# SCHOOL LEADERSHIP AND TEACHERS WITH HIV/AIDS: STIGMA AND DISCRIMINATION IN GAUTENG PROVINCE SCHOOLS

by

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DECLARATION

I, Zvisinei Moyo, declare that

SCHOOL LEADERSHIP AND TEACHERS WITH HIV/AIDS: STIGMA AND DISCRIMINATION IN GAUTENG PROVINCE SCHOOLS

is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references

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MOYO ZVISINEI DATE

Dedicated to my children, Alex Kudzai and Nyasha,
my mother, Odence Enester
and my late father, Musara

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*

* Teacher 2 has since passed on; may his soul rest in eternal peace.

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# ABSTRACT

Since the discovery of HIV/AIDS in the late 1980s, the pandemic has become the leading cause of death in South Africa and one of the leading causes worldwide. South Africa has the largest number of people infected with HIV/AIDS in the world. South African teachers, in particular, have experienced unparalleled challenges as a result of HIV/AIDS.

This qualitative research study was designed to explore how principals handle the sensitive HIV/AIDS-related issues affecting teachers in schools in South Africa's Gauteng Province. The study was carried out within the constructivist paradigm. The narrative inquiry research design within the qualitative research approach was used with purposive and network sampling of participants. The sample consisted of ten handpicked principals and eight teachers living with HIV/AIDS accessed through network sampling from around the province. Data were collected through narrative interviews and the compilation of a reflective diary. The data were analysed according to the qualitative content analysis method. Consent was elicited from participants with confidentiality, anonymity and trust maintained throughout the study.

The participants' most common responses were that teachers living with HIV/AIDS are faced with the dilemma of disclosure and stigma and discrimination. This research showed that principals are experiencing a range of challenges due to teachers living with HIV/AIDS. The goals of quality education are often defeated because of the challenges surrounding teachers living with HIV/AIDS. Once teachers succumb to the opportunistic illnesses associated with HIV/AIDS, their productivity deteriorates. Principals were clear about the inadequacy that they experience in responding to HIV/AIDS-related issues amongst teachers. They lack the training and management skills to develop long-term strategies to mitigate the impact of HIV/AIDS on teaching and learning. Teacher absenteeism is rife, causing drastically detrimental effects to teaching and learning programmes and posing serious challenges to principals, who are not equipped with the required information and resources. It was evident in this research study that infected teachers often fail to

take responsibility or disclose their status; instead, they look to principals for solutions to their HIV/AIDS-related problems.

Key terms: HIV, AIDS, Antiretroviral Therapy (ARV), Leadership, Transformational Leadership

# CHAPTER ONE

## Introduction, Background and Purpose of the Study

### 1.1 Introduction to the Study

This study seeks to explore how principals in South Africa's Gauteng Province are handling the sensitive issues relating to HIV/AIDS amongst their teachers. The purpose of this study is to explore the experiences of a sample of principals in handling sensitive issues related to HIV/AIDS amongst teachers. Furthermore, a sample of teachers living with HIV/AIDS was selected to explore their experiences of living with HIV/AIDS and how this is dealt with by school leadership. It was anticipated that this study would generate knowledge that would contribute to existing research and literature on the topic, providing insights for improving relevant policies. This study utilised the qualitative research design and methodology in order to understand the phenomenon under investigation. The participants of this study included 10 principals, who were purposefully selected, and eight teachers living with HIV/AIDS, who were selected through the networking sampling method.

The framework of this study is given in this chapter, which includes an outline of background and context. Immediately after the background and context has been explored, the theoretical framework, the literature study, the problem statement, the purpose of the study, the problem statement and sub-questions are unpacked. Furthermore, this chapter includes the aims and objectives of the study as well as an overview of the research design and methodology. At the end of this chapter, some definitions of key concepts are offered and the chapter divisions are given. The background of the study follows next.

### 1.2 Background of the Study

Since the discovery of HIV/AIDS in the late 1980s, the pandemic has caused the largest number of deaths in South Africa (Sinelela, Venter, Pillay & Barron, 2015: 1).

South Africa has the largest number of people infected with HIV/AIDS in the world and Statistics South Africa (2014: 7) estimates prevalence at 10.2% of the total South African population. It is in this context that Sinelela, Venter, Pillay and Baron (2015: 2) postulate that:

> South Africa is home to the largest concentration of people living with HIV anywhere in the world; of all the HIV-positive people in the world, nearly one fifth live in South Africa.

Nevertheless, South Africa has the largest programme to treat people living with HIV/AIDS. Moreover, Statistics South Africa (2014: 7) highlights a sharp rise in HIV/AIDS prevalence from 4.09 million in 2002 to 5.51million in 2014. This is not good news, considering the urgency of bringing down the rate of infection. However, as South Africa approaches the fourth decade of the HIV/AIDS pandemic, Doyal and Doyal (2013: 1) observe that much progress has been documented in the education of people about HIV/AIDS. However, with regard to HIV/AIDS prevalence, South Africa is not an exception amongst the list of countries, such as Botswana, Lesotho, Swaziland, Zimbabwe, Mozambique and Zambia, feeling the full impact of HIV/AIDS (Campion, 2015: 301).

Equally important, the advent of antiretroviral treatment has lengthened the lives of people living with HIV/AIDS (Squire, 2013: ix). There is a dire need to contain the spread of HIV/AIDS and managing it. Those of working age, and teachers in particular, are amongst the worst affected groups (Campion, 2015: 301). Therefore, the effects of HIV/AIDS on education cannot be underestimated.

This research took place in the Gauteng Province, which has the greatest population density in South Africa (Statistics South Africa, 2014: 3). The supply and demand of teachers has been affected by the pandemic. The HIV/AIDS prevalence rate amongst teachers is similar to that amongst people in the public (United Nations Programme on HIV/AIDS, 2012: 86). The impact of HIV/AIDS on education is huge.

In Gauteng, teachers are affected in much larger numbers, presumably because the province is home to the greatest portion of the population. The illnesses related to

HIV/AIDS cause consistent absenteeism amongst teachers living with HIV/AIDS (Bialobrzeska, Marneweck, Mhlanga & Mphisa, 2010: 1).

To this end, HIV/AIDS amongst teachers has presented unprecedented challenges to school leadership (Heidi and Fourie, 2015: 4). Most would agree that principals carry the mandate to ensure effective teaching and learning in their schools. For example, Bialobrzeska, Marneweck, Mhlanga and Mphisa. (2010: 1) observe that school leadership in South African schools has become increasingly complex amid the HIV/AIDS pandemic. Within this context, the role of the principal is indispensable and lies at the core of the education system. School principals are obliged to embrace the challenges of HIV/AIDS and treat them with the same dedication and responsibility as other areas of their duties. Principals are expected to support their teachers. Hence, poor organisational effectiveness and poor teacher commitment are the results of the absence of care, as asserted by Van der Vyver, Van der Westhuizen, and Meyer (2013: 63). If teachers fail to get care, they might be discouraged from caring for the learners. Research in the field of educational leadership has concluded that school leadership contributes significantly to school effectiveness and learner achievement (Louis, Leithwood, Wahlstrom & Anderson, 2010: 11). Therefore, principals need to be informed about HIV/AIDS and understand how it affects not only teachers but also learners. They need to understand their influential positions in relation to handling the sensitive issues around HIV/AIDS amongst their teachers. They need to understand the effects of the stigmatisation of and discrimination against HIV/AIDS-infected teachers.

Basic counselling skills are also beneficial. When principals respond to the challenges of teachers living with HIV/AIDS, they only address them as part of their mandate. Principals fulfil their natural caring role, referred to by Noddings (2002: 43) as a moral attitude.

Schools are regarded as key players in the reduction of the effects of HIV/AIDS (Buchel, 2006: 3). Hence, extensive research has been done on how education can be used to curb the spread of HIV/AIDS and, most importantly, intensify educational campaigns regarding the pandemic (Aggleton, Yankah & Crewe, 2011: 498). In the process, infected teachers are regarded as sources of knowledge (Bialobrzeska,

Marneweck, Mhlanga & Mphisa, 2010: 1). Like people living with HIV/AIDS in other walks of life, these teachers are faced with numerous challenges, including, among others, stigmatisation and discrimination, as well as the ever-present fear of death (Heidi and Fourie, 2015: 3). As argued by Van der Vyver, Van der Westhuizen, and Meyer (2013: 63), the caring role of principals in school management requires the creation of an empowering and supportive environment in which teachers can flourish. In consideration of the continuous spread of HIV/AIDS as well as its near-insurmountable effects, this research study seeks to provide insight into how principals are handling the sensitive issues of HIV/AIDS amongst their teachers.

## 1.3 Theoretical Framework

This research is underpinned by transformational leadership and ethics of care. Sonnenfeld (1995: 70) observes that the transformational leadership approach was first proposed by Burns (1978) and then elaborated upon by Bass (1985). According to Burns (1978: 101):

> A transformational leader is one who motivates followers to work for transcendental goals and for higher-level self-actualising needs, instead of working through simple exchange relationships with his/ her followers.

In order to achieve goals, transformational leaders must be charismatic enough to inspire others; they must meet their subordinates' individual emotional needs and/ or stimulate them intellectually (Bass, 1991: 21). The transformational leadership approach is known for its normative approach, which capitalises on a series of methods that leaders can implement to inspire followers (Bass, 1991: 21). In this context, Holly, Igwe and Kamienski (2010: 134) assert that transformational leadership is inclusive and considers staff members as able to contribute to the success of the organisation. Furthermore, transformational leadership is based on a leader's ability to communicate a shared vision to motivate followers to engage in behaviour that will help the organisation to achieve that vision (Schaubroek, Cha & Lam, 2007: 110).

The transformational leadership approach has been deemed relevant for this research study because of its dimensions, namely charisma/ inspiration/ vision, developing goal consensus, offering individual support, providing intellectual

stimulation, modelling best practices and important organisational values, demonstrating high performance expectations, creating a productive school culture, and developing structures to foster participation in school decision. Therefore, the qualities of this approach make it more ideally suited to the emerging paradigm in which principals not only fulfil their traditional roles only but also immerse themselves in sensitive HIV/AIDS-related issues: By the same token, Koggel and Orme (2010: 10) describe the ethics of care as a normative ethical theory that is about what makes actions right or wrong. Ethics of care, as propounded by Noddings (1984: 5), holds that caring should be rooted in receptivity, relatedness and responsiveness (Kordi, Samaneh & Reza, 2012: 146). In addition, ethics of care focuses attention on caring as an appropriate way to relate to people and how people help others (Noddings, 1984: 5). According to Noddings (2009: 9), caring relations are basic to human existence and consciousness and caring relationships consist of two parties – the one doing the caring and one who is cared for.

In elaboration, Slote (2009: 212) highlights that the ethics of care:

> Takes into account how certain communities and people are more vulnerable than others and that the non-vulnerable population should afford extra consideration to the vulnerable communities.

Principals can apply transformational leadership and the ethics of care to establish an on-going relationship with teachers and attend to their individual needs. It is against this background that transformational leadership and ethics of care have been chosen in this study to explore how principals are handling the sensitive issues of HIV/AIDS amongst their teachers.

## 1.4 Literature Study

A literature study was conducted to gain theoretical insights into the research phenomenon in question and substantiate the rationale of the study (Randolph, 2009: 2). Researchers cannot carry out significant research without a substantial understanding of the existing literature in the field. The purpose of reviewing literature was to establish the context of this study, identify what has been researched and what still needed to be researched, as well as to gain enough

knowledge to be able to make recommendations for further research (Hart, 1998: 27). The review of related literature provided the background, methodology, information regarding previous findings, and, to a large extent, considerable evidence supporting the relevance of this study (Hart, 1998: 27). Books, journal articles, theses, dissertations, conference proceedings, reports and other documents were useful sources of information.

## 1.5 Purpose

The purpose of this study is to explore the experiences of eight teachers living with HIV/AIDS and the perceptions of ten principals of HIV/AIDS in schools. It is anticipated that, through an enhanced understanding of the perceptions and needs of principals and teachers, more informed decisions and policies can be made by principals, teachers, the Department of Education and the South African government. Furthermore, issues and challenges faced by principals as well as the expectations and the challenges of teachers living with HIV/AIDS amid stigmatisation and discrimination are discussed.

## 1.6 Problem Statement and Research Questions

Research shows that teachers are not the only group suffering the negative effects of the ever-escalating prevalence of HIV/AIDS. The mainstream population is also enduring the effects of HIV/AIDS. Principals, as leaders, have to deal with the sensitive issues of HIV/AIDS amongst their teachers. Given the critical role of principals, one can assume that research into how they handle such issues is needed. Literature shows that this area has not received adequate attention. It is for this reason that this study seeks to explore how principals manage HIV/AIDS-related issues under increasingly difficult circumstances in Gauteng schools. Given this problem statement, I pose the following research question:

How do principals understand and respond to their leadership roles in the handling of sensitive issues arising from HIV/AIDS amongst teachers in schools in the Gauteng Province, given their expectations?

## 1.7 Sub-Questions

1. What are the school leadership challenges that principals face in the context of teachers living with HIV/AIDS?
2. How are leaders expected to provide solutions to the problems of handling HIV/AIDS-related issues amongst teachers and how do principals facilitate the process?
3. How do principals perceive their role in handling the challenges posed by HIV/AIDS and what do they think can be done to practically and functionally deal with HIV/AIDS-related issues?
4. What are the challenges faced by teachers living with HIV/AIDS?

## 1.8 Aims and Objectives of the Study

The purpose of this inquiry is to explore how principals are handling the sensitive issues surrounding HIV/AIDS amongst teachers living with HIV/AIDS in schools in the Gauteng province. The specific objectives of this inquiry are as follows:

1. Unveil the school leadership challenges faced by principals in relation to teachers living with HIV/AIDS.
2. Explore the perceptions of principals about problems associated with HIV/AIDS amongst teachers and describe how principals facilitate this process.
3. Understand the perceptions of principals in handling the challenges posed by HIV/AIDS and what they think can be done practically and functionally to deal with HIV/AIDS-related issues.
4. Explain the challenges faced by teachers living with HIV/AIDS.

## 1.9 Population and Sampling

This study obtained data from a purposefully selected sample of principals using networking sampling, and a purposive sample of teachers living with HIV/AIDS. Cohen, Manion and Morrison (2012: 156) emphasise that, in purposeful sampling, researchers carefully choose participants based on whether or not they possess the unique characteristics requisite to yield empirical data in response to the relevant research question/s. Accordingly, in this study, participants were chosen because they were “critical cases” akin to “critical events”. As Creswell (2012: 206) asserts:

> In qualitative data collection, purposeful sampling is used by researchers to intentionally select individuals because they have experienced the central phenomenon.

Creswell (2012: 205) furthermore explains that the primary basis for the selection of participants and sites is the degree to which they are “information rich”. In this instance, the selection of participants was done to maximise what could be learnt during the research study period (McMillan and Schumacher, 2010: 138).

## 1.10 Research Design

This research utilised narrative inquiry as a qualitative research design. Qualitative research attempts to collect rich descriptive data in respect of a particular phenomenon or context, with the intention of developing an understanding of what is being observed or studied. Attention, therefore, is directed at the way in which individual people and groups regard and extract meaning from their world and how they interpret the meaning of their experiences (Bryman, 2012: 690). Through narrative inquiry, an understanding of and knowledge about how principals manage the sensitive issues surrounding HIV/AIDS amongst their teaching staff was obtained. This is in line with an explanation by Huber, Caine, Huber and Steeves (2013: 220), who contend that “narrative inquiry is increasingly written about as not only a research methodology but as a relationship”.

Huber, Caine, Huber, and Steeves (2013: 220) refer to Griffiths and MacLeod (2007: 274), who accentuate that narrative inquiry “provides a hearing for the stories of

people on the margins, whose experience is generally not heard". A narrative inquiry opens the possibility of giving a voice to the powerless and voiceless, like children or marginalised groups (Caine, Estefan & Clandinin, 2013: 582). Likewise, Briggs, Coleman and Morrison (2012: 224) reinforce that narrative inquiry is particularly suitable for studies that explore perceived and subjective experiences.

## 1.11 Data Collection

With the approval of the Research Ethics Clearance of the University of South Africa, I studied the perceptions and experiences of 10 principals and eight teachers living with HIV/AIDS. Data collection was done via semi-structured narrative interviews designed to gather information-rich stories.

These interviews seldom spanned long time periods and usually required the participants to answer only a few questions (Rubin and Rubin, 2012: 3). The interviews were distributed over a scheduled timeframe and they were done more than once. I explored the participants' views, ideas, beliefs and attitudes about the handling of sensitive issues regarding HIV/AIDS. Tracy (2013: 132) stresses that:

> The aim of qualitative interviews is to see the world through the eyes of the participant, and they can be a valuable source of information, provided they are used correctly.

To support the findings drawn from the narrative interviews, I compiled a reflexive journal.

## 1.12 Data Analysis

This study utilised the qualitative content method of data analysis, which was first developed by Labov and Waletzky in 1967 and later turned into a narrative to interpret human action by a number of scholars, including Bruner (1986) and Cronon (1992) (Huberman and Miles, 2002: 217). Each of these narrative interviews with teachers living with HIV/AIDS and their principals was transcribed verbatim. Individual narratives were created and then collective stories were written, based on these individual narratives. During the process, I familiarised myself with the data,

including interview transcripts, and began to form a clearer understanding of the information by compiling narratives for each participant. As I read the data repeatedly, I aimed to discover underlying meanings. I coded the data using open coding and, thereafter, conducted qualitative content analysis by looking for specific words for which themes could be identified (Riessman, 2002: 246). Themes were identified separately for the teachers' and principals' collective narratives. Thereafter, common themes were developed for the combined narratives. Data were grouped according to the main themes and sub-themes. The data were discussed according to the themes and, subsequently, findings and conclusions were drawn.

## 1.13 Methodological Considerations regarding Trustworthiness of the Inquiry

In order to achieve rigour and quality in this study, Tracy's (2010: 835-848) model on criteria for excellent qualitative research was utilised. This model requires: a worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, and ethical and meaningful coherence. I engaged more than one method of data collection; that is, interviews and a reflective journal, which Merriam (2009: 201) acknowledges as a generally accepted guarantor of quality work. Effort was made to verify data soon after soliciting it from participants. I kept a journal of all decisions during the research process; especially as far as data collection and analysis was concerned.

To enhance credibility, other participants and other people were allowed to comment on the study. Findings were verified and validated through consultation with participants, who were given the opportunity to comment on the inquiry. A reflection on each activity was carefully done to avoid bias. Another measure was to prolong engagement in the field by repeating interviews, as suggested by Lincoln and Guba (1985: 219).

## 1.14 Definition of Key Terms

### 1.14.1 HIV

According to Van Dyk (2012: 496), it is the human immunodeficiency virus (HIV) that causes AIDS. This virus weakens the immune system of the body, thereby making the sufferer more vulnerable to potentially life-threatening diseases.

### 1.14.2 AIDS

AIDS is the acronym for Acquired Immunodeficiency Syndrome, a name which emphasises that the disease is acquired and not inherited. It is caused by a virus that invades the body and attacks the immune system and makes it so weak and ineffectual that it is unable to protect the body from both serious and common infections and pathogens (Van Dyk, 2012: 492).

### 1.14.3 Antiretroviral Therapy (ARV)

These are drugs that suppress or prevent the replication of HIV in blood cells (Van Dyk, 2012: 493).

### 1.14.4 Leadership

According to Bush, Bell and Middlewood (2010: 4), leadership is the process by which one person has an effect on other people's willingness and enthusiasm to be directed and influenced to achieve defined group or organisational goals. In this study, leadership refers to the process whereby the principal influences the teachers and learners to achieve set goals.

### 1.14.5 Transformational Leadership

Transformational leadership is an approach that motivates people to redefine their mission and vision, reiterate their commitment, and reorganise their methods for

successfully achieving their aims and goals. A relationship is developed such that the leaders and the followers are mutually stimulated and followers are elevated and changed into leaders and leaders converted into moral agents (Leithwood and Jantzi, 2006: 202). Transformational leadership has been selected in this research study because it is grounded in moral foundations, democracy and the ability to transform a rapidly changing environment.

## 1.15 Chapter Divisions

Chapter 1: Introduction
The outline of the study, including the introduction, research problem and research questions, aim and objectives, theoretical framework, literature study, brief overview of the research design and methodology, and definition of terms.

Chapter 2: Literature review and conceptual framework
A review of related literature and the theoretical framework with regard to school leadership and HIV/AIDS.

Chapter 3: Research methodology
An in-depth description of the research process, including the research design and methodology explained in detail with regard to how it was followed in the research study.

Chapter 4: Research results
Data presentation, analysis and description.

Chapter 5: Data interpretation and discussion
Discussion of data with reference to literature reviewed as well as other new theories.

Chapter 6: Conclusions

Summary of findings emanating from the revelations yielded by answers to the research questions; discussion and recommendations for policy, practice and further research; and limitations of the study.

## 1.16 Conclusion

This study explores how principals handle the sensitive issues surrounding HIV/AIDS amongst their teachers. This chapter has provided a general introduction and the orientation of this research study by outlining a brief background to the rationale of the research. A theoretical framework as well as a synopsis of existing literature was outlined. In addition, the purpose of the study and formulation of the problem statement, research questions and aims and objectives have been explained; this included the research design and methodology. The following chapter provides the theoretical discussion of how principals are handling the sensitive issues surrounding HIV/AIDS amongst their teachers.

# CHAPTER TWO

## School Leadership and Teachers with HIV/AIDS: Stigma and Discrimination in Gauteng Province Schools

### 2.1 Introduction

Although there is still much to learn about how school leadership handles sensitive staff matters, there is already a significant body of research on which to build. It would thus be ill-advised not to stand on the shoulders of the researchers who have gone before me in undertaking my own research in this area (Louis, Leithwood, Wahlstrom & Anderson, 2010: 11). In this review of related literature, I state the matters concerning a complex and multifaceted view of how principals handle sensitive issues regarding teachers living with HIV/AIDS. There has been extensive research in the field of educational leadership since the beginning of the Twenty-First Century because of the common finding that school leadership contributes significantly to school effectiveness as well as student achievement (Bush, Bell and Middlewood, 2010: 3; Louis, Leithwood, Wahlstrom & Anderson, 2010: 11). In South Africa, transformation has a special meaning linked to the need to convert the previous highly stratified system into a new framework stressing equity and the redressing of historical injustices (Bush, 2007: 11). Although a variety of conceptual theories have been applied over the last 25 years of research in educational leadership, two major models have predominated; that is, transformational leadership and instructional leadership (Hallinger, 2003: 335). In this literature review, the transformational leadership model and the ethics of care theory frame the inquiry into schools leadership, particularly as it faces the challenges of handling sensitive issues related teaching staff.

This study has investigated how principals handle sensitive issues regarding HIV/AIDS amongst teachers in Gauteng schools. The role of school principals in

leadership is conceptualised in the literature from the transformational leadership viewpoint that leadership has the potential to exert influence on surrounding conditions and transform them to achieve performance goals (Leithwood and Jantzi, 2006: 203). School principals bear the responsibility of handling sensitive issues including HIV/AIDS amongst their staff. Evidence from research conducted by numerous researchers – including Marneweck, Bialobrzeska, Mhlanga and Mphisa (2008); Mortimore (1993); Townsend (2001); Heneveld and Craig (1996), Sammons, Hillman and Mortimore (1995); and Scheerens (2000) – has revealed that school principals play a crucial role in the successful development of the schools they lead (Bialobrzeska, Marneweck, Mhlanga & Mphisa, 2010: 1). They are the major players in enabling school effectiveness as well as setting the school tone and working climate (Mortimore, 1993: 16; Sammons, Hillman and Mortimore, 1995: 14). Similar research on school effectiveness has been carried out in developing countries by Heneveld and Craig (1996: 12), who identify school leadership as indispensable and influential to the success and effectiveness of schools. School principals have the potential to mitigate effects of HIV/AIDS on teachers (Bialobrzeska, Marneweck, Mhlanga & Mphisa, 2010: 1). In South Africa, principals need to improve their existing leadership and management skills to address the particular challenges posed by HIV/AIDS. Bialobrzeska, Marneweck, Mhlanga & Mphisa, (2010: 1) have the following to say:

> For schools to function as nodes of care and support for teachers, a particular form of leadership is required to enable this new role. There are reasonable actions that school leaders can take even in the face of the HIV and AIDS crisis.

School leaders are expected to expand their roles to include an ethics of care and the provision of relevant support structures in their schools. Principals in South Africa are expected to provide quality education under the strain caused by persistently absent, ill and unmotivated teachers. Government policies clearly advocate inclusivity as well as care and support for teachers living with HIV/AIDS (South Africa. Department of Education, 2003b: 5).

## 2.2 Context and Background of the Study

Good leadership has come to be recognised as an invaluable requirement within all sectors addressing HIV/AIDS-related issues as the epidemic approaches its fourth decade (Szekeres, 2008: 13). In sub-Saharan Africa, HIV/AIDS has long been regarded as a major evil and the cause of unprecedented human suffering that has yet to show any signs of abating. In South Africa, human lives are lost to HIV/AIDS every day. The limited improvements to the management and perception of HIV/AIDS are not enough to control its ever-worsening spread. Despite improvement in prevention and treatment measures since the time of discovery of the pandemic, stigmatisation and discrimination have continued to haunt those affected and infected by HIV/AIDS. HIV transmission is still widely associated with people's lifestyles and moral values. Renowned people, like former South African President Nelson Mandela, have played a crucial role in breaking the silence and eroding the taboo associated with HIV/AIDS. HIV/AIDS has not been treated like any other disease and continues to be the source of serious stigmatisation and discrimination.

Schools are regarded as focal points of community life, which has the power to make a great contribution to the fight against HIV/AIDS, as a matter of urgency, through the structures of the education system (Marneweck, Bialobrzeska, Mhlanga and Mphisa, 2008: 10). The school is therefore conceptualised as a source of information as well as knowledge.

The origin of HIV/AIDS and, by and large, its cure has been the primary focus of research in this field, both within the medical fraternity and elsewhere (McLennan, 2000: 7). As elaborated on by van Vollenhoven (2003: 87), the HIV/AIDS research has prompted discussions regarding the need for HIV/AIDS intervention in schools. There has been concern as to what actions can be taken to change misperceptions regarding the causes of AIDS and how to cure it, since a cure has yet to be found. Researchers in South Africa and the world over are working tirelessly to find the cure for HIV/AIDS.

The quest for answers has seen every sector of society participating in the fight against HIV/AIDS with the education system regarded as the disseminator of information. The Department of Education (South Africa. 2003a: v) confirms that:

> The HIV/AIDS epidemic is making life difficult for many South Africans. Many schools are already facing problems caused by the HIV epidemic. The good news is that education is already working in positive ways to lessen the impact of HIV/AIDS.

Therefore, schools have a role to play in the fight against HIV/AIDS. In fact, schools are expected to take the lead, with principals now performing their duties amid a plethora of HIV/AIDS-related challenges and complications. Figuring out how to deal with sensitive issues around HIV/AIDS, especially the stigmatisation of and discrimination against infected and affected teachers, remains a serious challenge.

The idea that the quality of leadership is a primary factor influencing school effectiveness has become widely accepted (Earley and Weindling 2004; Jones, 2005 in Rayners, 2007: 46). Principals should lead the way. Therefore, it is absolutely necessary that principals understand their ability to influence all the stakeholders in the organisational functioning of South African schools. The role of principals is gradually developing because the current status quo has effected a change in the relationship between local education authorities and schools. One of the major adjustments in this regard is that the responsibility for the provision of education has been shifted to schools themselves. Thus, some duties, which were previously performed by the District office, have been shifted to the school. This decentralisation of responsibility has ultimately led to an expansion in the roles played by principals.

School principals are major players in school effectiveness. However, school leaders need to do away with autocracy when they implement official policies (Bush and Middlewood, 2005: 11). They are strategically placed so that they can make a substantial contribution to the prevention of HIV/AIDS in schools at grassroots level.

The ever-increasing complexity of the education system makes it necessary for principals to show uniqueness in their leadership. Du Preez, Campher, Grobler and Shaba (2003: 89) maintain that school leaders must realise that schools should be effectively managed and matters related to education need to be efficiently handled. It is therefore vital that principals employ creativity in their leadership strategies. They must enhance their capability to adapt to the change of circumstances and

keep abreast of new contexts in a transformed South Africa. Accordingly, it will be absolutely necessary for school leaders to understand their own competence levels and to realise how they can develop themselves to be efficient leaders. They need to recognise the uniqueness in their own situations. It is only then that they can take actions appropriate to their situations, taking advantage of the variety of skills, qualities and abilities available to them (Jones, 2005; Sterling and Davidoff, 2000). It is also important to reinforce the changing roles of principals in consideration of their most important function as community leaders. Schools play a major function in identifying and supporting teachers who are infected with or affected by HIV/AIDS. Principals must realise that they need to sharpen their skills and improve efficiency in their organisations. Principals, as transformational leaders, have taken on new exciting roles as they continue to deal with the ever-changing face of education, while using their knowledge and skills to work both within and outside the school system to map new directions (Cashin, Crewe, Desai, Desrosiers, Prince, Shallow & Slaney, 2000: 149). Their changing roles call for optimum creativity. The issue in focus is working out how principals should deal with issues experienced by teachers living with HIV/AIDS and identifying the complexities that this entails for school leadership.

Teachers feature in the disconcerting statistics regarding adult HIV/AIDS infection rates worldwide (UNESCO, 2003: 45). Although sub-Saharan Africa constitutes only 3% of the world's population, 68% of newly infected people (in all age groups) recorded in 2007 lived in Sub-Saharan Africa. (Lurie and Rosenthal, 2009: v). Moreover, 5% of the adult population in sub-Saharan Africa are HIV-positive, a prevalence rate not matched anywhere else in the world, with no other region recording an infection rate of higher than 1% of its total population (*ibid.*, 2009: v).

In addition, people are not free to disclose their status because of the stigma attached to the disease. For the same reason, people also avoid or delay testing. However, in some schools, individual teachers have started their own initiatives to support their colleagues.

People who are living with HIV can continue working for many years. However, once they succumb to the disease, their immune system cannot fight the opportunistic

sicknesses and they begin to be absent from work for both long and short periods of time (Shisana, Peltzer, Zungu-Dirwayi & Louw, 2010: 10). Moreover, non-infected teachers who are still affected by the disease also frequently take time off work. These teachers either feel stressed and worried because they are sick themselves or because they are worried about an infected colleague, relative, friend or a student. This has negative consequences for the school, teachers and learners. Subsequently, they are unable to perform their tasks as teachers at an optimal level. Increased workload, loss of skilled and experienced teachers, overcrowded classes and learner adjustment problems are just some of the effects of HIV/AIDS (Shisana *et al.*, 2010: 10). The Department of Education (South Africa. 2003b: 17) contends that teachers infected with HIV/AIDS are increasing in numbers and most of them are concerned about how the disease is going to impact on their lives and work. Absenteeism may increase due to teachers attending funerals or due to sickness. When teachers fall sick, their classes may be taken on by other teachers, combined with other classes, or simply left untaught. Teachers often combine classes to cover for those who are ill, which is not conducive to proper learning (Louw, Shisana, Peltzer & Zungu, 2009: 207). School leadership and teachers talk informally about the stress caused by absenteeism. This kind of talk impacts negatively on the teaching and learning climate of the school and widens the rift between “us and them” – those who are not affected or infected and those who are affected and infected.

Great strides have been made in assessing the prevalence of HIV/AIDS, health status and related struggles experienced by teachers in South Africa. It is projected that the number of teachers living with HIV/AIDS is set to increase, which is cause for concern as action needs to be taken to implement prevention measures and provide antiretroviral medication (Rehle, Shisana, Glencross & Colvin, 2005: v). This condition impacts negatively on teachers’ lives and work. According to (Simbayi, 2010: 53), “13.5% of teachers were HIV-positive in 2004 and 2005 and 11.9% in 2008”. As is, Bennell (2005: 206) estimates that the rate of transmission amongst teachers will gradually increase to 11.5% but this is only a prediction. What appears to be needed are care programmes successfully implemented by the school leadership. To this end, school leaders require additional skills, which are most often not taught in educational leadership and management courses. The review of the

existing literature shows that not enough research has been done in school leadership in South Africa amid widespread evidence that HIV/AIDS has grown to be a rampant cause of negative effects in all aspects of school life (Rayners, 2007: 78). Therefore, there is a need to undertake this study.

The Gauteng Department of Education (GDE) has 2 045 principals leading and managing teachers, 59 175 teachers, 185 8745 learners and 6 237 public service staff in 2 612 ordinary schools (South Africa. Gauteng Department of Education, 2013: 3). Evidence from the research carried out by the HSRC (2008: 3) shows that people have realised that HIV/AIDS has become a menace to school life. There is a need to create a school climate in which teachers can feel free to discuss their most sensitive issues with their leaders. This is indeed a complex matter, given that school principals are seldom equipped with counselling or debriefing skills, and also because the spectre of people's natural fear of death hovers over all HIV/AIDS-related issues. In fact, many believe that AIDS is a punishment from God. Also, people make moral judgements of infected people and have preconceived ideas about their sexual behaviour.

In addition to the task of helping to prevent HIV/AIDS, school principals are required to provide care and support to those who are affected or infected:

> Experience has shown that a workplace HIV/AIDS prevention programme will only be successful when the programme has top management support and is developed, implemented and monitored by a committee that include all interested parties. (HIV/AIDS Technical Assistance Guidelines, 2000: 55)

The Human Resource Directorate has subsequently finalised a workplace policy on HIV/AIDS, with the objective of preparing the way for the formulation and implementation of strategies to mitigate the effects of the HIV/AIDS pandemic on employees (Rayners, 2007: 98).

Fundamental to this study is the understanding that the Gauteng Department of Education is an important regional institution in the province of Gauteng, which has the highest population in the country. The Gauteng Department of Education is labour intensive and the large workforce under its charge gives it significant power to

affect the education system. I envisage that this study will be of use to principals to develop their staff and that it will add value to their existing knowledge. In support of such an assertion, Rayners (2007: 105) holds that school leadership will be encouraged to question their values, attitudes, and practices pertaining to HIV/AIDS amongst members of the school community. Other researchers and planners can gain a better understanding of the strategies that may be employed in various contexts to successfully achieve their goals in this area. This increased knowledge can be utilised in other places to professionally develop those leaders who lag behind.

## 2.3 Understanding the Research Phenomenon from the Literature: Leading Schools in Sensitive Matters

School leadership in South African schools has become increasingly complex because of HIV/AIDS (Bialobrzeska, Marneweck, Mhlanga & Mphisa, 2010: 1). HIV/AIDS is the primary challenge to the leadership of schools. Nitsch (2006) observes that school leadership is being influenced by HIV/AIDS so much such that there is now an urgent requirement for a leadership cluster that is health oriented. Principals need to implement a number of sophisticated educational policies. The additional roles they play due to the HIV/AIDS pandemic amongst their teaching staff leaves them overburdened by responsibilities. Being the only disease of its kind, HIV/AIDS has presented enormous challenges to school principals who have been confronted with growing numbers of HIV-positive teachers on a daily basis (Rajagopaul, 2008: 116). Duties related to HIV/AIDS issues are more complicated than those in any other school leadership area because of the culture of silence that has always surrounded the disease.

As the HIV/AIDS pandemic continues to rear its ugly head, principals are compelled to deal with its negative impact. The Department of Education (South Africa. 2003a: 3) asserts that teachers, who are the main pillars of the education sector, are at risk and that this is affecting the school leadership system. Teachers are under pressure to achieve educational goals and maintain academic standards, whilst also motivating the teachers to achieve their potential even in adverse circumstances. Buchel and Hoberg (2007: 3) assert that principals' self-actualisation could be adversely affected if academic achievement is low. Change in deep-rooted behaviour patterns is unavoidable (Nitsch, 2006: 2). The principals need to influence the change of beliefs about the AIDS disease amongst their teachers. Principals can achieve this through a strong joint-venture with other community stakeholders and other leaders in other departments.

Most principals work under pressure. They deal with emotional and moral behaviour. Furthermore, school leaders may not wish to borrow ideas from other professional specialists outside the education system simply because they may feel undermined.

In addition, the HIV/AIDS epidemic has caused significant disruption to normal long-term plans in schools. Management of resources in the schools becomes disputed as school principals have to resort to crisis management (Buchel and Hoberg 2007: 2). Teachers who are infected with or affected by HIV/AIDS look up to their principals. This has prompted the rise of much stronger (sometimes borderline-autocratic) leadership approaches, with catastrophic events forcing people to search for tough leaders with charismatic qualities (Nitsch, 2006: 2). Nonetheless, dealing with teachers infected with an incurable disease and who fear death requires a single, definite type of non-autocratic leadership approach. Principals need to empower their teachers so that they can maximise the available support. On the 12th of April 2013, the South African Minister of Health announced that the government had rolled out a one-a-day Antiretroviral Treatment (ARV) treatment (voanews, 2013), the largest that the South African government has rolled out to date (UNAIDS, 2010b: 1). Sadly, however, South Africa still tops the world list in terms of prevalence, with 5.6% of South Africans living with HIV/AIDS. This constitutes 17% of the people living with HIV/AIDS in the world (voanews, 2013). Principals may be required to get teachers to disclose their HIV statuses so that they are correctly referred for support. Nitsch (2006: 4) advocates this more involved kind of leadership:

> There is a growing need for a new type of situational, facilitating and negotiating leadership for schools with an agenda for mediating or moderating between incipient bottom-up empowerment leadership.

Principals need to instil a culture of leadership connected to matters related to HIV/AIDS. School principals are faced with the challenge of making a significant contribution to the eradication of taboos surrounding HIV/AIDS since formal education is regarded as a primary source of community information (South Africa. Department of Education, 2003b: 5).

Principals also have to facilitate staff development by creating an environment in which they feel free to share information. HIV/AIDS needs to be accepted just as other life-threatening diseases, like cancer, are accepted. However, existing beliefs about HIV/AIDS are deeply entrenched. The extent of change possibly depends largely on the prevailing spirit of the school as well as social pressures from the

surrounding environment (Nitsch, 2006: 2). Principals must find a balance between formal medical facts about HIV/AIDS and cultural beliefs about it. They need to deal with the transformation of teachers' deep-rooted mind-sets, customs and ways of behaving. Van Dyk (2012: 465), in this regard, makes the following assertion:

> Effective management of AIDS in the workplace requires an integrated strategy that is based on an understanding and assessment of the impact of AIDS on the specific workplace.

Problem diagnosis is indispensable to the identification of solutions. School leaders need to possess expert knowledge about HIV/AIDS so that they are able to help their teachers. It is essential that principals are able to tap into the expertise of other institutions as a way to deal with teachers who need help. They need to promote leadership amongst their staff. Teachers need to be empowered within their peer networks. However, Nitsch (2006: 2) warns that this kind of attitude could damage school spirit and further compromise principals' leadership functions. Principals are left with dilemmas of crisis management that impact negatively on school discipline, teaching and learning processes, and self-actualisation (Buchel and Hoberg, 2007: 3). Teachers' ability to achieve self-actualisation may be undermined if their principals refer them to outsiders for help; they may feel exposed and that their privacy is being invaded.

The impact of HIV/AIDS continues to grow and is threatening the leadership of schools. School leadership bears the brunt of difficulties experienced by the education system's various levels of management because of their position. They are faced with teachers who refuse to disclose their status as HIV-positive.

International and national policies have been adopted to protect people living with HIV/AIDS and these emphasise *voluntary* counselling and testing (Sherman, Partner, Dickstein & Oshinsky, 2013: 8). For this reason, principals may have to work with teachers who are infected by HIV unknowingly, especially if infection is still in its early stages. Teachers may wait until the HIV has developed into full-blown AIDS before getting tested or disclosing their status. Before this happens, teachers may only be absent from work for a few days, keeping principals from realising the intensity of the problems to come (*ibid*.). *School Representatives' Manual: A Guide*

*for Peer Educators* (Prevention, Care and Treatment Access, n.d.: xi) makes the following observation:

> Because of fear of AIDS, people sometimes would rather not know their HIV status; due to this lack of knowledge, they are sometimes unable to distinguish between the facts and the myths about HIV/AIDS.

As a result of this, the consequences of the AIDS epidemic are ever more widely felt (UNAIDS, 2010a: 12). Principals play a role in influencing teachers to accept the disease and to lessen its impact.

The sensitivity with which HIV/AIDS-related issues must be handled requires that principals resort to holistic approaches (Bennell, 2009: 2). The HIV/AIDS pandemic is an emotional issue whether principals are dealing with an infected or affected workforce (Bureau for Economic Research and The South African Business Coalition on HIV/AIDS, 2003: 1). Once teachers know that they are HIV-positive, their confidence diminishes significantly and their emotional development suffers (Mfusi and Steyn, 2012: 6). This may impede their efficiency. Thus, the Education and Training Unit (2007: 13) contends that an individual's knowledge that he/ she is HIV-positive can cause a huge shock to them, leading to emotional and physical suffering. Principals are compelled to apply leadership styles that focus on teachers' emotional stability. Leaders need to consider the entire spectrum of their subordinates' lives; this includes physical and emotional well-being as well as intellectual development (Bureau for Economic Research and South African Business Coalition on HIV/AIDS, 2003: 3).

Improved teacher well-being cannot be achieved overnight. Principals may need time to work on a single approach for one teacher whilst others wait. The Education and Training Unit (2007: 13) stresses that the HIV/AIDS epidemic is shrouded in silence and people feel ashamed to talk about it, regarding the topic as scandalous. Principals face the challenge of having to break through several well-entrenched barriers.

As school leaders, principals have an obligation to accept the challenge of HIV/AIDS and manage it with the same responsibility and devotion with which they manage

other areas of school life (Mfusi and Steyn, 2012: 13). They cannot avoid the responsibility because they are in charge. Teachers bring their problems to school either deliberately or unintentionally. Principals have not been trained to handle HIV/AIDS-related issues. Yet, in light of the dire situation and the scale of the challenges posed by HIV/AIDS, it is necessary to think beyond the immediate and obvious functions of schools (Bialobrzeska, Marneweck, Mhlanga & Mphisa, 2010: 1). The substantial portion of the health sector's budget and focus goes towards research, prevention and treatment of HIV/AIDS. Principals do not receive sufficient support or training to cope with the problems they are facing (Buchel and Hoberg, 2007: 3; Aggleton, Yankah & Crewe, 2011: 496). Many schools are facing HIV/AIDS-related problems and the fact that they lack the resources to deal with such health-oriented challenges makes matters worse (South Africa. Department of Education, 2003a: 5). Because HIV/AIDS not only infiltrates the organisation's physical well-being but also affects the organisational psyche, it as the most complicated epidemic with which to deal (Bureau for Economic Research and The South African Business Coalition on HIV/AIDS, 2003: 2). Principals need to be proactive and possess the skills to assess their teachers' psychological states, thus adding social work to their long list of duties.

According to the Technical Assistance Guidelines (2003: 3):

> Fear of infection and death, may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are sick, not fully functional or away from work. This could lead to low staff morale.

Schools produce good results when their workforces are healthy. As Van Dyk (2012: 464) emphasises, one of the results of an unhealthy workforce is "low staff morale with employees resenting taking on or refusing to take on additional responsibilities for colleagues who are sick".

Other teachers may disassociate themselves from suspicious colleagues. People always gossip and diagnose others. This is a challenge for the principal, who has to build a culture of understanding and tolerance. Calculating how to influence mind-sets and perspectives is important. The bottom line is that HIV/AIDS is here to stay

until a cure is found; principals have no option but to be proactive and deal with the situation (Bennell, 2009). The long-term effects of HIV/AIDS are difficult to conceive of for both the infected and the affected. Extensive ignorance and prejudice surround HIV/AIDS and it often is viewed as a “death sentence” (UNAIDS, 2010b: 1).

As years go by, the impact of HIV/AIDS progresses and challenges in the workplace increase. The Bureau for Economic Research and The Business Coalition on HIV/AIDS (2003: 3) maintains that:

> The pure nature of HIV/AIDS introduces a cluster of complexities that require proper analyses and planning in ensuring successful roll-out. HIV/AIDS takes on many different forms and it requires sensitivity and diplomacy. People tend to close up when entering discussions involving issues of gender, race and sexuality in the workplace.

This is a management area that is surrounded by sensitivity and confidentiality. Principals need to get teachers to talk about the disease. The teachers need to be led to be united so that the corporate culture is passed on to new teachers who join the schools. Principals need to work on eradicating prejudices that lead to negative attitudes towards those infected with HIV/AIDS. There are set procedures in the Technical Assistance Guidelines (2003: 55) and the guide books published by the Department of Education for achieving this. Principals may enter into collaborative partnerships with government and key non-governmental agencies in order to share information and expertise on HIV/AIDS and discrimination (*ibid*.). School leaders lead the school HIV/AIDS committees.

Several policies have been enacted to protect people living with HIV/AIDS at work and elsewhere. The South African Department of Education (2000: 3) issued some guidelines to be adhered to by people responsible for the implementation of HIV/AIDS-awareness campaign programmes within the education system. According to the guidelines, schools are required to set up HIV/AIDS committees so as to offer support to all staff. Furthermore, the Technical Assistance Guidelines (2003: 55) outline the legal and policy framework and offer advice on how to handle HIV/AIDS-related issues in the workplace. Therefore, principals need to be acquainted with all national policies, human rights, and legal issues related to HIV/AIDS. According to (Mahabeer, 2008: 119) principals need this knowledge in order to devise strategies

to facilitate the handling of HIV/AIDS-related issues. While the policies protect the affected and infected, they are silent with regard to the school leaders, who bear the responsibility. Thus, Bialobrzeska, Marneweck, Mhlanga & Mphisa, (2010: 1) argue that, while a number of school leaders have been able to respond to the needs of learners, there is not much evidence that schools have been equally supportive of teachers' needs. Appropriately, Aggleton, Yankah and Crewe (2011: 495) point to the "absence or uneven distribution of clear policy frameworks and guidelines, the absence of HIV from most schools and education sector plans, yearly action plans and education budgets" as a major problem.

School leaders face difficulties when there is no support for policy implementation. Teachers are adult professionals and such issues need to be presented to them tactfully. This need for sensitivity could be a deterrent factor to the principals to commit themselves to support teachers, because their hands are already full. School principals hold the main influential role when it comes to decision making and effecting change in their schools (Mahabeer, 2008: 119). In addition, Bass and Bass (2008: 590) suggest that the quality of leadership is often considered to be the primary contributor to the failure or success of institutions. Thus, school leadership has a profound impact on the success of the whole school programme. However, principals are expected to transform their schools so that they are able to disseminate information about HIV/AIDS. Principals address the false impressions and ways of thinking that people have with regard to HIV/AIDS.

Principals need to ensure a caring, safe and non-discriminatory school environment (Mahabeer, 2008: 92). This may depend largely on whether teachers have voluntarily disclosed their HIV status. Other factors that could impede principals' ability to create such an environment are religious, cultural and traditional beliefs (Banks and McGee Banks, 2010: 67). In a similar vein, Aggleton, Yankah and Crewe (2011: 495) make the following assertion:

> Because the stigma associated with HIV is so strong, teachers may be afraid to talk about it for fear of themselves being stigmatised by people and the whole community for knowing too much about something that is difficult to talk about sensitive and taboo.

It takes great skill for principals to make such breakthroughs. This is why it is highly problematic when they fail to commit themselves fully to dealing with teachers' social issues, which are so sensitive, because they have other performance standards to implement.

Following the decentralisation in the education system, school leadership has been transformed, mainly in the direction of a higher degree of autonomy for school-level management (Bush, 1989: 56). Traditionally, in contrast to this current trend, principals used to follow the Department of Education's instructions without much initiative expected from them. Principals' roles have shifted to coordinating, planning, directing, delegating, communicating, and motivating (Mahabeer, 2008: 92). There has been movement from bureaucratic approaches to transformational and charismatic methods (Bass and Bass, 2008: 22; Leithwood and Jantzi, 2006: 207; Bush, 2007: 11). However, although principals are responsible and accountable for everything that happens in their schools, they cannot do it alone. Nevertheless, a principal can make or break his/ her school, and is largely accountable for all failures and conflicts (*ibid*.). Due to the HIV/AIDS pandemic, principals' duties have become multifaceted and their leadership approaches have been transformed from those of unsociable and unfriendly rulers to more charismatic and transformational influencers (Bass and Bass, 2008: 22).

Principals ensure the smooth running of their schools – from organisation to administration (South African Department of Education, 1997: 7). Principals used to be looked at as kingpins by their teachers. With the advent of HIV/AIDS, however, they have had to become approachable and caring, and create an environment conducive to teachers opening up about their HIV status. Botha (2006: 3) concurs that schools have been encouraged to use democratic, participative and consultative approaches.

As much as schools have gained autonomy, there remains a need for a rigorous support system. They are under pressure to effect policies that encompass complicated and sensitive HIV/AIDS programmes. They must talk about religious beliefs as well as traditional customs (Rayners, 2007: 23). Principals need to talk about sex, which is a private subject according to most people's beliefs and not the

business of one's employer or school principal. It may take time and the acquisition of extensive expertise on the part of school leadership for this to change. Mahabeer (2008: 137) confirms that policies outline that schools can serve as disseminators of HIV/AIDS information and nurture a safe and caring environment for teachers. Teachers come from various social backgrounds. They have been socialised in different cultures and are subjects of different traditions and they speak different languages. Therefore, it is the principal's duty to build up an organisational culture in which all members share the same vision and understand and adhere to the same guidelines and rules (Bass and Bass, 2008: 590). Principals can utilise an organisational culture that equalises all its members. They can use it to roll out a robust HIV/AIDS programme for their schools (Van Dyk, 2012: 465). Leaders make the difference; they stimulate others (Bass and Bass, 2008: 590). School leadership determines the school climate. However, principals remain under pressure to improve academic results, often preventing them from realising the urgency and deep-rootedness of HIV/AIDS in their schools. They need support to make up for the additional roles they must play as a result of HIV/AIDS. It is not all principals who possess the required expertise and experience to achieve this mammoth task.

School principals need to influence teachers to take initiative and contribute to decision making, goal setting, development of new skills and competencies, and ultimately improve the whole school programme (Mahabeer, 2008: 60). Principals need to constantly motivate their teachers, who are often stressed, prejudiced, and afraid of death. A negative school environment causes profound feelings of sadness, depression, loneliness, and anxiety amongst teachers affected by or infected with HIV/AIDS, causing them to become withdrawn (Mahabeer, 2008: 60). This is a major drawback to principals' relentless efforts to drive teachers towards common goals. Instead, such negative feelings weaken the network of social support. Principals need to be inspirational. However, their duties demand them to produce results against which their performance is measured. Bush (1989: 67) therefore asserts that:

> Good leadership and management in education is displayed by someone who is people oriented, a problem solver, manages conflicts, is flexible, practical and motivational, who delegates responsibilities as a way of empowering staff and who improves efficiency in an organisation.

The principals may not be able to cope, considering the magnitude of the impact of HIV/AIDS.

## 2.4 The Impact of HIV/AIDS on Teachers

### 2.4.1 Prevalence of HIV/AIDS amongst Teachers

According to the South African Department of Health (2012: 12):

> Although HIV prevalence has plateaued; the absolute number of people living with HIV/AIDS is on a steep increase of approximately 100 000 additional people who live with HIV/AIDS each year.

Moreover, UNAIDS (2009: 8) asserts that:

> Although the epidemic appears to have stabilised in most countries of the world there is no good news for Sub-Saharan Africa. Sub-Saharan Africa remains the most heavily affected region in the world accounting for 71% of all new infections in 2009.

The Global Report issued by UNAIDS (2012: 6), cautions that:

> Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide.

The African continent is the poorest of all the continents. According to Van Dyk (2012: 465), southern African countries remain the most heavily affected by the epidemic and the region is host to the nine countries, including South Africa with 16.9%, with the highest HIV prevalence in the world. Access to antiretroviral treatment is motivating people to go for voluntary counselling and testing. This could be the reason why statistics indicate that the number of people living with HIV/AIDS is increasing, as maintained by Avert (2012: 46). South Africa has the highest HIV/AIDS prevalence in the world.

Teachers are among those affected and infected. In fact, teachers, as an occupational group, constitute a large portion of South Africa's working population

and, as a result, the high rate of infection amongst them is major cause for concern (Shisana *et al.,* 2005: 2). In Botswana, the overall teacher mortality rate has increased from 0.7% out of 1000 in 1994 to 7.1 out of 1000 in 1999. In Tanzania, more and more teachers need to be trained to replace those who are dying (International Labour Organisation, 2009: 23). The UNAIDS (2012a: 13) estimates that 1.5% of teachers die each year due to AIDS-related illnesses in Zimbabwe, Kenya, and Zambia and Zimbabwe.

The percentage of HIV-positive teachers is 30% in Malawi and Uganda, 20% in Zambia, and12% in South Africa. (Shisana *et al.,* 2005: 2). This exerts considerable pressure on school leaders as they are in charge of teachers who cannot fully execute their duties.

In spite of these alarming statistics, there is no evidence of the government committing itself to reducing the impact of HIV/AIDS on teachers. Accordingly, Bennell (2009: 2) argues that teachers are a high-risk group when it comes to HIV infection. Hence, the teachers' unions have taken upon themselves to lobby for support of their members.

**Table 1: 2011 Antenatal Sero-Prevalence Survey of HIV/AIDS by Province**

| Province | Prevalence |
|---|---|
| Limpopo | 21.9% |
| Mpumalanga | 35.1% |
| North West | 25.5% |
| Northern Cape | 18.4% |
| Eastern Cape | 29.9% |
| Western Cape | 18.5% |
| Free State | 30.6% |
| Kwa-Zulu-Natal | 39.5% |
| Gauteng | 30.4% |

(Source: South Africa. Department of Health, 2012: 3)

The table above shows that Kwa-Zulu-Natal has the highest prevalence (39.5%), followed by Mpumalanga (35.1%), the Free State (30.6%), and Gauteng (30.4%). These figures are horrifying and call for intensification of programmes to mitigate the impact of HIV/AIDS. As always, teachers are included within these statistics.

The Human Science Research Council, Medical Research Council and a Mobile Task Team were commissioned to carry out a study on the demand for and supply of teachers in South Africa in 2004 (Bennell, 2005: 205). This has been the only government research done on the impact of HIV/AIDS on teachers as well as the prevalence of HIV/AIDS amongst teachers (Shisana *et al.*, 2005; Human Science Resource Council, 2009; Mampane, 2011; UNAIDS, 2009; Rehle and Shisana, 2005; Rehle *et al.*, 2005).

**Table 2: Prevalence of HIV/AIDS among Teachers by Age and Gender in South Africa in 2012**

| Ages | Females | Males |
|---|---|---|
| 25-29 | 21.5% | 12.3% |
| 30-34 | 24.2% | 19% |
| 35-39 | 14.1% | 16.6% |
| 40-44 | 10.1% | 10.5% |
| 45-49 | 6.3% | 7.6% |
| 50-54 | 3.8% | 5.8% |
| 55+ | 3.7% | 1.6% |

(Adapted from: South Africa. National Department of Health, 2012: 2)

The table above indicates that the age group with the highest percentage of infections is the 25- to 39-year-olds, which is also the most economically productive group. Basing on this statistics, there is a high probability that many new teachers joining the teaching profession are already HIV-positive. Ross and Deverrell (2010: 6) assert that certain significant emotional, mental, behavioural and physical problems result when a person's physical and emotional limits are exceeded.

Furthermore, Van Dyk (2012: 495) stresses that people living with HIV/AIDS may feel hopeless, sad, anxious, and overwhelmed by a sense of worthlessness and emptiness. Teachers, as disseminators of information, need to be extremely motivated, as they are role models for the learners who spend most of their time at school.

Teachers may be engulfed by a sense of shame for having contracted HIV (Mampane, 2011: 16). Rehle *et al.* (2005: v) reveal that 8.5% of total population of teachers were infected with HIV between 2004 and 2005; this was equivalent to 1.1% of the total population of teachers.

**Table 3: Prevalence of HIV amongst Teachers by Sex, Race and Age**

| Characteristics | Number | HIV-positive % | 95% |
|---|---|---|---|
| **Total** | 17088 | 12.7 | 12.0 – 13.5 |
| **Sex** | | | |
| Men | 5455 | 12.7 | 11.6 – 13.9 |
| Women | 11621 | 12.8 | 12.0 – 13.6 |
| **Race** | | | |
| African | 12022 | 6.3 | 15.5 – 17.1 |
| White | 2165 | 0.4 | 0.2 – 0.8 |
| Coloured | 2309 | 0.7 | 0.4 – 1.3 |
| Indian | 533 | 1.0 | 0.5 – 2.1 |
| **Age** | | | |
| < 24 | 240 | 6.5 | 3.4 – 12.0 |
| 25-34 | 4282 | 21.4 | 19.9-23.0 |
| 35-44 | 7443 | 12.8 | 11.8 – 13.8 |
| 45-54 | 4274 | 5.8 | 5.0 – 6.7 |
| 55 and above | 842 | 3.1 | 2.1 – 4.6 |

(Adapted from: Shisana *et al.*, 2005, in Simbayi, 2010: 4)

In the above table, it is shown that the two sexes are infected at a very similar rate. The African race is the worst affected, most probably because of it constitutes the

largest portion of the population. The worst affected age group is that aged between 25 and 34; this is also the most economically productive age group.

These disturbing statistics become even more disconcerting if one considers the role played by teachers in achieving education for all, which is one of the Millennium Development Goals. Education is an indispensable tool for total economic emancipation in Africa and elsewhere. This is why it is great cause for concern that teachers, who are the main drivers of education, are so strongly affected by HIV/AIDS. A large part of the profound impact of HIV/AIDS is felt in education and threatens the quality of education (Buchel and Hoberg, 2007: 3). In addition, according to Khangale (2005, in Buchel and Hoberg, 2007: 3), the deaths of 4 000 teachers due to HIV/AIDS complications were recorded in 2004 and 45 000 (12.5%) of the total number of teachers were reportedly HIV-positive. This is a disturbing state of affairs considering that the population is growing and the demand for teachers continues to escalate. It is a sheer waste of resources for teachers to be lost at such a tremendous rate. The rate at which teachers are dying is nearly equal to the number of new teachers who qualify each year (Jansen 2004, in Buchel and Hoberg, 2007: 3). Meanwhile, the Human Science Research Council presents the following information regarding HIV prevalence amongst teachers between 2008 and 2013:

**Table 4: HIV Prevalence amongst teachers in South Africa**

| Year | HIV Prevalence (%) | 95% CI |
|---|---|---|
| 2008 | 11.4 | 10.0 – 12.7 |
| 2010 | 10.8 | 9.9 – 11.8 |
| 2013 | 10.9 | 10.0 – 11.9 |

(Adapted from: Human Sciences Research Council, 2013: 5)

This Human Sciences Research Council report is not as alarming as the one regarding the period between 2004 and 2005. However, the percentage totals do not indicate any notable decline in infection rates.

In 2009, a cross-sectional survey was done on public school teachers. According to Louw *et al.* (2009: 206):

> The results [showed] that HIV [was] highly prevalent among South African public educators (12.7%) and the educators who were absent from school for longer periods (20 days or more).

It is significant that teachers are so profoundly affected by HIV/AIDS; more informative research needs to be done, not only with regard to prevalence but also into how principals are coping with the impact of the pandemic on teachers.

Teachers' health continues to be threatened and Bennell (2009: 2) asserts the following:

> Teacher HIV prevalence is projected to increase from 12,5% in 2000 to 30% by 2015 and annual mortality rates are to increase eight fold from 0,5% to 4, and 0% during the same period. Cumulative teacher deaths between 2000 and 2015 are estimated to be around 120000, which is one third of the total number of teachers employed in 2000.

The above prediction is confirmed by Campion (2015: 301) and Sinelela, Venter, Pillay and Barron (2015: 1-2) who highlight that in South Africa about 18% of all adults are HIV-positive. It is without a doubt that the Department of Education must urgently put antiretroviral treatment programmes in place to save its scarce human resources. The only conclusive and comprehensive research carried out to assess the risk of HIV/AIDS to teachers was carried out in 2008 (*ibid.*). The scarcity of such informative research may lead to complacency. Teacher-related HIV/AIDS statistics must be readily available and up to date as such information can be a powerful deterrent against behaviours that would place teachers at risk of contracting the disease. Moreover, the silence resultant of insufficient information may send the wrong message, creating the false impression that HIV/AIDS is under control whilst it continues to take its devastating toll.

Rehle *et al.* (2005: 6), however, estimate that teacher HIV prevalence will *decline* to 11.5% by 2015. This estimation is refuted by Sinelela, Venter, Pillay and Baron (2105: 301) and Campion (2015: 1-2). Nevertheless, this is only an estimation

projected from current HIV prevalence. A robust programme is called for to initiate behaviour change in teachers, support the infected and affected, and put empowering policies in place. The Department of Basic Education issued the integrated HIV, STIs and AIDS Strategy to guide the response amongst the 12 million learners and their teachers in 2010 (South Africa. Department of Health, 2012: 6). However, such policies and guidelines are often controversial and difficult to follow in reality, owing to the sensitivity surrounding HIV/AIDS-related issues.

### 2.4.2 Unproductivity

The HIV/AIDS pandemic poses profound challenges to teachers. It undermines the education system. Staff turnover amongst teachers is accelerating, placing strain on school leadership (UNAIDS, 2009; Buchel and Hoberg, 2007; Hewu-Banjwa, 2012; Marneweck, Bialobrzeska, Mhlanga and Mphisa, 2008: 10). According to James-Traore, Finger, Ruland and Savariaud (2009: 11), teacher attrition caused by HIV/AIDS leads to the deterioration of the education system through a severely stressed human resource base, greater learner-to-teacher ratios, loss of trained and experienced teachers, growth in the demand for staff health benefits, and increased pressure on teacher training colleges to meet the increased demand for newly qualified teachers.

Teachers cannot keep a healthy mind when they know that they are infected with an incurable disease. While they are away seeking medical attention, the remaining teachers take over their classes and imbalanced learner-to-teacher ratios are not conducive to good learner achievement. Even before they develop full-blown AIDS, teachers experience emotional distress regarding their HIV-positive status and this hinders their productivity (Theron, 2008: 47). Consequently, the problem of the growing teacher shortage cannot be resolved.

Not only is the HIV/AIDS pandemic intensifying the teacher shortage but it is also affecting teachers' ability to teach (Buchel and Hoberg, 2007: 4). The teaching programme is disrupted and this poses serious challenges to principals who are accountable for the success or failure of their schools' learners. Teachers who are continuously absent cannot cover the entire curriculum. The standard of performance is compromised. Teachers may be required to teach in subject areas in

which they have not specialised as they stand in for sick or deceased colleagues (Kelly, 2008: 9). Teachers who are overloaded with their colleagues' teaching duties may feel extremely stressed and discouraged (Avert, 2012: 46; South African Department of Education, 2003: 5). Teachers who are infected and affected need support. The Department of Education (South Africa. 2003: 5) asserts the following:

> Educators are not immune to the effects of the epidemic. HIV/AIDS affects education in many ways. Educators die or they are unable to work hard because of stress and chronic illness. The Education Department finds it difficult to provide enough educators, managers and other staff to replace those who are ill or who have died.

The DoE is aware of the problems faced by teachers with regard to HIV/AIDS but there is no support or clear guidelines to lead the way. Teachers are surrounded by problems. Mahabeer (2008: 131) argues that the quality of teaching and learning is compromised as a result of the loss of experienced teachers, high learner-to-teacher ratios and little or no motivation and support for teachers. This may lead to deterioration in the content and quality of education.

### 2.4.3 Mortality and Morbidity

Bennell (2009: 2) confirms that a robust analysis of teacher attrition through the perusal of records of salaries and other computerised information was carried out from 2004 to 2005. The resultant report found that the death rate amongst teachers in 2005 was three to four times higher than the existing rate (*ibid*.). In light of this, it is clear that research into how school leaders are handling the sensitive issues surrounding HIV/AIDS is long overdue.

There is more happening on the ground than is reflected in the available statistical information, which is only the tip of the iceberg. Teachers are vulnerable to HIV/AIDS and they have been shut out by their government, which, instead of supporting them, expects them to be the ones to educate the community about the mitigation of the transmission and impact of HIV/AIDS (Kelly, 2008: 9; Rehle and Shisana, 2005: 3). It is not only South African teachers who are affected. James-Traore *et al.* (2009: 11) assert that the "[Zambian] Ministry of Education trains 2 000 teachers each year

while annual losses from all mortality average is around 1 000 per year". Swaziland is striving to train more teachers than it would have trained if there were no HIV/AIDS-related deaths (Hewu-Banjwa, 2012: 7). Although there are numerous reasons for the loss of teachers, HIV/AIDS is the principal cause. In South Africa, antiretroviral therapy can now be accessed by two million or 80% of people in need of treatment (Avert, 2012: 46). However, whilst this provision caters for the country's population, teachers are amongst the population that have access to treatment.

Teachers may deteriorate in health, but they continue teaching. Sick teachers cannot effectively accomplish their professional performance standards and cannot contribute to the attainment of academic goals. Different teachers develop different problems as a result of HIV/AIDS and principals are forced to identify all of their needs and implement appropriate support programmes, whilst always remaining sensitive to the nature of the disease and its impact (Mahabeer, 2008: 131). This calls for a stronger support structure that is health oriented. Allemano (2003: 28) contends that:

> Since the average time [that] passes between the developments of AIDS is about a year, it is a fair assumption that each new AIDS case results in the loss of one year of professional time.

In an endeavour to drive home the idea that teachers are suffering due to HIV/AIDS, Mfusi (2011: 32) maintains that the immune system continues to weaken while the person suffers a number of opportunistic illnesses. Considering the number of teachers living with HIV/AIDS, the aforementioned lost time is considerable cause for concern.

Although teachers are professionals in their own right and society looks up to them, they also need professional help when they are infected with or affected by HIV/AIDS. They need a steadfast support system. Society, however, continues to look to its teachers for the solution and the resultant pressure on teachers can become a major burden (UNAIDS, 2009b: 1). Nevertheless, the fact remains the teachers are major role players in the situation and responsibility is placed upon them under the leadership of their principals.

### 2.4.4 Teachers as Ambassadors of Good Health

Teachers have traditionally been expected to serve as ambassadors of a healthy school environment, role models, and key custodians of information (James-Traore *et al.*, 2009; UNAIDS, 2010; Kelly, 2008; South Africa. Department of Education, 2000). Unfortunately, there has not been much attention given to what teachers go through as individuals and unpacking the problems that this causes for school leadership. As their immune systems weaken, infected teachers' health problems multiply, forcing them to keep working in order to be able cover their medical and related expenses. It is beyond doubt that the HIV/AIDS pandemic is seriously threatening the school leadership.

Interestingly, while it has widely been noted that teachers tend to be absent from work when they are sick (Allemano, 2003; Van Dyk, 2012; Rayners, 2007; Mampane, 2011), "survey findings show that teachers who are HIV positive are less likely to be absent as a result of unhealthy days than teachers who are HIV negative" (Bennell, 2009).

This is very surprising, considering how many teachers are now regularly taken ill because of the high rate of HIV infection. In fact, it is suspected that these teachers may deliberately push themselves too hard in order to accelerate the decline of their health and so cut their suffering short. Their morale deteriorates, their ability to self-actualise fades away and they may develop a negative attitude to life (Van Dyk, 2012: 465).

Therefore, UNAIDS (2009: 2) strongly recommends a robust support structure with a comprehensive approach. This should include programmes and policies that are directed at addressing the needs of teachers, especially those who are affected by or infected with HIV/AIDS, as individuals and as professionals to empower them to perform their indispensable roles in the prevention of HIV/AIDS.

Teachers have families and relatives and they are deeply affected when one of their own contacts HIV/AIDS. Bialobrzeska, Randell, Hellman and Winkler (2009: 21) argue that the effects of HIV/AIDS are not only felt by those who have the disease but also by their families, friends and the community at large, multiplying the

negative impact. In this context, Calitz, Fuglestad, and Lillejord, (2002: 149), maintain that the increase of teacher absenteeism can be attributed to deaths in families, colleagues and friends. Although a high mortality rate is the ultimate outcome of AIDS, it is its rate of morbidity that presents the greatest difficulties (Allemano, 2003: 29).

HIV/AIDS is often associated with immoral behaviour, which could be a major reason why people choose to remain silent about their status. Increased research will change people's mind-sets in this regard and an informative study on how teachers perceive their own problems in the workplace will contribute immensely to the change of cultural beliefs. As quoted by the Department of Education (South Africa. 2007: 6), the Human Science Research Council (2005) predicted, in 2005, that teacher shortage of 15 000 would be reached by the end of 2008. Overall teacher shortage of 30000 is currently looming until 2025 (Louw, 2015: 4). The major contributing factor to the shortfall has been attributed to mortality at the hands of HIV/AIDS (*ibid*.). Attrition amongst teachers may be the result of employee termination or resignation but mortality remains the primary cause.

## 2.5 HIV/AIDS Stigma and Discrimination in Schools

According to Skinner and Mfecane (2004: 157), "it is well documented that people living with HIV/AIDS experience stigma and discrimination on an on-going basis". In support of this, Mbonu, Van den Borne and De Vries (2009: 11) maintain that people living with HIV/AIDS not only experience medical problems but are also confronted with social challenges surrounding the pandemic. Therefore, it cannot be denied that teachers living with HIV/AIDS suffer the consequences of stigmatisation and discrimination. Given the prominence of HIV/AIDS-based stigmatisation and discrimination, this review deems it significant to study the manner in which such it manifests at within the teaching profession.

Stigma is referred to by Skinner and Mfecane, (2004: 158) as:

> A deeply discrediting attribute that reduces a person to someone who is in some way tainted and can therefore be denigrated.

In elaboration, Mbonu *et al.* (2009: 10) assert that stigma is generally recognised as an “attribute that is deeply discrediting", which reduces the person “from a whole and usual person to a tainted, discounted one”. The first definition, unlike the second, uses the word “tainted” to drive home just how badly people living with HIV/AIDS (PLWHA) are treated. The word “denigrated” carries connotations of marginalisation. The second definition implies that people who are HIV-positive do not belong. In reference to discrimination, Mahajan, Sayles, Patel, Remien, Ortiz, Szekeres and Coates (2008: 2) hold that:

> When in the absence of objective justification, a distinction is made against a person that results in that person being treated unfairly and unjustly on the basis of belonging or being perceived to a particular group.

It is therefore appropriate to assert that stigma leads to discrimination. Thus, Avert (2011: 11) suggests that “AIDS related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV/AIDS”. In short, stigmatisation and discrimination related to HIV/AIDS involve negative, socially constructed labels.

### 2.5.1 Causes of HIV/AIDS-related Stigma and Discrimination

Stigma and discrimination pose a huge challenge to people living with HIV/AIDS and also to the people around them. In this regard, the Prime Minister of Tanzania, the Honourable F.T. Sumaye, in the 2001 Regional Consultation Report (cited in Skinner and Mfecane, 2004: 158), made the following assertion:

> If we are to address stigma, we must first understand it. We should focus our attention on understanding what causes us as a society to react in this way to people living with HIV/AIDS – people who are suffering enough either physically or mentally to be challenged yet again by the judgements of others by the very people who yesterday were their neighbours and who should be reaching out to them.

This is a strong appeal, highlighting how people living with HIV/AIDS are treated in society. It is beyond doubt that there are reasons, as will be shown in the following section, driving society to react in this manner to people living with HIV/AIDS.

#### 2.5.1.1 Cultural and Moral Beliefs

Several researches have unearthed the common causes of HIV/AIDS-related stigma and discrimination as cultural and moral beliefs embedded in society (Avert, 2011; Mbonu *et al.*, 2009; Kamau, 2012; UNAIDS, 2007; Parker and Aggleton, 2002; Skinner and Mfecane, 2004; Van Niekerk and Kopelma, 2005). Since its inception, the causes of HIV/AIDS have mainly been attributed to indecent and even evil behaviour that has seen victims labelled as social deviants (Warwick, 1999, in Parker and Aggleton, 2002: 3).

Society believes that people living with HIV/AIDS have been infected because of their irresponsibility. Sexual promiscuity has been viewed as a primary cause of infection and the infected people thus viewed are as deserving of punishment (Avert, 2011: 46). These ideas regarding the sinfulness of deviant sexuality and immorality (Campbell, Foulis, Maimane & Sibiya, 2005: 3) are believed to be contributory factors to stigmatisation and discrimination.

The different ways in which people perceive HIV/AIDS hinge on beliefs that the pandemic is a life-threatening disease caused by immoral behaviour and that infected people are invading healthy societies (Kamau 2012: 1). The moral blame ascribed to PLWHA and those who are close to them has profound roots in the punishment theory (van Niekerk and Kopelma, 2005: iii). PLWHA are believed to be enduring the punishment of their sins. The stereotyped beliefs (Mahajan *et al.*, 2008: 1) lead to the ostracism of PLWHA. The reality that AIDS is incurable, the immorality associated with how it is acquired, and the assumption that it is a just punishment for said immorality, subdue PLWHA, causing them to feel victimised. The fear of stigmatisation instils the idea that HIV/AIDS only happens to other people and causes people to avoid voluntary testing and counselling in various contexts (UNAIDS 2007: 6).

#### 2.5.1.2 Fear of Infection

A high degree of fear surrounds the HIV/AIDS pandemic. The fear of contracting HIV through daily contact with people who are HIV-positive (UNAIDS, 2007: 6) creates a barrier between those who are infected and those who are not. People who are infected are pushed into the margins of society. The anxiety caused by fear of contagion and other negative attributes assigned to PLWHA further exacerbate the stigma associated with HIV/AIDS (Avert, 2011: 11). Society reacts to the HIV/AIDS pandemic so intensely because it is life threatening. As a result, AIDS is regarded with horror, causing people who are infected to be feared and demonised (*ibid*.).

The Centre for the Study of AIDS (CSA, 2007: 5) emphasises that stigma has surrounded the disease throughout its history, most often based on the fear of contagion. This mixture of fear and the perception of HIV/AIDS sufferers as somehow tainted manifests as stigmatisation, resulting in ostracism, avoidance and isolation, with others distancing themselves from such groups of people.

The various metaphors associated with AIDS have also contributed to the perception of HIV/AIDS as a disease that affects "others" especially those who are already stigmatised because of their sexual behaviour, gender, race, or socio-economic status and have enabled some people to deny that they personally could be at risk or affected (Daniel and Parker, 1993; UNAIDS, 2000, in Parker and Aggleton, 2002: 3). Anyone can contract HIV/AIDS regardless of race or gender, people need to refrain from thinking that they are smart.

