responded that the impact of HIV and AIDS includes the drop-out rates at schools; most educators and learners are dying because of HIV/AIDS; and the quality of education deteriorates and school enrolments decline.

Research Objective 1: To come up with recommendations that will help the government fight the spread of HIV/AIDS.

Decision on objective 1: Co ordination of HIV/AIDS prevention and control activities in education is highly recommended.

Research Objective 2: To suggest to the government the best possible way to educate scholars about the danger of HIV/AIDS.

Decision on objective 2: About 90% of learners do not know about the danger of HIV/AIDS because they admitted that they do not abstain from sex and that they have sex without using condoms. Therefore the government should ensure that it trains educators to educate learners about the dangers of HIV/AIDS.

Research Objective 3: To empower youths at school and all vulnerable and disadvantaged groups to protect themselves against HIV/AIDS.

Decision on objective 3: Youths at school and all vulnerable and disadvantaged groups are empowered to protect themselves against HIV and AIDS; youths are told to abstain from sex, to use condoms, and to be faithful.

Research Objective 4: To ensure that every learner is exposed to appropriate information on the dangers of HIV/AIDS.

Decision on objective 4: The best possible way to educate learners about the dangers of HIV/AIDS has been suggested to the

Lesotho government. Parents are encouraged to talk to their children about sex issues.

## 5.5 SUMMARY OF OPEN-ENDED QUESTIONS AND INTERVIEWS

### 5.5.1 Introduction

The interviews were used to complement the structured questionnaire. This was to gather data in relation to the Impact of HIV/AIDS on education in Lesotho. With an interview, one can use both structured and unstructured questions and can probe the subject for the most appropriate response.

The interviews were carried out with Heads of Department and Principals.

### 5.5.2 Results of the responses given to the other items

The items are shown in Table 5.41, which show the response rate of the Heads of Department on the items.

**Table 5.41 Response rate of the Head of Department**

| <b>ITEMS</b>   | <b>Agree (%)</b> | <b>Disagree (%)</b> |
|--|------------------|---------------------|
| 5) How does the impact of HIV/AIDS affect learners and educators?  | 9 (75%)          | 3 (25%)             |
| 7) Are affected children able to continue schooling?   | 11 (91.7%)       | 1 (8.3%)            |
| 8) Can school systems respond most effectively to the needs of children with HIV/AIDS?                                 | 8 (66.7%)        | 4 (33.3%)           |
| 9) Does the fact that other members of staff may perhaps suffer from HIV/AIDS have an effect on your duties at school? | 10 (83.3%)       | 2 (16.7%)           |
| 11) Does the fact that other members of staff may perhaps suffer from HIV/AIDS have an effect on                       | 10 (83.3%)       | 2 (16.7%)           |

|   |              |           |
|---|--------------|-----------|
| the quality of education provided?  |              |           |
| 12) Does the fact that learners may perhaps suffer from HIV/AIDS have an effect on your ability to teach?     | 12<br>(100%) | 0 (0%)    |
| 13) Do you provide care and support to orphans and vulnerable children in your school community?              | 6 (50%)      | 6 (50%)   |
| 14) Do you receive any support (e.g. financial, emotional) in taking care of orphans and vulnerable children? | 7 (58.3%)    | 5 (41.7%) |

The following are their responses to questions 6, 10, 11, 13 and 14.

Question 6: *“How many children does this disease affect?”*

Answers:

1. “Many” ..... 2 (16.7%)
2. “I don’t know” ..... 4 (33.3%)
3. “I don’t know because they are not disclosing” .... 1 (8.3%)
4. “A lot of children are affected” ..... 5 (41.7%)

Question 10: *“Please explain briefly how the prevalence of HIV/AIDS among your colleagues’ impacts on your duties at school”*

Answers:

1. “We are being overloaded” ..... 6 (50%)
2. “Since some of our colleagues who are perhaps suffering from HIV/AIDS are leaving school, we have to carry on with their duties” ..... 5 (41.7%)
3. “It is very stressful to find other teachers who will take the job” ..... 1 (8.3%)

Question 11: *“If HIV/AIDS has an effect on the quality of education provided, please explain briefly”*

Answers:

1. “HIV/AIDS deteriorate the quality of education” ... 7 (58.3%)
2. “Qualified teachers die because of HIV/AIDS” ..... 2 (16.7%)
3. “Learners are dying because of HIV/AIDS” ..... 1 (8.3%)
4. “Yes, HIV/AIDS has an effect on the quality of education because well educated teachers are lost to HIV/AIDS” .....

Question 13: *“If you do provide care and support to orphans and vulnerable children, please explain briefly how you provide care and support”*

Answers:

1. “No, we do not provide any care and support” ..... 4 (33.3%)
2. “Yes, we do provide care and support” ..... 3 (25%)
3. “Not sure” ..... 4 (33.3%)
4. Yes, orphans and vulnerable children do get care and support because they are given clothes and food” .....

