

Managing pupils with HIV/AIDS in primary schools in Zimbabwe: A policy issue.

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Abstract

The purpose of this study was to find ways of helping teachers to manage HIV positive pupils in primary schools. It was motivated by the fact that, teachers have no resources on which to rely for the management of HIV positive pupils in their classrooms. HIV/AIDS campaigns centered on awareness, preventive measures and have nothing on teachers' care of HIV positive pupils. Teacher education curriculum and the primary school curriculum are silent on the care of HIV positive pupils. The study contributes to the achievement of three, Millennium Development Goals namely: Goal 3, "achieve universal primary education", Goal 4, "reduce child mortality" and Goal 6, "combat HIV and AIDS". The study was guided by a descriptive survey. Data were collected from a cluster sample of 91 primary school teachers who completed a self reporting questionnaire. This was complemented by data from Opportunistic Infections clinic documents, teachers' pupil health records and focus group discussions. The study revealed that, Opportunistic Infections clinic records had 458 cases of pupils who were confirmed HIV positive. Teachers suspected 71 cases and had only 20 cases in their pupil health records. Hence a lot of HIV positive cases are not reported. Some teachers are also not sure as to whose responsibility is it to manage HIV positive pupils in their classrooms. HIV positive pupils are affected by high rates of absenteeism due to illnesses. The school curriculum has no provisions for ill healthy HIV positive pupils. The study recommends marketing of these findings to education policy makers. Further studies can be done in other district to verify findings. Teacher education curriculum can include the management of HIV positive pupils in schools. Workshops on strategies to manage HIV positive pupils in primary schools can be held. Parents can be advised to inform teachers of the HIV status of their children.

Key Words: Primary school, HIV positive pupils, Policy, Managing schools.

Introduction

The words HIV and AIDS are common in primary schools. Teachers and pupils are affected by the pandemic. It is more challenging for primary school teachers who suspect a pupil to be HIV positive but have not been educated to assist such pupils appropriately. In Zimbabwe it is illegal for anyone to compel anyone to tell his/her HIV status, but primary school children require more supervision regarding the taking of ARVs. More important is that these HIV positive pupils require teachers' social and psychological support. Researchers and care giving organizations focus on food provision and home counseling, yet primary school children spent most of their time at school under a teacher acting in loco parentis. Lets trace the origins of HIV/AIDS.

According to Fieldman and Manchester (2002), AIDS was discovered in the United States in 1981 after many cases of unusual opportunistic infections. The most frequent infection was an unusual form of pneumonia called

Pneumocystis Carini Pneumonia. These cases of infection were reported in previously healthy homosexual men in California in New York. It was given the name HIV-1 in 1986. Anastasi (2000) proposed that in 1985, there was another rarer case contributing to AIDS, which was isolated in West Africa and was called HIV-2. Studies of stored serum specimen by UNAIDS (2001), have revealed that Central Africa had cases of HIV-2 for two decades before the recognition of the clinical syndrome of AIDS. During the 1980s, the HIV epidemic spread widely and became a pandemic.

Anastasi (2000) established three continents epidemiological patterns of HIV/AIDS. Pattern 1 countries include North America, Western Europe, Australia and New Zealand which had the epidemic starting in the late 1970s and early 1980s. The epidemic is said to have started among homosexual men and injecting drug users in Pattern 1 countries. Pattern 2 countries include most Sub-Saharan Africa and areas of the Caribbean. Transmission is predominantly heterosexual and peri-natal with an additional contribution from unscreened blood transfusions and inadequate injection procedures. Pattern 3 countries include North America, the Middle East, Eastern Europe and most of the countries of Asia with increasing numbers of HIV amongst intravenous drug users and prostitutes.

Zimbabwe, Karoi urban in particular where the study was carried out is in the Pattern 2 countries in Sub-Saharan Africa. According to Anastasi (2000), HIV/AIDS transmission in such areas is mainly through unscreened blood transfusions and inadequate injection purification procedures. This may be a contribution from national poverty and lack of resources for blood screening.

United Nations Report for 2002 propounds that 22 million people had died of AIDS by 2000, more than 40 million were living with the AIDS virus and 40 million, (75%) of them were in Sub-Saharan Africa. UNAIDS (2001) approximates that in every ten seconds somebody in the world dies of AIDS. These statistics are based on the adult population. Primary school children although among the victims, were sidelined.

Contextual Analysis

Ministry of Health and Child Welfare (2003) (MOHCW) suggest that HIV/AIDS was first reported in Zimbabwe during 1980s. UNAIDS (2004) elaborates that Zimbabwe has been hit hard by HIV/AIDS, and there is every sign that the impact will get worse in the next few years. MOHCW (2003) estimates the prevalence of HIV infection among adults in Zimbabwe to be 24.6% with an estimated 2000 people dying per week. Many of these people are parents who leave behind an even larger population of children with the HIV-Virus. Crouch (2002:120) shows that the number of Zimbabwe's children who have lost one or both parents to the virus is estimated to exceed 780 000. The probability of these children being HIV-positive is also high.

UNICEF (2004) reports that, the devastating impact of the AIDS epidemic is at its worst in the Southern Africa sub-region, where Zimbabwe is situated. This region is benchmarked against a historical context of widespread socio-economic vulnerability of the population over many decades. This vulnerability subjects adults and children to economic and social re-engineering in such a manner that they are left with little or no survival strategies. UNDP (2004) suggests that when the HIV virus first struck Zimbabwe in 1985, it found in place fertile socio-economic ground in the form of prostitution, intermarriage traditions and poverty.