HIV/AIDS is connected to groups of people who have traditionally been marginalised. The people living with HIV/AIDS are classified as belonging to the marginalised groups since HIV/AIDS is associated with prostitutes, injection drug users, promiscuous people, and homosexuals (Parker and Aggleton, 2002: 3). Fear increases amongst PLWHA as they avoid the labels associated with the pandemic and the social baggage that come with them. A number of researchers – including Kok, Kolker, de Vroome and Dijker (1998, in Van Dyk, 2012: 465), Education International Development Centre/ World Health Organisation (2009); Southern African HIV/AIDS Information Dissemination Service (2009), UNAIDS (2007), Parker and Aggleton (2002), and Avert (2011)., among others – have written extensively about the fear surrounding the HIV/AIDS pandemic. Fear of death causes people to

suspect others (Education International Development Centre/ World Health Organisation, 2009: 6) and this may lead to deterioration in teachers' morale at work. The extent of this fear is evidenced by Van Niekerk's and Kopelman's (2005: iii) reference to HIV/AIDS as a moral test. This statement associates PLWHA with immorality.

#### 2.5.1.3 Social Constructions

It is beyond doubt that HIV/AIDS - related stigmatisation and discrimination are socially constructed. SAFAIDS (2009: 10) traces the origins of stigmatisation to Ancient Greece, where criminals or slaves were marked to show that they were the outcasts of society. In elaboration, Campbell *et al.* (2005: 5) contend that theoretical literature shows that stigma does not only emanate from the fear of physical contagion but also from the fear of symbolic contagion, which threatens the individual's health and well-being as well as the legitimacy of the status quo. Gradually, society is classified into different groups. The complicacy linked to the welfare of people in a community segmented unequally causes a considerable number of groups to be devalued in order for other groups appear superior (Mahajan *et al.*, 2008: v). The feelings of inferiority result in a sense of hopelessness for PLWHA, while other groups think themselves superior, and therefore immune to infection.

Stigma and discrimination continue to weaken efforts made to include PLWHA in mainstream society. In this context, Mbonu *et al.* (2009: 11) warn that stigma can be used to marginalise affected or infected individuals or groups according to the normalised social order of "us and them" and the separation devalues those who are marginalised. These marginalised groups suffer from feelings of alienation as they are socially excluded. In 1987, Jonathan Mann, the then-director of the World Health Organisation Global Programme on AIDS, categorised the HIV/AIDS pandemic into three stages – HIV/AIDS, AIDS, and then stigma, discrimination and denial(Parker and Aggleton, 2002: 9). He referred to this phenomenon of stigma and discrimination as an epidemic in itself because of its negative impact on PLHWA, undermining intervention strategies to help people who are infected with and affected by HIV/AIDS.

Appropriately, Parker and Aggleton (2002: 9) make the following assertion:

> Social and political theory can help us to understand that stigma and discrimination are not isolated phenomena or the expression of individual attitudes but are social processes used to create and maintain social control and to produce and reproduce social inequality.

It is quite difficult for HIV-positive teachers to survive in this context, especially considering that they are expected to be role models and custodians of knowledge. It may be difficult for them to stand up and proclaim their roles as major players in the education system. Society stereotypes certain groups and individuals and ascribes negative characteristics to those people, perceiving them as misfits and social deviants (Mbonu *et al*., 2009: 2). These characteristics are purely social constructs and people use them to distinguish between normal and abnormal. The Centre of the Study of AIDS (CSA, 2007: 57) makes the following assertion:

> Because stigma and discrimination are rooted in social processes, from gossip at community level to media representations of PLHWA to differential allocation of resources, simply focusing on education about the routes of transmission of HIV/AIDS and the negative impact of stigma is insufficient to address it.

Social processes have the power to disempower people and cause PLHWA to withdraw from society. As Kamau (2012: 1) elaborates:

> Since the onset of HIV in the 1980s, a similar social construction of stigma has been directed at PLWHA who by virtue of possessing HIV/AIDS are perceived to be different and therefore undesirable – associated with immorality.

School life suffers most because of its role in the community. People develop negative attitudes towards PLWHA. SAFAIDS (2009: 6) cautions that these attitudes cause people who are HIV-negative to acquire dominant social status over those who are infected.

#### 2.5.1.4 Lack of Information and Prejudices

Although it has been three decades since the inception of HIV/AIDS, people are still gripped by the fear of the pandemic; it is not letting up. Back in the 1980s,

information available about transmission was very limited, which exacerbated people's fear of those who were infected (Avert, 2011: 47). Great strides have since been taken in bringing information about HIV/AIDS to the fore. However, the fact that the disease is incurable often trumps all other facts and causes the fear to remain. UNAIDS, (2007: 5) argues that there has not been enough knowledge disseminated and awareness cultivated regarding stigma and discrimination and, more specifically, the adverse effects of these phenomena on PLWHA. Lack of information firmly stands as a major contributing factor to enduring prejudicial attitudes. Moreover, stigma varies from context to context, with different varieties of stigma manifesting themselves differently, depending on their bearing on social inequality and social differences and to further legitimise the continued dominance of certain socially influential groups (Campbell *et al*., 2005: 10). Such prejudice may automatically lead large sections of society to dislike certain groups of people, including those who are HIV-positive.

As HIV/AIDS continues to wreak havoc on humankind, Van Dyk (2012: 467) observes that society's tendency towards moral judgements and assumptions regarding the sexual behaviour of HIV-infected people have increased. PLHWA are stigmatised and discriminated against. As such, society may influence caregivers not to care for PLWHA because the epidemic is incurable and sufferers are simply waiting to die, making any attempts at intervention pointless. Such attitudes stem from the stigmatisation and discrimination that characterises responses based on moralising attitudes and a lack of knowledge (Parker and Aggleton, 2002: 3). Such attitudes are detrimental to the fight against the pandemic. In other communities, PLWHA may be regarded as bringing disgrace to families and communities (Parker and Aggleton, 2002: 3).

The way in which stigma and discrimination are manifested depends on the way in which different communities react to HIV/AIDS. In this study, teachers may find themselves in a work environment filled with professionals who are well informed about HIV/AIDS-related issues but within a surrounding community wherein lay people prejudge HIV-positive teachers. The reason for such judgments against teachers could be mainly the result of their expectations of the professionals with whom their children spend the greater part their days. The community's response to

HIV-positive may be hostile. Stigmatisation and discrimination is a reality for PLWHA. Avert (2010: 47), cited in Kamau (2012: 1), is adamant that:

> Stigma and discrimination of PLHWA is exacerbated by ignorance about the disease, misconceptions about how HIV is transmitted, limited access to treatment, responsive media reporting, incurability of the disease and fears and prejudices relating to socially sensitive issues including sexuality.

All this is fertile ground for the development of stigma and discrimination. PLWHA may succumb to the disease prematurely due to stigma and discrimination. Society can cruelly assign certain identifiable characteristics to PLWHA so that they can be recognised, either erroneously or correctly, by markers such as weight loss and skin rashes (Mbonu *et al.*, 2009: 11). They are distinguished from the rest of the society through such labels. In addition, Brennan, Emlet and Eady (2011: 107) maintain the following:

> ARV treatment has improved life expectancy, other physical complications and treatment side effects have arisen and older adults continue to face a myriad of psychosocial and sexual health issues related to the disease.

Moreover, people may be incorrectly diagnosed and this leads to the development of negative ideas and prejudices about people bearing any of the aforementioned traits believed to be indicators of infection. Furthermore, the stigmatisation and discrimination experienced by PLWHA accumulates on top of existing prejudices connected to gender, race, culture and socioeconomic status and other marginalised attributes (SAFAIDS, 2009: 14).

Therefore, it may not be the teachers alone who suffer; the whole school may also be viewed as tainted. All of these causes of stigmatisation and discrimination impact negatively on PLWHA, as will be shown in the next section.

### 2.5.2 Effects of Stigmatisation and Discrimination on Teachers living with HIV/AIDS

Stigmatisation and discrimination have detrimental psychological, emotional and physical effects on PLWHA, as UNAIDS (2007: 9) cautions:

> Stigma associated with HIV and the resulting discrimination can be as devastating as the illness itself; abandonment by spouse/ family, denial of medical services, lack of care and support and social ostracism.

Stigmatisation and discrimination manifest themselves differently across different levels of society and affect those infected with the virus and those who are not in different ways, as explained below.

#### 2.5.2.1 Loss of Status and Professional Identity

UNAIDS (2007: 9) reveals that people feel tremendously worthless, depressed and ashamed after being diagnosed with HIV/AIDS. Internalised stigmatisation destroys the self of an individual. PLHWA may view themselves as no longer belonging to mainstream society or the workplace (Parker and Aggleton, 2002: 2). In extreme situations, this situation may lead individuals take their own lives. Self-stigmatisation results in feelings of shame, fear and guilt in PLWHA and other forms of stigma are built on this (SAFAIDS, 2009: 8). As a result of stigmatisation and discrimination, PLWHA experience loss of social status that makes it difficult for them to deal with the disease (Kamau, 2012: 1). PLWHA may develop internal stigmatisation as a coping mechanism designed to protect them from external stigmatisation. This often results in denials and refusal or reluctance to divulge and/ or accept HIV-positive status and avoidance of treatment (Mbonu *et al*., 2009: 2).

This condition may emotionally destabilise individuals and, subsequently, destroy their inner selves. Discrimination is acted out externally by those who are not affected and it undermines the professional identities of teachers living with HIV/AIDS. The feelings of shame, fear and denial tear teachers apart emotionally (Aggleton *et al.*, 2011: 495). Most researchers concur that feelings of worthlessness, lowered status, and loss of reputation are the adverse effects of stigmatisation and discrimination (Skinner and Mfecane, 2004; Kamau, 2012; Avert, 2011; Van Dyk, 2012; UNAIDS, 2007; Aggleton *et al.*, 2011). Thus, teachers living with HIV/AIDS cannot fully perform their roles of teaching. The quality of teaching and learning may grossly deteriorate. Although teachers continue to present classes before the onset of AIDS, knowledge of their HIV status causes severe emotional distress that make it difficult for them to be productive (Theron, Geyer, Strydom & Delport, 2008: 13;

Buchel, 2006: v). Teachers lose their reputation and learners, parents and other teachers begin to view them differently. Teachers living with HIV/AIDS generally have low morale and low self-esteem, and may feel demotivated. When teachers fall sick, the whole process of teaching and learning is disrupted and this compromises the quality of education. This is detrimental to the education system, which is currently plagued by a severe shortage of skills (Mfusi, 2011: 76), especially with regard to essential subjects like science and mathematics (*ibid*. 2011: 76). The situation may be worsened by the need for healthy teachers to take over the classes of sick teachers. Principals need time to replace sick teachers and to counsel and support them and this places a further strain on resources. Some concepts in the syllabus may not be fully covered or may need repetition. The pressure of handling social issues and professional duties may become too much for teachers living with HIV/AIDS. Teachers are expected to deliver and failure to do so may lead to verbal abuse, leading to further damage of their emotional states. In this regard, Kamau (2012: 1) cites former South African President Nelson Mandela's speech at the Barcelona Conference in July, 2002: "Many people suffering from AIDS are not killed by the disease itself but are killed by the stigma surrounding everybody who has HIV/AIDS". Their hopes of life may be shattered.

#### 2.5.2.2 Disclosure

In evidence of the impact of stigmatisation and discrimination on HIV-positive individuals propensity to disclose their status, Mbonu *et al.* (2009: 11) and UNAIDS, (2007: 9) agree that it is difficult for PLWHA to disclose their status when they are in denial, afraid and, above all, face the threat of stigmatisation and discrimination. Stigma is strongly connected to secrecy and denial, and these two factors stand in the way of a lessening of transmission (Mbonu *et al.*, 2009: 11). The effects of antiretroviral treatment on the physical appearance of PLWHA, however, may lead to forced disclosure (Avert, 2011: 46), although people may also be falsely labelled as HIV-positive since HIV/AIDS is not the only medical condition that causes changes physical appearance. The profound fear surrounding HIV/AIDS often deters people from getting tested and therefore stands in the way of the implementation of preventive measures, treatment and support (UNAIDS, 2007: 11). This can be a barrier to the fight against the effects of HIV/AIDS (Avert, 2011: 47 and CSA, 2007:

13). Nevertheless, the uptake in antiretroviral treatment has decreased the burden of caring for PLWHA (Avert, 2011: 46). As Kamau, (2012: 1) assert, “medical advances have greatly extended the life expectancy of many PLWHA by transforming HIV/AIDS from being an acute terminal illness to a chronic condition”.

Carter (2009: 13) describes the campaigns launching HIV testing and free provision of condoms by the South African government as a commitment to relieve the effects of HIV. It is important for teachers to get tested for HIV so that they can benefit from the free HIV/AIDS interventions available. As Skinner and Mfecane (2004: 159) contend:

> A prime impact of discrimination is that it pushes the epidemic underground, forcing people who have contracted HIV and anything else associated with the disease into hiding.

People’s inner feelings about their status determine how they interact with their outside world. Teachers spend the majority of their time with their leaders and learners. They may be used as scapegoats when learners give excuses for not coming to school. They suffer as a result of stigmatisation by their colleagues, learners and learners’ parents. Learners may fear contamination. Fellow teachers may not wish to mix or share food with fellow HIV/AIDS positive teachers. Parents may push for the transfer of teachers with HIV/AIDS to other schools and may influence others to withdraw their children from these teachers’ classes or schools. Van Dyk (2012: 467) reveals that, if learners refuse to be taught by infected teachers or other teachers refuse to work with teachers believed to be HIV-positive or have AIDS, disciplinary action may be taken. It may be difficult for teachers living with HIV/AIDS to stand up for their rights in the face of so much stigmatisation and discrimination in schools. School communities and society at large may blame teachers for contracting the disease. This elevates their feelings of guilt and shame. Therefore, infected teachers may restrict their own participation in society and life in general. Teachers living with HIV/AIDS may also blame themselves and engage in changed patterns of social interaction. Meanwhile, the community often blames them for bringing the HIV/AIDS pandemic into their midst. Furthermore, this blaming intensifies as teachers are increasingly absent from classes and the quality of their performance becomes erratic.

#### 2.5.2.3 Social Exclusion

HIV/AIDS-related stigma leads to social differences that cause many forms of negative treatment of PLWHA (Kamau, 2012: 1). They can be socially excluded by colleagues at work and shunned by family and the community at large. This may hamper individuals' efforts to come to terms with the HIV/AIDS pandemic (Avert, 2011: 46). Furthermore, Mbonu *et al.* (2009: 11) reveal that this cultural context causes infected individuals to fall into social disgrace, becoming isolated from the rest of the community and this affects their quality of life.

As such, Kamau (2012: 1) cautions that:

> Exclusion and rejection were persistently sources of social and psychological stress, which lead to low motivation, poor self-perception, low motivation, poor self-perception, low esteem, loss of status and limited social interactions.

Negative labelling leads to stereotyping. In this context, United Nations Secretary-General Ban Ki Moon acknowledges that stigma continues to be the single most influential barrier to public action (Avert, 2011: 5). It is the major reason why most people are scared to get tested, which is a precondition for early intervention and treatment. When people go into hiding to avoid the social disgrace of openly talking about the pandemic, the perception of HIV/AIDS as sinister and shameful is perpetuated and exacerbated. They are afraid and ashamed to take advantage of the available intervention campaigns, even though these are spoken about nearly every day. Stigma is the reason why the HIV/AIDS pandemic continues to destroy societies worldwide. Although some people may have sympathy with teachers who have contracted HIV/AIDS and are attempting to make the disease invisible, HIV-positive teachers are still ridiculed and harassed within the school or community. As the most stigmatised epidemic in history, HIV/AIDS has proved a fierce challenge to humanity. Teachers are even stigmatised within their closest social circles, whose support they actually need most. Their social support systems may become eroded (UNAIDS, 2010: 1). Teachers are often unable to perform at their best when they are depressed, anxious, lonely, and withdrawn. Efforts to shift perceptions and shatter stereotypes may be difficult in the face of such stigmatisation and discrimination.

## 2.6 Theoretical Framework: Transformational Leadership Approach

Theory is useful in justifying whatever decisions leaders choose to make. The role of leaders is enhanced by awareness of the theoretical framework supporting practice in educational situations (Bush, 2005: 65). Over the years, the theories of educational management have been classified into different categories. Among these categories is the transformational model, which is one of the foremost models, according to a number of empirical studies, in addition to the ethics of care approach. The transformational leadership approach has been deemed complete because of its normative approach, which capitalises on a series of methods that leaders can implement to influence the school results and the direction of outcomes (Bush and Middlewood, 2005: 11). A number of researchers – such as Burns (1978); Peterson (2009); Bush (2008); Sonnenfeld (1995); Crigger and Godfrey (2011); Bass and Bass (2008); Mahabeer (2011); Holly *et al.* (2010); Bass (1991); Bush, Bell and Middlewood (2010) and Nwagbara (2011) – have placed great emphasis on the value of the transformational leadership approach. They agree on the inclusiveness of transformational leadership and assert that high productivity is linked to job satisfaction and a work environment that considers staff members as contributors to the success of the whole organisation. Hallinger (2007: 335) comments that transformational leadership focuses on building the capacity of subordinates in addition to exercising control, leadership, directorship and coordinating the process. Transformational leadership is based on a leader's ability to communicate a shared vision and to motivate followers to engage in behaviour that helps the organisation to achieve that vision (Schaubroek, Cha & Lam, 2007: 110). As Bush (2007: 392) explains:

> The transformational leadership approach has the ability to involve all stakeholders in the achievement of educational objectives. In the South African context, transformation requires action at all levels and there are limits to what principals can achieve in the absence of appropriate physical, human and financial resources.

The qualities of this model make it ideal within the emerging paradigm in which principals must not only fulfil their traditional roles only but also have to immerse themselves in sensitive HIV/AIDS-related issues. Burns (1978), as quoted by Nwagbara (2011: 61), declares that:

> At the core of the formulation of transformational leadership is the concept of transformation, a change with variation in performance, productivity and management that brings about a break from the norm as well as a marked departure from existing leadership structures.

Therefore, the role of the principals is undergoing a transformation so as to embrace new leadership challenges in the era of HIV/AIDS. A review of current literature in the field of transformational leadership is indispensable to successful intervention. The literature will be drawn from relevant sources, both local and international, alongside attempts to apply the tenets of transformational leadership theory to the manner in which school principals handle sensitive HIV/AIDS-related issues. The basics of transformational leadership theory will be explained in relation to fundamental educational practices and philosophies within the unavoidable new era imposed by HIV/AIDS. Manley, McCormack and Wilson (2008: 5) and Bass (1991: 21) assert that the principles of transformational leadership – namely intellectual stimulation and idealised influences – when implemented, can enhance school leaders' skills whilst offering better ethical outcomes as compared to more traditional transactional approaches to ethics.

The need for fundamental organisational change makes it imperative that school leaders possess the capacity to lead the way in developing teacher commitment to meeting HIV/AIDS-related challenges. However, a clarity concerning the practice and purposes of related actions persists (Bennet, Crawford & Cartwright, 2003: 7). School principals have been referred to as torch-bearers for change in education in addition to playing a major role in meeting social expectations (Begley, 2010: 31). Despite this, Pashiardis (2009: 18) maintains that principals have no control over the various essential elements required to support school improvement.

Principals play a crucial role in nurturing leadership skills for the management and supervision of school-based HIV/AIDS committees. Relationships formed out of

mutual stimulation and support change subordinates into leaders and has the potential to change leaders into moral agents (Cashin *et al.*, 2000). Principals facilitate such behavioural change (Bush, 2012b; Bass, 1991; Mahabeer, 2011; Begley, 2010).

Aside from modelling effective leadership behaviour for teachers, principals must also increase their followers' motivation levels to keep their school communities abreast of the changes brought about by HIV/AIDS (Rayners, 2007: 189). According to Bush (2003: 64), transformational leadership has been described as powerful and the ideal type of leadership for transforming a rapidly challenging environment. The transformational leadership model is developmental and seeks to involve every individual in the organisation. School leadership in South Africa has undergone remarkable change. The education system is threatened by HIV/AIDS. Changing South Africa's education system depends largely on a vision for the transformation of the day-to-day realities of the people working within the system (Coleman, 2003: 6). Therefore, approaches resting on moral foundations and that keep teachers informed about the goals of the school are ideal for principals to use.

This study is framed within the transformational leadership and ethics of care theories. The transformational leadership approach emanates from the work of Leithwood (1994, in Leithwood and Jantzi, 2000: 205). Researchers in this field have come up with extremely useful and stimulant tools that can be used by school principals to improve their skills levels; these focus on charisma, inspiration, vision, development of goal consensus, and intellectual stimulation (Leithwood, Tomlison & Gene, 1996: 52). The objectives are to offer individualised support, model best practices and important organisational values, demonstrate high performance expectations, create a productive school culture, and develop structures to foster participation in school decisions (Bush, 2007: 11). There are practices used to solve problems with each of these dimensions.

The theory of transformational leadership was first formed by Burns in 1978 and has since come to be highly valued within the context of education. According to Burns, transformational leadership can have an effect between two people on the micro-level and influence social systems to drive institutions to reform on the macro-level

(Rayners, 2007: 56). Furthermore, Burns (1978: 21) insists that transformational leadership can influence processes amongst peers, supervisors and subordinates, and he indicates that the outcome is performance growth, increased levels of change, and development (Rayners, 2007: 21). Yet, transformational leadership is not a panacea; it may not be applicable in some situations, where other approaches like transactional leadership are better applied (Bass, 1991: 19).

Burns (1978: 20), as cited by Rayners (2007: 65), defines transformational leadership as moral leadership:

> It is moral in that it raises the level of human conduct and ethical aspirations of both the leader and the led and thus has a transforming effect on both.

In addition, Cashin *et al.* (2000) contends the following:

> [Transformational leadership] is that which facilitates a redefinition of a people's mission and vision, a renewal of their commitment and the restructuring of their systems for goal accomplishment. It is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents.

Therefore, the transformational leadership model ensures that all members of an organisation make a contribution to the decision making. Bush (2008: 64) suggests that the main features of the transformational leadership model are as follows:

- It has a strongly normative in orientation.
- It is particularly appropriate for organisations such as schools, in that teachers have the authority of expertise that contrasts with the positional authority associated with formal models.

Bush (2005: 64) notes the following regarding transformational leadership:

- It assumes that professionals should be placed on an open platform in order to contribute to the wider decision-making process. Shared decisions are likely to be better informed and are also much more likely to be implemented effectively.
- It assumes a converging set of values amongst members of the organisation.
- The size of decision-making groups is an important element.

Brundrett (1998: 305) suggests that transformational leadership assumes that “decisions are reached by consensus; problems are solved by agreement". The possible value of the transformational leadership approach in handling HIV/AIDS derives mainly from its involvement of everyone in the organisation. Leaders try to raise their followers’ consciousness by appealing to higher ideals and values, such as liberty, justice, peace and humanitarianism, instead of dysfunctional emotions such as fear, greed, jealousy and hatred (Rayners, 2007: 189). The transformational leadership theory, paired with the ethics of care approach, could yield positive results in circumstances where people have lost hope due to the effects of HIV/AIDS. This concept of despair and loss of hope drives certain forms of behaviour, which promote the spread of HIV/AIDS and worsen the stigma of those directly affected – transformational leadership as an intervention is effective in such contexts (Rayners, 2007: 189). When people feel hopeless, they imagine that their world has come to the end. Involving all members of an organisation enhances people’s sense of belonging and nurtures positive thinking.

Therefore, intertwining the transformational leadership and ethics of care theories is bound to achieve positive results in school leadership with regard to HIV/AIDS. Both theories are grounded in moral foundations. Within this approach, principals tactically create a climate in which people feel inclined to care and do things well. Principals are undoubtedly responsible for setting up the conditions under which a culture of caring can thrive.

Furthermore, multicultural South Africa needs transformational leadership that caters for its cultural diversity. There needs to be a context in which people from different cultural backgrounds feel valued and respected. School principals undoubtedly have teachers from different cultural backgrounds under their jurisdiction. The movement towards transformational leadership requires a different way of taking into account the leadership role of principals, especially those who have hitherto regarded themselves as instructional leaders or managers (Hallinger and Hausman, 1994: 337). A movement away from the instructional approach is necessary in South Africa, especially now, so long after the end of apartheid, with different cultural groups having long since merged with one another. South Africa requires a paradigm shift in education management training; the old scientific education management

approach should be replaced with a new approach that focuses on the leadership role of the manager in change management, relationship building, strategic alignment, and continuous learning (Joubert and Rooyen, 2008: 65). There is a need for a complete overhaul of the system.

Rather than focusing specifically on direct coordination, control and supervision of curriculum and instruction, transformational leadership seeks to build the organisation's capacity to select its purposes and to support the development of changes to practices in teaching and learning. Transformational leadership may be viewed as distributional in that it focuses on developing a shared vision and shared commitment (Hallinger, 2010: 331).

As Rayners (2007: 89) asserts, transformational leaders employ idealised influence, inspirational motivation, intellectual stimulation, and individualised consideration so as to attain greater levels of achievement. In addition, Kouzes and Posner (1995: 8) group the characteristics of transformational leadership into four categories: enabling others to act, modelling the way and encouraging the heart, challenging the process, and inspiring the vision. Both parties – principals and teachers – are motivated.

Leithwood *et al.* (1996: 52), Bush (2012b: 9) and Bass (1991: 19) maintain that followers need to feel leadership. This type of approach closes the gaps created by formal models. Principals as transformational leaders need to employ some behaviour that includes setting goals and a vision for the school. They need to facilitate teamwork to bring people together in decision making, render individualised support for their staff, and be role models. Their acceptable professionalism will lead to them being looked up to as examples of what is expected. Most importantly, this will encourage individuals who are affected or infected to come forth and seek help. The various dimensions of transformational leadership are outlined below.

### 2.6.1 Charisma/ Inspiration/ Vision

Charisma, inspiration and vision are referred to by Calitz *et al.* (2002: 3) as "idealised influence". Their point of departure is the development of a leader alliance in which

every stakeholder of the organisation is involved. Around 1990, there was a major shift in research to leadership approaches – for instance, empowerment, distributed leadership, and organisational learning – believed to be more consistent with gradually developing trends in educational reform (Hallinger, 2003: 339). This creates a space in which teachers feel at ease to discuss their most sensitive issues with their principals.

Transformational leadership has often been regarded as the same, in some ways, as charismatic leadership. There has been much debate to regarding whether an empirical or conceptual distinction exists between the transformational and charismatic leadership theories. According to Murphy and Louis (1994: 78), transformational leaders enhance their followers' commitment by appealing to their self-concept through increasing some noticeable identities and values. Leaders commit themselves to the organisational vision and mission that promotes its identities and values. Therefore, transformational leadership promotes the motivation of staff and keeps staff members informed about how to maximise their self-efficacy (Schutte and McLennan, 2001: 45).

Transformational leaders are charismatic visionaries and can influence subordinates to transcend their own self-interests for the good of the organisation (McLennan, 2001; Bush *et al.*, 2010; Bass, 1985; Crigger and Godfrey, 2011; Nwagbara, 2011). As much as there is large volume of literature on charismatic leadership that strongly overlaps with the literature on transformational leadership, charismatic leadership is not considered to be the same as transformational leadership in this study. Nonetheless, charisma is an important aspect in transformational leadership. Intensive research into charismatic leadership predates research on transformational leadership by many years (Leithwood *et al.*, 1996: 21). Conger and Kanungo (1987: 638) refer to charisma as an "attribution phenomenon". Followers attach charismatic qualities to leaders depending on the leaders' behaviour and the realised results associated with the behaviour. According to Bryman (1992, in Rayners, 2007: 69), these attributions take place in relation to the existence of social relationships, in which, by virtue of unusual qualities attributed to leaders by followers, the charismatic leader is regarded with combined reactions of great respect, awe and unflinching dedication.

However, problems may arise if the leader fails to measure up to the subordinates' expectations, as there is no guarantee that subordinates continue to look up to their leaders indefinitely. Bush (2005: 64) argues that something is gained when teachers work together and something is lost when they do not. In agreement, Sonnenfeld (1995: 72) claims that followers become proud, faithful, respectful, and willing to go the extra mile when they are kept informed of the organisation's mission.

Conger and Kanungo (1987: 638,) propose certain specific forms of behaviour, including:

> Enthusiastically advocating an appealing vision that is acceptable to the followers; making self-sacrifices and risking personal loss of status, money or organisational membership in pursuit of the espoused vision; and acting in unconventional ways to achieve espoused vision.

Conger and Kanungo use these characteristics to identify charismatic leaders. Ethical charismatic leaders achieve functional organisational outcomes such as example organisational change and solicit remarkable performance standards from their colleagues. With ethical charismatic leaders, followers are developed into leaders through empowerment. Followers grow in confidence, independence and capability. Alternatively, if charismatic leaders are unethical, they can destroy the people whom they are leading. Conger and Kanungo (1988: 15) argue that ethical and unethical charismatic leadership is, in simple terms, the product of a leader's value system.

Charismatic leaders need to make the organisational vision as attractive as possible in order to convince followers to believe in it (Rayners, 2007: 25). Leaders should be able to deal with crises in their organisations. It is questionable whether charisma can be effective in handling crises and uncertainty. The ability of leaders to change their followers depends, for instance, on the extent to which they are able to behave in what followers think is acceptable and to stimulate their followers intellectually. Both how leaders behave and the situations in which followers find themselves consequently lead to charismatic attributions. Although the intensity of charisma may differ, it can cluster individuals into groups and extend to the whole organisation. In

the process, transformational leaders inspire self-confidence, self-esteem, and the spirit of dedication in their followers. They create remarkable relationships with their followers while articulating a vision known to everyone. Nevertheless, followers who are more independently minded are less likely to follow even charismatic leaders (Bass and Bass, 2008: 22). Holly *et al.* (2010: 134) argue that leaders with large amounts of energy and enthusiasm can make teachers weary and so actually decrease their motivation. Part of the toll of the HIV/AIDS pandemic has been its unprecedented erosion of the workforce, especially in terms of teachers. Principals need to create a vision that includes staying on top of the demands of their new roles as support agents. It is beyond question that principals have the responsibility to build visions for their schools and that, in order to achieve this, they need to be inspirational and influential (Sterling and Davidoff, 2000: 23).

The leader needs to be one of the people. Kouzes and Posner (1995: 26) argue that, in order to obtain people's support for a vision; it is important that leaders identify with their subordinates and speak their language. It is imperative that principals are aware of the HIV/AIDS prevalence in the schools within the Gauteng Department of Education. Principals need to be prepared to go the extra mile in line with their performance areas so as to inspire a shared vision within others in their workplaces. They can do partly achieve this by modelling certain behaviours for their followers to emulate.

In spite of several studies utilising charismatic leadership as a conceptual framework, there is no one set of leadership behaviour and characteristics upon which all theorists can agree (Bolman and Deal, 1997: 16). Bush (2007: 12) observes that the existence of several different perspectives creates "conceptual pluralism: a jangling discord of multiple voices".

### 2.6.2 Developing Goal Consensus

The most noticeable characteristic, according to Bennett, Crawford and Cartwright (2003: 7), is that transformational leadership encourages greater levels of personal commitment and enhances the capacity for the accomplishment of organisational

goals. Transformational leadership empowers and elevates people to greater heights. However, this model emphasises the existence of mutual interests between leader and followers (Burns, 1978: 9). A leader's behaviour, as claimed by Leithwood *et al.* (1996: 52), should encourage cooperation amongst employees and bring them together to achieve set goals. Leaders need to be highly committed to engaging their colleagues.

A principal is an intermediary between subordinates, the school, and the transforming context within which they all have to work. Principals influence and inspire teachers to focus on moving in the direction of common goals (Cunningham and Cordeiro, 2009: 6; Rath and Conchie, 2008: 45).

Principals empower their teachers (Mahabeer, 2011: 92). Leaders must exercise influence instead of authority, especially when dealing with sensitive HIV/AIDS-related issues amongst their teachers. In support of this assertion, Bush (2012b: 9) offers the following remarks:

> The increasing range of complexity of leadership and management responsibilities in schools and colleges means that it is no longer possible, if it was, for the principals to be sole leaders.

Thus, principals must now delegate duties and their leadership is distributed. In their empirical studies, Leithwood, Mascall and Strauss (2009: 59) have clearly shown that the distribution of leadership has improved school effectiveness, development, and the achievement of outcomes. It is important for principals to be able to acknowledge that they are not all-knowing. However, Holly *et al.* (2010: 134) warn that delegation of duties by principals actually may be regarded as pushy and forceful by teachers. Teachers may not be willing to participate in leadership activities or any other duties besides those included in their job descriptions.

It is of paramount importance to identify appropriate approaches for dealing with the stigma attached to HIV/AIDS in partaking of HIV/AIDS policies at school level. Leaders' most important duty is to try to understand the people they lead and situations in which they find themselves, as well as how to respond in an appropriate and meaningful manner (Sterling and Davidoff, 2000: 16). By interacting with their

subordinates and colleagues within the same organisation and observing their behaviour, leaders can identify their needs (Noddings, 1984: 69; Noddings, 2003: 19). Thus, the extent to which principals understand themselves as leaders lays the foundations for their ability to understand others.

### 2.6.3 Offering Individualised Support

The transformational leadership approach emphasises that the school leader must show respect and consider different individual interests, needs, value systems, and feelings (Calitz *et al.*, 2002: 3; Podsakoff, Mackenzie, Moorman & Fetter, 1990: 24). School leaders need to commit themselves to understanding other people's feelings, assessing situations accurately, and having a good sense of social judgement in the process of considering people as individuals. Gornall and Burn (2013: 46) assert that teachers will trust their leaders if they give them their undivided attention and take time to find out about their problems and prioritise them on their agendas. Sonnenfeld (1995: 72) maintains that principals coach and advise teachers; whilst Bass and Bass (2008: 22) argue that people follow leaders in order to develop a sense of purpose because they have poor senses of self and low self-esteem themselves. Teachers should not be treated as a homogeneous group because each person's needs are different.

The most important asset in any organisation is its human resource force. The prosperity of the organisation depends on the wellbeing of its people, which can be assured via, for instance, successful HIV/AIDS-management programmes (Grobler, Warnich, Carrell, Elbert & Hatfield, 2002: 8). Echoing this sentiment, Swanepoel, Erasmus, Van Wyk and Schenk (2003: 5) contend that transformation in South Africa depends largely on the way in which the people within organisations –their employees/ human resources – are managed. This is a clear indication that change is possible with regard to the general attitude towards the HIV/AIDS epidemic. Amongst all the resources available to principals, it is only people who can grow, develop, and become motivated about the achievement of desired goals (Riches and Morgan, 1989: 15). Principals need to explore and adopt ways of approaching

teachers who are infected and affected by HIV/AIDS. Before teachers are engaged in discussions, prior planning is fundamental.

It is widely acknowledged that some meaningful transformation away from traditional ideas of personnel management has been experienced. Traditionally, this was regarded as an administration task performed by a skilled group of personnel experts. The new era has seen the major shift towards human resource management, which has considerable implications for the idea of managerial autonomy for principals (Human Resource Management, 1997, in Beckman, Bray, Foster, Maile, Smith & Squelch, 2000: 12). The term "Human Resource Management" (HRM), as described by Tyson and Kakabadse (1987: 13), is designed to convey the importance of managing people the same way as one would manage scarce resources, so that care and attention are devoted to the acquisition, utilisation, motivation, and development of organisational members. In support of this, Hallinger (2003: 336) posits the following:

> Behavioural components such as individualised support, intellectual stimulation and personal vision suggest that the model is grounded in understanding the needs of individual staff rather than coordinating and controlling them towards the organisation's desired ends.

Thus, the approach aims at influencing organisational members by supporting them from the bottom up as opposed to from the top down. The education system needs a human resource management plan that approaches employees from an angle that systematically identifies the specific management development activities that institutions are in need of to achieve set objectives through quality management and dynamic leadership (Loock, Campher, Du Preeze, Grobler & Shaba, 2000: 12). The process of structuring and designating specific duties must be preceded by thorough observation and analysis of information regarding the nature of the job in question (*ibid:* 12). The education environment has become more complex and dynamic, necessitating the development of more influential school principals. Principals are governed by several policy initiatives and the different situations in which the management of HIV/AIDS take place. Grobler *et al.* (2002: 9) explain that departmental heads must play their parts in managing their human resources, as this has major effects on the whole organisation.

Hence, the transformational approach emphasises collaboration between the principal and the teachers in order to ensure success in creating conditions necessary for achieving organisational goals. Leadership may, to a certain extent, be shared by the teachers and the principal (Leithwood and Jantzi, 2006: 226). This creates a strong foundation for the ever-increasing need to legislate workplace policies related to equity, health and safety. Riches and Morgan (1989: 17) refine this idea by indicating that, if human resource management is done effectively and efficiently, it leads to optimum performance, which is one of the goals of leadership. The new South African government advocates ideologies supporting economic growth and frugality. The task of human resource management in South Africa has grown to be more complicated, as a result of statutory and legislative development that impacts on human resource management (Beckman *et al.*, 2000: 11).

It is crucial that principals be cognisant of human resource management policies when applying HIV/AIDS policies in an effort to enhance their holistic leadership approaches. How they go about their human resource management has major consequences for their school organisations (South Africa. Department of Education, 2007: 3). Policies of education continue to evolve and principals need to keep abreast of these developments.

### 2.6.4 Providing Intellectual Stimulation

Transformational leaders intellectually stimulate subordinates, encouraging them to gradually acquire more innovative ways in viewing problems (Calitz *et al.*, 2002: 3; Holly *et al.*, 2010: 134; Bass, 1991: 23). Subordinates are given the chance to exercise authority; they are coached as well as advised. Leaders have an obligation to commit followers to work and convert them into leaders. Intellectual stimulation refers to challenging followers to re-examine some of their work and to rethink how it can be performed (Podsakoff *et al.*, 1990: 16).

Leadership is a process whereby the school is developed in an on-going way. Leadership is about developing subordinates' capacity to handle challenges in an

appropriate and flexible manner; it is not necessarily about creating the perfect school. (Sterling and Davidoff, 2000: 24). This teaches the staff to be prepared for change. Transformational leadership emphasises the motivation of followers to achieve their full potential by influencing them. Transformational leadership appeals to followers' standards of behaviour and moral values to develop different problem-solving strategies. (Rowling, 2003: 25). This increases the probability that teachers will be able to open up when necessary.

### 2.6.5 Modelling Best Practices and Important Organisational Values

As has been commonly found, one of the contributory factors to school effectiveness is the style and quality of leadership offered by the school principal (Bush and Middlewood, 2005; Bush, 2005: 1; Bush and Jackson, 2000: 418; Girvin, 1995: 5; Jirasinghe and Lyons, 1996: 7; Nathan, 2000: 3). It is vital that principals understand their key duties as they are responsible for their schools' organisational functioning with the context of South Africa. Bush (2012b: 25) highlights that there is a greater probability of teachers committing themselves if they feel valued by their principals. A gradual development in school leadership supported by new legislation has, to a large extent, transformed the relationship between district education authorities and schools. The most important aspect of this altered relationship is the need to lead and "manage educational provision at school level" (West and Ainscow, 1991: 35). Principals are expected to shift away from autocratic approaches.

The new era imposed by HIV/AIDS has presented daunting challenges for people in leadership and management. The HIV/AIDS pandemic has wreaked indescribable devastation on the people of South Africa. The war against HIV/AIDS will be won by the majority initiating action at grassroots level (Whiteside and Sunter, 2001: 15). Individuals can make contributions toward the extermination of the HIV/AIDS pandemic. Nevertheless, effective and efficient leadership is also a necessity.

Principals are in the strategic position to lead huge school communities at grassroots level, where they can substantially contribute to initiatives to curb the HIV/AIDS pandemic. It is therefore important for school leaders to reflect on competence levels

and identify the nature of development they need in order to be effective, holistic and efficient leaders. Principals, as leaders, need to acknowledge the requirements of their own organisations as unique and be able to choose from the diverse repertoire of qualities, abilities and expertise at their disposal (Sterling and Davidoff, 2000: 34). This aspect of transformational leadership includes a wide range of behaviours and values that the leader consistently models as an example for subordinates to follow (Podsakoff *et al.*, 1990: 7). In support of this assertion, Leithwood *et al.* (1996: 810) contend that "transformational leaders also engage in forms of behaviour that are intended to reinforce key values of others". Principals are therefore obligated to be role models.

### 2.6.6 Demonstrating High Performance Expectations

The growth in complexity of the education environment and its particular dynamics calls for efficient, effective and holistic approaches. This demands principals who are determined to execute a high level of performance:

> [Principals] have the responsibility for all members in the organisation that is teachers, learners and non-teaching staff. Furthermore, they appoint, deploy and develop all staff members. (Nathan, 2000: 98)

School principals liaise with parents, the Department of Education, local industries and surrounding communities, while working in partnership with school governing bodies. Transformational leadership involves forms of behaviour that show the principal's expectations of excellence, quality, and optimum performance on the part of followers (Podsakoff *et al.*, 1990: 7). Principals need to interact with teachers as unique individuals and develop policies that consider the school community as a whole. Principals set the school tone.

As suggested by Leithwood *et al.* (1996: 59), principals' expectations motivate teachers view the goals pursued by the school as exciting challenges. Principals are thus able to clarify the way in which teachers perceive the gap between the aspirations of the school and its current accomplishments. In support of this contention, several researches stress that transformational leadership impacts greatly on how teachers perceive school conditions, their obligation to change, and

the teaching and learning that takes place in the whole school (Bogler, 2001; Day, Harris and Hatfield, 2001; Fullan, 2002). School principals, as leaders, have profound influence over the way in which teachers perceive progress within the school. Leaders influence the implementation of reform initiatives and interventions to improve student outcomes (Hallinger, 2003: 337). Teachers cannot do this alone, without the principal setting the direction. Therefore, teachers are determined to achieve the set goals.

### 2.6.7 Creating a Productive School Culture

The most important challenges facing South African principals are reconstruction and change (Sterling and Davidoff, 2000: 3). Principals have a challenge to encourage all community members to take it upon themselves to make a difference within the school. Principals have a responsibility to facilitate strategic, cultural change and develop the organisation in the face of continuous environmental change. Fortunately, as Leithwood (1992: 124) insists, people can be taught new leadership skills that can be successfully used to encourage collaboration in the school culture. It was mentioned earlier in this paper that school leaders set the school tone and that principals build the culture of the school. Cultural components include those forms of behaviour that are aimed at the development of school values, norms, and beliefs commonly held by community members. Transformational leadership advocates forms of behaviour that enhance collaboration in problem-solving, which is likely to yield positive results. Bass and Bass (2008: 59) explain that principals may be forced to appeal to the values of the group, about which they may not be able to identify certain hidden details. They can influence researchers' motivation to transform their contextual beliefs.

Teachers grow professionally through close working relationships with peers, thereby enhancing their efficacy (Leithwood *et al.* 1996: 60). These forms of behaviour give shape to the transformation of schools' cultural content and strength. School are powerful components of society that can influence people's beliefs regarding HIV/AIDS. Hallinger (2003: 340) makes the following conclusion: "The collaborative process encourages teachers to advance their studies, learn more, and

seek and share information". The collaboration of all stakeholders accelerates school improvement.

### 2.6.8 Developing Structures to foster Participation in School Decisions

The school structure is of paramount importance for the development of people in any given school organisation. Schools are regarded as influential beacons in their communities and the Gauteng Department of Education must acknowledge the way in which schools are strategically situated to aid in the prevention of HIV/AIDS (O'Connor, 2003: 31). Thus, the leadership of schools matters. The different structures, such as the HIV/AIDS committee, within these organisations play an important role. Alongside this the role of the modern principal is far more extensive than it once was.

Principals are instrumental in the new South African education system, which has gone through extensive transformation and reconstruction. They need to be aware of the challenges they are faced with and be fully conversant with the new contexts in which they work in order to deal with them appropriately. Therefore, principals must be able to get to know their subordinates and see the best in them in order to be able to understand and support them in their struggles.

Schools implement policies passed down from regional, provincial and national level. The uniqueness of the school as an organisation requires a transformational type of leadership to in order to debunk the horror stories and myths surrounding HIV/AIDS. Followers must be given opportunities to contribute to decision-making about matters that affect them. This transformational leadership dimension engenders discreetness and independence for followers. Sergiovanni (1991: 75) and Leithwood *et al.* (1996: 61) suggest that all members have a duty to mould the school into an ideal reflection of society. The Department of Education views schools as the central points of their communities. Schools are expected to lead the way and forge partnerships, thereby ensuring a clear and logical response to the impact of HIV/AIDS (South Africa. Department of Education, 2003a: 5). Such behaviour has the potential to transform

people's minds by impacting positively on their beliefs and arousing their emotions. Principals need to provide informative feedback to teachers in relation to their performance (Leithwood *et al.* 1996: 61).

## 2.7 Ethics of Care Theory

School leaders have a duty to both care and take responsibility for their subordinates. This can present ethical challenges, hampering their efforts to perform their duties effectively (Ciulla, 2009: vi). In this study, the ethics of care theory will be explained in relation to how it can be employed by school principals in dealing with teachers living with HIV/AIDS. The ethics of care approach, as propounded by Noddings (1984: 69), maintains that caring should be rooted in receptivity, relatedness and responsiveness (Kordi, Samaneh & Reza, 2012: iv). Koggel and Orme (2010: 10) refer to ethics of care as a normative ethical theory regarding what makes actions right or wrong. Caring relationships are basic to human existence and consciousness and they consist of two parties; that is, the carer and the person being cared for (Noddings, 2009: 9). It is the principal's responsibility to care for teachers living with HIV/AIDS.

Tronto (2010: 5) argues that all human beings need care at all times although it is all in the minds of people that it is those people who are vulnerable or dependent who need help. Teachers living with HIV/AIDS are vulnerable and dependent on principals for support. Principals are morally compelled to attend to sick teachers' needs and challenges. Thus, Held (2006: 10) posits the following:

> The central focus on the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibilities.

Principals are faced with new challenges in the face of the HIV/AIDS pandemic. The carer should display qualities referred to as "engrossment" and "motivational displacement", and the person receiving care should display some form of response to the caring (Noddings, 1984: 67). This approach is ideal for the current scenario in education in which principals have to handle the effects of HIV/AIDS amongst their teaching staff. The ethics of care theory appeals to our desire to do the right thing,

especially for those who are concerned about us (*ibid.*, 1984: 67). Gilligan (2011: 23) elaborates:

> The most important thing about ethics of care morality is grounded in a psychological logic, reflecting the ways in which we experience ourselves in relation to others and that the origins of morality lie in human relationships as they give rise to concerns about injustice and carelessness.

The ethics of care speaks to the concerns about oppression and abandonment that happen in everyday life and argues that human beings need care for survival. Basically, all human beings need care and are dependent on one another in order to achieve their various interests. Teachers living with HIV/AIDS are in particular need of such care.

In this study, the term "caring" refers to the relationships between principals and teachers. As teachers attempt to address their learners' needs, they may deem it necessary to design activities that cater for individual learner differences as they interact with them every day get to know their needs and interests (Noddings, 1984: 5). Similarly, it is fundamental to caring that principals understand their teachers as individuals and not treat them like a collective, homogenous entity. Furthermore, Gilligan (2001: 7) and Hoffman (2000: 8) emphasise empathy and moral development in caring. Principals need to establish continuous relationships with teachers so as to develop a deeper understanding of their needs. As a result, Noddings (1984: 6) proposes the practice of engrossment, whereby someone thinks about other people in such a way as to gain a more in-depth understanding of them. Moreover, Siegel (2009: 217) posits the following:

> An ethics of care is likely to claim that we have a stronger obligation to help someone whose stress we are witnessing than to help a person whom we do not know.

Principals are tasked with trying to understand the problems experienced by their teaching staff. Caring ought to be a principle underlying ethical decisions because caring is a fundamental human need (Noddings, 2009; Tronto, 2010; Ruddick, 2009; Capuzzi and Stauffer, 2012). Noddings (2002: 14) and Sander-Staudt (2011: 29) argue that caring relationships should develop naturally out of the instinctual desire

to do something good rather than out of abstract moral reasoning. Thus, Noddings (2003: 19) contends the following:

> A major act done grudgingly may be accepted graciously on the surface but resented deeply inwardly whereas a small act performed generously maybe accepted nonchalantly but appreciated inwardly.

The cared-for may be satisfied with their care depending on the concern and interest shown by the person doing the caring. The HIV/AIDS pandemic carries with it a strong stigma so that the cared-for desperately want to see genuineness in those who care for them.

Noddings (2009: 89) indicates that the carer and cared-for each make a contribution, with the cared-for recognising the effort of the carer and thus completing the relationship. Noddings (2009: 87) elaborates that we cannot care for everyone and that caring needs direct contact. A caring relationship between teachers and principals is bound to prosper as they are frequently in contact.

Caring relationships are bound by moral significance and that the ethics of care theory strives to maintain relationships by encouraging the welfare of the ones giving care and those receiving it while networking social relations (Sander-Staudt, 2011: 29). It instils strong motivation in people to care for people who are vulnerable and dependent. In essence, principals are encouraged to care for teachers living with HIV/AIDS out of a sense of moral responsibility. The ethics of care theory seeks to hinder the accretion of power to those already in power and to encourage activities that give rise to shared power (*ibid.*: 29). Transformational leadership also encourages the distribution of power. This encourages moral relations and relationships. Consequently, Tronto (1993: 45) has come up with the following ethical factors that facilitate the penetration of followers' sensitive issues of care:

### 2.7.1 Attentiveness

The ethics of care theory requires people to recognise of other people's needs so as to respond to them.

### 2.7.2 Responsibility

People who care need to take upon themselves the responsibility to do so. There must be willingness to pay attention to the needy. However, the terms “responsibility” and "obligation” clearly mandate action. Principals are responsible for their teaching staff to the extent that they are obligated to care for them.

### 2.7.3 Competence

When providing care, one needs to be competent to do so; i.e. one has to be adequately equipped to meet the needs of the person for whom you are caring.

### 2.7.4 Responsiveness

The cared-for are expected to respond to their care. Care has to do with circumstances of vulnerability and inequality. Responsiveness is a way of understanding the vulnerability and inequalities of those who are vulnerable share their experiences. In point of fact, responsiveness and reciprocity help the carer to figure out how those for whom they are caring are feeling.

The ethics of care encourages responsiveness in relationships as there is a need to pay attention, listen and respond. The theory’s logic is inductive, contextual and psychological (Gilligan, 2011: 1):

> The ethics of care starts from the premise that as humans we are inherently relational, responsive beings and the human condition is one of connectedness or interdependence.

The transformational leadership approach is advocating the communication of the organisational goal and common vision to all stakeholders because communication helps to build up relationships. In fact, Gilligan (1982: 89) refers to the necessity of a network of relationships and explains that people cannot stand alone. This network of relationships engenders a sense of belonging amongst teachers living with HIV/AIDS. Such networks are powerful tools for fighting stigmatisation and discrimination. Therefore, Noddings (2003: 19) offers the following remarks:

> The one-caring is sufficiently engrossed in the other to listen to him and to take pleasure or pain in what he recounts; whatever she does the cared-for is embedded in a relationship that reveals itself as engrossment and in an attitude that warms and comforts the cared-for.

Both parties play a part in building up the relationship:

> Prospects for human progress and flourishing hinge fundamentally on the care that those needing it receive and the ethics of care stresses the moral force of the responsibility to respond to the needs of the dependent. (Held, 2006: 10)

Teachers living with HIV/AIDS depend on their principals for support. Principals cannot avoid responsibility for their teachers' social welfare and overall wellbeing because they are bound by a moral imperative. In reference to morality, Noddings (2009); Koggel and Orme (2010); Capuzzi and Stauffer (2012); Held (2005); Tronto (2010); Ruddick (2009); Kittay and Meyers (1987) assert that caring manifests as a moral attitude connected to the complicated skills of interpersonal reasoning and that it is neither without its own forms of strictness nor professionally less significant than the calculated skills of formal logic. In addition, Baier (1995: 32) strongly contends that a basic relationship and trust are fundamental to morality and encourages development of character traits such as agreeability, gentleness, sympathy, compassion and good temperedness. Accordingly, Noddings (2002: 43) makes the following assertion:

> Ethical caring, the relation in which we do meet the other morally [arises] out of natural caring – that relation in which we respond as one caring – that relation in which we respond as one-caring out of love or natural inclination. The natural caring [is] the human condition that we consciously or unconsciously perceive as good? It is that condition toward which we long and strive and it is our longing for caring – to be in that special relationship – that provides the motivation for us to be moral. We want to be moral in order to remain in the caring relation and to enhance the ideal of ourselves as one-caring.

Similarly, Noddings (1984: 8) asserts that the carer acts in motivational displacement, by which their motive energy flows towards the cared-for individual. The art of talking is fundamental to relationship building. To refine this point, Noddings (1984: 9) contends that dialogue contributes to growth of the cared-for. Furthermore, Siegel (2009: 216) explains that the best way to show love for other people is to directly focus our attention on and be emotionally engaged with them.

Thus, Noddings (2003: 2) recommends the following:

> Ideally we need to talk to the participants to see their eyes and facial expressions, to receive what they are feeling; moral decisions are after all made in real situations, they are qualitatively different from the solution of geometry problems.

Principals need to sacrifice time to explore the inner feelings of teachers and teachers need to learn to open up. Teachers may also develop a sense of caring. Teachers living with HIV/AIDS may be vulnerable and have a firm need to depend on their principals. In order to maintain a caring relationship, carers must deal with others' expressed needs in a positive manner (Mattson, 2009: 63). Noddings (1984: 70) emphasises the need for principals to always make an effort to respond to the needs expressed by teachers by discussing the moral and social issues surrounding these needs. The HIV/AIDS pandemic inspires great fear in infected and affected teachers so that they may be in too severe a state of shock to open up about their status. Therefore, principals face the challenge of devising a way to get these teachers to open up. A basic requisite of achieving this is to always act appropriately to establish, maintain or enhance caring relations (Noddings, 2002: 43).

School principals act as role models and mentors. They can influence their teachers to practise caring and reflection, thus developing them into people who care for one another. Noddings (2009: 10) refines this point by suggesting that principals model ideal behaviour by demonstrating caring in their relations with their colleagues. People often either deliberately teach other people not to care, or can place each other in situations that do not allow them to care. Principals can influence teachers to care. Koggel and Orme (2010: 10) stress affirming and encouraging the best in others. Thus, the ethics of care model stresses the need for school leaders and teachers to interact as a whole community. At the same time, the ethics of care theory emphasises modelling, dialogue, practice and confirmation as indispensable in education and as central to the cultivation of caring in society in its widest sense (Noddings, 2002; Noddings, 2006; Engster, 2005).

The ethics of care theory emphasises that people choose to care for others because they believe that caring is the appropriate way to relate to them (Held, 2006: 10). People in organisations can either purposefully or unknowingly contribute to the deterioration of other members' ethical ideals (Noddings, 1984: 8). The onus rests upon principals to develop insight into the moral values required in the practices involved in caring.

## 2.8 Summary

In this chapter, literature has been sourced and described to place the research phenomenon into context. The HIV/AIDS pandemic continues to pose unparalleled challenges to teachers, who are the main drivers of the education system. Teachers are unable to perform their duties effectively and this is, to a large extent, compromising the quality of education (Mfusi, 2011: 76). This situation has subsequently seen school principals put on the spot. They have to lead schools amid the delicacy and sensitivity surrounding HIV/AIDS-related matters. They are no longer simply fulfilling traditional leadership roles; they now bear extra duties relating to the HIV/AIDS pandemic.

The ideal is that principals treat the challenges of HIV/AIDS like any other leadership issue on their agendas. They must commit themselves to keeping abreast of the multifaceted transformations that HIV/AIDS necessitates in terms of leadership styles and approaches. Principals need to be role models in their schools so that they can spearhead school-based support teams aimed at assisting teachers living with HIV/AIDS. More importantly, principals can play a significant role in reducing the impact of stigmatisation and discrimination on teachers living with HIV/AIDS. Principals need to lead by example (Gornall and Burn, 2013: 37).

In Chapter 3, a detailed account of the research methodology and research design will be given.

# CHAPTER THREE

## Research Design and Methodology

### 3.1 Introduction

All research is founded on underlying philosophical assumptions regarding what comprises acceptable research and determines appropriate methods for developing knowledge in a chosen research field. It is crucial for a researcher to explore these assumptions so as to conduct any research. This chapter presents the qualitative research and its assumptions and the narrative inquiry design that underpins this study. The social constructivist paradigm, which forms the framework of this study, is also explained in this chapter.

The narrative design is presented in relation to understanding and obtaining knowledge with regard to how principals manage sensitive issues surrounding HIV/AIDS amongst their teaching staff. The chapter also discusses sampling and site selection, which are connected to data gathering via narrative interviews. I also discuss the qualitative content analysis method through which the findings will be described and interpreted. Methodological criteria, including trustworthiness, are also described. A statement of subjectivity is given and I also outline my own predispositions as a researcher.

### 3.2 Qualitative Research and its Assumptions

Although several researchers have attempted to define qualitative research, I prefer the particularly comprehensive definition offered by Creswell (2007: 37):

> Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is inductive and establishes patterns of themes. The final written report or presentation includes the voices of participants, the

reflectivity of the researcher, and a complex description and interpretation of the problem.

Qualitative research seeks to inquire, via social channels, about the way in which people interpret and derive sense out of what they have experienced and the world in which they live. In research, qualitative approaches are used to explore how people behave, their perspectives and feelings about and experiences of other people, and what lies at the innermost core of their lives (Creswell, 2012: 37). Qualitative research originates from social science and is primarily concerned with understanding *why* people behave as they do as it seeks to uncover their knowledge, attitudes, beliefs, fears and more. In an endeavour to explain the assumptions of the qualitative research approach, I quote McMillan and Schumacher (2010: 321), who outline the following characteristics of qualitative research:

- Natural settings;
- Context sensitivity;
- Direct data collection;
- Rich narrative description;
- Process orientation;
- Inductive data analysis;
- Participant perspectives;
- Emergent design;
- Complexity of understanding and explanation.

### 3.2.1 Natural Settings

Qualitative research is naturalistic, as it studies people in their own environments, within naturally occurring settings such as the school, home, the street (Willig, 2008: 9). Qualitative research methods are developed in the social sciences to enable researchers to study social and cultural phenomena. Qualitative research is based on the assumption that multiple realities are socially constructed by the individual and by society. To reinforce this idea, Denzin and Lincoln (2011: 3) make the following assertion:

> Qualitative research consists of a set of interpretive, material practices that make the world visible. [Qualitative researchers] study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them.

The natural setting is the source of data. Researchers study behaviour as it occurs naturally because they believe that behaviour is best understood as it occurs in the absence of artificial constraints (McMillan and Schumacher, 2010: 321). Researchers spend a great deal of time out in the field collecting data and they neither influence the occurrence of behaviour nor bring in external restrictions. Qualitative researchers are opposed, for instance, to the quantitative method of issuing questionnaires to participants, arguing that this creates an artificial environment in which participants will not behave as they normally do (Harding, 2013: 10). They therefore focus on understanding behaviour occurring in specific settings.

### 3.2.2 Context Sensitivity

Being aware of the context within which behaviour occurs is fundamental to understanding that behaviour in qualitative research. Social interaction takes place within social contexts and people within those specific contexts assign unique meanings and interpretations to their own and others' behaviour. This is why this study has taken a constructivist approach, since, according to Given (2008: 821):

> Constructivism argues for research that is context sensitive, engaged with the practical needs of the subjects of research, and committed to supporting resistance to power and authority.

For qualitative researchers to interpret meaning in those social contexts, they need to understand that they cannot separate socially constructed knowledge from the social contexts from which it is derived. Meaning is interpreted from the knowledge and behaviour of participants in the settings. I therefore interviewed my participants at the schools where they work. As noted by Matthews and Ross (2010: 25), knowledge is acquired by people within specific contexts and researchers need to gather that knowledge. This idea is strongly based on the assumption that human action is influenced by the settings in which it occurs and that any understanding of

meaning is bound by politics, gender, race, class and social factors (McMillan and Schumacher, 2010: 324). In reality, this is where the lens through which researchers interpret behaviour is formed.

### 3.2.3 Direct Data Collection

The researcher is immersed in the social situation. In this research study, I conducted narrative interviews with 10 school principals and eight teachers living with HIV/AIDS, with the aim of obtaining information directly from the source. As Tracy (2013: 6) emphasises, qualitative research is relational in that data are collected by using one-to-one interactions between researcher and participants. I spent a considerable amount of time with my participants so as to gain a fuller understanding of them.

In qualitative research, the researcher is usually the main instrument of data collection and endeavours to understand and empathise with participants (Matthews and Ross, 2010: 51). However, Rubin and Rubin (2012: 19) caution that seeing things from someone else's perspective requires one to suspend one's own cultural assumptions for long enough to see and understand those of another. The researcher interacts with participants in a relationship within which s/he extracts data from the participants by virtue of their shared humanity. Field research enhances the establishment of trust and rapport that encourages a level of disclosure unparalleled by self-reports or snapshot examinations of a scene (Tracy, 2013: 6). The aim of qualitative research is to describe and explain experiences, as opposed to predicting outcomes. Qualitative research can uncover salient issues that can later be studied.

### 3.2.4 Rich Narrative Descriptions

Rich description is directly linked to the social context in which researchers immerse themselves. Meaning cannot be made without a rich contextual description. With qualitative research, as Tracy (2013: 4) explains:

> The aim is to draw large conclusions from small but very densely textured facts to support broad assertions about the role of culture in the construction of collective life by engaging them exactly with complex specifics.

The qualitative researcher's approach is based on the assumption that every behaviour or action is important and that observing it enhances the researcher's understanding of phenomena. Geertz (1973: 5, in Tracy, 2013: 3) refers to researchers as cultural interpreters who bring to the fore vivid descriptions that unpack values, beliefs and actions in groups and societies. They seek to explain what they have seen. Qualitative research is judged by its ability to discover new themes and explanations, rather than by its generalizability, as well as its density, vividness and accuracy in describing complex situations (Rubin and Rubin, 2012: 64). It is known for its in-depth exploration of phenomena and potential to elicit rich and voluminous data.

The aim of qualitative research is to enable rich descriptions that cannot be represented by numerical data. As such, McMillan and Schumacher (2010: 326) hold that nothing escapes scrutiny or is taken for granted in the qualitative researcher's detailed approach to description, which is necessary to get a total understanding of events and correctly reflect the complexity of human behaviour. Tracy (2013: 5) lauds this sort of research, remarking that:

> Such work has potential to provide insight about marginalised, stereotyped or unknown populations – a peek into regularly guarded worlds, and an opportunity to tell a story that few know about.

All of this is held up as evidence that the qualitative research method is the most appropriate for exploring the sensitive issues surrounding teachers living with HIV/AIDS.

### 3.2.5 Process Orientation

Qualitative researchers seek to establish why behaviour occurs and, as a result, they investigate the processes by which behaviour occurs. This emphasis on process allows for conclusions that explain the reasons for results (McMillan and Schumacher, 2010: 332). Harding (2013: 10) refines this point:

> Qualitative research often wishes to consider the series of events that lead to the action that they are studying to describe a scene in order to understand the human behaviour within it or to study every part.

Researchers keep record of the whole chronological flow, exploring why events occur and explaining the causes of particular events. The use of a variety of methods and perspectives provides flexibility to envision new possibilities (Cooper and White, 2012: 6). Engaging participants in narrative interviews has allowed me to gain a greater understanding of how school principals are managing the sensitive issues surrounding HIV/AIDS amongst their teaching staff.

### 3.2.6 Inductive Data Analysis

An obvious distinction that lies at the heart of the assumptions of qualitative versus quantitative research is that the former implies inductive reasoning to understand a particular situation, whilst the latter does not. According to Bryman (2012: 690), qualitative research predominantly emphasises an inductive approach to the relationship between theory and research, in which the emphasis is placed on the generation of theories. Researchers select sites and populations and then develop meaning from the data collected from the field (Myers, 2012: 56; Parker, 2011: 67). Explanations are built from the ground up. In contrast, quantitative research tests hypotheses. Collected data are synthesised inductively to generate findings. In qualitative research, inquirers present data as descriptive narration in words and findings are progressively generated from the data.

### 3.2.7 Participant Perspectives

Qualitative researchers seek to understand social situations from the participants' perspectives. McMillan and Schumacher (2010: 331) allege that qualitative researchers try to reconstruct reality from the standpoint of participants' perspectives and, therefore, their focus is on the meaning of actions expressed by participants. The purpose of this is to gain an understanding of the views of participants as expressed in their own voices. In this sense, qualitative research views reality as the subjective meanings constructed by the participants. Consequently, the final reports

of qualitative research consist of the perspectives of participants. As Rubin and Rubin (2012: 15) affirm, both researchers and participants make interpretations and it is impossible to eliminate all bias. Since qualitative research acknowledges researchers' influence on results, I have given a description of my role in this research study in the reflexivity and subjectivity sections. Furthermore, qualitative researchers believe that there are various truths to be discovered and that all perspectives have validity (Leedy and Ormrod, 2010: 135). As a result, qualitative research studies are able to illuminate the darker aspects – such as emotional abuse – of relationships.

### 3.2.8 Emergent Design

One other strength of qualitative research is that it is flexible. Most qualitative researchers – for example, Creswell (2012: 37); Matthews and Ross (2010: 17); and McMillan and Schumacher (2010: 320) – agree that researchers have limited knowledge of their participants and must try to get past their own preconceptions before they can begin their research. In other words, researchers cannot begin the research study with an accurate design. They can only fully understand which research design a significant time after they have visited the sites and interacted with the participants. Thus, designs begin to emerge as the study unfolds and interview questions to be asked may change.

### 3.2.9 Complex Understanding and Explanation

According to McMillan and Schumacher (2010: 324), "central to qualitative research is the belief that the world is complex and that there are few simple explanations for human behaviour". Qualitative research focuses on depth as opposed to breadth, which is the focus of quantitative research. Behaviour is a result of the interaction of multiple factors. Hence, the need for complex data-capturing tools. Although researchers seek to consider carefully those multiple perspectives, it is impossible to capture every complex behaviour that occurs. Consequently, researchers need to apply complex methods as well. I have utilised the narrative interview so as to allow participants to narrate their own stories fully. Issues under study often have many

dimensions and layers and require the researcher to portray them in their multifaceted forms (Leedy and Ormrod, 2010: 145).

Qualitative researchers must therefore strive to examine the multiple complexities of particular phenomena. In elaboration, Wertz, Charmaz, McMullen, Josselson, Anderson & McSpaden (2011: 2) maintain that conceptualising the matter under investigation as a whole and in its parts, the way in which these parts are organised as a whole, and how the whole is similar to and different from others leads to better understanding of that particular phenomenon. Researchers aim to explain a complex situation without simplifying it.

Finally, qualitative research assists researchers to understand complex issues and achieve a variety of research goals. Qualitative methodology brings to the fore knowledge about issues that serves humankind. The next section looks at the social constructivist paradigm.

#### 3.2.9.1 Social Constructivism

All research is guided by ways of interpreting the world, referred to as theoretical orientations. The principles of ontology and epistemology differentiate research methods and guide work in different paradigms. This research study is guided by the social constructivist paradigm, fundamentally to which is the assumption that human beings create knowledge through social interactions (Denzin and Lincoln, 2011: 19). Individuals strive to understand the world in which they live and subjectively develop meaning out of their experiences. The meaning created varies greatly from person to person so that the researcher must unpack a complex multiplicity of views (Creswell, 2009: 8). The use of open-ended questions in narrative interviews in this study facilitated participants' expression of their views. As Given (2008: 116) asserts:

> Ontological and epistemological views in the constructivism paradigm disallow the existence of an external objective reality independent of an individual from which knowledge may be collected and gained, instead each individual constructs knowledge and his/ her experience through social interaction.

Therefore, the researcher gains a greater understanding of phenomena through detailed description. More importantly, qualitative researchers attempt to understand

the complex world of lived experiences from the point of view of those who live it (Guba and Lincoln, 1989: 7). Moreover, realities are constantly changing. Researchers gain insights upon which they describe different perspectives of the unique realities and identities of participants. Research studies seek to reveal the multiple perspectives, each of which has equal validity, of different people (Leedy and Ormrod, 2010: 94).

In addition, within the social constructivist paradigm, researchers are concerned with interpretation, illumination and meaning, through which they gain knowledge. As a result, Matthews and Ross (2010: 23) insist that all human action is meaningful and, hence, must be interpreted and understood within the context of social practices. The researcher's purpose is to interpret the meanings others ascribe to the world. The research question is answered through the description and explanation of events and the collection of participants' beliefs, experiences and understandings. Different perspectives are explored via the interpretation of the social world. The researcher generates theory by working with the collected data.

Since human beings create knowledge through social interactions, knowledge is continuously constructed and reconstructed, depending on different cultural contexts. People come up with common ways of judging things by routinely interacting in different places. Different concepts are entirely human creations, which are attached to different behaviours by different societies. Holstein and Gubrium (2008: 341) explain this concept in more detail:

> Much of this has centred on the interactional constitution of meaning in everyday life, the leading principle being that the world we live in and our place in it are not simply evidently 'there' but rather variably brought into being.

The different forms of social interaction form a platform upon which everyday realities are constructed. Researchers gain knowledge through interacting with participants (Matthews and Ross, 2010: 51). From the social constructivist's point of view, therefore:

> Reality is not something "out there", which a researcher can clearly explain, describe or translate into a research report… rather both reality and knowledge

> are constructed and reproduced through communication, interaction and practice. (Tracy, 2013: 4)

In qualitative research, social constructivism brings into being some significant relationships between the researcher, the participants, the audience, and society at large. It is within these relationships that knowledge resides, rather than in the individuals' minds. As Guba and Lincoln (1994: 111) allege:

> The variable and personal nature of social constructions suggests that individual constructions can be elicited and refined only through interaction between and among investigator and respondents.

Then qualitative researcher's goal in research is, to a large extent, to rely on the views of the participants about the studied situation.

#### 3.2.9.2 Ontology

The basic tenet of the social constructivist paradigm is that reality is socially constructed. The fact that reality is socially constructed implies that there are many ways of seeing the world and, through the course of study, perceptions will shift. There is no objective reality that can be known; rather, there are multiple realities (Cooper and White, 2012; Creswell, 2009; Guba and Lincoln, 1989; Lapan, Quartaroli & Riemer, 2012; Matthews and Ross, 2010; Rugg and Petre, 2007). As Matthews and Ross (2010: 24) argue:

> Our ideas and perspectives on knowledge, what we know and how we know will then impact on the way in which we think about and design social research […] ways of thinking about the social world, what there is to know and how we can know about it.

As a result, the social constructivist methodology disputes the existence of objective reality, instead insisting that realities are social constructions that take place in the mind and that several constructions exist in relation to different individuals (Denzin and Lincoln, 2011: 110.)

Meanings and understandings are plural and individual people view and interpret reality through their own lenses (Rubin and Rubin, 2012: 15). There are many ways

of seeing the world and, through the course of study, perceptions are bound to change. In elaboration, I quote Creswell (2009: 9) at length for further explanation:

> Humans engage with their world and make sense of it based on their historical and social perspective – we are all born into a world of meaning bestowed upon us by our culture. Thus, qualitative researchers seek to understand the context or setting of the participants through visiting this context and gathering information personally. They also make interpretation of what they find, interpretation shaped by the researcher's own experiences and backgrounds.

There is no objective reality that can be known (Mertens, 2010: 260). Given the multiple realities, it is not possible to set unchangeable research questions before the time. Pre-set questions do, however, guide the research process. Concepts like disability, minority and feminism (Mertens, 2010: 260) are socially constructed and have different meanings for different people. In elaboration, Blaikie (1993, in Matthews and Ross, 2010: 28) offers the following explanation:

> Knowledge is seen to be derived from everyday concepts and meanings – the social researcher enters the social world in order to grasp the socially constructed meanings and then reconstructs them in social scientific language.

Also, Tracy (2013: 3) emphasises that human activity is not regarded as a tangible material reality to be discovered and measured; rather, it is considered to be a "text" that can be read, interpreted, deconstructed and analysed. The researcher aims to gain a holistic understanding of concepts.

#### 3.2.9.3 Epistemology

Social constructivists believe that knowledge is socially constructed in the research process and that the duty of the researcher is to understand this complex experience from the participants' point of view (Mertens, 2010: 249). The researcher and the subject influence each other. Accordingly, I have chosen a more personal and interactive method of data collection – namely, the narrative interview – to provide opportunities for participants' voices to be heard. Qualitative researchers focus on the specific contexts in which people live and work in order to understand the historical and cultural settings of the participants (Creswell, 2009: 18). I therefore asked broad and general questions, which facilitated participants to construct

meaning out of situations while we interacted. I listened carefully to the narrations of the participants in their natural settings.

Huber, Caine, Huber, and Steeves (2013: 217) observe that participants in human research are no longer treated as static, a-temporal and decontextualized. On a more fundamental level, I conducted my interviews leaning on the idea propounded by Packer (2011: 42) that interviewers need to be flexible and responsive, treating the interviewee as a fellow human being who has something important to say. As such, I showed sensitivity and reciprocity when interacting with participants.

Furthermore, this paradigm asserts that the inquirer negotiates subjective meanings socially. Interaction with participants is indispensable, as this is how researchers elicit data, in addition to considering historical and cultural norms that exist in individuals' lives within the social constructivist paradigm (Kvale and Brinkman, 2009: 241). In keeping with this, Guba and Lincoln (1989: 43) make the following assertion:

> The constructivist paradigm denies the possibility of subject-object dualism, suggesting instead that the findings of a study exist precisely because there is an interaction between observers and observed that literally creates what emerges from that inquiry.

Appropriately, constructivist qualitative research typically emphasises interviews, as their aim is to understand phenomena from the perspective of those experiencing them (Given, 2008: 545). In this qualitative research study, I gained knowledge through mutual interaction with participants within their natural settings. The concept of language is central to the development of knowledge through social interactions.

As such, it is impossible to separate the socially constructed knowledge from the contexts or settings within which they occur. For qualitative researchers to understand the social contexts of their chosen setting, they must understand and interpret meaning in agreement with the participants in the setting rather than with their own ideas (Lapan *et al.*, 2012: 113). They remain so engrossed in the study that the findings of the study are the exact creation of the inquiry process. More explicitly, Guba and Lincoln (1994: 111) postulate that "the investigator and the

object of investigation are assumed to be interactively linked so that the ‘findings’ are literally created as the investigation proceeds”.

Hence, I conducted interviews more than once. In the next section, I present the narrative inquiry design.