Question 14: *“If you receive any support in taking care of orphans and vulnerable children, please provide brief information on the sources and type of support that you receive”*

Answers:

1. “No” ..... 2 (16.7%)
2. “Not sure” ..... 3 (25%)
3. “Yes, we receive financial support from South-African Mines” .....
4. “Yes, we receive emotional support from churches and non-governmental organizations” 1 (8.3%)



On reviewing statistical figures obtained from schools, it was found that most of the respondents (about 97%), said that the issue of the HIV/AIDS pandemic is a serious problem in the nation. Homeless children's loss of the opportunity of schooling and parents who are victims of HIV/AIDS, result in school enrolments declining. Another problem is that educators and learners are dying of HIV/AIDS and these results in the poor quality of education and an inability of educators to teach.

## **5.6 CONCLUSION**

This chapter presented the results of the data analysis carried out to assess the teachers' and learners' attitudes towards the impact of HIV/AIDS on education. In so doing, a description of data cleansing procedure and characteristics of sampling were done. The results of the statistical analysis are based on age, gender and level of education. The percentages for each item in "*Agree*" and "*Disagree*" were presented. Discussions taken on the hypotheses under investigation were reported. Decisions taken on research questions, research aims and objectives were also reported. Finally interviews done with the Heads of Department were summarized and analyzed.

Chapter 6 presents the summary, discussions, conclusions, recommendations and suggestions for further research.

## **CHAPTER SIX**

### **SUMMARY, DISCUSSIONS, CONCLUSIONS, RECOMMENDATIONS AND SUGGESTIONS FOR FUTURE RESEARCH**

#### **6.1 INTRODUCTION**

This chapter firstly presents a summary of the study; secondly it presents discussions; thirdly the conclusions drawn from the research findings are presented. Finally the recommendations for the prevention and control of the impact of HIV/AIDS on education in Mohale's Hoek are made. Suggestions for further research are also made.

#### **6.2 SUMMARY**

The literature review indicates that, with the escalating number of HIV/AIDS orphans and vulnerable children, it can be concluded that education is affected, people living with HIV/AIDS are stigmatized and also experience some form of discrimination. This deadly disease is eradicating the active population of the country. Lesotho, with a population of a million people, is said to be among the countries in the sub-continent where the HIV/AIDS pandemic is increasing at an alarming rate. The percentage which stood at 2% in 2001 has increased by 29% to 31%, to date.

The research methodology explains how research design procedures were employed in the study as well as the population and the sample. The instrumentation used demonstrates a rationale for and a description of the procedure employed to determine the impact of HIV/AIDS on education at Mohale's Hoek, Lesotho. The results of the data analysis indicate the teachers' and learners' negative attitudes towards the impact of HIV/AIDS on education. A description of data cleansing procedures and the characteristics of samples have been given. The results of the statistical analysis also indicate the age, gender and level of education. The percentages for each

item in “*Agree*” and in “*Disagree*” have been presented. Decisions taken on the assumptions under investigation have been reported, as well as decisions taken on the research questions, research aim and objectives. Interviews done with the Heads of Department have been summarized and analyzed.

Most of the participants in this study agree that primary and secondary enrolments are declining because of HIV/AIDS, members of staff and learners are suffering from HIV/AIDS and the quality of education provided is being affected. Lastly the ability of educators to teach is also deteriorating as a result of HIV/AIDS.

### **6.3 DISCUSSION**

AIDS is no longer just a health problem. It is a developmental crisis with potentially ominous consequences for Lesotho and the world. Yet a culture of silence, fear and denial continues to reign and prevent action. The stigma and the fear engendered by AIDS fuels discrimination, persecution and ignorance. Its toll of devastating illness, widespread and indiscriminate death, deteriorating quality of education and life expectancy, threatens to reverse the hard earned social and economic prosperity of Lesotho districts and ultimately, the very future of the country.

According to the research and data collected it is clear that school going children face many challenges and find themselves in very painful circumstances. It had been deduced that learners lose their childhood owing to the illness of a parent as they are now expected to care for the younger sibling. Owing to the stigma discrimination and negative attitudes towards HIV/AIDS, children may be faced with ostracism by their schoolmates.

About 75% of the educators in this study have indicated, regarding drop out rates at Mohale’s Hoek schools that many learners do not have a choice to continue school when their parents succumb to AIDS. Consequently they do not have the opportunity to complete their education, with the result that the

projected number of children requiring education will decline and school enrolments will deteriorate.

Many children may not reach primary schooling ages as a result of the high mortality rate and an increase in infants. The investigation on the lives of these children has indicated that HIV orphan rate is escalating as the birth rate continues. These orphans will have less access to education, owing to lack of funding.

