THE IMPACT OF AN EPIDEMIC ON SCHOOLS
A STUDY ON THE EFFECTS OF HIV AND AIDS IN BOTSWANA

Bachelor Thesis/Teacher Education Programme

Philippa Johansson

2012

SCHOOL OF EDUCATION AND BEHAVIOURAL SCIENCES, UNIVERSITY OF BORÅS
Nature of the work: Teacher Education Programme, Bachelor of Education for the Pre School Class and Compulsory School recreational activities 210 credits. Thesis ”Att utforska pedagogisk verksamhet II”, 15 credits in educational science.

Year of Publication: 2013

Title: The epidemics impact on schools – a study on the effects of HIV and AIDS in Botswana.

Author: Philippa Johansson

Supervisor: Susanne Björkdahl Ordell

Examiner: Sonja Kihlström

Key Words: HIV, AIDS, Botswana, teachers, schools, Africa, diseases

Summary

Background
HIV is a virus, which attacks the immunesystem in the body. In the year 2000 the millennium declaration was adopted. Combat against HIV and primary education for all the children are two goals that were presented. HIV was predicted to have big consequences on school because there would be a lack of trained teachers, there would not be any children to teach and the quality of the education would be low.

Purpose
The purpose of this study is to look into how the effects of HIV and AIDS have affected the school situation in Botswana.

Method
The choice of method is based on hermeneutics with influences from a phenomenographic approach. The data collection tool used is self-report, where the informants get to write about their own perceptions of a question.

Results
Absenteeism, the Work-load for Teachers and Awareness are the three biggest effects of HIV and AIDS on the selected schools for this study.
Table of Contents

Thanks! 3
1 INTRODUCTION 4
2 PURPOSE 4
3 BACKGROUND 5
  3.1 HIV AND AIDS 5
  3.2 BOTSWANA 6
    3.2.1 HISTORY OF BOTSWANA 6
    3.2.2 BOTSWANA TODAY 7
    3.2.3 MILLENNIUM GOALS 7
  3.3 HIV AND AIDS IN BOTSWANA 8
    3.3.1 Impacts of HIV and AIDS on families and primary education in Botswana 8
    3.3.2 Impact of AIDS in sub-Saharan schools 9
4 THEORY 10
5 METHOD 11
  5.1 DATA COLLECTION 12
  5.2 SELECTION OF SCHOOLS AND INFORMANTS 12
  5.3 MODE OF PROCEDURE 13
    5.3.1 RESEARCH ETHICS 13
    5.3.2 VALIDITY AND RELIABILITY 14
  5.4 ANALYSIS 15
6 RESULTS 16
  6.1 ABSENTEEISM 16
    6.1.1 ENROLLMENT AND DROP OUTS 16
    6.1.2 PERFORMANCE 16
    6.1.3 LACK OF TEACHERS AND QUALITY OF EDUCATION 17
    6.1.4 STIGMA AND DISCRIMINATION 17
    6.1.5 PSYCHOLOGICAL ISSUES 18
  6.2 TEACHERS’ WORK 18
  6.3 Awareness 20
7 DISCUSSION 21
  7.1 RESULT DISCUSSION 21
  7.2 METHOD DISCUSSION 22
  7.3 DIDACTIC CONSEQUENCES 23
  7.4 CONTINUED RESEARCH 23
8 LIST OF REFERENCES 24
APPENDIX 1- Self-report questions 26
APPENDIX 2- INFORMED CONSENT ENGLISH 27
APPENDIX 3- INFORMED CONSENT SETSWANA 29
APPENDIX 4- PERMIT FROM MINISTRY OF EDUCATION 31
There are many people that I would like to thank. First of all I would like to thank SIDA, Swedish international development agency, and Lärarförbundet, the Swedish teachers union, for the scholarships that made it possible to travel to Botswana and conduct this study. Secondly I would like to thank my contact person, Kerstin Jackson Main, for all your help, support and guidance from the beginning of April throughout the whole procedure with permits, selecting schools and for arranging accommodation. I would also like to thank Mike Main for all the interesting points of view and for helping me through the complicated times with your knowledge about the country and the people living there. Great thanks go to Ms. Ranganai at the Ministry of Education for issuing my permit and helping me to recommend suitable schools for the study. Also to Mr. Motlhanka and Bailey at the Ministry of Health for helping me with the application forms and for issuing my permit. Other people who have helped me in different ways are Nonofo, Gorata, Lottie, Birgitta, Christine, Cecilia and Fabian, thank you. To all my informants and all the schools that agreed to be a part of this project, thank you, without you there would not be a study. I would like to thank my supervisor at the University of Borås, Susanne Björkdahl Ordell, for your input in the consent forms, self-report questionnaires and in the construction of this report. Last, but not least, I would like to thank my husband, Oskar, for supporting me from the beginning of January, when I got the idea to conduct this study, throughout the whole procedure.
1 INTRODUCTION
When teachers are off sick from work in Sweden, according to my experience, the colleagues have to resolve the situation the best they can, without any substitute teachers. Many feel that this is a heavy burden to bear, but often this is only for a few days or a week. How would it be, if something where to happen that would result in shortage of teachers permanently? How would that impact on the schools? This is the situation in some countries that have been struck with diseases and/or natural disasters.

For instance, both UNICEF\(^1\) and Rädda Barnen\(^2\) (Save the Children Sweden), write about the epidemic of HIV and AIDS and its impact on the children. They state that in Africa, in the sub-Saharan countries, AIDS is the most common cause of death. This affects the children directly, since they often have to go out and provide for the family when the parents are sick. Many children become orphans and the children themselves can be infected with the virus. Indirectly the children are affected because the teachers are sick or die. The last part caught my interest and I started to research what I could do with this information.

In the middle of January 2012 I got information about the opportunity to get a scholarship for conducting a minor field study in a developing country. I got interested quickly and started searching for a topic to write my thesis on. Since it had to have some connection to the international development process and also I wanted to connect it to my field of study, education and behavioural sciences, I wanted to pick a topic that really got me interested. I searched different organizations webpages and when I got to the webpages of UNICEF and Rädda Barnen (Save the Children Sweden) the epidemic of HIV and AIDS and its impact on the schools caught my interest and I decided that this was going to be the topic of my thesis.

I searched the Internet for the sub-Saharan countries to find out which ones they were, and compared those to numbers about, where HIV and AIDS was most prevalent. Botswana came high up on the list, but so did other countries. What determined me to pick Botswana was the fact that they have a well-developed education and health care system, and that they are not involved in any other crisis, like war for instance.

I wanted to find out how the epidemic of HIV and AIDS had affected the schools, in other ways than the death and illness of teachers. Since, I thought, the children probably would not know how the schools had been impacted I decided to look at it from a teacher’s point of view.

2 PURPOSE
The purpose of this study is to look into how the effects of HIV and AIDS have affected the school situation in Botswana.

\(^1\) http://www.unicef.se/fakta/barn-och-aids Available: 2012-01-23 and 2013-01-26
3 BACKGROUND
In this part of the report information about the diseases HIV and AIDS will be presented briefly and the country of Botswana will be introduced, both its history and the situation of the country today. The millennium goals related to this study will be described and I will look into what the problem of HIV and AIDS look like specifically in Botswana.