## 3.3 Research Design: Narrative Inquiry

After having read and reflected on which research design to use, I became influenced by authors who argue that studies of complex human social situations, histories, contexts and biographies should recognise the interaction between researcher and participants as the most important component of the research process (Andrews, Squire & Tamboukou, 2008; Clandinin and Huber, 2010; Floyd, 2012; Lemley and Mitchell, 2012; Matthews and Ross, 2010; Riessman, 2008; Wertz *et al.*, 2011; Caine *et al.*, 2013; Huber, Caine, Huber, and Steeves 2013).

These writers strongly assert that narrative inquiry helps researchers to explain the complexities of certain social situations, such as how school leadership deals with the sensitive issues surrounding teachers living with HIV/AIDS, which is the subject of my study. Therefore, I have used the narrative inquiry research design to answer my doctoral research question. Among the several definitions of narrative inquiry, I favour the comprehensive one offered by Lieblich, Tuval-Mashiach and Zilber (1998, in Lemley and Mitchell, 2012: 221):

> Narrative inquiry refers to any study that uses or analyses narrative materials. The data can be collected as a story (a life story provided in an interview or a literary work) or in a different manner (field notes). It can be the object of the research or a means of the study of another question. It may be used for comparison among groups to learn about a social phenomenon/ historical period or to explore a personality.

Narrative inquiry is a branch of qualitative research that deals with manners of understanding experience (Given, 2008: 541) and/ or how people perceive their own personal experiences of single or multiple events (Newby, 2010: 19). It is beyond doubt that this research design suits studies with research questions exploring individual perspectives and subjective experiences. Creswell (2007: 34) points out that the different forms of narrative research include autobiography. Here, the narrative is constructed by the researcher via an oral history in which individuals or individual people in a group reflect on specific events and life histories, with each individual's entire life being narrated. I used the oral history approach. Oral history places emphasis on the inside of the experience, with individuals talking not only about past events but also about how they understood those events and their

meanings (Saldaña, 2011: 12). In this study, this was achieved through one-on-one narrative interviews with eight teachers living with HIV/AIDS and 10 principals.

The narrative inquiry acknowledges that the historical influences on a person's biography have an effect on their current experiences and perceptions. As Goodson and Sikes (2001, in Floyd, 2012: 224) explain:

> Lives are not hermetically compartmentalised into, for example the person we are at work (the professional self) and who we are at home (parent/ child/partner selves) and that consequently anything which happens to us in one area of our lives potentially impacts upon and has implications for other areas too.
> There is a crucial interactive relationship between individuals' lives, their perceptions and experiences and historical and social contexts and events.

The above assumptions are inextricably linked to my research question. The expectations of Gauteng principals and how they understand and respond to their leadership roles in handling HIV/AIDS-related issues amongst teachers cannot be understood without consideration of wider biographical influences. Thus, my interest in narrative inquiry has grown to the point that I now consider it to be the most appropriate means of answering my research questions.

Among all forms of discourse, Andrews *et al.* (2008: 41) declare that narrative inquiry concerns itself with how and why events occur. I have been deeply touched by the key ideas put together by Lemley and Mitchell (2012: 215):

- Narrative inquiry is a qualitative research methodology that critically analyses social and cultural contexts of human experience.
- Narrative inquiry is cross-disciplinary and is used by such fields as philosophy, education, science, religion, economics, law and medicine.
- A critical event approach to narrative inquiry focuses on what the research participant identifies as important in the story.
- Narrative inquiry challenges positivist notions that only one truth exists.
- Narrative inquiry researchers continually question "what I know" and "how I know it".

Significantly, the sensitivity of HIV/AIDS-related issues can be explored via intimate acquaintance with individuals' experiences for a period of time and within their natural context. In support of this contention, I refer to Clandinin and Huber (2010: 5), who emphasise that research texts, representative of participants' and inquirers'

experiences, are mined through on-going relationships between the two parties. This on-going negotiation enables stories to be told without participants' lives being harmed, whilst the integrity of both parties is maintained throughout the relationship and into the future. I actively listened to my participants throughout the interview sessions, largely by minimising my own significance in relation to theirs. I muted my own voice in order to give precedence to those of my participants.

Narrative inquiry seeks to illuminate an individual's lived experiences and render a unique, rich and delicate understanding of social life situations (Punch, 2009: 37). Narrative inquiry gives researchers simultaneous access to various situations, in which participants can relate sensitive issues in different social and professional settings, leading to insights that could not have been yielded otherwise (Matthews and Ross, 2010: 12). As a qualitative researcher, I was given the opportunity to review my own assumptions– a sign of the importance of exploratory research. The potential value of narrative research in accessing sensitive information made it the most appropriate design for my research study. Indeed, Ward (2005, in Matthews and Ross, 2010: 25), for example, was able to access complex, moving and painful life histories of a population lesbians – information that would not have been accessible by other design techniques. Having been a teacher for a decade and half, I related to my teacher and principal participants with sensitivity, humaneness and respect to establish a friendly rapport that enabled frank discussions based on trust.

In addition, Wertz *et al.* (2011: 317) assert that narrative inquirers need to possess empathy with (rather than keep their distance from) abroad spectrum of attitudes in order to connect with participants. Good relations between researchers and participants are indispensable to successful research. In this regard, Franklin (2012: 78) remarks that narrative researchers can only enter into dialogue with people's stories if they have sufficient psychological proximity to participants.

Researchers must ceaselessly strive to preserve the integrity of participants' stories and to maintain those lived stories in the most complete way possible (Lemley and Mitchell, 2012: 216). Throughout my research, I have remained cognisant of the sensitivity of HIV/AIDS-related issues. As Riessman (2008: 137) asserts, when people tell stories about difficult moments in their lives, they become emotional and

they search for meaning and this enables them to connect with others. Through storytelling, individuals make sense of events in their lives.

Narrative inquiry focuses on the organisation of human knowledge as opposed to the collection and processing of information. I therefore identified this research design as the most appropriate for my research study. Knowledge is valued even if it is only in the possession of one person (Clandinin and Huber, 2010: 24). Narrative inquiry seeks to explore the unquantifiable parts of knowledge. My argument for the use of narrative inquiry is grounded in the assumption that humans, both individually and socially, lead storied lives (Clandinin, Pushor & Murray Orr, 2008: 12). The stories that people tell about their lives portray their modes of making meaning and how they understand their lives. Most generally, the narrative inquiry is situated in the interpretive framework, which consists of researcher and participant subjectivity based on textual material written by the researcher (Wertz *et al.*, 2011: 317). Human experience is explored and conceptualised in depth via the penetration of participants' lives.

In this context, Packer (2011: 42) postulates another distinguishing feature of narrative inquiry – it provides an important perspective that enlightens researchers about critical moments in the collective experience of historically marginalised communities. As has been discussed in the literature review, HIV/AIDS is the most stigmatised chronic disease and people who are infected or affected are pushed into the margins of society. Therefore, it is not only stories but also what these stories mean to both researcher and participant that illuminate participants' experiences.

It is the skilfulness of the researcher that facilitates the extraction of rich data, especially from traditionally marginalised individuals. Raw narratives draw particular attention to details that could be overlooked by or inaccessible via methods such as surveys. Raw narratives provide access to information that may not be available elsewhere. Narrative inquiry is fundamental to human social life in that it carries with it a rich set of meanings (Speedy, 2008: 15). This research design can be used to acquire insightful understandings of how individual people derive meaning from different events. The relationship between the researcher and the participants is

central to the study and understanding of human experience. According to Caine *et al.* (2013: 580):

> These relationships invite us into more playful ways of being as we world-travel, a relational journey in which we come alongside others and ourselves, in different times places and relationships.

The narrative inquiry process capitalises on the engagement of participants in the field for a long time. Throughout this process, researchers should be cognisant of ethical tensions, responsibilities and obligations in their relationships with participants (Given, 2008: 116). My starting point was to listen to each participant tell his or her story in interview sessions. In the event of such complex in-depth research, researchers' lives tend to become intertwined with participants' lives. I began by negotiating a relationship with each participant. As suggested by several theorists (Caine *et al.*, 2013; Clandinin and Huber, 2010; Clandinin, Pushor, and Murray Orr 2008; Given, 2008; Huber *et al.*, 2013; Lemley and Mitchell, 2012), I began negotiations by paying particular attention to three keys dimensions – temporality, space and place, all of which need to be explored simultaneously.

### 3.3.1 Temporality

Narrative inquirers' attention is drawn to the idea that both people and events have a past, present and future and that understandings of people, events and processes are always in transition (Clandinin, Pushor, and Murray Orr 2008: 9). The emphasis on temporality in narrative research has its roots in the assumption that narratives determine the quality of experience though time. Data are collected over time through multiple interactions with participants as they reflect on their earlier life experiences.

### 3.3.2 Sociality

This dimension, as put across by Clandinin and Huber (2010: 7), unfolds in two ways; that is, personally and socially. Personal conditions refer to hopes, feelings, desires, moral dispositions and aesthetic reactions, whilst social conditions refer to the context in which people's experiences and events unfold (Clandinin, Pushor, and

Murray Orr, 2008: 9). Sociality directs inquirers to pay attention to the relationship between researchers and participants. Narrative researchers cannot exclude themselves from the inquiry relationship.

### 3.3.3 Place

This is referred to by Packer (2011: 42) as the specified concrete and physical place or places where the inquiry and events take place. The natural location where the events unfold cannot be left out in narrative inquiry. Given (2008: 118) emphasises that this dimension directs attention to places where lives have been lived. Data are embedded within participant and researcher relationships in this field of social science research.

Researchers need to be flexible and resilient. The outcome of the entire research project is dependent on researcher-participant relationships. As such, Riessman (2008: 137) remarks that researchers need to abandon the self in a quest to enter the world of another and that this is not something that happens quickly. Riessman goes on to argue that researchers' identities and perceptions come into play, particularly during interviews about sensitive issues: "All sorrows can be borne if you can put them in a story" (2008: 137). Narrative inquiry places storytellers at the centre, where they provide rich, dense data. This design's uniqueness rests largely on the fact that it focuses on the research participants other than the research itself. Narrative inquiry has developed to be a less exploitative method of inquiry, specifically in the study of historically marginalised communities such as people of colour, women, homosexuals, bisexuals and, in this case, people living with HIV/AIDS. Narrative research offers an almost egalitarian research relationship that recognises inter-subjective modes of knowledge production through negotiation (Lemley and Mitchell, 2012: 215). Research relationships are based on the notion that knowledge is produced and communicated through interaction. In this regard, Caine *et al.* (2013: 580) offer the following remarks:

> This composition of a self in the midst of lives and relationships necessitates a shift in attention from methodological considerations about how to construct research correctly, to sensitivity to the conditions around which we become with each other.

Narrative research breaks taboos around some stories that have traditionally been sacred in mainstream educational research discourses. Narrative inquiry subscribes to the interpretive paradigm, thereby facilitating an illustrative view and a more equitable platform for teachers living with HIV/AIDS.

It is impossible for the inquirer to put him-/herself into the shoes of participants. As Riessman (2008: 137) suggests, in the human sciences, the researcher does not discover narratives but, instead, participates in their creation. The aim is to understand experience. Human understanding is achieved through narratives (Knowles and Cole, 2008: 157). Narrative inquiry begins with a highly empathic approach, whereby researchers are determined to reach the broad spectrum of another's experience, facilitated by the research relationship. Thus, Wertz *et al.* (2011: 317) declare the following:

> Although we recognise that we can never fully know another person, empathy is premised on continuity, recognising that kinship between self and other offers an opportunity for their deeper and more understanding.

Narrative inquiry concerns itself with detailed stories mined from participants that reveal how participants understand and view their lives. The most important feature of narrative inquiry is that it is able to explore what the narrator thinks is important. This helps to make participants feel that they are part of the research (Saldaña, 2011: 11). Narrative inquirers place themselves in different positions across a wide range of understandings of what it means to be human (Speedy, 2008: 6). Narrative inquiry serves as a way of gaining absolute access to the lives and experiences of research participants. Stories that have always been there are recognised in this research technique.

The most remarkable truth that I encountered in my narrative inquiry is that the participants' stories are lived before and after the interview. In keeping with this, Clandinin and Huber (2010: 3) assert the following:

> As researchers, we come to each new inquiry field living our stories. Our participants also enter the inquiry in the midst of living their stories. Their lives do not begin the day we arrive nor do they end as we leave.

These circumstances incline the researcher to negotiate possibly difficult situations that may be encountered in each interview. In this regard, Floyd (2012: 221) warns that revisiting distressing events may be painful, shocking, disturbing and unexpected for some participants whilst others may be quite prepared to relate their stories because doing so has become part of their lives. Researchers need to position themselves in such a way as to be able to think about the possible implications of their involvement in the lives of participants. Therefore, in keeping the aims of this research study, the holistic narrative inquiry design revealed some meaningful ways in which schools are handling HIV/AIDS-related issues. It opened the possibility of giving a voice to the powerless, voiceless and marginalised groups (Cohen, Manion and Morrison 2011: 165). Another strength of narrative inquiry design is that it is has the potential to reach people in situations that might otherwise be overlooked or deemed too sensitive, as in the case of school principals, who have to manage people infected with or affected by HIV/AIDS. It provides a large amount of information and detail about the research topic, allowing the researcher to deal with different kinds of raw data. It includes descriptive and exploratory data collection methods in the study. The design capitalises on unusual methods of becoming acquainted with new things. Researchers are privileged and obligated to pay attention to what they regard as being of great enough importance. However, despite the various features that make narrative inquiry suitable for this research study, Bryman (2012: 14) criticises the method, arguing that the data yielded by narrative inquiry are too subjective, difficult to validate and not generalizable, and therefore not of sufficient quality. Conversely, Dhunpath (2000, in Floyd, 2012: 221) argues that the focus of narrative inquiry is not the factual accuracy of the constructed story but, rather, the meaning that it holds to the participant. A detailed account of the research methodology follows in the next section.

## 3.4 Research Methodology

Qualitative research methodology is so concerned with meaning that researchers have vested interests in how people make sense of the world and how they experience events (Parker, 2011: 68; Willig, 2008: 9). Qualitative methodology aims to understand what it is really like to experience specific conditions; i.e. how it feels to be a teacher living with HIV/AIDS. The suitability of a set of methodological tools depends on context and the nature of the research study. Thus, Rubin and Rubin (2012: 3) stress that "when context and richness are important, when you need to know what something feels like […], unique, naturalistic research tools are more appropriate".

Hence, the use of narrative interviews in my study. My choice of qualitative research has been intertwined with the narrative inquiry design, which Bamberg (2010: 9) describes as more interested in the manner in which researchers confer meaning onto experience, particularly in narratives of personal experience related to concrete life events. Narrative inquiry involves a methodology that allows participants to tell their stories. Qualitative approaches are suitable in providing the insight necessary to understand the roles of participants in events as well as their perceptions of their experiences. My study looks into how school leadership deals with sensitive issues related to teachers living with HIV/AIDS. This methodology creates a gateway to this sensitive information from a population that had restricted opportunities for open discussions (Gledhill, Abbey & Schweitzer, 2008: 13). Methodology entails strategies that are used by researchers such that their work may be critiqued, repeated and adapted. These strategies include sampling, data collection and data analysis (Schensul, 2012: 237). Appropriately, I have gone to great lengths to integrate my research questions, sampling strategy, data collection and data analysis techniques. An explanation of my sampling strategy follows.

### 3.4.1 Sampling and Site Selection

Apart from the appropriateness of methodology and instrumentation, the quality of a research study is also determined by the suitability of the sampling technique that

has been employed. This research study obtained data from a purposefully selected sample; this is one of the features of qualitative research. Purposive (or purposeful) sampling is frequently used for obtaining information in qualitative research. Given the sensitive nature of HIV/AIDS and the socially constructed aspects associated with the disease, the use of purposeful sampling intertwined with inductive methodology using narrative interview is the most appropriate method for exploring related issues. Cohen, Manion and Morrison (2011: 156) emphasise that, in purposeful sampling, researchers carefully choose participants whom they feel have the greatest potential to yield information rich enough to satisfy their particular requirements. Simply put, researchers handpick the individual(s) to be part of a sample based on their possession of the characteristics under investigation. Purposive sampling is most appropriate when a small sample is studied, using intense and focused methods such as narrative interviews (Gledhill *et al.*, 2008: 345). The nature of my research is aligned to purposive sampling, which lends greater depth to my study. With Purposive sampling, participants are chosen because they are critical cases akin to critical events:

> In qualitative data collection, purposeful sampling is used by researchers to intentionally select individuals because they have experienced the central phenomenon. (Creswell, 2012: 206)

Sampling has profound significance in qualitative methodology as it is central to the design, which, in this research study, is narrative inquiry. Several scholars attest to the fact that, in purposive sampling, participants are selected because they possess certain defined characteristics that automatically classify them as the holders of the information needed for the study. Therefore, in this study, sampling decisions were made for the specific purpose of obtaining the richest possible sources of information in order to answer the research question.

In line with this, Saldaña (2011: 12) asserts that purposive sampling is not only restricted by participant selection but also by settings, incidents and events included in data collection. More importantly, I was deeply moved by Cohen, Manion & Morrison, 2011: 158) assertion that purposive sampling is suitable for “hard to reach groups including minorities, marginalised or stigmatised groups ‘hidden groups’”. My study explores HIV/AIDS-related issues amongst teachers and, according to Cohen,

Manion and Morrison (2011: 539), people living with HIV/AIDS are among the minority groups that are marginalised, stigmatised and discriminated against.

Qualitative research places emphasis on “the uniqueness, the idiographic and exclusive distinctiveness of the phenomenon” (*ibid.* 158). Therefore, I purposefully selected a sample of 10 principals in the Gauteng province whom I deemed to be adequate sources of data substantial enough to meet the requirements of a doctoral thesis. The 10 principals of both genders were handpicked from different secondary, primary and special schools. In this study, the aim was not to represent the wider population but to explore the particular individuals under investigation. Studying a small sample in depth produces a rich profile (Saldaña, 2011: 12). Based on my knowledge of the population, I selected those principals whom I considered to have the greatest potential of advancing my understanding of how principals handle the issues in question.

Creswell (2012: 8), echoing Gay, Mills and Airasian (2011: 12), contends that qualitative research studies with single participants or a limited number of cases are of value because the ability of the researcher to yield in-depth insights diminishes with the addition of more participants or sites. A large sample does not necessarily mean that the results will be authentic. Purposive sampling facilitates the in-depth interpretation of data sources that are systematically selected and this is the hallmark of qualitative research (Morgan, 2008: 648). Purposive sampling in qualitative research coheres with the interpretation of a single sample or small number of information-rich data sources.

Equally important, I chose to use network sampling for the teachers living with HIV/AIDS. Network sampling is referred to by Gallardo, Davids and Lachlan (2013: 166) as “using social networks to locate or recruit study participants”. According to LeCompte (2008: 78), network sampling sees primary participants naming other people in their social or other networks, such as workplace support groups and organisations. In this context, Atkinson and Flint (2009: 19) and Sirken (2005: 9) affirm that network sampling, like purposive sampling, is suitable for identifying populations (for example, AIDS sufferers) that are hard to reach and/or hidden, marginalised and socially stigmatised. People who live within or in close proximity to

such populations have potential to enable the researcher to reach them. Hence, I chose one teacher on the criterion that that teacher had to be living with HIV/AIDS and working in one of Gauteng province schools. I selected one teacher living with HIV/AIDS using my own experience and knowledge. Indeed, according to Gay *et al.* (2011: 141):

> Qualitative researchers spend time in the research setting before selecting a sample to observe and obtain information that can be used to select participants whom they judge to be thoughtful, informative, articulate and experienced with the research topic.

The teacher in question is male, aged 46, and married. He holds a Bachelor of Education and has 15 years of teaching experience. This, combined with his experience of living with HIV/AIDS, made him the most abundant source of information of all the participants. He was also able, through his networks, to refer me to other teachers living with HIV/AIDS. As suggested by Yin (2011: 12), researchers compile the particulars of newly suggested participants and communicate with them to establish rapport and obtain consent to go on with research. In this research study, all the teachers who were suggested by the first participant were contacted and deemed suitable for the interview. One challenge, as Hennink, Hutter and Bailey (2011: 37) explain, is that network sampling recruits participants who are all from the same social network. In order to broaden the range of participants in this research, therefore, I tapped variety of networks.

The goal of my research study was to develop an in-depth and highly contextualised understanding of how principals handle the sensitive issues surrounding teachers living with HIV/AIDS. Such a goal is well suited to small sample sizes. I interviewed my participants in their workplaces (schools), which is their natural setting. As Lapan *et al.* (2012: 216) contend, historically, qualitative researchers have assigned value to context, believing that behaviour, events and actions are meaningful in terms of the context in which they are embedded.

Thus, awareness of context enables researchers to make meaning where there appeared to be no meaning before. I engaged my participants in their own native surroundings. This arrangement was well suited to my research design (narrative

inquiry), which assumes that participants use context to connect and situate particular experiences so they can put together different events and structure stories as experienced. My goal was to capture the richness and complexity of behaviour that occurs in natural settings in which the participants experience the phenomenon in question. Central to this is the idea that who participants are as well as where they are located are important.

Equally important, access to the school was secured with the Gauteng Department of Education via a formal application process. Access negotiation is one of the ethical considerations that can motivate participants to cooperate significantly in a study. It also enhances efficiency and facilitates the soliciting of quality data, especially regarding sensitive matters such as HIV/AIDS. Official provincial approval of my research allowed me to apply for and secure access to the schools and, therefore, their principals and teachers, as is explained in the following section on data collection.

### 3.4.2 Data Collection

Qualitative research scholars – such as Creswell, (2012); Denzin and Lincoln, (2011); Given (2008); Hennink *et al.* (2011); Holstein and Gubrium (2011); Lapan *et al.* (2012); Matthews and Ross (2010); May (2011); Riessman, (2008); and Yin (2011) – focus, to a large extent, on the socially constructed character of lived realities. For this reason, data collection methods have to be participant-led. Qualitative research is practical and, therefore, researchers always convey a sense of their first-hand experience and try to give readers a feeling of what O'Donoghue (2007: 53) refers to as "walking in the participants' shoes". The objective of data collection is to compile comprehensive records of participants' words and actions (Willig, 2008: 9). Moreover, as Riessman (2008: 137) asserts, researchers and their participants co-construct narrative meaning. Researchers provide detailed description of phenomena. My research was guided by the research question: How do principals understand and respond to their leadership roles in the handling of sensitive issues arising from HIV/AIDS amongst teachers in schools in the Gauteng

province, given their expectations of care and support? This was the beacon of my study.

The research question determines what is to be considered as data in the study, which consequently determines the most appropriate techniques to employ. Since my primary focus was on HIV/AIDS, the most stigmatised disease shrouded in highly sensitive issues, the most appropriate tool for data collection was the narrative interview. Tracy (2013: 54) refers to the narrative interview as an open-ended, relatively unstructured interview that facilitates the participants to relate stories in a manner other than simply by answering questions. The interviews were face-to-face and semi-structured. The decision to conduct only person-to-person interviews was again backed by the objectives of the research study. The nature of the guiding research question suggested a relatively higher degree of flexibility in the process of interviewing. Nevertheless, I opted for narrative interview and, as McMillan and Schumacher (2010: 324) recommend, I aligned my questions with the research questions.

Narrative interviews are particularly interested in the stories that participants have to tell; that is, the plots and narrative structures of their descriptions. These stories may be shared freely without any prompting during the interview or may be elicited by the interviewer (Kvale and Brinkman, 2009: 47).

As their name suggests, narrative interviews focus on the life of one person, or a single part of a person's life (Bryman, 2008: 41). As Harding (2013: 10) asserts, life experiences are examined more holistically with narrative interviews than with other styles and, most importantly, breadth is sacrificed for depth with regard to the information solicited. This type of interview appealed the most to my research design and methodology because it would allow participants to narrate their stories as they saw fit. As Ayres (2008: 34) remarks, narrative interviews provide participants with a much wider array of options with which to personally select and order events than would be possible with an interview with a predetermined structure.

In collaboration with the participants, the researcher decides about relevant and irrelevant content, although no answers are considered wrong and all information can contribute to the meaning of the story. Questions are sufficiently open-ended to

urge participants to give their accounts fully, although every question is not guaranteed to elicit a story. Probes and open-ended questions solicit participants' thoughts regarding the underlying connections between experiences. The goal of narrative interviews is to reveal those connections. The close relationship between researcher and participant creates the sense that there is a balance of power (Creswell, 2013: 34) between them that privileges the storyteller's perspective. These concrete experiences are achievable through continued proximity (Flyvberg, 2011: 245), which is one of the features of the qualitative inquiry; to study meaning of participants' lives under real-world conditions.

In narrative research, rich data, ideas and information are generated by varying the questioning level and sometimes quizzing the interviewee more intensely on specific issues. I refer to Rubin and Rubin (2012: 3), who enumerate the strengths of narrative interview:

- Researchers talk to people who have experienced and have knowledge of the problem of interest.
- Researchers see the world from the perspectives of participants through exploring, in detail, their experiences, views and opinions.
- As researchers listen carefully to others, they extend their intellectual and emotional reach across a variety of barriers.
- It facilitates the reconstruction of events that researchers have never experienced, from illegal border-crossings to becoming a paid assassin.
- Through repeated and retrospective interviews conducted over time, change is captured and complex as well as contradictory matters are explored.
- It allows exploration of multiple perspectives toward an issue in the real world, which is the goal of qualitative researchers as naturalistic researchers.
- It allows wholeness whereby researchers can see life from all angles leading to more thoughtful and nuanced conclusions.
- It is most appropriate for exploring personal and sensitive issues or morally ambiguous choices made by people.
- It is particularly useful when the processes being studied are almost invisible, for example, HIV known to victims.

I thus viewed the narrative interview as a finely tuned explorative instrument that was highly appropriate to my research objectives. The nature of this research study was very personal, as I am a teacher myself. So, in interviewing these fellow teachers and principals, I aimed to relate to them with consideration, sensitivity and genuineness, establishing a good rapport, and ensuring trust to facilitate relaxed communication – fundamental principles within qualitative research (Cohen *et al.*, 2011: 182).

The narrative research process that I have pursued is a highly personal and intimate area of educational research, demanding an extreme degree of caring and sensitivity on the part of the researcher (Gay *et al.*, 2011: 321). It was a great privilege to be allowed access to such deeply personal thoughts and emotions to help me to understand how principals handle the sensitive issues in question. My interviewees thus gave me the precious gift of information to compile the data for which I was looking. In this regard, Clandinin and Huber (2010: 35) remark that the transaction between researchers and participants “makes ethical issues and concerns about living well with others central to the inquiry”. I poured my whole being and all my thoughts, emotions, energy and understanding into my interactions with participants. These interactions were careful intrusions into the intimate experiences and private lives of my interviewees. Appropriately, Cohen *et al.* (2011: 185) contend that "being sensitive is as much about ethics and behaving ethically as it is about research itself”. Such research can give voices to the voiceless, who are used to being negatively labelled and stigmatised. Therefore, I made a point of being a good listener and treating my interviewees with dignity. I was careful to avoid being patronising, domineering or high-handed.

I chose to gather data via narrative interviews because of the ability of this form to extract lived experiences and stories with a distinct plot, detailing social interactions, which unfolding temporal order (Kvale and Brinkman, 2009: 47). The conversational mode of the narrative interview allowed my interviewees the time and setting to reconstruct their own experiences and realities in their own words (Yin, 2011: 19). The initial interviews covered participants 'life histories as teachers as well as some of the events they had experienced due to their being teachers living with HIV/AIDS. This spilled over into Interview Two, when my interviewees reflected on the meaning

of their experiences. My interviewees talked about their experiences in a free-flowing, open-ended discussion. My interview question, “How did you become aware that you were HIV-positive?” encouraged my interviewees to begin telling me how they fell sick, relating, in a chronological sequence, how they came to be tested and how their understandings changed over time as they underwent medical examinations and began taking antiretroviral drugs.

However, participants did move back and forth in time to some extent in recounting their stories. I remained a listener and occasionally posed questions to follow up and for clarification and kept the interview going with open-ended questions. Such informal discourse leads participants to speak readily and easily and enables the researcher to follow their trains of thought (Riessman, 2008: 22).

Principal participants enjoyed engagement throughout the interviews. The interviews, which were held at the participants’ workplaces, were (with the interviewees’ consent) digitally recorded and transcribed later. I dressed casually for these interviews and did my best to adopt an unassuming demeanour. Powerless people may feel resentful of a well-dressed researcher who appears to come from a more privileged background than they do (Cohen *et al.,* 2011: 173). As a result, if I had dressed more smartly, participants may have felt antagonised and discouraged from disclosing their true feelings and opinions. This antagonism would have been further aggravated if the interviews had been held in some clinical office in an unfamiliar environment.

Even more important than setting is structure. Data collection in narrative inquiry requires the researcher to allow participants to structure the conversations, with the researcher asking follow-up questions (Bell, 2010: 56). Thus, my narrative inquiry into the question of how principals handle sensitive issues surrounding teachers living with HIV/AIDS involved extended narratives with 18participants. My interviews allowed an incredible and multi-faceted understanding of the phenomenon. This convinced me of the significant value of narrative interviews in helping me to understand my research question. Narrative interviews are focused on specific and often sensitive issues; they seek to uncover personal meanings and feelings.

Narrative interviews are thus effective because human beings have evolved to interpret personal experiences in terms of stories (Bruner, 1986, in 2012: 456).

Basically, qualitative research relies on human perception and understanding, with the researcher acting as an instrument to elicit data and often deliberately performing a subjective role in the research study. This means that the researcher uses his/her own personal experience to interpret meaning.

Hence, Stake (2010: 133) emphasises that qualitative researchers should possess empathy and advocacy in their lifestyles so as to be able to bring to the fore complexity of the background and understanding of the phenomenon. Therefore, my study concerning HIV/AIDS could not be measured by external instruments but data could be revealed by my talking to the right people. The researcher extracts information from the interviewee by virtue of their shared humanity. I was very sensitive, compassionate and patient. I was present at the scene of action physically, emotionally and cognitively. As Yin (2011: 12) asserts, the researcher has a human personality and cannot perform as a faceless robot or a machinelike recorder of human events. As the main instrument for obtaining knowledge, I maintained moral integrity and remained dedicated to being sensitive to ethical issues (Kvale and Brinkman, 2009: 47). I familiarised myself with the ethical guidelines because, as Yin (2011: 47) explains, the researcher's experience, knowledge, fairness, and honesty contribute to their integrity decide the outcome of the study.

Furthermore, I obtained research approval from the Gauteng Department of Education through an application form that bore the aims, timetable of research, and proposed data gathering techniques of the study. I submitted an ethical clearance application form to the University of South Africa's College of Education Research Ethics Committee, with the Department of Education approval letter attached. Once the Research Ethics Committee approved my research, I obtained access to the principals and teachers and their schools through application letters that indicated that my research was fully endorsed by the university and the Department of Education.

The initial communications with my interviewees were the beginning of relationships that continued throughout the study. The fact that I paid them visits in their working environment enhanced the research relationship in a positive and professional way. My interviewees signed declarations of consent, which contained a description of the purpose of the study and details of the interview sessions. The consent form contained assurance of anonymity, voluntary participation, and right of withdrawal from the study without prejudice.

I stored my data on my personal computer in a folder name known only to me and I kept copies on a flash drive as well as on my external hard drive. The data were treated in a manner that protected the confidentiality and anonymity of my participants. Given that my research goal was to understand a personal phenomenon, my interviewees invited me into their lives as more than a mere bystander. Instead, our connections were real and I was extremely conscious of my role throughout data collection. Good relationships and a positive rapport with each of them allowed for the collection of rich and valuable data.

### 3.4.3 Data Analysis

> *If there is only one truth, you couldn't paint*
> *a hundred canvases on the same theme.*
> – Pablo Picasso, 1966

On a more fundamental level, qualitative research is based on the collection and interpretation of episodes (Stake, 2010: 133). After conducting interviews, the researcher transcribes and/or translates data and then analyses the data obtained. The researcher adopts an empathic style, respects the participants and their as they portray it. More often than not, the researcher identifies the information that will lead to a better understanding of the phenomenon and the research report is "the researcher's dressing of the teller's story" (*ibid.*: 133).

Moreover, in qualitative research, data analysis begins during the data-gathering process. In this study, all of the interviews were recorded and transcribed verbatim. I

transcribed data on the same day after each interview so that I could try to get a sense of it before moving on. This allowed me to develop my theory and decide on follow-up questions. This study utilised the qualitative content analysis method of data analysis, which enabled me to narrow down the data into themes (Merriam, 2009: 67). As put forward by Grbich (2013: 190):

> Content analysis is a systematic coding and categorising approach you can use to explore large amounts of existing textual information in order to ascertain the trends and patterns of words used, their frequency, their relationships and the structures, contexts and discourses of communication.

Similarly, Heidi (2008: 120) insists that:

> Content analysis is the intellectual process of categorising qualitative textual data into clusters of similar entities, or conceptual categories, to identify consistent patterns and relationships between variables or themes.

These definitions illustrate an emphasis on integrated readings of texts that include their contexts. Most importantly, content analysis extracts themes and patterns that may be hidden in a text. Qualitative researchers acknowledge that textual data yields subjective interpretation, depends on content, and always reflects multiple meanings (Heidi, 2008: 120). It also allows researchers to subjectively understand given social realities. That said, the content analysis method seeks to reduce data while making sense of it or, simply put, to derive meaning out of it. Numerous scholars attest that content analysis is the most suitable method when one is dealing with a wide variety of textual data, including interview transcripts, narratives, responses to open-ended questionnaires, speeches, and recorded observations (Bryman, 2012; Cohen *et al.*, 2011; Devlin, 2006; Franklin, 2012; Grbich, 2013; Heidi, 2008; Matthew and Ross, 2010; Packer, 2011; Rugg and Petre, 2007; Zhang and Wildemuth, 2009).

In addition, content analysis involves close reading and interpretation of texts. To begin with, content analysis involves purposively selected texts that inform the research question. It has its roots in a constructivist ontological orientation, an interpretivist epistemological orientation, an inductive role of theory, and (most importantly) themes grounded in the data (Bryman, 2012: 13).

In qualitative research, participants provide rich descriptions and express how they view the social world. Therefore, participants' views are better understood by the researchers and eventually by the readers via this method. To a large extent, content analysis values unique themes that reflect a variety of meanings of phenomena as compared to the statistical significance of the occurrence of texts (Rugg and Petre, 2007: 91). Content analysis employs inductive reasoning whereby themes and categories emerge from the data when the researchers immerse themselves in and carefully examine and constantly compare the data.

Matthews and Ross (2010: 395) propose that the purpose of content analysis is to validate a conceptual framework or theory. The researcher interprets the data, by linking the process of making meaning with the research questions. This provides the starting point, literature and the theoretical ideas that scholars have used to illuminate issues (Bryman, 2012: 13). Another advantage of content analysis is that it gives full traceability, drawing particular attention to how the researcher moved from collecting the raw data to forming categories and themes (Rugg and Petre, 2007: 91). Content analysis holds that there is no objective reading of a text; rather, multiple meanings exist as well as multiple interpretations. Furthermore, Cohen *et al.* (2011: 237) posit that:

> [Content analysis] focuses on language and its linguistic features, meaning in context, is systematic and verifiable (e.g. in its use of codes and categories) as the rules for analysis are explicit, transparent and public.

If used properly with codes and categories accurately designed, this sort of research can be replicated and enhances credibility. To obtain the initial set of codes in my data, I analysed my transcriptions several times. I kept my codes displayed on my desk for easy access and so that I could constantly reflect on them. With regard to this, Cohen *et al.* (2011: 563) explain that, through coding, meanings can be seen at a glance, memorised and recalled easily. When coding is transformed into categorisation, the meaning of long interview responses is reduced to a few categories (Kvale and Brinkman, 2009: 47).

This enabled me to see similar situations, which Newby (2010: 467) notes as one of the uses of coding. I familiarised myself with the data by continually reviewing them

and reading the transcriptions. While reviewing, I was highly analytic. I looked for distinctive features of my study and how the collected data linked with my research question. In this way, the analysis process began. As each narrative interview with teachers living with HIV/AIDS and principals was transcribed verbatim, individual narratives were created and then two collective stories – one for teachers and another for principals – were written based on these individual narratives. Verbatim transcripts were numbered line by line.

Afterwards, a thematic collective narrative of a combination of teacher and principal narratives that spoke to similarities and differences of their experiences was put together based on the combination of themes. The themes were based on the individual narratives that were shared by teachers living with HIV/AIDS and school principals. Sub-themes were developed and presented in a table together with the main themes. The themes formed a framework that illustrated the insights that the participants offered into how principals handle issues surrounding HIV/AIDS amongst their teaching staff.

Some guidelines of qualitative content analysis are given by Delvin (2006: 196); Grbich (2013: 197); Harding (2013: 24); and Zhang and Wildemuth (2009: 11):

Step1: Read through the transcriptions and make notes of emerging themes.
Step 2: Group similar themes together.
Step 3: Create a list of themes/categories depending on the total number of participants (data reduction).
Step 4: Assign data to relevant themes.
Step 5: Interpret meaning within the content.

After identifying patterns and commonalities, I put similar ones together with the intention to draw and verify conclusions. Accordingly, I established recommendations as indicated by my participants and also in the literature that has been reviewed. The intention was to move from description to explanation and theory generation. Nevertheless, my research findings and recommendations could be useful in similar contexts despite the fact that generalisation is not permissible in qualitative research.

## 3.5 Rigour and Quality: Methodological Consideration

According to Saumure and Given (2008: 121), the concept of rigour can be thought of with regard to quality of the research. Therefore, it follows that if the research is highly rigorous, the research findings are trustworthy. Likewise Tracy (2010: 40) asserts that rigour is achieved through richness of data, appropriate sample in relation to the study goals, prolonged engagement in the field as well as appropriate procedure interviewing practices and analysis procedures. She explains further that the research topic must be interesting and that it must make a significant contribution to the understanding of social life.

As I have argued in the literature review, not much research has been carried out on school leadership and teachers living with HIV/AIDS; rather intense research has been carried out on learners as being vulnerable. So I believe my research has been correctly timed as I am deeply touched by Richardson (2000, in Tracy, 2010: 846) "bring clarity to confusion, make visible what is hidden or inappropriately ignored, and generate a sense of insight and deepened understanding". My research has theoretical significance. An accurate representation of the data affects the rigour of the study. Assessment of trustworthiness is fundamental in qualitative research because this approach studies the empirical world from the perspective of the research participants. Trustworthiness is participant oriented that is researchers discover human experiences according to the perceptions and views of participants. I explain how I assessed rigour in my study in the next section.

### 3.5.1 Trustworthiness

Trustworthiness is an important component in qualitative research as it gives researchers a marker by which to assess the virtues of qualitative research as opposed to quantitative research. Trustworthiness of research is a fundamental methodological issue, as numerous scholars confirm, including Lincoln and Guba (1985); Cohen, Manion and Morrison (2011); Creswell (2009); Leedy and Ormrod (2010); Kvale and Brinkman (2009); Maxwell (2009); Merriam (2009); Mertens (2012); O'Donoghue (2007); and Yin (2011).

Hence, the concepts of validity, reliability, generalizability and objectivity, have traditionally been used. These concepts have been replaced by credibility, dependability, confirmability and transferability.

Tracy (2010: 6, in Lincoln and Guba (1985: 219) lists the following eight requirements for high quality across paradigms:

- Rich rigour;
- Sincerity;
- Credibility;
- Resonance;
- Significant contribution;
- Ethical;
- Meaningful coherence.

These eight elements will be discussed together with credibility, dependability, confirmability and transferability, as they are intertwined and they strive to achieve the common goal of quality. Indeed, trustworthiness pertains to the measures that qualitative researchers apply to ensure that credibility, dependability, confirmability and transferability are evident in their research (Given, 2008: 895). Simply put, trustworthiness is the measure of quality of research or the extent to which results are believable.

Yin (2011: 12) recommends that, to achieve trustworthiness, qualitative research must be carried out in a publicly accessible way. Equally important, all research procedures need to be documented and data must be available for inspection. Maree (2007: 80) refers to trustworthiness assessment as the acid test of data analysis, findings and conclusions.

The term “trustworthiness” applies to the event whereby the inquirer persuades the audience that the findings of the study are worth paying attention to and that the research is of a high quality (Lincoln and Guba, 1985, in Mertens, 2010: 13).

Below is Tracy's (2010: 840) model for qualitative research:

**Table 5: Eight Criteria for Excellent Qualitative Research**

| Criteria for quality (end goal) | Various means, practices and methods through which to achieve |
|---|---|
| Worthy topic | The topic of the research is<br>➢ relevant;<br>➢ timely;<br>➢ significant; and<br>➢ interesting. |
| Rich rigour | The study uses sufficient, abundant, appropriate and complex:<br>➢ theoretical constructs;<br>➢ data and time in the field;<br>➢ sample(s);<br>➢ context(s); and<br>➢ data collection and analysis process. |
| Sincerity | The study is characterised by:<br>➢ self-reflexivity about subjective values, biases and inclinations of the researcher(s); and<br>➢ transparency about the methods and challenges. |
| Credibility | The research is marked by:<br>➢ detailed description, concrete detail, explication of tacit knowledge and showing rather than telling;<br>➢ triangulation or crystallisation;<br>➢ multivocalty; and<br>➢ member reflections. |
| Resonance | The research influences, affects or moves particular readers or a variety of audiences through:<br>➢ aesthetic evocative representation;<br>➢ naturalistic generalisations; and<br>➢ transferable findings. |

| Criteria for quality (end goal) | Various means, practices and methods through which to achieve |
|---|---|
| Significant contribution | The research provides a significant contribution:<br>➢ conceptually/theoretically;<br>➢ practically;<br>➢ morally;<br>➢ methodologically; and<br>➢ heuristically. |
| Ethical | The research considers:<br>➢ procedural ethics (such as human subjects);<br>➢ situational and culturally specific ethics;<br>➢ relational ethics; and<br>➢ existing ethics (leaving the scene and sharing the research). |
| Meaningful coherence | The study:<br>➢ achieves what it purports to be about;<br>➢ uses methods and procedures that fit its stated goals; and<br>➢ meaningfully interconnects literature, research questions/foci, findings and interpretations with each other. |

Moreover, Bush (2012a: 75) enumerates two reasons why it is important to assess truth in educational leadership and management:

- It helps in assessing the quality of studies undertaken by other researchers.
- It helps in determining their research approach and methodology.

To ensure trustworthiness in this inquiry, my teacher and principal participants participated voluntarily; confidentiality and anonymity were guaranteed and they signed letters of consent before the interviews commenced.

In the next section, I explain how I addressed Tracy's eight criteria to establish trustworthiness in my study.

#### 3.5.1.1 Worthy Topic

To begin with, good qualitative topics have the potential to facilitate "educative authenticity", as purported by Guba and Lincoln (1989: 210). Making a similar point, Tracy (2010: 840) asserts that good qualitative topics are counterintuitive. Worthy studies bring to the fore some surprises and appeal to the reader's common sense assumptions. In addition, worthy topics must not produce obvious results through confirming people's existing assumptions.

In this study, I chose the topic "School leadership and teachers with HIV/AIDS: stigma and discrimination in Gauteng Province schools". Little is known about how principals are handling the sensitive issues surrounding HIV/AIDS amongst teachers. This study brought revealed valuable, previously unknown information about what it is like to be a teacher living with HIV/AIDS and how principals respond to the challenges of leading such teachers.

#### 3.5.1.2 Rich Rigour

As reinforced by Cooper and White (2012: 7), detailed description is one of the qualities that need to be observed by qualitative researchers because they are concerned with *understanding* the phenomenon. Several researchers attest to the importance of rich rigour; in particular, Tracy (2010: 841) recommends abundant data and includes the following questions about rigour:

- Are the data enough to support significant claims?
- Did the researchers spend enough time to gather interesting and significant data?
- Is the context or sample appropriate given the goals of the study?
- Did the researcher use appropriate procedures in terms of field note style, interviewing practices and analysis procedures?

In an endeavour to achieve rich rigour in this study, I carefully considered these questions. I sampled eight teachers living with HIV/AIDS through network sampling and I gathered unique and rare data. I developed rapport with my participants so that

I could obtain significant data. The principal participants sampled through purposive sampling enjoyed engagement. Each participant was interviewed more than once.

#### 3.5.1.3 Sincerity

However, Tracy (2010: 841) remarks that rich data alone is not sufficient to obtain high quality work. Sincerity can be achieved through self-reflexivity, transparency, vulnerability, honesty and data auditing (Tracy, 2010: 841). Mertens (2012: 8), echoing Cohen, Manion and Morrison (2011: 234), remarks that sincerity refers to the extent to which the data and interpretations of the study are grounded in events rather than the inquirer's personal constructions. Interpretations and findings should match the data – all claims should be supported by the data.

Tracy (2010: 132) uses the term "transparency" to describe how researchers deliberately leave an audit trail by documenting every research activity and decision made. This technique also requires the researcher to account for individual subjectivity and bias. It is of the utmost importance that the researcher keeps data where they are retrievable and made available when there is need for example storing them on an external hard drive.

For the sake of sincerity in this study, a transparent "audit trail" was made available. I referenced all of my data by numbering all the lines of verbatim transcripts. I properly documented the records – including raw data, analysis records, and data reduction – used in my study, as well as my personal attitudes toward these over time. Such documentation helps readers to judge whether the findings are grounded in the data. Accordingly, Ellis and Bochner (2000, in Riessman, 2008: 192) maintains that:

> The narrative rises or falls on its capacity to provoke readers to broaden their horizons, reflect critically on their own experience, enter empathically into a world of experience different from their own, and actively engage in dialogue regarding the social and moral implications of the perspectives and standpoints encountered.

As will be seen in the next two sections, I have explained my own reflexivity and subjectivities, as opposed to attempting complete objectivity, in an endeavour to understand the phenomenon. On a more fundamental level, I maintained coherence

and genuineness throughout my research. In this context, Tracy (2010: 132) reiterates that the literature review situates the findings and the findings are linked to research questions and everything is interconnected.

#### 3.5.1.4 Credibility

Credibility is equivalent to internal validity and is referred to by Mertens (2010: 45) as the verification of whether the data collected and data analysis are trustworthy and believable. In the same vein, Tracy (2010: 40) propounds that “credibility refers to the trustworthiness, verisimilitude, and plausibility of the research findings”. These definitions converge at "trustworthy", "authentic" and "convincing".

Along these lines, Given (2008: 138) mentions that credibility is achieved when qualitative researchers accurately and richly describe the phenomenon under study. Similarly, Tracy (2010: 3) insists on detailed description, whereby researchers immerse themselves in their research and extract concrete details to obtain tacit knowledge. To achieve this, researchers need to spend significant time in the field so as to be able to explore beneath the surface. The philosophy underlying qualitative research asserts that reality is closely related to the meaning that people create within their social constructs. As such, Denzin and Lincoln (2011: 13) contend that:

> The constructivist paradigm assumes a relativist ontology (there are multiple realities) a subjectivist epistemology (knower and respondent co-create understandings) and a naturalistic (in the real world) set of methodological procedures.

Rubin and Rubin (2012: 60), furthermore, make the point that the credibility of the study is judged by readers based on their understanding thereof. Tracy (2010: 3), meanwhile, discusses the concepts of crystallisation and triangulation. Crystallisation encourages researchers to use multiple theoretical frameworks as well as data. I therefore acknowledged the existence of multiple realities in my study. To ensure credibility in my study, I sampled participants who had knowledge and first-hand experience. The interviews were recorded and transcribed verbatim. I summarised what had been said and checked the accuracy of my understanding with my interviewees.

Triangulation is the most important method of achieving credibility. It involves ensuring consistency amongst data sources and methods. I engaged my participants at length on several occasions, taking heed of Yin's advice to "converse with the participant for more than twice" (2011: 78). Bush (2012a: 75) refers to this as "respondent triangulation", which is one of various possible types of data triangulation. I gathered rich and extensive data through prolonged engagement in the field. This approach is described by Mertens (2012: 14) as sustained involvement in the research setting.

The time I spent with my interviewees helped me to access what Tracy (2010: 3) refers to as "tacit knowledge" to explore some cultural values. I monitored my thoughts by keeping a journal with notes about my preconceived ideas, beliefs, and biases and how they changed over the course of the study.

In addition, to ensure the credibility of this study, I analysed raw data using the qualitative content analysis method that deals only with actual data and nothing else besides. As Stake (2010: 113) asserts, qualitative researchers write about what actually happened; they do not write fiction. I wrote about what my participants experienced, which Tracy (2010: 41) refers to as *verstehen* (German, meaning "to understand").

Tracy also uses the term "multivocalty", which incorporates some notions of crystallisation. In multivocalty, there is more than one voice in analysis as well as the research report. I constantly checked the congruence between findings and reality; that is, whether or not my findings reflected the data I had collected. Reference was always made to the raw data to make verifications of conclusions, gather more information, and ask for feedback from participants. More importantly, the research questions, and the aim and objectives of the study guided me throughout. I continually returned to these touchstones through collaboration with my participants to reflect on the research findings. I was aware that meaning is interpreted from the data and of Willing's (2008: 15) contention that data collection and preliminary data analysis should be done in real-life settings to enhance credibility.

#### 3.5.1.5 Resonance

Resonance is comparable to external validity or generalizability. As Cohen, Manion and Morrison (2011: 539) explain, intensive personal involvement and in-depth responses from participants in qualitative data collection secure a sufficient level of trustworthiness. Qualitative research aims at understanding the internal dynamics of phenomena.

Tracy (2010: 49) uses the term "resonance" to express the power of a research study to echo and move the feelings of readers. She further argues that researchers can employ practices that encourage empathy, reverberation and identification with the participants. Nevertheless, Loh (2013: 14) warns of the challenge that poses to qualitative research because of the subjectivity of the researcher as the key instrument. I will not, however, pursue that debate here. Rather, as I mentioned earlier, my role as a researcher was as a human being; I was the key instrument in data collection and data analysis and my interpretations were based on the data. Furthermore, my data could be closer to reality because I used narrative interview, which Lumley and Mitchell (2012: 230) strongly advocate:

> The power of narrative interview lies in its ability to mine the unique insights and tacit understandings that inherently reside within and form the basis for the stories that we tell.

As Tracy (2010: 132) remarks, evocative, engaging, vivid and heart-rending narratives are aesthetically appealing to readers. Resonance as parallel to external validity is described by Stake (2010: 133) in terms of detailed description. Rich description makes it easy for readers to incorporate researchers' descriptions into their own experiences. Everything is context bound in qualitative research and the aim is not to draw conclusions that can be generalised to the larger population (Gay *et al.*, 2011: 76). Therefore, inclusion of much detail in my study enables readers to accurately imagine the setting in their minds. Different readers make different interpretations, emanating from their own experiences (Stake, 2010: 134). They vicariously experience the action described in the study. In this regard, Given (2008: 592) argues that a study cannot be deemed to be without worth simply because it cannot be applied to broader contexts; instead, the worthiness of a study is

determined by the applicability of the findings to alternative contexts. I have been able to gather what Tracy (2010: 845) terms “direct testimony” and I wrote in an invitational tone.

Tracy (*ibid.*) argues convincingly that transferability occurs when readers get the feeling that the research overlaps with their own situations and researchers aim to generalise within cases by taking small examples and placing them within a bigger frame. Most often, readers become vicariously aware and reflect on their own actions. In addition, I constantly reflected on my research question and qualitative research approach in addition to engaging in interactive introspection, as encouraged by Tracy (201: 845). Similarly, Willig (2008: 16) stresses that:

> Reflexivity ensures that the research process as a whole is scrutinized throughout and that the researcher continuously reviews his/her own role in the research.

This prevents the researcher from imposing meaning and thus promotes credibility. Again, I chose a sizable sample so that I could understand the phenomenon in depth. My sampling method is supported by Lemley and Mitchell (2012: 230) assertions on the subject:

> This focus on the local and particular, as opposed to an expansive and general unit of analysis contributes to narrative research’s capacity for deep exploration and explanation of a phenomenon.

It is the responsibility of the researcher to provide sufficient detail through extensive and careful description of context, place and time to enable readers to make their own judgments. Furthermore, I documented and justified my research study’s methodological approach and I explained, in detail, the procedures and processes that I used to construct, connect and shape meanings to do with the phenomenon. More importantly, throughout my study I was sensitive to possible biases by acquiring knowledge of multiple realities and interpretations.

#### 3.5.1.6 Significant Contribution

According to Tracy (2010: 845), the significance of a study is determined by its ability to contribute to the understanding of social life. Furthermore, a good study must bring to the fore that which has been hidden or unfairly ignored, provide clarity to confusion, and generate a sense of insightful understanding (Tracy, 2010: 846). As was explained in the review of literature in Chapter Two, the issue of school leadership and teachers living with HIV/AIDS has not received enough attention in research. Therefore, this study offered unique understandings of how principals are handling the sensitive issues surrounding HIV/AIDS amongst their teachers. This study provided conceptualisations that enable greater understanding the life experiences of teachers living with HIV/AIDS. It also provides what Tracy (2010: 846) terms "heuristic significance"; that is, it has the power to move other people to take this research further. Teachers living with HIV/AIDS belong to the marginalised, stigmatised and discriminated sections of society (Cohen, Manion and Morrison, 2011: 539). The knowledge obtained from this study might be useful to shed light on the phenomenon and, more importantly, empower participants to view the world in a different way.

#### 3.5.1.7 Ethics

It is important that the researcher adheres to ethical guidelines throughout the research process as this authenticates and validates the study (Creswell, 2012: 263). Tracy (2010: 846) remarks that all of the above-explained practices refer to ethical research and, in particular, self-reflexivity and multivocalty.

It was important for me to implement the following principles in order to achieve these guidelines:

***Procedural Ethics***

Procedural ethics includes the significance of accuracy and the eradication of fabrication and fraud (Tracy, 2010: 847). Participants have the right to know the nature and consequences of the research and, most importantly, that their participation is voluntary (Schensul, 2012: 22). This could include, among others, obtaining letters of consent and permission to interview, and undertaking to destroy

audiotapes (Caine *et al.*, 2013: 580). In this study, I obtained individual verbal informed consent from each of the principals and teachers, who cited their willingness to participate in the research. The processes and purposes of the research were explained to the participants. The dialogues were always conducted in a two-way manner.

### *Situational Ethics*

Based on the Christian commandment to "love thy neighbour as thyself", situational ethics asks researchers to do no harm to their participants (Tracy, 2010: 847). According to Burns (2000: 127), both the researcher and participant must have a transparent understanding regarding the confidentiality of the results and findings of the study. Therefore, I continuously critiqued and reflected on my ethical decisions. I treated each participant individually with dignity. I consistently checked the moral goals of the study against its potential to harm to the participants.

### *Relational Ethics*

The term "relational ethics" refers to the ethical consciousness according to which researchers pay particular attention to their characters, actions and the impact thereof on others (Tracy, 2010: 847). I treated my participants with compassion, affection and even maintained relationships after the interviews. Cohen, Manion and Morrison (2011: 165) suggest that open discussions and negotiation usually promote fairness to the participants and to the research inquiry. I initiated trust through the in-depth data collection methods and, above all, practised the highest degree of care in handling sensitive matters surrounding HIV/AIDS. I, as chief research instrument, built up trust and rapport with participants in addition to being sensitive to their body language.

### *Exiting Ethics*

As indicated by Tracy (2010: 847), exiting ethics goes beyond data collection to how researchers leave the scenes and publish the results. In this regard, researchers

should consider how best to avoid what Tracy (2010: 847) terms ‘”unjust consequences”. Cohen Manion and Morrison (2011: 539) remark that stories about populations that are stigmatised, marginalised and discriminated can cause an aggravation of the condition. Moreover, McMillan and Schumacher (2010: 338) assert that settings and participants must not be identifiable in written form. Therefore, the names of places, people and settings were concealed by codes and pseudonyms. In this study, all participants’ information and responses solicited during the research process were kept confidential and anonymously presented.

### 5.1.8 Meaningful Coherence

The term "meaningful coherence" is essentially a synonym for reliability and, according to Merriam (2009: 44), it can be thought of as the extent to which research findings can be replicated within similar contexts with similar participants. Therefore, the researcher is encouraged to account for and describe the changing contexts that are important to the consistency of the research results.

Nonetheless, human behaviour is highly affected by contextual factors and keeps on changing. The quality of judgments to a large extent depends on the readers’ personal construction of meaning as well as data gathering skills. That said, Tracy (2010: 848) suggests that meaningful coherence in a qualitative research must be determined by the consistency between the research findings and data collected.

In an endeavour to achieve dependability in my study, I gave a clear explanation of the theory and assumptions underpinning it. I interviewed each of my participants several times and at length. I clearly explained how I collected data and the method of narrative interview that I used allowed for the tracing the data to its source. Mertens refines this point by describing it as a “chain of evidence” (2012: 29), whilst Lincoln and Guba (1985, in Gay *et al.*, 2011: 391) use the term “audit trail”. I recorded, transcribed, and archived data and compiled numbered verbatim transcripts line by line, to enable readers to follow the data to its source and point to the verbatim examples that support my conclusions. I created a permanent audit trail

in my study to “walk readers through” (O’Donoghue, 2007: 100) from the beginning to the end. Qualitative research emphasises that data collection and description is elaborative to allow auditing. However, Yin (2011: 78) argues that "dependability" can be a challenge to qualitative researchers because the social world is constantly changing. I explained my research methodology so that other people could collect data in the same manner I did. According to Loh (2013: 3), the idea is that, under similar conditions, similar explanations for the phenomenon can be established.

Accordingly, although I made a concerted effort to adhere to these techniques and criteria, I am aware that there is a possibility that my data may neither have predictive value nor saturation. As a matter of fact, I cannot state that I was able, in my study, to identify all the possible themes about the experience of change. I cannot claim that these themes are typical to all teachers and principals. Thus, I provide my subjectivity statement in the next section.

## 3.6 Researcher Subjectivity Statement: Matters of Reflexivity

To begin with, researchers consciously and unconsciously bring their assumptions, predispositions and beliefs to the research setting. These factors may diverge or align with those of their participants. Hence, Preissle (2008: 844) contends that “a subjectivity statement is a summary of who researchers are in relation to what and whom they are studying”. In elaboration, Tracy (2010: 2) exhorts that sincerity can be achieved through self-reflexivity; that is, it can be achieved by the researcher being honest about how their biases, foibles and goals affect methods and mistakes of their research. In this regard, Yin (2011: 19) elaborates that qualitative researchers cannot do away with their own research lenses in the final analysis to render reality. The purpose of a subjectivity statement, according to Preissle (2008: 844), is as follows:

- It helps researchers identify how their personal features, experiences, beliefs, feelings, cultural standpoints and professional predispositions may affect their research.

- It conveys this material to other scholars for their consideration of the study's credibility, authenticity and overall quality or validity.

Moreover, Peredaryenko and Krauss (2013: 38) hold that predispositions, beliefs and personal interests are an integral part of the human instrument. I was the key data collection instrument, as well as data analyst and interpreter, in my research study.

As Yin (2011: 19) recommends, researchers cannot avoid seeing through their own "lenses" in perceiving reality. In this context, Caine *et al.* (2013: 582) assert that "we listen casually, with purpose, and with pre-understandings that arise from earlier experiences". I acknowledged the existence of multiple interpretations in my study, which prevented me from inadvertently imposing my own interpretation onto my participants' interpretations. According to Tracy (2010: 3), reflexivity is closely linked with ethics. As I explained in the data collection section, I obtained written consent from my participants and I honoured my obligation to protect them throughout my research and thereafter.

My research study gave me the opportunity to study a real-world setting in its uniqueness and eventually exposed me to a broad array of study topics. I thought about what Yin (2011: 21) refers to as the satisfaction derived from doing the qualitative research and the knowledge gained thereafter. It was greatly humbling to have my research participants pour out their personal stories about the most world's stigmatised disease, HIV/AIDS. I endured interacting with experiences of other qualitative researchers.

Hatch (2002: 9) articulates that qualitative research must rely on subjective judgments to enable understanding of inner states. In addition, Tracy (2010: 233) contends that this period requires a deep subjective and spiritual process. In this regard, Caine *et al.* (2013: 582) reveal that "our senses are complicit in the uptake and interpretation of meaning". I kept a self-reflexive commentary with regard to my feelings and meaning making. More importantly, my use of the first-person voice reminds the readers about my presence in the context. Qualitative researchers need subjective judgment in description, analysis and interpretation.

Nonetheless, I could not let my own assumptions and predispositions prevent my understanding of the phenomenon in the instant I acquired hands-on research experience. I was likely to be influenced by own subjectivity or less aware of it than seasoned researchers. I was strongly influenced by Peredaryenko's and Krauss's (2013: 1) suggest that:

> Even though all qualitative researchers (ideally) try to make meaning of their research experience regardless of level of experience and proficiency, novices might be especially acute of their initial experience due to steep learning curve that occurs at the beginning of the journey.

I was aware that fieldwork descriptions are co-constructed and, most importantly, provide rich and meaningful information. Reflexivity comes into play when the researcher realises his/her own subjectivity, bias and predisposition, as will be explained in the next section. Reflexivity is a technique that researchers may use to address and even guard against bias (Morrison, 2012: 231) and keeping a reflexive journal may be an invaluable tool in this regard. Reflexivity helps to point to researchers' subjectivity. Accordingly, Riessman, (2008: 137) insists that:

> Inter-subjectivity and reflexivity come to the fore as there is dialogue between researchers and researched, text and reader, knower and known – the research report becomes "a story" with readers, audience, shaping meaning by their interpretations.

To put it differently, Bailey (2012: 397) argues that "the goal of reflexivity is not to reduce bias; such a goal presumes an objective view is attainable". Appropriately, within the constructivist paradigm that believes that researchers are connected to what is researched, reflexivity is a tool that researchers use to think about how their assumptions often nourish the research process (*ibid.*).

I am a 40-year-old black Christian woman and I have been socialised in the traditional African value of *ubuntu*. I am a special-needs education teacher and part-time tutor at the University of South Africa. I believe that no goal is impossible to reach and that hard work brings success.

This background naturally shaped my approach to the sensitive research topic of how principals deal with issues surrounding teachers living with HIV/AIDS and research in general. In this regard, Tracy, (2013: 3) propounds that:

> The mind and body of a qualitative researcher literally serve as research instruments – absorbing, sifting through and interpreting the world through observation, participation and interviewing.

These factors make researchers' subjectivity – and, indeed, their bodies and minds – context-specific. My narrative inquiry situated within the qualitative research, was underpinned by constructivist paradigm principles. I chose participants through purposive and network sampling. Data were collected via narrative interviews.

It occurred to me that a qualitative research study presented a unique opportunity for me to explore the process of self-reflection. This is a key principle in interpretive research that Bush (2012a: 85) describes as "writing yourself into your research". The exploration of my experiences provided potentially fresh and valuable insights into how I adjusted myself as a human instrument. Moreover, I approached this topic with all my humanness. I entered my study as a professional and social person with a distinctive and genuine purpose. I accumulated more knowledge and my perceptions about HIV/AIDS were eventually transformed. Hence, Cohen, Manion and Morrison (2011: 175) suggest that:

> Adaptability and responsiveness, knowledge, ability to handle sensitive matters, ability to see [the] whole picture, ability to clarify and summarise to explore to analyse, to examine a typical or idiosyncratic responses are the roles of the researcher.

My personal values influenced the generation and discovery of new knowledge. As a teacher, I have always been puzzled by the topic of this study. In the beginning, I was experience considerable anxiety about entering this research is but my perceptions changed when I engaged with my participants.

My predisposition motivated and illuminated my inquiry. I assumed an advocate position because of my teaching background, which has involved dealing with learners with mental disabilities and I did not allow this to interfere with my participant's experiences. My goal was to achieve what Yin (2011: 138) calls "accelerated intimacy" in order to get to the heart of the matter. It was my first time

talking to someone living with HIV/AIDS and eliciting the data was a major breakthrough. Although sympathy cannot be separated from empathy, I was empathic. Therefore, Mertens (2010: 352) recommends that researchers build more inclusive ways to discover their participants' multiple views. I understood that I had to recognise and suspend my own assumptions in order to get into the world of other people whose lenses and understandings were radically different from mine.

Finally, I adhered to Tracy's (2010: 849) maxim that "good qualitative methodologists conduct research the way they conduct themselves in their personal lives, and 'seek the good'". As a person who strives to live life according to a certain moral code, I feel that my research into school leadership and teachers living with HIV/AIDS will contribute towards the understanding of how marginalised people feel and on, a more fundamental level, influence the enactment of policies.

## 3.7 Summary of the Chapter

This chapter focused on the qualitative research approach and its assumptions in relation to ontological, epistemological and methodological dimensions of the study. These were explained in an effort to situate this study within an interpretive perspective. The narrative inquiry design was selected to acquire accurate descriptions of the school leadership and relatedness to teachers living with HIV/AIDS. A discussion on research methodology was given with regard to purposive and network sampling, data collection and data analysis. Further I explained the measures to ensure trustworthiness of the study and the ethical principles that guided this study. In the following chapter the data are discussed in terms of the analysis and the accompanying interpretation.

# CHAPTER FOUR

## Teacher and Principal Narratives

### 4.1 Introduction to Teacher Narratives

The teachers in this study are living with HIV/AIDS. They have experienced and continue to experience stigmatisation and discrimination from their colleagues and others. Stigmatisation and discrimination causes feelings of isolation and often makes these people isolate themselves from the people closest to them. Their social world has fallen apart and they have been exposed to severe psychological and emotional distress as a result of their HIV/AIDS status. Each narrative interview with teachers living with HIV/ AIDS was transcribed verbatim, individual narratives were created, and then a collective story was written based on these individual narratives. The focus of the narrative was on how teachers experienced their principals' leadership with regard to this issue. These experiences spoke to different sensitive HIV/AIDS-related issues amongst teachers in schools in the Gauteng Province compared to their expectations thereof.

### 4.1.1 Teacher 1: Mr Machalaga[†]

**Table 6: Biographical Details of Teacher 1**

| | |
|---|---|
| Age | 46 years |
| Teaching experience | 15 years |
| Qualifications | STD and ACE |
| Marital status | Married |
| Number of children | 7 |

[†] All names used are pseudonyms. They have been changed to protect the participants' privacy.

Mr Machalaga knew about his HIV status when he got very sick and was admitted to hospital, where doctors tested him. He received counselling on how to live with HIV/AIDS, including, among other things, how antiretroviral treatment works. It did not take him long to accept his status because of the support that he received from his family. He told me that:

> Firstly, there was this assumption that, if ever you contracted with this particular disease, you are going to die. I was losing weight and, as you can see, I'm thin naturally so, if ever I lose weight, I become very thin. So I could see people were pointing fingers at me because of my weight. A colleague advised me to go and test for HIV. But, after realisation of the support that is counselling that I underwent, I started to be strong; not to worry about the disease. There was a lot about information that you can live longer as long as you follow the prescriptions. But stigma was there; firstly, because you see you are unaware of your condition and then you discover that you are sick. I wanted to be alone when I didn't want my colleagues to visit me. I knew they will destroy me. I knew they will gossip. It was somehow traumatic but, later on, that stigma became less and less and also the people around from the family from the colleagues and then I was accepted as a normal person. At first, I could see people around me discriminated me and I suffered from that stigma. Actions speak louder than words. It's really painful. I did not receive much support from the school level. I was sort of isolated, whereas I expected my colleagues to sympathise with me. Although some measures are taken to protect us at work but it is painful to be discriminated. Our school celebrates the AIDS day but, for this particular stigma, it is not enough; it comes once in a year. (Mr Machalaga p. 3-4 lines 50-69)

He relayed to me how he stayed away from work when he was sick and did not communicate with the principal. He stayed away from school for extended periods of time and soon realised that he was actually disrupting the activities of the school programme. When he came back to work, he submitted doctors' reports that reflected his HIV status. He assumed that the principal would become aware of his illness by consulting these medical records. He even approached one of the departmental heads and, still, the principal was silent about it. He has since failed to approach the principal and considered approaching district officials. He did not have a good relationship with the principal, particularly as a result of his leaving school early and sleeping in class. This was worsened by his failure to communicate with the principal when he went away. His antiretroviral treatment is subsidised because he is a member of the Government employees' medical scheme.

Mr Machalaga complained that he did not receive support from his workplace. He indicated that he expected his principal to support him and to consider lessening his workload because he is sick. He even said he believed that principals should provide answers to the problems faced by teachers living with HIV/AIDS.

### 4.1.2 Teacher 2: Mr Nkosi

**Table 7: Biographical Details of Teacher 2**

| | |
|---|---|
| Age | 59 years |
| Teaching experience | 40 years |
| Qualifications | STD and ACE |
| Marital status | Divorced |
| Number of children | 3 |

Mr Nkosi has been traumatised by his positive HIV status and has been fighting to accept the situation. He knew about his HIV status when doctors decided to test him after he was unwell for a long time. He received thorough counselling and has hope now that he is on antiretroviral treatment. Although he still suffers from skin sores and thrush, his routine of eating healthily and taking ARVs has kept him apart from the rest of his colleagues.

He disclosed his status to the principal because he had to be absent from work to attend routine check-ups with his doctors. The principal counselled and advised him regarding the Employee Wellness Programme at the District office. He was reluctant to join the support groups facilitated by the Department of Education because he felt exposed. Colleagues speculated about his loss of weight and this was his biggest challenge.

Mr Nkosi explained that stigma and discrimination can cause emotional breakdown. He commented on how colleagues can be ruthless and unsympathetic:

> You know people can be very speculative. Losing weight was one of my biggest challenges. I could see all the symptoms and signs on me. (p. 3 lines 49-49)
> It destroys! When one shows symptoms, people avoid you. I eat alone and sit alone in my class to avoid trouble. (p. 4 lines 53-54)

> It's difficult; this place is not the best one for me. I know I have to work for the income I get but I don't like this place. I'm not myself anymore; I'm not free. (p. 4 lines 59-61)
> I not sure about what support we should get so thus why I appreciate the little that we get. It's all up to us to augment what we get. (p. 5 lines 76-77)

Among other things, he expected his principal to take initiative in leading HIV/AIDS campaigns. Teams need leaders, whilst teachers living with HIV/AIDS need support. However, he stated that it was an extra duty for principals to lead teachers with social problems and that schools do not function properly when teachers are absent.

### 4.1.3 Teacher 3: Mrs Ninga

**Table 8: Biographical Details of Teacher 3**

| | |
|---|---|
| Age | 42 years |
| Teaching experience | 12 years |
| Qualifications | Diploma in Education |
| Marital status | Married |
| Number of children | 2 |

Mrs Ninga transferred to the Gauteng province to be closer to her family for care and support. Her husband, whom she married whilst she was still a virgin, left her for another woman. Her sister encouraged her to test for HIV. Although she had suspected that she was HIV-positive, her results came as a shock to her.

She has since joined a support group, where she learnt to stick to healthy eating and taking ARVs. Although her health has improved with ARVs, Mrs Ninga described her experiences with HIV/AIDS as traumatic:

> There was a time I could see that, although people sympathised with me, they looked at me with fear and they were so overwhelmed. I wasn't sure of myself and asked the principal about retiring and he advised me to soldier on. I could not do my sporting codes as I used to do. (p. 3 lines 35-38)
> It is a challenge to disclose. Stigma and discrimination is a challenge. However, disclosing facilitates access to support. (p. 4 lines 63-64)
> It affects the school tone. Teachers cannot effectively do their duties. Principals are under pressure to achieve good results. (p. 8 lines 111-112)

Nonetheless, the support of family and some of her colleagues has seen her pull through to recovery. She mentioned that she disclosed her status to the principal because it eventually became too obvious to hide. Being absent from work and her failure to perform some of her duties exposed her to stigmatisation and discrimination. She shared a perception that principals have influence and can change people's mind-sets. They set the tone. She alleged that stigma and discrimination hindering disclosure. Principals also face the challenge of improving results amid the high rate of teacher absenteeism.

### 4.1.4 Teacher 4: Ms Rakani

**Table 9: Biographical Details of Teacher 4**

| | |
|---|---|
| Age | 41 years |
| Teaching experience | 4 years |
| Qualifications | STD and ACE |
| Marital status | Single |
| Number of children | 2 |

Ms Rakani fell sick after giving birth to her second child. She tested positive for HIV when she was admitted in hospital. She received counselling and was immediately put on ARVs. It was during this difficult time, her principal visited her in hospital and came to know that Ms Rakani was HIV-positive and had severe anxiety. The principal informed her colleagues so that, her colleagues did not expect her to return to work because they assumed she was not going to make it out of hospital. She commented that:

> I got tested because my health was deteriorating. My doctors proposed and that's when I knew. It was like a dark cloud had fallen over my head. [The principal] visited me in hospital and he knew about my status from my hospital records. He is the one who informed my colleagues here at work... As a senior teacher, I'm in curriculum so teachers resist change and see me as a bad person who has failed to protect herself from HIV but am able to overload teachers with curriculum changes. (p. 2 lines 12-25)

Since then, Ms Rakani has been called names, ridiculed and ostracised. This was totally the opposite of what she expected from her colleagues. Ms Rakani repeatedly

stated that she has been ostracised and discriminated against at work, and that this caused her to lose her dignity. She related how she has been judged and undermined by colleagues. She suggested that principals have influence over the management of HIV/AIDS in schools. The principal supported Ms Rakani with her responsibilities and motivated her to take ARVs. Stigma and discrimination are part of nightmare of living with HIV/AIDS that prevents teachers from disclosing their status to their principals. Due to sensitive nature of HIV/AIDS-related issues, principals' face challenges, such as teacher absenteeism, in leading and managing schools. However, Ms Rakani expressed the view that principals should set good examples and eradicate gossip. She insisted that, although they cannot provide instant answers, principals are more experienced and they are have the power to make a huge contribution to reducing the spread of HIV/AIDS. The culture of schools in this regard has an impact on how such issues are handled. HIV/AIDS-related issues are delicate and confidential.

### 4.1.5 Teacher 5: Mrs Mabona

**Table 10: Biographical Details of Teacher 5**

| | |
|---|---|
| Age | 46 years |
| Teaching experience | 21 years |
| Qualification | Dip in Ed., BSc SPED, B.Ed. Honours |
| Marital status | Married |
| Number of children | 4 |

Mrs Mabona works in a school where there is high prevalence of HIV/AIDS. The condition of living with HIV/AIDS has subjected Mrs Mabona to a number of challenges at work. She has been isolated by colleagues and the school management team. Therefore, Mrs Mabona felt that she was being undermined and that her colleagues did not listen to her even if she raised some crucial points and made significant contributions. She found it difficult not to disclose her status because she had to attend routine check-ups and awareness programmes. She revealed that she struggled to cope until she was introduced to a support group, where she met other people in the same predicament. She experienced a great deal

of anxiety. She declared that support to boost the management of HIV/AIDS in her school is not at its optimum level:

> There are no support services here except the HIV/AIDS committee, which is not functional at all... We are not given that platform to show our talents. Therefore, some problems are never solved. Most of the things are done according to his own way. The principal cannot address HIV/AIDS openly like other issues. Once the principal starts talking about HIV/AIDS, then teachers would want to know why. Therefore, HIV/AIDS needs to be addressed with individuals affected. There needs to be lots privacy. (Mrs Mabona, p. 3-4 lines 41-69)

She said that the principal's support was intermittent, making it difficult to manage HIV/AIDS. Furthermore, she declared that the involvement of the principal goes a long way in increasing efficiency. With great sadness, she described how her colleagues have kept a distance from her since she revealed her HIV status.

