# CHAPTER 1

GENERAL ORIENTATION

1. INTRODUCTION

According to the UNAIDS Epidemic Update (2007:15) sub-Saharan Africa is the most affected region in the global AIDS pandemic. The update states that more than two-thirds (68%) of all people who are HIV positive live in this region. Southern Africa is most seriously affected – 35% of all infected people live in this region, and South Africa is noted as the country with the largest number of HIV infections in the world (UNAIDS Epidemic Update, 2007:16). The statistics cause serious concern, as illustrated by World Health Organisation's researchers in Figure 1-1 below.
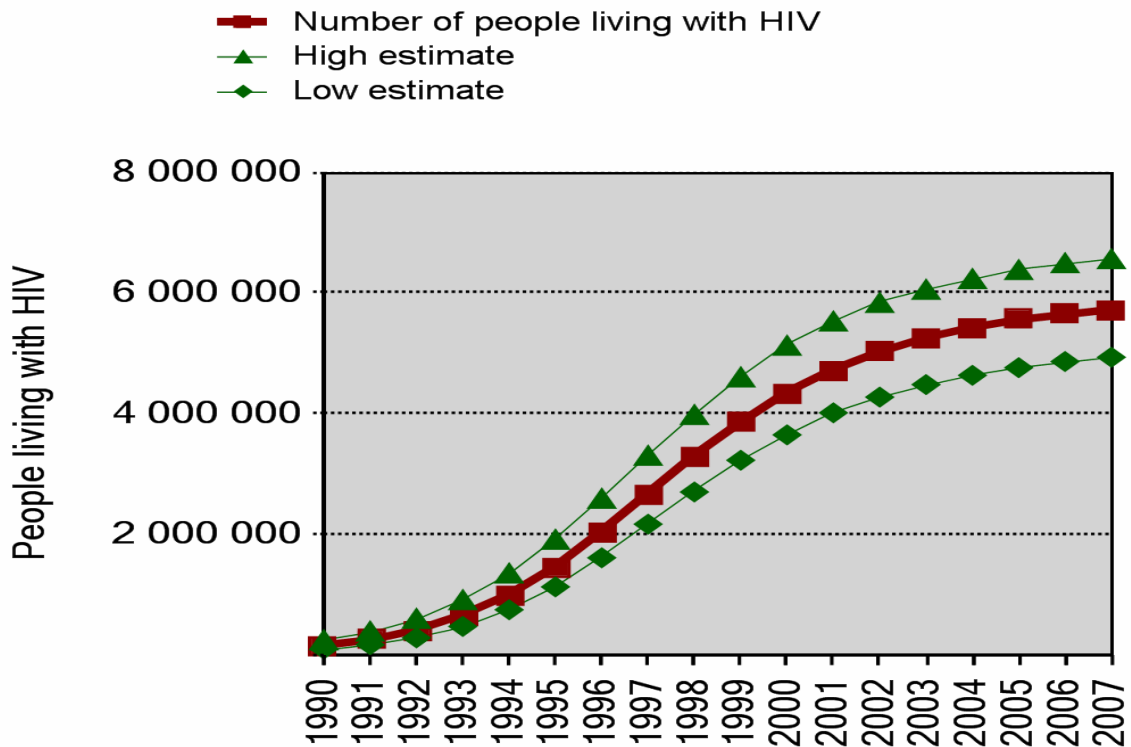
Figure 1-1 People living with HIV and AIDS in 1990 – 2007 in South Africa

As noted in Figure 1-1, the UNAIDS Epidemiological Fact Sheet on HIV and AIDS (2008:4) states that approximately 5 400 000 people above the age of 15 are living with HIV and AIDS in South Africa. As such, HIV and AIDS have a serious impact on people and the environment and affect all the important structures (social, economic, political, health, education and so forth).

The education sector is affected in a number of ways: The UNAIDS Epidemiological Fact Sheet on HIV and AIDS (2008:6) states that the estimated number of children in South Africa who have lost their mother or father or both parents to AIDS and who were alive and under the age of 17 in 2007 was 1 400 000. Thus, it can be assumed that a substantial number of these children are of school-going age, and that they are taught by educators.

Coombe (2000:16) states that qualified educators and officials will be lost to education through death, illness or departure for other jobs. Theron (2005:56) mentions that the quality of education is being eroded by having fewer experienced educators. This will have a negative impact on the educators remaining at schools – they will need to carry on doing the work, with fewer people. This can increase the stress on each educator, and the researcher is of the opinion that the loss of colleagues places remaining educators in the category of being affected by HIV and AIDS. HIV and AIDS affected educators are defined by Theron (2007a:18) as educators having loved ones, colleagues or learners who have died from AIDS-related illnesses as well as educators who teach AIDS orphans or learners affected by HIV and AIDS.

HIV and AIDS have a detrimental impact on children as well. Coombe (2000:16) notes that children are dying of AIDS complications, and children who are ill, impoverished, orphaned, caring for younger children, or earning and producing, stay out of school. Ansell and Van Blerk (2004:688) note that children's migration is not a new strategy for meeting the needs of children and households in times of stress, but it is acquiring growing significance in the context of Southern Africa's HIV and AIDS pandemic. Theron (2005:56) found in her research that due to AIDS the demand for education is decreasing mainly because fewer children are entering and/or remaining in school. This statement is supported by Shisana, Peltzer, Zungu–Dirwayi and Louw (2005: xiv) who found that learners who are affected by the AIDS pandemic are quitting school or relocating. The researcher is of the opinion that the statements of Coombe, Theron and Shisana *et al.* are valid, because statistics released by UNAIDS (2007:8) found that in sub-Saharan Africa, 2.2 million children under the age of 15 are living with HIV and AIDS, and the UNAIDS Epidemiological Fact Sheet on HIV and AIDS (2008:5) state that 300 000 live in South Africa.

Worldwide there were approximately 370 000 children newly infected with HIV in 2007.

Many of these infected children stay away from school, due to various reasons. Educators see that children are no longer attending school, and they need to face the reality that the children may no longer be alive, or they may be very ill. This has a negative effect on the educator. The HIV and AIDS affected educators need to function in a community where AIDS is taking its toll. They are community members, but also adults who take the responsibility for the orphaned and HIV affected learners in their classes.

The school system is also negatively affected by the pandemic. Coombe (2000:16) mentions that management, administration and financial comparison in the education system are already fragile, and predicted that AIDS may make it even more difficult to sustain the structures necessary to provide formal education of the scope and quality envisioned by the democratic government's policies. Theron (2005:56) backs this statement by saying that education sector costs are soaring as substitutes and temporary educators are required. These are only some of the physical impacts of HIV on the education sector.

The emotional effect of the pandemic on educators should also be considered. Coombe (2000:16) suggests that no educator is exempted from the detrimental impact of the HIV and AIDS pandemic. Coombe (2000:16) projects that HIV will cause incalculable psychosocial trauma, which will overwhelm affected educators, affected children and their families. She says at the very least school effectiveness will decline where a significant proportion of educators, officials and children are ill, lacking morale and unable to concentrate.

According to Hall, Altman, Nkoma, Peltzer and Zuma (2005:30) the impact of HIV and AIDS is likely to intensify in the future and have an additional impact on attrition. Attrition is defined in the Oxford Minidictionary (1991:28) as "wearing away." In order to prevent attrition, they suggest that support mechanisms for infected and affected educators should be implemented in order to secure excellence and sustainability in service provision. According to Theron (2006:27) in this regard, the general response to the impact of HIV and AIDS was to launch preventative programmes, and to write policy.

