

Redefining home-school-community partnerships in South Africa in the context of the HIV/AIDS pandemic

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Estimates suggest that approximately 12% of South Africans are HIV positive. As a result of the rapid increase of infections in the mid-1990s and the concomitant increase in HIV/AIDS-related deaths, it is estimated that 13% of children have lost one or both parents due to AIDS. In this study data were obtained by open-ended written accounts by teachers and in-depth interviews with teachers and school principals in a small sample of selected schools in KwaZulu-Natal. Findings indicated that in severely affected communities, teachers were often compelled to assume roles traditionally filled by parents. AIDS awareness programmes formed part of the schools' curriculum. However, many schools did not consider involving grandparents, other care-givers and community members in the physical, emotional and cognitive support needed by learners because teachers lacked training and schools lacked a policy of parent and community involvement in education of learners.

Introduction

It is assumed that in most societies parents will prepare their children for school, guiding and teaching them to create a pedagogical climate that is conducive to children's learning and good conduct at schools (Epstein & Sanders, 2000:286). However, when parents are ill or deceased, this function is lost to families. This implies that the school and community need to play a stronger role in the socialisation of children. Therefore, it is imperative for social structures other than the family to harness available social capital to enrich children's social, cultural and learning experiences essential for academic development.

While the term 'social capital' only became fashionable during the past decade or so, Furstenberg and Kaplan (2004:218) argue that the concept is at the core of two strands of classical sociological thinking rooted in the works of Durkheim and De Tocqueville. Durkheim (1951; 1961) observes that a cohesive social system, characterised by normative consensus, connectedness and social control promotes the welfare of its members. Similarly, De Tocqueville (1945) recognised that vibrant social communities create a virtuous cycle of social life by generating trust that in turn promotes civic involvement and a commitment to the common good. However, it was Coleman (1988; 1994) who first used the concept to explain educational achievement. Coleman defined social capital as an inclusive concept to refer to social resources available to children which promote educational growth. Forms of social capital include the interest shown by parents in their child's development and the norms held and enforced by parents or other adults in the community that shape and control children's activities and their relationships with adults. Unlike other forms of capital, social capital "inheres in the structure of relationships

between actors and among actors” (Coleman, 1988:98). An important implication of Coleman’s theory of social capital is that new strategies should be devised to strengthen the relationships between schools, families and the communities to support the learner’s development. In the light of this, this article aims to explore the current practices of a small sample of South African schools to improve home-school-community relations, particularly in communities severely affected by HIV/AIDS.

HIV/AIDS in South Africa

In the past decade, South Africa has experienced an exponential growth in the prevalence of HIV infections. The scale of this epidemic is enormous and the effects of HIV/AIDS-related deaths are felt by families, communities and institutions. However, recognition of the unfolding tragedy has been slow to gain momentum partly due to the stigma attached to HIV infections, partly due to denial at a personal and community level and partly due to the confused approach of government to the pandemic (Hall, 2003:34).

HIV/AIDS infections of women attending antenatal clinics

In South Africa, the rate of infection of women attending public antenatal clinics is used to determine the extent of the epidemic (Crothers, 2001:6). The first survey was conducted in 1990 and has been repeated every October since then (Hall, 2003:37). An analysis of the survey results enables the Department of Health to monitor the HIV infection rate and assess the prevalence at regional, provincial and national levels. The antenatal survey is confined to women in the age group 15–49 years and generalisations to the whole population are based on the ASSA 600 model of the Actuarial Society and a commercial model from Metropolitan Life (Dorrington, 2003). The results show an exponential growth in HIV prevalence. For example, in 1990, less than 1% of women attending antenatal clinics were HIV positive; in 2002 the figure was 24.5% after which it has stabilised somewhat (Quinlan & Willan, 2005:241). This means that approximately one in four women attending these clinics will, in all probability, die before their child enters school should they not receive ante-retroviral treatment (Quinlan & Willan, 2005:242).

Tests done throughout the country also show that HIV prevalence levels monitored at antenatal clinics vary across different geographic regions. KwaZulu-Natal continues to be the province with the highest prevalence and one of the highest infection growth rates recorded at antenatal clinics from 19.9% in 1996 to 36.5% in 2005 (Quinlan & Willan, 2005:241). For this reason, the site visits for this research were conducted in KwaZulu-Natal.