ABBREVIATIONS
HIV- Human Immunodeficiency Virus
AIDS- Acquired Immune Deficiency Syndrome
ARV- Antiretroviral, drugs used in HIV treatment
ART- Antiretroviral therapy, the treatment with three or more antiretroviral drugs
UN- United Nations
UNICEF- United Nations Children’s Fund
WHO- World Health Organization
BDP- Botswana Democratic Party

3.1 HIV AND AIDS
According to WHO, World Health Organization (2012), HIV is a virus that attacks the immune system and makes the infected individuals immunodeficient, which means that they no longer have the ability to fight off infections that individuals, who are not carrying the virus, usually do not get. AIDS is the furthest developed stage of HIV and takes somewhere between two and fifteen years to develop. When/if AIDS has developed; the individual is receptive to certain kinds of cancers and infections that define the disease.

WHO (2012) writes about the symptoms of HIV, how HIV transfers, the diagnosis of HIV, how to prevent transmission and treatment for the disease. When infected with the virus, the individual, usually, is the most infectious although the individual often does not know about its status until later. The first symptoms of HIV are like an ordinary cold with fever, headache and a sore throat. Later, as the infection progresses, common symptoms are weight loss, diarrhoea, cough, fever and swollen lymph nodes. If no treatment is given the individual can develop tuberculosis and different kinds of cancers.

The transmission of HIV can occur in different ways but ultimately it comes down to an exchange of body fluids (WHO, 2012). It can be through blood, breast milk, semen or vaginal secretions. Activities where exchange of body fluids are most common are, unprotected sex and if there are other sexual transmittable diseases the risk of HIV transmission is greater, using needles or being stung by needles contaminated with infected blood or in medical treatment where contaminated blood can occur.
A HIV test is a blood test that shows if there are any antibodies to HIV in the blood (WHO, 2012). If there are antibodies in the blood, the individual is transmitted with HIV. To prevent infection the securest way is to practice secure sex with a condom. To prevent transmission of the virus testing for HIV and other sexual transmittable diseases are advised. Other ways are voluntary male circumcision, ARV based prevention harm reduction for injecting drug users and elimination of mother-to-child transmission.

WHO (2012) writes that the transmission from mother-to-child, if no interventions are made, are between fifteen and forty-five percent. If treatment in the form of ARV drugs is provided, it will prevent almost all the cases of mother-to-child transmission. ARV drugs are not only used in the case of mother-to-child transmission prevention, but also in general antiretroviral therapy, ART. There is no cure for HIV, but with the ART, the viral load can be reduced and the individual’s immune system has a chance to build up. If an individual is infected with HIV, but is receiving treatment through ART, the individual can lead healthy and productive lives.

3.2 BOTSWANA
Landguiden, Utrikespolitiska Institutet (2012) writes that Botswana is a country situated in the southern part on the continent of Africa. It is situated on the tableland and has an average altitude of 1000 meters. Botswana does not have any coast and two-thirds of the country is semi-desert, the area of Kalahari. The country is adjacent to South Africa, Namibia, Zambia and Zimbabwe. The capital city is Gaborone and in total the country have about two million inhabitants. The number of inhabitants per square kilometre is three, which makes Botswana a sparsely populated country. The main population group is Tswana but there are also minority groups like the native San people. The majority of the inhabitants are Christians but many people also believe in other religions only or beside Christianity, and this is well respected. The languages spoken in the country are mainly Setswana and English.

3.2.1 HISTORY OF BOTSWANA
According to Landguiden (2012) the native San people has been living in this area for many thousands of years. In the 16th century, the Tswana people came and forced the san people out into the desert. The Tswana people, later, formed eight chiefdoms in the country, where each chief decided over their area.

In the 19th century, three chiefs travelled to Britain to ask for protection against the Boers in the east and Ndebele tribes in the northeast (Wikipedia, 2013). In 1885 the Government of Britain took Botswana, then Bechuanaland, under protection. The chiefs kept most of the power in the country (Landguiden, 2012), and in the 1950’s nationalism grew in the country and a preparations were made for emancipation from Britain, with the support of Britain.

In 1966 Botswana became independent without any violence and major political conflicts (Landguiden, 2012). Seretse Khama became the first president of the country and the same party has remaind in power ever since. Shortly after the independence, diamonds where found in Botswana and because of that the country has had great economical growth.
3.2.2 BOTSWANA TODAY

Today Botswana is considered to be a middle-income country (Landguiden, 2012) and a country with political stability. Ian Khama became president in 2008 after his party, the BDP, had been elected. Since the independence, the country has had democratic governance. Fundamental civil and freedom rights do apply in general and the judiciary is considered to be independent.

In Botswana, education is a priority. All children have the right to a ten-year primary education, and about 80% compete over these ten years (Landguiden, 2012). 50% then continue on to the two-year secondary school.

Even though Botswana is, in many ways, a success story, the country also has its problems. For instance they have a big income inequality, electricity shortage, only one twentieth part of the land is cultivable, almost all the consumer goods needs to be imported, even the food and almost half of the population is estimated to stand outside the formal economy (Landguiden, 2012). Even though Botswana has well-developed social services and health care, they are one of the worst hit by the epidemic of HIV and AIDS.

3.2.3 MILLENNIUM GOALS

In the year 2000, UN had a meeting where the Millennium declaration was adopted (UNA Sweden, 2012). This declaration defines which values that the UN and the member states would work for in the new millennium.


Goal number 2 implies that every child in the world should have the opportunity to complete a primary education. Goal number 4 means to fight death of children younger than five years of age. Goal number 6 is to prevent the spread of HIV/AIDS, make treatment for HIV/AIDS available for everyone that needs it and retain and decrease the spread of malaria and other major diseases.

The Republic of Botswana and United Nations (2010) write about the development Botswana has had in line with the millennium goals. To start with goal number two, “Achieve universal primary education all girls and boys in the world should be able to complete a primary education by 2015”, Botswana has placed its target higher than the global one and aims to: “Achieve universal access to 10 years of basic education by 2016” (p. 25). Botswana is on its way to achieve this goal but it is unlikely that the target will have been met by 2016. Although the goal: To improve the relevance and quality of basic education (p. 25) is likely to be met by 2015. The results show that most children start school at age seven instead of six, which is the official school entry age (p. 26). Dropping out of school in Botswana, the rate shows, is not common, and for every year since 2005 the numbers have decreased (p. 27), but a big challenge is all the teenage pregnancies that make girls drop out of secondary school (p. 29). Botswana has high enrolment rates but needs to work hard to reach the children in the most rural areas (p. 29). Although the country invests more per capita in education than any else in Africa, the test results do not show this investment (p. 29).
Goal number four, “Reduce child mortality; reduce the mortality rate among children, less than five years, by two thirds between 1990 and 2015”, is harder to reach, since Botswana is struggling with the HIV and AIDS (Republic of Botswana and United Nations, 2010, p. 36). It is unlikely that Botswana will reach the global target by 2015, and it is also unlikely that they will meet two out of three national targets (p. 37). The report shows that, without HIV and AIDS, Botswana would probably meet the targets set up (p. 38). This is because even with the great success of different programmes, HIV is still a major threat to child survival.

Goal number six is “Combat HIV/AIDS, malaria and other diseases, contain and reverse the spread of HIV/AIDS by 2015, achieve universal access to treatment for HIV / AIDS for all those who need it by 2015 and contain and reduce the incidence of malaria and other major diseases by 2015”. Botswana is likely to meet, or already have met, both the global targets and national targets by 2016 (Republic of Botswana and United Nations, 2010, p. 46).