According to the data and research available, infected teachers will not be able to fully fulfil their duties, and high absenteeism will ensue. These factors impact negatively on the learning environment of the child and the quality of education, which he/she should receive. Experts warn that it will worsen the projected shortage of teachers, affect their ability to teach, increase infection rates among pupils, change enrolment patterns and generally disrupt schooling because of erratic attendance rates, as teachers and pupils take time to care for family members with AIDS. The resulting shortages will culminate in a subsequent reshuffling of physical resources at educational facilities, by accommodating learners in single classrooms when the respective educators are absent.

According to the findings, there is significant difference in the independent variables that were tested in the 16 items, with regard to the impact of HIV/AIDS on school enrolment. The independent variables were age, gender, years' of experience of educators and the field of tuition.

Out of 50 questionnaires sent to school educators, 40 were returned. This is a good response with a return rate of 80%. Out of 60 questionnaires sent to the learners, 56 were returned, thus a return rate of 93%, which is also a good response.

## **6.4 CONCLUSIONS**

The HIV/AIDS situation in Mphahle's Hoek, Lesotho and its impact on school going children cannot be over emphasized. Emotional and social handicaps are serious because of learning difficulties; the fact that they are not easy to identify and quite difficult to deal with, exacerbates the situation. There is a need for all those who deal with children to trace the root of the problem, rather than to make assumptions and rush to conclusions about what may be going on with the child. Problem diagnoses should precede the labelling of children. In defining children's problems, it is important to take into account the social milieu, such as the home, friends and peers of the child. For adults to understand and appreciate what children feel and are going through, there is need to put in a great deal of effort, interest and patience.

The findings of this study are reasonable enough for the Department of Education (DoE) to take urgent measures to develop a targeted intervention which provides antiretroviral therapy and treatment of opportunistic infection for HIV-positive educators and learners. The findings also show that both educators and learners need a course on HIV/AIDS. Crowther (1999:20) argues for an approach that integrates HIV/AIDS with all subjects rather than just setting up a separate new course.

In conclusion, the youth must be educated at school regarding HIV/AIDS and carry that knowledge to society at large. The findings clearly show that HIV/AIDS impacts negatively on school enrolments because many staff members and learners are either suffering or dying because of HIV/AIDS.

## **6.5 RECOMMENDATIONS**

This part of the chapter deals with the recommendations that need to be considered in order to prevent the impact of HIV/AIDS on primary and secondary education in Mphahle's Hoek, Lesotho.

According to the data and research available, it has been found that respondents have inadequate knowledge of how to protect themselves against contracting HIV/AIDS. For example, 80% of respondents (teachers) have indicated that learners are not exposed to appropriate knowledge on HIV/AIDS and the dangers of unprotected sex, while 60% of respondents (learners) have said abstinence and the use of condoms does not reduce high risk of HIV infection. In addition, most teachers at their schools do not improve coordination of HIV/AIDS prevention and control, which is the main reason why most learners are not exposed to knowledge on HIV/AIDS.

The following recommendations are made:

- ◆ The Minister of Education in Lesotho should see to it that an officer must be appointed to liaise with the National AIDS control programme to coordinate the implementation of the AIDS control and education programme at school level, especially in Moleleke's Hoek.
- ◆ A post of Education Officer (special projects-HIV/AIDS) should be created in the Department of Curriculum Development and Evaluation, to specifically concentrate on this implementation at Moleleke's Hoek.
- ◆ HIV/AIDS and HIV/AIDS-education should aim at changing existing behaviour, and developing appropriate values and needs as early as possible. To this effect, the Minister of Education has to take a firm stand to integrate and infuse AIDS education into the curriculum at all levels of education.

The infusion must take place in all the subjects, thereby providing reinforcement addressing issues as well as offering every teacher a chance to handle issues of concern. Given appropriate teaching methodologies, the approach will go a long way in influencing values, behaviour and practices that will lead to a reduction in disease incidents.

### **6.5.1 Recommendations for Empirical Research**

There is no doubt that education and social objectives need to be broadened to meet the demands of emerging issues. Since children who are infected or whose parents are infected are already experiencing pain, they would benefit from the presence of compassion and understanding by those around them. If parents and teachers could model human behaviour and attitudes towards the infected and affected, children are less likely to tease or criticise those in the situation. The schools have to address broader issues of wellness and illness so that children are sensitive and aware of the implications of HIV/AIDS. The Minister of Education therefore has to be proactive in combating the problem. A multi-sectoral approach is viewed as the most practical and effective way to benefit government in dealing with the HIV/AIDS situation in Lesotho.