The National Policy on HIV and AIDS for learners and educators in public schools and students in further education and training institutions of 1999 is, according to Van Dyk (2005:355–361), a guideline that can be used by educators, caregivers and counsellors to discuss the management of HIV and AIDS in the school environment and to support learners and educators living with HIV or affected by the HIV pandemic. According to the researcher this policy is a great idea – the problem is however that the policy focuses on prevention and not on the implementation of a support programme (Theron: 2006:27). The researcher shares the opinion of Theron that the policy gives guidelines on how educators can be supported, but there is no actual plan on how the support can be implemented. This is in the researcher's view one of the shortcomings of the current policy.

Theron (2006:35) reports that research conducted among 457 educators in Gauteng in 2005 to determine which measures of support they required to cope with the pandemic, suggested that the educators are in need of a comprehensive support system – something they do not currently have access to. These programmes need to assist HIV and AIDS affected educators to become emotionally strong and teach them to become resilient.

Resilience is the ability to persevere and adapt successfully when things go amiss (Jenson & Fraser, 2006:8). Schoon (2006:16) defines resilience as a dynamic process where individuals positively adapt despite difficult circumstances. Theron (2007b:375) views resilience as the ability to do well in a context fraught with risk. Resilience is all about the way an individual responds in an adverse or difficult situation. Responsive emotions such as anger, guilt, defeatism, vulnerability and worry or responsive emotions such as persistence, perseverance, diligence and determination can be perceived as the thinking style of an individual (Reivich & Shatte, 2002:3). The researcher sees a person as being resilient if they have the ability to cope emotionally after they have experienced some kind of setback. Esterhuizen (2007:8) concluded that resilience is not only derived internally, but also from the dynamic interaction between an individual's external and internal world.

In response to the research done by Theron in 2005, the nine-module Resilient Educators support programme (REds) was developed as a support programme that relies on active participation of educators.   The aim of the programme, as stated by

Theron, Geyer, Strydom and Delport (2008:84) is to empower HIV and AIDS affected educators to cope more resiliently with the challenges of the HIV pandemic by supporting educators to respond adaptively to a teaching context that demands responses such as grief counselling, solving family problems, finding resources and so forth – these responses are not part of the educators' role. These responses are typical to that of social workers, trained counsellors and health care professionals. The REds programme covers some of these aspects, with the goal in mind to empower educators to cope better with the demands.   The content of the programme focuses on:

- Giving and gaining support;
- How to remain psychologically well;
- How to cope with stigma and fatigue;
- Educator rights with regard to the HIV and AIDS pandemic;
- Health education – staying healthy despite being infected;
- Health education – caring for ill loved ones; and
- Resilience in the face of the HIV and AIDS pandemic (Theron, 2006:38).

Since 2006, the REds programme was implemented by independent researchers in four South African provinces, Gauteng, Mpumalanga, the North-West province and the Free State. The rationale for implementing the programme repeatedly was to create a database of knowledge that would provide sufficient proof and motivation for the REds programme to be implemented nationally. Theron *et al.* (2008:84) state that the REds programme was developed further after each implementation, according to participant and facilitator feedback.   Theron *et al.* (2008:85) note that some of the developments included adding additional sessions, amending the content to be more culturally sensitive, altering the sequence of the modules and including more information and activities that focus on addressing learner grief. In a personal interview, Theron (2009) articulated that the methodology of implementing the programme has also changed according to findings in previous rounds.

During the personal interview Theron (2009) remarked that based on previous implementations of the programme, two recommendations were made pertaining to cultural sensitivity and cultural preferences. These responses are incorporated as

changes in the current REds programme. Theron (2009) also says that some recommendations after the pilot tests were that the pre- and post-test media (e.g. questionnaires; incomplete sentences) be shortened and specifically that the wording and format of the ProQol standardised questionnaire be simplified; that session times be lengthened; and that resilient, HIV positive community members be invited to participate as voices of realism and encouragement for participating educators. Once again, the 2009 version of the REds programme included these suggestions. Theron (2009) pointed out that the previous implementations of the programme did not provide them with facts that the programme made a difference – after the implementation of the REds programme, the HIV and AIDS affected educators noted an improvement in their resilience, but as no comparison group was used, researchers could not pronounce that the improvement was due to the programme. During 2009, the aim of the research will be on empowering affected educators to cope more resiliently with the challenges of the HIV pandemic, and further to evaluate the effectiveness of the adapted REds programme as a support programme.

The researcher has decided to implement and evaluate the adapted 2009 version of the REds programme in the D9 and D12 teaching districts in Johannesburg, Gauteng. During a conversation with Esterhuizen (2009), she expressed that HIV and AIDS affected educators feel helpless, saddened and unmotivated to continue working under the current circumstances that they face. She said that many educators considered leaving the profession. Mrs Mothibe (2008), headmaster of a primary school, mentioned that the educators in her school tend to become very involved with the children –one teacher has taken four orphans into her home, and another supports families financially. Mothibe herself has fostered one of the children in the school whose parents have passed away from an AIDS-related illness. This shows that the educators do not only carry the burden of HIV and AIDS in the classroom, but many become involved with the learners and their families on a personal level. This has an effect on the educators, and if they do not have the skills to deal with the emotional aspects, they will feel helpless and unmotivated to continue.

The rationale for this round of implementation of the REds programme would be to focus on gathering comparative data to prove that the programme has a positive

impact on the quality of life and resilience of educators. This should be done in order to provide to the greater REds programme the opportunity to generalise the findings of the programme, and implement it on a national level.

2. PROBLEM FORMULATION

The question arises, how are the educators coping with the effects of the HIV and AIDS pandemic? According to Hall *et al.* (2005:4), South African educators are seen as a high-risk group in terms of HIV and AIDS, because the profiles of people living with HIV and AIDS and those of South African educators are so similar. Both are mostly African, female, and on average 32 years old.

Educators are faced with the effects of the pandemic on a professional and personal level. This is confirmed by Theron (2006:36) who states that the impact of living with or caring for someone with HIV is both professional and personal. Theron (2005:59) articulated that educators reported psychological trauma, stress, depression and suicidal ideation. She also notes (2005:39) that HIV and AIDS affected educators lack in skills, assertiveness and positive psychological perceptions needed to sustain wellness.

The concept of wellness focuses on the physical health of an individual, and the prevention of the loss of health. Hall *et al.* (2005:23) agree with this statement – in their study they found that educators' experiences are typified by depression and sadness. These negative feelings of depression and sadness are aggravated by the effect that HIV and AIDS had on learners. In this regard, Cluver, Gardner and Operario (2007:756) marked the following psychological distress indicators among AIDS-orphaned children in South Africa: depression, anxiety, peer problems and post-traumatic stress symptoms. The study was done at schools, and thus the logical conclusion can be made that these symptoms will have an effect on the educator. As earlier stated the researcher is of the opinion that the loss of colleagues and learners, the increase in the number of orphans and the increased workload are all factors that can contribute to the educators' feelings of depression and sadness.