3.3 HIV AND AIDS IN BOTSWANA

In 1987 the government of Botswana established a one-year plan to work against the spread of infection of HIV (Allen & Heald, 2004, p. 1144). Around that time they also invested in large campaigns to inform the people about the disease. Until the mid 1990’s the campaigns succeeded each other, but they then faded out because the people’s reactions were destructive (Allen & Heald, p. 1144). Not until the late 1990’s would people even consider getting tested for the disease, and then there were only a few who actually did consider it. Up to this time there had only been seven people in the whole country who had confirmed that they were HIV positive (Allen & Heald, p. 1145). Since this time Botswana has financed all HIV prevention without resources from help organizations because of their economic growth. In 1999 a national program for modifying drugs was introduced and was expected to cure the country of the epidemic. These expectations were not met because of the high reluctance to get tested for HIV (Allen & Heald, p. 1145).

3.3.1 Impacts of HIV and AIDS on families and primary education in Botswana

Torstensson and Brundrett (2011) have conducted a study about the impact that HIV and AIDS has on primary education, from a child’s perspective. Their findings showed that HIV and AIDS have impacted on the families, on the children’s social-emotional well-being and on the children’s learning.

The impact on the families has been hard for the children because their relationships towards their family members has changed (Torstensson and Brundrett, 2011, pp. 401-402). The authors state that the diseases have also affected the children’s family economics and the roles inside the family, as the children had to take all the responsibility for the household and caring for everyone in it. When the parent got sicker, it was possible to see the changes in the children’s behaviour. They were having problems with feeling confident, planning, to give priorities and to socialise (Torsensson and Brundrett, pp. 401-402).

According to Torstensson and Brundrett (2011, pp. 402- 405), the impact on socio-emotional well-being were bigger for those children who were orphans or vulnerable children, which meant that they had one parent that was infected (Torsensson and Brundrett, pp. 402-405). Although the socio-emotional well-being was affected in different grades in all the children, the authors found that the children were afraid of being infected by the virus
through being raped, in a fighting situation or when caring for their siblings and they were afraid of becoming orphans (pp. 402-405).

As regards the impact of HIV and AIDS on children’s learning, findings showed that, because of sorrow and worry for their family members, the children were affected indirectly by these diseases, as they were not able to concentrate in school (Torstensson and Brundrett, 2011, p. 407). The authors also found that these children were occupied with being worried about the stigma, that they were not able to listen to the teacher, they performed poorly on assignments and they were not able to be on time or keep up the attendance. This all led to, the children’s grades dropping and that many children were confused and hopeless, according to Torstensson and Brundrett (p. 407).

3.3.2 Impact of AIDS in sub-Saharan schools
UN (2004, p. 69) writes that there is a shortage of teachers. Illnesses and deaths have impacted on education. The epidemic of HIV and AIDS threatens achievements since many children, affected by HIV and AIDS, postpone enrolment in school or drop out (UN, p. 69). UN (p. 69) states that the epidemic of HIV and AIDS could impact schools and education in three ways: Access to teachers, children enrolled in school that stays in school and the quality of the education.

The teachers’ absenteeism and deaths reduces the access to teachers (UN, 2004, p. 69). Those who are infected might want to relocate or disappear totally and those who are not infected might want to relocate to areas where the spread of the virus is not as great, which means declining numbers of teachers in the area (UN, p. 69).

The number of children enrolled in school, are depending on the number of deaths among children and parents (UN, 2004, pp. 69-70). This because fewer children will enrol in school and older children will drop out to be able to take care of sick family members (UN, p. 69). Another issue is that the presence in school declines, because the children are infected by HIV or sick from diseases related to AIDS, according to UN (p. 70). That also makes it hard to keep up their performance and the ability to learn.

According to UN (2004, p. 70) there is a possibility that the quality of education will reduce because of the teacher’s absence from school or the teachers not being able to uphold the same standard, if they get sick. There is also a risk that less money will be put in to education and that the quality of education will be decreasing because of the UN (p. 70). Another reason for the declining quality of education might be that if a teacher gets sick, the person replacing this teacher will not have a proper education or enough experience (UN, p. 70).
4 THEORY
The reason why the study is based on systems theory is because the whole country, as I see it, is a macrosystem that has a problem to solve. The study narrows down to the school, which is included in both teachers’ and pupil’s micro- and mesosystems, and ultimately is a part of most people’s exosystem. These systems are interrelated to one another and one thing cannot happen in one system without the other systems being affected. Also I do not think that I can come in and conduct a study in schools and not be aware of the influences that the children, teachers, society and politics have on the school. That is why this theory helps me to be aware of the different parts that may impact on how schools have been affected by HIV and AIDS.

Bertalanffy (1968, p. 37) writes that general systems theory is about wholeness and specifies this by the fact that that it is not possible to study a small part of an organization and then, after analysing, make statements about the whole organization. This is because the part studied would be looked at in isolation and in any organization there are many systems connected to each other, no part stands alone. The author also states that this theory is based on one of the simplest equations that exist, which means that it is applicable in various fields (Bertalanffy, pp. 34-35). Bertalanffy (p. 39) states that there are two types of systems, open and closed. Closed systems are those that are considered to be isolated from their environment, while open systems are those that cannot be characterized as closed systems. This means that open systems include any system in which living organisms are included.

Bronfenbrenner (1977) has developed a model in systems theory, directed towards human development, which includes four structures. These are the micro-, meso-, exo- and macrosystems. Bronfenbrenner (pp. 514-515) explains the concepts as being that the microsystem has the individual and this person’s relations to the immediate surroundings, where the individual spends time, in focus. These surroundings can, for instance, be the school and home. The mesosystem, Bronfenbrenner (p. 515) describes as a system of microsystems. This means that all the environments where the individual spends time are included and the system puts focus on one specific time in the individual’s life. An exosystem is described, as a larger mesosystem, where other structures that do not involve the individual directly, but affect the individual’s surroundings, are included (Bronfenbrenner, p. 515). The last of the four structures is the macrosystem and is different from the rest by not focusing on the individual per say. This system involves the whole society in terms of economic, social, educational, legal and political systems (Bronfenbrenner, p. 515).
5 METHOD

The choice of method is founded on hermeneutics, a qualitative method, which means that the researcher is looking to understand, not only to grasp, a phenomenon (Thurén, 2007, p. 94). Hermeneutics is also about interpreting people’s actions and perceptions, instead of seeking the absolute truth according to Thurén (p. 103). The author also writes that three important sources of knowledge in hermeneutics are empiricism, logics and empathy, because it is necessary to understand people when interpreting their actions and the result of actions (p. 103).

According to Larsson (1986, p. 7) a qualitative method is not the right method if the purpose is to describe size, amounts or quantity. The qualitative method aims to describe a phenomenon or relations in the surrounding world through categories that are constructed by measuring or testing (Larsson, p. 8).

A phenomenographical approach is, according to Marton (1981, p. 180), used when trying to describe how people perceive the surrounding world. Marton (2005, pp. 154-155) writes about how people create their own view on the world. The author states that different people perceive things and situations in different ways and, because of this, forms their own, different, conception of right and wrong. This basic understanding of right and wrong is then the foundation for what people perceives and remembers. Marton (pp. 161-163), however, does not mean that these perceptions are solid, but that people because of a new experience can start perceiving things in a different way than before.

According to Marton (1981, p. 178), in phenomenography there are two perspectives, the first-order perspective and the second-order perspective. The first-order perspective can be observed from outside and is based on facts. The second-order perspective is about how other people experience or perceive something. Marton (pp. 180-181) writes about phenomenography in four descriptions. The first one is that in phenomenography it is not applicable to separate the first- and second-order perspective because people cannot unclench the experience from perceptions of the experience. The second one is the essence in the studies. There will be variations in experiences but usually the essence in human experiences, of the same phenomenon, has little difference. The third one is that phenomenography is subject-oriented and the last, the fourth one, is that in a phenomenographic study people's lived experiences should be taken into consideration, their experiential experiences and their conceptual experiences.