HIV/AIDS among the general population

Based on the statistics obtained at antenatal clinics, the Medical Research Council (MRC), suggests that the prevalence of HIV infections for the general population is about 12%, which means that more than five million of 43.8 million South Africans are HIV positive. Furthermore, the MRC estimates that

the infection is most widespread in the age cohort 30–44 years, peaking at 35% in this age group. Although the exact number of South Africans infected with the HIV virus is contested by various groups and government, this seems hardly relevant when one considers that in 2004, it was estimated that only 40 000 HIV positive South Africans were receiving anti-retroviral treatment and that the vast majority of people with AIDS could therefore soon die (Quinlan & Willan, 2005:241).

Possible effect of HIV/AIDS on the teaching profession

In terms of the impact of HIV/AIDS on the teaching profession, research undertaken on behalf of the Education Labour Relations Council determined that 12.7% of educators in South Africa are HIV positive and that the prevalence was highest in the age group 25–34 years (21.4 %) and lowest (3.1%) in the age group 55 and older (Shisana, Peltzer, Zungu-Dirwayi & Louw, 2005:53). The death of teachers and student teachers impacts on both the supply and demand for teachers. For example, research in KwaZulu-Natal showed a 50% increase in teacher deaths due to illnesses and natural causes between 1998 and 2001 (Quinlan & Willan, 2005:244). Moreover, the effects of the HIV epidemic do not end with issues of teacher mortality. AIDS and AIDS related illness among teachers result in high rates of absenteeism which is disruptive to the education system. Of the available estimates, it is assumed that each infected teacher loses a total of 18 months of working time due to AIDS-related secondary illnesses (Shisana *et al.*, 2005:3). Moreover, when a teacher is absent for long periods or dies, some schools cope by combining classes, thus increasing the learner-teacher ratio and the teaching burden on other teaching staff. The morale of educators is also likely to fall as they deal with the illness and mortality of colleagues, relatives and friends (Shisana *et al.*, 2005:12). Moreover, when teachers become ill, their teaching capacity decreases, further limiting the quality of instruction. When infected teachers are able to attend classes, the emotional stress experienced by them is significant and lesson preparation, homework correction and classroom interaction are often a last priority (Hepburn, 2002:91). In research by Hall, Altman, Nkomo, Peltzer and Zuma (2005:23) a total of 30% of teachers indicated that the disease affected them in the practice of their profession. In the sample 7% said that they were affected through AIDS infections among colleagues; 20% through AIDS among learners and their families; and 13% through ill relatives.

Demographic effects of HIV/AIDS

On the assumption that there is no drug intervention, the life expectancy after infection with the HIV virus is gauged at three to seven years (Internet, 2003b). It is estimated that by 2010 life expectancy in South Africa will drop from 68 to 48 years (Coombe, 2000:12) and that by 2015 the population loss due to HIV/AIDS related deaths will be 4.4 million (Internet, 2003b). In 2020 it is expected that the total population of South Africa will be 23% smaller

than it would have been in a no-AIDS scenario (Rehle & Shisana, 2003:4). Although death certificates can be used to determine the extent of the AIDS epidemic, many medical practitioners dealing with AIDS patients only list opportunistic illnesses as cause of death. This is often done to protect family members and other relatives who fear the stigma attached to people with AIDS from social pressure and discrimination (Crothers, 2001:6). This reluctance to elaborate on the cause of death is further heightened by the consequences of exclusion clauses in insurance and funeral benefits if HIV/AIDS is identified as cause of death.

Aids orphans and vulnerable children in South Africa

An orphan is defined by UNAIDS as a child less than 15 years of age who has lost his/her mother (maternal orphan) or both parents (Skinner, Tsheko, Mtero Munyati, Segwabe, Chibatamoto, Mfecane, Cahndiwana, Nkomo, Tlou & Chitiyo, 2005:2). In South Africa, current data suggest that 13% of children aged 2–14 years have lost a mother, a father or both parents due to HIV/AIDS (Townsend & Dawes, 2004:69). Even if these figures prove to be an overestimate, evidence indicates that a large number of children in South Africa, now and for many years in the future, will grow up without the benefits of an intact family life.