Hall *et al.* (2005:23) asserts that HIV and AIDS affected educators were more likely to leave teaching; their stress levels were notably higher due to elevated workloads, overcrowded classes and absent colleagues. According to Coombe, (2000:17) teaching time is also lessened by funerals due to AIDS-related deaths.

The UNAIDS Inter Agency Task Team on Education (2006:6-7) found that there is a continued need for increased support for educators confronted by the HIV and AIDS pandemic. In addition to the UNAIDS report, it was found by Theron (2006:15) that although the *National Policy on HIV and AIDS for learners and educators in public schools and students and educators in further education and training institutions* of *1999* is in place, it seems as if support that is specifically aimed at HIV and AIDS affected educators, is missing from the policy. In order to address the need for support, the REds project was started during 2006, focusing on supporting HIV and AIDS affected educators. The researcher is interested in determining, with sufficient experimental evidence, how effective the 2009 version of the REds programme is in supporting HIV and AIDS affected educators to become more resilient.

The problem can thus be summarised as follows: HIV and AIDS affect many people, but HIV and AIDS affected educators work in close contact with children who fall victim to the pandemic and the educators themselves can also be affected within their families. The problem is that we have a lack of knowledge as to how the educators cope with being HIV affected human beings, and we want to know how effective the REds programme is in enhancing the quality of life and resilience of these HIV and AIDS affected educators.

The specific focus of this study would thus be to evaluate how effective the current 2009 version of the REds programme is in enhancing the quality of life and resilience of HIV and AIDS affected educators.

3. GOAL AND OBJECTIVES OF THE RESEARCH STUDY

The goal of a research project can be seen as the "dream" of what the researcher would like to achieve with the research, while the objectives are steps one has to take, one by one, realistically at grassroots level and within a certain time span in order to attain the dream (Fouché & De Vos: 2005a:105). The Oxford Minidictionary

(1991:350) defines a goal and an objective as the same concept. The term objective is defined as "…a thing one is trying to achieve, reach or capture." The researcher is of the opinion that there is a difference between the goal and the objective of a study. The researcher agrees with Fouché and De Vos (2005a:105) when they note that it is first and second order thinking that takes place to indicate the intended result of the study.

3.1   Goal of the study

The goal of this study was to evaluate the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng.

3.2   Objectives of the study

In order to obtain the goal the following objectives were formulated:

- To theoretically conceptualise the phenomenon of HIV and AIDS and the impact thereof on South Africa, specifically the school environment and HIV and AIDS affected educators as well as the concept resilience.
- To empirically evaluate the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng.
- To draw conclusions and make recommendations based on the empirical results, to adjust and improve the REds programme in order to implement it on a national level.

4. HYPOTHESIS

The researcher's study forms part of a larger (macro) REds study. Data collected with this specific study will be fed into a large database. This data will be used by the project leader to generalise if the REds programme will make a difference in the quality of life and resilience of HIV and AIDS affected educators. In order to have the ability to generalise, the researcher has decided to use a hypothesis rather than a research question. A hypothesis is defined by Babbie and Mouton (2001:643) as a statement that postulates that a certain relationship (correlation or causality) exists between two variables.

For the purpose of this study, the researcher was interested in testing the effectiveness of the REds programme in increasing quality of life and resilience. Hudson (1995) as cited by De Vos (2005b:381) states that there can be no such thing as effectiveness unless and until there is detectable or measurable change. Thus, the outcome of the programme needs to be evaluated, and this can be done by formulating a hypothesis. In the case of this study, the researcher formulated the hypothesis by taking into account the research problem.

After the implementation of previous evaluative studies of the REds programme (Kupa, 2008; Esterhuizen, 2007), educators (participants) noted an improvement in their resilience, but as no comparison group was used, researchers could not pronounce that the improvement was due to the programme. Thus, the research problem was that the effectiveness of the REds programme as a support programme for HIV and AIDS affected educators was not yet evaluated in such a way that researchers can generalise the findings. In the light of the afore-mentioned research problem, the researcher utilised an experimental design in her study and therefore formulated the following hypothesis to guide the study:

- If the Resilient Educators support programme (REds) were implemented among HIV and AIDS affected educators, then their quality of life and resilience will be increased.

Greenwald (1993:419) defines a null hypothesis as the hypothesis of no association between variables. The researcher sets the following null hypothesis to be proved or disproved:

- There is no association between the independent variable (the Resilient Educators support programme) and the dependent variables (resilience and quality of life).

5. RESEARCH APPROACH

In order to gain complete information about the effectiveness of the REds programme as a support programme for HIV and AIDS affected educators, both quantitative and qualitative data were collected and analysed in the same study, thus

the mixed methods research approach was used, as both quantitative and qualitative data were collected, mixed and analysed in a single study. The quantitative data assisted in determining the quality of life and resilience of participants prior to, and after implementation of the programme by making use of standardised measuring instruments. The qualitative data assisted in determining the emotional and personal impact HIV and AIDS has had on participants by using narratives and drawings before and after implementation of the REds programme.

6. TYPE OF RESEARCH

For the purpose of this research study, the researcher used applied and evaluative research. Applied research was appropriate to the researcher's study, as part of the goal of the study was to identify possible solutions for the proposed problem of resiliency of HIV and AIDS affected educators. In the context of applied research, evaluative research was also utilised because the aim of this study was to evaluate the effectiveness of the REds programme.

7. RESEARCH DESIGN AND METHODOLOGY

7.1 The research design

For the purpose of this study, the researcher chose the mixed methods research approach, and then the concurrent triangulation design (Creswell & Plano Clark, 2007:62). The REds programme was designed to give equal weight to the quantitative and qualitative measures; therefore, this design is valid, because triangulation can be used to compare quantitative and qualitative data sets to produce well-validated conclusions. The REds programme did exactly this – the qualitative and quantitative data carried the same weight in the results of the study, and the data sets were merged in the interpretation to produce well-validated conclusions. When comparing the pre- and post-test results, both the quantitative and qualitative data were used to indicate if the null- hypothesis was true or false.

7.1.1 Quantitative research design

For the quantitative part of the study, the researcher made use of a quasi-experimental design namely the comparison group pre-test – post-test design. The dependent variables (HIV and AIDS affected educators' quality of life and resilience) were tested with a pre-test administered to both the experimental and the

comparison groups. After the pre-test, the independent variable (the REds programme) was introduced to the experimental group. After the implementation of the programme, a post-test was conducted with both the experimental and comparison groups. The same standardised measuring instruments were used for the post-test. Results of the pre-test and post-test were compared to determine if the independent variable (the REds programme) has had an effect on the dependent variables. Due to a comparison group being utilised, the researcher was able to see if the REds programme made a difference to the participants' quality of life and resilience.

7.1.2   Qualitative research design

For the qualitative part of the study, the researcher was interested in the participants' experiences of their lives in the era of HIV and AIDS. The researcher was also interested to explore how HIV and AIDS have affected the participating educators. In order to gain this information, the researcher used a collective case study design. This design was appropriate in order to understand the support needs of HIV and AIDS affected educators as a social issue. The researcher would also like to generalise that the REds programme had an influence on the wellbeing of the group rather than that of the individual.

7.2   Data collection method

Data collection is the process in which the researcher goes out and collects the information. Both quantitative and qualitative data collection methods were used in this study.