In fact UNAIDS (2003) laments the erosion of previous and hard won infant and child survival gains in Zimbabwe during the 1980s by HIV/AIDS. UNICEF (2003) explicitly pegs the infant mortality at 72% higher than it would have been without the pandemic. It is estimated that AIDS will account for 70% of all child deaths, and that by 2010 the mortality rate among children in Zimbabwe was estimated to be three and half times as high as it would be without AIDS. UNAIDS (1999) estimates that between 57 to 100 000 children are living with HIV infection in Zimbabwe but does not tell teachers how to assist them. UNICEF (2003:51) suggested that by the end of 2001, the number had risen to 240 000 children between the ages, zero to fifteen. The majority of these children were infected by their mothers during pregnancy, delivery and through breast feeding. These children are in primary school requiring the help of the teacher. This implies that a high number of HIV positive children in Zimbabwe below the age of fifteen, which is the primary school going age are HIV-positive. As a result, treatment and medication of HIV positive children may be hard to get. Schools and teachers specifically became important sources of comfort, health care supply and caregivers.

HIV/AIDS Policies in Zimbabwe

The Zimbabwe government responded to the HIV/AIDS scourge through creation of a protective environment. It passed the Sexual Offences Act of 2000. The act clarifies that willful transmission of HIV/AIDS in a consensual

relationship or nonconsensual sex is a criminal offense. This includes marital rape and all rapists are now subjected to an HIV test which determines the stiffness of penalty. The anomaly in this law is that it does not enable vulnerable people like women and children to protect themselves at all. The law rather waits for them to be assaulted and infected so that it starts to be effected. In fact the transmission is “willful” when the accused admits knowledge of being HIV positive and had the intention to pass it on to the victim. This condition makes it difficult for any victim to pin the accused.

UNAIDS (2004) explain another piece of law that makes it an offense to traffic sexual minors. Children below 18 years in Zimbabwe are not allowed to be lured into the sex industry. The primary school age groups are within the sexual minors’ age group.

The Labour Relations (HIV and AIDS Regulations) of 1998 reiterates the constitutional rights of infected people in the workplace (Kaliyati et al, 2002). This implies that no one is supposed to be dismissed or victimized because of being HIV positive. Implied in this regulation is the fact that, teachers who are HIV positive cannot be dismissed. The possibility of the classroom teacher and pupil being HIV positive is also high. This could be a strong source for the teacher’s empathy for pupils who are HIV positive. Unfortunately parents may not declare the pupil’s HIV status.

Child Protection and Adoption Act makes it an offense to let children roam the streets, let them miss school or be dismissed from school because of their HIV positive status (Woods, 2008). Most children are missing school and some are even dismissed due to fear of stigmatization and isolation as highlighted by Mount Zion Ministries (2000). Such infringements of the law means that laws per se do not mean much if there are no material resources to effect or ensure that the tenets of the laws become reality.

The government of Zimbabwe also reacted to the AIDS pandemic by introducing the AIDS Levy. Fieldman and Manchester (2002) describe the AIDS Levy as a (3%) three percent deduction on the salary of every Zimbabwean. The money goes to the national coffers administered by a body called the National AIDS Council (DAAC). Whilst the idea behind the AIDS Levy is a noble idea, many AIDS victims including HIV positive teachers and pupils, are not aware of it, and hence not benefiting from the fund.

The other area that needs to be revealed is that, reports say that HIV/AIDS funds are at times delayed to be disbursed to beneficiaries. Mpofo et al (2003) noted that some districts fail to account for funds. For example, in 2002, nine districts in Matebeleland North failed to account for \$45 million given to them for AIDS. This led to delays in releasing more funds for beneficiaries. This implies that people infected with HIV/AIDS were suffering while millions of dollars were lying idle or misused due to failure to account for funds.

The Ministry of Education, Sport and Culture in Zimbabwe has embarked on HIV/AIDS awareness campaigns focusing on methods of HIV –virus transmission and preventive measures. There is nothing that has been put in place for the management of pupils who are already HIV positive. AIDS education was introduced from Grade three (3) and the AIDS syllabus and textbooks are supplied in schools. The syllabus concentrates on awareness and spread. However, it is silent on how teachers can assist HIV positive pupils in their classes.

School HIV/AIDS Activities in Karoi Urban

Various school activities that are HIV/AIDS related in Karoi urban primary schools are taking place. Teachers in the school, Non Governmental Organizations (NGOs), drama groups and other Anti-AIDS activists activate HIV/AIDS activities in Karoi. The kind of training and in-service these received lacked ideas or literature on the management of HIV positive pupils. As a result infected children are left out. They are at times forced by the situation to sing songs, recite poems or act drama on issues that do not concern them or assist their well being. As a result, school programmes that they are made to be part of, do not benefit them. Examples of the programmes or activities in Karoi urban primary schools are: AIDS awareness campaigns, Youth Festivals, Education through Sport, Competitions, Drama and Poetry, Formation of Anti-AIDS clubs in schools. Unfortunately all programmes on HIV/AIDS prevention do not help the child who is already HIV positive.

Other programmes include personal testimonies by HIV positive persons in prevention work. Crouch (2004) explain that visibility of persons living with HIV/AIDS within communities and schools have promoted more open discussion on AIDS and sexuality. Such activities do not assist on how the sick child with HIV in the classroom can be managed. In extreme cases the sight of a person at the advanced stage of HIV/AIDS related infection can be a strong source of fear and loss of hope for a child who is HIV positive.

School textbooks and the AIDS syllabus overlooked HIV positive children. School syllabus and the AIDS education syllabus concentrate on HIV/AIDS awareness. The way teachers are trained at teachers' colleges and workshops just equip them with skills to make pupils aware and reduce the HIV –virus transmission and not to manage them.