Kihlström (2007, p. 160) states that there are several different data collection tools that can be used in a phenomenographic study. Interviews are the most common one, but self-reports, observations and drawings can also be used.

The study, presented in this report, is a qualitative study with influences of a phenomenographical approach. Since the purpose of the study was to find out how the selected teachers perceive that the diseases HIV and AIDS have impacted on the schools, I found it suitable to use a qualitative method. The second-order perspective of the phenomenographical approach inspired me when thinking about the data collection tool. The selected tool related to the approach is self-report, a tool that gives the informants an opportunity to write down experiences about a situation.
5.1 DATA COLLECTION
The data collection tool used in this study is self-report. Self-report implies that the informants get a question, and from that question they are asked to write about their own experiences of the phenomenon (Davidsson, 2007, pp. 70-71). These texts are then analysed.

Davidsson (2007, p. 71) argues that, when constructing a self-report question, it is important to consider the fact that it is not possible to ask any follow-up questions. Therefore the question should be drafted so that you get the informants’ perceptions or experiences, of the occurrence, in focus. According to Davidsson (pp. 71-72), self-report may be preferable to interviews because of the time that is given to the informants, to answer the question. The extra time is of value for the depth and content in the text.

In this study I chose to use self-report as the data collection tool because of its quality of giving the informants an opportunity to remain anonymous and for the teachers to take up to two weeks to think about their experiences. When creating the self-report question, I used the purpose from study as a starting point. I could not find only one question that would ensure that the informants would answer all the aspects of the situation that I was interested in. Instead of using one question, I decided to create a self-report questionnaire with three questions ‘How has the effects of HIV and AIDS affected the school?’, ‘How has your work as a teacher changed due to the effects of the diseases?’ and ‘How has the children’s school situation been affected by the diseases?’. The teachers were asked to write three to five pages with focus on the situation.

5.2 SELECTION OF SCHOOLS AND INFORMANTS
Larsson (1986, p. 29) writes that in a qualitative study, where the focus is to find out different views of a phenomenon, you should choose informants from different groups that may have perceptions about the subject. In line with what Larsson (p. 29) writes, the criteria for the informants were, teachers, men or women, working in primary schools, junior secondary schools or senior secondary schools as teachers and able to read and write preferably in English but Setswana was also possible, in the study proposal. I also wanted to have schools both in a city and in more rural areas. The Ministry of Education suggested schools in different areas and different age groups, which helped to narrow the number of schools down to three senior secondary schools, two junior secondary schools and ten primary schools. I chose informants from the same profession but from different age groups and locations to enable more varied responses. The study was carried out in the southern and south-eastern part of Botswana.

Out of these numbers we, my contact person, a Setswana speaking interpreter and myself, chose six schools which my contact person and the interpreter thought it might be interesting schools would be interesting to hear from. At four out of the six selected schools I went and talked to the head or deputy head teacher about the study. Three out of these schools wanted to participate. To the two other schools, we made the contact by calling them and then we visited the school to talk to the head or deputy head teacher.

The selection of informants, who actually participated in the study, where chosen by the head- or deputy head teachers. I never met these informants in person but I had shared the selection criteria with the persons responsible for the election at the particular schools. In total 16 teachers from five different schools participated in the study.
5.3 MODE OF PROCEDURE
The first thing in the study procedure was to fill in application paperwork for permits from the Ministry of Education (appendix 4) and Ministry of Health (appendix 5). The permits were essential for the study since, without them I would not have been able to come into the schools that I visited. These application procedures started in August and I had both my permits at the beginning of November.

Through Ministry of Education I got a list of schools that were situated in suitable locations in and around the city. With the help of my contact person and her experience we selected schools in the city and went there to visit them. Through my contact person I also came in contact with a person who spoke Setswana and helped me to contact the selected schools in rural areas, before we went to visit them. This person also came with me to the rural areas to help explain the study proposal in Setswana if needed. In total we presented the study proposal to the head teacher or the deputy head teacher at six schools. Five out of these six, heads of schools were positive to letting the teachers participate in the study. One of the schools did not want to participate because, according to the head teacher, they had not noticed any affects of HIV and AIDS in the school. The participating schools, in the end, were three primary schools, one junior secondary school and one senior secondary school.

To those who were positive towards the study I left the self-report questions (appendix 1) and the informed consent forms (appendix 2 and 3) with the head or deputy head teacher. They selected informants according to my directions and collected the questionnaires when the teachers had completed them. At one school I waited while the teachers answered the questions. At three out of five schools I left the questionnaires and stayed in contact with the school for information about the teachers’ completion of the questions. At the last school I left the questionnaires and the head teacher came and dropped them off at my accommodation when the teachers had completed the forms. At the schools where I left the papers to give the teachers time to answer, an envelope was left with the papers to enable for the informants to keep the information confidential.

I got information from five different schools. In total I handed out 18 questionnaires and I got 16 in return, which makes a loss of two questionnaires.

5.3.1 RESEARCH ETHICS
To be able to conduct this study I had to apply for a research permit from the Ministry of Health (appendix 5) in Botswana, because the study involved humans and concerned HIV and AIDS. For the permit to be issued the researcher had to be able to show that the informant’s safety had been taken into consideration and that measures had been taken to minimize the risk of participation.

Hermerén (2011, pp. 49-50) writes that it is necessary with an informed consent from the informants if they are human and risk being harmed by participating in the study. Hermerén (pp. 66-67) means that there often is confusion between secrecy, anonymity and confidentiality. According to Hermerén (p. 67) anonymity means that nobody, not even the researcher, can connect a piece of information to a participating informant. This can be done through a data collection tool that does not require identifying of the informant (Hermerén, p. 67). The author also clarifies confidentiality and means that it is when the researcher protects the collected data from unauthorized people.
The study relates to these research ethics by first informing the head- or deputy head teacher about the study and its purpose. They then gave their response to letting the teachers participate. The teachers, chosen by the head teacher or deputy head teacher, got a letter of information and consent (appendixes 2 and 3) in both English and Setswana. In this letter they could read everything about the study and what was expected from them if they took part. It also informed them of their rights as informants and the risks of participation in the study.

The informants identities has been kept anonymous from the beginning and the schools involved have neither been presented by name or location. Even from me, the researcher, the informants have been anonymous, since it was the head or deputy head teachers that chose the participants.

The risks of participating in this study could have been great since there is, still, a fear of stigma and discrimination connected to issues about HIV and AIDS. But the risks of participating in the study were minimized through keeping the identities both of the schools and informants covered. Also by choosing a data collection tool that enabled the informants to be anonymous and not asking personal questions about their own status minimized the risks.

Only myself as the researcher has had access to the collected data. The interpreter that came with me on visits and helped me translate self-reports written in Setswana, only had access to certain parts of the information. This person was also aware of the fact that this information was confidential. The envelopes, which were handed out together with the papers at four out of five schools, all came back sealed. This implies that the data has been kept confidential from unauthorized people. Information from this research has only been used for this study and to put together this report.

5.3.2 VALIDITY AND RELIABILITY
Thurén (2007, p. 26) describes the concepts of validity and reliability. Validity means, according to the author, that the right thing has been researched, that the purpose of the study and the research itself is compatible with each other. Reliability means that the research is done in a correct way.