Often grandmothers take over the full-time care of young children. However, in a significant number of cases, the eldest siblings have to assume these duties, thus taking on unfamiliar adult roles for which they are ill-prepared (Ebersohn & Eloff, 2002:78). Such children become the primary caretakers of orphaned siblings or of their infected adult family members, washing, cooking for and feeding them, as well as taking care of cattle and growing maize for sustenance in rural areas. In addition, a consequence of the loss of a breadwinner in a home is a drastic reduction in the family's earnings and the ability to care for and protect its children, who become prey to neglect and abuse (Ebersohn & Eloff, 2002:79).

During the period 1995 to 2002, a significant increase in the number of orphans had not yet occurred which suggests that South Africa will still experience the full impact of AIDS on orphanhood (Brookes, Shisana & Richter, 2004:22). This means that there are still opportunities to plan for what is to come. Improving the role which schools, caregivers/parents and communities play in supporting the education of children is a strategy which could address some of the challenges in future.

Methodology

We explored the experience of teachers of parent-school-community partnerships in South Africa within the context of the HIV/AIDS epidemic by means of an empirical investigation. Two phases in the research can be identified.

During the first phase teachers attending an in-service teacher training workshop were asked to give a written description of their schools' practices to support parents/caregivers in communities severely affected by HIV/AIDS.

Responses were anonymous. The written responses were considered a first-person document describing an individual's actions, experiences and beliefs about a phenomenon (Schumacher & McMillan, 1993:434). Such documents are powerful primary sources of data collection because they focus on a single topic and can be readily assembled for analysis (Blase & Blase, 1999:356). In total, 50 written reports were received.

During the second phase, one of the researchers visited schools in a rural area near Hluhluwe, KwaZulu-Natal (Table 1). The rural area is divided into three areas, each under a tribal chief (Nkosi). The province of KwaZulu-Natal was chosen because this province is categorised as one of the regions having the most HIV positive cases in the world (Singh, 2003:1).

Approximately 70 000 people live in this area served by only one hospital, two full-time doctors and five part-time doctors. A number of primary health care clinics are run by community nurses. The community is very poor. Four schools were included in the research and focus group interviews were conducted with teachers and principals at the schools. In total, 23 participants were included in the interviews. An interview schedule was used to ensure that all issues were dealt with. However participants had the freedom to raise any issues from their own point of view. Identities of participants were confidential and participants were able to refuse to answer any questions or to withdraw from the discussion at any time.

Table 1 Characteristics of participating schools

Schools	Learners	Teachers	Classrooms	Infrastructure
School A: Primary	450	13	7	Very poor — no toilets
School B: Secondary	835	22	12	Poor — a few pit latrines and one meeting room for staff
School C: Primary	708	19	11	Few pit latrines. No storeroom — building material and stores for school feeding scheme kept in principal's makeshift office
School D: Pre-school on game reserve	14	1	1	Adequate

The four schools were chosen on the basis of accessibility to the researcher who was introduced to principals by a gatekeeper in the district who had the confidence of the community. Analysis of data obtained from the focus group interviews and responses to open-ended questions in the questionnaires was done through content analysis, which entailed identifying, coding, and categorising the primary patterns in the data (Miles & Huberman, 1994; Strauss & Corbin, 1990). In this way categories and sub-categories started to

emerge. Literature, observation, and experience assisted the researchers in identifying the final categories.

Findings of the research

Significant patterns emerging from the analysis of the participants' responses were synthesised and brought into relation with prior research and theory as viewed in the literature.

Limited knowledge of living conditions in learners' homes and communities

Several researchers (Redding, 2005; Comer, 2004; Edwards, 2004) contend that parent involvement programmes must be targeted to local needs. Therefore schools should devise clear and tailored strategies corresponding to the specific problems and dynamics of each school and the community it serves. In other words, understanding the school community is a necessary first step to establishing an effective partnership between schools and families.