AIDS education textbooks in primary schools (Talk About It) also don't cover the aspect on strategies, skills and management of HIV/AIDS pupils in the classroom. Unfortunately some primary schools do not have the book. Some teachers have not been told of the status of some HIV positive pupils and don't know that such pupils exist in their classes. It is against all this that the researcher meant to find out strategies that teachers in Karoi urban can be equipped with to manage HIV positive pupils in their primary schools.

Statement of the Research Problem

The study is disturbed by the fact that HIV/AIDS campaigns concentrate on awareness, methods of HIV virus spread and sideline management strategies for HIV positive pupils in schools. According to Chimhangwa (2011), children have largely been excluded from HIV vaccine research over the years because of the need to first demonstrate the vaccine efficacy in adults. The problem is compounded by the fact that, teachers are not informed of pupils' HIV positive status, they have no resources to lean on making it difficult for them to render appropriate assistance to HIV positive pupils. Teachers' social record books are silent on the HIV positive pupils' status because legally, the HIV status of an individual is confidential.

The problem is affecting pupils. They cannot cope with their ill-health and school work leading to poor school performance. It also affects the school due to death rate, absenteeism and low school performance. Some pupils who may be an asset and useful to the school may even drop out of school due to deterioration of health.

Research Questions

The study sought answers to the following research questions:

1. What is the distribution of HIV positive pupils in Karoi urban primary schools?
2. What challenges do HIV positive pupils experience?
3. What challenges do teachers experience in managing HIV positive pupils?
4. What management strategies can improve teaching and learning of HIV positive pupils?

Significance of the Study

This study provides feedback to policy makers in education on gaps in HIV/AIDS programmes. It adds on to literature on HIV/AIDS positive pupils and how teachers can strategically manage them in primary schools. It is a source of HIV/AIDS programme debate by service providers. Curriculum designers and implementers, specifically teachers benefit from management strategies provided in the study which can also be included in the primary school curriculum. In addition, the study contributes to the achievement of three Millennium Development Goals namely: Goal 3, "achieve universal primary education", Goal 4, "reduce child mortality" and Goal 6, "combat HIV and AIDS".

Literature Review

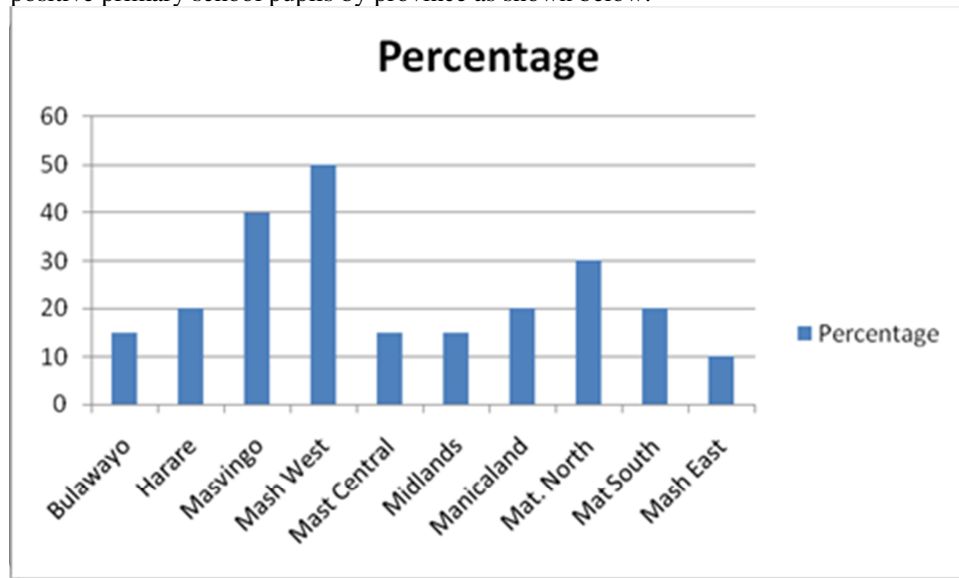
Distribution of HIV Positive Pupils in Primary Schools

Zimbabwe has one of highest prevalence of HIV/AIDS in the world as asserted by Fieldman et al (2002). In 1999, Zimbabwe estimated a population of approximately 12 million HIV positive people of whom 56000 were children zero to fifteen years (0-15). This is the age range in which primary school children are found. They are still young and need parental help provided by teachers.

UNICEF, (2000) claimed that, Zimbabwe has nearly 2 million orphaned children due to AIDS, and an estimated 142000 children below 15 years are HIV positive. Anonymous surveillance of women attending antenatal clinics in 2004 reported that 24 and 33 percent of pregnant women in urban areas and 53 percent of those in rural areas were HIV positive (UNAIDS, 2000). This implies that a high number of HIV infected children are through parent-child infection. This also implies that a high number of infected children are in primary schools.

The prevalence of HIV/AIDS among primary institution suggests that there are high infection rates as propounded by ZDHR Report (2002). This may be based on the belief that if men have sex with a virgin or young girl, it cures them of HIV and prevents them from developing full-blown AIDS. Shell and Zeilt in (2000)

also identified another source of children's HIV virus when they say some primary children in grades four, five, six and seven are involved in transactional sex for luxury goods. The ZHDR Report of (2003) compared HIV positive primary school pupils by province as shown below:-



Source: Malaba and Kaliyati, (2003:39) ZHDR Statistics.

Mashonaland West tops the list probably because it is a busy traffic route where commercial sex work has been reported to be rampant. This then poses a danger to the infection rate of primary school going children in Mashonaland West and Karoi urban in particular.

Reports by UNICEF (2004) reveal that the diagnosis of HIV in children is usually very difficult because of the presence of maternal antibodies in children. Most children infected will be symptomatic within three years. This means that most parents or medical practitioners may not know that a child might be HIV positive at an early age. Maybe when a child begins primary grades, he or she can show some signs and symptoms, unless the child had been tested at an early age.