According to Kihlström (2007, p. 164) validity in a phenomenografic study is based on how well the research is presented and communicated to the reader. Anyone who reads the study report should be able to understand and discuss the results of the study. For the researcher it is important to describe all the steps of the work in such a way that the reader can follow the process from the beginning until the end of the study. Larsson (1986, p. 39) means that one way to present the result categories is to illustrate them with quotes. These quotes should not be too long and each category should only be presented by one or maximum two quotes.

According to Larsson (1986, p. 38) the reliability is to determine whether the results are reasonable or if the researcher’s personal idea permeates the results. Both Kihlström (2007, p. 164) and Larsson (1986, pp. 38-39) points out that one way to try the validity and reliability of a study is to get help from an independent assessor. This independant assessor looks into the collected data and puts it into categories (Larsson, pp. 38-39).
This study relates to validity and reliability through me, having a supervisor who has been reading the report and left comments about the presentation and the communication to the reader. The categories are also illustrated by quotes, only one per category. I have not had an independent assessor, in the truest sense, in this study but I have had discussions with people who have been involved in the process to increase the ability to be truthful in the interpretation of the data from the self-reports. These people have not had access to the information in the self-reports, but we have brought up some of the content that I needed help with, to be able to interpret the content correctly.

5.4 ANALYSIS

Larsson (1986, p. 20) writes about how analysing is done through a qualitative analysis. This means that the informants’ responses will be categorized. When all the texts are divided into categories, it is time to look for similarities and differences, according to Larsson (1986, p. 31). When interpreting the collected data it is important to create categories that are as true as possible to the informant’s responses (Larsson, p. 32).

The aim for a qualitative analysis, according to Malmqvist (2007, p. 123), is to detect occurrences that are unknown. Malmqvist (p. 122) also, like Larsson (1986, p. 20), write that when processing the collected data the information will be sorted and in the end put into categories. The author (p. 122) means that it is to a big advantage if the researcher thinks about the analysing process early in the study, because then you know which direction and which method to use when getting there. Malmqvist (pp. 124-125) writes that there are two ways to approach the analysis. One is the holistic analysis where the researcher detects recurrent information and connects it to themes. The other way is to start with individual statements and create an understanding for the selected information. Malmqvist (pp. 124-125) points out that no matter which way the analysis is approached, it is important to be structured and systematic. Also the researcher needs to continuously go back to the purpose of the study to make sure that the analysis and the purpose are consistent with each other. When the information have been sorted into categories the analysis is not over, this is when the process of twisting and turning the data to make it understandable for others and to make it answer to the purpose of the study, according to Malmqvist (p. 127).

In the analytical part of the study I have made a content analysis of the information in the self-reports. I started with transcribing all the self-reports on the computer. Next, I compiled all the self-reports in different compositions to be able to compare and detect similarities and differences in the information. These compositions were age-homogeneous groups from primary school, junior secondary school and senior secondary school in three different groupings. I also did one from schools in rural areas and one from schools in the city. From these different compositions of self-reports I first discovered the similarities and had a hard time finding much of a difference in the statements. However, when I had reflected on the information for a while the differences appeared, too, and I created categories, which turned into results.
6 RESULTS
These are the experiences of 16 teachers from primary schools, junior secondary schools and senior secondary schools of how HIV and AIDS have impacted on their schools and their line of work. The following categories: Absenteeism, Teachers’ work and Awareness, are based on the statements of the informants self-reports. Under each category there are elements that exist because of the main category.

6.1 ABSENTEEISM
“Some become depressed and eventually leave school as they see no reasons for continuing, eventually affecting their future.”

All the participating teachers observe that the schools are mostly affected by absenteeism due to various reasons, ill health being the most common one amongst both students and teachers. It can be ill health, because of HIV- or AIDS related diseases, of the own individual or even family members that needs to be taken care of. Often, the absence is related to hospital visits, medical check-ups and collection of medications. When it is the teacher that is absent from school, it affects all the children, not only learners that are affected by the diseases themselves. Some individuals spend more time in hospitals than in school. Even if the learners come to school and are present it does not mean that they are participating in the education. This is due to some learners taking drugs to cope with their diseases which makes them drowsy.

6.1.1 ENROLLMENT AND DROP OUTS
“At the end they leave school and become caregivers at home.”

The enrollment has gone down according to most of the teachers. One reason for the decreasing enrollment is that the schools have lost some students to ill health and death. Also the school enrollment has gone down because, some learners, who have lost their parents, find it fit for themselves, not to enroll in school. Instead they get a job and are able to provide for their family. Also pressure from other family members, about taking care of the family, has a big influence on the enrollment.

6.1.2 PERFORMANCE
"Some students who have been infected with the virus spend alot of time staying away from classes because they have to go for medical check-ups, hence failing to write examinations and therefore dropping the performance of the school."

Because of the high number of occasions of absenteeism, the children’s, teachers’ and schools’ performances have gone down. The main issue is that the children and teachers miss classes and the burden of accumulated work becomes too heavy for the children, so their performances decrease. Also, when spending so much time away from school, the learner fails to write exams and the performance is reduced. Taking care of the family is another reason why the performance goes down. The learner does not have the time to study and play, which limits the child’s development into a holistic learner. Also many children are occupied with concerns for their loved ones and some students have lost their parents who were financially well off and these situations affect them academically. Children
infected with HIV, who are taking medication, are not able to perform well because of the short attention span, caused by the drugs.

For the schools’ performance it is important to have extra curricular activities and the competitions that are held for these activities. When a pupil is infected and on medication they cannot participate in the extra curricular activities, so if a school have many learners that are infected, it performs poorly during these competitions. Schools also have poor results due to the fact that children are not well cared for at home, since they do not have support, care and love from their biological parents.

6.1.3 LACK OF TEACHERS AND QUALITY OF EDUCATION

"The school system relies more on less qualified teachers with less experience and this results in a decrease in the quality of education."

Often when a teacher is off work, sick, or at a medical check-up, the children do not have a teacher. The teachers left at the school have to take responsibility for the other teachers’ pupils and the work burden becomes too big for these teachers to handle. This situation decreases the quality of the education.

One teacher experienced that there had been some loss of trained teachers, but that these were too few to be of any significance. While others experienced that the losing of trained teachers was a significant problem, and felt frustration over the long wait that can occur when replacing the former teacher. Sometimes the wait has been up to six months and during this time; the pupils do not have a teacher. When they get a teacher the quality of education might not improve, since the school system, more or less relies on less qualified teachers with less experience.

6.1.4 STIGMA AND DISCRIMINATION

"The most important factor in this is stigmatization."

According to some of the teachers, the most important impact of the diseases is stigmatization. Children do not feel comfortable when they know that the other students know about their status. Some students even leave school because other students were making fun of them. When going on school trips (educational or for sports), infected students find it hard to medicate, because they do not want to disclose their status. It is not uncommon for students to leave school and stay at home because of fear of being stigmatized. This also apply for the academically gifted students, who are either infected or affected; the fear of stigmatization is so strong that they choose to drop out of school, destroying their future.

"Learners sometimes stigmatize themselves, they have a feeling that everyone knows about their status and then they don’t feel free at school and they end up absconding from school."

Sometimes learners stigmatize themselves, they have a feeling that everyone knows about their status and when they do not feel free or comfortable in school they abscond. These children are also affected emotionally and socially because other students discriminate against them. The infected or affected students have a tendency to be isolated and not interact well with other people. This leads to infected students not participating in class.
Also for the school, stigmatization looks bad. Since the discriminated student might transfer to another school, the reputation of being a discriminating school could be harmful.