According to the written responses, teachers estimated that about 38% of primary school learners and 20% of secondary learners enrolled in these schools did not live with their biological parents. However, this was not supported by data from the Department of Education (DE) which show that there are more primary schools (16 816) than secondary schools (5 513) in South Africa and that many secondary school learners are compelled to stay with relatives in villages that have access to a secondary school (DE, 2000:5). The perceived lack of knowledge of the school community shown by teachers in secondary schools could be because the latter are less focused on the learner and his/her home circumstances than primary school teachers. Findings of focus group interviews with secondary school teachers at school B were similar. Although they judged that a large number of learners were not living with their biological parents, they did not know whether these learners were living with relatives or on their own. They explained that this was due to "*our culture*" where it is not customary for a young person to discuss his/her personal problems with a teacher. They added that secondary school learners seldom discussed problems about living conditions with teachers as most realised that teachers themselves were struggling to make ends meet and would not be able to help them financially. Teachers at school B also admitted to seldom providing learners with emotional support in spite of recognising that learners in difficult home circumstances or without family support tended to "*become very quiet at school*". Schools with poor understanding of their learners' circumstances were unlikely to develop or implement effective home-school partnerships. A participant defended his school's lack of knowledge of the effects of HIV/AIDS on their community, by saying: "*It is difficult for educators to search for such info, because most families keep it a secret.*"

Teachers at school A, a primary school, seemed to have slightly more knowledge of the children and their families. However, they defended their lack of family involvement in the school by stating that they were teaching under difficult circumstances and had to interact with caregivers who were

largely illiterate. This attitude was confirmed by the written responses of a number of teachers and was consistent with Redding's (2005:8) statement:

When educators huddle among themselves, disappointed, disgruntled, and besieged, they vent their frustrations on the deficiencies and intractability of parents.

In contrast, the principal of school C knew exactly how many children were living with their grandmothers (290 of the 708 learners) and the number (70) of grandmothers younger than 60 years of age and who therefore did not receive old-age pensions. This principal had also implemented strategies to involve parents, grandparents and community members in improving the education provided to learners in her school.

School D serves a small community and the teacher had extensive knowledge about the parents of learners attending the school. She disclosed that two children in the school had lost their parents due to AIDS-related illnesses and that a father, recently diagnosed with AIDS, was consulting a traditional healer. This had so upset the child that she had developed a stutter. However, the principal was a white woman who did not speak Zulu and was therefore considered an "*outsider*". Consequently, she had to be very sensitive of the way she approached issues relating to HIV/AIDS within the community.

Recent research (MacGregor, 2005; Ravn, 2005) emphasises that many home-school partnership strategies and policies fail because they treat parents and families as homogenous groups having similar kinds of beliefs, attitudes and skills. Given the diversity of schools, families and communities, particularly in South Africa, it was evident that there was no single answer to the way schools should form partnerships with families and communities. However, whatever the strategy chosen by the school, it would always have to be grounded in a clear knowledge and understanding of the families and communities it serves.

Limited use of social capital available within the school

Recent attention has been given to the kind of social capital which is provided by schools. Hargreaves (2001:506) argues that some schools are richer in social capital than others, depending, among other things, on the prevailing school culture and the strength of networks between teachers and between teachers and other stakeholders. High levels of social capital in the school will strengthen its intellectual capital and this, in turn, will benefit learners. Conversely, ineffective schools with weak social capital undermine learner achievement and perpetuate mediocrity.

Some written responses showed that a number of teachers did not focus on the strengths of their schools, rather they focused on the poor physical conditions of school buildings and the poverty and poor education of many parents and caregivers in the community. This did not take cognisance of the fact that even buildings in urgent need of repair could be used for many community activities. Moreover, teachers did not seem to appreciate that they were often the most highly qualified in a community and could use their knowledge to help parents and learners alike. However, a few teachers men-

tioned that their school buildings were used for Adult Basic Education and Training classes, while many mentioned that their schools assisted caregiver-grandparents to apply for child support grants. This task entails obtaining the child's birth certificate and death certificates of the parents and is something that few illiterate grandparents manage without assistance. On the other hand, such help is given only to those seeking it, thus leaving the initiative to the grandparents who may not have the confidence to approach the school for help.