### 4.1.6 Teacher 6: Mrs Mhlanga

**Table 11: Biographical Details of Teacher 6**

| | |
|---|---|
| Age | 37 years |
| Teaching experience | 13 years |
| Qualifications | Dip in Ed. BSc SPED |
| Marital status | Married |
| Number of children | 1 |

Mrs Mhlanga was always sick, complaining mainly of chest pains, coughing and headaches until she decided to test for HIV. She found it difficult to accept her status. She has since adopted balanced diet and begun exercising. Her principal frequently shares knowledge about HIV/AIDS with teachers. Mrs Mhlanga indicated that it was difficult to manage HIV/AIDS in her school because most teachers are not willing to test:

> Managing HIV/AIDS in my school is challenging because most educators do not know their status, they are afraid of being tested... The sensitivity around HIV/AIDS makes it difficult for management to discuss about it. It has forever been difficult to deal with it... Disclosing about my status was not at all easy. Several times, I thought and decided to disclose my status but I kept on postponing. Stigma is a problem; I was afraid that people, colleagues, were going to isolate and talk about me every time. (Mrs Mhlanga, p. 2-3 lines 19-29)

Mrs Mhlanga explained that the sensitivity surrounding HIV/AIDS makes it difficult for the school management team to discuss it openly. Disclosing is not easy. Stigma, discrimination and uncertainty about the reaction of her colleagues deterred her from disclosing. She maintained that she felt that her status was a personal matter that she could not disclose to the principal. Moreover, she felt that the principal would not have the time to listen to her personal problems. However, she stressed that she was aware of policies that protect teachers at the workplace.

Societies look up to principals to provide solutions to the problems experienced by teachers living with HIV/AIDS. The sensitivity surrounding HIV/AIDS-related issues makes it difficult for principals to manage them. Mrs Mhlanga noted that her principal strived to create and maintain an environment conducive to the eradication of stigma and discrimination.

### 4.1.7 Teacher 7: Miss Hlengwe

**Table 12: Biographical Details of Teacher 7**

| | |
|---|---|
| Age | 40 years |
| Teaching experience | 10 years |
| Qualifications | Dip in Ed |
| Marital status | Single |
| Number of children | 2 |

Miss Hlengwe was so visibly unwell that colleagues gossiped and assumed that she had AIDS. Her health was shaky and, at the time of her interviews, she was pregnant. Some of her colleagues supported her by occasionally providing her with cooked meals. The district offered to extend her sick leave because she was still not well after she has exhausted her standard annual quota. It is against this background that Miss Hlengwe continues to hide her status. She only told the principal that she had tuberculosis.

Miss Hlengwe told me that she feared that her colleagues would to discriminate her and label her as someone who sleeps around. She said the following to me:

> I was very sick; colleagues at work were not that supportive. All they could do was to gossip about my health and diagnosing what could be the illness... Truly, I have not done that as I think people will discriminate and label me that I have been sleeping around... I gave up hope of life. Counselling was not helping. I had this question 'why me'. It was just difficult to go outside and be seen by neighbours. (Ms Hlengwe, p. 2-3 lines 12-35)

Miss Hlengwe cautioned that stigma and discrimination starts at health facilities. She became aware of her HIV status after several tests that were recommended by doctors. Miss Hlengwe has since isolated herself. She expressed the view that principals are well positioned to lead the way for teachers in managing HIV/AIDS-related issues. They are influential in the execution of HIV/AIDS programmes.

### 4.1.8 Teacher 8: Mrs Mehlo

**Table 13: Biographical Details of Teacher 8**

| | |
|---|---|
| Age | 43 years |
| Teaching experience | 15 years |
| Qualification | B Ed degree |
| Marital status | Widow |
| Number of children | 2 |

According to Mrs Mehlo, HIV/AIDS is a very sensitive topic that is never really open for discussion. Several people questioned her about her excessive weight loss. Their lay diagnosis of her intensified after her husband passed away.

Mrs Mehlo described her experiences as unbearable:

> It is very sensitive thing and it is not an open discussion topic. It is one man for himself and God for us all. (p. 1 lines 1-2)
> Staff members avoided me and always backbiting about my health. The district is not convinced why I am always on regular check-ups and they seem to suspect I am hiding something because of absenteeism. (p. 2 lines 9-11)

> The principal is the worst of all; I would rather tell the other staff members than her. She is not approachable and it is difficult to predict her mood. (p. 3 lines 23-24)

Mrs Mehlo's colleagues began to avoid and gossip about her. Stigma and discrimination have been other stumbling blocks in Mrs Mehlo's life. She was called names and colleagues winked knowingly at one another when she was around. The news of her status came as a serious blow, causing her to feel that her world was coming to an end. She isolated herself from the rest of the teachers. She explained that she could not approach her principal to disclose her status; she mentioned that she would be more comfortable approaching a colleague instead. She indicated that she was not aware of support services offered by the district. She has since joined two support groups at her church and at the local hospital. She received counselling before and after testing. Her principal does not address HIV/AIDS-related issues. Similarly, the principal did not play any noticeable role in building the school vision in terms of the management of HIV/AIDS. Teachers often do not disclose their status because they do not trust their principals. Meanwhile, principals who are willing to listen without judgement face challenges due to the taboo around speaking about the disease. Mrs Mehlo noted that principals face challenges when teachers living with HIV/AIDS are continuously absent from work and this has placed considerable strain on the education system. A lack of support for teachers living with HIV/AIDS exposes them to stigmatisation and discrimination.

The thematic collective narrative that follows is based on the stories told by eight different teachers.

## 4.2 Themes of the Teacher Collective Narrative

The collective narrative of individual teachers living with HIV/AIDS revealed the challenges that they are experiencing in their workplaces. These teachers have experienced such severe stigmatisation and discrimination that they have opted to lie low to minimise their suffering. This collective narrative highlights the shared experiences of those teachers living with HIV/AIDS as they come from similar

backgrounds. The story is a combination of narratives that illuminate the experiences and concerns of various teachers in similar predicaments.

Appropriately, the teachers' collective narrative is juxtaposed with that of the principals, who appear unaware of the issues faced by teachers living with HIV/AIDS. Principals are portrayed as not offering appropriate support. In this way, the collective story connects teachers living with HIV/AIDS and excludes the teachers who are not infected with HIV/AIDS and society in general, which lacks the shared experience of suffering that binds teachers living with HIV/AIDS together.

I created six themes based on the individual stories in order to present a collective narrative about the teachers living with HIV/AIDS. These themes were dialogical because they were part of narratives and the focus group interviews between the teachers living with HIV/AIDS, which produced and reaffirmed the collective story. As a result, the themes cannot be reduced to individual teachers or be treated designated acts of storytelling. Instead, they emerged during the narrative interviews and focus groups as the teachers jointly acted out their collective story within the group environment. The unfolding of the collective story was shaped by the following themes: stigma and discrimination, the dilemma of disclosure, ostracism and self-isolation, teachers' experiences of principals' leadership, acceptance and belonging, and normalising and legitimising suffering.

### 4.2.1 Theme 1: Stigma and Discrimination

One of the themes surrounds the fact that HIV/AIDS is highly stigmatised and teachers infected are discriminated against. There is no trust, care and compassionate support in their schools. Since it first emerged, HIV/AIDS has been a highly sensitive social issue. Talking about HIVAIDS has always been considered taboo. Teachers living with HIV/AIDS do not trust their colleagues or their principals. As a result, there is very little, if any, compassionate support and care. Like any other chronic disease, HIV/AIDS is difficult to talk about. Therefore, teachers living with HIV/AIDS find it hard to thrive in school communities and mainstream society.

This concept is highlighted in Mr Machalaga's revelation that:

> I came back to work when I was feeling better. I was desperate for support, I went for counselling again and I was told about support groups for people like me. I got to know how to contact the Department's support system through a text messages. Usually, the Department sent us information documents regarding the support of all the chronic diseases that the individuals are having. You just take to the helpline concerning whatever chronic disease. Then they contact you about the support there is, though I never attended workshop concerning that and they used to email or text messages regarding all those necessary support that they can give you. In terms of counselling generally, not necessarily for HIV-related or whatever problems but also financial as well as other things in life, like if you are, for example, somehow alcoholic. Those are some of the kinds of support, though I never attended that kind of a thing but that's the kind of support from the Department. The scheme GEMS (Government Employees Medical Scheme) but from the team from the Department whereby they will organise workshops at school level and the likes. I didn't see any support and, since I never saw workshop concerning HIV from particular Department in effect. Government Employees Medical Scheme is part and parcel of the government. (p. 3 lines 33-48)

Mr Machalaga's challenges resonate with those faced by Mrs Mehlo, who experienced profound difficulties before and after she knew about her HIV status. Several people questioned her about her excessive weight loss. They expressed suspicion due to the deteriorating state of her skin. They laid accusations that there was "something hidden behind her weight loss and chapped skin".

As discussed, these lay diagnoses intensified after her husband passed away. She heard people say that it was obvious that she was HIV-positive. She remarked that her experiences have been "unbearable". Her challenges went as far as the District and were more concentrated within the school community. Many of her colleagues began avoiding her and gossiping about her health. The District was suspicious of her persistent absenteeism (to attend regular check-ups) and repeatedly insisted that Mrs Mehlo was hiding something. She told me that:

> I have been questioned about weight loss by several people. I was queried about my skin and accused of hiding something. After my husband passed away I could hear people say "it's obvious". It has been unbearable. Staff members have been avoiding and backbiting about my health. The District is not convinced why I am always on regular check-ups. They seem to suspect that I am hiding something because of absenteeism. (p. 2 lines 6-11)

All of the teachers living in this study were exposed to profound stigmatisation and discrimination at work before and after knowing their status. It was a traumatic experience. Some indicated that they felt suicidal for a long time after they got sick. They felt rejected, especially when they attempted to get support from their workplaces. Mrs Ninga also conveyed her thoughts:

> Stigma and discrimination are really destroying. People make you to feel guilty; after the stroke I thought I was not going to make it. My sister instilled a positive mind in me. However, there was a time when I felt like giving up. (p. 2 lines 28-30)

Ms Rakani, who was hospitalised for a long time and subjected to severe stigmatisation and discrimination after her principal revealed her status to her colleagues, expressed the following sentiments:

> Stigma and discrimination are destructive and especially when coming from people close to you. After visiting me in hospital, the principal divulged to colleagues that I was very sick and I wasn't going to make it. Since then, I have been given names and my colleagues hate me. (p. 2 lines 19-22)
> Due to sensitivity of the issue as well as stigma and discrimination – it is a challenge. Other teachers complain when they have to stand in for absent teachers. It is difficult to stop gossiping. (p. 4 lines 53-56)
> What makes it difficult to disclose is stigma and discrimination. If the campaigns could include accepting the disease like any other chronic disease then people can disclose. In terms of here at work, the principal need to set a good example. He needs to eradicate gossiping than spread it. (Ms Rakani p. 5 lines 64-67)
> School communities are aware of such policies but unruly teachers ridicule one another and they discriminate. (Ms Rakani p. 5 lines 70-71)

This reflects these teachers' encounters with the negative effects of living with HIV/AIDS. Stigma and discrimination have been a hindrance to teachers soliciting care and support. This is also evident in the comments made by Mrs Mabona:

> A lot of discrimination and stigma is attached to HIV/AIDS. We are taken to be not capable of performing some duties like sports activities. I am regarded as physically not fit to perform. Sharing the same utensils with other staff members in the staff room has been a problem. Some people still have the notion that the disease is transferrable or rather contagious, which not the case is. (p. 2 lines 17-21)
> It is ideal to deal with stigma and discrimination. The misconceptions of HIV/AIDS need to be dealt with so that people can focus on how to deal with HIV/AIDS. Once people know that you are HIV-positive, they look at you as a wrong doer. (p. 5 lines 75-77)

It is evident that this illness is characterised by visible physical symptoms. The physical symptoms expose teachers living with HIV/AIDS and make other teachers feel uncomfortable. Stigma and discrimination hinder disclosure. However, teachers cannot access support unless they disclose their status. People have been made to believe that HIV/AIDS is the disease of adulterers and promiscuous individuals. It is against this background that HIV/AIDS has become highly stigmatised. Teachers experience the stigmatisation and discrimination regarding HIV/AIDS as unbearable.

### 4.2.2 Theme 2: The Dilemma of Disclosure

Another theme of the collective story was the dilemma of disclosure. Numerous teachers living with HIV/AIDS indicated that disclosing their HIV status was a dilemma. They found it difficult to disclose their status to their principals. The difficulty of disclosing is evident in the following comments by Mr Machalaga:

> The thing of uncertainty, fear of disclosure and the likes; maybe it depends according to how you relate to your colleagues and principal in terms of sharing information and then maybe also it might happen that after sharing information they will gossip or discriminate against you. Or how the problem is you get worried about how they are going to react. In terms of relationships, information sharing depends on trust. Maybe it is part of the reason whether they would take that in a positive way or in a negative way. I think, with regard to the stigma of HIV/AIDS, reaction is major. (p. 6-7 lines 126-133)

The teachers living with HIV/AIDS in this study all indicated that disclosing to principals is difficult, with some mentioning that even disclosing to their families was difficult. Mrs Mehlo, who is a widow, had the following experience after learning of her positive HIV status:

> I never wanted to tell anyone (p. 2 lines 15-16)
> I started feeling insecure. I couldn't understand myself. I didn't know how to disclose to my children, siblings, parents and colleagues. I felt as if it was full-blown AIDS. I could feel as if everyone was looking at me and knew my status. I was always suspicious. (p. 3 lines 27-30)

The above comments reflect a situation in which teachers living with HIV/AIDS find it very difficult to disclose their status. They showed that approaching other people about their status was not easy. Mrs Mabona also found it difficult to disclose her

status but, in the end, she had to do it because she had to explain her absence from school while attending awareness programmes, which sometimes took place on working days.

With an air of desperation, she remarked on how she was left with no choice but to disclose her status at work:

> It has been difficult for me to disclose my status but, due to the fact that one needs to go for check-ups and awareness programmes at times during school days, I was left with no choice but to disclose my status at work. It took me some time to do so but, due to the fact that I needed to justify my absenteeism, I ended up gaining guts to approach the principal. (Mrs Mabona, p. 2 lines 12-16)
> It is a haunting situation, which needs one to have a lot of guts because of the after effects of disclosure. Some people do not take well if you say you are HIV-positive. They think they can be infected through contact. After disclosing, my colleagues some of them keep a distance from me. (Mrs Mabona, p. 4 lines 70-74)

It is clear that disclosing HIV/AIDS status is rather traumatic for most teachers. For instance, some teachers living with HIV/AIDS could not approach their principals, they rather submitted medical records attached on the sick leave forms and assumed that principals would know. They thought that principals would get the information about their HIV status in this way. As Lisa explained:

> I have done so during my sick leave but it was quite difficult to tell him exactly that I am HIV-positive. I only mentioned that I have tuberculosis (TB). (p. 2 lines 22-23)

Mr Machalaga adopted a similar approach with regard to disclosure:

> No, I assumed that, through that report and the conversations that we sometimes have – like, let's say, when I was in the process of applying for medical unfit – through that conversation, I think maybe I needed not to repeat myself to him regarding my status. I was talking to him about how we qualify for medical unfit and things like that. But I did talk to the principal regarding that and then maybe I should make some follow-ups. Well, I intend to sit down with him and talk many things regarding that. Not necessarily my status but other issues, so I think I need to sit down with him. (p. 6 lines 110-117)

The uncertainty about what would happen after disclosing has caused anxiety amongst teachers. This is evident in one teacher's decision to approach a

departmental head rather than the principal. However, there is an impression that disclosing brings a sense of relief – a load off of one's shoulders.

One teacher who chose to speak to someone other than the principal was Mr Machalaga:

> I approached a manager, not the School Head. I wasn't sure whether to approach the principal himself. Particularly, I think, maybe I assumed that the Head knew about that because of the information that I submitted after being absent from work for a long time; the doctors' reports and sick leave forms that I submitted and the likes. I submitted medical reports. (p. 5-6 lines 105-109)

It is clear that teachers living with HIV/AIDS hate to have their colleagues know about their HIV status. They all explained that their failure to disclose their status was caused by the assumption that their colleagues were going to discriminate against and label them as promiscuous. Nevertheless, the teachers who *did* disclose their status or who made it known to their families received proper support from their loved ones. Many teachers, such as Mrs Ninga, felt that they did not have to officially disclose their status their situations were obvious:

> My situation was open. Anyone could tell I was sick. My colleagues sympathised with me. My principal and other colleagues will ask me and check on me every morning. One day I had a chat with the principal and I told him that I had been diagnosed with HIV/AIDS. I received support from everyone in the school. Sometimes they would exempt me from afternoon activities and ask me to go home. I felt helpless, especially for my children. (p. 2 lines 21-26)
> It starts from what people believe. We have been made to hide our HIV status because the disease is highly stigmatised. However, principals can influence people basing on their strategic positions. (Mrs Ninga, p. 5 lines 75-77)

In other instances, the principals, to whom teachers disclose their status in confidence, are the ones responsible for divulging this information to their rest of the staff. This was highlighted by Mrs Rakani in the following comments:

> In my own case, it is not good enough that the principal spread the news about my HIV status and my anxiety. My colleagues have used this to judge me. I have lost my dignity. My colleagues undermine me and think that I deserve my HIV status. (p. 5 lines 60-63)
> Disclosing is one thing that has its own challenges. Colleagues become very speculative and after knowing they discriminate. People like talking about the innermost information and they don't put themselves in your shoes. (p. 4 lines 50-52)

Mrs Mhlanga reported having similar experiences:

> The sensitivity around HIV/AIDS makes it difficult for management to discuss about it. It has forever been difficult to deal with it. (p. 3 lines 23-24)
> Disclosing about my status was not at all easy. Several times I thought and decided to disclose my status but I keep on postponing. (p. 3 lines 26-27)
> I can't face [the principal]. I feel it's too personal and more of my life. I don't think he has time for that. (p. 4 line 30)

Each teacher in the study stressed that it was very difficult to disclose their status. The above comments show the anxiety experienced in this regard as a key feature of the collective story. The following comments came from Mr Machalaga:

> I think it's a good point if ever sometimes I think our government; our education department, they are trying their level best to ensure support about AIDS-related issues. But now the only challenge I have realised is to convince the people about the manner in which they should disclose. Disclosure that is the manner in which people should protect themselves in terms of sex the main causes of which to me plays a very important role in spreading HIV. Poverty also plays a very important role in people sleeping around. Also, protocol; is it possible to let's say where to start from maybe from your colleague to a senior to the main manager who is the principal and the like. All those make it very important because it might be possible where maybe you can disclose that to your colleague or your friend colleague. You are not sure whether they will go to your manager or they will gossip about it. I think that protocol makes everything difficult. You see the main problem is our department. They don't have that vision of convincing people how to disclose and then people are still afraid of this kind of protocol. People are still afraid. If there could be a mechanism whereby people feel free because you see to me HIV/AIDS is not that much scary; it is one of the chronic diseases whereby it's not that much as people think. We used to have this assumption that whenever or if any person will contract AIDS that person will die. There are many chronic diseases like sugar diabetes, which are much more dangerous compared to HIV/AIDS so if people can realise that; I think it will also be simpler for them to can disclose and when you have disclosed you become relieved and whatever you are doing you become free. (p. 5 lines 80-101)

Mrs Mehlo's sentiments summarise the issue of disclosure very succinctly:

> It is not easy to disclose at work. The principal is the worst of all. I would rather tell the other staff members than her. She is not approachable and it is difficult to predict her mood. (p. 3 lines 22-24)
> I am too scared to let the District know for I think I may lose my job. (p. 3 lines 33)
> You start thinking about how people are going to react towards me if I disclose my status. I cannot trust people especially my colleagues. (p. 6 lines 60-63)

The unspoken connection in this collective story was based on mutual understanding of each other's traumatic experiences. This was among the commonly stated aspects of the collective story.

### 4.2.3 Theme 3: Ostracism and Self-Isolation

The collective story revealed numerous profound challenges experienced by teachers living with HIV/AIDS. Feelings of isolation are one of the major challenges they faced. They felt isolated by their significant others and also began to isolate themselves from the outside world. They were overwhelmed – both by the fear of death and by a diminished sense of self-worth. This caused most of them to develop inferiority complexes. They could no longer bond with their colleagues. Mrs Mehlo described the adverse circumstances that she faced in this regard at work:

> I have been called all sorts of names like Omo, Bus and others. People avoid or suddenly they change subjects in my presence. People look at me in an unusual way and people exchange signs and wink eyes, which mean a lot to me. It wasn't easy for me to accept my status. It came as a blow. I thought it was the end of the world. I started putting myself in my own world – my grave. (p. 2 lines 12-16)

This loss of confidence makes teachers living with HIV/AIDS compromise their sense of belonging. Mrs Ninga, who got sick barely two years after securing employment with the Department of Education, was infected with HIV/AIDS whilst in a marriage that she entered when she was still a virgin:

> I was in a malaria infested area and when I got very sick I thought it was malaria. For a long time I did not get better. I got a transfer on medical grounds and moved to Gauteng. My sister and her husband asked me to move in with them. I stayed with them together with my two sons. While I was sick, my husband was busy taking a second wife. He stopped supporting me and my children. It was so hard to be so sick and be in a new workplace. You know when you can't pretend to be well. (Mrs Ninga, p. 2 lines 9-15)

It is also worthwhile considering what Mr Nkosi, a divorcee, shared on the subject of isolation:

> I maintained a low profile. I did not like knowing about my status. I stay in my classroom, I don't leave. I have to eat and take my medication. I didn't want anyone to know. (p. 3 lines 31-33)
> It destroys! When you show symptoms people avoid you. I eat alone. I avoid trouble. I have seen colleagues segregating others. My divorce is known, it makes me a bad person. Hey, even the learners discriminate others. (p. 4 lines 53-55)
> There is a lot of uncertainty. Everyday I'm worried about my health. I have no peace. Luckily I am in a special school. I don't think I was going to cope in high

> school. I'm in solitary confinement. I sometimes imagine myself falling very sick and unable to walk. I ask myself a lot of questions. Apart from that it affects teaching and learning when I feel weak. (p. 7 lines 103-107)

While the above comments are evidence that teachers living with HIV/AIDS isolate themselves, Mrs Mabona's stresses that, in addition to isolating themselves, teachers living with HIV/AIDS were ostracised by colleagues and loved ones:

> Firstly, I tried to establish how this came to be but didn't get any answers. This made me suffer psychologically because I didn't get answers to this. I experienced a great deal of depression and anxiety. I lost a lot of weight. I was not in a position to eat. I isolated myself from colleagues and from anyone else because I thought they know what was going on. (p. 3 lines 36-40)
> I have been isolated by colleagues and even by the school management team who thought that I could not cope with school duties due to the fact that sometimes I don't come to work. Being stigmatised and isolated has seen me being undermined and not being listened to even if I have a point to make. I am always taken for granted. (Mrs Mabona, p. 1 lines 8-11)

The above comments reveal that teachers living with HIV/AIDS commonly experience isolation and even isolate themselves. Isolation was thus a prominent aspect of the collective story. One serious negative impact of the threat of isolation is denial. Mrs Mabona, for instance, tested several times until she was willing to believe her positive results. While she remained in denial, she continued to lose weight and her health deteriorated at a drastic rate. Ironically, in order to hide what she was going through, she isolated *herself* from her colleagues. She thought that she would avoid suspicion if she kept people at a distance and she intended to conceal her status indefinitely. However, her struggle to cope continued until she was introduced to a support group.

Mr Machalaga's experience mirrored those of Mrs Mabona:

> It depends on where you come from; whether you get support from family namely wife, parents, brothers and sisters. They have supported me. If you are not supported then you are stigmatised. If you are discriminated [against], it has a negative effect. Considering the workplace or, before the workplace, the community from society at large; churches, clubs that is burial societies and the work situation. If you are experiencing discrimination; that is, then you can experience stigma, which might contribute to the deterioration of your health and you are psychologically affected. Psychological effects, which may be in form of more negative treatment like strained relations with society. Because, once you are psychologically affected, you feel you are rejected, you feel the best way is

> to take your life but, through counselling, I can say that, for the past five years, those people who have this disease... It has become much better because government has made various input regarding educating people that being HIV-positive is not the end of life. But, prior to that, there was not enough support. You remember former President Thabo Mbeki, when he was saying ARV tablets could not treat HIV/AIDS, whatever, but, after that, people from level of families to communities people have realised that a person living with HIV/AIDS must be accepted in the community, the workplace and should not be discriminated. (Mr Machalaga, p. 7 lines 134-156)

Mr Machalaga went on to say that:

> I think it depends on the type of work that one does because level of knowledge depends on the type of work and work environment. People practise discrimination like at school level I think through of lack of knowledge and professional language; people fail to understand what support we need. I think that way… if we get support it makes one to feel stronger. (p. 7 lines 134-156)

All of the participating teachers found that their colleagues speculated about their health and avoided them lest they contract HIV/AIDS, which is still regarded as contagious through touch or close physical proximity and viewed as an automatic death sentence. Fear and uncertainty are a hindrance to disclosure. The relationships between the teachers living with HIV/AIDS and their colleagues prior to infection determines the extent of information sharing in some instances. As a result, some teachers indicated that they maintained a low profile at work. There is no trust and compassionate support. Stigma and discrimination have been described as major deterrents to disclosure. Failing to get support from the "workplace, community, church, clubs; burial societies and society at large might contribute to the deterioration of one's health", as commented by Mr Nkosi (p. 6 lines 93-94).

The impact on these teachers' psychological health affected the way in which they related to their colleagues. Ms Hlengwe aired her views on the subject as follows:

> Well, I would say discrimination starts at the health facilities. When everyone knows that a certain area or ward is for people living with HIV/AIDS they attach labels. After my illness I was labelled hot plate by people around me. (p. 2 lines 24-26)

The teachers shared that, even after disclosing, they did not necessarily get help. The stigma surrounding HIV/AIDS causes its victims to be troubled by anger, fear and uncertainty about the future, leading to strained relationships with colleagues

and family. Amidst such intense stigma and discrimination, teachers living with HIV/AIDS are left out in the cold.

The culture of the school in this regard has an impact on how issues related to HIV/AIDS are handled. Such issues are delicate and confidentiality is of great importance. A work environment with gossipers is equally as destructive as the HIV/AIDS disease itself, as Mrs Mehlo's experiences show:

> I lost a lot of weight. I went down to size 36 from 40. I started losing confidence because I couldn't get any better. My flu will be so severe and longer. People around me started discriminating me; let alone my colleagues. They made me to feel bad. (p. 4 lines 36-39)

The collective story revealed a connection shared by teachers living with HIV/AIDS in Gauteng schools, even if they do not know one another. The comments that were made in this regard highlight the importance of researching and responding to how teachers living with HIV/AIDS are coping in the school workplace. This is a key feature of this collective story.

### 4.2.4 Theme 4: The Experiences of Teachers of Principals

Most of the observations expressed by the teachers participating in this collective story reflected common experiences and feelings amongst teachers living with HIV/AIDS. Their feelings did not need to be articulated yet they indicated the plight of teachers living with HIV/AIDS. They have shared perceptions about the roles of the principals in this regard. They have high expectations of their principals. Consider, for instance, the story told by Mr Machalaga:

> I think through the conversation that we had. But being the manager or the headmaster I think he is supposed to be more knowledgeable because he is dealing with subordinates; in effect he is the father. He is sure that we need information regarding this, even though he might not have enough knowledge he might inquire. He needs to go out and look for information and support that I want. He needs to look after his staff. (p. 6 lines 119-125)
> From the school level, I think we should have some regular workshops in order to address or talk more about this kind of disease and not only this one alone but other chronic diseases as well. Also, support groups whereby people talk more about supporting one another. (p. 8 lines 157-160)

Mr Machalaga described the support of teachers living with HIV/AIDS as one of their principals' duties:

> I think they play an important role in educating the community at large. They are role models; they produce products into the society and they must be seen to possess knowledge that enriches communities. Of course I with the condition that I have, I look up to him. It is easy for people of his level to outsource expertise to help their staff. (p. 12 lines 264-269)

The above comments show that teachers living with HIV/AIDS look up to their principals. Mr Machalaga, for example, perceived his principal as the answer to the problems he faced as a teacher living with HIV/AIDS and therefore expected him to play an important role in educating the teachers and the community at large. He argued that principals can perform extra duties through good time management and that they can use their status to implement change. This is highlighted in the comments below:

> I have worked with different principals, the majority of them that I have worked with used to perform extra work if required and to me I think they wanted to gather or I think to gain support in terms of the needs of the school protection, fundraising, understanding the community in terms of their needs; promoting their school, getting the support of the community by bringing the confidence of the school by sending more learners and you know there is competition in our schools you see like we have different schools around and the principal is not working properly with the community around, parents may send their children to other schools. So I think by working with the community that is trying to understand them, trying to handle them you see you gain support. It's good to work well with the community around; you understand them, they understand you. Principals can engage the community, they can bring people together. Really it is a challenge. The principal has the duty to bring in experts regarding the problem, for instance, psychologists, social workers; those people who have expertise to come and maybe motivate educators and learners regarding this kind of situation. He can just organise professionals because really he can find himself overworked because some of the duties are demanding. (Mr Machalaga, p. 13-14 lines 277-294).

It was commonly stated by the teacher participants that principals can influence surrounding communities to send their children to their schools and that, likewise, they can use their influential positions to change people's minds. The principals can reach out to professionals like counsellors and psychologists to give support to their teachers. They have the power to outsource resources and experts. It was also argued that, although principals have the expertise to motivate their teachers, due to the demands of their jobs, principals were often too overworked to take full

advantage of this. The following statement from Mr Machalaga best explains this issue:

> Yes, it's a challenge. This is very sensitive. We should not be scared to approach them. I think clarity is lacking. Intervention goes to known people because now let's say right now I don't know whether I can trust someone else let's say if I'm comfortable in talking to someone from the District level. Should I approach that person directly or that person should come to report to the principal or also it might cause negative impact or maybe the principal might say you jumped me and went to the district. I think we need clarity regarding this because you might be wrong you might be right. I really don't know. In effect we do have an HIV/AIDS committee but I think that committee needs a person who will attend workshops actively so that always he/she advises the whole staff about new developments with the disease and whatever in relation to the stigma. (p. 15-16 lines 335-348)

Although the teachers understood the sensitivity of dealing with HIV/AIDS, they expected principals to be able to see that teachers were not coping with their work. Mr Machalaga explained:

> I think there are more challenges. I think if ever people have people living with HIV/AIDS with them, maybe they should be particularly be given a lot of support from school level to district level. In terms of work-related issues; maybe to check whether some sort of maybe whether as an educator you are coping with your work with this chronic disease so that kind of if you are not coping with your work with this chronic disease. If you are not coping, they must determine what kind of support do you need in relation to the workload that you are facing for example maybe I'm teaching at a high school level maybe there is a lot of subjects workload and I must support this, I must support that and mark and so this means all these things only find me in an over loaded situation and then it affects also my health and thinking. (p. 4 lines 70-79)

In addition, teachers looked up to principals as possibly having answers to problems they face due to HIV/AIDS. Most of the times principals cannot live up to such expectations and data reveal that principals encounter severe challenges in dealing with teachers living with HIV/AIDS. Ms Rakani suggested the following:

> [Principals] have the potential and they can make a huge contribution. It all depends on how much they care. Their strategic position allows them to influence communities. I have seen principals go an extra mile. Their voices are easily heard. (p. 6 lines 75-77)
> The principal as a leader should set good examples and be a role model. The principal binds people together. He influences people's perceptions towards achieving goals. (p. 4 lines 43-45)

> Although they cannot answer but we look up to them they are more experienced and they are connected to other professionals due to their influential positions. They contribution to educating people about HIV/AIDS cannot be undermined. (p. 5 lines 72-74)

Mrs Ninga added the following:

> Really, it is an extra duty. However, because principals have the capacity to lead by example, they are able to inform people and educate society at large. They arrange relief teachers for in case some teachers are absent. (p. 5 lines 65-67)

Narrative data revealed that principals are leaders who should set good examples and be good role models. It is principals' duty to bind teachers together and influence people's perceptions towards achieving goals. Principals should stimulate teachers to feel and act like leaders to give them an overall sense of purpose in managing HIV/AIDS. Teachers have duties delegated to them according to their strengths so that every teacher has a responsibility. Participants like Ms Rakani blamed her principal for divulging her HIV status to the entire staff. In reality, however, the principal said that she was very ill, not that she was HIV-positive.

Mr Nkosi expressed the following sentiments in relation to this issue:

> As a leader he is able to influence change. He sometimes tells us to be responsible as professionals. He is concerned – especially when we lost a colleague and even an ex-colleague. I heard him say that we need to have medical aid. (p. 5 lines 70-73)
> Yes, he is the leader, he leads the way. Leaders have an effect; e.g. the president, Mr Zuma, has been very supportive. He has unrolled the biggest ARV programme in the world and he has initiated voluntary testing and counselling campaigns. The principals can initiate programmes that can see the school being the disseminator of knowledge. Teams need leaders. (p. 5 lines 78-82)
> I disclosed to him because I feel he can support me and I wanted him to get it from me. (p. 5 lines 84-85)
> He has to be committed. He needs to have an ear to listen to all our problems. (p. 6 lines 86-87)
> I think the principal has the power to set the tone. He has the power to pull people towards the set goals. Indeed, they are role models; they have the power and they have the authority… They can use resources at their disposal to conduct enrichment programmes. They may face challenges, yes, maybe, because of their demanding jobs. They are accountable for bad results. So I admit that such extra duties exert pressure for them to improve results. I think they can do it. They are always visible in society. They are associated with academic knowledge as well as general knowledge. (p. 6 lines 93-99)

The above comments depict principals as having a role to play in dealing with HIV/AIDS-related issues. They influence change through their positions. Likewise, the principals can initiate programmes that can make schools into disseminators of information, taking the lead in HIV/AIDS campaigns. As Mrs Mabona commented, “the involvement of the principal along the way increases efficiency. Obviously, united we stand and divided we fall” (p. 3 lines 52-53). This was a major theme, with the responses of teachers living with HIV/AIDS indicating high expectations of principals.

### 4.2.5 Theme 5: Acceptance and Belonging

Feeling part of a collective story fostered a strong sense of acceptance and belonging amongst participants. This drove forward the collective story. This sense of acceptance and belonging was reflected in the comments by Mrs Mabona, a married female teacher who described how she became a support group member:

> When I first knew, I went through the denial stage. I thought that the tests were not authentic. I completely denied the results. I thought there was something wrong with the testing machine. I tested thrice and I did it at different centres, trying to establish that I was really HIV-positive. After the last test, I told myself that there was no way out. The true reflection had come out. I struggled to cope until I was introduced to a support group. The support group helped me to cope and that’s when I began to realise that there are many people living with HIV/AIDS. (p. 2 lines 22-28)
> At first, my family had problems trying to come to terms with it but finally they have accepted. We go to the same support group with my husband and we are a happy family, which has accepted our status. (p. 3 lines 33-35)

Instead of concentrating on challenges like stigma, discrimination, and feelings of isolation (as has been shown in the other themes), this theme looks at the experiences of participants who belonged to support groups. They felt supported amongst people who understood them. Being rejected at work by colleagues did not prevent them from belonging where they were accepted and supported. This aspect emerged as part of the collective story. An example of this was given by Mrs Ninga, who managed to disclose her status to the principals because she felt that her situation was an open book; everyone could see that she was sick:

> I lived with fear; fear that parents and learners will complain that I was sick. Generally, my colleagues and management supported me so that, without my colleagues, I wouldn't have made it this far. They understood that I needed my job to fend for my children. (p. 3 lines 31-34)
> I have been able to influence change of perceptions through encouraging people to test for HIV. (p. 4 lines 60-61)
> My sister and her husband suggested that I be tested. I received thorough counselling before testing and after. I was alone with the counsellor when results were presented to me. I was immediately put on antiretroviral treatment because my CD4 count was very low. My sister supported me to go to work and eat healthy. (p. 2 lines 16-20)

The teachers living with HIV/AIDS in this collective story brought something positive out of their situations. They received counselling before and after testing. They even indicated that the counselling that they have received lessened their fears of death and, rather, raised their hopes of living, especially coupled with their antiretroviral treatment. Mrs Ninga's story is different in terms of how her school community supported and understood her. As a person who had gone through traumatic experiences, she developed a positive attitude and was able to see and appreciate the acceptance she received from colleagues and family:

> I was on sick leave when I knew about my status for (30 days). I attended counselling sessions. (p. 2 lines 21-22)
> What can you say? We are at work and that little concern that colleagues show is enough although it could be more. After all, we are at work. (p. 5 lines 74-75)

With regard to counselling, Ms Rakani described her experience as follows:

> It wasn't easy. I was admitted in hospital for a long time. My health had deteriorated and my doctors decided to test me; that is when I knew. I had just given birth to my daughter. I received a lot of counselling. I started taking ARVs. I went into depression and I was diagnosed with anxiety. (p. 2 lines 8-11)

The usage of antiretroviral treatment (ARVs) has been a positive aspect of this story. This was highlighted by Mrs Mehlo who reiterated that, after being discharged from hospital, she started taking ARVs. Most of the teachers living with HIV/AIDS received counselling, which every person who gets tested for HIV is advised to seek. Counselling before and after testing is meant to ease the situation and help people accept their new status. This was highlighted in the comments made by Mrs Mehlo:

> You can't just get tested for HIV without counselling. It's someone who encourages you to accept your new status. It's the day I will never forget. I sweated and won't forget the fear. The body language of the counsellor showed me that my results were positive. Anyway, I'm trying to get over it. (p. 4 lines 40-43)

On a fundamental level, this theme highlights as the positive aspect of counselling and support groups. Prolonged sickness with severe physical deterioration is often a symptom, which this theme highlights one of the ways in which teachers came to know about their HIV status. They all got sick and, afterwards, got advice from doctors and/or family to test for HIV/AIDS, as Mr Machalaga revealed:

> I started getting sick on and off for a long time. After that sickness, I got admitted at the hospital and not knowing that what kind of a disease I'm having. I even exhausted my leave days and later the doctors tested and told me about the disease. They counselled me about the disease and how to live life with the disease, like taking the ARVs regularly. The disease is not yet curable but treatable. You can live long life as long as you follow prescriptions and like eating healthy; for instance, foods like fresh vegetables, fruits or any foods that are having enough proteins and vitamins... all those types of foods or any other type of foods that have proteins and vitamins that are necessary. I was devastated. I felt like it was the end of the world. Later, I started taking those ARVs and then going for check-ups. The Department also is supporting in terms of helping with this kind of disease because they are augmenting with a subsidy... even the tablets. If you are a member of the medical scheme that is a certain medical scheme, you are entitled to receive the ARVs according to prescription of the doctors. (p. 2 lines 12-27)

All the teachers in this study mentioned support groups. In these groups, their HIV status was accepted rather than stigmatised and they were easily recognised rather than diagnosed. The comments made above highlight how the participants came to feel accepted not as a result of individual perceptions, but rather because of actions – for example, greeting, embracing and information sharing– that took place within the support groups. Similarly, the participants' stories revealed that a profound sense of belonging and acceptance was experienced in the company of other people living with HIV/AIDS. Support group members could be more socially authentic within the group and this spilled over into other areas. Being around other people and teachers living with HIV/AIDS allowed participants to re-establish their identities, which enabled them to communicate their needs to their loved ones. Here, they felt like members of a closely knit group when they met with one another. Their lost sense of

belonging and value in everyday life was restored every time they interacted with the other members at support group meetings.

### 4.2.6 Theme 6: Normalising and Legitimising Suffering

The participants in this study frequently described the experience suffering and distress associated with living with HIV/AIDS. Indeed, as the teachers mentioned in the above theme, they were part of a cultural group who had suffered great emotional distress. Unfortunately, many of the teachers endured much of their suffering alone because the stigma attached to HIV/AIDS made them too afraid to seek help. However, when the teachers were engaged and asked to tell their stories, they were able to reinterpret their suffering through the lens of a collective story. Below are comments from the teachers.

Mrs Mabona:

> I have attended workshops on HIV/AIDS awareness and acquired some knowledge through literature on HIV/AIDS. HIV/AIDS is a challenge in relation to the demands for eating healthy, taking medication every day and facing stigma and discrimination. (p. 1 lines 1-4)
> I was sick on and off, suffering from different diseases until I was advised by my general practitioner that I should go for various tests of which I did and that's when I knew. I received counselling before and after testing. (p. 2 lines 29-31)
> Since the advent of HIV/AIDS, the workforce has been affected and so is everyone else. There are times when I feel that I'm not strong enough to work. I'm not as strong as I used to be. (p. 5 lines 86-88)

Mrs Ninga (p. 3 lines 35-37):

> There was a time I could see that, although people sympathised with me, they looked at me with fear and they were so overwhelmed. I wasn't sure of myself and asked the principal about retiring and he advised me to soldier on.

Mrs Mehlo (p. 5 lines 55-57):

> Management cannot sit with us and talk and come up with some strategies. Rather, everything is a gossip and people like me are in the receiving end. I don't think our principal is in a position to entertain such issues.

Mr Machalaga (p. 10 lines 219-224):

> Like I said earlier on, I really suffered at work and I'm still suffering. But I would regard myself as lucky enough to get the support that I got from my family. It was good support. I never experience much stigma in the community because, you

> know, once you fail to get support from your family, you get stigmatised and it might affect you; it can traumatise you a lot. But, anyway, the main support comes from the family, although I expected it from my workplace.

Ms Rakani (p. 3 lines 28-30):

> There are people living with HIV/AIDS here. They are in the same predicament like me. Some I have heard, but some I know. We have lost more than two teachers due to HIV/AIDS.

Mr Nkosi:

> You know people are very speculative. Losing weight was one of my biggest challenges. I could see all the symptoms and signs on me. I was touched by one of the testimonies given by an HIV-positive woman on AIDS day. I started reading about the disease. (p. 3 lines 48-52)
> But I tell you I once counselled others. We had a very sick colleague and he confided in me. He fell very sick and died when I was trying to make him test and take medication. (p. 4 lines 56-58)
> I am aware of my rights as a person with this status. I have the right to work and no one can discriminate against my status. (p. 4 lines 64-65)

This narrative revealed that, through reading this collective narrative, the teachers living with HIV/AIDS came to understand that they were not the only ones suffering from the disease and that HIV/AIDS is not necessarily as death sentence, as many of them had originally believed. This suggests it could be helpful to in normalising the experience of psychological and emotional distress and reassuring people living with HIV/AIDS that the emotions they are feeling are normal. In addition, it could convince people that seeking help does not have to ruin their reputations or social identities as human beings, who have the right to life. Reading this collective narrative may facilitate the realisation that there are other teachers living with HIV/AIDS, who know their rights and are not afraid to seek support. This could give teachers the courage to reach out for support without fear of ruining their self-concepts, self-images and self-efficacy.

## 4.3 Introduction to Principal Narratives

The principals who participated in this study narrated their experiences with regard to teachers living with HIV/AIDS. They asserted that working with teachers living with

HIV/AIDS has been a challenge. The sensitivity surrounding HIV/AIDS-related issues makes it difficult for principals to deal with them. The rampant absenteeism of teachers has posed even more challenges for the principals. However, despite the challenges they have experienced, the principals' collective narrative emphasises how principals, as responsible and accountable officials, are dealing with HIV/AIDS-related issues amongst their teachers.

### 4.3.1 Principal 1: Mr Dube

**Table 14: Biographical Details of Principal 1**

| | |
|---|---|
| Age | 48 years |
| Teaching experience | 23 years |
| Experience as a principal | 14 years |
| Qualifications | STD, B.Ed. |
| Marital status | Divorced |
| Number of teachers | 33 |

Mr Dube revealed that some of the teachers living with HIV/AIDS in his school and had passed away. He noted that these teachers felt that they could not disclose their status until the eleventh hour. Some teachers, instead, disclosed their status by submitting medical records. Mr Dube provided counselling to some teachers and some have started taking antiretroviral treatments, which he says alleviated the situation to some extent. However, he also noted that HIV/AIDS has caused a profound "brain drain" (loss of qualified individuals) in the teaching profession.
According to Mr Dube, HIV/AIDS has been a major setback in moving toward the vision and mission of the school:

> We have experienced a high rate of absenteeism due to this illness, HIV/AIDS and, as a result, learners were deprived opportunity of teaching and learning, since most of or some of staff was suffering from the disease. So it has affected even our non-teaching staff and, at the end of the day, it challenged our vision and mission of the school because, at the end of the day, we cannot attain the aims for goals of the organisation if people are working ill. (p. 3 lines 48-53)

Mr Dube reiterated that good relationships were built when teachers disclosed their status and kept him informed. He stated that it made his work easier because he

understood their positions and he asserted that this eventually informed him as to how to handle the teachers. He is currently completing a psychology degree to add to his capacity to handle human beings.

### 4.3.2 Principal 2: Mr Muloyi

**Table 15: Biographical Details of Principal 2**

| | |
|---|---|
| Age | 50 years |
| Teaching experience | 24 years |
| Experience as a principal | 24 years |
| Qualifications | Dip, B.Ed., B.Ed. Honours |
| Marital status | Married |
| Number of teachers | 30 |

Mr Muloyi noted that the Department of Education is continuously losing teachers whilst it struggles to find the capacity to develop programmes improve results for critical subjects like mathematics and science. Some of his teachers were sick and their productivity was reduced. Even when they were present, their functionality was reduced to a large extent.

In one instance, Mr Muloyi found that, if he allowed sick teachers to consult doctors regularly during school hours, other teachers wanted to be allowed the same privileges. He was aware that teachers gossiped in his school, making armchair diagnoses of their sickly colleagues. Mr Muloyi is prepared to go the extra mile and provide counselling for his teachers in distress:

> We are a Christian school; most of us here are Christians, so we use the Christian values, beliefs and practices to deal with gossiping. We start our school days with prayers and we have since intensified the programme so that we have prayer sessions for those who are sick. Visits are resuming; teachers collect donations and visit the sick. We emphasise people not to diagnose. I have been talking about change of views. (p. 6 lines 89-93)

He noted that teachers with HIV/AIDS were gossiped about, stigmatised and discriminated against, based on their physical symptoms. Mr Muloyi insisted that several of his attempts to get teachers to disclose their status to him were fruitless

and that he had consequently lost hope. Furthermore, Mr Muloyi revealed that perceptions about, for instance, the causes of HIV/AIDS have not changed. He has taken to using the tenets of the Christian faith to create harmony in his school. He pointed out that society ascribes roles to the teachers. They are looked upon as custodians of knowledge and role models, who are expected to be morally irreproachable and lead healthy lives. Disclosure would mean revealing that they have not lived up to these roles, which is why many teachers choose to remain silent.

### 4.3.3 Principal 3: Mr Mokena

**Table 16: Biographical Details of Principal 3**

| | |
|---|---|
| Age | 55 years |
| Teaching experience | 29 years |
| Experience as a principal | 16 years |
| Qualifications | STD, Dip, ACE, B.Ed., B.Ed. Honours |
| Marital status | Married |
| Number of teachers | 45 |

Mr Mokena understands HIV/AIDS as a pandemic that destroys the immune system and exposes the human body to opportunistic diseases. He claimed that HIV/AIDS is rife mostly within black communities and that the pandemic has caused unbearable havoc in all sectors of life. He emphasised his experience that teachers living with HIV/AIDS disrupted teaching and learning to a large extent in his school:

> Teaching and learning is affected. To curb the problem, I have always insisted on daily attendance. Teachers must perform to their maximum. Everyone must play his/her part; the cleaners must clean, the drivers must fetch learners on time and, likewise, everyone else. The last thing I want to know is the disruption of the teaching and learning timetable. Therefore, I demand to know the reasons behind the absenteeism. They are aware that I do not condone teachers who buy medical certificates from doctors to justify their sick leaves. I insist on checking teachers' attendance and performance so that teachers living with HIV/AIDS have been left with the only option of disclosing so that I understand the intensity of their problems. (p. 2 lines 18-26)

Several teachers had disclosed their HIV status to Mr Mokena and he kept everything a secret. He monitored his teachers so closely that teachers had no

choice but to declare their HIV status. He indicated that he did not condone gossiping; the root of stigma and discrimination. He had brought harmony to the school and established a culture of hard work, respect and tolerance. He mentioned that he supported his teachers. However, he lamented the fact that principals are not, in turn, supported by the Department in dealing with HIV/AIDS-related issues amongst their teachers.

### 4.3.4 Principal 4: Mrs Motsepe

**Table 17: Biographical Details of Principal 4**

| | |
|---|---|
| Age | 49 years |
| Teaching experience | 27 years |
| Experience as a principal | 9 years |
| Qualifications | STD, ACE – Education Management |
| Marital status | Married |
| Number of teachers | 27 |

Mrs Motsepe acknowledged that, although her teaching staff had not been entirely spared the impact of HIV/AIDS, it had been affected to a lesser extent than elsewhere. Like those in the other schools discussed, teachers in Mrs Motsepe's school regularly took time off to seek medical attention, which always impacted badly on the smooth running of the school. Teachers did not disclose their HIV status. Mrs Motsepe related how her school was profoundly affected when one of her teachers fell sick. Everyone could see by the physical symptoms and that he was probably HIV-positive. The teacher isolated himself. Other teachers and learners were afraid of him in the school. Mrs Motsepe tried to give him support but, unfortunately, he eventually died. He suffered from stigmatisation and discrimination because of his lifestyle. Mrs Motsepe (p. 4-5 lines 71-82) shared the following sentiments:

> I always follow up on teachers when they are not feeling well. I would phone them and encourage them to consult doctors. They must eat and take medication. I also provide counselling. Teachers cannot expect me to babysit them. They must reciprocate my support because there are so many of them and, besides, I have a life and family as well to take care of. I always tell them: "don’t lean on me". They must live their lives responsibly and always bear the socially constructed role of being role models in society. They must face their

> problem head on and fulfil their duties. They are expected to work towards achieving the school's vision and mission. They must execute their duties efficiently. That's why, when I phone them, I want to know if they have been to the doctors and someone would tell me that he is sleeping at home. I just tell that teacher to please go to the hospital; sleeping will not help. It is important for teachers to join medical aid schemes.

Most importantly, Mrs Motsepe believed that seeing what the teacher who passed away went through actually had a positive impact on the other teachers. Possibly, witnessing his suffering acted as a deterrent to risky behaviour for other teachers, causing to change their own lifestyles if necessary. She claimed that she was not aware of any of her teachers making such dangerous lifestyle choices since the passing of the aforementioned teacher.

### 4.3.5 Principal 5: Mrs Pule

**Table 18: Biographical Details of Principal 5**

| | |
|---|---|
| Age | 44 years |
| Teaching experience | 21 years |
| Experience as a principal | 8 years |
| Qualifications | STD, ACE, B.Ed. |
| Marital status | Married |
| Number of teachers | 15 |

Miss Pule noted that people perceived HIV/AIDS as the result of sexual promiscuity. This, she asserted, was the cause of the stigma and discrimination surrounding the disease that was keeping people living with HIV/AIDS from disclosing their status. Nonetheless, she applauded the South African government for the antiretroviral treatment programme that has lessened the burden. Mrs Pule remarked on how one of her teachers used to throw temper tantrums. The teacher was very emotional and tended toward frequent absenteeism. It was a difficult time for all the staff members. Mrs Pule stressed that she did not know how to deal with the situation and she felt that she was being emotionally blackmailed. Despite other teachers' complaints about this teacher's inappropriate behaviour, however, her principal considered it inhumane to discipline her:

> The government of South Africa has played its part. There have been rigorous campaigns to inform people about HIV/AIDS. A number of awareness campaigns have been followed by a lot of support at grassroots level. The government has offered support like free circumcision, which is aimed at reducing the spread of HIV/AIDS. It will be improper to expect more than what the government has offered. For instance, the Department of Education has provided support to the extent of [teachers] being exempted from their duties because they are living with HIV/AIDS. Teachers must try their best; they must take full responsibility of their health. (p. 3 lines 39-47)
>
> I do not mind that pastoral duty for the teachers because it is part of my job description. But I do not have to mother the teachers. I do not have to care for teachers at work. I cannot lower their duties because they are sick. They must be productive; they cannot expect other teachers to work for them. (p. 4 lines 55-58)

When the sick teacher decided to disclose her status, Mrs Pule supported her. She helped her accept her status so that she could even talk about how well her ARVs were working. Eventually, the teacher transferred to another province. Mrs Pule argued that the demands of support for teachers living with HIV/AIDS were well beyond her means to supply. She noted that the health of teachers living with HIV/AIDS degenerated whilst they remained in denial.

### 4.3.6 Principal 6: Mr Sebeko

**Table 19: Biographical Details of Principal 6**

| | |
|---|---|
| Age | 46 years |
| Teaching experience | 25 years |
| Experience as a principal | 5 years |
| Qualifications | M.Ed. |
| Marital status | Married |
| Number of teachers | 51 |

Mr Sebeko acknowledged the presence of teachers living with HIV/AIDS in his school after one male teacher passed away, and more disclosed their status to him. Before his death, the deceased teacher posed many problems to management because he was always absent from work and did not perform his duties properly. He took advantage of people's sympathy and even solicited money from learners in exchange of good marks. As a result, the two teachers who disclosed their status

were required to justify their absenteeism so that Mr Sebeko could avoid a repetition of the late teacher's behaviour. Therefore, he made agreements with the two teachers to be dedicated to their work and, above all, make arrangements for their classes to be taught when they were absent.

Mr Sebeko offered the following comments on the situation:

> After the workshop here at school with the counsellor, [the late teacher] was referred to the District wellness programmes. Still after the programmes, the teacher expected sympathy and his conduct was not good. (p. 3 lines 49-51)
> In effect, his behaviour came as a wakeup call for me and the school management team. I mean, we did not expect such kind of behaviour from him because colleagues had expressed sympathy. How could he drink so much while he was taking medication? (p. 4 lines 56-60)

Mr Sebeko elaborated that, although he respected teachers' decisions to disclose their status and he felt obliged to protect them, he always guarded against them taking advantage of his support. He expected them to do their work normally. He reported that, although the Department of Education does not pay principals enough for all extra duties, they are still obliged to go the extra mile. He acknowledged that there are responsibilities laid on principals because they are leaders, custodians of knowledge, and role models.

### 4.3.7 Principal 7: Mrs Louw

**Table 20: Biographical Details of Principal 7**

| | |
|---|---|
| Age | 50 years |
| Teaching experience | 28 years |
| Experience as a principal | 13 years |
| Qualifications | STD, ACE – Education Management |
| Marital status | Married |
| Number of teachers | 19 |

Mrs Louw indicated that some of her teachers had not been well for a long time and, as a result, the school could function to its full capacity. She sadly related how she had lost two teachers to HIV/AIDS in recent years. She revealed how tried to get

closer to one of these teachers to express her concern about his deteriorating health. Based on humanitarian grounds, she felt it difficult for her to leave him alone.

Finally, the teacher disclosed his status and died shortly thereafter. While she was looking for his replacement, another female teacher died. There were other teachers who are also sick and their colleagues complained when they had to take over classes in their absence. Hence, Mrs Louw made the following comments:

> Like I said, I can only refer teachers for counselling. They are attended to by experts. I sit with them to listen to their problems. I talk to their colleagues to bear with them and adhere to the relief programme. I cannot be seen to be pestering people about their personal problems. They have to be responsible. If they are sick then they have to produce medical certificates. (p. 5 lines 73-78)
> I cannot ask if someone has tested for HIV because such issues can get you into trouble. I could be asking in good faith whilst someone feels offended and get you prosecuted. (p. 5 lines 81-83)

Mrs Louw indicated that teachers supported one another, possibly because they realised that they might end up in the same situation at some point. In addition, Mrs Louw explained that teachers may unintentionally discriminate against their sick colleagues because they are constant reminders of death.

### 4.3.8 Principal 8: Mr White

**Table 21: Biographical Details of Principal 8**

| | |
|---|---|
| Age | 50 years |
| Teaching experience | 28 years |
| Experience as a principal | 13 years |
| Qualifications | STD, Dip, BA |
| Marital status | Married |
| Number of teachers | 53 |

Mr White revealed that there were teachers living with HIV/AIDS in his school. Four of them had decided to break the taboo of silence and disclosed their status to him. Other teachers had decided to conceal their status but had begun to show physical symptoms.

Absenteeism was rife in his school. When sick teachers were present at work, they remained seated when they taught and their performance was not up to standard. It became a practice amongst teachers and learners to raise three fingers to indicate their belief that someone had HIV/AIDS:

> One of the teachers, a female, unfortunately has developed physical symptoms like sores all over and her hair is thinning. She has been ridiculed by other teachers and even learners. Other teachers call her names. They raise the three last fingers as an indication that they know that she is HIV-positive. Therefore, colleagues pass rude remarks. (p. 4 lines 53-57)

Mr White asserted that teaching and learning were profoundly affected by persistent absenteeism. It had become a trend that teachers absented themselves during the first week of the month. He indicated that he did not refer his teachers to the District because they were busy with their own personal support groups. He advised his teachers to eat healthily, go to church, gym and join support groups.

### 4.3.9 Principal 9: Mr Ntolela

**Table 22: Biographical Details of Principal 9**

| | |
|---|---|
| Age | 58 years |
| Teaching experience | 34 years |
| Experience as a principal | 18 years |
| Qualifications | STD, PGDE, BA, B.Ed., M.Ed. |
| Marital status | Married |
| Number of teachers | 60 |

Mr Ntolela stressed that, whilst he could tell (based on the physical symptoms) that some teachers were living with HIV/AIDS, not a single teacher had disclosed their status to him. The prevalence of HIV/AIDS had caused a difficult situation in his school. The teachers had, for a long time, been absenting themselves from work for days on end and then returning for just a few days.

One of the teachers suffered from shingles and was in a great deal of pain. Similarly, he related instances in which teachers came to work one week in and were absent the next, making it difficult to provide substitute teachers. Such teachers could not finish their syllabi. This was described in the following statement:

> If a teacher is not able to work because is sick and that condition is confirmed by medical doctors, I am able to substitute that teacher. But then, if I am not warned in time, I cannot substitute in time. It is difficult, though, to get someone who fits in the position and function exactly the way the sick teacher was working. It is even worse if that teacher teaches more than two subjects; an exact substitute is difficult to find and it is a problem if a teacher cannot come to work for four to five weeks. I need to find a substitute or substitutes when teachers are suffering. (Mr Ntolela p. 3 lines 31-39)

Mr Ntolela observed that he was forced to tolerate what was taking place. Once he tolerated one teacher, other teachers expected the same. He revealed that it shook his authority as a leader. He emphasized that ensuring care and support for teachers living with HIV/AIDS was an extra burden. He insisted that, when principals are given elevated status, it enhances their positions as principal and, by and large, it encourages teachers to trust them.

### 4.3.10 Principal 10: Mr Den

**Table 23: Biographical Details of Principal 10**

| | |
|---|---|
| Age | 55 years |
| Teaching experience | 29 years |
| Experience as a principal | 10 years |
| Qualifications | STD |
| Marital status | Divorced |
| Number of teachers | 34 |

Mr Den noted that teachers' absenteeism because of HIV/AIDS was on the increase. He mentioned that some teachers had resigned because of HIV/AIDS.

He insisted that, since his school is a specialised institution, it took a great deal of time to capacitate new and inexperienced teachers. Teachers did not approach him

to disclose their status; rather, they disclosed via medical records. He made the following observation:

> Teachers are just as vulnerable because of socio-economic aspects. Teachers who cannot afford to buy houses stay in areas that are of high risk. As such, they belong to social circles that are of the lowest class. Another issue is frustration caused by not having something to do, especially after work. They indulge in unbecoming behaviour because of social circles. Problems like unwanted pregnancies [and] addiction are caused by idling and/or, I can say, redundancy. They do not participate in some productive activities; rather, they go to *shebeens*[‡] for entertainment. Too much intake of alcohol makes people to sleep around. I am not sure of statistics though. We have two or so teachers here. (Mr Den p. 2 lines 14-22)

Mr Den elaborated that the issue of confidentiality was posing serious challenges to the school leadership and management. He discussed how teachers were dragging their feet, taking advantage of their sickness. He added that, if he spoke to them about it, they felt segregated and stigmatised. He declared that, sometimes, teachers living with HIV/AIDS had no strength or energy to work.

## 4.4 Themes of the Collective Principal Narrative

The thematic collective narrative that follows is based on the narratives shared by ten principals. The collective narrative of principals unearthed how principals are dealing with issues of HIV/AIDS amongst their teachers. These principals have experienced difficulties in dealing with HIV/AIDS. Nonetheless, they narrated how they were committing themselves in supporting and caring for teachers living with HIV/AIDS. The story accentuates the mutual experiences of principals. This narrative is a combination of narratives that highlight concerns of other principals in the similar predicament. Teachers living with HIV/AIDS are portrayed as causing problems to the whole school system. Appropriately, the collective narrative connects principals who have experienced the phenomena in this study. I created six themes based on the principal individual narratives in order to present a collective narrative from the principals. These themes were dialogical because they were elicited through narrative interviews between the principals and reaffirmed the collective story.

[‡] Taverns.

Hence, the themes cannot be reduced to individual principals or be treated as designated acts of storytelling. The following themes shaped the collective narrative: dilemma of disclosure, stigma and discrimination, challenges faced by principals, persistent absenteeism, teachers' experiences of principals, and acceptance and belonging.

### 4.4.1 Theme 1: Dilemma of Disclosure

One of the themes elicited from the raw data was that disclosure of HIV status by teachers was a dilemma. The responses of all the principals showed that the dilemma of disclosure was a common problem running throughout the sampled principals' experiences, as is evident in the following comments by Mr Muloyi:

> As I have said, teachers do not disclose. They always pretend to be strong when they are not. It is unfortunate that some of them have resorted to excessive drinking, maybe to ease their stress. The goals of the school are underachieved. (p. 2 lines 26-28)
> No matter how much I try to show concern and support to the sick teachers, they remain tight-lipped about their HIV status. That is their innermost secret. (p. 4 lines 52-53)
> As leaders, we need to deal with disclosure. Teachers need to be encouraged to disclose. All society sections must come to together and deal with issues like sigma that is the reason why teachers do not disclose. People living with HIV/AIDS have the right not to disclose and, at the same time, they need to disclose to get help. The policies are too protective. (p. 5 lines 70-74)

The principals in this study all indicated that teachers living with HIV/AIDS were not willing to disclose their status. This was evident in the following comments by Mr Sebeko, who lost one of his teachers to HIV/AIDS:

> Our teaching staffs have really been affected. However, disclosing is a stigma. Teachers have always indicated that they are not well and you can see by the rate they lose weight and sometimes hospitalised. Surprisingly, they sometimes recover miraculously. But others do not gain complete body recovery. Although the physical symptoms incline someone to suspect HIV/AIDS, you just respect their decision not to disclose. (p. 1 lines 7-12)
> He did not disclosure to me, I think, because I could not offer the sympathy not to work with he was looking for. When he was still fit, he did not commit himself to his job. He was always bunking classes and kept management on their toes

> until he was very sick and died. My efforts to get teachers to disclose have been fruitless. (p. 4 lines 52-55)

On the same note, Mr Ntolela expressed the following sentiments:

> I do not remember a teacher disclosing their status to me. I have never seen one. In actual fact, I can see that some teachers are sick and I am afraid I cannot diagnose. The symptoms clearly point to HIV/AIDS. (p. 2 lines 14-16)
> This is very sensitive information that I cannot reveal. I cannot talk about their illness. It is my responsibility to keep their information. I need to respect their integrity. I am aware that I can be sued for divulging such information. Leadership needs to be trained and be aware about the seriousness of HIV/AIDS. Experiences deter teachers from disclosing. The sick teachers need counselling so that they can be educated to reveal to the principal as a representative of the employer, which is the Gauteng Department of Education. (p. 5 lines 81-87)

The above comments are in agreement with those made by Mrs Motsepe. She indicated that sick teachers did not disclose their status:

> Teachers do show some physical symptoms of HIV/AIDS but not much. Teachers have disclosed about, for example, operations and depressions but they do not disclose their HIV status. Sometimes you can see that they are not well. If they do not want to disclose, I cannot force them. They always pretend to be not seriously ill. Mostly, they complain about flu, colds, headache and running stomach. About 10 years ago, our school was badly affected by HIV/AIDS. The teacher started when I was still a deputy principal and we felt effects when I was a principal. (p. 2 lines 16-29)

Mrs Motsepe went on to relate her experience with one particular teacher:"

> One of the teachers fell sick and everyone suspected HIV/AIDS according to the physical symptoms that he resembled. He would always sit in his [classroom] and he would isolate himself. He became very arrogant and he did not want to talk to anyone. He would swear at anyone who looked at him and he showed a lot of anger. Learners would ridicule him. They would laugh at him and call him names. Some teachers spared their time to chat with him and the rest were was afraid. As a result, he would fall asleep in his classroom. (p. 2 lines 16-29)
> When I became the principal, I did ask him to disclose but he did not. I asked him several times; he only remarked that he knew what he was suffering from. (p. 3 lines 39-40)
> Teachers do not disclose even after developing full-blown AIDS. They do not communicate to arrange for sick leave application. (p. 4 lines 64-66)

In this collective narrative, principals shared comments that showed the difficulties faced by teachers living with HIV/AIDS in disclosing their status. Mrs Louw shared the following comments about one such teacher:

> She was very good at her work; of course, she would take some days off to consult doctors, for I remember she was asking for a good doctor here around. Also, the coughing was severe. I did understand even her pretence to be well, because I assume she was desperate to keep her job. Yes, you can see by the way they are losing weight and the symptoms could be those of HIV/AIDS. They have not said anything to me. You cannot show that you suspect because this is a very sensitive disease. (p. 3 lines 40-44)
> Much as it is sensitive; it is confidential. I have to keep it confidential to protect someone's dignity. I informed my deputy so that we could come up with a programme to make sure the absenteeism of teachers does not affect our goals as a school, especially teaching/learning. (p. 5 lines 85-88)
> When teachers disclose, you cannot tell the next person in terms of work-related issues. You can not address the staff about it like we can tell the staff that Mr so and so has high blood pressure. It's too confidential and delicate. I can say. You cannot ask teachers to disclose. A problem shared is a problem solved, they say. I cannot go deeper into teachers' personal issues. (p. 6 lines 105-108)

There was evidence in the narrative that teachers were so intimidated by the idea of disclosing their HIV status that they chose to submit medical records (and assume their principals would find out that way) instead of approaching their principals directly.

Mr Dube explained the situation as follows:

> They do come to my office but, most of the time, they come with their papers and they do declare with their medical certificates and I keep that confidential. Some confide in me and we talk about it and it makes my work easier as I understand their position and how to handle them. I am able to understand their position and know how to handle them and that makes our relationship to improve. When one of my teachers did not report to work, I phoned and got to know that he was very sick. I drove to his place and I found his fiancé feeding him with soft porridge and he was struggling to eat. I took him to a public hospital because he did not have medical aid. He got admitted. The following day I visited him and he disclosed his status to me. His health had extremely deteriorated and he died the following day. Another teacher declared his status through medical reports; I kept everything private and confidential. Actually, the teacher had gone away for a long time without notifying me. I tried to contact him to no avail. When he came back, he presented reports from the doctors. He later came for consultation on medical unfit and I advised. (p. 4 lines 89-103)

Mr Den echoed Mr Dube's observations:

> We are guided by the code of secrecy, issues of confidentiality. For example, if a teacher tells me about having been infected by a sexually transmitted disease, I cannot divulge such information. The secrecy policy covers a lot of issues and I can be sued for divulging such information, unless teachers decide to disclose on their own or give mandate for me to do it or maybe in order to share knowledge. I have known about this information through records and behaviour. Sick teachers submit records that are necessary when submitting sick leave forms. The info is not clearly marked; sometimes it describes the teachers' CD4 count and explains the functionality of the system in relation to what medication they should take. The information is private and confidential. I suspect the following for teachers finding it difficult to disclose: 1) how they interact every day, 2) the relationship that we have always had with teachers, 3) the character of that teacher and personality as well (some people won't just give away information), 4) stigma and discrimination (it can be an embarrassment to colleagues). (p. 4-5 lines 87-103)

Some of principals indicated that teachers were forced to disclose their status because teachers have to give valid reasons for absenting themselves from work.

Mr Mokena revealed the following in this regard:

> More than four teachers have disclosed and some date back as far ten years. The reasons of confessing could be that they want me to understand circumstances in which they are living and why they absent themselves from work. Another reason could be that they want to break this to anyone to lessen their burden. Also, they are in need of help, for instance, referrals. They want to inform me about the genuineness and reality if their sickness. (p. 2 lines 27-32)

Several teachers also disclosed their status to Mr Sebeko:

> Two teachers have disclosed their status to me. They explained their conditions in relation to schedules with doctors. The two male teachers approached me on different occasions and I am not sure if they know about one another. Both teachers asked me not to disclose to anyone, even the deputy principal. I have kept the promise. I approach them cautiously with due respect. I offer them necessary protection. For instance, it has happened that, as per protocol, I forgot to inform their HODs until they reported to me. Then I had to simplify the matter; I apologised and explained that I had forgotten. Since day one, I pleaded with them not to disturb teaching/learning. They inform me whenever they have to take days off and they complete leave forms. I do not give them special treatment for they also do not ask for special treatment. (p. 4 lines 19-30)

Mr White also indicated that some of his teachers disclosed their status to him:

Four teachers have disclosed; two females and two males. I have been very sympathetic with them. I was also affected because I did not expect it. I provided basic counselling and advised people to eat healthy, go to the gym and be positive about living longer. I have advised them to pray, for I provided comforting words. (p. 3 lines 49-52)

### 4.4.2 Theme 2: Stigma and Discrimination

It was evident from the principals' responses that HIV/AIDS is highly stigmatised. All the principal participants in this collective narrative shared views that stigma and discrimination of HIV/AIDS was so intense that, as discussed, it deterred teachers.

Mr White shared the following experiences with regard to stigma and discrimination:

> One of the teachers (a female) unfortunately has developed physical symptoms like sores all over and her hair is thinning. She has been ridiculed by other teachers and even learners. Other teachers call her names. They raise the three last fingers as an indication that they know that she is HIV-positive. Therefore, colleagues pass rude remarks. When I spoke to her, she indicated that she does not like these symptoms and she sleeps always after taking medication. She is always tired. I have known about her HIV status but I cannot tell anyone else. I do not want them to blame me tomorrow when they hear that their innermost secrets are circulating amongst the staff. After all, we can also be victims. The lady has always had issues with her HOD. She has been always fighting with the HOD. I always calm situations and try to protect the teacher and I won't explain why. Apparently she has not been in good terms with the staff and, to a large extent, her lifestyle has contributed to how she is being treated. They suffer quite a lot. When teachers quarrel they mention those innermost secrets they have known about others in order to humiliate and hurt them. People do that naturally. It is typical of human beings. They gossip, they call each other names, and I would say that's why teachers do not disclose. They have no trust. Teachers need to be advised to correct their behaviour. You tell one person that you are living with HIV/AIDS and they circulate the matter around the school. Being so protected information, it goes viral the moment people know. Such behaviour deters other teachers from disclosing. (p. 4-5 lines 53-79)

The above experiences and the principals' opinions speak to ethical issues. Learners' practice of raising three fingers at people with HIV/AIDS is a sign of poor discipline that allows bad behaviour. Over and above this, it indicates the absence of the spirit of *ubuntu*. In relation to stigma and discrimination, Mr Muloyi made the following observation:

> The physical symptoms subject them to stigma and discrimination; people gossip. We have had a practice whereby teachers would organise themselves and visit sick colleagues in hospital or at home. It is during these visits that people diagnose and it has now reached a point whereby people do not want to be visited. They would say that those teachers that have been involved in sexual relations with the sick teachers will also die. They would say a lot of things like,

> they are sick because they have been sleeping around they blame them for having been infected by HIV. (p. 6 lines 81-88)

Furthermore, one of the female principals, Mrs Pule, described the situation in her school in relation to the stigmatisation and discrimination experienced by teachers living with HIV/AIDS as follows:

> HIV/AIDS is known as a disease of the wrong-doers. It has been known to be associated with sleeping around with different partners and, mostly, fast-lane lifestyle. Families have been known to disown their members who would have disclosed their status. They will be regarded as failures. People are afraid of losing family members and being disowned at work. For example, a cabinet minister is caught exceeding the speed limit while drunk. It is a disgrace to the people, the government and his/her family. So teachers would rather hide their status than be seen as a disgrace. I mean, people always show sympathy. Other teachers showed sympathy and especially that [an infected teacher's] marriage was falling apart, which could be the reason why she could not control her temper. She was worried about her physical symptoms and she did not like it. She isolated herself. She has since transferred to another province. There needs to be mind-shift from the primitive ways of thinking amongst teachers. They can be ambassadors of breaking taboos about HIV/AIDS. Teachers need to be informed about the advantages of knowing about their HIV/AIDS so that they can access medication. (p. 4-5 lines 59-75)

Mrs Motsepe, another female principal, lost a teacher in her school after a long illness:

> As time went by, he got worse. Teaching and learning were adversely affected. He could not effectively do his duties. As a result, he was exempted from some of his duties, like extra-curricular activities. He was very weak to work. The thought of death affected the whole school morale. Everyone in the school was afraid of looking at him, especially during the last stages of his illness. He lost weight and he was so thin that everyone could see that he had developed full-blown AIDS. He was staying in an upmarket suburb and lived a fast-lane life. He was not in touch with his family and then I was so lucky that, just when he was about to die, I found his distant [relative]. When he passed away, I sent a delegation to represent us. The [relative] helped to locate his family. There was not any contact to his family. It was because of his lifestyle. He lived a luxurious life and cared about himself only. He impregnated women and deserted them with no support. He slept around. He severely suffered from stigma and discrimination and, [back] then, there were not ARVs, which have recently been discovered. [Back] then, society believed that the causes of HIV/AIDS were related to lifestyle. Thus, when he fell sick, people judged him according to the life he lived. The situation was very bad. It disharmonised the school. The teacher was engulfed by anger and fear of death and he did not get enough support. (p. 3 lines 33-54)

In other instances, some principals convinced some but not all of their teachers living with HIV/AIDS to disclose their status. Principals strived to normalise situations so that stigma and discrimination were minimised. This was evident in what Mr Sebeko said:

> That is why I have kept everything secret because the issue about the fighting was related to HIV/AIDS and we could not be involved because they were female teachers. I have normalised everything now. (p. 5 lines 73-75)

Likewise, principal participants like Mr Dube, who have had incidents of quarrelling in their schools related to HIV/AIDS, took disciplinary action against the teachers and other staff involved. He shared the following sentiments:

> If an educator stigmatises somebody about HIV/AIDS that is regarded as a serious misconduct and that teacher can go through a disciplinary hearing whereby he/she can be charged for such misconduct. And even our country states that people must not stigmatise other people, harassing and talking ill about people living with HIV/AIDS. So it becomes an issue that is treated with care. People are not very careless about that. They know the repercussions. People also understand that one out of ten people is HIV-positive. They know about that reality. They know HIV/AIDS is something within families, with schools, with institutions and so, the moment you talk ill about somebody or ridicule, so you are also talking ill about your own. So people are very conscious; they do not talk ill of other people. What affects you indirectly affects someone directly. So we are all affected. (p. 7 lines 166-176)

In addition, Mr Mokena, who asserted that he did not condone gossip in his school, had this to say about stigma and discrimination:

> It has been minimal. Gossip, which is the main cause of stigma and discrimination, is not dignified in this school. We do not condone it; we do not entertain it. Yes, it depends on physical symptoms. The moment it shows, we dismiss it completely. We do not endorse gossip, we do not repeat it. I always ignore and give an ear to things worth talking about. I make sure victims are protected. I have known some teachers to be living with HIV/AIDS for ten years now and everything has been kept under wraps. (p. 5 lines 77-83)

The above sentiments reflect the principals' efforts to eradicate stigma and discrimination. This was also evident in the following statement by Mr Den:

> Placing HIV/AIDS information everywhere helps encourage disclosure. We even encourage teachers to accept one another. We also encourage disclosure. We even encourage them to write letters and make them aware of wellness

> programmes. If teachers disclose then support can be channelled towards them. It gives other teachers the courage to disclose. To be always suspected of having HIV/AIDS is traumatic. Other teachers gossip, which leads to stress and stress leads to depression to stroke and finally death. (p. 6 lines 108-114)

This concern regarding the stigmatisation of and discrimination against teachers living with HIV/AIDS was also highlighted by Mrs Louw:

> I just normalise the situation. I pretended as if it was something small, though I was afraid. You know, to have a teacher collapse here at work... It was so scary. I would inform management, for the situation was bad. Teachers support one another and they visit other teachers in hospital. We have always had a culture of supporting one another for maybe teachers have no choice but to support. Just imagine you segregate your sick colleagues and tomorrow it's you. Even the learners were scared. I always have that on my mind that; what if teachers get tested and take medication before they show all these signs like losing weight? People out there are doing well with ARVs. According to our situation, it's not that teachers do it intentionally. It's not easy to see someone in that situation every day. Teachers feel sorry for one another and they are seen to be wishing their colleagues to get better. They visit and they help in arranging funerals. Sick teachers isolate themselves. I mean, they want to be alone for I think they feel bad. All those physical symptoms keep them away from the rest. You cannot rule out the possibility of denial. (p. 5 lines 89-104)

Mr Ntolela also conveyed his thoughts with regard to stigma and discrimination:

> There is need for education. Everywhere in the media, people are informed about HIV/AIDS but they are not learning. As a community and as a nation, people need to be made aware. People are in denial and they always say "not me" and that denial has caused a lot of deaths. The information that there are new infections and the rate is so high shows lack of education. (p. 6 lines 103-108)

The principals indicated that stigmatisation of and discrimination against teachers living with HIV/AIDS exists. Under the present circumstances, it is sometimes difficult for principals to take proactive steps to support teachers living with HIV/AIDS. Nonetheless, some principals have taken considerable measures to eradicate stigma and discrimination.