Common agreement is required to include the influence of the pandemic into educational and cross-sectoral planning. The Ministry of Education should deploy the best managers and leaders it can find to counteract the pandemic. Because so much is at stake, it is essential to recruit and appoint, at national and districts levels, dedicated teams on proven, mature section managers on contact, if necessary. The fight against the impact of HIV/AIDS, protecting children, teachers, other educators and the system itself, is a full-time assignment, at least in the short and medium-term, until the situation stabilises. Job descriptions must be completely transparent and clearly defined.

The guidance and counselling programme in schools ought to offer HIV/Aids-education as well as counselling to the affected and infected learners. Teachers should receive HIV/AIDS counselling as a component of their in-service training, (efforts are under way to provide HIV/AIDS education and counselling skills to other teachers). Learners must also receive training in order to play a vital role in education on HIV/AIDS and related problems in the school. Heads of schools must also be sent on HIV/AIDS management courses so that the school system can cope with the scourge. The schools at

Mohale's Hoek, either by themselves or in clusters, have to run school based workshops for their learners, teachers and staff. Where these initiatives exist training has increased the level of awareness and led to the formation of HIV/AIDS clubs for continued awareness creation and education on HIV/AIDS in some of the schools in Mohale's Hoek, Lesotho.

According to Coombe (2000:41), the education system should ensure that it provides more comprehensive, integrated care for young children in distress and those who look after them. AIDS affected children should be admitted to school and continue their education, or be offered alternative basic education programmes. The rights of HIV/AIDS affected children and educators should also be protected. A culture of care in schools in Mohale's Hoek should be nurtured and effective counselling, teaching and guidance of children affected by HIV/AIDS, should be established.

It is again recommended that the school system should ensure that it operates in more flexible (non-formal) ways to promote subsidies for children in distress. School calendars and timetables for AIDS affected children should be adjusted. Single sex schools and boarding hostels, should provide a second chance for those whose schooling has been random. This will avoid creating a double standard system, with special education for poorer children.

For educators who are HIV positive and who are affected by HIV/AIDS, a strong system of support is recommended. It is important to have a physician who understands HIV and AIDS, such as a mental health professional used to working with people with life-threatening diseases or friends who will allow the person who is HIV positive to share his or her fears, joys, experiences and hopes. The more AIDS education becomes available and the more open people are about this disease, the more the world gains in understanding, compassion and acceptance.

HIV prevention has to be seen as the core business of everyone working in the education sector. Greater investment in support and capacity for the skills programme in primary and secondary schools and mainstreaming of



prevention into educational levels are required. Programmes must reach beyond the target audience (the learners) to address risks in the socio-economic environment of learners and their parents which include aspects such as abuse and relationships of learners with older people.

## **6.6 SUGGESTIONS FOR FUTURE RESEARCH**

Schools in Mohale's Hoek will have to fight the spreading of HIV/AIDS among learners and educators and it can only succeed if educators' attitudes towards HIV/AIDS education are positive. Sex education with the emphasis on healthy hetero-sexual relationships should be stressed. Learners should take responsibility for their own sexuality.

Peer counselling is another option that is effective at school level, especially in areas where cultural values and traditional inhibit young people from discussing matters, including HIV and AIDS, with their parents.

Since student teachers from the University of Lesotho are part of the society, they need to be instilled with vital information about HIV/AIDS prevention so that they can be able to teach learners at schools about HIV/AIDS.

## **6.7 SUMMARY**

Chapter 6 presented a summary of the study; the discussions of the study have been presented, and, the conclusions drawn from the research findings have been presented. Finally recommendations for the prevention and control of the impact of HIV/AIDS on education at Mohale's Hoek, Lesotho, have been put forward, and the suggestions for future research are made.

## **BIBLIOGRAPHY**

- ABT Associates 2002. *Impact of HIV/AIDS on the South African Department of Education*, Bloemfontein. Department of Education.
- Allen, A. 1990. *HIV/AIDS Prevention*. Maseru: Ministry of Health Publication.
- Allison, R.T. 1996. page 51 in Litheko S.R.S. 2002a. *An appraisal model for academic staff performance at Technical Colleges in South Africa*. Welkom. Vista University.
- Arnold, E. 1999. *Infection Control*. Great Britain: British Medical Association.
- Ary D. and Jacobs L. 1996. *Introduction to Research in Education*. Harcourt Brace. Britain: College Publication. City: Publishers.
- Baggaley, V. 2000. *Education Sector*. Ministry of Education, Maseru.
- Benett, A., Chilisa, P. & Hyde, R. 2001. *The impact of HIV/AIDS on the university of Botswana: Developing & comprehensive strategic response*. Ministry of Education. Department for International Development.
- Blaxter, J. 1994. *Managing education theory and practice*. Biddle Ltd Guildford.
- Blaxter, J. 1996. *How to research*. Buckingham: Open University Press.
- Bowling A. 1997. *Research methods in health*. London. Open University Press, Great Britain.
- Buckens, V. 2002. *The Impact of HIV/AIDS in Schools*. Morija. Morija publications.
- Burger D. 1999. *Managing HIV/AIDS disaster beyond 2000*. Harcourt Brace: College Publishers.
- Chishold, R. 1999. *HIV and AIDS in Schools*. Maseru. Ministry of Health publications.
- Cohen, D. 2002. *Human Capital and the HIV Epidemic in Sub-Saharan Africa*. Geneva: ILO programme on HIV/AIDS and the World of Work.