6.1.5 PSYCHOLOGICAL ISSUES

“Emotional stress- caring for a sick person usually distresses. Both students’ and teachers’ work may suffer, because often they find themselves overwhelmed- caring for their beloved and at the same time having to attend to their duties.”

In the discussions of HIV and AIDS there are a lot of psychological issues that appear and many of these are reasons enough to leave school or not attend it regularly. The schools have been affected psychologically, because the children are really suffering; they are often sick and cannot cope with schoolwork. The educators are also affected by having sick learners in the classroom and there is always the feeling that there is nothing to do to help, since their suffering is beyond the teacher’s control. Not only is the children’s suffering devastating for the teacher’s, but also their own health and stress makes the work unpleasant.

Caring for a sick person is a stressful situation and both students’ and teachers’ work suffers badly because these individuals often find themselves overwhelmed. Sometimes when the children become orphans, they have to move into their relative’s house and it is not uncommon that the relative will use them sexually and have them do more chores than the other children living there. These experiences are the ones that the children bring to school and when demands are put on them to perform, they are not able to, and they become absent from school. The grief over losing a parent is tremendous and most children are not able to handle this sorrow. The infected learners are affected through their mobility, happiness, focus and the will to do well. These learners do not see themselves as having futures to look forward to and everytime they go for check-ups they are reminded of the disease. Many affected children have low self-esteem and are usually easy influenced by peers to be involved with older men and use alcohol and drugs.

Sometimes learners and facilitators on drugs can have side effects, which can make the school suffer. In some cases the learner becomes tired all day long due to the drugs, and sometimes the child’s social skills are hindered by the side effects. Learning is about fun, if a child’s social skills are a problem, school becomes a problem to the child. Many children living with HIV or the affects of HIV have a great fear of death, which can make them emotionally disturbed. Most of the learners are frustrated, because the diseases have changed the people they have been living with and now life is not the same. Others have been moved from their schools to different schools and this has affected their education and their behaviour. It also affects the relationship amongst learners and staff at school. At some schools there is a lot of gossip concerning those who are infected, and this affects the relationship between the children and the children and teachers.

6.2 TEACHERS’ WORK

“As a teacher my work has changed alot as I have to be a teacher, a mother, a friend, a counsellor and a caretaker at all times to different children.”

The main difference in the teachers’ work is the counselling for the learners. The children are often upset at school due to the effects of this infection since they are taking care of their parents and relatives. Since the teachers take on other roles, for instance that of being a
nurse, instead of a teacher, this affects the pace in which the teachers and learners develop and the principal activity is put aside. The main reason for taking on all these roles is to create a conductive environment for the children. The children start gaining confidence and being open, the reasons being for the children to feel free to talk about their status and advice other students on how to take care of themselves. Under circumstances like these, with the diseases, teachers need to provide solace to the young minds and to let them know that outside their homes, somebody does care. The teachers try to fill a sense of hopefulness on the learners; this is done through infusion of life skills and support groups.

Some teachers consider that dealing with HIV patients in class helps them to be emotionally intelligent when dealing with other issues. It also helps them to integrate the issues into the subjects that they teach. In addition, it helps them to acquire counselling skills so that they can deal with children and as teachers they tend to become more supportive to those they know are affected and infected. As educators the teachers have to find some strategies for how to help the children be a part of the class and participate in the education. These strategies often do not work because the learners often are tired. Most of the times the teachers do not know how to pass information on to other learners, and at the same time look to the affected or infected learners’ needs. More time must be spared in order to cater for the pupils infected; yet this creates extra work for the teachers. The teacher has to issue new exercise books more often, since pupils lose theirs and this increases the consumption of stationary and the pupils’ work is difficult to follow or track, whether they’re improving or not. This frustrates the teachers, as their work now does not show any forwardness.

Teachers are stakeholders in different organizations dealing with HIV/AIDS. Therefore, they are often off duty dealing with the national issues concerning the minimalisation of spreading of HIV/AIDS. Having HIV and AIDS problem in class means having to work at a slow pace, so that the teacher can help the children in need of extra attention. Teachers spend some time motivating and trying to encourage learners. This is a challenge as skills and talents are now becoming important to the handling of sensitive issues. The teachers have been challenged with how to treat infected learners, also the procedure for delivering content have had to be changed. Nowadays the teachers need to be more concerned with individual learners, understanding the learners more than just coming to teach, because classroom delivery is not enough anymore.

"I sometimes even feel uncomfortable raising some issues which could touch on some nerves of the victims of the disease. So most of the time, I emphasise repeatedly that the discussions or points raised are in no way meant to humiliate anybody."

Many teachers find it difficult to teach on the subject of HIV and AIDS because they might be viewed as deliberately targeting someone with HIV. In addition, they often wonder if what they teach learners is not influencing them to have certain negative perceptions about other learners, infected with HIV and AIDS. This has made them emphasise sex/sex education. They spend plenty of time teaching children about this virus so that the children will not discriminate those who are affected. One teacher was worried about their tradition killing the communication between teachers and children because it is hard to talk about sex with children. Easy communication could help them to solve many problems and that is a way they have never worked in schools before.

One teacher experienced that the fact nowadays is, due to providings of ARVs, HIV is almost treated such as sugar diabetes and high blood pressure. They talk about it, but they are no longer scared and secretive about it. These medications have brought a lot of chances
in a lot of people’s life. But all the other teachers stated that HIV impacts on their work and on the schools where they work.

6.3 Awareness

"Also, dealing with many learners, a school needs specialised training with some school personnel, where the school’s mindset is changed so that many learners affected/infected by HIV and AIDS can be accepted and viewed right, just like any learners suffering from any common ailment." 

Awareness is one part that has impacted on the schools in Botswana. Lack of training on how to handle infected learners has been viewed as crucial to their existence in school. In some cases, infected learners have ended up not getting enrolled in school, although they wanted to, because of lack of knowledge from the head teacher and other teachers at that school. Teachers have been negative to enrolling infected learners since it becomes an extra workload for them.

"Some kids are infected by this virus because their parents didn’t have the knowledge of the virus and didn’t dare to get an HIV-test, then passing the virus on to the children."

There are different reasons why children are infected with the virus, some have got it from their parents who did not know about the virus and when they got the information, they did not go to get a HIV-test for one reason or another. Other children are infected due to engaging in sexual activities with older men without using protection. The teachers are aware that there are learners who could be affected or infected by HIV so, whenever they address issues pertaining to the HIV virus, they become sensitive to the fact that the topic at hand could be affecting some learners.

The teachers wrote that the government is trying but their efforts do not always go all the way. The government is aware of the problems in the communities and funds different programs to enable the children to go to school and have home-based care personnel. This is good for the schools since more learners have the possibility to stay in school. But some teachers were critical of the Government of Botswana for spending money buying medicines to help infected people, when this very same money could be spent on maintaining school facilities and send more teachers to get further education, in order to acquire more education, which will help learners later on. Another thing the teachers did not understand was that the government is trying by hiring temporary staff when this at the same time is more expensive for the government.
7 DISCUSSION
The following part contains discussions about the result of the study, the method used in this study, which the didactic consequences are and ideas for further research.

7.1 RESULT DISCUSSION
The results show three main effects of HIV and AIDS on the selected schools in Botswana, absenteeism, teacher’s work and awareness. The participating teachers wrote about everything from the child, to the teacher, to the school, to the society and the government. This shows that system theory (Bronfenbrenner, 1977) was a suitable theory to build this study on. The teacher, in this case, since the study is made from a teacher perspective, is the microsystem. The children at the school and the school itself become the teachers’ mesosystem. The exosystem can be anything from the area the teacher lives and which supermarket the teacher buys the groceries from and the macrosystem involves the whole of Botswana with its political system and the social- and economical development.