### 4.4.3 Theme 3: Challenges faced by Principals

One of the most commonly raised issues in the collective story pertained to the challenges that principals experienced with regard to managing teachers living with

HIV/AIDS. According to the sampled principals, management of the schools was greatly affected by teachers living with HIV/AIDS, as was highlighted in the following comments by Mr Ntolela:

> Leadership and management are affected even worse. I am forced to tolerate what's taking place. Once I do that with one person and others are watching, they will come and expect me to give them the same tolerance. Therefore, it shakes authority as a leader [if] you tolerate this and not that. I cannot be expected to tolerate cases that are not the same. A teacher with HIV needs to be tolerated more than a person who has some other issues. (p. 3 lines 50-55)
> I am challenged as a leader to say how far I should tolerate. I am responsible for making sure that teaching and learning take place during the absence of other teachers. Teachers complain, especially if such arrangements last longer. Sometimes teachers disclose to the principal and not their families; then that needs to be respected. (p. 6 lines 94-98)
> It is an extra burden. I need to spend time with the teacher to reassure him/her that I will never divulge this to other teachers. I have to work to gain confidence and talk about how health issues are. I need to promise that it's between the two of us. Nevertheless, they do not disclose. I even reach the extent of visiting teachers at their homes because of their long absence. I have to find out why and, even if I suspect HIV/AIDS, it is wrong to diagnose. Right now we have a case of a repeatedly absent teacher. I understand he is receiving treatment at home. He has since relocated to stay with his mother for support. (p. 4 lines 70-78)

Similarly, Mr Muloyi described the following experiences:

> The epidemic has reduced productivity in all sectors of the economy and, mostly, it has wiped out the most productive age group. Family units have been dismantled. Teachers, who are the main drivers in the provision of quality education, have badly affected some of the expertise that is lost [and it] is irreplaceable. For instance, in South Africa, scarce skills like mathematics and science teachers are not enough. The Department of Education is continuously losing teachers and, at the same time, it is intensifying mathematics and science programmes to improve critical subjects. You can see that people are sick. Teachers lose weight and their productivity deteriorates. In South Africa, education is politicised. There is very little left for the original teacher. Teachers belong to unions and are called by the name "comrade". We are losing something as teachers. The determination of duty in relation to conservative ethics commits teachers to come to work when they are sick. The guilt feeling incline them to pretend to be strong. A lot has to be done to harmonise the school. (p. 2-3 lines 13-42)

Mr Dube's narrative highlighted similar issues:

> We had also an incident whereby teachers and support staff were teasing one another that, "you are fat because of ARVs" and the other one will counteract

> that, "you are thin because you are about to die of AIDS. You are dying soon". So we called those people to the office and spoke to them and, in fact, the matter was referred to the District office and then it was resolved amicably. (p. 4-5 lines 103-108)
> Among the teaching staff; we need to always make sure that the issue of confidentiality of the staff is not exposed to anyone. As a school principal, what I can say is that I can speak in general. I cannot be specific and mention names in this regard but I can talk about it in general. As a school principal, you hear that one school has lost seven teachers. You start worrying that maybe one day it will be my school. (p. 3 lines 44-47)
> I have realised that to be a school principal nowadays is not about academic staff; it involves being a counsellor, social worker and psychologist. To capacitate myself I decided to register for psychology, which helps me to understand the minds of people and other issues. So it really capacitated me. It is a study of humanities. You become aware of ways on how to handle people. So ever since I started to register this programme, I can counsel; I feel much better and I am able to deal with people with greater understanding. So I am a principal, social worker and counsellor and I even interact with social workers amongst my staff and I interact a lot and invite stakeholders to come to school with different issues. It gave me a better understanding of different challenges and, as a principal, I can deal with human problems. (p. 6 lines 144-155)

Furthermore, the following remarks by Ms Pule reflected difficulties faced by principals in dealing with HIV/AIDS-related issues amongst their teachers:

> It was so bad and I did not know how to deal with the situation. I was blackmailed; I was emotionally unstable. This is a sensitive matter to deal with, I am not a counsellor. The teacher's absenteeism got worse; other teachers complained. I could see that she was in a difficult situation and charging her was going to be inhuman. She started taken ARVs and her behaviour improved. She would come and show me how the ARVs are and how she took them. She appreciated the help she got from me. (p. 2 lines 24-29)
> You know in the case of that teacher other teachers would complain that she was not supposed to behave in that manner at work. (p. 5 lines 70-71)

The collective narrative of individual principals revealed the challenges they are experiencing in the leadership and management of schools and the issues of teachers living with HIV/AIDS. This was highlighted by Mr White in the following comments:

> The issues of HIV/AIDS are protected by law and it is not possible for me to ask. About four teachers have disclosed and I always advise teachers to focus on their business. I know such issues can land me in jail. I can be sued. It is a very sensitive matter. Sometimes, when assemblies are longer, teachers that have been pointed at have a pattern of leaving before the end of the assembly. They will be going to take their medication. I cannot confront them because I can see

> they are sick and I have been informed by people close to them. We have a catch up programme for those classes that have frequently missed lessons. There is no support. We have committees like the HIV/AIDS but they are only for events. The school based support team is for learners not teachers. (p. 2-3 lines 25-34)

Mr Sebeko conveyed his thoughts as follows:

> I closely monitor and supervise teaching and learning. When teachers cannot execute their duties; there is a problem. (p. 2 lines 17-18)
> We had a teacher who has since passed on five years ago. He lied and took advantage. He took advantage of our sympathy. He disclosed at the final stages of his infection. It was an open book, everyone could see. He drank excessively and did not teach effectively even when he could. He would lie about being to the hospital because he could not produce any medical certificates. He went to an extent of asking for some money from the learners for not submitting tasks or for marks. (p. 3 lines 37-47)

Mr Sebeko continued:

> Whenever we asked him why he was doing all these things, he would simply answer that everyone knows that he was sick and he was waiting for his day. Rather, he blamed HIV/AIDS than taking responsibility of his wrong behaviour. I was so frustrated. Teaching and learning was disrupted and the teacher carried on with his habits of dishonesty. I was so frustrated. (p. 3 lines 37-47)
> Everything is confidential. We had a situation whereby two female teachers were fighting about issues related to health. We then tasked the Guidance Head to resolve the matter but the teachers declined because the Life Orientation Head, who has transferred, does not keep secrets. (p. 4 lines 69-72)
> There are no support structures and resources to support; for example, workshop training on HIV/AIDS. Principals need to be supported. Presently, they are not sure of how to deal with HIV/AIDS issues, considering the magnitude and sensitivity of the disease. (p. 6-7 lines 113-117)

The collective narrative continued to reveal the challenges faced by principals in handling issues surrounding HIV/AIDS amongst their teachers. Reflecting a concern commonly expressed by the participants, Mr Mokena offered the following observation:

> We are not supported. A support programme is launched and, soon after taking off from the ground, it disappears, only resurfacing after, say, four years. So teachers are not supported in terms of health. This is a very sensitive epidemic that needs a lot of support. My duties limit me from, say, going deeper into the issues, even with the teachers who have disclosed because I am not an expert in this field of health. (p. 5 lines 84-88)

> Yes, I am aware about such policies. I cannot discuss such policies with teachers because you cannot be sure of their frame of mind. The labour relations code of conduct does not allow me to call teachers and discuss with them about policies, especially those that have disclosed. The first time they came to me, I was available and I indicated referrals. Handling such issues is well above my knees. My line of duty limits me from directly referring a teacher upon suspicion that the person needs help in line with HIV/AIDS. The jurisdiction allows me to support and counsel. (p. 4 lines 62-69)

Challenges faced by principals were also evident in Mr Den's comments:

> Also, there is the issue of confidentiality. We have teachers dragging their legs, taking advantage of their sickness; then you feel undermined. If you speak to them, anyhow, they feel segregated or stigmatised. They have no strength and/or energy to work and their performance deteriorates. As a manager, I am forced to express empathy or sympathy. You start considering how you should talk to that person because you are aware of his/her situation. Work and other duties are not equally distributed and it affects the leadership and management of the school. (p. 3 lines 48-55)
> After submitting results, teachers start behaving in a manner of taking advantage. When I reprimand them especially our work relationship gets sour. I'm forced to sympathise. Teachers expect that I must understand because I know about their HIV status. So they expect me to consider that when I address them. Their sickness contributes to absenteeism for, sometimes, I am forced not to question. Some naturally react naturally to the nurturing environment. Therefore, their reaction shows that they are aware that they are at work. Some are influenced by friends, who tell them that, because they have HIV/AIDS, they must not worry about their duties because it is known that they are sick. Some are instinct to stigma and trauma. (p. 6-7 lines 115-123)

The above comments also show that principals are sometimes compelled to adjust their planning strategies to accommodate the impact of HIV/AIDS. This was also evident in the following statement by Mrs Louw:

> I had a meeting... meetings, rather, with the school management team to come up with a programme so that the teaching and learning timetable is not disturbed. Yes, teachers are sick and they need to seek medical attention when they are not well. But the learners need to learn and the vision and mission of the school need to be adhered to. We came up with a relief programme that has, so far, been running smoothly. Teachers grumble, especially when the sick teachers are absent; they feel they have to be granted off days as well. It leaves me in dilemma. Above all, it's difficult to replace teachers; you can never get the same teachers. (p. 3-4 lines 50-58)
> HIV/AIDS campaigns have been held and cannot address such sensitive issues in public. People are in denial. I can only support teachers who have come open and told me about their status. The Department is doing a lot in relation to

> support. Teachers receive counselling free of charge. Support can be provided to those who indicate that they need it. (p. 4 lines 68-72)

All the principal participants reported feelings of disillusionment with regard to dealing with HIV/AIDS-related issues amongst teachers.

### 4.4.4 Theme 4: Persistent Absenteeism

In this collective narrative, principal participants were in agreement that persistent absenteeism by teachers living with HIV/AIDS was a serious problem in schools. Their comments highlighted that HIV/AIDS leads to high levels of teacher absenteeism, which leads to low levels of productivity. Mrs Louw shared the following experience related to this issue:

> The school cannot run smoothly when teachers are sick. Around 2009, we lost a teacher. He was very sick. He was in and out of hospital for a long time. Sometimes, when he came to work, he would not be well and he would leave early. He got sick that it was full-blown AIDS. (p. 2 lines 10-13)
> Really, teaching and learning has been affected and is being affected. When he could not make it, then I would ask other teachers to stand in for him. And sometimes, even when he was here at work, he could not teach. I did ask the departmental head to make arrangements so that teaching and learning continues. Unfortunately, such arrangements overloaded other teachers, who have not planned for the disturbances. Even right now, teachers are not well and we have two who have been in and out of hospital. When I was still looking for a replacement of the late teacher, another teacher was getting worse and worse. She was always coughing – so much such that she could not do her work. She was losing weight a lot. She did her work but I could see that she was getting weaker. Eventually, she passed away. (p. 2-3 lines 25-35)

When teachers living with HIV/AIDS become ill, learning is affected because learners are often left unattended without consistent teaching. This was evident in Mr Den's remarks:

> We are talking about many diseases that attack the normal functionality of the body. So it's true and, immediately when someone is infected, staying away from work is frequent. HIV/AIDS has become a bad resemblance to society. Long absence is as rampant as teachers need to seek medical attention or they are too weak to work. Obviously, the normal functioning of the body is affected as well as the school system. Sometimes we have to seek replacement. Other teachers have resigned because of HIV/AIDS. We have no right to discriminate and so what we can do is get a temporary teacher until teachers who are sick

> pass on or resign. There is nothing we can do. Others go for counselling and rehabilitation. Others are afraid to take medication in front of society and, when they do, it interferes with work. This is a specialised institution and it takes a lot of time to capacitate the new teachers. (p. 2-3 lines 23-48)

Mr Den continued:

> We held several workshops to develop teachers in different disabilities. So when we hire that temporary teacher who is not qualified to teach learners with disability, it impacts negatively as well as disadvantaging learners. There is nothing we can do but to keep on bringing new teachers for development of our learners. We have a whole school plan that runs for three years and the plan addresses nine performance areas. Teacher development is one of the areas and has some financial implications. When running teacher education and/or development programmes, you do not achieve if a teacher is absent during the course of development. One who takes over won't catch up for it affects the next three-year plan. Development won't carry on because of HIV/AIDS. The whole school management structure is affected; for instance, departmental heads that monitor the curriculum. Teacher absenteeism derails processes of development and it impacts negatively on the mobility of development. (p. 2-3 lines 23-48)

Principals continued to air their views about persistent teacher absenteeism due to illness, with Mr Mokena passing the following remarks on the subject:

> Teachers living with HIV/AIDS have disrupted teaching and learning here. During the last periods of infection, teachers take errands to see doctors until everything stabilises, then attendance improves. I have encouraged teachers to apply for medical aid for it is very important. It helps when people consult and buy medicine. Teacher absenteeism has carried on for a long time and, due to the advent of antiretroviral treatment, everything has stabilised. However, we have had teachers who were very sick and fragile to work so much such that they had to resign. It was too late for interventions like ARVs. Teacher absenteeism disrupts teaching and learning. (p. 2 lines 8-17)

Mr Sebeko also highlighted the problem of teacher absenteeism:

> I do query the frequent absenteeism and I approach individual teachers to find out what is troubling them. Mostly, I get the response, "I am not well". I have no choice but respect that I do not need to be involved in people's private matters. Therefore, I keep a distance and watch from far. (p. 2 lines 13-16)
> Currently, there is not much disturbance in teaching for learning caused by the two [HIV-positive teachers]. They are performing well; they report absenteeism and they even arrange for colleagues to stand in for them when they are away. This is exactly what I asked from them when they disclosed. I have tried to avoid a repeat of that late teacher. (p. 4 lines 61-64)

Mr White observed the following with regard to teacher absenteeism:

> But it does not mean learners are not affected because they would have missed lessons. Mostly, teachers do not finish the syllabi. It has become a trend that, every month, like, for instance, with the other teachers, they are absent in the first week. Probably, they are taking medicine. I have heard from friends that the teachers will be collecting their medication. They would say that, "Mr or Ms So-and-So are taking medication". But, as a principal, I can only observe and I cannot ask. (p. 2 lines 18-24)

Ms Pule also asserted that teachers living with HIV/AIDS frequently absent themselves from work:

> Teachers absent themselves from work to seek medical attention and it disrupts teaching and learning. Other teachers have to stand in for absent teachers. I make a follow up on teachers who are sick. They do not disclose, although they bear the symptoms of HIV/AIDS. One of my teachers used to throw temper tantrums. She was very emotional and always absent. It was difficult for all staff members. She did not do her duties effectively. (p. 2 lines 13-18)

On the same note, Mrs Motsepe shared the following sentiments:

> Teacher absenteeism has always impacted badly on the smooth running of the school. For teaching and learning to take place normally, absent teachers need to be replaced. Those teachers who replace absent teachers would do not teach the way the responsible teachers would teach. Relief teachers would not plan for what to teach to the absent teachers' classes due to short notice. (p. 2 lines 10-15)

As the collective narrative unfolded, Mr Muloyi shared his experiences, which also spoke to the frequent absenteeism of teachers living with HIV/AIDS:

> Teachers show all the symptoms of HIV/AIDS. They do not disclose. They are always affected by opportunistic diseases and they are always absent. Teaching and learning has been affected to a large extent. (p. 2 lines 23-25)
> The goals of the school are underachieved. Absent teachers have their classes and subjects taught by other teachers and it imposes a burden on teachers who stand in for their sick colleagues. You will find it is very difficult for effective teaching and learning to take place when other teachers are absent. It poses a decline on learner achievement. Everyone is affected and the whole system is disrupted. So I get caught up in a dilemma whereby sometimes I have to allow time off so as to protect the sick teachers. It causes clicks amongst teachers and disharmony.
>
> Mr Muloyi continued:

> But I feel that, if teachers could disclose, they will get help. Rather, they are silent and some even miss medical routines because they feel bad about causing disharmony in the school. Otherwise, disclosure remains a big challenge. I feel as if I am not doing enough when other teachers grumble that I have a soft spot for sick teachers. But these teachers need medical attention because of opportunistic diseases. Their absenteeism affects teaching and learning for it reduces the functionality of the whole school. (p. 2-4 lines 28-51)

The above comments reflect that frequent teacher absenteeism was disrupting the smooth running of schools. Nonetheless, teachers living with HIV/AIDS are not prepared to disclose their HIV status. They are not prepared to take responsibility for disclosing, although they know that they are sick. This was also reflected in the following sentiments shared by Mr Ntolela:

> It is difficult a lot. Absenteeism is rife amongst teachers affected and infected. I have had teachers absenting themselves for days and coming to work for few days and it has become a trend. We have teachers who absent themselves for weeks sometimes. In particular, I have a teacher who always complains of a variety of conditions. He has shingles; some sores that go round his body and I am made to understand that if the shingles (which go in a circular manner) meet or come back to the point where they started, it means death. This teacher has been complaining for a long time now. (p. 2 lines 17-30)
> In other instances, teachers who are sick attend one week in one week out and, according to the department's policy, I cannot substitute. Teachers who are always absent do not finish the syllabi even when they are present and they are too weak to work. They do not give work and they do not mark. They cannot keep momentum in the learners and learners are affected. Teachers cannot keep their momentum also and learners lose interest. In such instances, I ask other teachers to step in. The situation becomes very difficult because these teachers have their own classes. It is always difficult to get a teacher with the necessary skills; it is not easy. It burdens other teachers as well as me. (p. 3 lines 40-49)

The above comments reveal that learners lose momentum when teachers are continuously absent from work. When learners lose momentum, their learning is not effective.

Mr Dube shared the following observation in this regard:

> My particular experience as a head of the school is that we have experienced a high rate of absenteeism due to this illness HIV/AIDS and, as a result, learners were deprived opportunity of teaching and learning, since most of or some of staff was suffering from this disease. So it has affected even our nonteaching staff and at the end of the day it challenged our vision and mission of the school because, at the end of the day, we cannot attain the aims and goals of the

> organisation if people are working ill. It brought about fear to both teachers and learners. (p. 3 lines 48-54)

### 4.4.5 Theme 5: Teachers' Experiences of Principals

According to the sampled principals, teachers had great expectations of their principals, although they disrupted the management of the schools:

> Society ascribes role to us, even in health. Society assumes that teachers are good. It has made the teachers to be secretive so as to keep the good image. As role models, they are put in a situation whereby they are regarded as pure, healthy or innocent. They are custodians of knowledge for they are leaders. For example, it will be awkward to see teachers selling vegetables; society has its own expectations from teachers. It would not be appropriate for teachers to come out about their HIV status. It is high time society accepts that AIDS is a problem for everyone. (Mr Muloyi p. 6-7 lines 100-107)

In this theme, most of the observations made by principals showed that teachers looked up to principals. Each principal was perceived as a sort of Messiah, with all the answers. Hence, Mr Sebeko expressed the following sentiments:

> Yes, I have felt the extra load but it is very difficult to pull away. I am prepared to go an extra mile, although the government does not pay for that. We need to go out of our way. Just last week our life orientation teacher stopped a suicide attempt by one of our female students living with HIV/AIDS. Society perceives principals as having answers to the HIV/AIDS issues. I know there are responsibilities laid on principals because of their role model status. We cannot retreat but, rather, take advantage of their positions and bring stakeholders together so as to improve dissemination of information. Different parties need to communicate so as to conquer the war on HIV/AIDS. Leadership is very important in influencing people to understand HIV/AIDS issues. People need to be given knowledge. (p. 6 lines 100-110)

Mr Sebeko's comments reflect some positive sentiments. Principals were willing to make sacrifices to support their teachers living with HIV/AIDS. As Mr Dube asserted:

> Principals and managers are not from heaven. They are just human beings who have been entrusted with responsibilities to manage and lead institutions. We are human beings and we know that communities look at us as custodians and ambassadors of knowledge about HIV/AIDS. It places measurable amount of pressure on us as leaders to ensure that we give direction to communities, to the schools and society at large. We are really ambassadors. For instance, Mr Zuma has played an important role as far as antiretroviral tablets are concerned, conversely to what he has been ridiculed about HIV/AIDS when he said people

> must wash with showers for them not be infected by HIV, which was really disgusting. So, as a leader, you should not do like what our president did. On the [one] hand, he is doing this and, on the other hand, [he] is doing that, so you lose people's confidence and credibility. We must be leaders of substance and people must look upon us as people who are custodians of and ambassadors of HIV/AIDS. (p. 7-8 lines 181-194)

Indeed, the above comments acknowledge that teachers should have considerable expectations of their principals, as discussed by Mr Ntolela:

> It is good when principals are placed on pedestal. They have to act accordingly; they have to act it. They do not have to abdicate the responsibility to themselves. It enhances position as principal; it educates people to trust. If I do not act, people get disappointed. (p. 6 lines 99-102)

Mrs Motsepe explained:

> I am prepared to take extra load of my demanding job to help teachers with their personal problem. They look up to me, I know, but then if they do not disclose, then how they can get help? They choose to keep quiet until they die. I even approach them personally to no avail. (p. 6 lines 91-94)

Furthermore, in this collective narrative, principals highlighted the issue of their having to shoulder the responsibility of protecting teachers. This is evident in the following remarks by Mr White:

> I have the responsibility of protecting teachers but I can't explain why to other school management team members and teachers. Sometimes they query, "why I should protect absent teachers?", but [I] still handle the issue so that both parties calm down. I even protect teachers who have not disclosed to me because I know how they feel. Those extra duties are part of my responsibilities. Everything starts with me and ends with me as a leader. I am the only person who has the prerogative to support and encourage. I have to help teachers to do their work effectively. (p. 5 lines 80-87)

Mr Mokena also conveyed his thoughts on the subject:

> The Department's support programmes are sporadic; maybe after four years. When I refer teachers, duty limits me from directly referring a person. I have no jurisdiction and I am not supported. Sometimes, I am not sure about the frame of mind so that the labour relations set limits. (p. 3 lines 51-54)
> Yes, my duties incline me to counsel, support and advice. I have known teachers get some sigh of relief after they disclose to me. Teachers look up to me. I have not disappointed; I have been always available. I have led health discussions,

> which have led to the acquiring of first aid kit boxes to help in case of injuries. (p. 5 lines 89-92)

Mr Den added the following observations to this aspect of the narrative:

> It is proper that way. Those are good qualities of leadership. Subordinates should not be afraid to come to you. They must not ask themselves questions about you. That will inform how colleagues interact with you about their health. If you are open to teachers, they should not be afraid of saying what they want. Anybody expects answers if they have questions. I cannot be in a position to provide answers for every question but what I do about their expectations matters the most. I am not a god and therefore cannot provide everything. Making them aware that I cannot do this but that informs them the extent I can go. I get them information so as to earn continued trust. (p. 7 lines 124-132)

In addition, comments passed by Mrs Louw in relation to the expectations of teachers showed that teachers look up to principals:

> Yes, teachers look up to me. Although I am not an expert in health issues, I apply my basic knowledge. I delegate teachers according to their strengths. We have done very well in supporting the sick, even in times when they are admitted in hospital. I cannot avoid that duty of advising and supporting. My duties are overlapping as compared to what principals used to do. I have to do that so that teachers can be able to perform their duties. If I take a back seat then the unity falls apart. (p. 6 lines 109-115)

The above comments show that teachers expected to be cared for and principals were ready to help but that the failure of teachers to disclose was a stumbling block.

### 4.4.6 Theme 6: Acceptance and Belonging

This part of the collective narrative revealed that effort was put in by the sampled principals to create atmospheres where teachers living with HIV/AIDS felt a sense of belonging and were gently encouraged to disclose their status. Mr Den gave the following explanation:

> There is a wellness programme provided by the Department for free. We management assist to phone and arrange for counselling and we recommend to the employer. If the teacher gets worse, we recommend for transfer and the programme (wellness) recommends placement. Such placement considers issues like light duties. We cannot help financially, medically or psychologically. We have a social worker here amongst us but, if we involve her in such issues,

> then circumstances will force her to reveal teachers' status. Such is not our jurisdiction and we do not recommend that teachers get help from the social worker unless outside our protocol. (p. 5-6 lines 53-64)
> We invite counsellors who are knowledgeable in terms of workshopping teachers. We have embarked on capacity building. Any organisation structure can be invited as well as support groups. We try for get a lot of information from the District. (p. 6 lines 104-107)

Similarly, Mr Mokena expressed the following sentiments:

> I have to know when my teachers are not feeling well so that I plan accordingly. Learners must not lose their learning time and those gaps opened by absent teachers need to be filled. Teachers have come forth to disclose. My teachers trust me with their innermost secrets. I have not disclosed to anyone about my teachers' status. Possibly, this has encouraged other teachers to disclose. I have provided counselling to those teachers who have disclosed to me. I offer support, comfort and advice. The aim is to make teachers perform. Through counselling, I have come to know about medical examinations and routines that they go through until they are put on the antiretroviral treatment. Some have experienced unbearable family problems due to their status; for example, disintegration. I have always been available to provide counselling, support and advice. Some teachers, however, have not disclosed, possibly due to the fear of death. We also refer teachers to the District for psychological help. I advise teachers to get medical help like antiretroviral pills that lengthen lifespan. I fight to minimise disruptions in the teaching and learning timetable. Absence of one teacher affects the whole system. Teachers do attend HIV/AIDS workshops. (p. 3 lines 33-50)
> Teachers need counselling and support. Keeping their confidential information maintains their dignity. Teachers are involved in sexual relationships amongst themselves with teachers living with HIV/AIDS to show that their status is not known. I do not have to ask why they are in these relationships because I also assume that, as adults, they know how to protect their partners. We review our policies that are health issues during our end-of-year whole school planning that lasts for three years. Committees come up with year programmes. (p. 4 lines 55-61)
> Like I said, I have earned trust amongst my teachers because I do not share it with anyone, even my deputy. We have a culture of standards. We have dealt away with gossip. We do not give it a chance. Corridor talk is not credited. It is not resuscitated. We marginalised it. We have an agreement that we all make a contribution to maintain the standards. If it helps then it happens in private corners so that our culture of secrets does not allow it to reach the victims. (p. 4 lines 70-76)

Mr White aired his views on the subject as follows:

> Teaching and learning has been affected quite a lot. This is a combined school right and, if one teacher is not there, the one who is available takes over the lessons. (p. 2 lines 15-17)

> I can always advise teachers to take their medication as prescribed. I encourage them to attend support groups, go to the gym, and use protection to avoid re-infection and they must discuss issues with families. (p. 3 lines 43-45)

Mr White continued:

> I have talked to those teachers to correct their behaviour. I reminded them that they are not doctors and, therefore, they cannot diagnose. If we suspect that someone is HIV-positive, we cannot conclude. We are also affected and we can be infected any time. (p. 4-5 lines 67-70)

Mrs Pule also conveyed thoughts that reflected the concerns of teachers living with HIV/AIDS:

> When the teacher decided to disclose, I attempted to help her with by basic counselling skills. I felt obliged to help her because of her decision to disclose to me. She indicated to me that she was battling to accept her HIV status. I advised her to do her work effectively because she could not afford to lose her job. I spoke to her several times and kept everything confidential. I always checked her to remain focused on her job. I aimed at helping her manage her stress. (p. 2-3 lines 19-32)

It is also evident in the following sentiments expressed by Mrs Motsepe that principals showed sympathy:

> I would ask him politely to go and consult doctors and, whenever possible, speak to him to express sympathy and support. He would, however, reciprocate by telling us that he did not need anyone's sympathy. He appreciated the support. (p. 3 lines 30-32)
> Actually, I would say that teacher's death had a positive impact on my teachers' behaviour. I think it acted as a deterrent to other teachers and possibly came as a reason to correct their behaviour. Since then, we have never seen such kind of lifestyle. (p. 4 lines 55-58)
> I, as an individual, always support my teachers when they have problems. I call in relevant professionals to workshop and advice about, for instance, leave days. Teachers have had problems because they exhausted their leave days and, later on, they become desperately in need of them. (p. 6 lines 61-64)
> I always take it upon myself to contact teachers and advise them. I remember, at one time, I had to call one of the teachers' wives to come and sign leave forms. The teacher had just disappeared and indicated that he was sick. His salary was going to be affected when he really needed it with his family. (p. 4 lines 67-70)

Mr Ntolela (p. 4 lines 59-62) put it as follows:

> The Gauteng Department of Education has a counselling arrangement. We refer teachers to phone a certain number for they receive counselling even on the

> phone if they do not want contact sessions. Teachers are referred to social workers. I have the number, which teachers phone.

Confidentiality was among the commonly raised issues within the collective narrative. Mr Sebeko shared the following suggestions on the topic:

> I have always respected confidentiality. I never thought of counselling because I do not have knowledge. I have done some counselling courses and attend workshops but I feel I do not have enough knowledge. HIV/AIDS issues need to be approached with caution or maybe I should try my little knowledge. I feel obliged to protect the teachers and I expect them to work normally. I have always advised them to attach medical certificates each time they consult doctors. (p. 3 lines 31-36)
> I invited the District's Educator Wellness Unit to come and workshop the whole teaching staff. (p. 3 lines 48-49)
> We support teachers who have disclosed and we understand their situation. (p. 4 lines 56)
> My teaching staffs relates very well. There are no attitudes; everything is normal. Even if they know, they would not treat them badly because we are all affected. Our teachers love one another and they respect each other. They would not behave undesirably, even if they know that one of theirs is living with HIV/AIDS. They would not utter bad things nor treat them badly. Considering the prevalence of HIV/AIDS in black communities, each one of us is either affected or infected. They have the obligation to accommodate others. The two teachers have never shown any attitudes; they have behaved normally. (p. 5 lines 76-83)

These views are consistent with what Mr Muloyi shared:

> Teachers who are in charge of the HIV/AIDS committee are seniors who are also part of the management team. The committee always holds campaigns, you know, to remind people about the disease. (p. 4 lines 59-61)
> It is all about our principles and the effort we put to practise them. The Christian values, like I said, have been very useful. If teachers decide to gossip, they do it in such a manner that it does not reach the ears of the victims. I encourage teachers to treat one another in a dignified manner, for those who talk ill about other teachers will face the consequences. (p. 5 lines 75-80)

Mr Dube also shared the following experiences about the acceptance and belonging of teachers living with HIV/AIDS:

> First and foremost, teachers are weak and sick because of HIV/AIDS; however, if teachers are unable to come to work, the Department of Education has systems in place. We employ during the absence of the teacher, for instance, if the teacher has been laid off by medical doctors for a period of 30 days or so. (p. 5 lines 109-113)

> At times I bring them to my office and I engage them I give them counselling. Some are very much afraid to talk openly. But I remember I called one teacher and told her that look your heath is not good, how about you going for tests; I kept on asking until she responded. And you know they recover quickly when they take their medication. When somebody has confided in me I understand for instance; I reduce workload. I do not demand work unlike somebody who does not talk to me even if he is a little behind. I become positive and understand. I become sympathetic. (p. 5-6 lines 121-139)

Likewise, the same view was shared by Mrs Louw:

> I had to draw closer to him and show how much I was concerned about his health; I mean, on humanitarian grounds it is difficult to just leave him to be on his own. I mean, even his leave days had been exhausted. He tried to be strong and pretended to be well but sometimes he would collapse especially when he started taking ARVs. I would sit and talk to him. I encouraged him to eat healthy and rest. (p. 2 lines 14-19)

In this collective narrative, it was evident from the principals' responses that some of the views, comments, sentiments and perspectives were commonly stated.

## 4.5 Similarities and Differences of Teacher and Principal Narratives

The following thematic collective narrative is a combination of teacher and principal narratives that speak to similarities and differences in their experiences. The combined teacher and principal collective narrative elicited seven themes. The themes were based on the individual narratives that were shared by teachers living with HIV/AIDS and school principals who had teachers living with HIV/AIDS on their staff.

The unfolding of the combined collective narrative was shaped by the following themes: dilemma of disclosure, stigma and discrimination, acceptance and belonging, teachers' experiences of principals, persistent absenteeism, challenges faced by teachers living with HIV/AIDS and their principals, and normalising and legitimising suffering.

### 4.5.1 Theme 1: Dilemma of Disclosure

One of the themes that shaped the unfolding of the combined collective narrative was the dilemma of disclosure, as the raw data indicated that whether or not to disclose their HIV status was a dilemma for teachers. The responses of all the principals showed that dilemma of disclosure was a common problem running throughout the sampled principals. The dilemma of disclosure is evident in the following comments by Mr Muloyi:

> As I have said, teachers do not disclose. They always pretend to be strong when they are not. It is unfortunate that some of them have resorted to excessive drinking, maybe to ease their stress. The goals of the school are underachieved. (p. 2 lines 26-28)
> No matter how much I try to show concern and support to the sick teachers, they remain tight-lipped about their HIV status. That is their innermost secret. (p. 4 lines 52-53)
> As leaders, we need to deal with disclosure. Teachers need to be encouraged to disclose. All society sections must come to together and deal with issues like sigma that is the reason why teachers do not disclosure. People living with HIV/AIDS have the right not to disclose. As leaders, we need to disclose to get help. The policies are too protective. (p. 5 lines 70-74)

Similarly, numerous teachers living with HIV/AIDS indicated that disclosing their HIV status was a dilemma. They found it difficult to disclose their status to the principals.

The difficulty of disclosing was evident in the following comments by Mr Machalaga, one of the sampled teachers:

> The thing of uncertainty, fear of disclosure and the likes; maybe it depends according to how you relate to your colleagues and principal in terms of sharing information and then maybe also it might happen that after sharing information they will gossip or discriminate against you. Or how the problem is you get worried about how they are going to react. In terms of relationships information sharing depends on trust. Maybe it is part of the reason whether they would take that in a positive way or in a negative way. I think with regard to the stigma of HIV/AIDS reaction is major. (p. 6-7 lines 120-133)

The principals in this study all indicated that teachers living with HIV/AIDS were not willing to disclose their status. This was evident in the comments by Mr Sebeko, who lost one of his teachers to HIV/AIDS:

> Our teaching staffs have really been affected. However, disclosing is a stigma. Teachers have always indicated that they are not well and you can see by the

> rate they lose weight and sometimes hospitalised. Surprisingly, they sometimes recover miraculously. But others do not gain complete body recovery. Although the physical symptoms incline someone to suspect HIV/AIDS, you just respect their decision not to disclose. (p. 1 lines 7-12)
> He did not disclosure to me. I think because I could not offer the sympathy not to work with he was looking for. When he was still fit, he did not commit himself to his job. He was always bunking classes and kept management on their toes until he was very sick and died. My efforts to get teachers to disclose have been fruitless. (p. 4 lines 52-55)

As is indicated in the above sentiments, teachers face difficulties in disclosing their HIV status. Many are not willing to disclose their status, while some teachers living with HIV/AIDS take advantage of their illness. The teachers living with HIV/AIDS in this study all indicated that disclosing to principals was difficult, with some mentioning that disclosing even to their families was difficult.

Mrs Mehlo, who is a widow, described her experiences after learning of her positive HIV status as follows:

> I never wanted to tell anyone. (p. 2 lines 15-16)
> I started feeling insecure. I couldn't understand myself. I didn't know how to disclose to my children, siblings, parents and colleagues. I felt as if it was full-blown AIDS. I could feel as if everyone was looking at me and knew my status. I was always suspicious. (p. 3 lines 27-30)

Mr Ntolela described things from a principal's perspective:

> I do not remember a teacher disclosing their status to me. I have never seen one. In actual fact, I can see that some teachers are sick and I am afraid I cannot diagnose. The symptoms clearly point to HIV/AIDS. (p. 2 lines14-16)
> This is very sensitive information that I cannot reveal. I cannot talk about their illness. It is my responsibility to keep their information. I need to respect their integrity. I am aware that I can be sued for divulging such information. Leadership needs to be trained and be aware about the seriousness of HIV/AIDS. Experiences deter teachers from disclosing. The sick teachers need counselling so that they can be educated to reveal to the principal as a representative of the employer, which is the Gauteng Department of Education. (p. 5 lines 81-87)

Mrs Mhlanga also commented on the difficulty she experienced in disclosing her status:

> The sensitivity around HIV/AIDS makes it difficult for management to discuss about it. It has forever been difficult to deal with it. (p. 3 lines 23-24)
> Disclosing about my status was not at all easy. Several times I thought and decided to disclose my status but I keep on postponing. (p. 3 lines 26-27)
> I can't face him. I feel it's too personal and more of my life. I don't think he has time for that. (p. 4 line 30)

The above comments reflect a situation in which teachers living with HIV/AIDS find it very difficult to disclose their status. They explained that approaching other people about their status was not easy. Mrs Mabona also found it difficult to disclose her status but, in the end, she had to do it because she had to explain her absence from school to attend awareness programmes, which sometimes happened on working days.

Mrs Mabona desperately remarked how she was left with no choice but to disclose her status at work:

> It has been difficult for me to disclose my status but due to the fact that one needs to go for check-ups and awareness programmes at times during school days. I was left with no choice but to disclose my status at work. It took me some time to do so but due to the fact that I needed to justify my absenteeism I ended up gaining guts to approach the principal. (p. 2 lines 12-16)
> It is a haunting situation, which needs one to have a lot of guts because of the after effects of disclosure. Some people do not take well if you say you are HIV-positive. They think they can be infected through contact… After disclosing, my colleagues some of them keep a distance from me. (p. 4 lines70-74)

The above comments reveal how teachers often had to disclose against their will. Mrs Motsepe described how that teachers who were clearly sick still refused to disclose:

> Teachers do show some physical symptoms of HIV/AIDS but not much. Teachers have disclosed about, for example, operations and depressions but they do not disclose their HIV status. Sometimes you can see that they are not well. If they do not want to disclose, I cannot force them. They always pretend to be not seriously ill. Mostly, they complain about flue, colds, headache and running stomach... About 10 years ago, our school was badly affected by HIV/AIDS. The teacher started when I was still a deputy principal and we felt effects when I was a principal. One of the teachers fell sick and everyone suspected HIV/AIDS according to the physical symptoms that he resembled. He would always sit in his [classroom] and he would isolate himself. He became very arrogant and he did not want to talk to anyone. He would swear at anyone who looked at him and he showed a lot of anger. Learners would ridicule him.

> They would laugh at him and call him names. Some teachers spared their time to chat with him and the rest were was afraid. As a result, he would fall asleep in his classroom. (p. 2 lines 16-29)
> When I became the principal, I did ask him to disclose but he did not. I asked him several times; he only remarked that he knew what he was suffering from. (p. 3 lines 39-40)
> Teachers do not disclose even after developing full-blown AIDS. They do not communicate to arrange for sick leave application. (p. 4 lines 64-66)

In this combined collective narrative, principals discussed the difficulties faced by teachers living with HIV/AIDS in disclosing their status:

> [One of the sick teachers] was very good at her work; of course, she would take some days off to consult doctors, for I remember she was asking for a good doctor here around. Also, the coughing was severe. I did understand even her pretence to be well, because I assume she was desperate to keep her job. Yes, you can see by the way they are losing weight and the symptoms could be those of HIV/AIDS. They have not said anything to me. You cannot show that you suspect because this is a very sensitive disease. (Mrs Louw, p. 3 lines 40-44)
> Much as it is sensitive; it is confidential. I have to keep it confidential to protect someone's dignity. I informed my deputy so that we could come up with a programme to make sure the absenteeism of teachers does not affect our goals as a school, especially teaching/learning. (Mrs Louw, p. 5 lines 85-88)
> When teachers disclose, you cannot tell the next person in terms of work-related issues. You can not address the staff about it like we can tell the staff that Mr so and so has high blood pressure. It's too confidential and delicate. I can say. You cannot ask teachers to disclose. A problem shared is a problem solved, they say. I cannot go deeper into teachers' personal issues. (Mrs Louw, p. 6 lines 105-108)

Mrs Mehlo's sentiments below summarise disclosure appropriately:

> It's not easy to disclose at work. The principal is the worst of all. I would rather tell the other staff members than her. She is not approachable and it is difficult to predict her mood. (p. 3 lines 22-24)
> I am too scared to let the District know for I think I may lose my job. (p. 3 lines 33)
> You start thinking about how people are going to react towards me if I disclose my status. I cannot trust people especially my colleagues. (p. 6 lines 60-63)

There was evidence in this combined collective narrative that teachers were so uncomfortable with disclosing their HIV status that they submitted medical records (assuming the principal would find out that way), rather than approaching the principal directly.

Mr Dube explained the trend of teachers submitting medical records instead of openly discussing their status as follows:

> They do come to my office but, most of the time, they come with their papers and they do declare with their medical certificates and I keep that confidential. Some confide in me and we talk about it and it makes my work easier as I understand their position and how to handle them. I am able to understand their position and know how to handle them and that makes our relationship to improve. When one of my teachers did not report to work, I phoned and got to know that he was very sick. I drove to his place and I found his fiancé feeding him with soft porridge and he was struggling to eat. I took him to a public hospital because he did not have medical aid. He got admitted. The following day I visited him and he disclosed his status to me. His health had extremely deteriorated and he died the following day. Another teacher declared his status through medical reports; I kept everything private and confidential. Actually, the teacher had gone away for a long time without notifying me. I tried to contact him to no avail. When he came back, he presented reports from the doctors. He later came for consultation on medical unfit and I advised. (p. lines 81-103)

Mr Machalaga, a teacher, explained the choice as follows:

> No, I assumed that through that report and the conversations that we sometimes have like let’s say when I was in the process of applying for medical unfit. Through that conversation I think maybe I needed not to repeat myself to him regarding my status. I was talking to him about how we qualify for medical unfit and things like that. But I did talk to the principal regarding that and then maybe I should make some follow ups. Well, I intend to sit down with him and talk many things regarding that. Not necessarily my status but other issues so I think I need to sit down with him. (p. 6 lines 110-117)

The uncertainty about what will happen after they disclose has caused anxiety amongst teachers. This was evident in one teacher's choice to approach a departmental head rather than the principal. However, there is an impression that disclosure does provide some relief. This is evident in Mr Machalaga's assertions:

> I approached a manager not the school head. I wasn’t sure whether to approach the principal himself. Particularly I think maybe – I assumed that the Head knew about that because of the information that I submitted after being absent from work for a long time; the doctors’ reports and sick leave forms that I submitted and the likes. I submitted medical reports. (p. 5-6 lines 105-109)

Mr Den's experience was also that teachers believed that they had informed their principals by submitting medical records:

> We are guided by the code of secrecy, issues of confidentiality. For example, if a teacher tells me about having been infected by a sexually transmitted disease, I cannot divulge such information. The secrecy policy covers a lot of issues and I can be sued for divulging such information, unless teachers decide to disclose on their own or give mandate for me to do it or maybe in order to share knowledge. I have known about this information through records and behaviour. Sick teachers submit records that are necessary when submitting sick leave forms. The info is not clearly marked; sometimes it describes the teachers' CD4 count and explains the functionality of the system in relation to what medication they should take. The information is private and confidential. I suspect the following for teachers finding it difficult to disclose: 1) how they interact every day, 2) the relationship that we have always had with teachers, 3) the character of that teacher and personality as well (some people won't just give away information), 4) stigma and discrimination (it can be an embarrassment to colleagues). (p. 4-5 lines 87-103)

It is clear that disclosing HIV/AIDS status is rather traumatic for most teachers. Some principals and teachers described disclosure through medical records. For instance, some teachers living with HIV/AIDS could not approach their principals; they rather submitted medical records attached on their sick leave forms and assumed that principals would know. They thought that principals would get the information about their HIV status. As one of the teachers who participated, Ms Hlengwe, explained:

> I have done so during my sick leave but it was quite difficult to tell him exactly that I am HIV-positive. I only mentioned that I have tuberculosis (TB). (p. 2 lines 22-23)

Some of the principals indicated that teachers were forced to disclose their status because they had to give valid reasons for being absent from work. Mr Mokena shared the following experience:

> More than four teachers have disclosed and some date back as far ten years. The reasons of confessing could be that they want me to understand circumstances in which they are living and why they absent themselves from work. Another reason could be that they want to break this to anyone to lessen their burden. Also, they are in need of help, for instance, referrals. They want to inform me about the genuineness and reality if their sickness. (p. 2 lines 27-32)

In other instances, the principals, who are expected to have their teachers' confidants, are the ones responsible for divulging their teachers' HIV status to the rest of the staff. This was highlighted by Ms Rakani in the following comments:

> In my case, it is not good enough that the principal spread the news about my HIV status and my anxiety. My colleagues have used this to judge me. I have lost my dignity. My colleagues undermine me and think that I deserve my HIV status. (p. 5 lines 60-63)
> Disclosing is one thing that has its own challenges. Colleagues become very speculative and after knowing they discriminate. People like talking about the innermost information and they don't put themselves in your shoes. (p. 4 lines 50-52)

Mr Sebeko also had teachers disclosing their status to him:

> Two teachers have disclosed their status to me. They explained their conditions in relation to schedules with doctors. The two male teachers approached me on different occasions and I am not sure if they know about one another. Both teachers asked me not to disclose to anyone, even the deputy principal. I have kept the promise. I approach them cautiously with due respect. I offer them necessary protection, for instance, it has happened that, as per protocol, I forgot to inform their HODs until they reported to me. Then I had to simplify the matter; I apologised and explained that I had forgotten. Since day one, I pleaded with them not to disturb teaching/learning. They inform me whenever they have to take days off and they complete leave forms. I do not give them special treatment for they also do not ask for special treatment. (p. 4 lines 19-30)

In another scenario, Mrs Ninga explained that she did not have to disclose her status because her situation was an open book:

> My situation was open. Anyone could tell I was sick. My colleagues sympathised with me. My principal and other colleagues will ask me and check on me every morning. One day I had a chat with the principal and I told him that I had been diagnosed with HIV/AIDS. I received support from everyone in the school sometimes they would exempt me from afternoon activities and ask me to go home. I felt helpless especially for my children. (p. 2 lines 21-26)
> It starts from what people believe. We have been made to hide our HIV status because the disease is highly stigmatised. However, principals can influence people basing on their strategic positions. (p. 5 lines n75-77)

Mr White was another of the principals to whom several teachers disclosed their status:

> Four teachers have disclosed; two females and two males. I have been very sympathetic with them. I was also affected because I did not expect it. I provided basic counselling and advised people to eat healthy, go to the gym and be positive about living longer. I have advised them to pray, for I provided comforting words. (p. 3 lines 49-52)

Each teacher in the study expressed that it was very difficult to disclose their status and the above comments highlight this concern as a key feature of the combined collective narrative. The following comments came from Mr Machalaga:

> I think it's a good point if ever sometimes I think our government; our Education Department they are trying their level best to ensure support about AIDS related issues. But now the only challenge I have realised is to convince the people about the manner in which they should disclose. Disclosure that is the manner in which people should protect themselves in terms of sex the main causes of which to me plays a very important role in spreading HIV. Poverty also plays a very important role in people sleeping around. Also, protocol; is it possible to let's say where to start from maybe from your colleague to a senior to the main manager who is the principal and the like. All those make it very important because it might be possible where maybe you can disclose that to your colleague or your friend colleague. You are not sure whether they will go to your manager or they will gossip about it. I think that protocol makes everything difficult. You see the main problem is our Department. They don't have that vision of convincing people how to disclose and then people are still afraid of this kind of protocol. People are still afraid. If there could be a mechanism whereby people feel free because you see to me HIV/AIDS is not that much scary; it is one of the chronic diseases whereby it's not that much as people think. We used to have this assumption that whenever or if any person will contract AIDS that person will die. There are many chronic diseases like sugar diabetes, which are much more dangerous compared to HIV/AIDS so if people can realise that; I think it will also be simpler for them to can disclose and when you have disclosed you become relieved and whatever you are doing you become free. (p. 5 lines 80-101)

Teachers and principals shared a common understanding that teachers' failure to disclose their status was caused by the assumption that their colleagues would discriminate against them, labelling them as people who sleep around. However, although teachers who disclosed their status were victimised, they were also able receive proper support from their loved ones. Principals expressed the will to support teachers who were willing to disclose their status. The unspoken connection in this combined collective narrative was based on participants' mutual understanding of each other's traumatic experiences. This was among the commonly raised issues within the collective story.

### 4.5.2 Theme 2: Stigma and Discrimination

Among the commonly raised issues within the combined collective narrative was stigma and discrimination. It was evident that the prolonged sickness experienced by HIV/AIDS sufferers was characterised marked physical symptoms. These physical symptoms exposed teachers living with HIV/AIDS and made other teachers feel uncomfortable, causing them to begin stigmatising and discriminating against their sick colleagues.

Stigma and discrimination hinder disclosure but disclosure is essential for teachers to access support. People have been made to believe that HIV/AIDS is a disease for adulterers and all those who sleep around. It is against this background that HIV/AIDS is highly stigmatised. Teachers experienced stigmatisation and discrimination regarding HIV/AIDS as unbearable. It was evident from the principals' and teachers' responses that HIV/AIDS is highly stigmatised. All the principal and teacher participants felt that the stigmatisation of and discrimination against HIV/AIDS sufferers was so profound that it deterred teachers from disclosing.

Mr White, one of the principals interviewed, shared the following experiences:

> One of the teachers (a female) unfortunately has developed physical symptoms like sores all over and her hair is thinning. She has been ridiculed by other teachers and even learners. Other teachers call her names. They raise the three last fingers as an indication that they know that she is HIV-positive. Therefore, colleagues pass rude remarks. When I spoke to her, she indicated that she does not like these symptoms and she sleeps always after taking medication. She is always tired. I have known about her HIV status but I cannot tell anyone else. I do not want them to blame me tomorrow when they hear that their innermost secrets are circulating amongst the staff. After all, we can also be victims. The lady has always had issues with her HOD. She has been always fighting with the HOD. I always calm situations and try to protect the teacher and I won't explain why. Apparently she has not been in good terms with the staff and, to a large extent, her lifestyle has contributed to how she is being treated. They suffer quite a lot. When teachers quarrel they mention those innermost secrets they have known about others in order to humiliate and hurt them. People do that naturally. It is typical of human beings. They gossip, they call each other names, and I would say that's why teachers do not disclose. They have no trust. Teachers need to be advised to correct their behaviour. You tell one person that you are living with HIV/AIDS and they circulate the matter around the school. Being so protected information, it goes viral the moment people know. Such behaviour deters other teachers from disclosing. (p. 4-5 lines 53-79)

Ms Rakani who was hospitalised for a long time and subjected to severe stigma and discrimination after her principal informed her colleagues about her HIV status, expressed the following sentiments:

> Stigma and discrimination are destructive and especially when coming from people close to you. After visiting me in hospital, the principal divulged to colleagues that I was very sick and I wasn't going to make it. Since then, I have been given names and my colleagues hate me. (p. 2 lines 19-22)
> Due to sensitivity of the issue as well as stigma and discrimination – it is a challenge. Other teachers complain when they have to stand in for absent teachers. It is difficult to stop gossiping. (p. 4 lines 53-56)
> What makes it difficult to disclose is stigma and discrimination. If the campaigns could include accepting the disease like any other chronic disease then people can disclose. In terms of here at work, the principal need to set a good example. He needs to eradicate gossiping than spread it. (p. 5 lines 64-67)
> School communities are aware of such policies but unruly teachers ridicule one another and they discriminate. (p. 5 lines 70-71)

The above views portray a community that has lost its strength of conviction in terms of ethical issues. The raising of three fingers to teachers suspected of having HIV/AIDS indicates an absence of the spirit of *ubuntu*, as does the tendency of teachers to ridicule their sick colleagues. In relation to stigma and discrimination, Mr Muloyi made the following observation:

> The physical symptoms subject them to stigma and discrimination; people gossip. We have had a practice whereby teachers would organise themselves and visit sick colleagues in hospital or at home. It is during these visits that people diagnose and it has now reached a point whereby people do not want to be visited. They would say that those teachers that have been involved in sexual relations with the sick teachers will also die. They would say a lot of things like, they are sick because they have been sleeping around they blame them for having been infected by HIV (p. 6 lines 81-88)

Mr Muloyi's observations resonate with the challenges faced by Mrs Mehlo, who experienced profound difficulties before and after she knew about her HIV status. Several people questioned her about her excessive weight loss. They expressed suspicion due to the deteriorating state of her skin. They laid the accusation that something was hidden behind her weight loss and chapped skin. The diagnosis intensified after her husband passed on. She heard people say that it was obvious that she was HIV-positive. She described her experiences as "unbearable". Her challenges extended to the District and were more concentrated within the school

community. Several of her colleagues began to avoid her and gossiped about her health. The District was also suspicious of her frequent absenteeism and repeatedly suggested that she was hiding something:

> I have been questioned about weight loss by several people. I was queried about my skin and accused of hiding something. After my husband passed away I could hear people say 'it's obvious'. It has been unbearable. Staff members have been avoiding and back biting about my health. The district is not convinced why I am always on regular check-ups. They seem to suspect that I am hiding something because of absenteeism. (Mrs Mehlo p. 2 lines 6-11)

Furthermore, Mrs Pule, one of the female principals, described the situation in her school regarding the stigmatisation of and discrimination against teachers living with HIV/AIDS as follows:

> HIV/AIDS is known as a disease of the wrong-doers. It has been known to be associated with sleeping around with different partners and, mostly, fast-lane lifestyle. Families have been known to disown their members who would have disclosed their status. They will be regarded as failures. People are afraid of losing family members and being disowned at work. For example, a cabinet minister is caught exceeding the speed limit while drunk. It is a disgrace to the people, the government and his/her family. So teachers would rather hide their status than be seen as a disgrace. I mean, people always show sympathy. Other teachers showed sympathy and especially that her marriage was falling apart, which could be the reason why she could not control her temper. She was worried about her physical symptoms and she did not like it. She isolated herself. She has since transferred to another province. There needs to be mind-shift from the primitive ways of thinking amongst teachers. They can be ambassadors of breaking taboos about HIV/AIDS. Teachers need to be informed about the advantages of knowing about their HIV/AIDS so that they can access medication. (p. 4-5 lines 59-75)

The above comments reflect how stigma and discrimination negatively shaped the experiences of teachers living with HIV/AIDS. Stigma and discrimination have been a hindrance to teachers seeking the care and support they need. This is evident in the following comments made by Mrs Mabona:

> A lot of discrimination and stigma is attached to HIV/AIDS. We are taken to be not capable of performing some duties like sports activities. I am regarded as physically not fit to perform. Sharing the same utensils with other staff members in the staff room has been a problem. Some people still have the notion that the disease is transferrable or rather contagious, which not the case is. (p. 2 lines 17-21)

> It is ideal to deal with stigma and discrimination. The misconceptions of HIV/AIDS need to be dealt with so that people can focus on how to deal with HIV/AIDS. Once people know that you are HIV-positive, they look at you as a wrong doer. (p. 5 lines 75-77)

Additionally, Mrs Motsepe, another female principal who lost a teacher in her school after a long illness, described stigma and discrimination in her school as follows:

> As time went by, he got worse. Teaching and learning were adversely affected. He could not effectively do his duties. As a result, he was exempted from some of his duties like extra-curricular activities. He was very weak to work. The thought of death affected the whole school morale. Everyone in the school was afraid of looking at him, especially during the last stages of his illness. He lost weight and he was so thin that everyone could see that he had developed full-blown AIDS. He was staying in an upmarket suburb and lived a fast-lane life. He was not in touch with his family and then I was so lucky that, just when he was about to die, I found his distant [relative]. When he passed away, I sent a delegation to represent us. The [relative] helped to locate his family. There was not any contact to his family. It was because of his lifestyle. He lived a luxurious life and cared about himself only. He impregnated women and deserted them with no support. He slept around. He severely suffered from stigma and discrimination and, [back] then, there were not ARVs, which have recently been discovered. [Back] then, society believed that the causes of HIV/AIDS were related to lifestyle. Thus, when he fell sick, people judged him according to the life he lived. The situation was very bad. It disharmonised the school. The teacher was engulfed by anger and fear of death and he did not get enough support. (p. 3 lines 33-54)

It is difficult to talk about HIV/AIDS the same way you would talk about other chronic diseases. Because of this, teachers living with HIV/AIDS find it hard to thrive in school communities and mainstream society. This concept was further emphasised in the following comments by Mr Machalaga:

> I came back to work when I was feeling better. I was desperate for support, I went for counselling again and I was told about support groups for people like me. I got to know how to contact the Department's support system through short message sending. Usually, the Department sent us information documents regarding the support of all the chronic diseases that the individuals are having. You just take to the helpline concerning whatever chronic disease. Then they contact you about the support there is, though I never attended workshop concerning that and they used to email or short message sending regarding all those necessary support that they can give you. (p. 3 lines 33-48)

Mr Machalaga elaborated:

> In terms of counselling generally, not necessarily for HIV-related or whatever problems but also financial as well as other things in life, like if you are e.g. somehow alcoholic. Those are some of the kinds of support, though I never attended that kind of a thing but that's the kind of support from the Department. The scheme GEMS (Government Employees Medical Scheme) but from the team from the Department whereby they will organise workshops at school level and the likes. I didn't see any support and since I never saw workshop concerning HIV from particular Department in effect. Government Employees Medical Scheme is part and parcel of the government. (p. 3 lines 33-48)

In other instances, some (but not all) teachers living with HIV/AIDS disclosed their status to the principals. Principals strived to normalise situations so that stigma and discrimination were minimised. This is evident in the following statement from Mr Sebeko:

> That is why I have kept everything secret because the issue about the fighting was related to HIV/AIDS and we could not be involved because they were female teachers. I have normalised everything now. (p. 5 lines 73-75)

Likewise, principal participants, like Mr Dube, took disciplinary action against the teachers and other staff involved in interpersonal conflicts related to HIV/AIDS in their schools:

> If an educator stigmatises somebody about HIV/AIDS that is regarded as a serious misconduct and that teacher can go through a disciplinary hearing whereby he/she can be charged for such misconduct. And even our country states that people must not stigmatise other people, harassing and talking ill about people living with HIV/AIDS. So it becomes an issue that is treated with care. People are not very careless about that. They know the repercussions. People also understand that one out of ten people is HIV-positive. They know about that reality. They know HIV/AIDS is something within families, with schools, with institutions and so, the moment you talk ill about somebody or ridicule, so you are also talking ill about your own. So people are very conscious; they do not talk ill of other people. What affects you indirectly affects someone directly. So we are all affected. (p. 7 lines 166-176)

The study revealed that teachers living with HIV/AIDS are exposed to profound stigmatisation and discrimination at work, before and after knowing their status, and that this is a highly traumatic experience. Some participants indicated that they became suicidal during periods of prolonged illness. They felt rejected, especially when they failed to get support from their workplaces. Mrs Ninga expressed her feelings on the subject thus:

> Stigma and discrimination are really destroying. People make you to feel guilty; after the stroke I thought I was not going to make it. My sister instilled a positive mind in me. However, there was a time when I felt like giving up. (p. 2 lines 28-30)

In addition, Mr Mokena, who refused to condone gossip in his school, had the following to say about stigma and discrimination:

> It has been minimal. Gossip, which is the main cause of stigma and discrimination, is not dignified in this school. We do not condone it; we do not entertain it. Yes, it depends on physical symptoms. The moment it shows, we dismiss it completely. We do not endorse gossip, we do not repeat it. I always ignore and give an ear to things worth talking about. I make sure victims are protected. I have known some teachers to be living with HIV/AIDS for ten years now and everything has been kept under wraps. (p. 5 lines 77-83)

This shows that principals made considerable efforts to eradicate stigma and discrimination in their schools, as was also evident in Mr Den's narrative:

> Placing HIV/AIDS information everywhere helps encourage disclosure. We even encourage teachers to accept one another. We also encourage disclosure. We even encourage them to write letters and make them aware of wellness programmes. If teachers disclose then support can be channelled towards them. It gives other teachers the courage to disclose. To be always suspected of having HIV/AIDS is traumatic. Other teachers gossip, which leads to stress and stress leads to depression to stroke and finally death. (p. 6 lines 108-114)

The issue of stigma and the discrimination of teachers living with HIV/AIDS was also highlighted by Mrs Louw:

> I just normalise the situation. I pretended as if it was something small, though I was afraid. You know, to have a teacher collapse here at work... It was so scary. I would inform management, for the situation was bad. Teachers support one another and they visit other teachers in hospital. We have always had a culture of supporting one another for maybe teachers have no choice but to support. Just imagine you segregate your sick colleagues and tomorrow it's you. Even the learners were scared. I always have that on my mind that; what if teachers get tested and take medication before they show all these signs like losing weight? People out there are doing well with ARVs. According to our situation, it's not that teachers do it intentionally. It's not easy to see someone in that situation every day. Teachers feel sorry for one another and they are seen to be wishing their colleagues to get better. They visit and they help in arranging funerals. Sick teachers isolate themselves. I mean, they want to be alone for I think they feel bad. All those physical symptoms keep them away from the rest. You cannot rule out the possibility of denial. (p. 5 lines 89-104)

In line with Mrs Louw's experiences, Mr Ntolela conveyed his thoughts with regard to stigma and discrimination:

> There is need for education. Everywhere in the media, people are informed about HIV/AIDS but they are not learning. As a community and as a nation, people need to be made aware. People are in denial and they always say "not me" and that denial has caused a lot of deaths. The information that there are new infections and the rate is so high shows lack of education. (p. 6 lines 103-108)

In the raw data, there is evidence that HIV/AIDS is highly stigmatised and discriminated against infected teachers is rife. There is no trust, care and compassionate support in these schools. Since its inception, HIV/AIDS has been surrounded by the highest level of sensitivity and it has become a taboo subject. Teachers living with HIV/AIDS feel that they cannot trust their colleagues or their principals and they are often justified in their suspicions. As a result, there is very little, if any, compassionate support and care for these teachers.

Both the principals and the teachers interviewed indicated that teachers living with HIV/AIDS experience stigmatisation and discrimination. Under the present circumstances, it is sometimes difficult for principals to take proactive steps to support teachers living with HIV/AIDS. Nonetheless, some principals have taken considerable measures to eradicate stigma and discrimination.

### 4.5.3 Theme 3: Acceptance and Belonging

In this theme, all teacher and principal participants attested to some positive experiences with regard to teachers living with HIV/AIDS. Moreover, feeling part of a collective story fostered a strong sense of acceptance and belonging for the participating teachers living with HIV/AIDS. This drove forward the combined collective narratives, as was reflected in certain comments by Mrs Mabona, a married female teacher, who described how she became a support group member:

> When I first knew, I went through the denial stage. I thought that the tests were not authentic. I completely denied the results. I thought there was something wrong with the testing machine. I tested thrice and I did it at different centres, trying to establish that I was really HIV-positive. After the last test, I told myself

> that there was no way out. The true reflection had come out. I struggled to cope until I was introduced to a support group. The support group helped me to cope and that's when I began to realise that there are many people living with HIV/AIDS. (p. 2 lines 22-28)
> At first, my family had problems trying to come to terms with it but finally they have accepted. We go to the same support group with my husband and we are a happy family, which has accepted our status. (p. 3 lines 33-35)

Importantly, this part of the combined collective narrative spoke to the fact that effort was put in by the sampled principals to create atmospheres where teachers living with HIV/AIDS felt a sense of belonging and acceptance.

Mr Den gave the following explanation:

> There is a wellness programme provided by the Department for free. We management assist to phone and arrange for counselling and we recommend to the employer. If the teacher gets worse, we recommend for transfer and the programme (wellness) recommends placement. Such placement considers issues like light duties. We cannot help financially, medically or psychologically. We have a social worker here amongst us but, if we involve her in such issues, then circumstances will force her to reveal teachers' status. Such is not our jurisdiction and we do not recommend that teachers get help from the social worker unless outside our protocol. (p. 5-6 lines 53-64)
> We invite counsellors who are knowledgeable in terms of work shopping teachers. We have embarked on capacity building. Any organisation structure can be invited as well as support groups. We try for get a lot of information from the district. (p. 6 lines 104-107)

The teachers living with HIV/AIDS in this combined collective narrative did have certain positive experiences, including the counselling they received before and after testing. They even indicated that this counselling lessened their fears of death and raised their hopes of living, especially when this was coupled with antiretroviral treatment. Mrs Mabona's school community supported and understood her. As a person who had gone through traumatic experiences, she developed a positive mind-set to be able to see and appreciate the acceptance she received from colleagues and family.

Mr Nkosi also shared his experience in this regard:

> I was on sick leave when I knew about my status for (30 days). I attended counselling sessions. (p. 2 lines 21-22)
> What can you say? We are at work and that little concern that colleagues show is enough although it could be more. After all, we are at work. (p. 5 lines 74-75)

Ms Rakani's experiences with regard to counselling were described as follows:

> It wasn't easy. I was admitted in hospital for a long time. My health had deteriorated and my doctors decided to test me; that is when I knew. I had just given birth to my daughter. I received a lot of counselling. I started taking ARVs. I went into depression and I was diagnosed with anxiety. (p. 2 lines 8-11)

In addition, principals offered counselling when they found out about their teachers' HIV-positive status, as described by Mr Mokena:

> I have to know when my teachers are not feeling well so that I plan accordingly. Learners must not lose their learning time and those gaps opened by absent teachers need to be filled. Teachers have come forth to disclose. My teachers trust me with their innermost secrets. I have not disclosed to anyone about my teachers' status. Possibly, this has encouraged other teachers to disclose. I have provided counselling to those teachers who have disclosed to me. I offer support, comfort and advice. The aim is to make teachers perform. Through counselling, I have come to know about medical examinations and routines that they go through until they are put on the antiretroviral treatment. Some have experienced unbearable family problems due to their status; for example, disintegration. I have always been available to provide counselling, support and advice. Some teachers, however, have not disclosed, possibly due to the fear of death. We also refer teachers to the District for psychological help. I advise teachers to get medical help like antiretroviral pills that lengthen lifespan. I fight to minimise disruptions in the teaching and learning timetable. Absence of one teacher affects the whole system. Teachers do attend HIV/AIDS workshops. (p. 3 lines 33-50)
>
> Teachers need counselling and support. Keeping their confidential information maintains their dignity. Teachers are involved in sexual relationships amongst themselves with teachers living with HIV/AIDS to show that their status is not known. I do not have to ask why they are in these relationships because I also assume that, as adults, they know how to protect their partners. We review our policies that are health issues during our end-of-year whole school planning that lasts for three years. Committees come up with year programmes. (p. 4 lines 55-61)
>
> Like I said, I have earned trust amongst my teachers because I do not share it with anyone, even my deputy. We have a culture of standards. We have dealt away with gossip. We do not give it a chance. Corridor talk is not credited. It is not resuscitated. We marginalised it. We have an agreement that we all make a contribution to maintain the standards. If it helps then it happens in private corners so that our culture of secrets does not allow it to reach the victims. (p. 4 lines 70-76)

Instead of concentrating on challenges like stigma, discrimination and feelings of isolation, this section considers the experiences of teachers living with HIV/AIDS

who belonged to support groups. They felt supported by people who understood them. Moreover, being rejected at work by colleagues did not deter them from belonging in a place where they are accepted and supported.

This issue emerged as part of the combined collective narrative. An example thereof was given by Mrs Ninga, who managed to disclose her status to the principals because she felt that life was an open book and that everyone could see that she was sick.

> I lived with fear; fear that parents and learners will complain that I was sick. Generally, my colleagues and management supported me so that, without my colleagues, I wouldn't have made it this far. They understood that I needed my job to fend for my children. (p. 3 lines 31-34)
> I have been able to influence change of perceptions through encouraging people to test for HIV. (p. 4 lines 60-61)
> My sister and her husband suggested that I be tested. I received thorough counselling before testing and after. I was alone with the counsellor when results were presented to me. I was immediately put on antiretroviral treatment because my CD4 count was very low. My sister supported me to go to work and eat healthy. (p. 2 lines 16-20)

Mr White, meanwhile, aired his views on the matter as follows:

> Teaching and learning has been affected quite a lot. This is a combined school right and, if one teacher is not there, the one who is available takes over the lessons. (p. 2 lines 15-17)
> I can always advice teachers to take their medication as prescribed. I encourage them to attend support groups, go to the gym, and use protection to avoid re-infection and they must discuss issues with families. (p. 3 lines 43-45)
> I have talked to those teachers to correct their behaviour. I reminded them that they are not doctors and, therefore, they cannot diagnose. If we suspect that someone is HIV-positive, we cannot conclude. We are also affected and we can be infected any time. (p. 4-5 lines 67-70)

The taking of antiretroviral treatment (ARVs) has been a positive aspect in this story, as was highlighted by Ms Rakani, who started taking ARVs after she was discharged from hospital. Most of the teachers living with HIV/AIDS received counselling, as it is every person that gets tested for HIV should receive counselling.

Counselling before and after testing is meant to ease the situation and help people to accept their new status, as was highlighted in the following comments made by Mrs Mehlo:

> You can't just get tested for HIV without counselling. It's someone who encourages you to accept your new status. It's the day I will never forget. I sweated and won't forget the fear. The body language of the counsellor showed me that my results were positive. Anyway, I'm trying to get over it. (p. 4 lines 40-43)

Mrs Pule also conveyed thoughts that reflected her concern for teachers living with HIV/AIDS:

> When the teacher decided to disclose, I attempted to help her with by basic counselling skills. I felt obliged to help her because of her decision to disclose to me. She indicated to me that she was battling to accept her HIV status. I advised her to do her work effectively because she could not afford to lose her job. I spoke to her several times and kept everything confidential. I always checked her to remain focused on her job. I aimed at helping her manage her stress. (p. 2-3 lines 19-32)

This theme highlights the positive value of counselling, which encouraged teachers to seek treatment for the prolonged sickness that results if HIV/AIDS is left untreated. Their lives improved exponentially when they joined support groups. The combined collective narrative also revealed the manner in which each of the teachers came to know about their HIV status. They all become sick and then were advised by doctors and/or family to test for HIV/AIDS, as described by Mr Machalaga).

> I started getting sick on and off for a long time. After that sickness, I got admitted at the hospital and not knowing that what kind of a disease I'm having. I even exhausted my leave days and later the doctors tested and told me about the disease. They counselled me about the disease and how to live life with the disease, like taking the ARVs regularly. The disease is not yet curable but treatable. You can live long life as long as you follow prescriptions and like eating healthy; for instance, foods like fresh vegetables, fruits or any foods that are having enough proteins and vitamins... all those types of foods or any other type of foods that have proteins and vitamins that are necessary. I was devastated. (p. 2 lines 12-27)

Mr Machalaga continued:

> I felt like it was the end of the world. Later, I started taking those ARVs and then going for check-ups. The Department also is supporting in terms of helping with

> this kind of disease because they are augmenting with a subsidy... even the tablets. If you are a member of the medical scheme that is a certain medical scheme, you are entitled to receive the ARVs according to prescription of the doctors. (p. 2 lines 12-27)

It was also evident in the following sentiments by Mrs Motsepe that principals expressed sympathy:

> I would ask him politely to go and consult doctors and, whenever possible, speak to him to express sympathy and support. He would, however, reciprocate by telling us that he did not need anyone's sympathy. He appreciated the support. (p. 3 lines 30-32)
> Actually I would say that teacher's death had a positive impact on my teachers' behaviour. I think it acted as a deterrent to other teachers and possibly came as a reason to correct their behaviour. Since then, we have never seen such kind of lifestyle. (p. 4 lines 55-58)
> I, as an individual, always support my teachers when they have problems. I call in relevant professionals to workshop and advice about, for instance, leave days. Teachers have had problems because they exhausted their leave days and, later on, they become desperately in need of them. I always take it upon myself to contact teachers and advise them. (p. 6 lines 61-64)
> I remember, at one time, I had to call one of the teachers' wives to come and sign leave forms. The teacher had just disappeared and indicated that he was sick. His salary was going to be affected when he really needed it with his family. (p. 4 lines 67-70)

Mr Ntolela (p. 4 lines 59-62) revealed the following with regard to departmental support:

> The Gauteng Department of Education has a counselling arrangement. We refer teachers to phone a certain number for they receive counselling even on the phone if they do not want contact sessions. Teachers are referred to social workers. I have the number, which teachers phone.