- Coll, D. 1996. *Cooperative education research in Vocational Education*. Columbus, OHIO.
- Coombe C. 2001. *Managing the Path of HIV/AIDS on the Education Sector*. Cec/H/ South Africa/Finalecg HIV doc. Pretoria: University of Pretoria.
- Coombe C. 2000. *HIV/AIDS and Trauma among learners' sexual violence and deprivation in South Africa*. Pretoria: University of Pretoria.
- Crowther C.E. 1999. *AIDS, a Christian Hand Book*. Great Britain: Epwork Press.
- Daniel, P. 2000. *Education Management Capacity is very fragile in Lesotho*. Maseru, Lesotho: Ministry of Education Publications.
- Daniel, M. 2003. *HIV/AIDS affect women with households responsibilities and economically active people*. Maseru. Ministry of Health publications.
- Davis, A. 1995. *The role of the Government of HIV/AIDS prevention*. Marija: Marija Publications.
- Department of Education. 2000. *Annual Report HIV/AIDS. Strategic plan for South Africa: 2000-2005*. Bloemfontein.
- Department of Health, 2001. *The Impact of HIV/AIDS in Lesotho*. Maseru. Ministry of Health publications.
- Dilly, J. & Helquist, M. 1998. *Face to Face. A guide to AIDS counseling*. Maseru: University of Lesotho. Ministry of Health and Social Welfare Publishers.
- Drum. September 2002. *Loving Safely*. Western Cape: Vamp Mega Print, Old Mutual.
- Evans, N. 1992. *Experiential Learning*. London: Rout Ledge.

- Frederick, S. 1997. *HIV and AIDS prevention in Lesotho*. Maseru. Ministry of Education publications.
- Fuller, C. 1992, *National Department of education report*. Bloemfontein. Department of Education publishers.
- Gillman, P. 2000. *Research Methods*. Britain. Harcourt Brace. U.S.A. publishers.
- Graphic Section. 2001. *S.T.D Prevention and Control Programme*, Lesotho, Maseru: Metropolitan life Group Publication.
- Gwai, B. 2005. *An investigation on the Integration of HIV and AIDS Education in the University of Botswana Curriculum*.
- Health Education Division, 2000. *Prevent AIDS*. Maseru, Lesotho: Ministry of Health.
- Hein Marais. 2000. *To the edge AIDS review*. Pretoria: University of Pretoria Publications.
- Henning, R. 1999. *The new disease called AIDS*. Morija. Morija Publishers.
- H.S.R.C. 1997. page 31. In Litheko S.R.S. 2002a. *An appraisal model for Academic Staff performance at Technical Colleges in South Africa*. Welkom. Vista University.
- Kelly, R.B. 2000. *Abused AIDS kids 2000*. Turffontein: Epwork Press.
- Kimaryo, S. 2003. *Living with AIDS*. Chicago. University of Chicago press.
- Kimaryo, S. 2003. *AIDS Orphans in Lesotho*. Maseru. Ministry of Education publications.
- Kirby, D. 1995. *Sexual and HIV/AIDS education in schools*. British medical journal, London No. 311, p.403.
- Le Clerc, Madel. 2001. *Living with AIDS*. Chicago: University of Chicago.
- Lesotho Network of AIDS. 2002. *Community Home Based Care Reference Manual*. Maseru, Lesotho: Ministry of Health and Social Welfare publication.
- Lewis, M. 2003. *Do not stigmatize HIV/AIDS patients*. HIV/AIDS Bulletin No 1. Maseru: HIV/AIDS Control Department Publications.