7.2.1   Quantitative data collection methods

For the purpose of this study, two group administered standardised questionnaires were used to collect quantitative data. These two questionnaires were:
- The Professional Quality of Life Screening (ProQol) from Stamm (2005) which measures the quality of life of a person in the work environment, taking into account three variables, namely compassion satisfaction, secondary trauma and burnout.
- The Resilience Scale for Adults (RSA) developed by Hjemdal (2007) that measures a person's level of resilience.

Both of these questionnaires were used in the pre-tests and post-tests and the results were compared in order to evaluate the effectiveness of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators.

7.2.2 Qualitative data collection methods

The researcher used a narrative, drawings and observation to collect qualitative data. In the context of this study, the probe for the writing of a narrative asked the participant to write about their life as a teacher in the era of HIV and AIDS – this assisted in contextualising how life is when teaching people who are affected by HIV and AIDS. This probe was used in the pre- and post-tests and the researcher compared the narratives in an attempt to evaluate the REds programme.

In addition to writing a narrative, the participants were asked to make a free drawing of something that symbolises how HIV and AIDS have affected them. However, a drawing on its own does not have meaning without an explanation or conversation about it. In order to address this issue, the participants were asked to write two or three sentences to explain their drawings. From these explanations, the researcher was able to identify themes. The aim of using the drawings was to ensure that all possible data were collected, and that the research findings reflected the true effectiveness of the REds programme.

The researcher made use of an observer to assist in observing the reactions, discussions and group interaction during the sessions. These observations were used by the researcher to capture data on the group process and any other data that was relevant for the evaluation of the programme.

7.3 Data analysis

The data were analysed according to the relevant approach, whether quantitative or qualitative.

7.3.1 Quantitative data analysis

The purpose of analysis was to reduce data to an interpretable form, so that relations could be identified and conclusions drawn.

The quantitative data generated from the two questionnaires (ProQol and RSA) were marked and analysed by the Statistical Services of the University of the North-West. The analysis focused on comparing the results of the pre- and post-tests.

7.3.2   Qualitative data analysis

The narratives, drawings and observation field notes will be studied and the researcher used content analysis to identify themes and seek to understand meaning. The researcher used coding and data interpretation to make inferences.

8. PILOT STUDY

8.1   Motivation for the study

Strydom (2005c:205) states that the researcher should have thorough background knowledge on a specific topic in order to conduct research on the topic. One way of gaining knowledge is by conducting a pilot study. The REds programme was pilot tested in Gauteng in 2006. In order to fine-tune the programme and data collection methods, the REds programme has been subjected to multiple pilot studies in Gauteng, Mpumalanga and the North-West province (e.g. Kupa, 2008; Esterhuizen, 2007). Various pilot studies have been done – so it was not necessary for the researcher to conduct a pilot study again.

8.2   Feasibility for the study

Strydom (2005c:208) states that it is necessary to obtain an overview of the actual practical situation where the prospective investigation will be executed. This is necessary to prevent the researcher from wasting time, money and energy on a research project that may fail, or is not properly planned. Pilot testing of the REds programme in Gauteng in 2006 gave evidence that the goal and objectives of the study, as well as the procedures of data collection and analysis were clear and feasible.

The researcher had a very specific and limited population where the main study was conducted. It was however necessary for the researcher to consider the following aspects:

- Cost – the cost of the study needed to be determined in order for the researcher to budget for the project and apply for funding. Funding was

received from the National Research Foundation, which enabled the researcher to cover transportation and administrative costs.

- Time – The time constraints for the study are imperative. The researcher completed the empirical study by November 2009, and the data were analysed by February 2010.

- Permission – permission to do the study was obtained from the Gauteng Department of Education (see Annexure 1). The researcher was responsible to acquire the permission. The researcher approached two schools in districts 9 and 12, which falls in the Teaching Districts of the Gauteng Department of Education, and permission was granted by the Gauteng Department of Education for the researcher to conduct the study.

- Availability of participants – the researcher needed at least two groups of 10 HIV and AIDS affected educators as participants. As mentioned, the schools were not too close to one another, to limit the contamination of data. The researcher identified two schools who indicated that they would be eager to take part in the study. The educators committed two hours per week to participate in the programme. In an effort to compensate for the possibility of educators dropping out of the programme, the researcher included more than 10 educators in each group.

8.3 Testing of data collection methods

The data collection methods were pre-determined by previous studies on the REds programme.

8.3.1 Quantitative measuring instruments

The Professional Quality of Life Screening (Stamm, 2005) and the Resilience Scale for Adults (Hjemdal, 2007) are standardised questionnaires with manuals, and therefore there was no reason to pilot test these instruments.

8.3.2 Qualitative data collection methods

The REds programme is a very comprehensive programme. The narrative has a comprehensive probe, the drawings have been used in the past implementation of the REds programme, and therefore the researcher did not need to pilot test them again. As earlier mentioned, the researcher used a response-guided approach

(Thomas, 2003:64). This meant that the researcher used her skills as a social worker to explore further where necessary.

9. RESEARCH POPULATION, SAMPLE AND SAMPLING METHOD

9.1 Research population

Due to the type of study, all HIV and AIDS affected educators in Gauteng formed the universe of the study.

The population of this study was all the HIV and AIDS affected educators in the Teaching Districts 9 and 12 in Johannesburg, Gauteng. In the context of this study, an initial sample 15 HIV and AIDS affected educators from one school in district 9 and another sample of 14 HIV and AIDS affected educators from one school in district 12 in Johannesburg, Gauteng, were selected.

9.2 Sample and sampling method

The researcher used purposive sampling to select an initial sample of 14 HIV and AIDS affected educators from one school in district 12 in Johannesburg, Gauteng, to form the experimental group and 15 HIV and AIDS affected educators from one school in district 9 in Johannesburg, Gauteng, to form the comparison group. Some of the participants dropped out of the groups, so the final sample that the researcher used, consisted of 7 participants in the experimental group, and 11 in the comparison group.

The following criteria were used to purposively select the participants for this study:

- They should be educators at a school in district 9 and 12 respectively, in Johannesburg, Gauteng.
- They should be HIV and AIDS affected.
- They should not have had prior exposure to the REds programme.
- They should be willing and available to participate in the study.

10. LIMITATIONS OF THE STUDY

The following limitations of the research project were identified:

- The sample of participants was small. In the experimental group, the researcher started with 14 participants. Due to several reasons, only 7 participants completed the pre- and post- tests. In the comparison group, 15

participants took the pre-test and only 11 the post-test. The data set is thus too small to make generalisations.

- 50% of the recruited participants withdrew, and none of the participants engaged in a conversation with the researcher stating their reasons for withdrawing from the programme. Because they did not formally withdraw, the researcher did not receive comments as to how the programme could be adjusted to ensure that people completed the programme.

- Due to the sessions starting after school hours, the sessions were pressed for time, as participants were already tired, had to arrange transport, or had other obligations. This influenced attendance, and it limited discussion time.

- The Resilience Scale for Adults (Hjemdal, 2007) was developed in the Northern countries, and is not necessarily applicable in an African context. The researcher is of the opinion that social and cultural aspects play a role in the resilience of and individual, and these aspects are not taken into account with the RSA.