A number of teachers mentioned how they, as wage-earners in a community where many are unemployed, provided financial assistance to orphans, paying their school fees and providing them with school uniforms and food. In a written response, a teacher described a home-based care group which had been founded at the school and was being organised by a member of staff. This group visited families who were in need and provided them with financial assistance where possible.

At school A teachers said that they used their knowledge to teach children about HIV/AIDS but maintained that this had not influenced learner behaviour at all. They maintained that children as young as 10 years old were sexually active. They did not offer workshops to parents and caregivers on sexuality education claiming that "... *parents will not listen, even if we tell them their child is being abused by the uncle*". Teachers at school B had a similar attitude and claimed that as teachers they were "*unable to make a difference*" in the lives of learners and their parents/caregivers.

In contrast, school C played a vital role in the community, using the school's knowledge and status in the community to assist grandmothers younger than 60 to obtain the *Nkos's* (tribal chief) approval to receive a disability grant. The school also provided food packages on Fridays to learners staying with grandparents so that they had food during the weekend. A similar example was given by a teacher in a written response. In their school parents were asked to provide the school with the names of children living on their own so that the school could assist them. Because orphans as well as children living with their grandparents generally did not get help with schoolwork, some teachers stayed after school to help children who had no support at home with schoolwork. School C had a similar practice and all children living with grandmothers were compelled to stay after school where a structured learning programme was provided for them. These classes were given by staff of the school. This strategy was important when considering that in research undertaken by the HSRC (2005:29) 65% of rural children said that no one at home was sufficiently educated to help them with their homework. In addition to assisting learners with their homework, school C set one afternoon aside to teach the children traditional crafts such as basket weaving, wood carving and beading. The principal explained:

"Even with a Grade 12 pass, some children do not get work. But if they know the traditional crafts they can always make some money selling these to tourists."

A teacher at school D had read extensively on HIV/AIDS and showed sound

theoretical knowledge of the epidemic. However, she complained of not knowing how to deal with some situations in her class due to laws prohibiting the disclosure of the HIV status of a person. She knew, for example, that one little boy was HIV positive, had skin lesions, was very weak, and fell asleep during lessons. She constantly had to deal with this situation in such a way that the child's medical history was not divulged to the other children in the class or to their parents.

Although both written responses and focus group interviews indicated that parents who could not pay school fees were exempted from doing so, this was only done when parents or caregivers applied for exemption. This policy is widespread and the Human Science Research Council reports that 57% of schools in rural areas profess to having an exemption policy, whereas fewer than 12% of caregivers say they know about it (HSRC, 2005:52). Thus, in many cases the financial needs of schools overshadow teachers' commitment to serve the parent community. Using the social capital available in the school is most important for those serving deprived communities. Halpern (2005:156) states:

... poor families living in poor areas suffer from a double disadvantage, first from being poor themselves, and second from the poverty of their neighbourhoods.

In such communities, schools can play a very important role.

Limited use of parents and caregivers to assist the school

Most teachers showed a limited idea of ways in which parents/caregivers could be used to assist education. Parents were usually invited to clean classrooms, cook meals for children, plant vegetables, care for the garden or do general maintenance work. Many grandparents were asked to prepare the food supplied to primary schools as part of the government's feeding scheme. Generally the school could only afford to "pay" them by giving them the left-over food after the children had had their meal. One teacher, whose school was able to pay volunteers a small sum of money, described the use of parent volunteers in the school's feeding scheme in the following words:

"Parents rotate for cooking for learners at school so that almost every disadvantaged family member can have an income at least once or twice per year."

These statements illustrated that in poverty stricken areas schools could not avoid playing a role in children's nutrition if education was to be effective. Unfortunately in extensive research undertaken by the Human Sciences Research Council (HSRC, 2005:55) school meals are poorly managed and irregular.

According to the written responses of teachers obtained in Phase one, some innovative schools had started asking more affluent parents at the school to "adopt" an orphan, paying his/her school fees and providing the child with a school uniform. Another school had started a vegetable garden where a few parents cared for the crops and shared the harvest. Another had a similar plan and had asked parents with a knowledge of farming to assist

other parents in these endeavours. However, no school mentioned using parents and other caregivers to assist in the teaching of children, with the exception of instruction in traditional dances. Thus, in spite of having some parents who had a matriculation certificate, schools did not use these parents to assist teachers who were ill or absent. This deprived the school of a valuable resource and the children of a learning opportunity.