- Litheko, S.R.S. 2002a. *Research Methods and Techniques*. Bloemfontein: Central University of Technology.
- Loewenson, P. & Whiteside, M. 1887. *HIV/AIDS epidemic takes toll on young women*. Maseru. Ministry of Health publications.
- Mabote, M. 1999. *The Psychosocial Impact of HIV/AIDS on school going children*. Maseru: Ministry of Education Publications.
- Mahler, H. 1987. *WHO Special Programme on AIDS*. Geneva. Progress Report No. 1.
- McMillen J.H. & Schumaker. 1997. *Research Methods in Education*. In Litheko S.R.S. 2002a: *An appraisal model for Academic Staff Performance at Technical Colleges in South Africa*. Welkom: Vista University.
- Metropolitan Life Group. 2002. *HIV prevention and Control*. Maseru, Lesotho: Metropolitan Life Publications.
- Ministry of Education. 2000. *Transmission of HIV/AIDS*. Maseru. Printing department.
- Ministry of Health, 2002. *HIV/AIDS sentinel surveillance surveys*. Bloemfontein.
- Ministry of Health & Social Welfare. 2004. *A three year rolling plan for the National Response to the HIV/AIDS epidemic in Lesotho*. Maseru: Ministry of Health Publications.
- Ministry of State President, 2003. *Second generation HIV/AIDS surveillance*. Botswana.
- Moe, A.M. 2000. *S.T.D./HIV/AIDS Prevention and Control programme*. . Maseru: Ministry of Health Publications.
- Monsen, E.R. 1992. *Research Successful Approaches*. Mexico: The American Dietetic Association.
- Motshwari, M. 1999. *The Impact of HIV/AIDS on Education*. Morija: Ministry of Education Publications.
- National Development Plan. 1998. *Community home based care reference Manual*. Maseru: Ministry of Health Publications.
- Paulins E. 2001, *HIV/AIDS manual for facilitators and trainers*. Lusaka: Catholic Publications.

- Piot, T. 2001. *AIDS pandemic*. Roma. University of Lesotho publications.
- Planned Parenthood Association. 2002. *Loving safely*. Western Cape. Vamp Mega Print.
- Robins, R. *Educational Research in Lesotho*. Maseru. Ministry of Education publications.
- Rosnow, R.L. 1996. *Beginning behavioural research*. 2<sup>nd</sup> Ed. New-Jersey: Prentice-Hall Inc.
- Saleledi, D.K. 1996. *Teachers' sense of Efficiency in Schools in the major urban centers of the Free State*. In Litheko S.R.S. 2002a. Thesis PhD. P.93. Welkom. Vista University.
- Schoteich, M. 2000. *Age and AIDS*. South Africa: South African's crime Vol. 8, No 4.
- Soul City. 2001. *Support HIV/AIDS education in Lesotho*. Morija: Morija Publications.
- Stanley, P. 2001. *The diseased heart of the world*. Bekely: University of California Press.
- Staton, D.L. & Way, M. 2003. *Infusing HIV/AIDS issues into baccuralaureate curriculum: Faculty participation*. Linois U.S.A. State University.
- The Community Home Based Care Reference Manual, 2002. *HIV and AIDS*. Ministry of Health and Social Welfare. Lesotho. In Collaboration with World Health Organization.
- The Department of Public information and the United Nations. 1992. *Impact of HIV/AIDS on Education Sector*. Maseru: Ministry of Education Publications.
- The National AIDS Strategic Plan. 2002. *S.T.D.'s and HIV/AIDS*. Maseru. Ministry of Health publications.
- The South African National Council. 2000. *AIDS - The Family disease*. Bloemfontein: Sanlam.
- The United Nation Development Plan. 1998. *Community Home Based Care reference*

*Manual Lesotho July 1998.* Maseru, Lesotho: Ministry of Health and Social Welfare Publication.

Thomas, M. & Thabo, P. 2005. *HIV/AIDS Getting down to business.* Maseru. Metropolitan life group.

Tshepo, N. 2001. *HIV/AIDS Prevention in schools.* Maseru, Lesotho: Ministry of Health Publications.

UNAIDS, Report on Global epidemic. 2000. (<http://www.unaids.org>)

UNICEF. 1999. *Training Component, School AIDS Action Programme, Documentation of experiences District Workshops.* Harare, UNICEF.

Update 2001. *AIDS epidemic.* Geneva. GPA publications.

Van der Westhuizen, V. 2002. *Impact of HIV/AIDS on school enrolment.* Technicon Free State Interim – Inter disciplinary Journal, Year 1.

World Bank. 2002. *The Impact of HIV/AIDS on the education sector costs.* World Bank report.

World Health Organization. 2001. *Global programme on AIDS.* (WHO/GPA): GPA publishers. New HIV/AIDS Data. Geneva.

## **APPENDIX A**

Questionnaires to the Educators



## IMPACT OF HIV/AIDS ON EDUCATION: A survey of Teachers opinion

This questionnaire is for all educators employed at primary and secondary schools in Lesotho. Please make a cross in the appropriate box, which reflects your opinion of each of the items in this questionnaire. All responses are confidential. Be sure to respond to all items. Try to respond to each item independently.

### CONFIDENTIAL

#### SECTION A : DEMOGRAPHIC VARIABLES

Thank you for participating in this study. Your responses are confidential and will be shown neither to others nor identified by your name or school. Below find questions enquiring about your personal information. This information is important for the processing of data.