Confidentiality was among the commonly raised issues within the combined collective narrative. Mr Sebeko offered the following suggestions on the subject:

> I have always respected confidentiality. I never thought of counselling because I do not have knowledge. I have done some counselling courses and attend workshops but I feel I do not have enough knowledge. HIV/AIDS issues need to be approached with caution or maybe I should try my little knowledge. I feel obliged to protect the teachers and I expect them to work normally. I have always advised them to attach medical certificates each time they consult doctors. (p. 3 lines 31-36)
> I invited the District's Educator Wellness Unit to come and workshop the whole teaching staff. (p. 3 lines 48-49)

> We support teachers who have disclosed and we understand their situation. (p. 4 lines 56)
> My teaching staffs relates very well. There are no attitudes; everything is normal. Even if they know, they would not treat them badly because we are all affected. Our teachers love one another and they respect each other. They would not behave undesirably, even if they know that one of theirs is living with HIV/AIDS. They would not utter bad things nor treat them badly. Considering the prevalence of HIV/AIDS in black communities, each one of us is either affected or infected. They have the obligation to accommodate others. The two teachers have never shown any attitudes, they have behaved normally. (p. 5 lines 76-83)

These views are consistent with what Mr Muloyi shared:

> Teachers who are in charge of the HIV/AIDS committee are seniors who are also part of the management team. The committee always holds campaigns, you know, to remind people about the disease. (p. 4 lines 59-61)
> It is all about our principles and the effort we put to practise them. The Christian values, like I said, have been very useful. If teachers decide to gossip, they do it in such a manner that it does not reach the ears of the victims. I encourage teachers to treat one another in a dignified manner, for those who talk ill about other teachers will face the consequences. (p. 5 lines 75-80)

Mr Dube also shared the following experiences regarding the acceptance of and sense of belonging amongst teachers living with HIV/AIDS:

> First and foremost, teachers are weak and sick because of HIV/AIDS; however, if teachers are unable to come to work, the Department of Education has systems in place. We employ during the absence of the teacher, for instance, if the teacher has been laid off by medical doctors for a period of 30 days or so (p. 5 lines 109-113)

Mr Dube continued:

> At times I bring them to my office and I engage them I give them counselling. Some are very much afraid to talk openly. But I remember I called one teacher and told her that look your heath is not good, how about you going for tests; I kept on asking until she responded. And you know they recover quickly when they take their medication. When somebody has confided in me I understand for instance; I reduce workload. I do not demand work unlike somebody who does not talk to me even if he is a little behind. I become positive and understand. I become sympathetic. (p. 5-6 lines 121-139)

Mr Dube's views were shared by Mrs Louw:

> I had to draw closer to him and show how much I was concerned about his health; I mean, on humanitarian grounds it is difficult to just leave him to be on

> his own. I mean, even his leave days had been exhausted. He tried to be strong and pretended to be well but sometimes he would collapse especially when he started taking ARVs. I would sit and talk to him. I encouraged him to eat healthy and rest. (p. 2 lines 14-19)

Many of the various principals' comments, sentiments and perspectives mirrored one another on this subject. All of the teachers in this study mentioned support groups. Within these groups, their HIV status was accepted rather that stigmatised and they felt recognised rather than diagnosed. The comments above reveal how a sense acceptance was cultivated, not by changes in individual perceptions, but rather through the actions – for example, greeting, embracing and information-sharing – taken within the support groups. Similarly, the teachers' stories described the profound sense of belonging and acceptance that they felt in the company of other people living with HIV/AIDS. The authentic social identities that teachers were able to adopt within the support groups spilled over into their everyday interactions with society. As a result of being around other people and teachers living with HIV/AIDS, these teachers were able to reclaim their identities and communicate their feelings and expectations to their loved ones. This was the positive result of their being members of closely knit groups. Any loss of their sense value and of belonging when they experienced in everyday life was quickly restored each time they interacted with group members at support group meetings.

### 4.5.4 Theme 4: Teachers' Experiences of Principals

Most of the observations expressed by the teachers living with HIV/AIDS participating in this combined collective narrative indicated similar emotions and experiences. They shared common perceptions about the roles of their principals, of whom they held high expectations. Consider, for instance, the story told by Mr Machalaga:

> I think through the conversation that we had. But being the manager or the headmaster I think he is supposed to be more knowledgeable because he is dealing with subordinates; in effect he is the father. He is sure that we need information regarding this, even though he might not have enough knowledge he might inquire. He needs to go out and look for information and support that I want. He needs to look after his staff. (p. 6 lines 119-125)
> From the school level, I think we should have some regular workshops in order to address or talk more about this kind of disease and not only this one alone but other chronic diseases as well. Also, support groups whereby people talk more about supporting one another. (p. 8 lines 157-160)
> I think it's one of their duties. I think they play an important role in educating the community at large. They are role models; they produce products into the society and they must be seen to possess knowledge that enriches communities. Of course I with the condition that I have, I look up to him. It is easy for people of his level to outsource expertise to help their staff. (p. 12 lines 264-269)

According to the sampled principals, teachers had high expectations of their principals, despite the fact that infected teachers disrupted school functioning, as Mr Muloyi asserted:

> Society describes role to us, even in health. Society assumes that teachers are good. It has made the teachers to be secretive so as to keep the good image. As role models, they are put in a situation whereby they are regarded as pure, healthy or innocent. They are custodians of knowledge for they are leaders. For example, it will be awkward to see teachers selling vegetables; society has its own expectations from teachers. It would not be appropriate for teachers to come out about their HIV status. It is high time society accepts that AIDS is a problem for everyone. (p. 6-7 lines 100-107)

These comments show that teachers living with HIV/AIDS look up to their principals. Mr Machalaga, for example, perceived his principal as the answer to the problems faced by teachers living with HIV/AIDS and therefore expected him to play an important role in educating the teachers and the community at large. He argued that principals can perform extra duties through good time management and, more

importantly, they can use their status to implement change. This is highlighted in the comments below:

> I have worked with different principals, the majority of them that I have worked with used to perform extra work if required and to me I think they wanted to gather or I think to gain support in terms of the needs of the school protection, fundraising, understanding the community in terms of their needs; promoting their school, getting the support of the community by bringing the confidence of the school by sending more learners and you know there is competition in our schools you see like we have different schools around and the principal is not working properly with the community around, parents may send their children to other schools. So I think by working with the community that is trying to understand them, trying to handle them you see you gain support. It's good to work well with the community around; you understand them, they understand you. Principals can engage the community, they can bring people together. Really it is a challenge. The principal has the duty to bring in experts regarding the problem, for instance, psychologists, social workers; those people who have expertise to come and maybe motivate educators and learners regarding this kind of situation. He can just organise professionals because really he can find himself overworked because some of the duties are demanding. (Mr Machalaga, p. 13-14 lines 277-294)

In this theme, most of the observations made by principals showed that teachers look up to their principals, perceiving them as all-knowing Messiah figures. Hence, the following sentiments from Mr Sebeko:

> Yes, I have felt the extra load but it is very difficult to pull away. I am prepared to go an extra mile, although the government does not pay for that. We need to go out of our way. Just last week, our life orientation teacher stopped a suicide attempt by one of our female students living with HIV/AIDS. Society perceives principals as having answers to the HIV/AIDS issues. I know there are responsibilities laid on principals because of their role model status. We cannot retreat but, rather, take advantage of their positions and bring stakeholders together so as to improve dissemination of information. Different parties need to communicate so as to conquer the war on HIV/AIDS. Leadership is very important in influencing people to understand HIV/AIDS issues. People need to be given knowledge. (p. 6 lines 100-110)

It was commonly argued by the teacher participants that principals can influence surrounding communities to send their children to their schools and that, likewise, they can use their influential positions to change people's minds. According to these teachers, principals can reach out to professional experts like counsellors and psychologists to give support to their teachers. They have the power to outsource

resources and people. The following quotation from Mr Machalaga best explains this issue:

> Yes, it's a challenge. This is very sensitive. We should not be scared to approach them. I think clarity is lacking. Intervention goes to known people because now let's say right now I don't know whether I can trust someone else let's say if I'm comfortable in talking to someone from the District level. Should I approach that person directly or that person should come to report to the principal or also it might cause negative impact or maybe the principal might say you jumped me and went to the district. I think we need clarity regarding this because you might be wrong you might be right. I really don't know. In effect we do have an HIV/AIDS committee but I think that committee needs a person who will attend workshops actively so that always he/she advises the whole staff about new developments with the disease and whatever in relation to the stigma. (p. 15-16 lines 335-348)

As revealed by Mr Dube, principals made sacrifices to support their teachers living with HIV/AIDS:

> Principals and managers are not from heaven. They are just human beings who have been entrusted with responsibilities to manage and lead institutions. We are human beings and we know that communities look at us as custodians and ambassadors of knowledge about HIV/AIDS. It places measurable amount of pressure on us as leaders to ensure that we give direction to communities, to the schools and society at large. We are really ambassadors. For instance, Mr Zuma has played an important role as far as antiretroviral tablets are concerned, conversely to what he has been ridiculed about HIV/AIDS, when he said people must wash with showers for them not be infected by HIV, which was really disgusting. So, as a leader, you should not do like what our president did. On the [one] hand, he is doing this and, on the other hand, [he] is doing that, so you lose people's confidence and credibility. We must be leaders of substance and people must look upon us as people who are custodians of and ambassadors of HIV/AIDS. (p. 7-8 lines 181-194)

Although the teachers understood the sensitivity of dealing with HIV/AIDS, they expected principals to notice when teachers were not coping with their work. Mr Machalaga explained:

> I think there are more challenges. I think if ever people have people living with HIV/AIDS with them, maybe they should be particularly be given a lot of support from school level to district level. In terms of work-related issues; maybe to check whether some sort of maybe whether as an educator you are coping with your work with this chronic disease so that kind of if you are not coping with your work with this chronic disease. If you are not coping, they must determine what kind of support do you need in relation to the workload that you are facing for

> example maybe I'm teaching at a high school level maybe there is a lot of subjects workload and I must support this, I must support that and mark and so this means all these things only find me in an over loaded situation and then it affects also my health and thinking. (p. 4 lines 70-79)

Indeed, the above comments indicate that teachers are entitled have certain expectations of their principals, as Mr Ntolela argued:

> It is good when principals are placed on pedestal. They have to act accordingly; they have to act it. They do not have to abdicate the responsibility to themselves. It enhances position as principal; it educates people to trust. If I do not act, people get disappointed. (p. 6 lines 99-102)

Furthermore, Mrs Motsepe explained her take on principals' duties with regard to teachers living with HIV/AIDS:

> I am prepared to take extra load of my demanding job to help teachers with their personal problem. They look up to me, I know, but then if they do not disclose, then how they can get help? They choose to keep quiet until they die. I even approached them personally to no avail. (p. 6 lines 91-94)

It is clear that the teachers looked up to their principals for the solutions to the problems they face due to HIV/AIDS. Most of the time, however, the principals could not live up to such expectations and the data reveal that they encountered severe challenges in this regard.

Ms Rakani made the following suggestions with regard to this issue:

> They have the potential and they can make a huge contribution. It all depends on how much they care. Their strategic position allows them to influence communities – yes, I have seen principals go an extra mile. Their voices are easily heard. (p. 6 lines 75-77)
> The principal as a leader should set good examples and be a role model. The principal binds people together. He influences people's perceptions towards achieving goals. (p. 4 lines 43-45)
> Although they cannot answer but we look up to them they are more experienced and they are connected to other professionals due to their influential positions. They contribution to educating people about HIV/AIDS cannot be undermined. (p. 5 lines 72-74)

In this combined collective narrative, principals highlighted the issue of having to shoulder the responsibility of protecting teachers, as was evident in Mr White's remarks:

> I have the responsibility of protecting teachers but I can't explain why to other school management team members and teachers. Sometimes they query, "why I should protect absent teachers?", but [I] still handle the issue so that both parties calm down. I even protect teachers who have not disclosed to me because I know how they feel. Those extra duties are part of my responsibilities. Everything starts with me and ends with me, as a leader. I am the only person who has the prerogative to support and encourage. I have to help teachers to do their work effectively. (p. 5 lines 80-87)

Mrs Ninga added the following comments:

> Really, it is an extra duty. However, because principals have the capacity to lead by example, they are able to inform people and educate society at large. They arrange relief teachers for in case some teachers are absent. (p. 5 lines 65-67)

Mr Mokena also conveyed his thoughts:

> The Department's support programmes are sporadic; maybe after four years. When I refer teachers, duty limits me from directly referring a person. I have no jurisdiction and I am not supported. Sometimes, I am not sure about the frame of mind so that the labour relations set limits. (p. 3 lines 51-54)

Mr Mokena continued:

> Yes, my duties incline me to counsel, support and advice. I have known teachers get some sigh of relief after they disclose to me. Teachers look up to me. I have not disappointed; I have been always available. I have led health discussions, which have led to the acquiring of first aid kit boxes to help in case of injuries. (p. 5 lines 89-92)

Narrative data revealed that principals are leaders who should set good examples and be good role models. Principals have the duty to bind teachers together and influence people's perceptions towards achieving goals. Principals should stimulate teachers to feel and act like leaders to give them an overall sense of purpose in managing HIV/AIDS. Teachers, meanwhile, have duties delegated to them according to their strengths so that every teacher has a responsibility. Participants like Ms Rakani blamed her principal for divulging her HIV status to the entire staff. However, all that the principal actually revealed was the severity of Ms Rakani's sickness – not her HIV status. Mr Nkosi shared the following sentiments:

> As a leader he is able to influence change. He sometimes tells us to be responsible as professionals. He is concerned – especially when we lost a colleague and even an ex-colleague. I heard him say that we need to have medical aid. (p. 5 lines 70-73)
> Yes, he is the leader, he leads the way. Leaders have an effect; e.g. the president, Mr Zuma, has been very supportive. He has unrolled the biggest ARV programme in the world and he has initiated voluntary testing and counselling campaigns. The principals can initiate programmes that can see the school being the disseminator of knowledge. Teams need leaders. (p. 5 lines 78-82)
> I disclosed to him because I feel he can support me and I wanted him to get it from me. (p. 5 lines 84-85)
> He has to be committed. He needs to have an ear to listen to all our problems. (p. 6 lines 86-87)
> I think the principal has the power to set the tone. He has the power to pull people towards the set goals. Indeed, they are role models; they have the power and they have the authority… They can use resources at their disposal to conduct enrichment programmes. They may face challenges, yes, maybe, because of their demanding jobs. They are accountable for bad results. So I admit that such extra duties exert pressure for them to improve results. I think they can do it. They are always visible in society. They are associated with academic knowledge as well as general knowledge. (p. 6 lines 93-99)

Mr Den made the following observation:

> It is proper that way. Those are good qualities of leadership. Subordinates should not be afraid to come to you. They must not ask themselves questions about you. That will inform how colleagues interact with you about their health. If you are open to teachers, they should not be afraid of saying what they want. Anybody expects answers if they have questions. I cannot be in a position to provide answers for every question but what I do about their expectations matters the most. I am not a god and therefore cannot provide everything. Making them aware that I cannot do this but that informs them the extent I can go. I get them information so as to earn continued trust. (p. 7 lines 124-132)

In addition, comments passed by Mrs Louw in relation to the expectations of teachers showed that teachers look up to their principals:

> Yes, teachers look up to me. Although I am not an expert in health issues, I apply my basic knowledge. I delegate teachers according to their strengths. We have done very well in supporting the sick, even in times when they are admitted in hospital. I cannot avoid that duty of advising and supporting. My duties are overlapping as compared to what principals used to do. I have to do that so that teachers can be able to perform their duties. If I take a back seat then the unity falls apart. (p. 6 lines 109-115)

The above comments reflect some positive sentiments. They showed that teachers expected to be cared for and principals were ready to help but that the failure of

teachers to disclose their status was a stumbling block. The above comments depict principals as having roles to play in the HIV/AIDS-related issues. They influence change through their positions. Likewise, principals can initiate programmes that can see schools as disseminators of information, taking the lead in HIV/AIDS campaigns. For instance, Mrs Mabona commented that “the involvement of the principal along the way increases efficiency. Obviously, united we stand and divided we fall” (p. lines 52-53).

### 4.5.5 Theme 5: Challenges faced by Teachers living with HIV/AIDS and their Principals

An issue that arose frequently in the combined collective narrative pertained to the challenges experienced by principals with regard to teachers living with HIV/AIDS. Meanwhile, teachers living with HIV/AIDS experienced challenges ranging from isolation to health problems. According to the sampled principals, management of the schools was greatly affected by teachers living with HIV/AIDS. This was highlighted by the following comments by Mr Ntolela:

> Leadership and management are affected even worse. I am forced to tolerate what’s taking place. Once I do that with one person and others are watching, they will come and expect me to give them the same tolerance. Therefore, it shakes authority as a leader [if] you tolerate this and not that. I cannot be expected to tolerate cases that are not the same. A teacher with HIV needs to be tolerated more than a person who has some other issues. (p. 3 lines 50-55)
> I am challenged as a leader to say how far I should tolerate. I am responsible for making sure that teaching and learning take place during the absence of other teachers. Teachers complain, especially if such arrangements last longer. Sometimes teachers disclose to the principal and not their families; then that needs to be respected. (p. 6 lines 94-98)
> It is an extra burden. I need to spend time with the teacher to reassure him/her that I will never divulge this to other teachers. I have to work to gain confidence and talk about how health issues are. I need to promise that it’s between the two of us. Nevertheless, they do not disclose. I even reach the extent of visiting teachers at their homes because of their long absence. I have to find out why and, even if I suspect HIV/AIDS, it is wrong to diagnose. Right now we have a case of a repeatedly absent teacher. I understand he is receiving treatment at home. He has since relocated to stay with his mother for support. (p. 4 lines 70-78)

On the other side of the situation, teachers living with HIV/AIDS faced feelings of isolation and also tended to isolate themselves. They were overwhelmed by the fear

of death, as well as feelings of insecurity and inferiority. As a result, they could not bond with their colleagues.

Mrs Mehlo made the following remarks in relation to the circumstances she faced at work:

> I have been called all sorts of names like Omo, Bus and others. People avoid or suddenly they change subjects in my presence. People look at me in an unusual way and people exchange signs and wink eyes, which mean a lot to me. It wasn't easy for me to accept my status. It came as a blow. I thought it was the end of the world. I started putting myself in my own world – my grave. (p. 2 lines 12-16)

Mr Muloyi, one of the principals, also conveyed his thoughts on the matter:

> The epidemic has reduced productivity in all sectors of the economy and, mostly, it has wiped out the most productive age group. Family units have been dismantled. Teachers, who are the main drivers in the provision of quality education, have badly affected some of the expertise that is lost [and it] is irreplaceable. For instance, in South Africa, scarce skills like mathematics and science teachers are not enough. The Department of Education is continuously losing teachers and, at the same time, it is intensifying mathematics and science programmes to improve critical subjects. You can see that people are sick. Teachers lose weight and their productivity deteriorates. In South Africa, education is politicised. There is very little left for the original teacher. Teachers belong to unions and are called by the name "comrade". We are losing something as teachers. The determination of duty in relation to conservative ethics commits teachers to come to work when they are sick. They guilt feeling incline them to pretend to be strong. A lot has to be done to harmonise the school. (p. 2-3 lines 13-42)

It is worthwhile considering what Mr Nkosi, a divorcee, shared about isolation:

> I maintained a low profile. I did not like knowing about my status. I stay in my classroom, I don't leave. I have to eat and take my medication. I don't want anyone to know. (p. 3 lines 31-33)
> It destroys! When you show symptoms people avoid you. I eat alone. I avoid trouble. I have seen colleagues segregating others. My divorce is known, it makes me a bad person. Hey, even the learners discriminate others. (p. 4 lines 53-55)
> There is a lot of uncertainty. Everyday I'm worried about my health. I have no peace. Luckily I am in a special school. I don't think I was going to cope in high school. I'm in solitary confinement. I sometimes imagine myself falling very sick and unable to walk. I ask myself a lot of questions. Apart from that it affects teaching and learning when I feel weak. (p. 7 lines 103-107)

Likewise, the following experience offered by Mr Dube highlights the same issues:

> We had also an incident whereby teachers and support staff were teasing one another that, "you are fat because of ARVs" and the other one will counteract that, "you are thin because you are about to die of AIDS. You are dying soon". So we called those people to the office and spoke to them and, in fact, the matter was referred to the District office and then it was resolved amicably. (p. 4-5 lines 103-108)
> Among the teaching staff; we need to always make sure that the issue of confidentiality of the staff is not exposed to anyone. As a school principal, what I can say is that I can speak in general. I cannot be specific and mention names in this regard but I can talk about it in general. As a school principal, you hear that one school has lost seven teachers. You start worrying that maybe one day it will be my school. (p. 3 lines 44-47)
> I have realised that to be a school principal nowadays is not about academic staff; it involves being a counsellor, social worker and psychologist. To capacitate myself I decided to register for psychology, which helps me to understand the minds of people and other issues. So it really capacitated me. It is a study of humanities. You become aware of ways on how to handle people. So ever since I started to register this programme, I can counsel; I feel much better and I am able to deal with people with greater understanding. So I am a principal, social worker and counsellor and I even interact with social workers amongst my staff and I interact a lot and invite stakeholders to come to school with different issues. It gave me a better understanding of different challenges and, as a principal, I can deal with human problems. (p. 6 lines 144-155)

From the participant statements presented thus far, it is clear that teachers living with HIV/AIDS are often severely ostracised by their peers and communities. The teachers interviewed all experienced feelings of isolation and sometimes even isolated themselves. Isolation was thus one of common themes of the combined collective narrative.

The experiences of Mrs Mabona are a case in point. She tested several times until she believed her HIV-positive results. Because of this, she failed to seek help and the disease began to take a drastic toll, with her losing a significant amount of weight. In order to hide what she was going through, she isolated herself from her colleagues. She was trying to avoid suspicion and felt that keeping them at a distance would allow her to conceal everything. She described how she struggled to cope until she was introduced to a support group.

Mr Machalaga’s experiences were similar to those of Mrs Mabona:

> It depends on where you come from; whether you get support from family namely wife, parents, brothers and sisters. They have supported me. If you are not supported then you are stigmatised. If you are discriminated [against], it has a negative effect. Considering the workplace or, before the workplace, the community from society at large; churches, clubs that is burial societies and the work situation. If you are experiencing discrimination; that is, then you can experience stigma, which might contribute to the deterioration of your health and you are psychologically affected. Psychological effects, which may be in form of more negative treatment like strained relations with society. Because, once you are psychologically affected, you feel you are rejected. You feel the best way is to take your life but, through counselling, I can say that, for the past five years, those people who have this disease... It has become much better because government has made various input regarding educating people that being HIV-positive is not the end of life. But, prior to that, there was not enough support. You remember, former President Thabo Mbeki, when he was saying ARV tablets could not treat HIV/AIDS, whatever, but, after that, people from level of families to communities people have realised that a person living with HIV/AIDS must be accepted in the community, the workplace and should not be discriminated. Also, I think it depends on the type of work that one does because level of knowledge depends on the type of work and work environment. People practise discrimination like at school level I think through of lack of knowledge and professional language; people fail to understand what support we need. I think that way… If we get support it makes one to feel stronger. (p. 7 lines 134-156)

The principals' collective narrative revealed the challenges they experienced in the leadership and management of schools and the issues related to teachers living with HIV/AIDS. This was highlighted by Mr White in the following comments:

> The issues of HIV/AIDS are protected by law and it is not possible for me to ask. About four teachers have disclosed and I always advise teachers to focus on their business. I know such issues can land me in jail. I can be sued. It is a very sensitive matter. Sometimes, when assemblies are longer, teachers that have been pointed at have a pattern of leaving before the end of the assembly. They will be going to take their medication. I cannot confront them because I can see they are sick and I have been informed by people close to them. We have a catch up programme for those classes that have frequently missed lessons. There is no support. We have committees like the HIV/AIDS but they are only for events. The school based support team is for learners not teachers. (p. 2-3 lines 25-34)

While the above comments show that teachers living with HIV/AIDS caused challenges to the leadership and management of schools, the convers is also true; teachers living with HIV/AIDS experienced considerable difficulties in their school communities. Their problems were reflected in Mrs Mabona's following comments

about how teachers living with HIV/AIDS isolated themselves and were isolated by colleagues and significant others:

> Firstly, I tried to establish how this came to be but didn't get any answers. This made me suffer psychologically because I didn't get answers to this. I experienced a great deal of depression and anxiety. I lost a lot of weight. I was not in a position to eat. I isolated myself from colleagues and from anyone else because I thought they know what was going on. (p. 3 lines 36-40)
> I have been isolated by colleagues and even by the school management team who thought that I could not cope with school duties due to the fact that sometimes I don't come to work. Being stigmatised and isolated has seen me being undermined and not being listened to even if I have a point to make. I am always taken for granted. (p. 1 lines 8-11)

Correspondingly, the following remarks by Mrs Pule reflected the difficulties faced by principals in dealing with HIV/AIDS-related issues amongst their teachers:

> It was so bad and I did not know how to deal with the situation. I was blackmailed; I was emotionally unstable. This is a sensitive matter to deal with, I am not a counsellor. The teacher's absenteeism got worse; other teachers complained. I could see that she was in a difficult situation and charging her was going to be inhuman. She started taken ARVs and her behaviour improved. She would come and show me how the ARVs are and how she took them. She appreciated the help she got from me (p. 2 lines 24-29)
> You know in the case of that teacher other teachers would complain that she was not supposed to behave in that manner at work. (p. 5 lines 70-71)

The colleagues of teachers living with HIV/AIDS were prone to speculating about their conditions and avoided them based on their fear that contact would cause them to attract the disease, which was viewed as a death sentence. Fear and uncertainty are hindrances to disclosure.

The relationship between the teachers living with HIV/AIDS and their colleagues prior to infection often determined the extent to which victims were prepared to disclose once they knew their status. Some teachers have indicated that they maintained low profiles at work as they did not trust their colleagues to provide compassionate support. Stigmatisation and discrimination have been described as major deterrents to disclosure. Moreover, an absence of support from the "workplace, community, church, clubs; burial societies and society at large might contribute to the deterioration of one's health" (Mr Machalaga p. 7 lines 138-139).

This had a profound impact on teachers' physical and psychological health, which, in turn, affected the way they related to their colleagues. Ms Hlengwe aired her views as follows:

> Well, I would say discrimination starts at the health facilities. When everyone knows that a certain area or ward is for people living with HIV/AIDS they attach labels. After my illness I was labelled hot plate by people around me. (p. 2 lines 24-26)

Mr Sebeko also conveyed his thoughts on the subject:

> I closely monitor and supervise teaching and learning. When teachers cannot execute their duties; there is a problem. (p. 2 lines 17-18)
> We had a teacher who has since passed on five years ago. He lied and took advantage. He took advantage of our sympathy. He disclosed at the final stages of his infection. It was an open book, everyone could see. He drank excessively and did not teach effectively even when he could. He would lie about being to the hospital because he could not produce any medical certificates. He went to an extent of asking for some money from the learners for not submitting tasks or for marks. Whenever we asked him why he was doing all these things, he would simply answer that everyone knows that he was sick and he was waiting for his day. Rather, he blamed HIV/AIDS than taking responsibility of his wrong behaviour. I was so frustrated. Teaching and learning was disrupted and the teacher carried on with his habits of dishonesty. (p. 3 lines 37-45)
> Everything is confidential. We had a situation whereby two female teachers were fighting about issues related to health. We then tasked the Guidance Head to resolve the matter but the teachers declined because the Life Orientation Head, who has transferred, does not keep secrets. (p. 4 lines 69-72)
> There are no support structures and resources to support; for example, workshop training on HIV/AIDS. Principals need to be supported. Presently, they are not sure of how to deal with HIV/AIDS issues, considering the magnitude and sensitivity of the disease. (p. 6-7 lines 113-117)

The teachers explained that they did not necessarily receive help after disclosing their status. Teachers living with HIV/AIDS were troubled by anger, fear, and uncertainty about the future, which led to strained relationships with colleagues and school leadership. As a result of the extent of stigmatisation and discrimination that takes place, teachers living with HIV/AIDS feel isolated and forgotten by their communities.

The culture of the school in this regard had an impact on how issues related to HIV/AIDS were handled. Such issues are delicate and confidentiality is of great

concern. A work environment with gossipers is equally as destructive as the HIV/AIDS disease itself, as Mrs Mehlo explained:

> I lost a lot of weight. I went down to size 36 from 40. I started losing confidence because I couldn't get any better. My flu will be so severe and longer. People around me started discriminating me; let alone my colleagues. They made me to feel bad. (p. 4 lines 36-39)

The principals' narratives continued to reveal the challenges they faced in handling the issues surrounding HIV/AIDS amongst their teachers. On this topic, Mr Mokena made the following remarks:

> We are not supported. A support programme is launched and, soon after taking off from the ground, it disappears, only resurfacing after, say, four years. So teachers are not supported in terms of health. This is a very sensitive epidemic that needs a lot of support. My duties limit me from, say, going deeper into the issues, even with the teachers who have disclosed because I am not an expert in this field of health. (p. 5 lines 84-88)
> Yes, I am aware about such policies. I cannot discuss such policies with teachers because you cannot be sure of their frame of mind. The labour relations code of conduct does not allow me to call teachers and discuss with them about policies, especially those that have disclosed. The first time they came to me, I was available and I indicated referrals. Handling such issues is well above my knees. My line of duty limits me from directly referring a teacher upon suspicion that the person needs help in line with HIV/AIDS. The jurisdiction allows me to support and counsel. (p. 4 lines 62 69)

The challenges faced by principals were also evident in Mr Den's comments:

> Also, there is the issue of confidentiality. We have teachers dragging their legs, taking advantage of their sickness; then you feel undermined. If you speak to them, anyhow, they feel segregated or stigmatised. They have no strength and/or energy to work and their performance deteriorates. As a manager, I am forced to express empathy or sympathy. You start considering how you should talk to that person because you are aware of his/her situation. Work and other duties are not equally distributed and it affects the leadership and management of the school. (p. 4 lines 48-55)
> After submitting results, teachers start behaving in a manner of taking advantage. When I reprimand them especially our work relationship gets sour. I'm forced to sympathise. Teachers expect that I must understand because I know about their HIV status. So they expect me to consider that when I address them. Their sickness contributes to absenteeism for, sometimes, I am forced not to question. Some naturally react naturally to the nurturing environment. Therefore, their reaction shows that they are aware that they are at work. Some are influenced by friends, who tell them that, because they have HIV/AIDS, they

> must not worry about their duties because it is known that they are sick. Some are instinct to stigma and trauma. (p. 6-7 lines 115-123)

These comments also show that principals are sometimes compelled to adjust their planning strategies to accommodate the impact of HIV/AIDS, as was explained by Mrs Louw:

> I had a meeting... meetings, rather, with the school management team to come up with a programme so that the teaching and learning timetable is not disturbed. Yes, teachers are sick and they need to seek medical attention when they are not well. But the learners need to learn and the vision and mission of the school need to be adhered to. We came up with a relief programme that has, so far, been running smoothly. Teachers grumble, especially when the sick teachers are absent; they feel they have to be granted off days as well. It leaves me in dilemma. Above all, it's difficult to replace teachers; you can never get the same teachers. (p. 3-4 lines 50-58)
> HIV/AIDS campaigns have been held and cannot address such sensitive issues in public. People are in denial. I can only support teachers who have come open and told me about their status. The Department is doing a lot in relation to support. Teachers receive counselling free of charge. Support can be provided to those who indicate that they need it. (p. 4 lines 68-72)

All the principal participants reported the feelings of disillusionment with regard to dealing with HIV/AIDS-related issues amongst teachers. They also shared experiences that spoke to the challenges that affected teachers living with HIV/AIDS. The combined collective narrative revealed a connection that teachers living with HIV/AIDS shared based on a mutual understanding of the challenges of living with HIV/AIDS. The comments made within this theme highlighted concerns regarding how teachers living with HIV/AIDS were coping in the school workplace. This was a key feature of the combined collective narrative.

### 4.5.5 Theme 6: Persistent Absenteeism

In this combined collective narrative, principal participants were in agreement that persistent absenteeism by teachers living with HIV/AIDS was a serious problem in schools. Their comments highlighted that HIV/AIDS led to high levels of teacher absenteeism, which led to low levels of productivity. Mrs Louw shared the following observations in this regard:

> The school cannot run smoothly when teachers are sick. Around 2009, we lost a teacher. He was very sick. He was in and out of hospital for a long time. Sometimes, when he came to work, he would not be well and he would leave early. He got sick that it was full-blown AIDS. (p. 2 lines 10-13)
> Really, teaching and learning has been affected and is being affected. When he could not make it, then I would ask other teachers to stand in for him. And sometimes, even when he was here at work, he could not teach. I did ask the departmental head to make arrangements so that teaching and learning continues. Unfortunately, such arrangements overloaded other teachers, who have not planned for the disturbances. Even right now, teachers are not well and we have two who have been in and out of hospital. When I was still looking for a replacement of the late teacher, another teacher was getting worse and worse. She was always coughing – so much such that she could not do her work. She was losing weight a lot. She did her work but I could see that she was getting weaker. Eventually, she passed away. (p. 2-3 lines 25-35)

When teachers living with HIV/AIDS become ill, learning is affected because learners are often left unattended without consistent teaching, as was evident in the following remarks made by Mr Den:

> We are talking about many diseases that attack the normal functionality of the body. So it's true and, immediately when someone is infected, staying away from work is frequent. HIV/AIDS has become a bad resemblance to society. Long absence is as rampant as teachers need to seek medical attention or they are too weak to work. Obviously, the normal functioning of the boy is affected as well as the school system. Sometimes we have to seek replacement. Other teachers have resigned because of HIV/AIDS. We have no right to discriminate and so what we can do is get a temporary teacher until teachers who are sick pass on or resign. There is nothing we can do. Others go for counselling and rehabilitation. Others are afraid to take medication in front of society and, when they do, it interferes with work. This is a specialised institution and it takes a lot of time to capacitate the new teachers. We held several workshops to develop teachers in different disabilities. So when we hire that temporary teacher who is not qualified to teach learners with disability, it impacts negatively as well as disadvantaging learners. There is nothing we can do but to keep on bringing new teachers for development of our learners. We have a whole school plan that runs for three years and the plan addresses nine performance areas. Teacher development is one of the areas and has some financial implications. When running teacher education and/or development programmes, you do not achieve if a teacher is absent during the course of development. One who takes over won't catch up for it affects the next three-year plan. Development won't carry on because of HIV/AIDS. The whole school management structure is affected, for instance, departmental heads that monitor the curriculum. Teacher absenteeism derails processes of development and it impacts negatively on the mobility of development. (p. 2-3 lines 23-48)

Principals repeatedly raised the issue of frequent teacher absenteeism as a result of prolonged illness:

> Teachers living with HIV/AIDS have disrupted teaching and learning here. During the last periods of infection, teachers take errands to see doctors until everything stabilises, then attendance improves. I have encouraged teachers to apply for medical aid for it is very important. It helps when people consult and buy medicine. Teacher absenteeism has carried on for a long time and, due to the advent of antiretroviral treatment, everything has stabilised. However, we have had teachers who were very sick and fragile to work so much such that they had to resign. It was too late for interventions like ARVs. Teacher absenteeism disrupts teaching and learning. (Mr Mokena p. 2 lines 8-17)

Also, Mr Sebeko highlighted the problem of teacher absenteeism as follows:

> I do query the frequent absenteeism and I approach individual teachers to find out what is troubling them. Mostly, I get the response, "I am not well". I have no choice but respect that I do not need to be involved in people's private matters. Therefore, I keep a distance and watch from far. (p. 2 lines 13-16)
> Currently, there is not much disturbance in teaching for learning caused by the two [HIV-positive teachers]. They are performing well; they report absenteeism and they even arrange for colleagues to stand in for them when they are away. This is exactly what I asked from them when they disclosed. I have tried to avoid a repeat of that late teacher. (p. 4 lines 61-64)

Mr White also shared his thoughts on the matter:

> But it does not mean learners are not affected because they would have missed lessons. Mostly, teachers do not finish the syllabi. It has become a trend that, every month, like, for instance, with the other teachers, they are absent in the first week. Probably, they are taking medicine. I have heard from friends that the teachers will be collecting their medication. They would say that, "Mr or Ms So-and-So are taking medication". (p. 2 lines 18-24)

Mrs Pule also asserted that teachers living with HIV/AIDS were frequently absent from work:

> Teachers absent themselves from work to seek medical attention and it disrupts teaching and learning. Other teachers have to stand in for absent teachers. I make a follow up on teachers who are sick. They do not disclose, although they bear the symptoms of HIV/AIDS. One of my teachers used to throw temper tantrums. She was very emotional and always absent. It was difficult for all staff members. She did not do her duties effectively. (p. 2 lines 13-18)

On the same note, Mrs Motsepe shared the following sentiments:

> Teacher absenteeism has always impacted badly on the smooth running of the school. For teaching and learning to take place normally, absent teachers need to be replaced. Those teachers who replace absent teachers would do not teach the way the responsible teachers would teach. Relief teachers would not plan for what to teach to the absent teachers' classes due to short notice. (p. 2 lines 10-15)

Mr Muloyi also shared his experiences with regard to teacher absenteeism:

> Teachers show all the symptoms of HIV/AIDS. They do not disclose. They are always affected by opportunistic diseases and they are always absent. Teaching and learning has been affected to a large extent. (p. 2 lines 23-25)
> The goals of the school are underachieved. Absent teachers have their classes and subjects taught by other teachers and it imposes a burden on teachers who stand in for their sick colleagues. You will find it is very difficult for effective teaching and learning to take place when other teachers are absent. It poses a decline on learner achievement. Everyone is affected and the whole system is disrupted. So I get caught up in a dilemma whereby sometimes I have to allow time off so as to protect the sick teachers. It causes clicks amongst teachers and disharmony. But I feel that, if teachers could disclose, they will get help. Rather, they are silent and some even miss medical routines because they feel bad about causing disharmony in the school. Otherwise, disclosure remains a big challenge. I feel as if I am not doing enough when other teachers grumble that I have a soft spot for sick teachers. But these teachers need medical attention because of opportunistic diseases. Their absenteeism affects teaching and learning for it reduces the functionality of the whole school. (p. 2-4 lines 28-51)

The above comments show that absenteeism of teachers disrupted the smooth running of schools. Nonetheless, teachers living with HIV/AIDS were not prepared to disclose their HIV status. They were not prepared to take responsibility for disclosing even though they knew that they were sick. This was also reflected in the following sentiments, shared by Mr Ntolela:

> It is difficult a lot. Absenteeism is rise amongst teachers affected and infected. I have had teachers absenting themselves for days and coming to work for few days and it has become a trend. We have teachers who absent themselves for weeks sometimes. In particular, I have a teacher who always complains of a variety of conditions. He has shingles; some sores that go round his body and I am made to understand that, if the shingles (which go in a circular manner) meet or come back to the point where they started, it means death. This teacher has been complaining for a long time now. (p. 2 lines 17-30)
> In other instances, teachers who are sick attend one week in one week out and, according to the department's policy, I cannot substitute. Teachers who are always absent do not finish the syllabi even when they are present and they are too weak to work. They do not give work and they do not mark. They cannot

> keep momentum in the learners and learners are affected. Teachers cannot keep their momentum also and learners lose interest. In such instances, I ask other teachers to step in. The situation becomes very difficult because these teachers have their own classes. It is always difficult to get a teacher with the necessary skills; it is not easy. It burdens other teachers as well as me. (p. 3 lines 40-49)

It is evident that learners lost momentum when teachers were continuously absent from work. When learners lose momentum, their learning is not effective. Mr Dube shared the following observation in this regard:

> My particular experience as a head of the school is that we have experienced a high rate of absenteeism due to this illness HIV/AIDS and, as a result, learners were deprived opportunity of teaching and learning, since most of or some of staff was suffering from this disease. So it has affected even our nonteaching staff and at the end of the day it challenged our vision and mission of the school because, at the end of the day, we cannot attain the aims and goals of the organisation if people are working ill. It brought about fear to both teachers and learners. (p. 3 lines 8-54)

### 4.5.6 Theme 7: Normalising and Legitimising Suffering

The participants in this study frequently described the experience suffering and distress associated with living with HIV/AIDS. Indeed, as the teachers mentioned in the above theme, they were part of a cultural group who had suffered great emotional distress. Unfortunately, many of the teachers endured much of their suffering alone because the stigma attached to HIV/AIDS made them too afraid to seek help. However, when the teachers were engaged and asked to tell their stories, they were able to reinterpret their suffering through the lens of a collective story. Below are comments from the teachers.

Mrs Mabona:

> I have attended workshops on HIV/AIDS awareness and acquired some knowledge through literature on HIV/AIDS. HIV/AIDS is a challenge in relation to the demands for eating healthy, taking medication every day and facing stigma and discrimination. (p. 1 lines 1-4)
> I was sick on and off, suffering from different diseases until I was advised by my general practitioner that I should go for various tests of which I did and that's when I knew. I received counselling before and after testing. (p. 2 lines 29-31)
> Since the advent of HIV/AIDS, the workforce has been affected and so is

everyone else. There are times when I feel that I'm not strong enough to work. I'm not as strong as I used to be. (p. 5 lines 86-88)

Mrs Ninga:

There was a time I could see that, although people sympathised with me, they looked at me with fear and they were so overwhelmed. I wasn't sure of myself and asked the principal about retiring and he advised me to soldier on. (p. 3 lines 35-37)

Mrs Mehlo:

Management cannot sit with us and talk and come up with some strategies. Rather, everything is a gossip and people like me are in the receiving end. I don't think our principal is in a position to entertain such issues. (p. 5 lines 55-57)

Mr Machalaga:

Like I said earlier on, I really suffered at work and I'm still suffering. But I would regard myself as lucky enough to get the support that I got from my family. It was good support. I never experience much stigma in the community because, you know, once you fail to get support from your family, you get stigmatised and it might affect you; it can traumatise you a lot. But, anyway, the main support comes from the family, although I expected it from my workplace. (p. 10 lines 219-224)

Ms Rakani:

There are people living with HIV/AIDS here. They are in the same predicament like me. Some I have heard, but some I know. We have lost more than two teachers due to HIV/AIDS. (p. 3 lines 28-30)

Mr Nkosi:

You know people are very speculative. Losing weight was one of my biggest challenges. I could see all the symptoms and signs on me. I was touched by one of the testimonies given by an HIV-positive woman on AIDS day. I started reading about the disease. (p. 3 lines 48-52)
But I tell you I once counselled others. We had a very sick colleague and he confided in me. He fell very sick and died when I was trying to make him test and take medication. (p. 4 lines 56-58)
I'm aware of my rights as a person with this status. I have the right to work and no one can discriminate against my status. (p. 4 lines 64-65)

This narrative revealed that, through reading this collective narrative, the teachers living with HIV/AIDS came to understand that they were not the only ones suffering from the disease and that HIV/AIDS is not necessarily as death sentence, as many of them had originally believed. This suggests it could be helpful to in normalising the experience of psychological and emotional distress and reassuring people living with HIV/AIDS that the emotions they are feeling are normal. In addition, it could convince people that seeking help does not have to ruin their reputations or social identities as human beings, who have the right to life. Reading this collective narrative may facilitate the realisation that there are other teachers living with HIV/AIDS, who know their rights and are not afraid to seek support. This could give teachers the courage to reach out for support without fear of ruining their self-concepts, self-images and self-efficacy.

## 4.6 Concluding Thoughts

This chapter presented data in the form of two thematic collective narratives compiled from the individual narratives of 1) teachers living with HIV/AIDS and 2) principals with teachers living with HIV/AIDS on their staff. The two thematic collective narratives were joined to form a combined narrative that highlighted some similarities and differences between the responses of teachers living with HIV/AIDS and those of the principals. Both the teacher and principal participants repeatedly stated that teachers living with HIV/AIDS were faced with the dilemma of disclosure as well as with stigmatisation and discrimination.

The comments made by the principals showed that they experienced significant challenges in leading and managing schools will chronically ill teachers, who were constantly absent from work. The teachers, meanwhile, felt that they were being isolated and, as a result, strived to normalise and legitimise their suffering. In addition, teachers expected principals to support and tolerate their situation. The principals did not mind this except that they felt that teachers living with HIV/AIDS were not taking responsibility for disclosing their status.

Finally, teachers living with HIV/AIDS felt accepted in their support groups and amongst people who gave them support. Principals also made efforts to create environments in which teachers living with HIV/AIDS felt accepted and like they belonged.

In the following chapter, theory will be applied to the interpretation of these themes.

# CHAPTER FIVE

## Data Interpretation and Discussion

### 5.1 Introduction

This chapter contains a discussion of the significant themes relevant to the research question: “How do principals understand and respond to their leadership roles in the handling of sensitive issues arising from HIV/AIDS amongst teachers in schools in the Gauteng Province?” The words of teacher and principal participants are quoted verbatim and referenced using page and line numbers. Eight themes have been constructed from the data analysis and are interpreted with reference to relevant theories and the literature. Data themes are discussed and contextualised in relation to the literature, as discussed in Chapter Two, as well as additional theory identified during the empirical data analysis. The eight themes are as follows:

- School leadership challenges;
- Leadership role reflections;
- Continuous absenteeism;
- Problems of disclosing;
- Stigma and discrimination;
- Challenges faced by teachers living with HIV/AIDS;
- Support and acceptance.

A brief summary of the categorised themes and sub themes is given in the Table 24 below:

**Table 24: Summary of the Main Themes and Sub-Themes**

| MAIN THEMES | SUB-THEMES |
|---|---|

| MAIN THEMES | SUB-THEMES |
|---|---|
| 1. School leadership challenges | ➢ HIV/AIDS causes management problems.<br>➢ It causes disruption of teaching and learning.<br>➢ There is inadequate professional development of school leadership.<br>➢ There are problems relating to the sensitivity of HIV/AIDS-related issues. |
| 2. Leadership role reflections | ➢ HIV/AIDS issues complicate school leadership.<br>➢ Principals are expected to model effective leadership.<br>➢ Schools are centres of community life.<br>➢ Teachers look up to principals. |
| 3. Continuous absenteeism | ➢ Teachers are hard to replace.<br>➢ Absenteeism causes conflicts amongst teachers.<br>➢ Absenteeism disrupts teaching and learning. |
| 4. Problems of disclosing | ➢ HIV/AIDS-related stigma keeps people from disclosing.<br>➢ Some teachers have disclosed their status. |
| 5. Stigma and discrimination | ➢ Physical symptoms caused people living with HIV/AIDS to experience stigmatisation and discrimination.<br>➢ Stigma and discrimination emanate from misconceptions about the causes of HIV/AIDS. |
| 6. Teachers' expectations of principals | ➢ They expect care and support from their principals.<br>➢ They view their principals as role models.<br>➢ They expect principals to lower their workloads. |
| 7. Challenges faced by teachers | ➢ Social death is a common reality.<br>➢ Sick teachers receive inadequate care and support. |
| 8. Support and acceptance | ➢ The Gauteng Department of Education offers support programmes.<br>➢ Principals are considered to be accountable and responsible.<br>➢ Principals are prepared to go the extra mile. |

Bass (1991: 27) maintains the following:

> Transformational leaders inspire, energise and intellectually stimulate their employees [...] Through training, managers can learn the techniques and obtain the qualities they need to become.

As discussed in Chapter Two, this research study is framed by two theories, namely transformational leadership and ethics of care. The transformational leadership approach is appropriate because of its normative style, which capitalises on a series of methods that view subordinates as major contributors to organisational success (Bush and Middlewood, 2005: 11). Transformational leadership encourages leaders to instil a collective vision based on the assumption that subordinates follow leaders who inspire them and that leaders care about their subordinates, always injecting enthusiasm and energy into their interactions (Holly *et al.*, 2010: 134). Ethics of care emphasises that caring relations are fundamental to human existence and consciousness (Noddings, 2009: 9). As such, caring ought to be a principle on which to base ethical decisions because caring is a fundamental need in the lives of human beings (Noddings, 2009; Tronto, 2010; Ruddick, 2009; and Capuzzi and Stauffer, 2012). I have interpreted the data within the eight themes through these lenses of transformational leadership and ethics of care, as discussed next.

## 5.2 School Leadership Challenges

To begin with, transformational leadership intellectually stimulates subordinates, encouraging them to gradually acquire innovative ways of viewing problems (Holly *et al.*, 2010: 134; Bass, 1991: 21). In this context, Koggel and Orme (2010: 10) submit that the ethics of care theory stresses the importance of context, interdependence and caring relationships. Consequently, other scholars have emphasised that, as school leaders, principals have an obligation to accept the challenge of HIV/AIDS and manage it with the same responsibility and devotion as they manage other areas of school life (Calitz *et al.,* 2002: 149, in Mfusi and Steyn, 2012: 13). In this study, the principal participants described experiencing a number of challenges because of teachers living with HIV/AIDS. They admitted that they often felt confused, disillusioned and, in some instances, manipulated. This shows that there is need for

fundamental organisational change, which requires school leaders who are systematically focused and committed to developing leadership skills amongst their teachers. The following sub-themes were created from the data; they address these challenges faced by principals.

### 5.2.1 HIV/AIDS Causes Management Problems

Transformational leadership is underpinned by various components, which include intellectual stimulation, individual consideration, inspirational motivation and role identification in addressing challenges (Bass, 1991: 23). This view is corroborated by Bush (2012b: 9), who argues that people-orientated forms of leadership are the ideal. Along the same lines, Koggel and Orme (2010: 11) remark that ethics of care is a normative ethical theory about what makes actions right or wrong.

In the data in question, most principals agreed that management of the schools was greatly affected by teachers living with HIV/AIDS. The authority of principals was questioned on many occasions because they were expected to tolerate the behaviour of teachers living with HIV/AIDS. This was highlighted by one of the principals:

> Leadership and management are affected even worse. I am forced to tolerate what's taking place. Once I do that with one person and others are watching, they will come and expect me to give them the same tolerance. Therefore, it shakes authority as a leader [if] you tolerate this and not that. I cannot be expected to tolerate cases that are not the same. A teacher with HIV needs to be tolerated more than a person who has some other issues. (Mr Ntolela p. 57 lines 50-55)

Furthermore, Mrs Pule explained that:

> It was so bad and I did not know how to deal with the situation. I was blackmailed; I was emotionally unstable. This is a sensitive matter to deal with, I am not a counsellor. The teacher's absenteeism got worse; other teachers complained I could see that she was in a difficult situation and charging her was going to be inhuman. (p. 59 lines 24-27)

De Bruyn (2009: 3) is just one of many theorists who stress that there has been evidence of a shift in the role of the school principals from the traditional organising,

planning, leading and control function to a more caring and supportive role. Bialobrzeska *et al.* (2010: 1) add that school leadership in South African schools has become increasingly complex because of HIV/AIDS. In this regard, Nitsch (2006: 2) argues that the field of school leadership has been influenced by the nature of HIV/AIDS. As it is, principals have a number of sophisticated educational policies to implement. The additional roles that they must play due to the HIV/AIDS pandemic leave them overburdened with responsibilities and unable to focus on the visions and missions of their schools.

The transformational leadership approach advocates influencing and persuading people (Bass and Bass, 2008: xvii) and also promotes the communication of organisational goals and sharing common visions. This is based on the contention that communication helps to build up relationships:

> The ethics of care starts from the premise that as humans we are inherently relational, responsive beings and the human condition is one of connectedness or interdependence. (Gilligan: 2011: 1)

Sonnenfeld (1995: 72) asserts that leaders who apply intellectual stimulation are able to show their followers new ways of looking at problems. The HIV/AIDS pandemic has presented devastating challenges to school principals, who have been confronted with a growing number of HIV-positive teachers on daily basis (Rajagopaul, 2008: 116). As the HIV/AIDS pandemic approaches its fourth decade, it continues to cause havoc, leaving principals struggling even more to cope with the situation, as explained by the participants:

> After the workshop, one of my teachers was referred to the District wellness programme. However, after this programme, the teacher still expected sympathy and his conduct was not appropriate. (Mr Sebeko p. 41: lines 49-51)
> In effect his behaviour came as a wakeup call for me and the school management team. I mean, we did not expect such kind of behaviour from him because colleagues had expressed sympathy. (Mr Sebeko p. 41 lines 55-59)

According to Bennett, Crawford and Cartwright (2003: 7), the most important feature of transformational leadership is that it motivates subordinates to strive for greater levels of personal commitment and enhances their capacity to accomplish their goals. The ethics of care theory emphasises caring relations that would enable

people from diversified cultures to live together peacefully (Held, 2006: 10). The literature states that management of resources in the schools becomes disputed as school principals have to resort to crisis management (Buchel and Hoberg, 2007: 3).

Several scholars, such as Mahabeer (2008: 137), recommend that school principals need to influence teachers to take initiative and contribute to decision making, goal setting, and the development of new skills and competencies in order to improve the whole school programme. It appears, therefore, that the whole school programme is compromised when the atmosphere is filled with sadness, depression, loneliness, anxiety and the tendency to withdraw amongst teachers affected by or infected with HIV/AIDS (Mahabeer, 2008: 119). The data reflect that principals must resolve disputes on serious matters:

> We had also an incident whereby teachers and support staff were teasing one another that one was fat because of ARVs and the other one counteracted that one was thin because he was about to die of AIDS. You are dying soon. (Mr Dube, p. 58 lines103-106)

HIV/AIDS amongst teachers derails the goals of school improvement and causes management problems, as indicated in the following statement by Principal Motsepe:

> As a result, he was exempted from some of his duties like extra-curricular activities. He was very weak to work. The thought of death affected the whole school morale. Everyone in the school was afraid of looking at him, especially during the last stages of his illness. (Mrs Motsepe, p. 53 lines 34-37)

Mr Den also shared his views in this regard:

> Work and other duties are not equally distributed and it affects the leadership and management of the school. After submitting results, teachers start behaving in a manner of taking advantage. When I reprimand them especially our work relationship gets sour. I'm forced to sympathise. Teachers expect that I must understand because I know about their HIV status. So they expect me to consider that when I address them. Their sickness contributes to absenteeism for, sometimes, I am forced not to question. Some naturally react naturally to the nurturing environment. Therefore, their reaction shows that they are aware that they are at work. Some are influenced by friends, who tell them that, because they have HIV/AIDS, they must not worry about their duties because it is known that they are sick. Some are instinct to stigma and trauma. (p. 61 lines 115-123)

It can therefore be concluded that the HIV/AIDS pandemic has caused significant disruption to long-term plans in schools and has subsequently hindered the proper management of schools.

### 5.2.2 Disruption of Teaching and Learning

As noted earlier, curriculum disruption is high up on the list of school leadership challenges. Literature reveals that people who are living with HIV/AIDS can continue working for many years. However, once they succumb to the disease, their immune systems cannot fight off opportunistic illnesses such as TB and they begin to be absent from work for both short and longer periods of time (Shisana *et al.*, 2010: 2). Even when these teachers are able to come to work, they are often unable to adequately perform their teaching duties. Increased workload, loss of skilled and experienced teachers, overcrowded classes, and learner adjustment problems are just some of the effects of HIV/AIDS (Shisana *et al.*, 2010: 2). The Department of Education (South Africa. 2003: 5) contends that teachers living with HIV/AIDS are increasing in numbers and that teachers are concerned about how the disease is going to impact on their lives and work. The disruption of teaching and learning was something that was frequently mentioned by the principal participants in this study:

> Teachers, who are the main drivers in the provision of quality education, have badly been affected; some of the expertise that is lost [and it] is irreplaceable. For instance, in South Africa, scarce skills like mathematics and science teachers are not enough. Teachers lose weight and their productivity deteriorates. (Mr Muloyi, p. 57-58 lines 15-23)

> It is difficult though to get someone who fits in the position and function exactly the way the sick teacher was working. It is even worse if that teacher teaches more than two subjects; an exact substitute is difficult to find. (Mr Ntolela, p. 44 lines 34-37)

It is therefore evident that the quality of education is compromised when teachers are sick as sick teachers cannot perform at optimum levels. Furthermore, Noddings (1984: 69) emphasises the importance of consistent efforts to respond to the needs expressed by the teachers by discussing the moral and social issues affecting them.

School leaders continue to endure problems related to the disruption of curricula. Indeed, a number of researchers agree that HIV/AIDS undermines the education system and the staff turnover of teachers is accelerating, which places immeasurable strain on school leadership (UNAIDS, 2009; Buchel and Hoberg, 2007; Hewu-Banjwa, 2012; Marneweck *et al.*, 2008). One principal described a particular experience in relation to this issue:

> The teacher drank excessively and did not teach effectively even when he could. He would lie about being to the hospital because he could not produce any medical certificates. He went to an extent of asking for some money from the learners for not submitting tasks or for marks. Whenever we asked him why he was doing all these things, he would simply answer that everyone knows that he was sick and he was waiting for his day. Instead he blamed HIV/AIDS than taking responsibility for his wrong behaviour. I was so frustrated. Teaching and learning was disrupted and the teacher carried on with his habits of dishonesty. I was so frustrated. (Mr Sebeko, p. 60 lines 46-47)

Thus, it is evident that effective teaching and learning is affected tremendously when teachers are sick, which, in turn, impacts negatively on school leadership. This is where the transformational leadership approach becomes useful. The transformational leadership approach encourages interaction amongst colleagues, with leaders considering their subordinates' welfare (Bass, 1991: 21). In this context, Tronto (2010: 17) recommends that all human beings need care at all times. The literature shows that teacher attrition caused by HIV/AIDS leads to the deterioration of the education system, which is already under severe stress as a result of a compromised human resource base, larger teacher-student ratios, loss of trained and experienced teachers, growth in the demand for staff health benefits, and intensified pressure on training colleges to meet the increased demand for newly qualified teachers.

As discussed, the research participants revealed that some teachers who were living with HIV/AIDS passed away during their tenure:

> He lost weight and he was so thin that everyone could see that he had developed full-blown AIDS. He was staying in an upmarket suburb and lived the fast-lane life. When he passed away, I sent a delegation to represent us. (Mrs Motsepe, p. 53-54 lines 37-44)
> I visited him and he disclosed his status to me. His health had extremely deteriorated and he died the following day. (Mr Dube, p. 49 lines97-99)

These responses show that a number of teachers have died due to HIV/AIDS whilst they were employed at the sampled schools. Amid teacher attrition and mortality, school principals have been referred to as torch-bearers of change in education as well as major community role players (Begley, 2010: 31). It is argued in the literature that, even before teachers develop full-blown AIDS, emotional distress hinders their productivity (Theron, 2008: 9). Also, Buchel and Hoberg (2007: 18) declare that the HIV/AIDS epidemic is not only worsening the teacher shortage but also affects the remaining teachers' ability to teach. The Human Science Research Council (2005) contends that the major contributory factor to the shortfall of teachers is mortality because of HIV/AIDS. This constrains effective teaching and learning.

This disruption of teaching and learning was frequently discussed in the participant interviews, with one respondent arguing that the "absence of one teacher affects the whole" (Mr Mokena p. 73 lines 49-50) and that "teaching and learning is affected" (*ibid*. p. 37 line 18). The findings of the literature consulted are in line with another principal's assertion that, "above all, it is difficult to replace teachers, and you can never get the same teachers" (Mrs Louw, p. 62 lines 1-14).

Principals continued to describe teacher attrition and mortality:

> Other teachers have resigned because of HIV/AIDS. We have no right to discriminate and so what we can do is get a temporary teacher until teachers who are sick pass on or resign. There is nothing we can do. (Mr Den, p. 63 lines 28-31)

Principal participants also maintained that replacing teachers was a challenge:

> When I was still looking for replacement of the late teacher, another teacher's health was deteriorating. She was always coughing – so much such that she could not do her work. She was losing weight a lot. She did her work but I could see that she was getting weaker. Eventually, she passed away. (Mrs Louw, p. 63 lines 31-35)

Therefore, when teachers are sick, teaching and learning is disrupted to a large extent. Furthermore, Bass (1991: 23) emphasises that transformational leaders initiate interaction channels amongst their followers and they do so in consideration of their welfare. Added to this, the ethics of care theory holds that if people are

morally obligated to treat others with care and that empathy is an important feature of moral life (Siegel, 2009: 215). The ineffectiveness of teachers living with HIV/AIDS is frequently referred to in the literature. For instance, it is suggested that, although teachers continue to attend classes before the onset of AIDS, their knowledge of their HIV status causes severe emotional distress, which causes adverse behavioural changes that carry over to the classroom (Theron, 2008: 9). This was also evidenced in the participant interviews:

> We are talking about many diseases that attack the normal functionality of the body. So it's true and, immediately when someone is infected, staying away from work is frequent. HIV/AIDS has become a bad resemblance to society. Long absence is as rampant as teachers need to seek medical attention or they are too weak to work. Obviously, the normal functioning of the body is affected as well as the school system. Sometimes we have to seek replacement. Other teachers have resigned because of HIV/AIDS. We have no right to discriminate and so what we can do is get a temporary teacher until teachers who are sick pass on or resign. There is nothing we can do. Others go for counselling and rehabilitation. Others are afraid to take medication in front of society and, when they do, it interferes with work. This is a specialised institution and it takes a lot of time to capacitate the new teachers. We held several workshops to develop teachers in different disabilities. So when we hire that temporary teacher who is not qualified to teach learners with disability, it impacts negatively as well as disadvantaging learners. There is nothing we can do but to keep on bringing new teachers for development of our learners. We have a whole school plan that runs for three years and the plan addresses nine performance areas. Teacher development is one of the areas and has some financial implications. When running teacher education and/or development programmes, you do not achieve if a teacher is absent during the course of development. (Mr Den p. 2-3 lines 23-48)One who takes over won't catch up for it affects the next three-year plan. Development won't carry on because of HIV/AIDS. The whole school management structure is affected, for instance, departmental heads that monitor the curriculum. Teacher absenteeism derails processes of development and it impacts negatively on the mobility of development. (Mr Den p. 2-3 lines 23-48)

One of the teacher participants added to this discussion:

> Since the advent of HIV/AIDS, the workforce has been affected and so is everyone else; there are times when I feel that I'm not strong enough to work; I'm not as strong as I used to be. (Mrs Mabona, p. 33 lines 86-88)

Clearly, the number of teachers living with HIV/AIDS is escalating, with more and more teachers frequently absenting themselves from work. New and inexperienced teachers are hired in place of teachers on sick leave and other teachers are overburdened by this situation.

### 5.2.3 Inadequate Professional Development for School Leadership

As observed by Bass (1991: 19), transformational leadership can be learned and creativity and innovation need to be nurtured. Similarly, Slote (2009: 226) argues that:

> It is after all, and a bit mysterious that when we feel another's pain we frequently are moved to help the other rather than to run away and try to forget about their pain.

Other scholars argue that principals do not receive sufficient support or training to cope with the problems they face (Buchel and Hoberg, 2007: 18; Aggleton, Yankah and Crewe., 2011: 495). In the interviews, not one principal participant indicated that there have been opportunities for professional development meant to improve their ability to respond to HIV/AIDS. Most of the principals indicated that, although they faced challenges because of their incapacity to handle HIV/AIDS-related issues amongst their teachers, they were prepared to support their teachers.

This commitment to support teachers was highlighted by Principal Mokena:

> We are not supported. A support programme is launched and, soon after taking off from the ground, it disappears, only resurfacing after, say, four years. So teachers are not supported in terms of health. This is a very sensitive epidemic that needs a lot of support. My duties limit me from, say, going deeper into the issues, even with the teachers who have disclosed because I am not an expert in this field of health. (Mr Mokena p. 60-61 lines 84-88)
> My line of duty limits me from directly referring a teacher upon suspicion that the person needs help in line with HIV/AIDS. The jurisdiction allows me to support and counsel. (Mr Mokena p. 61 lines 67-69)

It is evident that principals are not adequately trained to deal with the challenges of HIV/AIDS amongst their teachers, especially in light of the sensitive nature of these issues.

The literature confirms that principals do not receive sufficient support or training to cope with problems they face (Aggleton, Yankah and Crewe, 2011: 495 and Buchel and Hoberg, 2007). The Bureau for Economic Research and the South African

Business Coalition of HIV/AIDS (2003: 13) conclude that HIV/AIDS not only infiltrates an organisation's physical well-being; it also affects the organisational psyche as the most complicated epidemic with which organisations must deal. Principals' lack of knowledge is highlighted in the following sentiments:

> As a school principal, you hear that one school has lost seven teachers. You start worrying that maybe one day it will be my school. (Mr Dube p. 58 lines 46-47)
> I have realised that to be a school principal nowadays is not about academic staff; it involves being a counsellor, social worker and psychologist. To capacitate myself I decided to register for psychology, which helps me to understand the minds of people and other issues. (Mr Dube, p. 58 lines 144-148)

In this context, Bialobrzeska *et al.* (2010: 1) argue that, while a number of school leaders have been able to respond to the needs of learners, there is not much evidence that schools have been equally responsive to teachers' needs. Mahabeer (2008: 138), in this regard, proposes that knowledge of psychological issues is needed in order to devise strategies that facilitate the handling of HIV/AIDS.

One of the interviewed principals shared the following experience in this regard:

> One of the teachers fell sick and everyone suspected HIV/AIDS according to the physical symptoms that he resembled. He would always sit in his [classroom] and he would isolate himself. He became very arrogant and he did not want to talk to anyone. He would swear at anyone who looked at him and he showed a lot of anger. Learners would ridicule him. They would laugh at him and call him names. Some teachers spared their time to chat with him and the rest were afraid. As a result, he would fall asleep in his classroom. (Mrs Motsepe, p. 48 lines 23-29)

Aggleton *et al.* (2011: 495) also stress that there is a lack of support for principals:

> The absence or uneven distribution of clear policy frameworks and guidelines, the absence of HIV programmes from most schools and education sector plans, yearly action plans and education budgets are a challenge.

Moreover, there is evidence of disharmony and principals do not feel supported, as discussed by numerous participants:

> There is no support. We have committees like the HIV/AIDS but they are only for events like AIDS day celebrations. The school based support team supports learners and not teachers. (Mr White p. 59 lines 33-34)

> Teachers grumble, especially when the sick teachers are absent; they feel they have to be granted off-days as well. It leaves me in a dilemma. (Mrs Louw, p. 62 lines 55-57)
>
> There are no support structures and resources to support; for example, workshop training on HIV/AIDS. Principals need to be supported. (Mr Sebeko, p. 60 lines 113-117)
>
> [The HIV-positive teacher] could not effectively do his duties. As a result, he was exempted from some of his duties like extra-curricular activities. He was very weak to work. The thought of death affected the whole school morale. Everyone in the school was afraid of looking at him, especially during the last stages of his illness.

Although school policies protect affected and infected teachers, they are silent about school leaders, who bear the responsibility of caring for these teachers.

School leaders face difficulties when there is no support for the implementation of necessary policies. According to Bush (2008: 64), transformational leadership has been suggested as the ideal – a powerful type of leadership for transforming a rapidly challenging environment. The transformational leadership model is developmental and seeks to involve every individual in the organisation.

It is against this background that ethics of care scholars are guided by the need to create conditions in which caring for others can thrive. Despite this, many scholars attest to the lack of training available for principals to develop a caring leadership style:

> The leadership in South African schools consists of men and women who moved through the ranks of being a teacher, a head of department, deputy principal and then principal. There are no formal training programmes for school participants in leadership and management. Often good classroom teachers become school principals without having the necessary skills and knowledge to lead and manage people. (Van der Vyer, van der Westhuizen & Meyer, 2014: 62)

It is patently evident that leadership and management in schools are, to a large extent, affected by HIV/AIDS amongst teachers. Principals, as leaders, bear the burden of supporting teachers living with HIV/AIDS and the absence of support programmes and structures makes principals feel overwhelmed by the increased workload that this entails.

### 5.2.4 Problems related to the Sensitive Nature of HIV/AIDS-related issues

It is widely argued that transformational leaders are charismatic visionaries who can influence subordinates to transcend their own self-interests in exchange of the good of the organisation (McLennan, 2000; Bush *et al.*, 2010; Bass, 1991; Grossman and Valinga, 2009, in Crigger and Godfrey, 2011; and Nwagbara, 2011). In addition, social power, identity, relationships, and interdependency are the unique features of the ethics of care theory (Sander-Staudt, 2011: 9) and principals are able to empower their teachers (Mahabeer, 2011: 92).

The literature stresses that HIV/AIDS is an emotional issue, whether principals are dealing with an infected or an affected workforce (Bureau of Economic Research and The South African Business Coalition on HIV/AIDS, 2003). Accordingly, it was highlighted throughout the data that HIV/AIDS-related issues are extremely sensitive:

> The issues of HIV/AIDS are protected by law and it is not possible for me to ask. About four teachers have disclosed and I always advise teachers to focus on their business. I know such issues can land me in jail. I can be sued. It is a very sensitive matter. Sometimes, when assemblies are longer, teachers that have been pointed at have a pattern of leaving before the end of the assembly. They will be going to take their medication. I cannot confront them because I can see they are sick and I have been informed by people close to them. (Mr White, p. 59 lines 25-31)

Further, Mr Den (p. 61 lines 48-53) explained that:

> Also, there is the issue of confidentiality. We have teachers dragging their legs, taking advantage of their sickness; then you feel undermined. If you speak to them they feel segregated for being stigmatised. They have no strength and/or energy to work and their performance deteriorates. As a manager, I am forced to express empathy and sympathy. You start considering how you should talk to that person because you are aware of his/her situation.

Principals should exercise influence as opposed to authority, especially when dealing with sensitive issues such as those related to HIV/AIDS. The sensitive nature of HIV/AIDS-related issues necessitates individual-oriented leadership approaches.

According to Bass (1991: 25), transformational leaders show individualised consideration to their followers by giving them personal attention. By the same token, the ethics of care theory advocates emotional engagement with other people as individuals when assisting them, which involves thinking about what is good for them instead of merely following rules prescribing what ought to be done (Slote, 2009: 211). Bennell (2009: 2) supports the view that the sensitive nature of HIV/AIDS-related issues requires principals to resort to holistic approaches.

The literature reveals that, once teachers know that they are HIV-positive, they lose a significant amount of confidence and their emotional development suffers (Mfusi and Steyn, 2010: 13). The following sentiments came from the teacher participants:

> Yes, it's a challenge. This is very sensitive. We should not be scared to approach them. I think clarity is lacking. Intervention strategies are provided to people who have disclosed now let's say right now I don't know whether I can trust someone else. (Mr Machalaga, p. 26 lines 335-337)

> It is a very sensitive thing and it is not an open discussion topic. It is an each man for himself and God for us all situations. (Mrs Mehlo, p. 11 lines 1-2)

> Managing HIV/AIDS in my school is challenging because most educators do not know their status, they are afraid of being tested. The sensitivity around HIV/AIDS makes it difficult for management to discuss about it. It has forever been difficult to deal with it. (Mrs Mhlanga, p. 9 lines 19-22)

One of the principals pointed out the following:

> HIV/AIDS is known as a disease of the wrong-doers. It has been known to be associated with sleeping around with different partners and, mostly, fast-lane lifestyle. Families have been known to disown their members who would have disclosed their status. They will be regarded as failures. People are afraid of losing family members and being disowned at work. For example, a cabinet minister is caught exceeding the speed limit while drunk. It is a disgrace to the people, the government and his/her family. So teachers would rather hide their status than be seen as a disgrace. (Mrs Pule, p. 53 lines 59-66)

This response draws attention to the underlying factors that contribute to the sensitive nature of HIV/AIDS-related issues. Similarly, Mrs Motsepe remarked:

> And [back] then there were not ARVs, which have recently been discovered. [Back] then, society believed that the causes of HIV/AIDS were related to lifestyle. Thus, when he fell sick, people judged him according to the life he lived.

> The situation was very bad. It disharmonised the school. The teacher was engulfed by anger and fear of death and he did not get enough support. (p. 54 lines 50-54)

Teachers living with HIV/AIDS face ever greater challenges as a result of the pandemic. HIV/AIDS also affects the families of infected people as well as other people around them. This means that teachers need a space in which they feel at ease to discuss the most delicate issues with their principals.

Many scholars discuss how it feels to live with HIV/AIDS. Moreover, the Education and Training Unit (2007: 21) contends that the discovery that someone is HIV-positive can pose a huge shock to their family and the school where they teach, which leads to emotional deterioration and physical suffering. The Bureau for Economic Research and the Business Coalition on HIV/AIDS (2003: 3) supports this view:

> The pure nature of HIV/AIDS introduces a cluster of complexities that require proper analyses and planning in ensuring successful roll out. HIV/AIDS takes on many different forms and it requires sensitivity and diplomacy. People tend to close up when entering discussions involving issues of gender, race and sexuality in the workplace.

In keeping with this, one principal (Mr Muloyi, p. 58 lines 39-42) expressed the following opinion:

> The determination of duty in relation to conservative ethics commits teachers to come to work when they are sick. Their guilt feeling incline them to pretend to be strong. A lot has to be done to harmonise the school.

The response depicts the intensity of the sensitivity of HIV/AIDS-related issues. In this context, the principal Mrs Louw (p. 49 lines 43-44) cautioned that “you cannot show that you suspect because this is a very sensitive disease. Much as it is sensitive; it is confidential”. HIV/AIDS is a management area that is surrounded by sensitivity and confidentiality.

Therefore, it is ideal that principals use approaches that are grounded in moral foundations as well as where teachers are informed of the goals of the school.

## 5.3 Leadership Role Reflections

### 5.3.1 HIV/AIDS-Related Issues complicate School Leadership

According to Shamir and Howel (1999: 280):

> Followers are more likely to comply with the charismatic leader if they have a collective rather than an individualistic orientation if they have an expressive rather than an instrumental orientation to work life, if they have principled rather than pragmatic orientation towards the leader and if the leader appeals to the susceptible followers' values and identities.