UN (2004) made a good prediction about what the development in the schools would look like. But in Botswana things have not come as far. Yes, there seems to be a lack of educated teachers with experience, like the UN (pp. 69-70) writes, and it also seems to be the poorly educated, inexperienced teachers that replace the teachers who fall sick and die. But one main thing is that there is still a demand for education in Botswana, which was one of the three things UN (2004, p. 69) predicted there would not be.

This study was not very different from the one Tortensson & Brundrett (2011) made. I see parables between what they found out about the socio-emotional well-being of children affected by HIV and AIDS, to what the teachers in this study wrote about the psychological affects on the learners, of the epidemic.

Torstensson and Brundrett (2011, pp. 401-402) wrote about how the affected children’s relationship to their parents have changed due to the fact that the roles in the family have changed because of HIV and AIDS. The authors also state that the children participating in their study were not able to concentrate on their school-work because they were worried for their family-members and afraid of being stigmatized (p. 407). All of this is consistent with the information from the teachers in this study. Even though some say that stigma is no longer an issue, both this study and the study from Torstensson and Brundrett (2011) show that it is something the learners and teachers in Botswana worry about. Also the changes of roles in the families affect the schoolwork, because the learners are concerned about their parents’ health and because a learner chooses to stay at home to take care of the sick family-members instead of going to school.

The teachers in this study wrote about how the learners become drowsy from the drugs they take against HIV and how these make them unfocused and nable to concentrate. Also they wrote about the absenteeism because the infected persons need to go for medical check-ups and go away to collect their medicine.

During my time in Botswana I came in contact with some people that were involved in the medical work around HIV and AIDS and that worked with ARV’s. Some of these people told me that there was no side effect of the medications that made the individual drowsy. But they said that it was not unusual that the infected learner also had other diseases that they need to medicate against and that these drugs might make the learner drowsy and unfocused. Also I got the information that there would not be that many medical visits or collecting of
medicines so often that the infected individual would be absent from school and not able to keep up with the other learners. This made me question how valid the information from the teachers was to my study, since I was after the specific impact of HIV and AIDS on schools. Maybe there were other diseases that had a bigger impact on schools than HIV and AIDS?

On the other hand I met up with people that were also conducting studies for different reasons and they had got the same information as I had. They had found out from people infected with HIV that they actually felt drowsy from the medication and also had to go for medical check-ups often to try to find the right medication for them. In the end I chose to see the information from the teachers as valid for this study since other studies showed similar results.

7.2 METHOD DISCUSSION

The first thing I was told, when trying to describe this study, was that the people in Botswana are a talking and telling people, not a writing one. Well, since my whole study, somehow relied on written answers, in the main at any rate, I decided to try it out. I had expected to be able to hand out and collect between ten and twelve questionnaires in total, and in the end, I handed out 18 and received 16 back.

Why those two did not want to participate in the study is something I have been asking myself, and there are some possible reasons why. For instance, did I arrive about the same time as the students wrote their exams, which meant that the teachers did not have the time to answer these questions? But, then again, how did the other 16 have the time?

Was it the involvement in HIV and AIDS that made them feel uncomfortable? Was that the reason why they did not participate? Well I will never know the answers to these questions, but it is important, for the next study, to reflect over what mistakes that has been made in this one.

Would it have worked better if I had used interviews as my data collecting tool instead? This suggestion has gone through my head many times, and I do not think that it would have made a difference. Maybe I would have got the same amount of information but from fewer informants if I had used interviews, but with self-reports I got to hear a larger number of teachers perceptions of the situation and got the insight that many of them had the same experiences.

It was my first try, using self-reports as a tool for data collection and I enjoyed it. However, it was much harder analysing the collected data than I would have thought. It was difficult creating the categories, since all of them had connections to each other. From the beginning I had an idea of using a phenomenographical approach in this study, but in the end I had only been inspired in a few ways by this approach and I chose to state it as a qualitative study based on hermeneutics, with influences of a phenomenographical approach.

Something I would like to have done differently in this study is to meet the informants, to make sure that they are teachers working at the schools. I could have met the informants, given them all the documents and the envelopes myself. After that they could have contacted me personally when they had answered the questions and I could have collected the envelopes from the hand of the informants. There is a risk that the head teachers in control of the paperwork read the self-reports and that this made it difficult for the informants to write their true perceptions.

But in this case I chose to trust the head teachers because I think there could have been other problems if I had chosen not to. This time I was thankful when the head and deputy-head teachers offered to help out with distributing the questionnaires.
7.3 DIDACTIC CONSEQUENCES
In the result the teachers point out that their work has changed due to HIV and AIDS. In my opinion it seems as if they have been forced into teaching in a more humane way. Is that not a good thing? I believe it is. The teachers described how they had to talk to the learners individually and not as a collective, because that kind of teaching did not work any more. In my professional role I would like to practice this humane teaching style, because I think that the children will respond better to it, in the long run, than they would on sharp discipline.

Another thought is about the high absenteeism that the teachers in the study write about. The problem is to conduct meaningful and educational teaching under the circumstances that several individuals in the class, are absent numerous times every month. Personally, in Sweden, this is hard to imagine since we do not have the problems with HIV and AIDS that Botswana has. Somehow I think that you as a teacher have to lower your expectations on the learners in order for that to work. But like the teachers write, this more humane way of teaching causes them to have to work more, since it demands more from you as a teacher than just talking to a collective.

7.4 CONTINUED RESEARCH
If I had more time, I would like to do a mixed qualitative and quantitative study and find out how big a problem absenteeism really is in schools in Botswana. I would research statistics to find out how many children that are enrolled in the school-system, how many teachers that work in the school-system and then try to find out how many absent days are reported every year. Also the same study that I conducted but a bigger sample area that would cover most of the schools in the country. It would be interesting to see if the results would point in the same direction or if there would be large differences.
8 LIST OF REFERENCES


APPENDIX 1- Self-report questions
In Sweden, I have read reports from UNICEF, among others, which indicates that the school has been affected in many ways of the diseases HIV and AIDS. Please write according to your own experiences:

1. How has the effects of HIV and AIDS affected the school? (Please write 1 page).

2. How has your work as a teacher changed due to the effects of the diseases? Can you give some examples? (Please write 1-2 pages).

3. How has the children’s school situation been affected by the diseases? (Please write 1-2 pages).
The epidemic’s impact on schools.
A study on the effects of HIV and AIDS in Botswana.

Principal Researcher:
Philippa Johansson
Student at the Teacher Education Programme at the University of Borås.
Xxxxxxxxxxx xx, Sweden
0046xxxxxxxx or xxxxxxxx
xxxxxxxx@xxxxxxxx.se

Background:
You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you are informed why the research is being done and what it will involve. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.
The purpose of this study is: To look into how the effects of HIV and AIDS have affected the school situation in Botswana.

Study Procedure:
Your expected time commitment for this study is: Between one and two hours.

You will be asked to share your perceptions of the phenomenon, how the effects of HIV and AIDS have affected schools. This will be done by self-reports. Self-report imply that you will get a question and, from this write something where the matter is in focus.
You will get an envelope with a compendium of papers and three questions to answer.

• According to your experiences how has the effects of HIV and AIDS affected the school?
• How has your work as a teacher changed due to the effects of the diseases?
• How has the children’s school situation been affected by the diseases?

You will be asked to write three to five pages about your experiences. You will have one or two weeks, depending on your own thoughts on the matter, to your disposal to answer the questions.
Depending on the information given in the self-report, things might have to be clarified through interviews. In that case I will get in contact with you and decide time of an interview.