##### A. BIOGRAPHICAL INFORMATION:

- |    |                                   |                          |             |                          |
|----|-----------------------------------|--------------------------|-------------|--------------------------|
| 1. | Age: Above 30                     | <input type="checkbox"/> | Below 30    | <input type="checkbox"/> |
| 2. | Gender: Male                      | <input type="checkbox"/> | Female      | <input type="checkbox"/> |
| 3. | Years of experience as a teacher: |                          | 0-3 years   | <input type="checkbox"/> |
|    |                                   |                          | 4-10 years  | <input type="checkbox"/> |
|    |                                   |                          | 11-20 years | <input type="checkbox"/> |
|    |                                   |                          | 20-above    | <input type="checkbox"/> |

##### B. TRAINING / EDUCATION

- |    |  |                       |                          |
|----|--|-----------------------|--------------------------|
| 1. | Please indicate your highest level of Education (make a "x" on the appropriate box): | Doctorate             | <input type="checkbox"/> |
|    |  | Masters or its equiv. | <input type="checkbox"/> |
|    |  | B. Hons. Etc.         | <input type="checkbox"/> |
|    |  | BA, BSc, Bcom, etc    | <input type="checkbox"/> |
|    |  | Others (Specify)      | <input type="checkbox"/> |

2. Is HIV/AIDS prevention and control system in place at your School? Yes / No

3. If "Yes" above, who is in charge?

Principal

or

Teachers

### SECTION B: ATTITUDE TO THE IMPACT OF HIV/AIDS

C. Please make a cross (x) in the appropriate box, which reflects your opinion of each of the following statements:

|     | STATEMENTS  | Yes | Not sure | No |
|-----|---|-----|----------|----|
| 1.  | Does HIV/AIDS leads to loss of childhood?   |     |          |    |
| 2.  | Does HIV/AIDS leads to drop-out at school?  |     |          |    |
| 3.  | Are affected children go through a lot of stress and depression?                              |     |          |    |
| 4.  | Do you know of any learners who left school because of HIV/AIDS?                              |     |          |    |
| 5.  | Should children with HIV/AIDS be regarded under special education?                            |     |          |    |
| 6.  | Do you know any learners infected with HIV/AIDS?  |     |          |    |
| 7.  | Are learners exposed to appropriate information on HIV/AIDS or the danger of unprotected sex? |     |          |    |
| 8.  | Does HIV/AIDS affect school enrolments?   |     |          |    |
| 9.  | Do You encourage parents to talk about sex issues to their children?                          |     |          |    |
| 10. | Do you know any of your colleague infected with HIV/AIDS?                                     |     |          |    |
| 11. | Are affected children ostracized by their peers?  |     |          |    |
| 12. | Do they display signs of low self-esteem?   |     |          |    |
| 13. | Does HIV/AIDS increases the number of orphans and increase incidence of child labour?         |     |          |    |
| 14. | Do HIV/AIDS orphans eventually resort to be street children?                                  |     |          |    |
| 15. | Does HIV/AIDS provoke feelings of embarrassment and shame?                                    |     |          |    |
| 16. | Do HIV/AIDS orphans become aggressive, sullen or revert to drugs?                             |     |          |    |

17. What do you think is the biggest impact of HIV/AIDS ON Education and Schooling in Lesotho: please elaborate:

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**Thank you for participating in this survey !!!**

APPENDIX 3

## **APPENDIX B**

Questionnaires to the learners

## IMPACT OF HIV/AIDS ON EDUCATION: A survey of learners' opinions

This questionnaire is for all learners at primary and secondary schools in Lesotho. Please make a cross in the appropriate box, which reflects your opinion on each of the items in this questionnaire. All responses are confidential. Be sure to respond to all items. Try to respond to each item independently.

### CONFIDENTIAL

#### SECTION A: DEMOGRAPHIC VARIABLES

Thank you for participating in this study. Your responses are confidential and will be shown neither to others nor identified by your name or school. Below find questions enquiring about your personal information. This information is important for the processing of data.

##### A. BIOGRAPHICAL INFORMATION:

1. Age: Above 12  Below 12
2. Gender: Male  Female

#### SECTION B: ATTITUDE TO THE IMPACT OF HIV/AIDS

- B. Please make a cross (x) in the appropriate box, which reflects your opinion on each of the following statements:

|    | STATEMENTS  | Yes | Not sure | No |
|----|---|-----|----------|----|
| 1. | Does the number of learners decrease because some of them suffer from HIV/AIDS? |     |          |    |
| 2. | Does the number of educators decrease because of HIV/AIDS?                      |     |          |    |
| 3. | Are HIV/AIDS orphans able to continue with schooling?                           |     |          |    |
| 4. | Are they able to pay school fees?   |     |          |    |
| 5. | Do you think HIV/AIDS orphans resort to being street children?                  |     |          |    |
| 6. | Do HIV/AIDS orphans become aggressive, sullen or                                |     |          |    |