Challenges Experienced by HIV Positive Pupils

Trauma and Confusion

More and more people are learning about their HIV status. De Matteo and Roberts (2001) noted that when people learn that they are HIV positive, many are filled with intense emotion and realize that many aspects of their lives are going to change. They will need to closely monitor their health, follow a medical regime and be expective. The situation is more complex when children are involved. The children need to face the reality of either being infected or affected by the virus.

The stigma and life-threatening nature of HIV makes parents worry about the effects of disclosure of the HIV status of their children as explained by SAFAIDS (2008). Worry is caused by fear of their emotional and physical well-being and family relationships that may be disintegrated. Zaccour (1990) agrees with the above point where he elaborates that nearly half of the parents first told their child that he or she had a medical problem without naming it HIV or AIDS. Fear of disclosure can be attributed to the stigma that is attached to HIV/AIDS. In particular the marketed view that, HIV/AIDS is a disease associated with prostitution.

Most children who are HIV positive get confused with the health changes in their life style without the knowledge of what caused them. Aggleton (2002) gave an example of some children who are taking Anti-retroviral drugs (ARVs) without knowing what they are and why they are taking them. Changes in their healthy trips to hospitals raises children's concern about the nature of their illness. ZHDR report (2002) supports the same point which states that about one in five children who are HIV positive notice behavioral changes in parents that concerned and worried them. Examples of behavioral changes are signs of deteriorating health, heightened concern for a child's health, mood or behavioral changes or some things parents said or did.

Research by Penner (1996) reveal that a young girl was wondering why she was being frequently brought to an infections Disease Centre. The girl was certain she had no infectious disease. Because she was not informed of

her HIV positive status, she felt it pretty weird why she went to an Infectious Disease Centre regularly. The situation implies that keeping children in the dark increases their fear, trauma and confusion on changes in them and their parents' behaviors and own lifestyle.

DeMatteo and Roberts (2008) went on to add that children need three things during this time: love, support, information and being treated normally. Since primary school children value their teachers most and spend most of their time at school, teachers are expected to provide the necessary love, support, information and normal treatment.

Stigma and Discrimination

HIV related stigma and discrimination are often prevalent in many of the communities and local settings to children that are HIV positive. Many children are reluctant to associate with others sometimes creating a stumbling block to effective disclosure associated with the illness (SAFAIDS, 2008).

Igor (2001) observed that, in HIV/AIDS, it is not the condition itself that hurts most, but the stigma and the possibility of rejection and discrimination. People who are HIV positive also have to deal with misunderstandings from others and loss of trust. Mount Zion Ministries (2000) also have this to say, that children with AIDS have to live with fear of being judged and rejected. Stigma and discrimination are real and often become more deadly than the virus itself. Crouch (2004:140) agrees with the same point where she says that children living with HIV/AIDS need to defeat self-stigma by answering these questions:-

- What are they saying about me?
- Are they washing that cup thoroughly because it's dirty or because I used it last?
- Why do they avoid shaking my hand?
- Maybe my teacher hates me because I am sick.

The above implies that self-stigma is more active and destructive in the lives of HIV positive children. The situation is enhanced by the fact that the majority of HIV positive pupils are not aware of their status. Their teachers are also in the dark. As a result, HIV positive children are on the look out for tones of voice or body language that they consider negative to their ill-health and this increases their fear and stress. Fear and stress are very unhealthy for HIV positive primary school children because the two may cause them not to concentrate in school work. Woods (2008) noted that lack of concentration may therefore, lead to poor school performance, lack of interest in school or even dropping out.

Ill-Health

HIV positive children face bouts of life threatening illness interspersed with periods of reasonably good health. Chimhangwa (2011) explains that HIV positive children fall ill very often, and it is known that HIV exacerbates other preventable conditions of morbidity and mortality, such as acute respiratory infection, diarrhea, malaria, malnutrition and prenatal conditions. The children may not know how to protect themselves from opportunistic infections such as tuberculosis. Eventually, the virus begins to take its toll and the infected child may be bedridden. Such ill-health that is on and off had challenges on children's performance at school since absenteeism due to ill-health may be the order of the day. Lack of attention due to sickness or attention to some timetable to take medication may disrupt a child's learning activities.

ARVs are generally in short supply as highlighted by the Irish Aid (2008). As a result, frequent shortages of the ARVs may mean that the children may inevitably miss taking their drugs for some periods. This is cause for concern as skipping to take them may lead to drug resistance. Irish Aid (2008) also explains the ethical challenge and questions the anomaly of giving children ARVs without telling them why they are taking them. It is unethical and an infringement on children's rights since children should be aware of why they are taking the drugs. Such a challenge may lead HIV positive children not to have trust in all adults, including the teachers that teach them. Lack of trust may lead to barriers to communication or communication failure in the teaching or learning situation.

In the absence of ARVs, the majority of children do live beyond their primary school level. Chimhangwa (2011) however argues that unfortunately, children have largely been excluded from HIV vaccine research over the years because of the need to first demonstrate the vaccine efficacy in adults. As a result, 13 300 children under the age of fifteen died from advanced AIDS related illness in 2009 owing to lack of timely interventions. Lack of timely interventions may lead to various kinds of disruptions to primary school children because of several other preventable conditions that may be experienced such as diarrhea and tuberculosis.

Decline in the living standards

Malnutrition has contributed to a decline in living conditions for children living with HIV. They develop AIDS faster which decreases the effectiveness of ARVs for those who are receiving treatment. Some ARVs have to be taken before and after meals (SIDA, 2000). While it is essential that those on ARVs receive adequate nutrition for drugs to work effectively, Woods (2008) alleges that there are reports of HIV positive children in such desperation that they are actually selling their ARV medication in order to buy food. Such a situation poses a challenge to the health of such children since ARV course should be taken as instructed. If not taken as instructed, HIV positive children may experience bouts of illnesses that may be a challenge to their performance in school.