- The researcher got the impression that the principal was not really supporting the REds programme. When negotiations started with the school, the researcher dealt with a deputy principal, as the school was in a transition phase. After the new principal was appointed, the day that was pre-arranged between the researcher, participants and the deputy principal for meeting was changed. This caused some of the participants to stop attending. Participation in the group was also not considered a priority by the group. On two occurrences the researcher had to postpone sessions because the educators were otherwise engaged from the school's side – they had to attend meetings or sport activities.

- The researcher found that the educators were not motivated to attend the sessions. The researcher had to go through a lot of trouble to send text messages to the participants before each session to ensure attendance. Even with all the trouble, the sessions were still very poorly attended, and only one of the participants had a 100% attendance.

- The experimental group were on average younger than the comparison group. This might have an influence on the data that was gathered, because a more experienced educator might perceive the impact that HIV and AIDS

has on the educator in a different way. The age difference makes it difficult to generalise findings between the experimental and comparison groups.

- The comparison group mentioned that the pre- and post-tests were very lengthy and tiring.

- In the pre- and post-tests, the participants in the comparison group remarked that they found the narrative especially difficult to write, because they were not used to writing essays in English. In the comparison group, the data gathered from the narrative was very difficult to analyse, because the participants misunderstood the probe, and wrote general facts about HIV and AIDS down – this made the data difficult to use.

11.   ETHICAL ASPECTS

Berg (2007:53) states that social scientists have an ethical obligation to their colleagues, because they delve into the social lives of other human beings. Strydom (2005a:56) motivates the consideration for ethical issues by stating that humans are the field of study. When conducting research, the researcher needs to consider certain ethical aspects to avoid the collection of data harming the participants. According to Gravetter and Forzano (2003:60), researchers have two basic categories of ethical responsibility, namely responsibility towards humans and non-humans who participate in the study, and a responsibility to the discipline of science to be accurate and honest in the reporting of their research.   The researcher obtained permission from the Research Proposal and Ethics Committee of the University of Pretoria (see Annexure 2) to execute her research project on 30 July 2009. The most applicable ethical issues of this research project were the following:

11.1 Avoidance of harm

Strydom (2005a:58) notes that the subjects of a research study can be harmed in a physical and/or emotional manner. One usually accepts that the harm induced by social research will mainly be of emotional nature. Emotional harm, according to Strydom (2005a:58) is often more difficult to predict and to determine than physical discomfort, and usually has more far-reaching consequences.   Therefore, the researcher had the responsibility to protect the participants against potential harm. In this particular study, the researcher needed to guard against possibly harming the participants in the following ways:

During the pre- and post-tests, and for the duration of the session, the participants might have been confronted with their own personal circumstances or they may have re-lived the pain of losing loved ones or learners to HIV and AIDS. Prior to the completing of the pre- and post-tests, the researcher told the participants that the questions were personal, and that they might re-live pain or experience negative emotions. None of the participants indicated that the pre- or post-tests had upset them. During the presentation on the sessions on loss and grieving, the researcher ensured that no emotions were triggered that the participants could not deal with. The REds programme also concluded with a thorough debriefing session that ensured that all the participants found closure. If participants needed therapy or help, the researcher would have referred them to the local Department of Social Development to ensure that the participant will receive the necessary support and counselling. This was not necessary.

11.2 Violation of privacy/anonymity/confidentiality

Confidentiality is defined by Berg (2007:79) as an active attempt to remove from the research records any elements that might indicate the subjects' identities, and anonymity means that the subject will remain nameless. Sieber (1982:145) as quoted by Strydom (2005a:61) defines confidentiality as a continuation of privacy, which refers to agreements between persons that limit others' access to private information. The researcher protected the anonymity of the participants by giving each participant a sticker to identify themselves on their test, and to keep on using that symbol as a means of identifying themselves. This was done to enable the researcher to compare the pre- and post-tests without linking a person to a test.

The qualitative parts of the data were protected in the same manner. Hammond and Gantt (1998:272) state that artwork should be treated as symbolic speech, and thus the researcher had the responsibility to obtain written consent before using the symbolic drawings in a research report. The written consent was obtained in an informed consent letter (see Annexure 3 & 4) signed by all participants.

Because participants participated in a group, it was difficult to guarantee anonymity, because the participants will know what happened to the others. Therefore, the

researcher focused on protecting confidentiality. Confidentiality was protected by the following steps:

- The participants signed an informed consent letter (see Annexure 3 & 4) that gave the participant the assurance that the content of the pre- and post-test will be kept confidential.
- The researcher also verbally contracted with all group members in the first session, to ensure that they keep the discussions in the group confidential.
- The researcher explained the concepts to the participants, and ensured that they understand it.

The researcher is unaware of the fact that any confidentiality was breached.

11.3 Informed consent

Informed consent is defined by Berg (2007:78) as the knowing consent of individuals to participate in an exercise of their choice, free from any element of fraud, deceit, duress or similar unfair inducement or manipulation.

> Obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the procedures being followed during the investigation, the possible advantages, disadvantages and dangers to which participants may be exposed as well as the credibility of the researcher, be rendered to potential subjects or their legal representatives (Strydom 2005a:59).

This implied that the participants needed to sign a letter stating that they give consent to the study. The researcher provided background information on the study to the participants, before distributing the informed consent letters that were signed (see Annexure 3 & 4).

11.4 Release or publication of findings

Researchers should, according to Strydom (2005a:65), explain the findings of a study in a written report. The researcher had the responsibility to compile the research report as accurately as possible. The researcher discussed her findings with her research supervisor to ensure that they had the same understanding of the findings, and that the researcher did not interpret any of the findings in a different manner than the supervisor, so that they harmonise on the findings of the research.

The researcher used a reputable statistical analyst (provided by the University of the North-West) to ensure that the questionnaires were analysed correctly. In order to eliminate reporting and editorial errors, the researcher had her report proofread by a reputable editor (see Annexure 5) to ensure that the information is reported and recorded accurately.

The researcher also needed permission from participants to release her findings. The informed consent letters (see Annexure 3 & 4) gave the researcher the necessary permission to publish her findings, locally and internationally. The research report will be made available to the district/provincial office of the Department of Education, and a copy of the report can be submitted for publishing in appropriate academic journals.

11.5 Actions and competence of the researcher

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation (Strydom 2005a:63). The researcher was trained by the programme developer to conduct both the ProQol, and RSA pre- and post-tests. The researcher did the tests herself, and was therefore familiar with the content. She was able to address any questions concerning the data collection methods. The researcher was also trained in the content of the support programme, and possesses several social work micro skills, like interview skills, empathy and reflection, that assisted her during the implementation of the programme. The researcher is competent in doing research, as she successfully completed a mini-thesis as part of her undergraduate studies.

11.6 Debriefing of participants

According to Strydom (2005a:66) the researcher has the responsibility to rectify any misperceptions that may have arisen in the minds of participants. Judd *et al*. (1991:517) as quoted by Strydom (2005a:66) say that debriefing is one possible way of minimising potential harm. During the last session of the programme, the researcher debriefed the participants. The researcher did not pick up any areas of harm, and none of the participants needed to receive counselling.