On the same note, Noddings (2003: 19) asserts that it is a threatening experience when people who need care are treated as though they do not exist. As Bush (2012b: 9) remarks:

> The increasing range of complexity of leadership and management responsibilities in schools and colleges means that it is no longer possible, if it was, for the principals to be sole leaders.

Moreover, it has become clear that HIV/AIDS amongst teachers has caused widespread uncertainty amongst school leadership. School principals are realising their new roles in the face of various unprecedented challenges. Good leadership is indispensable to dealing with HIV/AIDS-related issues amongst teachers living with HIV/AIDS effectively.

This change in leadership roles is vital in the context of HIV/AIDS, which requires a shift away from traditional approaches. The principal participants indicated that they were aware of their roles with regard to teachers living with HIV/AIDS in their jurisdiction. Mr Ntolela (p. 69 lines 99-102), for example, stressed the following:

> It is good when principals are placed on a pedestal. They have to act accordingly; they have to act it. They do not have to abdicate the responsibility to themselves. It enhances [their] position as principal; it educates people to trust. If I do not act, people get disappointed.

Mr Ntolela's comment shows that teachers look up to principals and that this places certain responsibilities on principals. In addition, Bush (2007: 11) assert that "leaders are expected to ground their actions in clear personal and professional values".

School principals are assigned the task of handling sensitive issues, including HIV/AIDS amongst their teachers. Evidence from research conducted by numerous scholars – including Marneweck *et al.*(2008); Mortimore (1993); Townsend (2001); Heneveld and Craig (1996); Sammons, Hillman and Mortimore*,* (1995); Scheerens (2000); and (Bialobrzeska *et al.*, 2010)– has revealed that school principals play a crucial role in the successful development of the schools they lead. The principals interviewed indicated that they were aware that, as leaders, they were expected to give direction to communities, schools, and society at large. However, they also complained about the pressure that this places on them. One principal expressed the following sentiments:

> Society ascribes roles to us, even in health. Society assumes that teachers are good. It has made the teachers to be secretive so as to keep the good image. As role models, they are put in a situation whereby they are regarded as pure, healthy or innocent. They are custodians of knowledge for they are leaders. For example, it will be awkward to see teachers selling vegetables; society has its own expectations from teachers. It would not be appropriate for teachers to come out about their HIV status. (Mr Muloyi, p. 68 lines 100-106)

The expectations placed on teachers by society increase their feelings of inferiority when they discover that they have HIV/AIDS. This negative impact on teachers impedes their ability to fulfil meaningful roles in education.

### 5.3.2 Principals are expected to model Effective Leadership

Proponents of the transformational leadership approach have come up with a list of actions that are invaluable to school principals in dealing effectively with their subordinates: the cultivation of charisma/ inspiration/ vision, the development of goal consensus, and the provision of intellectual stimulation (Leithwood *et al.*, 1996: 32).

Noddings (1984: 5) suggests that, when we care for other people, we consider their points of view, needs and expectations. The literature indicates that leaders need to consider the entire spectrum of their subordinates' lives, including their physical wellbeing, and emotional and intellectual development (Bureau for Economic Research and South African Business Coalition on HIV/AIDS, 2003: 21). In their

responses, principals indicated that they were aware that they were regarded as role models, as Mr Sebeko (p. 68 lines 100-110) commented:

> Yes, I have felt the extra load but it is very difficult to pull away. I am prepared to go an extra mile, although the government does not pay for that. We need to go out of our way. Just last week, our life orientation teacher stopped a suicide attempt by one of our female students living with HIV/AIDS. Society perceives principals as having answers to the HIV/AIDS issues. I know there are responsibilities laid on principals because of their role model status. We cannot retreat but, rather, take advantage of their positions and bring stakeholders together so as to improve dissemination of information. Different parties need to communicate so as to conquer the war on HIV/AIDS. Leadership is very important in influencing people to understand HIV/AIDS issues. People need to be given knowledge.

In the above comments, there is evidence of the principal's commitment to take on his status as a role model. Principals feel overwhelmed by their increased responsibilities but acknowledge that they cannot avoid them. As the literature reveals, apart from modelling effective leadership behaviour for teachers, principals must motivate their school communities to stay abreast of the changes brought about by HIV/AIDS (Rayners, 2007: 159). Principals can influence and inspire teachers to focus on common goals (Cunningham and Cordeiro, 2009: 6 and Rath and Conchie, 2008: 45). Specific forms of behaviour proposed by Conger and Kanungo 1987: 638 in Rayners (2007: 51) are described below:

> Enthusiastically advocating an appealing vision that is acceptable to the followers; making self-sacrifices and risking personal loss of status, money or organisational membership in pursuit of the espoused vision; and acting in unconventional ways to achieve espoused vision.

In this study, principals described increases in their workloads due to the existence of HIV/AIDS amongst their teachers, as commented on by Mrs Motsepe (p. 69 lines 91-94):

> I am prepared to take extra load of my demanding job to help teachers with their personal problems. They look up to me, I know, but then if they do not disclose; then how they can get help. They choose to keep quiet until they die. I even approach them personally to no avail.

Mrs Motsepe's statements indicate that principals are willing to take on the necessary extra duties and feel betrayed when teachers whom they have supported

fail to take full responsibility by disclosing their status. The point being highlighted here is that, although teachers look up to principals, they do not take the responsibility to disclose their HIV status.

The literature on the subject repeatedly asserts that, as school leaders, principals have an obligation to accept the challenge of HIV/AIDS and manage it with the same responsibility and devotion as they manage other areas of school life (Mfusi and Steyn, 2012: 3). Bush (1998, in Mahabeer, 2008: 6) expands on this concept:

> Good leadership and management in education is displayed by someone who is oriented, a problem solver, manages conflicts is flexible, practical and motivational, who delegates responsibilities as a way of empowering staff and who improves efficiency in an organisation.

In this context, one of the principal participants gave the following explanation,

> I have the responsibility of protecting teachers but I cannot explain why to other school management team members and teachers. Sometimes they query, "why I should protect absent teachers?", but [I] still handle the issue so that both parties calm down. I even protect teachers who have not disclosed to me because I know how they feel. Those extra duties are part of my responsibilities. Everything starts with me and ends with me, as a leader. I am the only person who has the prerogative to support and encourage. I have to help teachers to do their work effectively. (Mr White, p. 70 lines 80-87)

Mr White's comments portray an empathic and caring attitude toward teachers living with HIV/AIDS. The principal has a responsibility to protect teachers and cannot discuss the issues openly, regardless of whether or not teachers disclose their status.

### 5.3.3 Schools as Centres of Community Life

School principals have been referred to as torch bearers for change in education as well as major community role players (Begley, 2010: 31). The ethics of care theory speaks to the primal human fears regarding oppression and abandonment, stressing that human beings need care for survival. The transformational leadership approach maintains that the ability of leaders to change followers depends, for instance, on the

acceptability of the leader's own behaviour as well as their ability to stimulate their followers intellectually. Gilligan (2011: 23) elaborates:

> The most important thing about ethics of care; morality is grounded in a psychological logic, reflecting the ways in which we experience ourselves in relation to others and that the origins of morality lie in human relationships as they give rise to concerns about injustice and carelessness.

A number of scholars argue that principals are in a position to empower their teachers (Mahabeer, 2011: 92) and Van der Vyver, Van der Westhuizen, and Meyer, (2014: 63) suggest that school leadership and management ought to be supportive, rather than dictatorial. The data revealed that teachers look up to principals, whose duty it is to support their subordinates. Mr Mokena (p.70 lines 89-92) declared the following:

> Yes, my duties incline me to counsel, support and advise. I have known teachers get some sigh of relief after they disclose to me. Teachers look up to me. I have not disappointed; I have been always available. I have led health discussions, which have led to the acquiring of first aid kit boxes to help in case of injuries.

The data clearly indicate that principals believe that they must be there for their teachers, as Mr Den (p. 70-71 lines 124-132) elaborated:

> It is proper that way. Those are good qualities of leadership. Subordinates should not be afraid to come to you. They must not ask themselves questions about you. That will inform how colleagues interact with you about their health. If you are open to teachers, they should not be afraid of saying what they want. Anybody expects answers if they have questions. I cannot be in a position to provide answers for every question but what I do about their expectations matters the most. I am not a god and therefore cannot provide everything. Making them aware that I cannot do this but that informs them the extent I can go. I get them information so as to earn continued trust.

The above comments show principals' acceptance of their leadership roles. However, they also reveal that there are limits to how much support a principal can provide. The government policies clearly advocate inclusivity as well as care and support for teachers living with HIV/AIDS (South Africa. Department of Education, 2003b: 5). This is in line with the ethics of care approach, as discussed by Held (2006: 10):

> The central focus on the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility.

Principals responsibilities include offering individualised support, modelling best practices and important organisational values, demonstrating high performance expectations, creating a productive school culture, and developing structures to foster participation in school decisions (Bush, 2007: 11). Principals are expected to provide quality education despite absent, sick and demotivated teachers. Moreover, although principals are not experts on health issues, teachers expect them to provide solutions to their problems, as indicated by Mrs Louw (p. 71 lines 109-115):

> Yes, teachers look up to me. Although I am not an expert in health issues, I apply my basic knowledge. I delegate teachers according to their strengths. We have done very well in supporting the sick, even in times when they are admitted in hospital. I cannot avoid that duty of advising and supporting. My duties are overlapping as compared to what principals used to do. I have to do that so that teachers can be able to perform their duties. If I take a back seat then the unity falls apart.

Van Dyk (2012: 465) describes the best approach to HIV/AIDS-related issues in the workplace as follows:

> Effective management of AIDS in the workplace requires an integrated strategy that is based on an understanding and assessment of the impact of AIDS on the specific workplace.

School leaders need to possess some knowledge in HIV/AIDS so that they are able to help their teachers. The principals also indicated, however, that teachers need to take responsibility for their health and lifestyle choices, as the government has played its part:

> The government of South Africa has played its part. There have been rigorous campaigns to inform people about HIV/AIDS. A number of awareness campaigns have been followed by a lot of support at grassroots level. The government has offered support like free circumcision, which is aimed at reducing the spread of HIV/AIDS. It will be improper to expect more than what the government has offered. For instance, the Department of Education has provided support to the extent of [teachers] being exempted from their duties because they are living with HIV/AIDS. Teachers must try their best; they must take full responsibility of their health. (Ms Pule p. 40 lines 39-47)
>
> I do not mind that pastoral duty for the teachers because it is part of my job description. But I do not have to mother the teachers. I do not have to care for

> teachers at work. I cannot lower their duties because they are sick. They must be productive; they cannot expect other teachers to work for them. (Mrs Pule, p. 40 lines 55-58)

The above sentiments reveal a longstanding trend of time of asking the teachers living with HIV/AIDS to realise that they have a role to play and cannot simply expect principals' to solve their problems.

### 5.3.4 Teachers look up to Principals

Marneweck *et al.* (2008: 10) argue that schools are regarded as focal points of community life and can make great contributions to the fight against HIV/AIDS as a matter of urgency through the structures in the education system. As (Nathan 2000: 98) asserts, "[principals] have the responsibility for all members in the organisation that is teachers, learners and non-teaching staff". The following relevant comments came from one of the principal participants;

> Principals and managers are not from heaven. They are just human beings who have been entrusted with responsibilities to manage and lead institutions. We are human beings and we know that communities look at us as custodians and ambassadors of knowledge about HIV/AIDS. It places measurable amount of pressure on us as leaders to ensure that we give direction to communities, to the schools and society at large. We are really ambassadors, for instance, Mr Zuma has played an important role as far as antiretroviral tablets are concerned, conversely to what he has been ridiculed about HIV/AIDS, when he said people must wash with showers for them not be infected by HIV, which was really disgusting. So, as a leader, you should not do like what our president did. On the [one] hand, he is doing this and, on the other hand, [he] is doing that, so you lose people's confidence and credibility. We must be leaders of substance and people must look upon us as people who are custodians of and ambassadors of HIV/AIDS. (Mr Dube p. 69 lines 181-194)

The above statement highlights that, while principals know what is expected of them by the teachers living with HIV/AIDS, they are against the common perception of them as messiah-like figures who can solve all problems.

According to the literature, transformational leadership involves behaviours that indicate principals' expectations of excellence, quality, and high performance on the part of followers (Podsakoff *et al.*, 1990: 18). In addition, Bush (2012b: 9) highlights

that there is a greater probability that teachers will commit themselves if they feel valued by their principals.

All the principals' indicated that they were placed on pedestals and had enormous responsibilities with regard to teachers living with HIV/AIDS. They were certain that dealing with HIV/AIDS-related issues amongst teachers was affecting education in an unprecedented manner. Nonetheless, the principals were quite adamant that their roles in supporting the schools vision and mission would not change. According to Mortimore (1993: 7) and Sammons, Hillman and Mortimore, (1995: 14), principals are the major players in enabling school effectiveness as well as setting the school tone and working climate.

## 5.4 Continuous Absenteeism

### 5.4.1 Teachers are Hard to Replace

Burns (1978: 2) insists that transformational leadership can influence processes amongst peers and between supervisors and subordinates. Burns adds that the outcome is performance growth, raised levels of change, and development. In this regard, Noddings (1984: 19) remarks that motivation in caring must be directed towards the protection, enhancement and welfare of the cared-for. Bush (2007: 9) observes that the existence of several different perspectives creates "conceptual pluralism: a jangling discord of multiple voices". As the data reflect, teacher absenteeism is rife. The following principal participant made an interesting point in relation to teacher absenteeism:

> Teacher absenteeism has always impacted badly on the smooth running of the school. For teaching and learning to take place normally, absent teachers need to be replaced. Those teachers who replace absent teachers would do not teach the way the responsible teachers would teach. Relief teachers would not plan for what to teach to the absent teachers' classes due to short notice. (Mrs Motsepe p. 65-66 lines 10-15)

Clearly, the teaching and learning programme is disrupted and this creates serious problems for principals, who are accountable for both success and failure. It is vital

patently obvious that teachers who are continuously absent cannot cover their curricula.

Other scholars, such as Bialobrzeska *et al.* (2009: 21), argue that the effects of HIV/AIDS are not only experienced by the infected person but also by his/her family, friends, and the community at large, which further exacerbates the problem. Also, it has widely been noted that teachers are absent from work when they are sick (Mampane, 2011: 16). Once they succumb to the disease, their immune systems cannot fight off numerous opportunistic illnesses and they begin to be absent from work for both short and longer periods of time (Shisana *et al.*, 2010: 2). One of the principal participants expressed his frustrations as follows:

> It is difficult a lot. Absenteeism is rife amongst teachers affected and infected. I have had teachers absenting themselves for days and coming to work for few days and it has become a trend. We have teachers who absent themselves for weeks sometimes. In particular, I have a teacher who always complains of a variety of conditions. He has shingles; some sores that go round his body and I am made to understand that, if the shingles (which go in a circular manner) meet or come back to the point where they started, it means death. This teacher has been complaining for a long time now. In other instances, teachers who are sick attend one week in one week out and, according to the department's policy, I cannot substitute. Teachers who are always absent do not finish the syllabi even when they are present and they are too weak to work. They do not give work and they do not mark. They cannot keep momentum in the learners and learners are affected. Teachers cannot keep their momentum also and learners lose interest. In such instances, I ask other teachers to step in. The situation becomes very difficult because these teachers have their own classes. It is always difficult to get a teacher with the necessary skills; it is not easy. It burdens other teachers as well as me. (Mr Ntolela, p. 66-67 lines 40-49)

The above observations sum up the problems endured by principals amid continuous teacher absenteeism. This results in poor learner achievement. While the level of absenteeism increases among teachers living with HIV/AIDS, the quality of instructional effectiveness decreases. Disruption of the teaching and learning programme consequently leads to poor academic achievement.

### 5.4.2 Absenteeism causes Conflicts amongst Teachers

It has also been noted in the literature that the infected teachers' morale deteriorates, their ability to self-actualise fades away, and they may develop negative attitudes to life (Van Dyk, 2012: 464). Further literature reveals that teachers may be required to teach in subject areas in which they are not specialised in place of sick or dead colleagues (Kelly, 2008: 9). Furthermore, teachers who are overloaded with their colleagues' teaching areas may be extremely stressed and may feel discouraged (Avert, 2012: 46; South Africa. Department of Education, 2003a: 5). Principals in this study revealed that teachers living with HIV/AIDS are continuously absent from work. Consider, for instance, this excerpt from the interviews with Mr Den (p. 63 lines 23-24):

> We are talking about many diseases that attack the normal functionality of the body. So it's true and, immediately when someone is infected, staying away from work is frequent.

This response reflects some of the numerous challenges that are encountered by school leadership due to teacher absenteeism. The above data indicate that some teachers resign and some pass away because of HIV/AIDS. This is corroborated by Principal Louw's (p. 62 lines 56-58) comments:

> Teachers grumble, especially when the sick teachers are absent; they feel they have to be granted off days as well. It leaves me in dilemma. Above all, it's difficult to replace teachers; you can never get the same teacher.

Other teachers complain when they are asked to take over classes of their sick colleagues. They feel that they also have the right to take days off like their sick colleagues. Consequently, the effectiveness of teachers is compromised by periods of illness and absenteeism.

Mahabeer (2008: 131) suggests that the quality of teaching and learning is retarded through loss of experienced teachers, high teacher-pupil ratios and little or no motivation and support for teachers. The prosperity of an organisation depends on the wellbeing of its people, which is ensured through measures such as successful

HIV/AIDS management programmes (Grobler *et al.*, 2002: 14). Without this, there will be a drastic decrease in quality of education.

Mention was made in the data that teachers living with HIV/AIDS have disrupted teaching and learning and that this has been going on for a long time:

> Teachers living with HIV/AIDS have disrupted teaching and learning here. During the last periods of infection, teachers take errands to see doctors until everything stabilises, then attendance improves. I have encouraged teachers to apply for medical aid for it is very important. It helps when people consult and buy medicine. Teacher absenteeism has carried on for a long time and, due to the advent of antiretroviral treatment, everything has stabilised. However, we have had teachers who were very sick and fragile to work so much such that they had to resign. It was too late for interventions like ARVs. Teacher absenteeism disrupts teaching and learning. (Mr Mokena, p. 64 lines 8-17)

Teachers living with HIV/AIDS cannot avoid absenteeism as it is reflected in the data they have to go for check-ups and collect medication. Another principal shared similar sentiments:

> But it does not mean learners are not affected because they would have missed lessons. Mostly, teachers do not finish the syllabi. It has become a trend that every month, for instance, with the other teachers, they are absent in the first week. (Mr White, p. 65 lines 18-21)

Certainly principals are faced with serious managerial problems, which affect their ability to lead and cause a great deal of stress.

### 5.4.3 Absenteeism disrupts Teaching and Learning

It is argued in the literature that teachers are vulnerable to HIV/AIDS and they have been shut off because, instead of being supported, they are expected to educate the community on the mitigation of HIV/AIDS (Kelly, 2008: 9; Rehle and Shisana, 2005: v). Literature supports this view and outlines that, before teachers develop full-blown AIDS, they may only be absent from work every now and then and principals may not realise the intensity of the problems they are faced with. (Sherman *et al.*, 2013: 16). Principal participants repeatedly aired their views about the persistent absenteeism of teachers:

> Teachers absent themselves from work to seek medical attention and it disrupts teaching and learning. Other teachers have to stand in for absent teachers. I make a follow up on teachers who are sick. They do not disclose, although they bear the symptoms of HIV/AIDS. One of my teachers used to throw temper tantrums. She was very emotional and always absent. It was difficult for all staff members. She did not do her duties effectively. Teachers living with HIV/AIDS do not disclose, although they bear the symptoms of HIV/AIDS. (Ms Pule, p. 65 lines 13-16)

Absenteeism prevents teachers living with HIV/AIDS from functioning optimally.

It is stressed in the literature that it is not only South African teachers who are affected. James-Traore *et al.* (2009: 11) reveal that in “Zambia for instance, the Minister of Education trains 2 000 teachers each year while annual losses from all mortality average is around 1000 per year”. Evidence from research carried out by the HSRC in (2008: 3) shows that HIV/AIDS has become a menace to school functioning. A high rate of absenteeism has been felt because of HIV/AIDS. As Van Dyk (2012: 464) emphasises, there is “low staff morale with employees resenting taking on refusing to take on additional responsibility for colleagues who are sick”

After one of their colleagues died of HIV/AIDS, two teachers disclosed their HIV status to their principal, Mr Sebeko:

> I do query the frequent absenteeism and I approach individual teachers to find out what is troubling them. Mostly, I get the response, "I am not well". I have no choice but respect that I do not need to be involved in people’s private matters. Therefore, I keep a distance and watch from far. (p. 64-65 lines 13-16)
> Currently, there is not much disturbance in teaching for learning caused by the two [HIV-positive teachers]. They are performing well; they report absenteeism and they even arrange for colleagues to stand in for them when they are away. This is exactly what I asked from them when they disclosed. I have tried to avoid a repeat of that late teacher. (p. 64-65 lines 61-64)

It is also mentioned in the data that absenteeism has caused staff factions and disharmony:

> They are always affected by opportunistic diseases and they are always absent. Teaching and learning has been affected to a large extent. The goals of the school are underachieved. Absent teachers have their classes and subjects taught by other teachers and it imposes a burden on teachers who stand in for their sick colleagues. You will find it is very difficult for effective teaching and

> learning to take place when other teachers are absent. It poses a decline on learner achievement. (Mr Muloyi, p. 66 lines 23-32)

Learners have been deprived of proper teaching:

> My particular experience as a head of the school is that we have experienced a high rate of absenteeism due to this illness, HIV/AIDS and, as a result, learners were deprived opportunity of teaching and learning, since most of or some of staff was suffering from this disease. So it has affected even our nonteaching staff and at the end of the day it challenged our vision and mission of the school because, at the end of the day, we cannot attain the aims and goals of the organisation if people are working ill. It brought about fear to both teachers and learners. (Mr Dube, p. 67 lines 48-54)

It was commonly stated in the data that absenteeism is high amongst teachers living with HIV/AIDS. As the spread of the pandemic escalates, more and more teachers contract the disease, resulting in illness and death. This has challenged long- and short-term goals that cannot be achieved whilst large numbers of teachers are frequently absent.

The transformational leadership approach is holistic because of its normative style, which capitalises on a series of methods that leaders can implement to influence school results for the better (Bush and Middlewood, 2005: 5, 11).

Transformational leadership is based on a leader's ability to communicate a shared vision and to motivate followers to engage in behaviour that helps the organisation to reach that vision (Schaubroeck, Cha and Lam, 2007: 10).

## 5.5 Problems of Disclosing

### 5.5.1 The Stigma of Disclosing

Burns (1978: 12) shares the following on transformational leadership:

> At the core of the formulation of transformational leadership is the concept of transformation, a change with variation in performance, productivity and management that brings about break from the norm as well as marked departure from existing leadership structure.

The transformational leadership theory, teamed with the ethics of care approach, could yield results in circumstances where people have lost hope due to the effects of HIV/AIDS. In their empirical studies, Leithwood *et al.* (2009: 59) have clearly shown that the redistribution of leadership responsibilities has improved impact on school effectiveness, development and outcomes. The possible value of the transformational leadership approach to handling HIV/AIDS lies mainly in its emphasis on involving everyone in the organisation. The majority of teacher and principal participants expressed that it was difficult for teachers living with HIV/AIDS to disclose their status. Mr Sebeko shared the following comments,

> Our teaching staffs have really been affected. However, disclosing is a stigma. Teachers have always indicated that they are not well and you can see by the rate they lose weight and sometimes hospitalised. Surprisingly, they sometimes recover miraculously. But others do not gain complete body recovery. Although the physical symptoms incline someone to suspect HIV/AIDS, you just respect their decision not to disclose. (p. 47 lines 7-12)

Mr Sebeko continued:

> He did not disclosure to me. I think because I could not offer the sympathy not to work with he was looking for. When he was still fit, he did not commit himself to his job. He was always bunking classes and kept management on their toes until he was very sick and died. My efforts to get teachers to disclose have been fruitless. (p. 47 lines 52-55)

It is extremely difficult for teachers to disclose their HIV status and their failure to disclose stands in the way of them forming caring relationships with their principals. In addition, Brundrett (1998: 75) suggests that transformational leadership assumes that decisions are reached by consensus and problems are solved by agreement. The ethics of care theory emphasises natural caring that requires no moral effort on the part of those who are caring because they are genuinely moved by the needs of the cared-for (Siegel, 2009: 215). In keeping with this, Mbonu *et al.* (2009: 11) and UNAIDS (2007: 9) agree that it is difficult for people living with HIV/AIDS to disclose their status when they live in fear of stigmatisation and discrimination. Teacher participants confirmed that disclosing at work was not easy, let alone approaching the principal. For instance, Mrs Mhlanga (p.19 lines 26-30) described the following experiences:

> Several times I thought and decided to disclose my status but I keep on postponing. I can't face him. I feel it's too personal and more of my life. I don't think he has time for that.

The following response from one of the teacher participants, Mrs Mehlo, describes similar experiences:

> It's not easy to disclose at work. The principal is the worst of all. I would rather tell the other staff members than her. She is not approachable and it is difficult to predict her mood. (p. 20 lines 22-24)
> I am too scared to let the District know for I think I may lose my job. (p. 20 lines 33)
> You start thinking about how people are going to react towards me if I disclose my status. I cannot trust people especially my colleagues. (p. 20 lines 60-63)
> I never wanted to tell anyone. I started feeling insecure. I couldn't understand myself. I didn't know how to disclose to my children, siblings, parents and colleagues. I felt as if it was full-blown AIDS. I could feel as if everyone was looking at me and knew my status. I was always suspicious. (p. 17 lines 27-30)

These comments indicate that teachers living with HIV/AIDS find it difficult to disclose their status. Stigma and discrimination are strongly connected to secrecy and denial and transmission will continue unabated if the silence is not lifted.

Rayners (2007: 129) asserts that transformational leaders employ idealised influence, inspirational motivation, intellectual stimulation, and individualised consideration so as to attain greater levels of achievement. Through interaction and observation, principals can thus identify their subordinates needs (Noddings, 1984: 11 and Noddings, 2003: 1). These findings are confirmed in the literature:

> Whatever their survival strategies, decisions about whether or not to disclose their status, when and to whom, will be central concerns. (Bond, 2010: 41)

The sensitivity surrounding HIV/AIDS makes it difficult for people to disclose their status. One of the principal participants, Mr Muloyi (p. 46 lines 26-28), expressed the following sentiments:

> As I have said, teachers do not disclose. They always pretend to be strong when they are not. It is unfortunate that some of them have resorted to excessive drinking, maybe to ease their stress.

Another principal, Mr Ntolela, made the following powerful assertions:

> I do not remember a teacher disclosing their status to me. I have never seen one. In actual fact, I can see that some teachers are sick and I am afraid I cannot diagnose. The symptoms clearly point to HIV/AIDS. (p. 47 lines 14-16)
> This is very sensitive information that I cannot reveal. I cannot talk about their illness. It is my responsibility to keep their information. I need to respect their integrity. I am aware that I can be sued for divulging such information. Leadership needs to be trained and be aware about the seriousness of HIV/AIDS. Experiences deter teachers from disclosing. The sick teachers need counselling so that they can be educated to reveal to the principal as a representative of the employer, which is the Gauteng Department of Education. (p. 47 lines 81-87)

Doyal and Doyal (2013: 41) offer the following explanation with regard to disclosure:

> Some may disclose immediately, usually to family members and sometimes to partners. Others may focus their efforts on keeping their status secret. The factors influencing these choices will be varied and will change over time as 'cost benefit' calculations and states of health shift.

On a more fundamental level, the literature reveals that teachers may feel engulfed by sense of shame for having contracted HIV (Mampane, 2011: 16). Aggleton *et al.* (2011: 495) make the following elaboration:

> Because the stigma associated with HIV is so strong, teachers may be afraid to talk about it for fear of themselves being stigmatised by people and the whole community for knowing too much about stigma that is difficult to talk about, sensitive and taboo.

In line with this, Mr Machalaga, one of the teacher participants, stressed that teachers' fear of what will happen when they disclose is immense:

> Uncertainty, fear of disclosure and the likes; maybe it depends on to how you relate to your colleagues and principal in terms of sharing information and then maybe also it might happen that after sharing information they will gossip or discriminate against you. (p. 16 lines 126-129)

These comments reveal the difficulty – emanating from, among other things, fear of stigmatisation and discrimination – that teachers experience in disclosing their status. One of the principals, Mr White (p. 52 lines 76-79), described the situation in his school:

> You tell one person that you are living with HIV/AIDS and they circulate the matter around the school. Being so protected information, it goes viral the moment people know. Such behaviour deters other teachers from disclosing.

Further, as reflected in the data, Mrs Motsepe stressed that teachers are not willing to disclose their HIV status:

> Teachers have disclosed for example operations and depressions but they do not disclose their HIV status. Sometimes you can see that they are not well. If they do not want to disclose, I cannot force them. (p. 48 lines 17-19)

Teachers also pretend not to be seriously ill when they are. One of the teacher participants (Mrs Mabona, p. 17 lines 12-16; 70-74) expressed difficulty in disclosing but said that she "ended up gaining guts to approach the principal" because she had to justify her absence from work.

Accordingly, Doyal and Doyal (2013: 41) offer the following remarks:

> Since many of those [...] will be diagnosed (if at all) when their disease is already well advanced, they may have little time to mend the emotional and psychological tears in the fabric of their lives or to come to terms with their situation.

The same findings are reflected in the Technical Assistance Guidelines (2003: 3):

> Fear of infection and death may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are sick, not fully functional or away from work. This could lead to low staff morale.

In the data, one of the principal participants added her voice to the chorus of principals lamenting the fact that teachers often do not disclose their status and that, when they do, the matter is not open for discussion (when, for instance, colleagues have to stand in for sick teachers):

> Also, the coughing was severe. I did understand even her pretence to be well, because I assume she was desperate to keep her job. Yes, you can see by the way they are losing weight and the symptoms could be those of HIV/AIDS. They have not said anything to me. You cannot show that you suspect because this is a very sensitive disease. (Mrs Louw, p. 48-49 lines 42-46)

Also, one of the teacher participants, Ms Hlengwe (p. 17 lines 22-23), shared her viewpoint:

> I have done so during my sick leave but it was quite difficult to tell him exactly that I am HIV-positive. I only mentioned that I have tuberculosis (TB).

Doyal and Doyal (2013: 48) indicate that people living with HIV/AIDS conceal their status out of the fear of being judged. This is uniquely expressed by Zhou (2007: 292, in Doyal and Doyal, 2013: 41), who notes that, “if I had cancer I could tell people about that, but if you get AIDS you cannot tell anyone about it. You have to endure it alone".

Mr Den also expressed his concern regarding nondisclosure of HIV status amongst teachers. The fact that Mr Den had to find out about his teachers’ HIV status through records shows how difficult it is for teachers to talk openly about their status:

> I have known about this information through records and behaviour. Sick teachers submit records that are necessary when submitting sick leave forms. (p. 50 lines 92-94)

Mr Machalaga’s statements vividly express the intensity of the fear that people feel about disclosing their status as HIV-positive:

> No, I assumed that through that report and the conversations that we sometimes have like let’s say when I was in the process of applying for medical unfit. Through that conversation I think maybe I needed not to repeat myself to him regarding my status. I was talking to him about how we qualify for medical unfit and things like that. But I did not talk to the principal regarding that and then maybe I should make some follow ups. Well, I intend to sit down with him and talk many things regarding that. Not necessarily my status but other issues so I think I need to sit down with him. (p. 18 lines 110-117)
> I approached a manager not the school head. I wasn’t sure whether to approach the principal himself. Particularly I think maybe – I assumed that the Head knew about that because of the information that I submitted after being absent from work for a long time; the doctors’ reports and sick leave forms that I submitted and the likes. I submitted medical reports. (p. 18 lines 105-106)

The teacher could not confront the principal, turning instead to a departmental head, who would not have been at liberty to discuss the matter with the principal. As in other cases, the teacher avoided direct confrontation by submitting medical reports containing his status instead of informing the principal verbally.

Manley *et al.* (2008: 5) and Bass (1991: 22) assert that the principles of transformational leadership – namely intellectual stimulation and idealised influence – can, when implemented, enhance school leaders' skills while offering better ethical outcomes. The ethics of care approach places emphasis on direct connections with the cared-for and on considering their fears, thoughts and desires. The literature confirms that people living with HIV/AIDS attempt to come to terms with their situation, as with any long-term illness, by attempting to reconstruct their "fractured selves" (Burchardt, 2010: 4). One of the principals shared this experience:

> They do come to my office but, most of the time, they come with their papers and they do declare with their medical certificates and I keep that confidential. Some confide in me and we talk about it and it makes my work easier as I understand their position and how to handle them. I am able to understand their position and know how to handle them and that makes our relationship to improve. (Mr Dube, p. 49 lines 89-93)

The words "relationship to improve" show that, when teachers do not disclose their status, relationships become unpleasant. Thus, Gilligan (2011: 1) asserts the following:

> The ethics of care starts from the premise that as humans we are inherently relational, responsive beings and the human condition is one of connectedness or interdependence.

Similarly, the Prevention, Care and Treatment Access (n.d.: xi) makes the following observation:

> Because of fear of AIDS, people sometimes would rather not know 'denial', due to this lack of knowledge they are sometimes unable to distinguish between the facts and the myths about HIV/AIDS.

Doyal and Doyal (2013: 48) describe the identity crisis suffered by those infected with HIV/AIDS as follows:

> Individuals diagnosed with HIV usually find themselves in a state of extreme "biographical uncertainty" with most reporting shame and despair. It is a time of "threat to the self" where the individual is faced with incorporating the bad identity, which is attached to the disease.

Similarly, Tronto (1993: 8) argues that responsiveness and reciprocity help the one caring to figure out how the cared-for are feeling. The ethics of care approach encourages responsiveness in relationships, which means that carers must pay attention, listen and respond. Bush (2012b: 9) highlights that teachers are more likely to commit themselves to their work if they feel valued by their principals. Another new point in the data was shared by Mrs Ninga (p. 18-19 lines 21-26), who explained that her situation was an open book and everyone could see that she was sick, so she did not have to disclose anything. Ms Rakani (p. 19 lines 60-63), by contrast, felt betrayed by her principal, who shared her status with the entire staff after visiting her in hospital, causing her to suffer the ugliness stigma and discrimination.

### 5.5.2 Some Teachers have disclosed their Status

The transformational leadership approach holds that professionals should be placed on an open platform from which they can contribute to the wider decision-making process (Bush, 2005: 64). According to this view, shared decisions are likely to be better informed and are also much more likely to be implemented effectively. Noddings (2002: 43) assertions are in keeping with this line of thought:

> Ethical caring, the relation in which we do meet the other morally [arises] out of natural caring – that relation in which we respond as one caring – that relation in which we respond as one-caring out of love or natural inclination. The natural caring [is] the human condition that we consciously or unconsciously perceive as good? It is that condition toward which we long and strive and it is our longing for caring – to be in that special relationship – that provides the motivation for us to be moral. We want to be moral in order to remain in the caring relation and to enhance the ideal of ourselves as one-caring.

To put it differently, three principals explained that some of their teachers disclosed their status to them (Mr Sebeko, p. 51 lines 19-30; Mr Mokena, p. 50 lines 27-32; Mr White, p. 51 lines 49-52). Mr Mokena (p. 50 lines 27-32) expressed the following sentiments:

> More than four teachers have disclosed and some date back as far ten years. The reasons of confessing could be that they want me to understand circumstances in which they are living and why they absent themselves from work. Another reason could be that they want to break this to anyone to lessen

> their burden. Also, they are in need of help, for instance, referrals. They want to inform me about the genuineness and reality of their sickness.

It is also worth noting that these principals created situations in which teachers felt comfortable to disclose their status because, for instance (as above), they wanted to inform others about the "genuineness and reality of their sickness". The existence of sound relationships and trust makes it possible for teachers to disclose their status. Another principal stated the following in this regard:

> Two teachers have disclosed their status to me. They explained their conditions in relation to schedules with doctors. The two male teachers approached me on different occasions and I am not sure if they know about one another. Both teachers asked me not to disclose to anyone, even the deputy principal. I have kept the promise. I approach them cautiously with due respect. I offer them necessary protection, for instance, it has happened that, as per protocol, I forgot to inform their HODs until they reported to me. Then I had to simplify the matter; I apologised and explained that I had forgotten. Since day one, I pleaded with them not to disturb teaching/learning. They inform me whenever they have to take days off and they complete leave forms. I do not give them special treatment for they also do not ask for special treatment. (Mr Sebeko p. 51 lines 19-30)

Furthermore, the literature reveals that national and international policies, adopted to protect people living with HIV/AIDS, emphasise voluntary counselling and testing (Sherman *et al.*, 2013: 13). Principals have a part to play in convincing teachers to disclose their status because, as Nitsch (2006: 2) argues, change in deep-rooted behaviour patterns is must take place in order for healing to begin.

As indicated in the literature, school principals are expected to make significant contributions to the eradication of taboos surrounding HIV/AIDS, since educational institutions are regarded as important disseminators of information (South Africa. Department of Education, 2003b: 5). Also, the Education and Training Unit (2007: 10) stresses that the HIV/AIDS epidemic is shrouded in an immense silence and people feel ashamed to talk about it, as it is regarded as scandalous.

Mr Mokena, who has always insisted on valid reasons for absenteeism, had more than four teachers disclose their status to him. His views on the matter are thus worth noting:

> To curb the problem, I have always insisted on daily attendance. Teachers must perform to their maximum. Everyone must play his/her part; the cleaners must clean, the drivers must fetch learners on time and likewise, everyone else. The last thing I want to know is the disruption of the teaching and learning timetable. Therefore, I demand to know the reasons behind the absenteeism. They are aware that I do not condone teachers who buy medical certificates from doctors to justify their sick leaves. I insist on checking teachers' attendance and performance so that teachers living with HIV/AIDS have been left with the only option of disclosing so that I understand the intensity of their problems. (p. 37-38 lines 18-26)

Mr White also had four teachers disclose their status to him and did not hide that he was affected because he did not expect it:

> Four teachers have disclosed; two females and two males. I have been very sympathetic with them. I was also affected because I did not expect it. I provided basic counselling and advised people to eat healthy, go to the gym and be positive about living longer. I have advised them to pray, for I provided comforting words. (p. 3 lines 49-52)

These incidents show that principals possess the ability to create environments in which teachers living with HIV/AIDS can disclose their status. It is possible for principals to rediscover their capacity to lead schools amid the challenges posed by HIV/AIDS. Nevertheless, for the moment, principals are not equipped with training sufficient to deal with HIV/AIDS-related issues properly.

Stigma and Discrimination

### 5.5.3 Physical Symptoms cause People living with HIV/AIDS to experience Stigma and Discrimination

Kouzes and Posner (1995: 8) group the characteristics of transformational leaders into four distinct categories: enabling others to act, modelling the way and encouraging the heart, challenging the process, and inspiring the vision. With transformational leadership, both parties – that is the principals and the teachers – are motivated. Leithwood *et al.* (1996: 52), Bush (2012b: 4) and Bass (1991: 32) maintain that followers need to feel leadership. Leaders' demonstrated professionalism will cause to them be looked up to as examples of what is expected. In this regard, Noddings (1984: 36, in Siegel, 2009: 211) explains that the caring

individual really focuses on another person, not out of self-concern but because they are fully engrossed in the reality of the other. There was evidence in all the participants' (principals and teachers) responses that HIV/AIDS is stigmatised and that those suffering from the disease experience discrimination. Almost all the participants pointed to stigma and discrimination as the reasons why disclosing HIV status is difficult. Ms Hlengwe, a teacher living with HIV/AIDS (p. 24 lines), shared the following experiences:

> Well, I would say discrimination starts at the health facilities. When everyone knows that a certain area or ward is for people living with HIV/AIDS they attach labels. After my illness I was labelled hot plate by people around me.

Revealing similar experiences, one of the principals made the following comments:

> The physical symptoms subject them to stigma and discrimination; people gossip. We have had a practice whereby teachers would organise themselves and visit sick colleagues in hospital or at home. It is during these visits that people diagnose and it has now reached a point whereby people do not want to be visited. They would say that those teachers that have been involved in sexual relations with the sick teachers will also die. They would say a lot of things like, they are sick because they have been sleeping around they blame them for having been infected by HIV. (Mr Muloyi, p. 52-3 lines 81-88)

Clearly, stigma and discrimination are rife in these schools and have increased the problems faced by teachers living with HIV/AIDS.

### 5.5.4 Stigma and Discrimination emanate from Misconceptions about the Causes of HIV/AIDS

On the frequently raised topic of stigma and discrimination, Skinner and Mfecane (2004: 159) make the following point:

> A prime impact of discrimination is that it pushes the epidemic underground, forcing people who have contracted HIV and anything else associated with the disease into hiding.

Skinner and Mfecane (2004: 157) add that "it is well documented that people living with HIV/AIDS experience stigma and discrimination on an on-going basis". Similarly, Mbonu *et al.* (2009: 11) maintain that people living with HIV/AIDS do not only

experience medical problems; they are also faced with social problems constructed around the epidemic. In the interviews, the response of another teacher participant, Ms Rakani, showed that she felt bitter about stigma and discrimination, which is characterised by “misconception”:

> A lot of discrimination and stigma is attached to HIV/AIDS. We are taken to be not capable of performing some duties like sports activities. I am regarded as physically not fit to perform. Sharing the same utensils with other staff members in the staff room has been a problem. Some people still have the notion that the disease is transferrable or rather contagious, which not the case is. (p. 15-16 lines 17-21)
> It is ideal to deal with stigma and discrimination. The misconceptions of HIV/AIDS need to be dealt with so that people can focus on how to deal with HIV/AIDS. Once people know that you are HIV-positive, they look at you as a wrong doer. (p. 15-16 lines 75-77)

Similarly, another principal described how teaching and learning as well as school morale were adversely affected by stigma and discrimination:

> He severely suffered from stigma and discrimination and, [back] then, there were no ARVs, which have recently been discovered. [Back] then, society believed that the causes of HIV/AIDS were related to lifestyles; thus when he fell sick. (Mrs Motsepe, p. 54 lines 49-51)

In keeping with this, De Vries (2009: 10) describes stigma as follows:

> [It is an] attribute that is deeply discrediting that reduces the person from a whole and usual person to a tainted, discounted one.

People in organisations can purposefully or carelessly contribute to the deterioration of other members’ ethical ideals (Noddings, 1984: 5). As Kamau (2012: 1) asserts:

> Stigma and discrimination of people living with HIV/AIDS is exacerbated by ignorance about the disease, misconceptions about how HIV is transmitted, limited access to treatment, responsive media reporting, incurability of the disease and fears and prejudices relating to socially sensitive issues including sexuality.

As reflected in the data, stigma and discrimination are a challenge. One teacher described her situation thus:

> Since then, I have been given names and my colleagues hate me. Due to sensitivity of the issue as well as stigma and discrimination – it is a challenge.

> Other teachers complain when they have to stand in for absent teachers. It is difficult to stop gossiping… What makes it difficult to disclose is stigma and discrimination. (Ms Rakani, p. 15 lines 21-22)

Stigmatisation and discrimination are clearly highly destructive, especially when coming from people close to the victim. Noddings (2002: 1) and Sander-Straudt (2011: 29) argue that caring should happen naturally, based on the natural desire to do good instead of abstract moral reasoning. In light of this it is relevant to consider that immoral behaviour has been assumed as the cause of HIV/AIDS by large sections of society since the disease first emerged (Warwick, 1999 in Parker and Aggleton, 2002: 4). This moral issue is the source of much of the stigma and discrimination surrounding the HIV/AIDS. The moral blame placed on people living with HIV/AIDS and those who are close to them has profound roots in the punishment theory (Van Niekerk and Kopelma, 2005: iii). Erroneous stereotypes (Mahajan *et al.*, 2008: 3) lead to the ostracism of people living with HIV/AIDS. One teacher expressed her frustration in the following words:

> Stigma and discrimination are really destroying. People make you to feel guilty; after the stroke I thought I was not going to make it. My sister instilled a positive mind in me. However, there was a time when I felt like giving up. (Mrs Ninga, p. 15 lines 28-30)

The same view is reflected in the following statement by one of the principals:

> HIV/AIDS is known as a disease of the wrong-doers. It has been known to be associated with sleeping around with different partners and, mostly, fast-lane lifestyle. Families have been known to disown their members who would have disclosed their status. They will be regarded as failures. People are afraid of losing family members and being disowned at work. For example, a cabinet minister is caught exceeding the speed limit while drunk. It is a disgrace to the people, the government and his/her family. So teachers would rather hide their status than be seen as a disgrace. (Mrs Pule p. 53 lines 59-60)

The reality that AIDS is incurable, combined with the immorality associated with how it is acquired, moves society to victimise people living with HIV/AIDS, who consequently become subdued and withdrawn.

With regard to this, the literature argues that complicacy linked to the welfare of people in a community who are unequally segmented causes a considerable number

of other groups to be devalued whilst other groups feel greater (Mahajan *et al.*, 2008: 3). The resultant feelings of inferiority plunge people living with HIV/AIDS into despair, while a misguided sense of superiority makes others think that they are immune to infection.

UNAIDS (2007: 9) stresses the importance of the impact of stigma and discrimination with regard to HIV/AIDS:

> Stigma associated with HIV and the resulting discrimination can be as devastating as the illness itself; abandonment by spouse/ family, denial of medical services lack of care and support and social ostracism.

Although stigma and discrimination are destructive no matter how extensive, this extreme experience shared by Mr White (p. 51-52 lines 53-57) really drives home their destructive power:

> One of the teachers (a female) unfortunately has developed physical symptoms like sores all over and her hair is thinning. She has been ridiculed by other teachers and even learners. Other teachers call her names. They raise the three last fingers as an indication that they know that she is HIV-positive. Therefore, colleagues pass rude remarks.

In addition, Mrs Louw described how everyone was fearful to the presence of a very sick teacher in her school:

> Sick teachers isolate themselves. I mean, they want to be alone for I think they feel bad. All those physical symptoms keep them away from the rest. You cannot rule out the possibility of denial. (Mrs Louw, p. 55-56 lines 102-104)

This raises ethical issues, especially in terms of learners' behaviour. The absence of the spirit of *ubuntu* is obvious. Stigma and discrimination manifest themselves in such situations.

People living with HIV/AIDS experience a loss of social status that makes it even more difficult for them to deal with the disease (Kamau, 2012: 3). Most researchers concur that feelings of worthlessness, lost status, and lost reputation are all adverse effects of stigma and discrimination (Avert, 2011; Skinner and Mfecane, 2004; Kamau, 2012; Van Dyk, 2012; UNAIDS, 2007; Aggleton *et al.*, 2011).

These findings tally with the story shared by the teacher, Mrs Mehlo:

> After my husband passed away I could hear people say “it’s obvious”. It has been unbearable. Staff members have been avoiding and back biting about my health, it has been unbearable. (p. 14 lines 7-8)

Among the commonly described aspects of stigma and discrimination in the data, the perception of HIV/AIDS as a “death sentence” stands out:

> At first, I could see people around me discriminated me and I suffered from that stigma. Actions speak louder than words. It’s really painful. I did not receive much support from the school level. I was sort of isolated whereas I expected my colleagues to sympathise with me. (Mr Machalaga, p. 3 lines 64-67)

These high levels of stigma and discrimination cause teachers’ effectiveness at work to diminish greatly. Moreover, Squire (2013: 5) argues that HIV/AIDS sufferers experience a sense of incompleteness in their everyday lives. Doyal and Doyal (2013: 41) assert that people living with HIV/AIDS are treated like an “undifferentiated” group, whose sickness is self-inflicted and whose experiences are of little value. Stigma and discrimination are “shaped by pre-existing social traditions” as well as inequalities (Burchardt, 2010: 4). A principal participant; Mr Ntolela (p. 56 lines 106-108), blamed individuals for refusing to learn when information is everywhere in the media:

> People are in denial and they always say “not me” and that denial has caused a lot of deaths. The information that there are new infections and the rate is so high shows lack of education.

Some principal participants, like Mr Dube (p. 54-5 lines 166-176), revealed that the stigmatisation of and discrimination against teachers living with HIV/AIDS had consequences in their school and merited disciplinary action.

Similarly, Mr Mokena declared that he had done away with gossip as the root of stigma and discrimination, which he described as minimal in his school:

> It has been minimal. Gossip, which is the main cause of stigma and discrimination, is not dignified in this school. We do not condone it; we do not entertain it. Yes, it depends on physical symptoms. The moment it shows, we dismiss it completely. We do not endorse gossip, we do not repeat it. I always ignore and give an ear to things worth talking about. I make sure victims are

> protected. I have known some teachers to be living with HIV/AIDS for ten years now and everything has been kept under wraps. (p. 55 lines 77-83)

This is evidence that stigma and discrimination can be minimised with care, support and good leadership. People can be influenced to view problems from the perspective of those living with HIV/AIDS.

In addition, the literature highlights that teachers sometimes absent themselves from work because of the way they are discriminated against by their colleagues (Rayners, 2007: 12). Appropriately, Burchardt (2010: 3) observes the following:

> With the diagnosis the perspective on the future is doomed to shrink. According to most studies, particularly during the first phase of confronting the diagnosis people inevitably find themselves thrown into a precarious and emotionally painful present in, which subjective uncertainty even about short term survival is radically disrupting all connections to an envisaged future.

Fear of death causes people to diagnose other people (Education International Development Centre/ World Health Organisation, 2009: 13). Mr Den (p. 55 lines 113-114) pointed out that:

> To be always suspected of having HIV/AIDS is traumatic. Other teachers gossip, which leads to stress and stress leads to depression to stroke and finally death.

Stigma and discrimination have proven to be major challenges that make the lives of teachers living with HIV/AIDS unbearable. The entire school community is affected as well. Ultimately, stigma and discrimination can contribute to victims succumbing to the disease.

## 5.6 Expectations of Teachers

Several researchers contend that transformational leadership impacts greatly on how teachers perceive school conditions, their obligation to change, and the teaching and learning taking place in the whole school (Bogler, 2001; Day *et al.*, 2001; Fullan, 2002). It is in this context that Slote (2009: 516) describe the ethics of care theory:

> [Care is] how good human beings react directly to perceived need. They do not consult principles, nor do they refer to formal relationships; they leap to save the child in the example of a child about to fall into a well.

As has been highlighted in the above theme, teachers do not disclose their status even though they are sick. They also have certain expectations of their principals despite their refusal to disclose. These are discussed next.

### 5.6.1 Care and Support

Every teacher participant interviewed indicated that teachers living with HIV/AIDS have expectations from their principals. One of the teacher participants expressed his expectations thus:

> The principals can initiate programmes that can see the school being the disseminator of knowledge. Teams need leaders. I disclosed to him because I feel he can support me and I wanted him to get it from me… He has to be committed. He needs to have an ear to listen to all our problems. I think the principal has the power to set the tone. He has the power to pull people towards the set goals. Indeed, they are role models; they have the power and they have the authority… They can use resources at their disposal to conduct enrichment programmes. They may face challenges, yes, maybe, because of their demanding jobs. They are accountable for bad results. So I admit that such extra duties exert pressure for them to improve results. I think they can do it. They are always visible in society. They are associated with academic knowledge as well as general knowledge. (Mr Nkosi p. 28 lines 80-81)

The above story shows that teachers have huge expectations from their principals. Nevertheless, they expressed sincere appreciation of the ARV programme that has recently been rolled out.

The expectations that teachers living with HIV/AIDS have of their principals is widely discussed in the literature (Bialobrzeska *et al.*, 2010: 1):

> For schools to function as modes of care and support for […] and teachers, a particular form of leadership is required to enable this new role […] there are reasonable actions that school leaders can take in the face of the HIV/AIDS crisis.

In addition, teachers need to feel the force of effective leadership (Leithwood *et al.*, 1996: 32; Bush 2012b: 9 and Bass, 1991: 21). Mr Machalaga described his expectations as follows:

> Principals can engage the community, they can bring people together. Really it is a challenge. The principal has the duty to bring in experts regarding the problem, for instance, psychologists, social workers; those people who have expertise to come and maybe motivate educators and learners regarding this kind of situation. (p. 25-6 lines 89-93)

In addition, what Mr Machalaga (p. 25 lines 119-125) had to say about his expectations of his principal cannot be ignored:

> But being the manager or the headmaster I think he is supposed to be more knowledgeable because he is dealing with subordinates; in effect he is the father. He is sure that we need information regarding this, even though he might not have enough knowledge he might inquire. He needs to go out and look for information and support that I want. He needs to look after his staff.

These sentiments indicate that principals are expected to provide support for their students. Principals are regarded as possessing solutions to the problems experienced by teachers living with HIV/AIDS.

### 5.6.2 Principals as Role Models

Gornall and Burn (2013: 46) maintain that teachers will trust their teachers if they give them focused attention, take the time to find out about their problems, and prioritise them on their agendas. As discussed by Sonnenfeld (1995: 72), principals should coach and advise teachers. By the same token, however, Bass and Bass (2008: 590) point out that people follow leaders for a sense of purpose, indicating that they have weak self-images and low self-esteem without them. As was

discussed in Theme 5.1, principals experienced challenges because of teachers living with HIV/AIDS, including teachers taking advantage of their illnesses to gain special privileges. Bass and Bass (2008: xvii) warn that principals may be forced to appeal to the values of the susceptible group. In her interviews, Ms Rakani stressed that principals make a huge difference:

> They have the potential and they can make a huge contribution. It all depends on how much they care. Their strategic position allows them to influence communities – yes, I have seen principals go an extra mile. Their voices are easily heard. (p. 27 lines 75-77)
> The principal as a leader should set good examples and be a role model. The principal binds people together. He influences people's perceptions towards achieving goals. (p. 27 lines 43-45)
> Although they cannot answer but we look up to them they are more experienced and they are connected to other professionals due to their influential positions. They contribution to educating people about HIV/AIDS cannot be undermined. (p. 27 lines 72-74)

Ms Rakani expects principals to go the extra mile and emphasises that their willingness to do so is an indication of how much they care. Furthermore, Van der Vyver, Van der Westhuizen, and Meyer (2013: 63) insist that the following is required for the principal to actualise his/her caring role:

> A management/ leadership approach should be followed where the people within the organisation are regarded as important and not only the skills and knowledge they can offer.

As remarked by Kroth and Keeler, (2009: 9), relationships between people facilitate caring. When teachers are cared for, it enhances their personal wellbeing, which is an indispensable prerequisite for high morale (Van der Vyver, Van der Westhuizen, and Meyer, 2013: 62). The statements of various participants support this claim:

> Really, it is an extra duty. However, because principals have the capacity to lead by example, they are able to inform people and educate society at large. They arrange relief teachers for in case some teachers are absent. (Mrs Ninga p. 28 lines 65-67)

Therefore, it is evident that principals have the ability to influence people and change their mind-sets.

### 5.6.3 Lowering Workload

It is further noted in the literature that, since leaders have the duty to care for their subordinates in addition to being responsible for them, they are faced with challenges of being ethical and effective in their duties (Ciulla, 2009: vi). While it is clear that teachers look up to their principals, the question of whether or not the teachers themselves are playing their part, for instance, by disclosing their status and taking initiative in support programmes. According to Siegel (2009: 217):

> An ethics of care is likely to claim that we have a stronger obligation to help someone whose stress we are witnessing than to help a person whom we do not know.

As was indicated earlier, teachers living with HIV/AIDS often do not disclose their status. Caring relations are fundamental to human existence and consciousness and consist of two parties; that is, the carer and cared-for (Noddings, 2009: 4).

Mr Machalaga's responses below further expand on teachers' expectations of their principals:

> I think if ever people have people living with HIV/AIDS with them, maybe they should be particularly be given a lot of support from school level to district level. In terms of work-related issues; maybe to check whether some sort of maybe whether as an educator you are coping with your work with this chronic disease so that if you are not coping with your work with this chronic disease. If you are not coping, they must determine what kind of support do you need in relation to the workload that you are facing for example maybe I'm teaching at a high school level maybe there is a lot of subjects workload and I must support this, I must support that and mark and so this means all these things only find me in an over loaded situation and then it affects also my health and thinking. (p. 27 lines 70-79)

Gilligan (2011: iv) and Hoffman (2000: 16) emphasise the importance of empathy and moral development in caring. In addition, Noddings (1984: 4) proposes the practice of "engrossment", whereby a person considers others in such a way as to gain an in-depth understanding of them. This argument is in line with literature that describes caring relationships as bound by moral significance and the ethics of care theory as striving to maintain relationships by encouraging the welfare of the ones giving care and those receiving it while networking social relations (Sander-Staudt,

2011: 12). As mentioned in Chapter Four, teacher participants expressed that it was difficult to approach principals when they wanted to disclose their HIV status because of a lack of trust. Additionally, inadequate moral support and/or sound relationships have kept teachers from approaching their principals. Obviously, relationships may sour if teachers chose to approach district officials instead of their principals.

## 5.7 Challenges faced by Teachers living with HIV/AIDS

All the teacher participants described experiences of suffering and social death in their workplaces because of their HIV status. Each of these is now discussed separately.

### 5.7.1 Social Death

The sensitivity, stigma and discrimination surrounding HIV/AIDS builds a wall between "us" and "them". Caring ought to be a principle underlying ethical decisions because care is a fundamental need in the lives of human beings and people need to be cared for (Noddings, 2009: 4; Tronto, 2010: 2; Ruddick, 2009: 12; Capuzzi and Stauffer, 2012: 7). Feelings of shame, fear and denial tear teachers apart emotionally (Aggleton *et al.*, 2011: 495). Ms Hlengwe (p. 24 lines 24-26) shared her experiences in this regard:

> When everyone knows that a certain area or ward is for people living with HIV/AIDS they attach labels. After my illness I was labelled hot plate by people around me.

Similarly, Ms Rakani (p. 19 lines 51-52) offered the following comments:

> Colleagues become very speculative and after knowing they discriminate. People like talking about the innermost information and they don't put themselves in your shoes.

The same is evident in the following statement by Mrs Mabona:

> I was not in a position to eat. I isolated myself from colleagues and from anyone else because I thought they know what was going on… I have been isolated by

> colleagues and even by the school management team who thought that I could not cope with school duties due to the fact that sometimes I don't come to work. Being stigmatised and isolated has seen me being undermined and not being listened to even if I have a point to make. I am always taken for granted. (p. 22 lines 8-11)

Because her colleagues assumed that she was incompetent, they side-lined her. Numerous researchers concur that the feelings of worthlessness, and lost status and reputation are the adverse effects of stigma and discrimination (Skinner and Mfecane, 2004; Kamau, 2012; Avert, 2011; Van Dyk, 2012; UNAIDS, 2007; Aggleton *et al.,* 2011: 495). Teachers, like Mr Nkosi (p. 22 lines 31-33), who are living with HIV/AIDS choose to maintain low profile:

> I maintained a low profile. I did not like knowing about my status. I stay in my classroom, I don't leave. I have to eat and take my medication. I don't want anyone to know. It destroys! When you show symptoms people avoid you. I eat alone. I avoid trouble. I have seen colleagues segregating others… There is a lot of uncertainty. Every day I'm worried about my health. I have no peace. Luckily I am in a special school... I'm in solitary confinement.

Teachers living with HIV/AIDS feel ostracised because their sense of belonging has been compromised by their contraction of HIV/AIDS, the most stigmatised of diseases. In this context, Squire (2013:iv) comments that people living with HIV/AIDS view themselves less as citizens living with HIV/AIDS and more as non-citizens, pushed out of society by their HIV status, who are, ironically, more alive physically than socially. One of the teachers described the situation in her school. She expressed her frustration as follows:

> I lost weight: I went down to size 36 from 40; I started losing confidence because I couldn't get any better. My flu will be so severe and longer. People around me started discriminating me; let alone my colleagues, they made me feel bad. (Mrs Mehlo, p. 24 lines 36-39)

The literature also reveals that teachers living with HIV/AIDS are often socially excluded by colleagues, shunned by family and rejected by the community at large and that this may negatively affect society's efforts to come to terms with the HIV/AIDS pandemic (Avert, 2011: 47). Furthermore, Mbonu *et al.* (2009: 11) contend that the cultural context in which stigma exists leads to social disgrace, causing

individuals or groups to be isolated from the rest of the community, which drastically diminishes their quality of life.

The transformational leadership approach encompasses behaviours that encourage discretion and autonomy, which facilitates the utilisation of people's expertise to the highest level. This is widely discussed in the literature:

> Exclusion and rejection were persistently sources social and psychological stress, which lead to low motivation, poor self-perception, low motivation, poor self-perception, low esteem, loss of status and limited social interactions. (Kamau, 2012: 1)

The exclusion of teachers living with HIV/AIDS from the rest of the staff is also evident in experiences shared by Mrs Ninga (p. 6 lines 35-37):

> There was a time I could see that, although people sympathised with me, they looked at me with fear and they were so overwhelmed. I wasn't sure of myself and asked the principal about retiring and he advised me to soldier on.

This teacher even considered retiring early because of the problems she experienced at work. Negative labelling leads to stereotyping. The responses of Mrs Mehlo (p. 2 lines 9-10) alluded to the ostracism experienced by teachers living with HIV/AIDS in the workplace: "staff members avoided me and always back biting about my health. Being called by names is unbearable". She also stated the following:

> I have been called all sorts of names like Omo, Bus and others. People avoid or suddenly they change subjects in my presence. People look at me in an unusual way and people exchange signs and wink eyes, which mean a lot to me. It wasn't easy for me to accept my status. It came as a blow. I thought it was the end of the world. I started putting myself in my own world – my grave. (Mrs Mehlo, p. 21lines 12-16)

Mr Machalaga also makes the following point:

> Psychological effects, which may be in form of more negative treatment like strained relations with society. Because, once you are psychologically affected, you feel you are rejected. You feel the best way is to take your life. (p. 23 lines 42-44)

Doyal and Doyal (2013: 41) observe that the physical and psychological changes associated with HIV/AIDS diminishes sufferers' capacity to carry on with their normal

lives, which inevitably affects how they see themselves as well as how others see them. Doyal and Doyal go on to claim that all of these experiences make physical death seem preferable to the “social death” they experience whilst still alive.

### 5.7.2 Poor Care and Support

Principals are morally compelled to attend to sick teachers’ needs and challenges. Thus, Held (2006: 10) posits that “the central focus on the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibilities”. Therefore, Basson and Smith (1991: 9) and Beck (2013: 12) argue that the achievement/performance of teachers is weaker in schools where care is not evident and that a negative climate is the result of negative organisation relationships. As was discussed, teachers living with HIV/AIDS expect support from their principals and colleagues; not getting it is painful. This was revealed in Mrs Mabona’s (p. 8 lines 41-68) comments:

> There are no support services here except the HIV/AIDS committee, which is not functional at all. Most of the things are done according to his own way. Therefore, HIV/AIDS needs to be addressed with individuals affected. The culture of non-discrimination is not practised. She expects the principal to address her as an individual amid the sensitivity around HIV/AIDS.

Ms Hlengwe (p. 10 lines 12-15) comments revealed similar experiences:

> I was very sick; colleagues at work were not that supportive. All they could do was to gossip about my health and diagnosing what could be the illness... I gave up hope of life.

This response shows that care and support are scarce in schools. It may be an indicator that teachers expect principals to give them more personal care and support as people with individual needs than as professional teachers. Comments by Mrs Mehlo (p. 33 lines 55-57) reflect a dire need for care and support:

> Management cannot sit with us and talk and come up with some strategies. Rather, everything is a gossip and people like me are in the receiving end. I don’t think our principal is in a position to entertain such issues.

It is clear that deficient care and support exacerbate the effects of HIV/AIDS and further ostracises those living with HIV/AIDS. The transformational leadership

approach emphasises that the school leader must show respect and consider different individuals' interests, needs value systems and feelings (Calitz *et al.*, 2002: 13; Podsakoff *et al.*, 1990: 21). Principals have the ability to empower their teachers (Mahabeer, 2011: 32).

Several researchers have placed emphasis on the transformational leadership approach's contention that high productivity is linked to job satisfaction and a work environment that considers staff members as contributors to the success of the whole organisation (Bush and Middlewood, 2005; Burns, 1978; Peterson, 2009; Bush, 2008; Sonnenfeld, 1995; Crigger and Godfrey, 2011; Bass and Bass, 2008; Mahabeer, 2011; Holly *et al.*, 2010; Bass, 1991; Bush *et al.*, 2010; Nwagbara, 2011). The literature describes the situation as follows:

> Experience has shown that a workplace HIV/AIDS prevention programme will only be successful when the programme has top management support and is developed, implemented and monitored by a committee that include all interested parties. (HIV/AIDS Technical Assistance Guidelines, 2000: 55)

It is traumatic not to get support and this causes much suffering, as revealed by Mr Machalaga (p. 33-34 lines 219-224):

> Like I said earlier on, I really suffered at work and I'm still suffering… It can traumatise you a lot. But, anyway, the main support comes from the family, although I expected it from my workplace.

The teacher participants indicated that they wished to see support at school level. For instance, they wanted to see more effective HIV/AIDS committees and a greater availability of information, as indicated by Mr Machalaga (p. 26-27 lines 345-348):

> We do have an HIV/AIDS committee but I think that committee needs a person who will attend workshops actively so that always he/she advises the whole staff about new developments with the disease and whatever in relation to the stigma.

Mr Nkosi (p. 5 lines 59-61) aired his views on the matter:

> It is difficult; this place is not the best one for me. I know I have to work for the income I get but I don't like this place. I'm not myself anymore; I'm not free. I not sure about what support we should get.

The principals also expressed concern about the sporadic support programmes; Mr Mokena (p. 61 lines 84-88) made the following strong assertion:

> A support programme is launched and, soon after taking off from the ground, it disappears, only resurfacing after, say, four years. So teachers are not supported in terms of health.

School principals have a task to help prevent HIV/AIDS as well as to render care and support to those who are affected or infected. Frick and Frick (2010: 31) explain that a caring environment may significantly contribute to the experience of care by teachers. Van der Vyver *et al.* (2013: 63) conclude that the caring role of principals with reference to teachers has long been largely overlooked in South Africa and internationally.

## 5.8 Support and Acceptance

### 5.8.1 The Gauteng Department of Education Support Programme

In this theme, participants' responses revealed the efforts that were made within schools to create an atmosphere where teachers felt acceptance and a sense of belonging. Gilligan (2011: 23) elaborates:

> The most important thing about ethics of care … morality is grounded in a psychological logic, reflecting the ways in which we experience ourselves in relation to others and that the origins of morality lie in human relationships as they give rise to concerns about injustice and carelessness.

The literature confirms that finding out how best to influence mind-sets and perspectives is important and that the bottom line is that HIV/AIDS will continue to exist until a cure is found. Principals have no option but to be proactive and deal with the situation (Bennell, 2009: 2). The majority of principals revealed that they refer teachers living with HIV/AIDS and other social problems to the Employee Assistance Programme for counselling. The programme is accessed at the District offices. Mr Ntolela (p. 75 lines 59-61) described the involvement of the Department thus:

> The Gauteng Department of Education has a counselling arrangement. We refer teachers to phone a certain number for they receive counselling even on the

> phone if they do not want contact sessions. Teachers are referred to social workers.

Mr Mokena (p. 72-3 lines 46-49) described the situation similarly:

> We also refer teachers to the District for psychological help. I advise teachers to get medical help like antiretroviral pills that lengthen lifespan. I fight to minimise disruptions in the teaching and learning timetable.

Principals expressed their willingness and ability to behave positively toward teachers living with HIV/AIDS. From the perspective of the transformational leadership approach, leaders have the potential to exert influence on surrounding conditions and transform them to achieve performance goals (Leithwood and Jantzi, 2006: 9). Furthermore, Gilligan (2001: iv) and Hoffman (2000: 6) emphasise the importance of empathy and moral development in caring. Thus, Bass and Bass (2008: xvii), Leithwood and Jantzi, (2006: 9), and Bush (2007: 5) all agree that principals can make or break the schools they lead; that is, they are responsible the failure and conflicts that take place under their leadership. Van Dyk (2012: 465), in this regard, makes the following assertion:

> Effective management of AIDS in the workplace requires an integrated strategy that is based on an understanding and assessment of the impact of AIDS on the specific workplace.

The widely shared desire to create an accepting environment for teachers living with HIV/AIDS was expressed by Mr Den (p. 72 lines 104-107) as follows:

> There is a wellness programme provided by the Department for free. We management assist to phone and arrange for counselling and we recommend to the employer. If the teacher gets worse, we recommend for transfer and the programme (wellness) recommends placement. Such placement considers issues like light duties. We cannot help financially, medically or psychologically… We invite counsellors who are knowledgeable in terms of work shopping teachers. We have embarked on capacity building. Any organisation structure can be invited as well as support groups. We try for get a lot of information from the district.

In this instance, teachers feel supported.

### 5.8.2 Principals are Accountable and Responsible

In another response that portrays a leader's accountability and responsibility, Mr Mokena (p. 72-3) offered an extensive explanation:

> I have to know when my teachers are not feeling well so that I plan accordingly. Learners must not lose their learning time and those gaps opened by absent teachers need to be filled. Teachers have come forth to disclose. My teachers trust me with their innermost secrets. I have not disclosed to anyone about my teachers' status. Possibly, this has encouraged other teachers to disclose. I have provided counselling to those teachers who have disclosed to me. I offer support, comfort and advice. The aim is to make teachers perform. Through counselling, I have come to know about medical examinations and routines that they go through until they are put on the antiretroviral treatment. Some have experienced unbearable family problems due to their status; for example, disintegration. I have always been available to provide counselling, support and advice. Some teachers, however, have not disclosed, possibly due to the fear of death. I advise teachers to get medical help like antiretroviral pills that lengthen lifespan. I fight to minimise disruptions in the teaching and learning timetable. Absence of one teacher affects the whole system. Teachers do attend HIV/AIDS workshops. (lines 33-50)
> Teachers need counselling and support. Keeping their confidential information maintains their dignity. Teachers are involved in sexual relationships amongst themselves with teachers living with HIV/AIDS to show that their status is not known. Like I said, I have earned trust amongst my teachers because I do not share it with anyone, even my deputy. We have a culture of standards. We have dealt away with gossip. We do not give it a chance. Corridor talk is not credited. It is not resuscitated. We marginalised it. We have an agreement that we all make a contribution to maintain the standards. If it helps then it happens in private corners so that our culture of secrets does not allow it to reach the victims. (lines 70-76)

This shows that principals are concerned about the teachers' problems but are also aware that teachers must be held accountable for teaching and learning. Principals need to establish continuous relationships with teachers so as to explore a deeper understanding of their needs.

The transformational leadership approach argues that leaders must maintain good staff morale (Bass, 1991: 23). Noddings (1984: 23) emphasises that is important for principals to make an effort to respond consistently to the problems expressed by their teachers by discussing their moral and social issues and needs. The literature also asserts that principals can and should facilitate behaviour change (Bush, 2012b;

Bass 1991; Mahabeer, 2011; Begley, 2010). In line with this, one of the principals interviewed conveyed his heartfelt concern about teachers living with HIV/AIDS:

> I can always advice teachers to take their medication as prescribed. I encourage them to attend support groups, go to the gym, and use protection to avoid re-infection and they must discuss issues with families…. I have talked to those teachers to correct their behaviour. I reminded them that they are not doctors and, therefore, they cannot diagnose. If we suspect that someone is HIV-positive, we cannot conclude. We are also affected and we can be infected any time. (Mr White p. 73 lines 43-70)

The above response contains sympathy and empathy. The principal strived to support his teachers. Principals have expressed that they applied their basic counselling skills when required and encouraged teachers to take their medication.

### 5.8.3 Principals are prepared to go the Extra Mile

As recorded in the data, Mrs Motsepe expressed her concern about including teachers living with HIV/AIDS:

> I would ask him politely to go and consult doctors and, whenever possible, speak to him to express sympathy and support. He appreciated the support. (p. 74 30-32)
> As an individual always support my teachers when they have problems. I call in relevant professionals to workshop and advice about, for instance, leave days. Teachers have had problems because they exhausted their leave days and, later on, they become desperately in need of them. I always take it upon myself to contact teachers and advise them. I remember, at one time, I had to call one of the teachers' wives to come and sign leave forms. The teacher had just disappeared and indicated that he was sick. His salary was going to be affected when he really needed it with his family. (p. 74 lines 61-70)

This response, again, reveals that the principal is concerned about her teachers' health. The effort that the Mrs Motsepe put in to support her teachers cannot be understated. Her behaviour was in line with the ethics of care tenet that the carer should display engrossment and motivational displacement and the cared for should display some response to the caring (Noddings, 1984: 24). A caring role is embedded in the leadership and/or management function of the principal (Van der Vyver *et al.*, 2013: 63). As a result, Noddings (1984: 26) proposes engrossment whereby someone thinks about other people in a way to gain some in-depth

understanding of them. Furthermore, comments passed by Mr Sebeko (p. 75 lines 76-83) reflect the will to help:

> Or maybe I should try my little knowledge. I feel obliged to protect the teachers and I expect them to work normally. I have always advised them to attach medical certificates each time they consult doctors. I invited the District's Educator Wellness Unit to come and workshop the whole teaching staff. We support teachers who have disclosed and we understand their situation. My teaching staff relates very well. There are no attitudes; everything is normal. Even if they know, they would not treat them badly because we are all affected. Our teachers love one another and they respect each other. They would not behave undesirably, even if they know that one of theirs is living with HIV/AIDS. They would not utter bad things nor treat them badly. Considering the prevalence of HIV/AIDS in black communities, each one of us is either affected or infected. They have the obligation to accommodate others. The two teachers have never shown any attitudes, they have behaved normally.

These views are also consistent with what Mr Muloyi (p. 75-76 lines 75-80) shared:

> Teachers who are in charge of the HIV/AIDS committee are seniors who are also part of the management team. The committee always holds campaigns, you know, to remind people about the disease… It is all about our principles and the effort we put to practise them. The Christian values, like I said, have been very useful. If teachers decide to gossip, they do it in such a manner that it does not reach the ears of the victims. I encourage teachers to treat one another in a dignified manner, for those who talk ill about other teachers will face the consequences.

The interview between me and Mr Muloyi was an eye-opener for the principal because he realised that, even with his basic knowledge, he could counsel the teachers who had disclosed their status to him. Christian values are also reflected here. The response indicated the effort made by the principal and the Department to create an environment where everyone feels accepted and that they belong.