Poor nutrition may also be a result of the fact that some HIV positive children are orphans. The HIV positive orphans may be transferred to various relatives who may offer them inadequate care and support reflected by inadequate schooling through poor performance, drop out and psychological scarring. This implies that the emotional and psychological well being of such children should be provided by the classroom teachers.

Challenges Experienced by Teachers in Managing HIV Positive Pupils

The Ministry of Education's response to HIV/AIDS has been described by President Mugabe as slow, weak and selective (Aggleton, 2000). Despite the talk of the need to implement a multispectral response, the response has largely been biomedical driven by the health sector. The biomedical approach focuses its solutions on prevention, care and support of the infected and the affected at community level. However, the infected and affected in the primary school classroom has no prescribed cookbook on how he or she can be managed.

Crouch (2004) noted that, the education curricula is silent on how HIV positive pupils can be managed. As a result, only those affected adults, pregnant women and others are taken care of and teachers are left to improvise management strategies for HIV positive pupils in their classrooms.

Most teachers during their training were not prepared to handle HIV positive children (Chiremba et al, 2004). As a result, when they are required to deal with HIV positive pupils, they feel lost because they lack knowledge on how to manage such pupils. HIV/AIDS textbooks for primary schools (Lets Talk Grade 4 – 7) are equally silent on the prescribed protocols of how teachers can manage HIV positive pupils.

SAFAIDS (2008) also elaborate another challenge that teachers face, the fact that parents do not disclose the HIV status of their children to teachers nor to the children themselves. As a result, some teachers do not know some children's drug timetables. Children are usually playful, and need the teacher's help when they forget the stipulated time to take their drugs. Some teachers may not even know why a child is absenting himself from school and may regard it as truancy or lack of interest in school work (Woods, 2008). Most teachers' Social Record books are silent on the HIV status of the children they teach (UNICEF, 2008).

Some teachers are also not sure as to whose responsibility is it to manage HIV positive pupils in their classrooms. Woods (2008) went on to add that it's not clear whether it is the headmaster's, deputy head's, teachers' or matron's responsibility to manage HIV positive pupils. What is not clear is how teachers in Karoi urban primary schools are managing HIV positive pupils in their classrooms.

The teacher-pupils ratio in schools also pose challenges for teachers to concentrate on HIV positive pupils all day long. As a result, Wood (2008) accepted that, excessive workload together with poor remuneration lowers teachers' morale to manage HIV positive pupils in the classroom. Some teachers cannot examine their beliefs, attitudes and behavior towards those who are infected and affected. Some teachers unknowingly promote stigmatization without realizing it through the way they talk or act.

Research Methodology

Research Design

The study made use of the descriptive survey research design. The design allowed data collection from many people in a short time to by asking questions. Heppner (2002) justifies surveys for allowing people to bring out feelings, emotions and experiences in a flexible language. Herbert (2004) propounds that the descriptive survey research identity variable existence. In this study, the required variables are HIV positive pupils and management strategies. The design explores possible factors in the study such as challenges faced by HIV positive pupils. Challenges faced by teachers in managing and teaching HIV positive pupils and the strategies that can be used in

managing HIV positive pupils are also to be explored. This kind of design allows the use of several methods and instruments in data analysis and presentation.

Population

The population of interest to this study are 125 primary school teachers and pupils in Karoi schools. Karoi urban has five primary schools. Karoi Junior has 18 teachers, Chikangwe Primary has 40, Tafara has 15 and Karoi Enterprises has 10 teachers. Each school is expected to have unique management strategies for HIV positive pupils. Each school is regarded as a cluster.

Sample

The researcher's sample was chosen using cluster sampling. Proportional sampling was applied from school to school to cater for the quantitative variations. Since the number of participants in each school is small, purposive sampling was applied. Participants were selected on the basis of their being available, willing to participate and having something to contribute. Fifty-one (51) teachers were chosen to respond to the questionnaire using cluster sampling. The number chosen was proportional to the number of teachers at the schools.

Purposive sampling was also used to choose participants for the Focused Group Discussions (FGDs). Herbert (2004) explains that this kind of sampling is when the researcher includes only those teachers or participants who were willing to be included in the Focused Group Discussions. 30 teachers participated in the FGDs. The sample size was considered statistically large enough for findings to be generalized.

Instruments

The main instrument for this survey was the questionnaire. It sought participants' demographic data, suspected HIV positive pupils by age and gender. Other questions sought challenges experienced by teachers in the management of HIV positive pupils in Karoi Urban. Challenges experienced by HIV positive pupils were also asked in the questionnaire. Questions also extracted strategies on the management of HIV positive pupils.

The issue of HIV/AIDS is sensitive, requires anonymity and individual responses offered by questionnaires. Data was gathered quickly even in the absence of the researcher. Teachers are literate and able to express their views in writing. Responses were kept in their original state for analysis. However, the questionnaire restricted the researcher from probing for information.

Focused Group Discussions (FGDs)

Sarason (1974) describe FGDs as discussions around a related topic of questions. FGDs were conducted to capture group views. These involved 10 teachers at a school. FGDs, were managed by the facilitators who conducted the discussion and the recorder. Three FGDs were conducted in total. Group interaction encouraged generation of ideas. Woods (1992) elaborates that FGDs have an effect on participants of producing correct information and insights that would not be obtained from individual interviews.