11.7 Freedom to withdraw

According to Elmes, Kantowitz, and Roedinger III (2006:283), the participants should be allowed to withdraw at any time. By asking the participants to voluntarily partake in the study, it was implied that they had the right to withdraw at any time. This had negative implications for the researcher, because she lost the data gathered from the participants and the ability to compare pre- and post-test findings. The researcher started with a group of 14 participants, and 50% withdrew. Only 7 participants completed the study. The researcher could be tempted to omit this right to the participants when starting with the study, or she might try to convince the participant to reconsider his or her withdrawal – both of which are unethical. To compensate for this problem, the researcher recruited more people than required. She explained to participants that the pre- and post-tests will be compared, and requested them to continue participation, but she clearly stated in the informed consent letter as well as during the introduction of the programme that they did have the freedom to withdraw at any stage; which they did. None of the participants formally withdrew from the programme – they simply stopped attending.

12.   DEFINITION OF KEY CONCEPTS

The research topic, "evaluation of the effectiveness of the Resilient Educators support programme (REds) among HIV and AIDS affected educators" implies the following key concepts: evaluation, Resilient Educators, support programme and HIV and AIDS affected educators.

12.1 Evaluation

According to Babbie and Mouton (2001:345), evaluation may be done to provide feedback to people who are trying to improve something.

Emener and Yegidis (2003:125) describe evaluation as a determination of the relative importance of something, an extent to which a predetermined goal or expectation has been attained, and the relative effectiveness or efficiency of specific activities or sets of activities.

For the purpose of this study, the researcher will use evaluation to determine if the goal of the programme has been attained (has the REds programme been effective in supporting and empowering HIV and AIDS affected educators in Gauteng) and to

provide feedback on the goal attainment to the programme developers in order for them to improve the programme.

12.2 Resilient Educators support programme

A support programme is defined by Reber and Reber (2001:726) as a programme designed to provide a person or a group with comfort, recognition, approval and encouragement. The aim is therefore to increase the greater wellbeing of the individual or group.

The REds programme is a newly developed programme, and therefore it is difficult to define it, as there is no literature available. Resilience on the other hand is defined in the Oxford Minidictionary (1991:439) as springy; readily recovering from shock.

The researcher therefore defines the Resilient Educators support programme (REds) as a programme that is designed to provide the participants with support and to increase their quality of life, concerning being resilient towards HIV and AIDS.

12.3 HIV and AIDS affected educators

Hall *et al.* (2005:23) define HIV and AIDS affected educators as educators who are either affected by the disease by being HIV positive themselves or indirectly affected because of colleagues, learners and relatives living with HIV.

Theron (2007a:2) defines HIV and AIDS affected educators as educators who have loved ones, colleagues or learners who are HIV positive, or whose loved ones, colleagues or learners have died from HIV-related diseases or who have AIDS orphans and vulnerable children in their classes.

AIDS is defined as a disease. The acronym AIDS stands for acquired immunodeficiency syndrome, which is caused by a virus called the human immunodeficiency virus (HIV) (Theron 2007a:70). Van Dyk (2005:3-4) notes that AIDS is a collection of many different conditions that manifest in the body because the HI virus has so weakened the body's immune system that it can no longer fight the disease-causing agents that are constantly attacking it, thus has the ability to kill the infected person in the final stages of the disease.

For the purpose of this study, the researcher defines HIV and AIDS affected educators as educators who are affected by having loved ones, colleagues or learners who are HIV positive, or have died from HIV related diseases, or have orphans due to HIV in their classes.

13.   OUTLINE OF RESEARCH REPORT

The content of the research report is set out in Table 1:

Table 1: Outline of the research report

CHAPTER	BRIEF DESCRIPTION OF THE CONTENT OF THE CHAPTER
Chapter 1	General introduction. The researcher will give a brief overview of the goals, objectives, research questions and approaches, research design and procedures, pilot study, sampling procedures, limitations of the study, ethical issues and definition of key concepts.
Chapter 2	Literature review on the impact of HIV in general, and the impact thereof on the education system. Firstly, the researcher will give a brief overview of what HIV is, how it affects people, and how AIDS develops. Afterward the global impact and the impact on Africa and South Africa will be discussed. Aspects such as statistics on the number of people who are affected and the manner in which they are affected will be covered. A literature review on the impact of HIV on the education system will be discussed. The focus will be on the impact of HIV on HIV and AIDS affected educators, learners and the school system itself.
Chapter 3	Resilience will be defined and conceptualised according to literature. The different factors influencing resilience in adults and children will be discussed. The researcher will also cover HIV and resilience, as well as education and resilience. The correlation between resilience and quality of life will be discussed briefly.
Chapter 4	The REds Programme. The researcher will discuss the content of the REds programme, as well as the manner in which it was

	presented.
Chapter 5	Empirical findings. In this chapter, the quantitative and qualitative data will be discussed. Data will be compared and findings will be tabulated, and where applicable graphed. The transcriptions of the qualitative data will be summarised, and relevant themes will be indicated.
Chapter 6	Conclusions and recommendations. The findings will be discussed and recommendations on the improvement of the programme will be described.

The next chapter focuses thus on a theoretical discussion of HIV and AIDS on the education system.

CHAPTER 2

HIV AND AIDS IN THE EDUCATION SYSTEM

1. *INTRODUCTION*

The global spread of HIV and AIDS has presented a major threat to both economic and social development. Cohen (2002:1) notes that one of the most significant features of the pandemic is its concentration in the working age population (aged 15-49) such that those with critical social and economic roles are disproportionately affected. This means that the people who are responsible for economic activity cannot fulfil their roles. This influences the economy in a negative way. Socially, it also has a negative impact. Cohen (2002:1) notes that a striking feature of the pandemic is that more women are being infected than men, and that woman typically get infected at much earlier ages than men (with consequent greater losses of healthy years of life). UNAIDS (2006:12) notes that South Africa's HIV pandemic is one of the worst in the world and it shows no evidence of declining. As Cohen (2002:1) states, the pandemic undermines development and thus further worsens the conditions in which HIV transmission thrives, simultaneously reducing the capacity of families, communities and nations to cope with the complex social, political and economic consequences. One of these social factors, are the education system.

The goal of this study is to evaluate the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng, and one of the objectives is to theoretically conceptualise the phenomenon of HIV and AIDS and the impact thereof on South Africa, specifically the school environment and HIV and AIDS affected educators. Therefore, Chapter Two will focus on HIV and AIDS as a pandemic, looking at the impact world-wide, and in South Africa as well as a discussion on the difference between being HIV infected and HIV affected and the impact of HIV and AIDS on the education system, and the educator.

2. CONCEPTUALISATION OF HIV AND AIDS

HIV is thought to have originated in non-human primates in sub-Saharan Africa and transferred to humans early in the 20th century (Worobey, Gemmel & Teuwen 2008:661). According to Pneumocystis Pneumonia (2008), the first paper recognising a pattern of opportunistic infections was published on 4 June 1981.

HIV or human immunodeficiency virus is defined by Wikipedia Online (2008) as a lentivirus (a member of the retrovirus family). Medical Terms Online (2008) explains that a retrovirus is a virus that has an RNA genome, and a reverse transcriptase enzyme. Using the reverse transcriptase, the virus uses its RNA as a template for making complementary DNA that can integrate into the DNA of the host organism. This means that HIV reproduces itself by becoming a "parasite" inside a living cell. The HI virus uses the DNA of a cell (like the human immune or CD4$^+$ T cells) and uses that DNA to replicate itself (Van Dyk, 2005:10-11). Because the virus uses the CD4$^+$ T cell to replicate, HIV infection leads to low levels of CD4$^+$ T cells. The human body, according to Van Dyk (2005:10-11) has no way of defending itself against the HI virus, because it uses and kills the human immune cells. The low levels of CD4$^+$ T cells can lead to acquired immune deficiency syndrome (AIDS), a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections, such as tuberculosis, pneumonia and influenza.