Risks:
The risks of this study are minimal. These risks are similar to those you experience when disclosing work-related information to others. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

Benefits:
There will be no direct benefit to you for your participation in this study. However, I hope that the information obtained from this study may spread your experiences to different
Ministries in the country. If this report shows facts that the Ministries did not know beforehand, perhaps your situation might change for the better.

**Alternative Procedures:**
If you do not want to be in the study, you may choose not to participate and leave your answers blank.

**Confidentiality:**
Every effort will be made by the researcher to preserve your confidentiality including the following:
Assigning code names/numbers for participants that will be used on all researcher notes and documents.
Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept in the personal possession of the researcher. When no longer necessary for research, all materials will be destroyed,
The researcher and the members of the researcher’s committee will review the researcher’s collected data. Information from this research will be used solely for the purpose of this study and any publications that may result from this study. All participants involved in this study will not be identified and their anonymity will be maintained.

**Person To Contact:**
Should you have any questions about the research or any related matters, please contact Philippa Johansson at xxxxxx@xxxxxx.se or phone number xxxxxxxx.

**Voluntary Participation:**
Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you do decide to take part in this study, you will be asked to sign a consent form. If you decide to take part in this study, you are still free to withdraw at any time, except from when the study is completed and going to print, and without giving a reason. You are free to not answer any question or questions if you choose. This will not affect the relationship you have with the researcher.

**Unforeseeable Risks:**
There may be risks that are not anticipated. However every effort will be made to minimize any risks.

**Costs To Subject:**
There are no costs to you for your participation in this study

**Compensation:**
There is no monetary compensation to you for your participation in this study.

**Consent:**
By signing this consent form, I confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, except from when the study is completed and going to print, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Signature ___________________________ Date __________________
APPENDIX 3- INFORMED CONSENT SETSWANA

The epidemics impact on schools.
A study on the effects of HIV and AIDS in Botswana.

Principal Researcher:
Philippa Johansson
Student at the Teacher Education Programme at the University of Borås.
XXXXXXXXXXXXXXX, Sweden
0046xxxxxxxxx or xxxxxxxx
xxxxxx@xxxxxx.se

Background:
O lalediwa go nna le seabe mo tshekatshekong e. Mme pele ga o ka tsaya karolo, go bothlokwa gore o thalaganye maikaelelo a go dira tshekatsheko e, le gore e tlhoka eng go atlega.
Moono wa tshekatsheko e ke go kanoka ka ha mogare wa HIV/AIDS o amileng, ebile ontse o tsweletse go ama seemo sa thuto mo dikolong tsa Botswana.

Study Procedure:
O kopiwa go dirisa ‘oura’ go ya go ‘oura’ tse pedi, go abelana le rona dikakanyo tsa gago ka fa o thalaganyang mogare wa HIV/AIDS, le ka mo o bonang o ama dikolo le thuto ka teng. Tshekatsheko e, e batla dikarabo tse di tseneletseng, di lebile maitemogelo a motho yo o di arabang.

Pampiri nngwe le nngwe e na le dipotso tse di latelang;

- Ka maitemogelo a gago, mo kgaolong e o e okametseng, mogare wa HIV/AIDS, o amile le go tswelela o ama dikolo jang?
- Tiro ya gago e amega jang ka mabaka a mathata a tlisiwang ke HIV/AIDS?
- Seemo sa baithuti mo sekolong sone se amegile jang ka mabaka a bolwetse.

O kopiwa go kwala ditsebe(pages) tse tharo(3) go ya go tshano(5) ka maitemogelo a gago mabapi le HIV/AIDS mo sekolong kgotsa mo thutong ya bana. Se o ka se dira mo nakong ya beke e le nngwe go ya go tse pedi.

Risks:
Ga ke tsyehe ha go na le borai jo bokalo mo go tseyeng karolo mo tlhotlhomisong e. o ka tlola kgotsa wa seka wa araba dipotso tse o sa batleng kgotsa o sa kgone go di araba.

Benefits:
Ga gona dimpho/dituelo tse o di fiwang go tsaya karolo mo tshekatshekong e. Dikarabo tsa gago di ka thusa wena le sechaba go lwantsha dikgwetho tse di le teng mabapi le mogare wa HIV/AIDS.

Go tsaya karolo mo tshekatshekong ga go patelediwe.

Dituelo:
Go tsaya karolo mo tshekatshekong e ga go duelelwe.

**Leletsa:**
Philippa Johansson:……

**Consent:**
Ke kwala sekano sa me mo pampiring e, e le sesupo sa gore ke thalogantse molaetsa otlhe mo yone le maikaelelo a tshekatsheko e.

Signature ___________________________ Date __________________
APPENDIX 4 - PERMIT FROM MINISTRY OF EDUCATION

REFERENCE: E1/20/2 XXIV (2)
Philippa Melissa Johansson
Regementsgatan 16
50431 Boras
Sweden

26th September 2012

Dear Madam/Sir,

RE: REQUEST FOR A PERMIT TO CONDUCT A RESEARCH STUDY

We would like to acknowledge receipt of your application for research permit to conduct a study. This serves to grant you permission to conduct your study in the sampled areas in Botswana to address the following research objectives/question/topic:

The Epidemic's Impact On Schools. A Study On The Effects Of HIV And AIDS In Botswana.

It is of paramount importance to seek Assent and Consent from Regional Education Office, School Heads of Senior Secondary Schools in Gaborone, Molepolole and Mochudi, Teachers and Students that you are going to collect data from. The interviews/questionnaires to students should be done in the afternoon to avoid students missing lessons. We hope that you will conduct your study as stated in your proposal and that you will adhere to research ethics. Failure to comply with the above stated, will result in immediate termination of the research permit. The validity of the permit is from 26th September 2012 to 25th September 2013.

You are requested to submit a copy of your final report of the study to the Ministry of Education and Skills Development, in the Department of Educational Planning and Research Services, Botswana.

Thank you.

[Signature]
For/Permanent Secretary
APPENDIX 5- PERMIT FROM MINISTRY OF HEALTH

Health Research and Development Division

Phillipa Johannson
University of Botswana
Education and behavioral Sciences

Protocol Title: THE EPIDEMICS IMPACT ON SCHOOLS: A STUDY ON THE EFFECTS OF HIV AND AIDS IN BOTSWANA

HRU Protocol Number: HRU 00772
Sponsor: N/A
HRU Review Date: 31 October 2012
HRU Expiration Date: 07 November 2013
HRU Review Type: HRU reviewed
HRU Review Determination: Approved
Risk Determination: Minimal risk

Dear Johannson

Thank you for submitting a new application for the above referenced title. This approval includes the following:
- Application form
- Proposal
- Consent forms
- Approval letter from IRB
- Data collection tools

This permit does not however give you authority to collect data from the selected site without prior approval from the management. Consent from the identified individuals should be obtained at all times.
The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

Continuing Review
In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol’s expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 10 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlanka, e-mail address: kgmnotlanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

Amendments
During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlanka, e-mail address: kgmnotlanka@gov.bw. In addition, submit three copies of an updated version of your original protocol application showing all proposed changes in bold or “track changes”.

Reporting
Other events which must be reported promptly in writing to the HRDC include:
• Suspension or termination of the protocol by you or the grantor
• Unexpected problems involving risk to subjects or others
• Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3914467 or Lemphi Moremi at lamoremi@gov.bw or Tel: +267-3632466. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

L. Moremi
For Permanent Secretary