Documentary Analysis

Information from the Opportunistic Infections Clinic records (O.I clinic) and Social Record Books for class teachers were analysed. Researchers got information of pupils from Karoi urban schools who are claimed to be HIV positive by age and sex from Karoi District Hospital. The O.I clinic records provided the number of primary school pupils who are registered as HIV positive pupils. The age of pupils on O.I records enabled the researcher to compare with the information from teachers' responses on questionnaires.

Findings and Discussions

Table 1, Teacher distribution by class and gender

N = 51

Grade Taught	Male	Female	Total
ECD (Grade Zero)	1	2	3
Grade 1	-	5	5
Grade 2	-	5	5
Grade 3	2	3	5
Grade 4	3	2	5
Grade 5	2	4	6
Grade 6	10	1	11
Grade 7	7	1	8
Special Class	-	2	2
Total Teachers	26	25	51
Percentage Frequency	51%	49%	100%

The respondents were composed of (51%) male and (49%) female. The gender responses by grade show that more female teachers are in the Infant classes and Special Classes than male teachers. One can infer that female teachers are regarded to understand children more than male teachers. Only two females (4%) are in grade 6 and 7 classes. Because female teachers seem to understand children more, they are deployed for young children (Infant classes) who require teacher patience and tolerance. Female teachers are expected to be sympathetic with children who are HIV positive.

Table 2, Distribution of known and suspected HIV positive pupils by gender N = 91

HIV status	Boys	Frequency	Girls	Frequency	Total Frequency
Known Reported Cases	5	0.5%	15	1%	2%
Suspected Cases	30	3%	41	4%	7%

The table shows that, there are more suspected cases (78%) than known reported cases of pupils who are HIV positive. More female pupils are reported and suspected to be HIV positive. Teachers considered a child as a suspect for the HIV-virus basing their evaluations on the pupil's health condition. This measure may also be dangerous since on and off diarrhea or loss of weight by a pupil may not imply that the pupil is HIV positive. Suspecting a pupil may also influence the manner in which the teacher treats that child. Preferred cases are those verified by doctors. The majority of teachers (75%) confessed ignorance of the HIV status of their pupils. Researchers deduced that, there is limited communication between teachers and parents about the HIV status of pupils.

Distribution of HIV Positive Pupils in Teacher's Social Record Books

The teachers' Social Record books, were had nothing on pupil's HIV positive status. No such column provisions. School heads explained the omission by saying, teachers cannot solicit information on pupils' HIV positive status. A pupil's HIV status is considered the pupil's confidential information. As a result, the silence on teachers' record books on pupil's HIV positive status implies that parents don't disclose such information to teachers or even to pupils themselves. One perspective could be that, teachers do not consider knowledge of their pupils' HIV status important for them.

The most common ill-health problems recorded in teachers' record books are tuberculosis, malaria, hepatitis, asthma, diarrhea, herpes and headaches. These ailments are usually associated with people who are HIV positive and they are also the opportunistic ailments that HIV positive people usually struggle with. The fact that these ailments were common in most Social Record Books made the researchers suspect that the majority of parents did not disclose the HIV status of their children to teachers.

Table 3, Opportunistic Infection Record of HIV Positive Pupils in Karoi urban N = 458

Gender	Number of Positive	Percentage
Boys	198	(43%)
Girls	260	(57%)
Total	458	(100%)

Opportunistic Infections records revealed that they are 458 pupils in Karoi urban who are HIV positive. They are 198 boys and 260 girls within the (5 – 15) years age group. The Opportunistic Infections staff explained that more girls than boys are HIV positive due to some cultural practices that do not protect the girl child. Examples of such practices are “chiramu” which pacifies girls to submit to sexual advances from their sisters’ husbands. Interviews with Opportunistic Infections staff also revealed that most girl children are also vulnerable because regardless of their age, girls may participate as caregivers to HIV positive parents. Since children are not trained as caregivers, they may end up contracting the disease because they won’t know the protective measures to take. Girl children in grade six and seven may exchange sex for food if they are left as child headers at their homes. Another view can be that, females generally report their health conditions more than males.

The Opportunistic Infections staff also revealed that the number of HIV positive pupils in Karoi urban might be more because some parents do not come for HIV screening with their children. As a result, the known cases may only be of those parents who were willing to bring their children for screening. Some parents still believe that HIV testing is expensive and don’t come for tests. Some are not willing to know, they are scarred of knowing that they are HIV positive.

Another issue of concern to the researchers is the difference between cases that were reported to the teachers and those from the Opportunistic Infections clinic. The difference is too big for teachers are managing pupils they are not aware of their ailments. Comparison of records from the Opportunistic Infections clinic from teachers’ responses is show below:

Table 4, Comparison of reported, suspected and verified cases of HIV Positive Pupils from

	Boys	Girls	Total
Reported known cases by teachers	5	15	20
Suspected cases by teachers	30	41	71
Opportunistic Infections Records	198	260	458

The difference between Opportunistic Infections records and reported cases is 438. The difference between Opportunistic Infections records and suspected cases is 387 and the difference between reported cases and the difference between reported cases and suspected cases is 51. This implies that some HIV positive pupils have not yet shown signs and symptoms of HIV infection. They look healthy and are cared for in any way by the school. The distribution of HIV positive pupils in Karoi urban do not tally to with known and suspected cases by teachers. This shows that teachers are kept in the dark on pupils’ HIV positive status yet they are the very people who are supposed to manage them.

Table 5, Challenges Faced by HIV Positive Pupils

Teachers in Karoi urban identified the following challenges HIV positive pupils’ experience.