Hornby (2005:31) states that HIV (human immunodeficiency virus) is the virus that causes AIDS. Wikipedia Online (2008) state that HIV spreads through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV-infection. Most of these people will develop AIDS because of their HIV-infection.

AIDS is defined as a disease. The acronym AIDS stands for acquired immunodeficiency syndrome, which is caused by a virus called the human immunodeficiency virus (HIV) (Theron, 2007a:70). Van Dyk (2005:3-4) notes that AIDS is a collection of many different conditions that manifest in the body because the HI virus weakens the body's immune system.

Whiteside and Sunter (2000:1) explain the acronym AIDS as follows:

> "The 'A' stands for acquired. This means that the person will not become infected by inadvertent or casual contact. The person has to "do something" like for instance come in direct contact with HIV infected blood.
> The 'I' and 'D' stands for immunodeficiency. The virus attacks the person's immune system, and breaks it down, thus making it deficient.
> The 'S' stands for syndrome. AIDS is not just one disease, but it presents itself as a number of diseases that come about as the immune system fails. Hence it is regarded as a syndrome."

Kupa (2008:29) views HIV and AIDS as part of a continuum; beginning with HIV infection and ending with AIDS. The researcher agrees with this statement. A person contracts the HI-virus, and as time passes, the immune system weakens to the extent that the immune system can no longer fight opportunistic illnesses, such as tuberculosis. The person eventually progresses to full-blown AIDS, and then dies.

Buchbinder, Katz, Hessol, O'Malley and Holmberg (1994:1125) found that without treatment, about nine out of every ten persons with HIV would progress to AIDS after 10 to 15 years. Many progress to the AIDS stage much sooner. The treatment that will slow down the AIDS stage is called antiretroviral treatment. Schneider, Gange, Williams, Anastos, Greenblatt, Kingsley, Detels and Munoz (2005:2013) report that anti-retroviral medication increases the life expectancy of people infected with HIV. Even after HIV has progressed to diagnosable AIDS, the average survival time with antiretroviral therapy (as of 2005) is estimated to be more than five years.

3. HIV AND AIDS PANDEMIC WORLDWIDE

HIV infection in humans is now pandemic. As of January 2006, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that AIDS has killed more than 25 million people since it was first recognized on December 1, 1981. It is estimated that about 0.6% of the world's population is infected with HIV. In 2005 alone, AIDS claimed an estimated 2.4 to 3.3 million lives, of which more than 570,000 were children (UNAIDS, 2006). According to estimates by UNAIDS (2005) HIV is set to infect 90 million people in Africa, resulting in a minimum estimate of 18 million orphans.

According to the latest report from the UNAIDS (2008a:3), a few milestones in the global fight against HIV and AIDS have been achieved. The following numbers were reported:

- A decline has been reported in the rate of people newly infected with HIV from 3 million in 2001 to 2.7 million in 2007.

- More positive news is that the number of children newly infected with HIV has declined from 450 000 in 2000 to 370 000 in 2007 due to increasing coverage of programmes for preventing mother-to-child transmission of HIV and the stabilization of HIV prevalence among pregnant women.

- Fewer people are dying from HIV-related illnesses: A decline from an estimated 2.2 million in 2005 to an estimated 2 million in 2007 was reported.

- In the developing world, in 2007 alone, one million more people are receiving HIV treatment in hospitals and clinics, increasing the total to 3 million people at the end of 2007 — a more than ten-fold increase from 2005.

- The total number of people living with HIV is however increasing due to ongoing new infections, persons alive because of treatment, and population growth.

The report from the UNAIDS is encouraging, but the infection rate is still very high, and the effect alarming. The UNAIDS (2008a:4) reports that for every two people put on treatment, five others are newly infected. With this continuing high number of new infections, and with so many deaths averted because of the provision of antiretroviral medicines, the number of people living with HIV has climbed, to 33 million people in 2007.

To draw it closer to home, it is worrying that UNAIDS (2008a:4) reports that the epicentre of the pandemic remains in sub-Saharan Africa. Two-thirds of all people living with HIV are African. Three-quarters of the deaths in 2007 were in Africa, and if 100 random adults in sub-Saharan Africa were tested, the average number of those found to be HIV positive would be five (UNAIDS, 2008a:3).

Figure 2-1 illustrates the distribution of new HIV infections globally, and shows that among the 2.7 million people newly infected with HIV in 2007, the largest portion (1.9 million) live in sub-Saharan Africa, and the largest portion live in the southern part of sub-Saharan Africa. UNAIDS (2008a:5) list the following countries as being part of southern sub-Saharan Africa: Angola; Botswana; Lesotho; Malawi; Mozambique; Namibia; South Africa; Swaziland; Zambia and Zimbabwe.

This means that among others, South Africa still has a very high rate of infection in comparison with the rest of Africa and the world, and even though the rate of infection has been reduced, sub-Saharan Africa is still the worst affected region in the world.
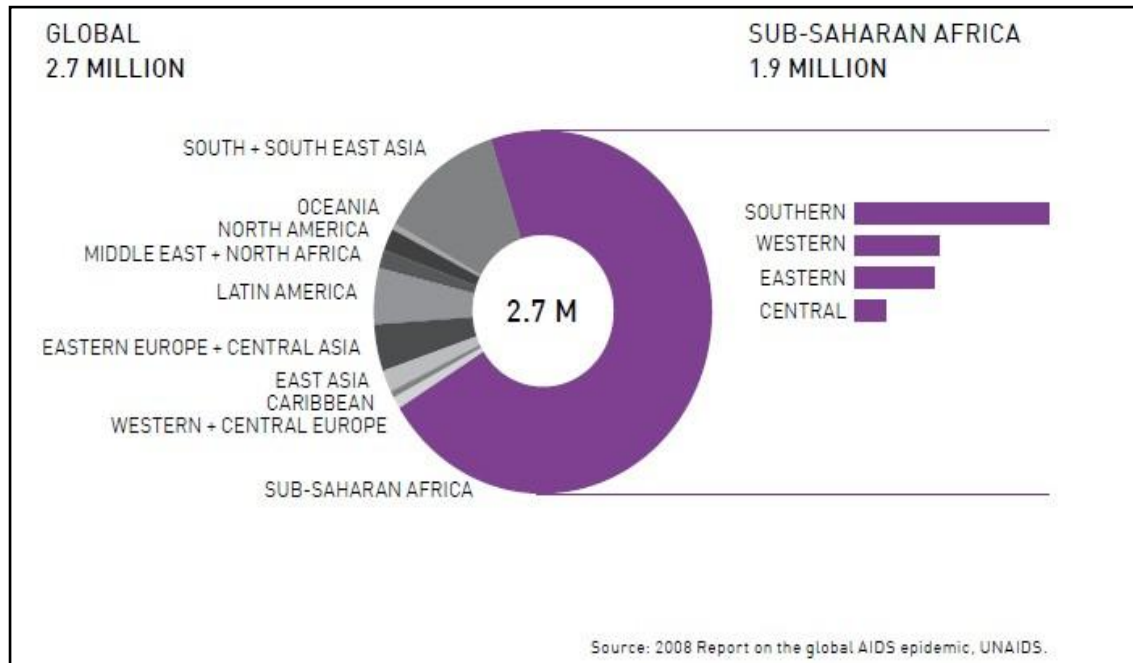

Figure 2-1: Global distribution of new HIV infections in 2007.