Identifying resources and fostering relationships with the community

In *per capita* terms South Africa is an upper-middle income country, but despite this relative wealth, the experience of most South African households is of outright poverty or of continuing vulnerability to being poor. In addition, the distribution of income and wealth in South Africa is among the most unequal in the world and many households still have unsatisfactory access to education, healthcare, energy and clean water (May, 1998:1). This means that many caregivers and parents have limited financial resources and are not able to provide for the basic needs of the children in their care. Therefore, schools serving poor communities — particularly those affected by HIV/AIDS — should make a concerted effort to identify institutions, businesses and individuals in the community who can support these families. Moreover, schools need to use the expertise available in the community to support education. In the schools in the study, some success had been achieved. Many teachers mentioned asking nurses, doctors and law enforcement agencies to speak to learners on issues of health and crime. Most teachers also mentioned that their schools made use of social workers to assist caregivers applying for social grants.

According to written responses given in Phase One, a school had instituted a School Support Team, consisting of teachers and parents, to liaise with medical practitioners, nurses, local social workers and police inspectors in the community. The School Support Team kept a register of vulnerable children and put these families in touch with the services they needed. The Support Team also contacted local businesses asking them to assist needy learners with school uniforms and stationery. In addition, the School Support Team worked closely with the churches in the community, putting them in contact with people who needed food or a place to stay. Moreover, the Support Team had a sub-committee which included the necessary expertise to counsel abused children. Another teacher mentioned taking children who needed help to a house of safety (Tunnellight House) where they could be cared for. School C, situated on a private game reserve, used the game reserve management to assist the school and also created opportunities for visiting tourists to the game reserve to contribute voluntarily to the school by contributing to a specific child's education or assisting financially with building projects at the school. Many of the school's classrooms had been built by the community with financial help from business and tourists.

Because HIV/AIDS affects the human immune system, the prevalence of Tuberculosis (TB) has increased dramatically (Crothers, 2001:8). Some children also present with skin lesions and other ailments. This makes it impera-

tive that schools form a close relationship with medical clinics serving the community, which was something the principal of School C had achieved. She often took children suffering from a variety of ailments to the local clinic for treatment. However, to do so, she needed the consent of the parent or caregiver. Where she suspected a child of being HIV positive, she asked permission to have him/her tested. This was generally refused and permission was given only to have secondary infections treated. The principal had arranged with the local clinic to give medical treatment to learners from the school as soon as possible, so that they could return to class and avoid missing important tutoring. Many teachers also mentioned increased co-operation with the police as an increasing number of children, growing up without parents and badly supervised by relatives and welfare organisations, had raised their risk of engaging in criminal activities (Coombe, 2000:13).

A surprisingly small number of teachers mentioned the role of the church in schools. If this finding is a reflection of conditions in other parts of the country, it is unfortunate as faith-based institutions can be effective structures for a range of social and material support. Church-based support can also serve to reduce the erosion of self-esteem and loss of mastery or control that often result from stressful life events (Amoateng, Richter, Makiwane & Rama, 2004:34).

The teachers in this inquiry taught in rural schools serving mostly poor communities, who were then further disadvantaged by the HIV/AIDS epidemic. The needs of children in these schools were great. Research by Halpern (2005) suggests that many such children underperform because of deficits in the social capital of their homes. However, the research also argues that these deficits can at least partly be compensated for by offering alternative forms of social capital. Thus, the school, church, business and other institutions in the community could be used to support the development and education of children living in such circumstances. As Halpern (2005:157) puts it, referring to the need for learners to excel at school:

... families can take you so far, but wider social networks help to take you that extra mile. But the main point is that their effects are broadly additive. More of either will help children.

Recommendations

Although there is still much debate about HIV/AIDS and the number of people affected as well as the number of orphans the country will have to provide for in future, the problem is extensive and schools will have to adapt to the impact this will have on educational provision in the country. As Coombe (2002:vii) puts it:

Learning institutions in an AIDS-infected world cannot be the same as those in an AIDS-free world. Challenged by this pandemic, the paradigm of education is shifting.