Challenges Identified by Teachers	Number of Teachers	Percentage
Absenteeism due to ill-health	51	100
Stigmatization	41	80
Discrimination	43	84
Lack of concentration due to Ill-health	51	100
May not trust friends or teachers	28	55
May experience labeling	33	63
Vivid signs of illness may lead to isolation	25	49
Poor school performance	51	100
Clash of timetables for those who are taking drugs and teacher is unaware.	24	47
Activities are not modified to match their health	13	25
Illness may result in drop out	35	67
Sleeping in class due to drug side-effects	30	59

All the respondents 100% indicated that absenteeism is the order of the day for HIV positive pupils because most times, the pupil may be too sick to attend school. All the respondents indicated that lack of concentration due to ill-health and poor school performances are challenges an HIV positive pupil encounters. Lack of concentration may be due to ill-health or attending to other ill-health issues such timetable for ARVs. If the teacher is not aware that the child is on ARVs, no one may assist the child or remind the child on the timetable for drug taking. Such a challenge may shift the child’s concentration from school work.

The other challenge that was indicated by 25% of the respondents is that school activities may not be modified to match their health. The other 45% of the respondents also indicated that vivid signs of HIV/AIDS illness may lead to isolation by other pupils and this may lead to poor self-esteem. Vivid signs of HIV/AIDS may also lead to stigmatization and discrimination and other respondents also indicated that some sick pupils may lose friends leading to further isolation or even drop out. The issue of dropping out of school due to ill-health was indicated by 67% of the respondents. The illness may take a high-toll on the child's health such that the pupil may end up leaving school.

Table 6, Challenges Experienced by Teachers in Managing HIV Positive Pupils

Challenges Experienced by Teachers	Number of Teachers	Frequency %
Lack of skills to manage them	41	82
Lack of knowledge to manage them	45	88
Lack of books for teachers to use on how to manage them	33	65
No exchange of knowledge between the school and home	36	71
No protective clothing such as gloves	29	57
The curriculum had no ideas for managing HIV positive pupils.	32	63
Difficult to improve their progress	31	61
No timetable at school for HIV positive pupils	27	

Respondents explained challenged that teachers experience in managing HIV positive pupils. On this view, 82% explained that the teachers had no skills to manage the HIV positive pupils. The training the teachers receiving during their Diploma training as indicated in their demographic data for qualifications did not equip them with skills to manage HIV positive pupils.

Also on teachers' challenges, 88% of the respondents also indicated lack of knowledge to manage them and 65% also explained on lack of books to use as cookbooks on how to manage HIV positive pupils. There are no prescribed books that teachers can use on strategies to manage HIV positive pupils since AIDS textbooks in primary schools (Let's talk) just carry information on awareness of HIV/AIDS and not on the strategies to manage HIV positive pupils in the classroom. They are a neglected group left to suffer alone with no-one having the skills or knowledge and prescription to manage them.

Managing pupils who are HIV positive is very difficult due to lack of resources. Some 57% of the respondents explained that lack of protective clothes like gloves makes it a challenge for teachers with HIV positive pupils in their classes to manage them.

The education curriculum itself is not tailor made to suit HIV positive pupils. On this point, 63% of the respondents explained that the school curriculum and even the HIV/AIDS syllabus did not put any ideas on how HIV positive pupils should be managed. The other 53% of the respondents also pointed out that the school timetable does not give teachers allowance to deal with HIV positive pupils but the whole class. The school timetable was only made with the healthy pupil in mind and no time is allocated for those pupils who are HIV positive and sick.

Table 7, Teacher Strategies to Manage HIV Positive Pupils

Management Strategies by Teachers	Frequency
Imparting life skills	72
Teach pupils to accept their HIV status	60
Encourage pupils to comply with medical assistance	56
Create child friendly schools	73
Uphold confidentiality and privacy	81
Discourage self-stigma	65
Ensure the HIV positive pupils is kept in school at all costs	53
Start school self-help projects e.g gardening	88
Show them love and hope	90
Don't give them preferential treatment, show them empathy not sympathy	92

Table 8, Assistance that Teachers Require to Help HIV Positive Pupils

Assistance Teachers Require	Frequency
Counseling skills	100
First aid kits and painkillers	65
Current information on managing HIV positive children	72
Staff development and workshops	95
Manuals and guides	55
Trained on basic skills of handling ailments in HIV positive pupils.	78

All the respondents agreed that teachers should have the management strategies to manage the HIV positive pupils. On this idea, 72% identified that teachers need to have a strategy of imparting life skills in pupils so that they can be aware of how they can deal with their HIV positive status. Also 60% of the respondents explained that teachers should have a strategy of teaching pupils to accept their HIV positive status.

About ARVs, 56% explained that some HIV positive pupils are on ARVs. Thus teachers should teach the pupils the strategy to encourage them to comply with medical assistance so as to avoid drug lapse and resistance. If the pupils comply with their medical assistance, it boosts their immune system and that's a way of managing them.

Respondents also highlighted that teachers should manage the pupils by creating child friendly schools. On this point, Seventy three (73%) of the respondents also explained that the HIV positive pupils should be protected from unruly pupils who may label or discriminate them. The other eighty one (81%) of the teachers also expressed that for teachers to create child friendly schools to HIV positive pupils, they should uphold the ethical code of confidentiality and privacy.

On teachers' challenges again, 72% of the respondents expressed that teachers needed current information on managing HIV positive pupils as well as manuals and guides on how they can manage the HIV positive pupils. On the same view, 95% of the respondents said that Staff Development and Workshops can equip teachers with strategies to manage ailments some HIV positive pupils experience here and there. In the whole, the suggested management strategies can only be useful if teachers are equipped with skills on how to apply them to manage HIV positive pupils.

5.4 Recommendations

The recommendations are aimed at creating or adopting a management strategy plan in the management of HIV positive pupils as follow:-

1. Marketing of findings of this study must done to the District Education Officer, and to also seek permission to discuss these findings at teachers or headmasters meetings.
2. Findings should also be marketed to teachers and seek their support. This can be attained through use of Focused Group Discussions with the teachers.
3. Headmasters to discuss findings with parents especially advocating reporting HIV positive cases to teachers than to leave teachers unaware.
4. Teachers should attend workshops so that they are equipped with knowledge of managing HIV positive pupils.