|     |  |  |  |  |
|-----|--|--|--|--|
|     | revert to drugs?   |  |  |  |
| 7.  | Do you know of any learner who has left school because of HIV/AIDS?    |  |  |  |
| 8.  | Are affected and infected children criticized by their peers?          |  |  |  |
| 9.  | Do affected learners show signs of low self-esteem?                    |  |  |  |
| 10. | Does HIV/AIDS provoke feelings of embarrassment and shame?             |  |  |  |
| 11. | Do affected young girls tend to sell sex to pay for their school fees? |  |  |  |
| 12. | Are affected children going through a lot of stress and depression?    |  |  |  |
| 13. | Do you talk about sex issues with your parents?                        |  |  |  |
| 14. | Do you ever have sex without condoms?                                  |  |  |  |
| 15. | Do condoms reduce the high risk of HIV infection?                      |  |  |  |
| 16. | Do you abstain from sex?   |  |  |  |
| 17. | Is there any cure for HIV/AIDS?  |  |  |  |
| 18. | Does HIV/AIDS kill only young people?                                  |  |  |  |
| 19. | Do affected children lose their childhood?                             |  |  |  |
| 20. | Are teenagers sexually active?   |  |  |  |

**Thank you for participating in this survey !!!**



## **APPENDIX C**

Questionnaires to the Heads of Department and Principals



## QUESTIONS ASKED TO THE HEADS OF DEPARTMENTS AND PRINCIPALS

### Impact on HIV/AIDS on Education

The survey is for all Mohale's Hoek High School educators. Please, be sure to respond to all items and try to respond to each item independently. All responses are confidential. Please answer honestly.

1. Gender:

2. Age: To which age group do you belong:

- a) Below 30
- b) 31 - 40
- c) 41 - 50
- d) Above 50

|  |
|--|
|  |
|  |
|  |
|  |

3. Teaching Qualifications: Tick the appropriate level ("x")

- a) Certificate
- b) Diploma
- c) Degree
- d) Masters
- e) Doctorate

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|  |

4. Which subject did you train as an educator?

- a) English language & Sesotho
- b) Mathematics & Science
- c) Religious Knowledge
- d) Business education
- e) Agriculture
- f) Technical subjects

|  |
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|  |

5. Does the Impact of HIV/AIDS affect learners and educators at your school?

- Yes
- No

|  |
|--|
|  |
|  |

6. How many children does this disease affect?  
Many   
Few   
Very few   
None

7. Are affected children able to continue schooling?  
Yes   
No

8. Can the school system respond effectively to the need of children with HIV/AIDS?  
Yes   
No

9. Does the fact that other members of staff may perhaps suffer from HIV/AIDS have an effect on your duties at school?  
Yes   
No

10. Please explain briefly how the prevalence of HIV/AIDS among your colleagues impacts on your duties at school?

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11. Does the fact that other members of staff may perhaps suffer from HIV/AIDS have an effect on the quality of education provided?  
Yes   
No

If YES, please explain briefly

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12. Does the fact that learners may perhaps suffer from HIV/AIDS have an effect on your ability to teach?

Yes

No

|  |
|--|
|  |
|  |

If YES, please explain briefly:

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13. Do you provide care and support to orphans and vulnerable children in your school community?

Yes

No

|  |
|--|
|  |
|  |

If YES, please explain how you provide care and support:

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14. Do you receive any support (e.g. financial, emotional) in taking care of orphans and vulnerable children?

Yes

No

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|--|
|  |
|  |

If YES, please provide brief information on the sources and type of support that you receive:

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## **APPENDIX D**

Letter to the respondents



Central University of  
Technology, Free State

CENTRAL UNIVERSITY OF TECHNOLOGY, FREE STATE  
SENTRALE UNIVERSITEIT VIR TEGNOLOGIE, VRYSTAAT  
YUNIVESITHI E BOHARENG YA THEKENOLOJI, FOREISTATA

**FACULTY OF MANAGEMENT SCIENCES**  
School of Teacher Education

2004-05-10

Dear Participant

This questionnaire is about the impact of HIV/AIDS on education in Mohale's Hoek, Lesotho. The information you provide will help the researcher understand the attitude of both teachers and learners towards the impact of HIV/AIDS. Since you are the one who can give a correct picture on the impact of HIV/AIDS on education, I request the respondents to respond to the questions honestly.

The respondents' responses will be kept strictly confidential.

Thank you for your time and co-operation. The researcher greatly appreciates the help in furthering this research.

-----  
**M. MOPELI**  
(M.Tech student)

**DR SRS LITHEKO**  
**DIRECTOR: SCHOOL OF TEACHER EDUCATION**  
/pp