One possible solution is for schools to strengthen their partnerships with caregivers and the community.

Schools should use all available 'capital' — parents/caregivers, the community and the strengths of the school itself

Social capital can be described as the set of

... intangible resources in families and communities that help people cope with stresses, develop their potential, take advantage of opportunities, and express aspirations beyond the immediate context (Amoateng *et al.*, 2004:31).

Halpern (2005:4) lists the following forms of capital available to communities and institutions: financial capital, physical capital, tangible assets (i.e. land), human capital and social capital. Schools need to be aware that all these can be of use if they are committed to improving the education children receive.

Margoribanks (2002:1) aptly summarises:

It is an expectation that such partnerships will be associated with the formation of more enriched learning environments, which in turn will be related to more positive school attitudes and associated with improvements in children's academic performance.

Train teachers for home-school community partnerships

This means making teachers and parents aware of the different types of home-school-community collaboration that can be explored. According to Lemmer's (2000) research on the implementation of parent involvement in diverse communities in South Africa, the Epstein typology of parent involvement works well within the South African context (Epstein, Coates, Salinas, Sanders & Simon, 1997:8-10). The six areas of involvement provide a framework against which current practices in schools can be evaluated and helps to identify areas of home-school-community involvement which have not yet been implemented. The six areas are:

- **Parenting:** This means providing parents/caregivers with clear, consistent expectations, information and guidance to help them practice specific family behaviours that enhance children's learning. In this regard teachers need to be reminded that
 - ... good, enthusiastic parenting can be found amongst mothers of all social classes and ethnic backgrounds, and where it is not found it can probably be taught (Desforges & Abouchar, 2003:33).
- **Communication:** Maintaining a variety of effective two-way communication between the school and the home about school programmes, the schools' expectations of parents and children's progress.
- **Volunteering:** This includes providing and encouraging opportunities for parents to help out at school, in the classroom and with school activities.
- **Learning at home:** This means schools need to show parents/caregivers how to help children with homework at home and provide them with information so that they can help their children with educational choices/options.
- **Decision making:** Although the South African Schools Act (RSA, 1996) makes the establishment of School Governing Bodies mandatory, schools need to involve all parents/caregivers in decisions affecting their children.

This includes decisions taken at classroom as well as school level.

- **Collaborating with the community:** Here schools need to realise that community must be broadly defined to include anyone who is involved with the future of the youth in South Africa.

However, identifying areas of involvement which need attention is not enough. There should be a concerted effort to improve parent involvement in all areas.

Schools should develop a home-school community policy and an organisational structure to drive it

In the light of the importance of the school's contribution in poor communities with limited social capital, it is important how teachers regard learners from impoverished families and what attitudes they demonstrate towards such families. This largely determines the nature of home-school-community relations in schools in these communities. This implies, in the first place, an acknowledgement of the value of such a partnership. Research shows that schools with poor parent involvement tend to blame it on the parents (Epstein *et al.*, 1997). This is often not true. All these challenges can be overcome if the school has a policy of involving parents. However, schools also need to have a structure which is tasked with establishing or improving home-school-community relations. In South Africa, linking this to the mandated school governing bodies is recommended.

Conclusion

Thurman (2000:6) states "AIDS is not just a health issue; it is an economic issue, a fundamental development issue, and a security and stability issue". This is important to note as South Africa, like all of Africa, tries to deal with the effects of the HIV/AIDS epidemic, particularly with what is called the third wave of the epidemic — its social impact (Brookes, Shisana & Richter, 2004: xi). The above discussion suggests that this impact also extends to the level of the school, where teachers, learners, parents and the community are deeply affected by the effects of the HIV/AIDS epidemic. However, Singh (2003:7) says that the education system needs to recognise in this "state of emergency" the opportunity to review and redesign the way we teach and learn, and re-direct the education system to new and higher ground. One way of doing so is to encourage a commitment by schools, caregivers and the community to form a partnership for the benefit of all children. As Gandara (quoted by Redding, 2005:9) puts it: "There is no better place to create a community of caring than in our schools — the heart of our future".

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