5. Pupils should be made aware that disclosing their HIV positive status to teachers who teach them is useful.
6. Periodic monitoring and evaluation of effectiveness of the Management Strategic Plan for managing HIV positive pupils at District level should be a must.

References

- Aggleton, X. (2002). *An Analysis of Zimbabwe's Programs in HIV/AIDS*. Harare: ZWPOW.
- Anastasi, B. (2009). *Applied Psychology*. London: Mgraw Hill.
- Crouch, M. (2004). *Community Home Based Care Standards*. Harare: MOHCW.
- Chimangwa, W.(2011). *HIV/ AIDS in Schools*. Harare: College Press.
- Chiremba et al (2004). *Health Behaviour*. Harare: Zimbabwe Open University
- Central Statistical Office (1999) *Zimbabwe Demographic and Health Survey*. Harare: MOHCW.
- DeMatteo, D. and Roberts,T. (2001). *Dealing with HIV AIDS in the Classroom*. Harare: Longman
- Fenald, L. D. and Fenald, P.S.(1989). *Introduction to Psychology*. Boston: Houghton Mifflin and Company.
- Fieldman, B. and Manchester,M. (2002). *Positive Children Voices and Zimbabwe Report*. Mauritius: Blackwell.
- Herbert, F.(2004). *Research Methods*. New York: Basil Publishers.
- Heppner, P.(2002). *Applied Research*. London: Blackwell Publishers.
- Igor, R. (2003). *Pastoral Counselling: A Christian Response Geneva Council of Churches*
- Irish AID 2008 *HIV AIDS in the Classroom*. Harare: University of Zimbabwe.
- Judd, R.(2004). *HIV Positive Children*. Dallas: Blackwell Publishers.
- Kaliyah et al (2002). *HIV/ AIDS and Child Labour in Sub Sahara Africa*. Harare: ILO
- Lourens, P.(2004). *Dealing with HIV Positive Children in Africa*. Cape Town: Breach Publishers.
- Makore- Rukuni, M.N. (2000). *Introduction to Research Methods Module CD 204*. Harare: Zimbabwe Open University.
- McLeod, F.(2000). *Research in Counselling*. London: Houghton Mifflin Company.
- Molestani, P. (2003). *The Challenges of Teachers in Dealing with HIV/ AIDS*. Lusaka: Longman
- Mhlovi, E. (2006). *The Challenges For The Educators*. Harare: Longman.
- Mount Zion Ministries (2000) *HIV/ AIDS In Home Based Conditions*. New York: Mount Zion Ministries
- MOESC (2001) *Declaration Of Commitment on HIV and AIDS* . Cape Town: Global Action Crisis.
- Mupawaenda, F.(2002). *HIV/ AIDS on Children*. Harare: Longman.
- Mupawaenda, F. and Murindi, J.(2002). *Impact of HIV /AIDS on School Children* .Harare: Longman
- Mpofu et al (2003). *Community Psychology*. Harare: Zimbabwe Open University
- Netzel et al (1991). *Resesarch Methods*. Boston: Basil Publishers
- Penner, Q.(1996). *The Zimbabwe HIV/ AIDS* .New York: UNAIDS

- Reynolds, D.(2002). HIV Positive Educators. Geneva: CDR Publishers
- SAFAIDS (2008). Facing The Challenges of HIV/ AIDS. Harare: SAFAIDS
- Sarafino, E. R. and Armstrong, P. W. (1980). Child and Adolescent Development. Dallas: Blackwell Publishers
- Sarason, P. (1974). Introduction to Psychology. London: Houghton Mifflin Company
- Shell, S. and Zeilit, P.(2000). Positive Outcomes ; Chances of Acquiring AIDS during School Going Years .Eastern Cape: UNICEF
- SIDA (2000). HIV/ AIDS and Education. Harare: SIDA
- UNAIDS (2010). The International Partnership Against AIDS in Africa. Geneva: UNAIDS
- UNAIDS (2002). The Impact OF HIV and AIDS. Cape Town :UNAIDS
- UNAIDS (2001). Gender and HIV AIDS. Harare: UNAIDS
- UNAIDS (2000). Best Practices in HIV and AIDS Programmes. Dareslam: UNAIDS
- UNAIDS (1999). Zimbabwe Fact Sheets on HIV and AIDS. Harare: UNAIDS
- UNICEF (2008). Teachers and HIV/ AIDS. Gaborone:UNICEF
- UNICEF (2005). Response to the HIV Pandemic .Harare: NatPrint
- UNICEF (2004). Health service provision for HIV positive children. Cape Town: UNICEF
- UNICEF(2003). Situational Assessment and Analysis of Children in Zimbabwe. Harare: UNICEF
- UNICEF (2002). Commitment in HIV/ AIDS. Gaborone: UNICEF
- UNICEF (2000). Situational Assessment and Analysis of Children in Zimbabwe. Harare: UNICEF
- UNICEF(2000). HIV/AIDS Strategies. Harare: UNICEF
- UNICEF (1984). The Impact of AIDS on Education . Lilongwe: Breach Publishers
- UNDP(2004). HIVand Human Development. New York: HDR Office
- UNESCO (2004). AIDS care:Learning From Experience. Gaborone: UNESCO
- Visser, R.(2006). Children Living with HIV/ AIDS. London: Blackwell Publishers
- Woods, E. R. (2008). Dealing with HIV/ AIDS in the classroom. Harare: Longman
- Zaccour, U.(1990). HIV/ AIDS and School Children. London :Blackwell Publishers

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