It is further noted in the literature that teachers who are led by caring principals experience greater morale as well as increased levels of job satisfaction, which enhances their quality of life (Roffey, 2007: 7). The intention of such leadership behaviour is to encourage cooperation amongst employees and bring them together to achieve set goals (Leithwood *et al.,* 1996: 9). In relation to the issues of acceptance and belonging, principals stated that they employed substitute teachers

to stand by in case sick teachers are forced to be absent and encourage teachers to test. Mr Dube shared his viewpoint on the matter:

> First and foremost, teachers are weak and sick because of HIV/AIDS; however, if teachers are unable to come to work, the Department of Education has systems in place. We employ during the absence of the teacher, for instance, if the teacher has been laid off by medical doctors for a period of 30 days or so (p. 75 lines 109-113)
> At times I bring them to my office and I engage them I give them counselling. Some are very much afraid to talk openly. But I remember I called one teacher and told her that look your heath is not good, how about you going for tests; I kept on asking until she responded... When somebody has confided in me I understand for instance; I reduce workload. I do not demand work unlike somebody who does not talk to me even if he is a little behind. I become positive and understand. I become sympathetic. (p. 75 lines 121-139)

In this context, Bush (2007: 11) acknowledges the role of the principal as offering individualised support, modelling best and important original values, demonstrating high performance expectations, creating a productive environment, and developing structure to foster participation in school decisions.

The principal participants showed the will to encourage their teachers, as was recounted by Mrs Louw (p. 76 lines 14-19):

> I had to draw closer to him and show how much I was concerned about his health; I mean, on humanitarian grounds it is difficult to just leave him to be on his own... I would sit and talk to him. I encouraged him to eat healthy and rest.

As such, caring ought to be a principle underlying ethical decisions because care is a fundamental human need (Noddings, 2009; Tronto, 2010; Ruddick, 2009; Capuzzi and Stauffer, 2012). For a caring relationship to be created, caring should happen naturally, based on a natural desire to do something good rather than on abstract moral reasoning (Noddings, 2002; Sander-Straudt, 2011: 12).

Caring should be rooted in receptivity, relatedness and responsiveness (Kordi, Samaneh & Reza, 2012: iv). Another response from a principal participant reflected acceptance as well as an appeal for reciprocity:

> They must reciprocate my support because there are so many of them and, besides, I have a life and family as well to take care of. I always tell them:

> "don't lean on me". They must live their lives responsibly. (Mrs Motsepe, p. 39 lines 74-76)

Many of the principal participants indicated a desire for teachers take more responsibility for themselves and their duties. Meanwhile, teacher participants also shared their experiences with regard to acceptance and belonging. Mr Machalaga (p. 13-14 lines 33-35), for example, related his experiences of the Employee Assistance Programme, where he received counselling:

> I was desperate for support, I went for counselling again and I was told about support groups for people like me. I got to know how to contact the Department's support system through a text message.

Other teachers indicated that they received counselling before and after HIV testing, which appears to be the trend at voluntary counselling and testing centres:

> I received thorough counselling before testing and after. I was alone with the counsellor when results were presented to me. I was immediately put on antiretroviral treatment because my CD4 count was very low. (Mrs Ninga, p. 30 lines 17-19)

Mr Nkosi (p. 30 lines 21-22) indicated that "I was on sick leave when I knew about my status for (30 days). I attended counselling sessions". In addition, Ms Rakani (p. 30 lines 10-11) revealed the following:

> I had just given birth to my daughter. I received a lot of counselling. I started taking ARVs. I went into depression and I was diagnosed with anxiety.

Mrs Mehlo (p. 31 lines 40-43) also explained his experience of counselling:

> You can't just get tested for HIV without counselling… It's the day I will never forget. I sweated and won't forget the fear. The body language of the counsellor showed me that my results were positive. Anyway, I'm trying to get over it.

The positive thing about the experiences of these teachers living with HIV/AIDS is that they received counselling when they tested for HIV.

The South African government has rolled out the biggest antiretroviral treatment programme in history (UNAIDS (b), 2010: 1). On the 12th of April 2013, the South African Minister of Health announced that the government had introduced out one-a-

day ARV treatment (voanews, 2013). This reflects the initiatives that exist to support people living with HIV/AIDS – teachers included. Carter (2009: 13) describes the launching campaigns on HIV testing and free provision of condoms (Essack, Slack, Koen, & Gray, 2010: 17) by the South African government as a commitment to relieve the effects of HIV. It is important for teachers to test for HIV so that they can benefit from the free HIV/AIDS interventions.

The “normalisation” process is, to a large extent, facilitated by membership to other HIV-related groups and organisations Doyal and Doyal (2013: 2). This is widely supported in the literature, as is the contention that the uptake of antiretroviral treatment has decreased the burden of caring for people living with HIV/AIDS (Avert, 2011: 46). Taking the argument further, Foster and Lyall, 2005 (in Kamau, 2012: 1) offer the following comment:

> Medical advances have greatly extended the life expectancy of many people living with HIV/AIDS by transforming HIV/AIDS from being acute terminal illness to a chronic condition.

Similarly, Doyal and Doyal (2013: 80) note the following with regard to HIV/AIDS treatment:

> It is clear that the availability of effective treatment has enabled many more HIV-positive people to participate actively in working life.

Teachers revealed that, after counselling, they joined support groups, where they met teachers in the same predicament, and began taking antiretroviral treatment (Mrs Mabona p. 29-30 lines 22-35; Mrs Ninga p. 30 lines 16-20; Ms Rakani p. 30 lines 8-11; Mrs Mehlo p. 31 lines 40-43; Mr Machalaga p. 31 lines 12-27). This may assist teachers living with HIV/AIDS to deal with stigma and hostility. To this end, the above responses serve as evidence that teachers partook of counselling services and joined support groups outside the school communities. This serves as an indication that support within the schools may be inadequate.

## 5.9 Conclusion

This chapter discussed the data using theory that was presented in Chapter Two as well as certain additional literature. The empirical data regarding how principals handle the sensitive issues surrounding HIV/AIDS amongst teachers in Gauteng Province schools were discussed. The data were consulted several times to ensure accurate interpretation. The empirical findings were mostly consistent with the literature. It is clear from this inquiry that principals face a number of managerial challenges directly resultant of HIV/AIDS-related issues, specifically those pertaining to teachers living with HIV/AIDS. With an ever-increasing number of teachers are contracting HIV/AIDS, the level of absenteeism is on the rise, which causes poor academic achievement. The emergence of HIV/AIDS amongst teachers has left principals overburdened with responsibilities. This is largely because principals are not adequately equipped and trained to deal with the sensitive issues surrounding HIV/AIDS amongst teachers. The delicate nature of HIV/AIDS-related issues necessitates individually-oriented leadership approaches such as that of transformational leadership. There is also dire need for approaches grounded in moral foundations, such as the ethics of care theory.

Sick and fragile teachers cannot perform at their best. Teachers who are too ill to work have to be replaced and it is difficult to find replacements of the same calibre. Although they do not take responsibility for disclosing their HIV status, teachers living with HIV/AIDS expect principals for support and assistance. Teachers living with HIV/AIDS experience stigma and discrimination. Stigma and discrimination manifest themselves, to a large extent, in situations where teachers living with HIV/AIDS show the physical symptoms of HIV/AIDS. In Chapter Six, a summary of the findings, conclusions and recommendations are presented.

# CHAPTER SIX

## Conclusions

### 6.1 Introduction

The previous chapter looked at the data interpretation and discussion, which were substantiated by verbatim quotes and reference to the literature. This study explored and gave an insight into how principals are dealing with the sensitive issues of HIV/AIDS amongst their teachers. This chapter presents the summary, discussion and recommendations for policy and practice and for further research drawn from this study.

### 6.2 Summary

Chapter One offered an introduction to the study, with a brief historical background of how principals have handled the sensitive issues related to HIV/AIDS amongst teachers. It was also highlighted that South Africa has the largest number of people living with HIV/AIDS in the world. Mention was made that teachers living with HIV/AIDS are faced with challenges in the school communities as well as in their workplaces. Teachers are affected in the same manner as the rest of the population. The Gauteng Province has the largest share of the population of South Africa. It was also mentioned in the introduction that the effects of HIV/AIDS on education cannot be underestimated. It was stated in the introduction that principals are faced with challenges with regard to teachers living with HIV/AIDS and that they need to understand their influential positions in this regard.

The purpose of this study was to explore the perceptions and experiences of eight teachers living with HIV/AIDS and ten principals with such teachers under their charge in Gauteng schools. It was anticipated that, through an enhanced understanding of the perceptions and needs of principals, more informed policies can be formulated for principals, teachers, and the Department of Education.

Furthermore, issues and challenges faced by principals as well as the expectations held and challenges experienced by teachers living with HIV/AIDS amid stigma and discrimination were discussed. The study aimed to reveal various school leadership challenges faced by principals in the context of teachers living with HIV/AIDS and to explain the challenges faced by teachers living with HIV/AIDS. In addition, the study aimed to explore the principals' perceptions of the problems associated with HIV/AIDS amongst teachers and how they facilitate in solving these problems. Understanding the perceptions of principals in handling the challenges imposed by HIV/AIDS and what they think can be done practically and functionally to deal with HIV/AIDS-related issues was also one of the aims.

The study was guided by the key research question: How do principals understand and respond to their leadership roles in the handling of sensitive issues arising from HIV/AIDS amongst teachers in schools in the Gauteng Province, given their expectations?

To answer the research question, qualitative research was applied. Qualitative research originates from the social sciences and is concerned with understanding why people behave as they do and seeks to uncover the knowledge, attitudes, beliefs, fears of research participants. Qualitative approaches are used to explore how people behave, as well as what they feel and experience with regard to a given phenomenon. The study was rooted in the social constructivist paradigm. The basic tenet of the social constructivist paradigm is that knowledge is socially constructed. I used the transformational leadership and ethics of care theories to frame this study.

In Chapter Two, the context and background of the study were explored to reflect that great strides have been taken to assess the prevalence of HIV/AIDS, health status and teacher attrition rates in South Africa. There estimated number of teachers living with HIV/AIDS has been a major cause for concern. School principals are regarded as major players in school effectiveness.

The review of related literature and previous findings provided a background to this study and its methodology and, to a large extent, rationalised the relevance of this study. Books, journal articles, theses, dissertations, conference proceedings, reports

and documentations were useful sources of information in understanding the phenomenon from the literature: leading schools in sensitive matters, the impact of HIV/AIDS on teachers, HIV/AIDS in schools, and the effects of stigma and discrimination on teachers living with HIV/AIDS.

Equally important, the two theories that underpinned this study were discussed: transformational leadership and ethics of care. The transformational leadership theory was discussed according to its various dimensions, namely; charisma/ inspiration/ vision, developing goal consensus, offering individual support, providing intellectual stimulation, modelling best practices and important organisational values, demonstrating high performance expectations, creating a productive school culture, and developing structures to foster participation in school decision.

The transformational leadership approach was deemed suitable for this study because of its normative style, which capitalises on a series of methods that leaders can implement to influence school results positively. The approach focuses on building the capacity of the subordinates (rather than executing control), leadership, directorship, and coordinating the process. It is based on a leader's ability to communicate a shared vision and to motivate followers to engage in behaviour that helps the organisation to reach that vision.

The qualities of this model make it ideal within an emerging paradigm where principals must not only fulfil their roles but also have to immerse themselves in sensitive HIV/AIDS-related issues. The mental wellbeing of the teachers is considered and teacher development is provided. Therefore, the role of the principals is undergoing a transformation so as to embrace the new leadership challenges in the era of HIV/AIDS.

The ethics of care theory, which is about what makes actions right or wrong, was explained in relation to how it can be employed by school principals in dealing with teachers living with HIV/AIDS. The ethics of care approach maintains that caring should be rooted in receptivity, relatedness and responsiveness. The ethics of care theory appeals to the commitment to do something that is deemed right and that there is a need to do the right things by the people who are concerned about us.

Furthermore, the ethics of care theory emphasises empathy and moral development in caring. It calls for principals to establish ongoing relationships with teachers so as to obtain deeper understandings of their needs. Engrossment is recommended in ethics of care whereby someone thinks about other people in a way to gain some in-depth understanding of them. The networks of relationships for this research makes teachers living with HIV/AIDS feel belonging.

In chapter three, a detailed discussion of the qualitative research and its assumptions were presented. In an endeavour to explain the assumptions of the qualitative research approach, I quoted McMillan and Schumacher (2010: 321) who outline the following characteristics: natural settings, context sensitivity, direct data collection, rich narrative description, process orientation, inductive data analysis, participant perspectives, emergent design and complexity of understanding and explanation. In addition the social constructivist paradigm that guided this study was presented. The social constructivist paradigm is concerned with interpretation, illumination and meaning through which they gain knowledge. The researcher's purpose is to interpret the meanings others have about the world. The research question is answered through the description and explanation of events and collecting participants' beliefs, experiences and understandings. Different perspectives are explored through the interpretation of the social world. The researcher generates theory through working with the collected data.

The narrative inquiry research design was explained according to its key ideas put together by Lemley and Mitchell (2012: 215) including that it is a qualitative research methodology that critically analyse social and cultural contexts of human experience as well as that it is cross-disciplinary and is used by such fields as philosophy, education, science, religion, economics, law and medicine. Another idea is it focuses on what the research participant identifies as important in the story. Narrative inquiry challenges positivist notions that only one truth exists. In addition narrative inquiry researchers continually question 'what I know' and 'how I know it'. The potential of narrative research in accessing sensitive information made it the most appropriate design for my research study.

At the same time, the research methodology was articulated, which entailed purposive network sampling, narrative interviews, rigour and quality as well as researcher subjectivity statement. I sampled eight teachers living with HIV/AIDS ten principals. Simply said, purposive sampling entails handpicking the individual(s) to be part of the sample basing on their personal experience of the research phenomenon. Network sampling was used to sample eight teachers living with HIV/AIDS. This method of sampling is suitable for identifying participants that are hard to reach and/or hidden, marginalised and socially stigmatised for example people living with HIV/AIDS. With the approval of the Research Ethics Clearance of the University of South Africa I collected narrative. Access to schools was sought through a comprehensive application to Gauteng Department of Education. Request letters were written to each participant. I chose to gather data through narrative interview because of the ability to extract lived experiences leading to stories with a distinct plot, a social interaction and a temporal unfolding. Narrative interviews are suitable for storied data that speak to experiences of research participants. Face-to-face interviews were conducted with each participant and thereafter each narrative interview with principals and teachers living with HIV/ AIDS was transcribed verbatim, and individual narratives were created. In order to achieve rigour and quality in this study, I used Tracy's (2010: 835-848) model, which includes criteria for excellent qualitative research to ensure trustworthiness and authenticity. The criteria include worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, and ethical and meaningful coherence. I was likely to be influenced by my own subjectivity or less aware of it than seasoned researchers. I was aware that fieldwork descriptions are co-constructed and most importantly provided rich meaningful information. Reflexivity comes into play when the researcher acknowledges his/her own subjectivity, bias and predisposition. The exploration of my experiences potentially provided fresh and valuable insights.

Chapter four presented themes of the teacher collective narrative, themes of the principal collective narrative and the similarities and differences of teacher and principal narratives. The raw data were described in relation to the eight themes. Then two collective stories were written based on the eight themes generated for the teachers' and principals' participants' individual narratives. Afterwards a thematic

collective narrative of the teacher and principal narratives was constructed that spoke to similarities and differences of their experiences.

In chapter five, data interpretation and discussion regarding the experiences of principals and teachers living with HIV/AIDS were done based on eight themes. Data interpretation and discussion were made with reference to the literature reviewed in chapter two. Reference was also made to verbatim comments from the raw data. The eight themes included: challenges, which were pointed out because of leading teachers with HIV/AIDS leading to: management problems, disruption of teaching and learning, inadequate professional development for school leadership and problems relating to sensitivity of HIV/AIDS. The second theme discussed challenges relating to leadership role reflections; principals indicated that HIV/AIDS amongst teachers has caused some widespread uncertainty amongst school leadership. A change of roles is indispensable due to the HIV/AIDS subsequently shifting from traditional roles. The third theme was challenges of continuous teacher absenteeism. Principals felt absenteeism is rife amongst teachers living with HIV/AIDS subsequently leading to failure to cover the syllabi. Although teachers living with HIV/AIDS might be present at work, they cannot optimally perform their tasks; they cannot keep their momentum and learners lose interest. Other teachers are overburdened when they take over relief classes. The other theme was challenges relating to problem of disclosing. Both teachers and principal participants shared views that it was difficult for teachers living with HIV/AIDS to disclose their status. Prejudices perceptions related to HIV/AIDS make teachers to conceal their status.

Furthermore, challenges emanating from stigma and discrimination were discussed. All the participants reflected that HIV/AIDS is stigmatised and those suffering from the disease suffer from discrimination. There are misconceptions about the causes of HIV/AIDS, for instance, sleeping around. Since inception, the causes of HIV/AIDS have been mainly attributed to indecent and wicked behaviour; labelled deviant and wrong-doers to the extent of raising three fingers for the HIV sign. Stigma and discrimination have proved to be a challenge that makes the lives of teachers living with HIV/AIDS to be unbearable and subsequently the entire school community is affected as well. All the teacher participants indicated that they have expectations

from their principals. Principals are expected to be more knowledgeable regarded as possessing answers to problems experienced by teachers living with HIV/AIDS. Problems were identified by teachers living with HIV/AIDS relating to social death. These teachers maintain a low profile and they isolate themselves as well as isolated by colleagues. They feel ostracised because their sense of belonging has been compromised by the most stigmatised disease. There were emanating challenges relating to deficient care and support. Teachers living with HIV/AIDS felt they were not protected from discrimination at work as well as being treated as individuals amid the sensitivity of HIV/AIDS. The last theme discussed strategies relating to creating an atmosphere where teachers felt accepted and belonging. Teachers living with HIV/AIDS were referred to the Employee assistance programme for counselling at the District offices.

As is, principals expected teachers to reciprocate their support and be responsible and disclose their status. The next section outlines the main conclusions from the empirical data.

## 6.3 Discussion

This part on discussion makes reflection on methodology, substantive reflection and scientific reflection. The methodological reflection follows.

My choice of qualitative research was intertwined with the narrative inquiry design, which has been remarked to be more interested in the manner in which researchers confer meaning onto experience particularly in narratives of personal experience related to concrete life events. The qualitative methodology provided me with the insight into how school leadership deals with sensitive issues related to teachers living with HIV/AIDS. Situated within the qualitative research approach, the narrative inquiry design allowed the collection of rich data through narrative interviews. Given the sensitive nature of HIV/AIDS and socially constructed aspects associated with the disease, the use of purposeful and network sampling was the most appropriate method of exploring HIV/AIDS-related issues in school leadership and management. This methodology was a gateway to sensitive information from a population that had

restricted opportunities to open. Teachers living with HIV/AIDS and principals shared their perspectives with regard to the phenomenon. The methodological tool box in this study suited the nature of this study. The substantive and scientific reflections are discussed in the following part.

In this study, conclusions are drawn from the empirical data that the principals' roles have shifted from traditional organising, planning, leading and control functions to a more caring and supporting role. The HIV/AIDS has ushered in complex approaches that are health oriented. Principals are faced with an increasing number of teachers living with HIV/AIDS and it has presented challenges to school leadership. The main drivers of education (teachers) are affected and it affects school leadership. Other researchers in the literature remark that HIV/AIDS has a devastating effect on the quality of education in South Africa. School leadership has become increasingly complex because of teachers living with HIV/AIDS. Principals are faced with a challenge to possess knowledge in HIV/AIDS so that they are able to help their teachers.

This research shows that principals are experiencing a range of challenges due to teachers living with HIV/AIDS. Principals demonstrated limited knowledge in tolerating the needs of teachers living with HIV/AIDS, which affects the school tone. Principals have no expertise that is required to go deeper into the HIV/AIDS-related issues amongst teachers. There is no consistence in the Department of Education's support programmes and principals feel devastated. The education system is continuously losing experienced teachers who are hard to replace. For instance, in South Africa, scarce skills like mathematics and science teachers are not enough. In the literature, other researchers reveal that principals are not adequately supported in terms of HIV/AIDS-related issues amongst their teachers. HIV/AIDS affects the physical wellbeing as well as the organisational psyche. Principals are appointed from the experienced teachers' group without acquaintance of knowledge and skills on how to lead people. HIV/AIDS-related issues are extremely sensitive. People tend to close up when entering discussions involving issues of gender, race and sexuality in the workplace.

Based on the research findings, it is evidently revealed that goals of quality education are defeated because of teachers living with HIV/AIDS. Once teachers succumb to the opportunistic illness associated with HIV/AIDS, their productivity deteriorates. The determination of duty in relation to conservative ethics commits teachers to come to come to work when they are sick. Their guilt feeling incline them to be strong. When teachers lose momentum, learners also lose momentum and there is no consistent teaching and learning. Subsequently teachers are unable to optimally perform their teaching task leading to overcrowded classes and learner adjustment problems. The findings of other researchers in the literature indicate that teachers continue teaching regardless of deteriorating health. Sick teachers cannot effectively accomplish their professional performance standards and cannot contribute to the attainment of academic goals. The different teachers develop different problems in relation to the epidemic and principals are forced to identify these requirements and support programmes paying particular attention to sensitivity.

Principals clearly declared their problems and inadequacies in responding to HIV/AIDS-related issues amongst teachers. They lack training and management skills as well as developing long-term strategies to mitigate the impact of HIV/AIDS on teaching and learning. The principals' jurisdiction allows only basic support whereas the challenges of the pandemic require expertise. They are not adequately supported in terms of resources and strategies. Literature shows that principals as leaders have a challenge of being ethical and effective in their duties. HIV/AIDS has presented devastating challenges to school principals who have been confronted with growing number of HIV-positive teachers. The HIV/AIDS pandemic has caused significant disruption to normal long/short term plans in schools.

HIV/AIDS-related issues are extremely sensitive. Issues to do with HIV/AIDS are highly confidential and protected by laws, which impose a cluster of complexities that demand sensitivity and diplomacy. Teachers living with HIV/AIDS take advantage of the sympathy and empathy and drag their feet in performing their duties, which undermines the authority of principals. HIV/AIDS amongst teachers has caused widespread uncertainty amongst school principals. While principals appreciate being put on pedestal, they are expected to act out and not abdicate responsibility to

themselves. Principals are viewed as role models who can go the extra mile and perform extra duties. Principals are expected to provide quality education amid absent, sick and demotivated teachers. Principals are not super human beings but individuals who have been entrusted with responsibility to manage and lead institutions. These conclusions are consistent with other researchers' findings that there are reasonable actions that principals can take in the face of HIV/AIDS crisis to make schools as models of care and support for teachers. Teachers will trust their principals if they give them deep attention and take time to find out about their problems and list them on their agenda. When teachers are cared for, their personal wellbeing is enhanced, which is an indispensable prerequisites for high morale.

The whole school programme might be difficult to improve when the school environment that is negative causes profound feelings of social disgrace, sadness, depression, loneliness, anxiety and withdrawal amongst teachers living with HIV/AIDS. Other researchers' works reveal that when teachers living with HIV/AIDS succumb to opportunistic diseases, they take periods of time off work; hence, they are unable to optimally perform their teaching task. Teachers are over loaded with their colleagues' teaching areas. The curriculum is tremendously disrupted.

The research findings showed that teacher absenteeism is rife, which drastically affects teaching and learning programmes and posing serious challenges for principals who are not equipped with the required information and resources. Teachers who are sick attend one week in one week out and they cannot be substituted. Many diseases attack the normal functioning of the body; immediately when someone is infected staying away from work is frequent. The HIV/AIDS epidemic is not only worsening the projected teacher shortage but also affect their ability to teach. The teaching programme is disrupted and this poses serious problems for principals who are continuously absent do not complete syllabi and during their absence, other teachers may be required to teach in subject areas they are not specialised in. The literature sates that the loss of experienced teachers retards quality teaching and learning. Before teachers develop full-blown AIDS, they are absent from work for a few days and principals may not realise the intensity of the problem they are faced with

Teachers living with HIV/AIDS find it difficult to disclose their HIV status to principals, which increases the dilemma of dealing with HIV/AIDS-related issues. The findings in this research indicate that disclosure usually takes place when the physical symptoms are at an advanced level. Principals cannot demand to know teachers' HIV status because of fear of violation of confidentiality. Stigma and discrimination, fear of death, sensitivity and poor relations are some of the major deterrents to disclosure. Principals are faced with breaking the taboo of silence. Literature reveals that it is difficult for people living with HIV/AIDS to disclose their status. Teachers are overwhelmed by sense of shame for having contracted HIV; hence, they conceal their status. The rate of infection is escalating. The impact of stigma and discrimination is so profound that it pushes the epidemic underground, forcing people living with HIV/AIDS into hiding.

The research findings showed that stigmatisation of and discrimination against teachers living with HIV/AIDS is exacerbated by stereotyped beliefs, fear associated with the disease's incurability, perceptions of teachers as sources of information, and other social constructs around the pandemic. All of this results in these teachers being ostracised, labelled as inferior, and stripped of their status, all of which leaves them feeling worthlessness. With regard to this, it is widely stated in the literature that stigma and discrimination are socially constructed attributes that deeply discredit and reduce people from a whole to a discounted one. Since inception, the causes of HIV/AIDS have been mainly attributed to indecent and wicked behaviour that has been labelled deviant. Stereotyped beliefs lead to ostracism beliefs of people living with HIV/AIDS.

It is evident in this research study that although teachers do not take responsibility and disclose their status. Instead, they look to principals for answers to their HIV/AIDS-related problems without even knowing which of their teachers is HIV-positive. Teachers expect principals to reduce their workload, be role models, be resourceful, care and support, initiate programmes, be tolerant and perform the extra duties. This is related to the findings in the literature that teachers are faced with challenges of prejudiced perceptions. Principals as leaders are required to be proactive and deal with the issues of HIV/AIDS amongst their teachers. Principals account for failure and conflict. Principals facilitate behaviour change in teachers. A

caring role is embedded in the leadership and/or management function of the principal. The South African has rolled out the biggest ARV programme and one-a-day ARV treatment. Principals influence and inspire teachers to focus in the direction of common goals. Principals as leaders have an obligation to accept challenge of HIV/AIDS and manage it the same responsibility and devotion as they manage other areas of school life. Teachers living with HIV/AIDS suffer from feelings of shame, fear and denial. The cultural context where stigma exists subsequently leads to social disgrace whereby individuals or groups are isolated from the rest of the community and this affects quality of life.

Based on the research findings, it is evident that teachers living with HIV/AIDS suffer from social death. Teachers living with HIV/AIDS are surrounded with a socially built wall that leaves them in shock and consequently leads to emotional destruction and physical suffering. In this regard, literature remarks that teachers are faced with challenges of prejudiced perceptions. Teachers living with HIV/AIDS suffer from feelings of shame, fear and denial. The cultural context where stigma exists subsequently leads to social disgrace whereby individuals or groups are isolated from the rest of the community and this affects quality of life.

It was evident in this study that teachers living with HIV/AIDS do not receive enough support. Principals need to address this problem because it pushes teachers living with HIV/AIDS further into the ground. Care and support of teachers living with HIV/AIDS is deficient as noted in the literature. The caring role of principals is largely overloaded in South Africa and internationally.

## 6.4 Recommendations for Policy and Practice

In accordance with the findings of the research, the following recommendations can be made for policy and practice:

- Teachers should know their HIV status before they fall sick and most importantly take responsibility of disclosing their HIV status. When teachers know their HIV status early they can access quality support. Teachers living

with HIV/AIDS should rely on antiretroviral programme and the Employee wellness programme, which are aimed at dealing with HIV/AIDS-related issues. Disclosing to principals facilitates the development of positive working relationship.

- Formal managerial training and development should acquaint school principals with theoretical knowledge, analytical skills and leadership skills to effectively device suitable strategic plans in the handling of HIV/AIDS-related issues amongst teachers. Management strategies include mitigation of stigma and discrimination, empowerment and support as well as sustaining quality education.

- School principals should be acquainted with more knowledge and adequate training and development to empower them with knowledge and skills to handle HIV/AIDS-related issues among their teachers. School principals should realise that teachers are prone to HIV infection and it is important that principals be exposed to more information, which will help break the taboo of silence around the pandemic. More information may assist principals to influence change of behaviour within schools and the community at large. Availability of updated HIV/AIDS prevalence regarding teachers will help principals determine and assess the impact of the pandemic in schools, eventually influencing strategic planning and decision making.

- School principals should be provided with support from the Department of Education to replace teachers timeously before teaching and learning are disrupted. In addition, teachers should disclose their status to the principals who are responsible for replacing them when they are sick.

- It is suggested that principals should encourage their teachers to live healthy and subscribe to medical aid institutions for assistance in time of ill health.

- Principals should strive to strengthen collaboration of stakeholders for schools to fulfil their function as centres of community life.

- School principals should adopt transformational leadership in the development of strategies to deal with HIV/AIDS-related issues amongst their teachers. Principals should initiate cooperation amongst teachers to accept one another. In so doing, they must be guided by ethics of care.

- There should be training skills and guidelines to develop HIV/AIDS policies within schools. Principals should initiate support programmes for their teachers to eradicate stigma and discrimination. There is need for workshops that will sustain effective management in schools. Principals need to be capacitated to deal with the challenges faced by teachers because of living with HIV/AIDS.

- Principals should observe confidentiality once teachers disclose their HIV status and give advice and support. Management strategies must be conducive to creating a trusting, open, caring and supportive environment that will encourage voluntary disclosure of HIV status in schools. Principals should eradicate sources of disharmony in schools.

- The Department of Education should increase support for teachers living with HIV/AIDS. A support structure is needed to help teachers to disclose their HIV status.

- A support structure is needed for example the Department of Education providing principals with a forum to share experiences and access support.

- Repeat of the same research conducted with a more representative sample of teachers and principals from other areas of Gauteng Province as well as other South African provinces will be useful.

- Further research is required with the school principals to determine leadership and management strategies that acquaint them with necessary skills and knowledge to handle HIV/AIDS-related issues more effectively with confidence.

## 6.5 Limitations of the Study

In this study, a small sample of teachers living with HIV/AIDS and school principals was used. A larger sample that accommodates other geographical areas could have provided a wider spectrum of views and perceptions. This study was limited to the Gauteng Province were the aim was to get an in-depth understanding of the research phenomenon and not a generalised view. Because of the small sample size, generalisations cannot be made to other provinces about how principals are handling issues of HIV/AIDS amongst their teachers. However, although generalisations cannot be made on this study, quite a number of common features about the role of school leadership and teachers living with HIV/AIDS: stigma and discrimination were evidently unveiled in this study, which could be transferred to similar contexts. To date, research on school leadership and teachers living with HIV/AIDS is limited and the findings of this study could not be compared therefore to those of previous studies. Given the sensitivity of the HIV/AIDS pandemic, I was also aware that participants were not always willing to talk to this topic, which meant I was limited in terms of the number of participants who did speak to me after all.

## 6.6 Conclusion

The main purpose of this inquiry was to explore how principals are handling the sensitive issues of HIV/AIDS amongst their teachers through literature study and research among sampled teachers and principals. This research study confirms that the school leadership is profoundly affected by HIV/AIDS as well as curriculum delivery because of additional responsibilities imposed by sick teachers. This qualitative study has provided the empirical data from the participants and provided new understanding of the difficulties caused by teachers living with HIV/AIDS in school leadership. This research study has highlighted the importance of developing support structures in order to alleviate the problems presented to principals by teachers living with HIV/AIDS. This qualitative study has provided the researcher with the opportunity to explore the unique individual perceptions, views and experiences and responses of teachers living with HIV/AIDS and principals to school leadership and teachers with HIV/AIDS: stigma and discrimination in Gauteng

Province schools. Participation of all the role players is indispensable in an effort to achieve optimum eradication of challenges.

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# APPENDICES

## Appendix A: Interview Schedule for Principals

**1. Questions on the impact of HIV/AIDS on teachers.**

2. I wish to know about your profile information.

3. How long you have been in teaching service.

4. How long you have been a school principal?
   - 4.1 Briefly share your knowledge of and experience with HIV/AIDS.
   - 4.2 To what extent is your school affected by HIV/AIDS?
   - 4.3 The number of teachers who absent themselves because they are infected or affected by HIV/AIDS is on the increase. How are you dealing with this problem in your school as a principal?
   - 4.4 How is teaching and learning affected in your school and how do you address this problem?
   - 4.5 How is HIV/AIDS affecting school leadership and management and how do you address this problem?

**5. Questions on workplace support systems.**
   - 5.1 What workplace support systems do you have in your school to help teachers living with HIV/AIDS?
   - 5.2 What strategies do you have to implement these support systems?
   - 5.3 What do you think should be the role of the Department of Education in monitoring workplace support systems?
   - 5.4 How can principals ensure the provision of care and support to teachers living with HIV/AIDS?

**6. Questions on the legal rights and policies on teachers living with HIV/AIDS.**

6.1 Tell me about the legal rights and policies of teachers living with HIV/AIDS.

6.2 How do you deal with disclosure of information related to HIV/AIDS?

6.3 How do you create an environment and a culture of non-discrimination against teachers living with HIV/AIDS?

6.4 There is a trend that once the HIV-positive status of teachers is known, those teachers suffer stigma and discrimination. How can this problem be dealt with in schools?

**7. Questions on challenges faced by school principals.**

7.1 What challenges do school principals' experience in managing teachers with HIV/AIDS? Share with me your knowledge and experiences of these challenges.

7.2 School leaders are perceived as the answer to problems met in the handling of HIV/AIDS-related issues amongst teachers. Briefly share your knowledge and experiences.

7.3 What are the recommendations that you would like to make with regard to the leadership and management of teachers living with HIV/AIDS in schools

## Appendix B: Interview Schedule for Teachers

1. Brief me about your background.
    1.1 Age
    1.2 Marital status
    1.3 Any children
    1.4 Qualifications
    1.5 Experience

2. Share with me your experiences and knowledge about HIV/AIDS.

3. How prevalent and problematic is HIV/AIDS in school community?

4. What challenges have you faced before you knew about your status at school?

5. What challenges are facing from school to district level?

6. Share with me your experiences about stigma and discrimination.

7. How did you know?

8. Have you been able to disclose at work?

9. Have you been able to approach the principal?

10. Help me understand how your family responded.

11. After knowing your status, brief me about your experiences.

12. What support services are available at work?

13. What support services are available from the district?

14. What challenges did you experience before you knew about you status?

15. What is the approach advocated by the Gauteng Department of Education to managing HIV/AIDS at your school?

16. What is the principal's leadership role in, influence on and concern about the management of HIV/AIDS in your school?

17. What is your school community's approach and strategy for managing HIV/AIDS?

18. What is your perception of the principal's role in building school vision of what you may be able to accomplish in managing HIV/AIDS in your work together as a team?

19. Does your school principal stimulate school staff to feel and act like leaders and give you sense of overall purpose for your leadership role in managing HIV/AIDS, to be innovative and creative to question assumptions, reframe problems and approach old situations in your ways?

20. What are your perceptions of the actual leadership challenges raised by managing HIV/AIDS in your school?

21. Help me to understand your experiences about disclosure.

22. What makes it difficult to disclose?

23. What do you think can be done to create an environment where people are free to disclose and accept one another?

24. What are the policies that you have known protecting people living with HIV/AIDS at the workplace?

25. How much are the school communities aware of such policies?

26. In society principals are leaders and societies look up to them maybe as an answer to some of those problems that we have. Do you share the same perspective that principals are perceived as an answer to problems faced by people living with HIV/AIDS?

27. Share with me the perspective that traditionally principals are expected to produce results. Do you see those encountering challenges?

28. Does your principal lead by telling or by doing?

29. What are the challenges presented to principals/ educators by HIV/AIDS?

30. Does your principal create environment of culture and non-discrimination where HIV-positive teachers can open about their HIV status without fear of being discriminated against? Briefly share your knowledge and experiences on this.

31. Does your principal treat you as an individual with unique needs and expertise and provide the necessary resources to support individuals implementing the school's HIV/AIDS programme?

32. Any recommendations that you would like to make.

## Appendix C: Request for Permission Letter (To the Schools)

23307 Orange Street
Protea Glen Ext 26
Protea Glen
1818

25 July 2013

The Principal
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Dear Sir/Madam

**Re: Request for permission to do a research interview.**

I hereby request for your permission to conduct an educational research interview with you. I am currently studying for a Doctor of Education degree in Education Management with the University of South Africa. The title is, 'School leadership and teachers with HIV/AIDS: Stigma and discrimination in schools in the Gauteng Province of South Africa'. This letter serves to inform you that I Moyo Zvisinei; student number 47685875 enrolled at UNISA will do my research according to POLICY ON RESEARCH ETHICS of the aforementioned university.

The study will involve two sessions of interviews, which will take one hour per session with you. This study is being conducted under the supervision of Professor B. Smit (smitb@unisa.ac.za).

I would like to promise you that the research will be undertaken outside the teaching hours and that the interviews will not affect your management duties. Interviews will be conducted in accordance to UNISA CODE OF ETHICS that you may at any time

decide not to answer certain questions if you so wish to discontinue participation in the research study as indicated in the informed consent letter accompanying this letter. I assure you confidentiality and anonymity in the study.

Thank you in advance for understanding and considering my request.

Yours Sincerely

Moyo Z.
Email: zvisinei.moyo@vodamail.co.za
Cell: 0785627722

## Appendix D: Request for Permission Letter (To the Teachers)

23307 Orange Street
Protea Glen Ext 26
Protea Glen
1818

25 August 2013

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Dear Sir/Madam

**Re: Request for permission to do a research interview**.

I hereby request for your permission to conduct an educational research interview with you. I am currently studying for a Doctor of Education degree in Education Management with the University of South Africa. The title is, 'School leadership and teachers with HIV/AIDS: Stigma and discrimination in schools in the Gauteng Province of South Africa'. This letter serves to inform you that I Moyo Zvisinei; student number 47685875 enrolled at the University of South Africa will do my research according to POLICY ON RESEARCH ETHICS of the aforementioned university.

The study will involve two sessions of interviews, which will take one hour per session with you. This study is being conducted under the supervision of Professor B. Smit (smitb@unisa.ac.za).

I would like to promise you that the research will be undertaken outside the teaching hours and that the interviews will not affect teaching and learning. Interviews will be conducted in accordance to UNISA CODE OF ETHICS that you may at any time decide not to answer certain questions if you so wish to discontinue participation in the research study as indicated in the informed consent letter accompanying this letter. I assure you confidentiality and anonymity in the study.

Thank you in advance for understanding and considering my request.

Yours Sincerely

Moyo Z.
Email: zvisinei.moyo@vodamail.co.za
Cell: 0785627722

## Appendix E: Consent Form for Principals

I ----------, hereby agree to take part in the research project on: School leadership and teachers with HIV/AIDS: Stigma and discrimination in Gauteng Province schools in South Africa.

I understand that I will have to be available for two individual interviews by appointment and that the interviews will be recorded by means of an electronic recording device.

I understand that I:

- will not be asked personal questions and may at any time decide not to answer questions if I so wish
- at any time may ask for access to the thesis or part thereof and
- shall stay anonymous in the study.

---------- ----------

(Principal) Moyo Z. (Researcher)

## Appendix F: Consent Form for Teachers

I ----------, hereby agree to take part in the research project on: School leadership and teachers with HIV/AIDS: Stigma and discrimination in Gauteng Province schools in South Africa.

I understand that I will have to be available for two individual interviews by appointment and that the interviews will be recorded by means of an electronic recording device.

I understand that I:

- will not be asked personal questions and may at any time decide not to answer questions if I so wish
- at any time may ask for access to the thesis or part thereof and
- shall stay anonymous in the study.

---------- ----------

(Teacher) Moyo Z. (Researcher)

## Appendix G: Request for Permission Letter (Gauteng Department of Education)

507 Mhlatosi Street
Senaoane
P. O. Chiawelo
1818

25 July 2013

The Director
Gauteng Department of Education
111 Commissioner Street
Johannesburg
2001

Dear Sir/Madam

Re: Request for permission to do a research study.

I kindly request permission to conduct a research study in ten schools in Gauteng province. The research will be undertaken outside the teaching hours. The normal teaching and learning programme of the schools will not be disrupted and the confidentiality and anonymity of the participants will be respected.

I am currently registered at the University of South Africa (UNISA) for the Doctor of Education degree in Education Management. In order to fulfil the requirements for this degree, I am required to undertake a research study and submit a thesis related to it.

**Registered title of thesis**

School leadership and teachers with HIV/AIDS: Stigma and discrimination in schools in the Gauteng Province of South Africa.

**Details of research project supervisor**

Professor Brigitte Smit: Cell: 0824118847

Email: smitb@unisa.ac.za

**Motivation for and a short description of thesis**

The HIV/AIDS pandemic has badly affected the labour force, causing the economy to dwindle and breaking social circles. South Africa has the highest number of people living with HIV/AIDS in the world. Teachers, who are the main drivers of education are among the infected population. This is threatening the plans to better human life through 'Education for All', for instance, and the conceptualisation of schools as centres of community life. Teaching and learning is disrupted when teachers are sick or die due to HIV/AIDS. School leadership is under pressure to deal with the sensitive issues of teachers living with HIV/AIDS. Therefore, a study of how school principals' deal with issues amongst teachers living with HIV/AIDS is indispensable as it leads to the development of intervention strategies and plans of action to give close attention to teachers who have been infected or affected by the pandemic.

**Duration of the research and research participants**

I have reached a stage whereby I would like to start interviewing the principals and teachers as soon as possible. The interviews will take approximately an hour for each participating principal and two hours for teachers. The interviews will take place during long breaks and after school hours.

Hoping that my request will be considered.

Yours faithfully,

Moyo Zvisinei

UNISA student number: 47685875
Email: zvisinei.moyo@vodamail.co.za
Cell: 0785627722

---------- ----------

Signature Date

## Appendix H: Gauteng Department of Education Research Approval Letter

**GAUTENG PROVINCE**
Department: Education
REPUBLIC OF SOUTH AFRICA

**For administrative use:**
**Reference no. D2014/208**

# GDE RESEARCH APPROVAL LETTER

| | |
|---|---|
| **Date:** | **26 August 2013** |
| **Validity of Research Approval:** | **26 August 2013 to 20 September 2013** |
| **Name of Researcher:** | **Moyo Z.** |
| **Address of Researcher:** | **507 Mhlatosi Street** |
| | **Senaoane** |
| | **P.O. Chiawelo** |
| | **1818** |
| **Telephone Number:** | **011 984 4472 / 078 562 7722** |
| **Fax Number:** | **086 666 7347** |
| **Email address:** | **zvisinei.moyo@vo9damail.co.za**<br>**47685875@mylife.unisa.ac.za** |
| **Research Topic:** | **School leadership and teachers with HIV/AIDS: stigma and discrimination in schools in the Gauteng province of South Africa** |
| **Number and type of schools:** | **THREE Primary; FOUR Secondary and TWO LSEN Schools** |
| **District/s/HO** | **Johannesburg Central and Sedibeng West** |

***Re: Approval in Respect of Request to Conduct Research***

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

Approved
2013/08/30

1

*Making education a societal priority*

**Office of the Director: Knowledge Management and Research**
9th Floor, 111 Commissioner Street, Johannesburg, 2001
P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506

**The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:**

1. *The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.*
2. *The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.*
3. *A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.*
4. *A letter / document that outlines the purposé of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.*
5. *The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.*
6. *Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Director (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.*
7. *Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year. If incomplete, an amended Research Approval letter may be requested to conduct research in the following year.*
8. *Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.*
9. *It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.*
10. *The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.*
11. *The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.*
12. *On completion of the study the researcher/s must supply the Director: Knowledge Management & Research with one Hard Cover bound and an electronic copy of the research.*
13. *The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.*
14. *Should the researcher have been involved with research at a school and/or a district/head office level, the Director concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.*

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards

.....

Dr David Makhado
Director: Education Research and Knowledge Management

DATE: 2013/08/30





**Office of the Director: Knowledge Management and Research**
9th Floor, 111 Commissioner Street, Johannesburg, 2001
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## Appendix I: Principal Interview 3 “Mr Mokoena”

23 March 2014

Researcher: I wish to know about your profile information.

| | |
|---|---|
| **Age:** | 55 years |
| **Gender:** | Male |
| **Teaching experience:** | 29 years |
| **Experience as a principal:** | 16 years |
| **Qualification:** | Senior Teachers’ Diploma |
| | Diploma in management, administration and leadership |
| | Further advanced certificate in special needs education |
| | Bed school management and leadership |
| **Marital status :** | Married |
| **Number of teachers:** | 45 teachers |

Researcher: Briefly share your knowledge of and experience with HIV/AIDS.

1.HIV/AIDS is an illness that destroys the immune system thereby exposing the 2.human body to opportunistic diseases. It is rife mostly within communities with 3.black people and it has destroyed lives. The number of orphans is on the increase 4.as well as child headed families.

Researcher: To what extent is your school affected by HIV/AIDS?

5.We have learners who are affected and infected by HIV/AIDS. Everyone here is 6.affected. We have teachers who are infected and affected as well. The non-7.teaching personnel also are infected.

Researcher: The number of teachers who absent themselves because they are infected or affected by HIV/AIDS is on the increase, however you dealing with this problem in your school as a principal?

8.Teachers living with HIV/AIDS have disrupted teaching and learning here. During 9.the last periods of infection, teachers take errands to see doctors until everything 10.stabilises, then attendance improves. I have encouraged teachers to apply for

12.medical aid and it is of very important. It helps when people consult and buying
13.medicine. Teacher absenteeism has carried on for a long time and due to the
14.advert of antiretroviral treatment, everything has stabilised. However, we have
15.had teachers that were very sick and fragile to work so much such that they had
16.to resign. It was too late for interventions like ARVs. Teachers' absenteeism
17.disrupts teaching and learning.

Researcher: How is learning and teaching affected in your school and how do you address this problem?

18.Yes, teaching and learning is affected. To curb the problem, I have always
19.insisted on daily attendance. Teachers must perform to their maximum. Everyone
20.must play his/her part… the cleaners must clean; the drivers must fetch learners
21.on time and like everyone else. The last thing I want to know is the disruption of
22.teaching and learning timetable. Therefore, I demand to know the reasons behind
23.the absenteeism. They are aware that I do not condone teachers who buy
24.medical certificates from checking teachers living with HIV/AIDS have been left
25.with the only option of disclosing so that I understand the intensify of their
26.problems.

Researcher: How many teachers have disclosed and how long have you known?

27.More than 4 teachers have disclosed and some date back as far as 10 years. The
28.reasons of confessing could be that they want me to understand circumstances in
29.which they are living and why they absent themselves from work. Another could
30.be that they want to break this to anyone to lessen the burden. Also, they are in
31.need of help, for instance, referrals. They want to inform me about the
32.genuineness and reality of their sickness.

Researcher: How is HIV/AIDS affecting school leadership and management and how do you address this problem?

33.I have to know when my teachers are not feeling well so that I plan accordingly.
34.Learners must not lose their learning time and those gaps opened by absent
35.teachers need to be filled. Teachers have come forth to disclose.

Researcher: What workplace support system do you have in your school to help teachers living with HIV/AIDS?

36.My teachers trust me with their innermost secrets. I have not disclosed to anyone
37.about my teachers' status. Possibly teachers have encouraged other teachers to
38.disclose. He has provided counselling to those teachers that have disclosed to
39.him. I offer support, comfort and advice. The aim is to make teachers perform.
40.Through counselling, I have come to know about medical examinations and
41.routines that they go through until they are put on the antiretroviral treatment.
42.Some have experienced unbearable family problems due to their status for
43.example disintegration. I have always been available to provide counselling,
44.support and advise. Some teachers, however, have not disclosed, possibly due to
45.the fear of death, we also refer teachers to the District for psychological help.

Researcher: What strategies do you have to implement these support systems?

46.I advise teachers to seek medical help like antiretroviral pills that lengthen life
47.span. I fight to minimise disruptions in the teaching and learning timetable.
48.Absence of one teacher affects the whole system. Teachers do attend HIV/AIDS
49.workshops we do not have any support systems for teachers but for learners.
50Regular and consistent workshops. Robust debates information sharing about
51.HIV/AIDS. The department's support programmes are sporadic – maybe after
52.four years. When I refer teachers, duty limits from directly referring a person. I
53.have no jurisdiction and I am not supported. Sometime I am not sure about the
54.frame of mind, So that the labour relations set limits.

Researcher: How can principals ensure the provision of care and support to teachers living with HIV/AIDS?

55.To give counselling and offer support. Keeping their confidential information
56.maintains their dignity; teachers are involved in sexual relations amongst
57.themselves with teachers living with HIV/AIDS to show that their teachers are not
58.known. I do not have to ask why they are in these relationships because I also
59.assume that, as adults, they know how to protect their partners. We review our
60.policies. That is health issues during our end of yea whole school planning that
61.lasts for 3 days. Committees come up with year programmes.

Researcher: Tell me about the legal rights and policies of teachers living with HIV/AIDS.

62.Yes, I am aware about such policies; I cannot discuss such policies with teachers
63.because you cannot be sure of their frame of mind. The labour relations code of
64.conduct does not allow me to call teachers and discuss with them about policies
65.especially those that have disclosed. The first time they came to me, I was
56.available and I indicated referrals. Handling such issues is well above my needs.
67.My line of duty limits me from directly referring a teacher upon suspicion that the
68.person needs help in line with HIV/AIDS. The jurisdiction allows me to support
69.and counsel.

Researcher: How do you deal with disclosure of information related to HIV/AIDS?

70.Like I said, I have earned trust amongst my teachers because I do not share it
71.with anyone, even my deputy.

Researcher: How do you create an environment and culture of non-discrimination against teachers living with HIV/AIDS?

72.We have culture of standards. We have away with gossip. We do not give it a
73.chance. Corridor talk is not credited. It is not resuscitated. We marginalised it. We
74.have an engagement that we all make a contribution to maintain the standards. If
75.it happens then it happens in private corners so that our culture of secrets does
76.not allow it to reach the victims.

Researcher: There is a trend that once the HIV-positive status of teachers is known, those teachers suffer stigma and discrimination. How can this problem be dealt with in schools?

77.It has been minimal gossip, which is the main cause of stigma and discrimination
78.is not dignified in this school. We do not condone it; we do not entertain it. Yes, it
79.depends on physical symptoms. The moment it shows, we dismiss it completely.
80.We do not endorse gossip, we do not repeat it. I always ignore and give an ear to
81.things worth talking about. I make sure victims are protected. I have known some
82.teachers to be living with HIV/AIDS for 10 years now and everything has been
83.kept under wraps.

Researcher: What challenges do school principals' experience in managing teachers living with HIV/AIDS? Share with me your knowledge and experiences of these challenges.

84.We are not supported. A support programme is launched and soon after taking off
85.from the ground; it disappears only resurfacing after say 4 years. So teachers are
86.not supported in terms of health. This is a very sensitive epidemic that needs a lot
87.of support. My duties limit me from, say, going deeper into the issue even with the
88.teachers who have disclosed because I am not an expert into this field of health.

Researcher: School leaders are perceived as the answer to problems met in the handling of HIV/AIDS issues amongst teachers. Briefly share your knowledge and experience

89.Yes, my duties incline me to counsel, support and advise. I have known teachers
90.get some sigh of relief after they disclose to me. I have not disappointed, I have
91.always been available. I have led health discussions, which have led to the
92.acquiring of first aid kit boxes to help in case of injuries.

Researcher: What are the recommendations that you would like to make with regard to the leadership and management of teachers living with HIV/AIDS in schools?

93.Particular power is given to people who give support. Principals, for instance,
94.form the school based support team. They have no power to refer, advice and
95.support. The department of education must support school based support teams.
96.Presently support for teachers' health is in disharmonious conditions. The
97.HIV/AIDS victims must be able to disclose and, therefore, confidentiality must be
98.a priority on training programmes. Otherwise people might die silently or keep on
99.infecting others. Support structure need to be available in schools presently
100.teachers are referred to psychologists who form part of a wellness programme
101.aimed at emotionally and psychologically supporting teachers. This is far below
102.the level of support that teachers living with HIV/AIDS need.

## Appendix J: Teacher Interviewee 1 ("Mr Machalaga")

12 August 2013

Researcher: Brief me about your background.

**Age:** 46
**Gender:** Male
**Experience:** 15 years
**Marital status:** Married with 7 children
**Qualifications:** Senior Teachers' Diploma, Advanced Certificate in Education

Researcher: I would like us to start by briefing me about your background – how long have you been in the teaching field?
1.Fifteen years.

Researcher: And how old are you now?
2.I'm forty-six.

Researcher: Where else have you taught besides here in Gauteng?
3.Yes, only here in Gauteng.
4.Firstly, it was somehow difficult to get a permanent post and I experienced some
5.difficulties. Remember when we started it was somehow difficult, the department
6.was doing redeployment and it was difficult to get a permanent post.

Researcher: Aha.
7.Then I worked for several years without a permanent post because the
8.Department was then doing redeployment to black teachers but until 1998 I was
9.absorbed permanently and to so far the challenges that I think we are facing
10.remuneration. And of course I think the money that we get is not good enough
11.to afford all our needs.

Researcher: These are the challenges that you face in the teaching field. Would you share with me your experiences as a person living with HIV/AIDS?

12.I started getting sick on and off for a long time. After that sick, I admitted at the
13.hospital and not knowing that what kind of a disease I'm having. I even
14.exhausted my leave days and later the doctors' test and told me about the
15.disease. Counselled me about the disease and how to live life with the disease
16.like taking the ARVs regularly the disease is not yet curable but treatable you can
17.live long life as long as you follow prescriptions and like eating healthy eating like
18.fresh vegetables, fruits or any food that are having enough protein, vitamin all
19.those types of foods or any other type of food that have a-a-a-a proteins, vitamins
20.that are necessary. I was devastated… I felt like it was the end of the world. Hey
21.later I started taking those ARVs and then going for check-ups.

Researcher: Aha.
22.And then after that I realised that the disease is more treatable like any other chronic disease.

Researcher: Aha.
23.And then the department also is supporting in terms of helping for this kind of
24.disease because they are subsiding even the tablets e-e-e-e if you are a member
25.of medical scheme… A certain medical scheme you are entitled to receive the
26.ARVs according to prescription of the doctors. Thus, my history about how I knew
27.I was positive until now.

Researcher: Did you inform your principal?
28.E-e-e-e no! Remember when I was away for a long time, my leave days got
29.finished, I was not worried about that… My status traumatised me. But I knew
30.my principal was looking for me. I did not contact him or my colleagues. My
31.colleagues phoned and I told them that I was at my rural home in Limpopo. I was
32.fragile and lost weight. I felt like quitting my job.

Researcher: After that you came back to work, how did you know about the support provided by the department?
33.I came back to work when I was feeling better. I was desperate for support, I
34.went for counselling again and I was told about support groups for people like me.
35.I got to know how to contact the department's support system through an SMS.

Usually, the Department sent us information documents regarding the support of all the chronic diseases that the individuals is having. You just take to the help line concerning whatever chronic disease. Then they contact you about the support there is, though I never attended workshop concerning that and they used to email or SMS regarding all those necessary support that they can give you. In terms of counselling generally, not necessarily for HIV related or whatever problems but also financial as well as other things in life, like if you are e.g. somehow alcoholic. Those are some of the kinds of support, though I never attended that kind of a thing but that's the kind of support from the department; the scheme GEMS (Government Employees Medical Scheme) but from the team from the department whereby they will organise workshops at school level and the likes. I didn't see any support and since I never saw workshop concerning HIV from particular department in effect. GEMS is part and parcel of the government.

Researcher: What challenges did you face before you knew about your status here at school?

I would stay away from work when I was sick. It happened for a long time and I could see that I was disturbing the smooth running of the school. Firstly there was this assumption but if ever you are contracted with the particular disease you are going to die. I was losing weight and as you can see I'm thin naturally so if ever I lose weight I become very thin. So I could see people were pointing fingers at me because of my weight. A colleague advised me to go and test for HIV. But after realisation of the support that is counselling that I underwent I started to be strong – not to worry about the disease there was a lot about information that you can live longer as long as you follow the prescriptions. But stigma was there firstly because you see you are unaware of your condition and then you discover that you are sick. I wanted to be alone when I didn't want my colleagues to visit me. I knew they will destroy me, I knew they will gossip. Yah it was somehow traumatic but later on that stigma became less and less and also the people around from the family from the colleagues and then. I was accepted as… as… a normal person. At first, I could see people around me discriminated me and I suffered from that stigma. Actions speak louder than words. It's really painful. I did not receive much support from the school level. I was sort of isolated whereas I

66.expected my colleagues to sympathise with me. Although some measures are 67.taken to protect us at work but it is painful to be discriminated. Our school 68.celebrates the AIDS day but for this particular stigma it is not enough…it comes 69.once in a year.

Researcher: Yes, shade some more light on challenges that you faced from school level up to district level – from the department what are the challenges like you mentioned that there is not enough support at school level?

70.I think there are more challenges. I think if ever people have people living with 71.HIV/AIDS with them maybe should be particularly be given a lot of support from 72.the school level up to district level.

Researcher: Aha.

73.In terms of work-related issues… maybe whether maybe some sort of maybe 74.whether as an educator you are coping with your work with this chronic diseases 75.so that kind of if you are not coping what kind of support do you need in relation 76.to the workload that you are facing for example maybe I'm teaching at a high 77.school level maybe there is a lot of subjects workload and I must support this, I 78.must support that and mark and so this means all these things only find me in 79.an over loaded situation and then it affects also my health and thinking

Researcher: You can shade light on what support system you expect from school level and the aspect of disclosure.

80. I think it's a good point if ever sometimes I think our government; our education 81.department they are trying their level best to ensure support about AIDS-related 82.issues. But now the only challenge I have realised is to convince the people the 83.manner in which they should disclose. Disclosure that is the manner in which 84.people should protect themselves in terms of sex the main causes of which to me 85.which plays a very important role in spreading HIV. Poverty also plays a very 86.important role in people sleeping around. Also, protocol; is it possible to let's say 87.where to start from maybe from your colleague to a senior to the main manager 88.who is the principal and the like. All those make it very important because it might 89.be possible where maybe you can disclose that to your colleague or your friend 90.colleague… you are not whether they will go to your manager or they will gossip

about it I think that protocol makes everything difficult. You see the main problem is our department they don't have that vision of convincing people how to disclose and then people are still afraid of this kind of protocol. People are still afraid. If there could be a mechanism whereby people feel free because you see to me HIV/AIDS is not that much scary is one of the chronic diseases whereby it's not that much as people think. We used to have this assumption that whenever or if any person will contract AIDS that person will die. There are many chronic diseases like sugar diabetes, which are much more dangerous compared to HIV/AIDS so if people can realise that; I think it will also be simpler for them to can disclose and when you have disclosed you become relieved and whatever you are doing you become free.

Researcher: Have you been able to disclose at work; maybe a senior manager or colleague to say "this is what I am"?

Yah, I don't know if I did the right thing; it's difficult; I don't think its proper to go to any person… maybe to approach the relevant person to say 1 2 3. I did tell my very close friend colleague.

Researcher: Have you been able to approach the principal?

No! I approached a manager not the school head. I wasn't sure whether to approach the principal himself. Particularly I think maybe I assumed that the Head knew about that because of the information that I submitted after being absent from work for a long time; the doctors' reports and sick leave forms that I submitted and the likes. I submitted a medical report.

Researcher: What makes you not to want to approach the principal as the head of the school?

No, I assumed that through that report and the conversations that we sometimes have like let's say when I was in the process of applying for medical unfit. Through that conversation I think maybe I needed not to repeat myself to him regarding my status. I was talking to him about how we qualify for medical unfit and things like that. But I did talk to the principal regarding that and then maybe I should make some follow ups. Well, I intend to sit down with him and

116.talk many things regarding that! Not necessarily my status but other issues so I
117.think I need to sit down with him.

Researcher: When did you submit doctors' reports?
118.Way back in 2009.

Researcher: Do you see your principal being able to handle that matter?
119.I think through the conversation; but being the manager or the headmaster I
120.think he is supposed to be more knowledgeable because he is dealing with
121.subordinates in effect he is the father. He is sure that we need information
122.regarding this, even though he might not have enough knowledge he might
123.inquire.

Researcher: Do you see him welcoming you?
124.He needs to go out and look for information and support that I want. He needs
125.to look after his staff.

Researcher: What about fear, let's go back to fear. Why are people not able to disclose freely?
126.The thing of uncertainty, fear of disclosure and the likes maybe it depends
127.according to how do you relate to your colleagues and principal in terms of
128.sharing information and then maybe also maybe it might happen that after
129.sharing information they will gossip or discriminate against you. Or how the
130.problem is you get worried about how they are going to react. In terms of
131.relationships information sharing depends on trust. Maybe it is part of the reason
132.whether they would take that in a positive way or in a negative way. I think with
133.regard to the stigma of HIV/AIDS reaction is major.

Researcher: HIV/AIDS is stigmatised and there is a lot of discrimination. Would you share this with me?
134. To me yes! It depends on where you come from whether you get support from
135.family wife, parents, brothers and sisters. They have supported me. If you are
136.not supported then you are stigmatised. If you are discriminated, it has a
137.negative effect. Coming to the workplace; or, before the workplace, the

community from society at large; churches, clubs that is burial societies and the work situation. If you are experiencing discrimination; that is, then you can experience stigma, which might contribute to the deterioration of your health and you are psychologically affected… psychologically affected, which may in more negative treatment like relations with society. Because once you are psychologically affected you feel you are rejected. You feel the best way is to take your life but through but my I can say that for the past 5 years those people who have this disease... It has become much better because government has made various input regarding educating people that being HIV-positive is not the end of life. But prior to that there was not enough support. You remember former President Thabo Mbeki when he was saying ARV tablets could not treat HIV/AIDS whatever, but after that people from level of families to communities people have realised that a person living with HIV/AIDS must be accepted in the community, the workplace and should not be discriminated. Also, I think it depends on the type of work that one does because level of knowledge depends on the type of work and work environment. People practise discrimination like at school level I think through of lack of knowledge and professional language; people fail to understand what support we need. I think that way if we get support it makes one to feel stronger.

Researcher: Let's get back to school level, what support do you think must be available?

From the school level, I think we should have some regular workshops in order to address or talk more about this kind of disease and not only this one alone but other chronic diseases as well. Also, support groups whereby people talk more and more. We have an HIV/AIDS committee in the school and possibly if we could have regular workshops from the department (Department of Education) or relevant departments regarding support of educators. I think that will also help in the discrimination and stigmatisation of AIDS patients.

Researcher: These are suggestions that you would want to see, right. Is there any support in the school?

In this school there is only an AIDS committee. I am not sure about how it works because I have seen them organise one particular event that is the AIDS day

commemoration. Maybe if they could come up with another programme whereby we will see, for instance, every Thursday possibly from 13:00 to 14:00 hours or from 14:00 to 15:00 hours a programme whereby they organise people who are knowledgeable to come and support whatever thoughts we have.

Researcher: Any support from district level?

I think there are workshops although I never attended, because I used to hear from the committee that they are attending workshops from the district. I think the support that I have known from the District is through the medical aid scheme GEMS HIV/AIDS support group.

Researcher: Do they support non scheme members?

No, they only support members.

Researcher: What do you think about them not helping non scheme members?

I think it's one of the loop holes because being the government people they are supposed to support people in terms of this kind of stigma. I'm not the department… But I assume that they are sending a message that they are paying a lot of money in subsidy for the particular group so it's another condition set maybe to attract members to join the scheme. Remember we have people who are appointed on temporary contracts who are not able to join, so it's another loop hole that should be looked into.

Researcher: Aha.

And also I think the manner in which the department is running this kind of support group is not good enough to convince people just to attend because you just receive an SMS to say on Friday at 14:00hrs in Parktown there will be a support group from GEMS so maybe if ever there can be a yearly programme whereby they can draw a proper programme to say from this district on these particular dates there will be HIV support group because sometimes I miss. I just get an SMS to say on Friday I must go to Parktown, sometimes I don't even know Parktown so such things make us not to attend. There is a loop hole there.

Researcher: So you suggest that workshops be held here around maybe at the District offices?
190. Yes, the distance is reachable.

Researcher: Any other support system at district level?
191.AIDS awareness campaigns. But those people who usually go there don't give
192.us feedback. Maybe it is because we don't have a functional committee that see
193.to the reporting back of what transpired at the workshops. So the manner in
194.which the department itself runs the workshop is not good enough, it's not
195.convincing enough because people are not receiving the information. Maybe if
196.they could develop a mechanism whereby all people can receive information in
197.time can convince them to attend all those things. I think it's another loop hole in
198.which the department are running their workshops. They are not doing enough
199.to can reach all the ears of the people more particularly from the grassroots;
200.those who are affected particularly.

Researcher: So the support system from school to district level is not very effective. If there is no knowledgeable representative who gives feedback after workshops then you are not in a position to know where you are supposed to go when you have a problem. I think there is a problem there. What about Gauteng as a region or at national level? Have you ever heard about support system?
201.Yes, what I only heard of is through the newspapers, or the media rather adverts
202.about awareness like using condoms and things like that. The department of
203.health only distributes condoms, pamphlets and the like but how to make people
204.more aware; I don't know how to put it clearly because if you say people must
205.use condoms when having sex I don't think it's enough regarding the awareness
206.of AIDS. So from the national level, the minister of education budgets for various
207.provinces to districts down until the schools. I think along the way it's not enough
208.and the system from the national to the province to school level.

Researcher: Can we go back to disclosure? Do you think people are disclosing enough?

209.Maybe I should say if you are HIV-positive, you are HIV-positive. Hiding your
210.status doesn't change anything rather support can reach you and remember I
211.told you that after you disclose you become free.
212.From the past era until now I think many people are now starting to be free to
213.disclose although depending on the relationship. If you still remember if we can
214.go back I said that it might also sometimes depend on the relationship to that
215.person but now according to my experience I think people are just free to
216.disclose unlike in the past when it was more stigmatised that is when people
217.used to believe that it is the end of the world and unlike right now people are
218.starting to see that its part and parcel of life to be HIV-positive. Researcher: We have talked about fear and disclosure; maybe you can share with me your experiences.
219. Like I said earlier on, I really suffered at work and I'm still suffering. But I would
220.regard myself as lucky enough to get the support that I got from my family. It
221. was good support. I never experienced much stigma in the community because
222.you know once you fail to get support from your family, you get stigmatised and
223.it might affect you; it can traumatise you a lot. But, anyway, the main support
224.comes from the family, although I expected it from my workplace.

Researcher: And that person you were able to disclose from management. What was the reaction of that person?
225. Kind and supportive.

Researcher: How long did it take you to approach that person?
226. Not really easy but you see in my case we differ according to how a person is
227.strong. It was after a long struggle of gathering courage. After observing and
228.having known that person for a long time, I assumed that that person would not
229.gossip about me and would pass the message to the school head.
230.However, it didn't take me so long you know after realising that I have got 1 2 3
231.didn't take me long to accept. Yah we differ, some people take long to just
232.accept just to say I'm so. If someone can think positively then it becomes easier
233.to disclose. Since I had support from my family, I took it as a part of life.

Researcher: To what extent has your school been affected?

234. I don’t have concrete evidence except through rumours that there are learners 235.with HIV. I have heard that there are teachers and public servants also who are 236.living with HIV/AIDS. I don’t have much information but I have been following the 237.rumours.

Researcher: How did you take the gossiping as a person who has knowledge about this disease? Was it speculative or is it one of the reasons why people do not want to disclose?

238. Obviously gossiping is not good, it’s speculative, and it’s destructive. People 239.judge other people. It’s not much supportive it’s destroying but if you realise it it’s 240.where you can realise that the majority of people are still lacking that 241.information. Yah-yah I think it destroys.

Researcher: Yes, I think those are some of the factors that scare away people from to disclose their status. What do you think can be done at school level about it?

242.Lack of knowledge! That’s why I think it depends on information or knowledge 243.that people have. That’s why I suggested workshops to reduce stigma of this 244.disease because people do not understand but like if you get a person who can 245.give more vivid detail regarding support, information and many things regarding 246.the support you need if you have that kind of stigma. Yah you just become free. I 247.suggest more workshops on the knowledge of this kind of disease.

Researcher: Who do you think must spear head the workshops so that people can gain more knowledge and accept one another?

248.I think to me I suggest professional people who have knowledge. Maybe people 249.who are living with the stigma as well as role models. You know, people who 250.can really convinces people that this kind of a stigma is not as bad as people 251.think. Yah I think people living with the stigma can spear head the campaign.

Researcher: So you would want to see professionals coming to workshop teachers.

Researcher: We need to just revisit the things that we talked about. Be free to share with me what you think I need to know, this is more of a conversation than interview.

252.Are there any policies that you have known meant to protect people living with 253.HIV/AIDS at work?

254.Yes, I am aware that the government has produced non-discrimination policies
255.for the people who are affected by this kind of disease. For in case your
256.employer is not required to discriminate against people who are affected in
257.whichever way like dismissing you. But I never saw the document but I heard
258.about through information through the media but the document itself, I didn't see
259.it and I know there are policies that protect us.

Researcher: How much are the school committees aware of such policies?
260.I think school committees are aware more especially that the government is
261.emphasising all those campaigns through whatever resources. So to me they
262.are aware unless if they are not practising it. Knowing is one and practising is
263.another.

Researcher: In society right, principals are leaders and society looks up to them maybe as an answer to some of these problems that we have. Share with me your sentiments about this perspective.
264.Yes! I think it's one of their duties. I think they play an important role in educating
265.the community at large. They are role models; they produce products into the
267.society and they must be seen to possess knowledge that enriches
268.communities. Of course I with the condition that I have, I look up to him. It is
269.easy for people of his level to outsource expertise to help their staff.

Researcher: Share with me the perspective that traditionally principals are expected to produce results. Here is another role as you have indicated to educate the community; do you perceive them encountering any challenges?
270.Yes! It's quite a big thing that may be an extra load. But they can perform those
271.extra duties as long as they have the skill to arrange their time management and
272.also maybe the main duty they are employed for is to run the school and see to
273.it that the school runs properly of which is the main thing for the learners to
274.perform well and manage the educators well as well as the needs of the school
275.but also they can through their status of information that might be required and
276.also to influence.

Researcher: In other words they need to use their positions and educate society and perform those extra duties. According to your experience, have you witnessed principals being able to stand up to perform those extra duties?

Yes. I have worked with different principals….yes the majority of them that I have worked with used to perform extra work if required and to me I think they wanted to gather I think to gain support in terms of the needs of the school protection, fundraising, understanding the community in terms of their needs; promoting their school, getting the support of the community by bringing the confidence of the school by sending more learners and you know there is competition in our schools you see like we have different schools around and the principal is not working properly with the community around, parents may send their children to other schools. So I think by working with the community that is trying to understand them, trying to handle them you see you gain support. It's good to work well with the community around; understand them, they understand you. Principals can engage the community, they can bring people together.

Researcher: Don't you think that all these extra duties like when a teacher is HIV-positive are social problems that need counselling?

Really, it is a challenge. The principal has the duty to bring in experts regarding the problem, for instance, psychologists, social workers….those people who have expertise to come and maybe motivate educators and learners regarding this kind of situation. He can just organise professionals because really he can find himself overworked because some of the duties are demanding.

Researcher: Indeed, it is a process considering that one has to disclose then there needs to be trust so that the principal can source out the professional help.

Yah-yah it is a challenge indeed. Social issues interfere with delivering to learners. Principals are in an influential position and when they source out help it is not the same when teachers seek help. I think the other challenge here is trust; you know sometimes we might have our principal but assume that if I need help from him, my principal cannot handle it the way I like and obviously I might not consider him because of that trust and also I can add also on the relationship because now sometimes it depends on how much you are related to your senior. You might find that you are not in a good relationship and you fail to

go to him just because you are not on good terms so I think it's another challenge. I think the principal should treat their staff equally regardless of their challenges. Yes, differences are there you know; you need to build trust with your staff so that whenever I feel I need help I mustn't hesitate to come to you. But now if ever I sit down and realise that we are not treated equally then I cannot come to you and you see I lose trust in you; you see I realise that the treatment should be equal amongst staff members so that whatever problems I encounter as a person living with HIV/AIDS I can quickly go and approach my principal directly. You see I think and – and ….you see even the protocol, the protocol is rather challenging. I being a junior educator I went to the HOD (Head of Department) to say I got this and that HOD had to report to the deputy principals, sometimes you may find that the message was not put properly or conveyed in a manner that I want. As such they might kill the information and I think it's a challenge. Maybe if ever we should know which kind of protocol; should I go directly to the HOD to the deputy principal or to the principal because now I'm caught up in a situation that I don't know what to do because he is silent.

Researcher: After approaching the HOD, did the HOD come back to you to say the message has been conveyed?

Yes, and she promised me that I will get the report back very soon. The HOD didn't give me the feedback that I expected that is to say I can go and meet the principal rather she only told me that he passed the message. I'm hundred per cent sure that he is aware of my situation; I gave him the doctors' reports with everything in black and white that I got this. Maybe it's the protocol that misinformed him or I don't know.

Now that because I didn't get the feedback then you know I'm not sure now whether I did the right thing or I followed the correct channel. But I did follow the correct channel. The principal didn't give a report back or to invite me to sit down and talk.

Yes-yes I'm just giving some of the loop holes that I have seen. It causes misunderstanding and mistrust.

Researcher: Do you think we need protocol in disclosing status?

334.I don’t think so. I think maybe I should go direct.

Researcher: We need protection we need to be free to ask to speak to the principal and he/she must open doors and be prepared to listen. I’m worried about teachers not likely to get support because they are not known.

335.Yes, it’s a challenge. This is very sensitive. We should not be scared to
336.approach them. I think clarity is lacking. Intervention goes to known people
337.because now let’s say right now I don’t know whether I can trust someone else
338.let’s say if I’m comfortable in talking to someone from the District level. Should I
339.approach that person directly or that person should come to report to the
340.principal or also it might cause negative impact or maybe the principal might say
341.you jumped me and went to the district. I think we need clarity regarding this
342.because you might be wrong you might be right. I really don’t know.

Researcher: I have heard about a research person; a teacher and colleague who give support. Do you have such kind of a person in your school?

343.No-no-no we don’t. I think that’s a good structure that we really need at school
344.level. It will help in many things especially if that person is post level one. In
345.effect we do have a committee HIV/AIDS committee but I think that committee
346.needs a person who will attend workshops actively so that always he/she
347.advises the whole staff about new developments with the disease and whatever
348.in relation to the stigma.

Researcher: You are most welcome! Thank you for what we shared today. We will meet again.

## Appendix K: University of South Africa Research Ethics Clearance Certificate

UNISA | college of education

# Research Ethics Clearance Certificate

This is to certify that the application for ethical clearance submitted by

**Moyo Z [47685875]**

for a D Ed study entitled

School leadership and teachers with HIV/AIDS: stigma and discrimination in Gauteng Province schools

has met the ethical requirements as specified by the University of South Africa College of Education Research Ethics Committee. This certificate is valid for two years from the date of issue.

Prof CS le Roux
CEDU REC (Chairperson)
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Reference number: 2013 OCT/47685875/CSLR

22 October 2013

Open Rubric