4. HIV AND AIDS PANDEMIC IN SOUTH AFRICA

To stress the impact of HIV and AIDS in South Africa, the WHO estimates in the UNAIDS Epidemiological Fact Sheet on HIV and AIDS (2008:4) the following statistics:

There are approximately 5.7 million people over the age of 15 living with HIV and AIDS in South Africa. The number of children under the age of 14 living with HIV and AIDS is estimated to be 280 000. The number of children under the age of 17 orphaned due to HIV and AIDS is, according to the UNAIDS Epidemiological Fact Sheet on HIV and AIDS (2008:7) 1.4 million. With an estimated population of 47 million people (in 2007), about 10% of all people living in South Africa are HIV positive. To stress this point, Foster (2007:1) states that South Africa has the highest prevalence of HIV in the world.

Due to the high rate of infection, the number of AIDS-related deaths is also increasing. As illustrated in Figure 2-2 the estimated number of deaths have increased significantly since 1990, and in 2007, UNAIDS (2008a:6) reported that approximately 350 000 people died from AIDS. In 2005, the International Labour Organisation (ILO) (2006:25) reported that in South Africa, as many as 100 children under the age of 15 die of AIDS on a daily basis.
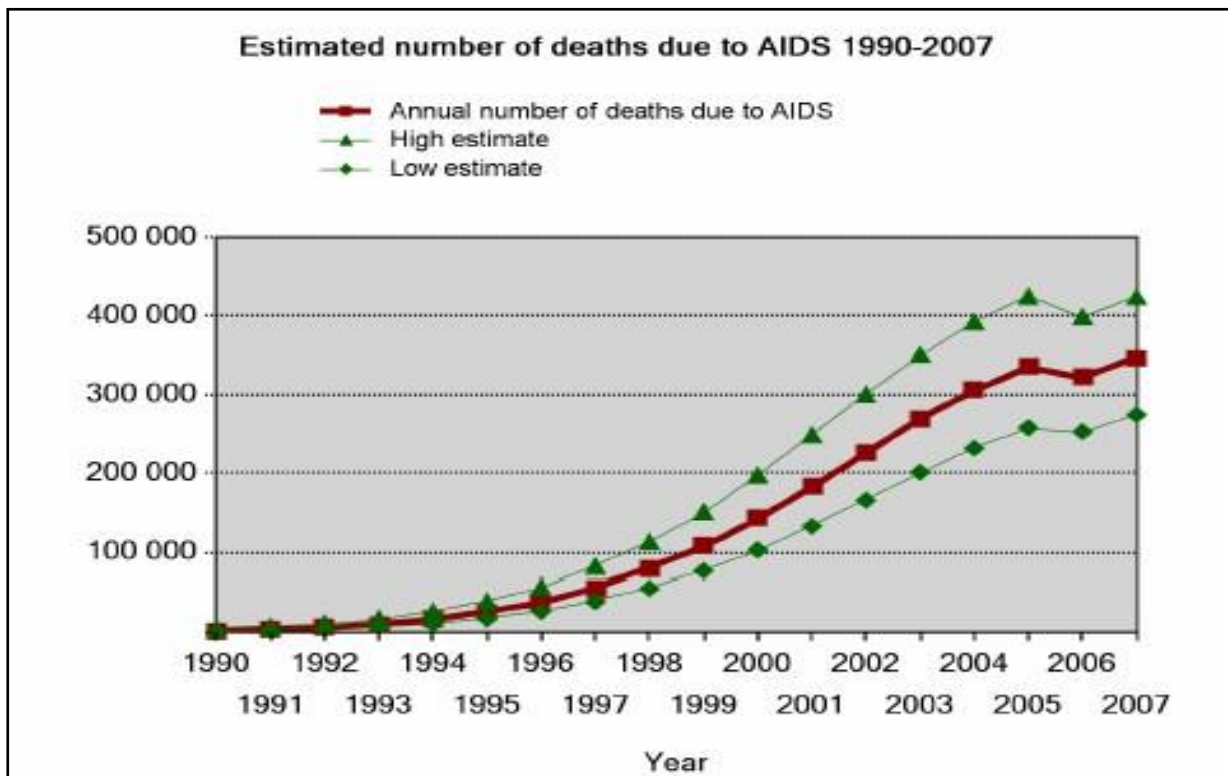
Figure 2-2: Number of deaths due to AIDS in South Africa 1990 - 2007

What is the impact of the high mortality rate? According to the ILO (2006:25), the impact of HIV undermines the process of human capital formation. The ILO (2006:25) notes that the deaths of children deprive families and societies of their potential contributions, drain their resources, and sap the morale in families. The researcher is of the opinion that the more people affected, the less human capital will form. The loss of human capital can have severe economic and social effects, and that can lead to higher HIV infection rates, due to issues such as child labour.

One of the impacts of HIV and AIDS that is not often discussed is that it can lead to an increase in child labour. In a study, Poulsen (2006:50) states that children are

living in disrupted and shifting family circumstances, i.e. living with foster parents, grandparents, stepparents, extended families or child-headed households. This may be because the primary care giver is ill, or has died from AIDS. According to Poulsen (2006:51), girls who do not live with their parents, often need to take on caring responsibilities, while many boys take on responsibility for earning income. The ILO (2006:34) found that children who are orphaned, and live with other family or in foster homes, are more likely to be taken out of school so that they can spend the time to do either household chores, or income generating activities. This can contribute to children dropping out of school, or not performing at school due to being too tired or stressed.

As seen from the previous paragraphs, HIV and AIDS influence all spheres of life. The sad reality is that HIV and AIDS can have a negative impact on people who are not infected by the HI-virus, like educators. The goal of this study is to evaluate the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng. In order to understand the goal of the study, it is necessary to understand the difference between being HIV infected and HIV affected.

5.   DIFFERENCE BETWEEN BEING HIV AFFECTED AND HIV INFECTED

You can be affected by HIV even if you are not infected! This means that all spheres of life can be influenced by HIV and AIDS. Cogan, Klein, Magongo and Kganakga (2005:2) found that the most profound effects of HIV are on the psychological, social and economic health of the infected person, their loved ones and the community. The difference between being HIV infected and HIV affected will be discussed below:

Kupa (2008:30) notes that being HIV infected means that a person has contracted the HI virus. A person can then progress to AIDS.

Being HIV affected is completely different. Hall *et al.* (2005:23) define HIV and AIDS affected as people who are either affected by the disease by being HIV positive themselves or indirectly affected by having of colleagues, and relatives living with HIV. Van Dyk (2005:218) explains that HIV and AIDS affected refers to the significant others in the life of a person living with HIV and AIDS. Significant others

may include colleagues, friends and family members. People are exposed to the lives of others, and their circumstances. If a person has a friend or loved one who is infected with HIV, their emotional and physical wellness will have an impact on the people around them and will affect them. If they look for support and help, the support systems are often friends, colleagues or family members, and thus the support systems are indirectly affected by the pandemic. Educators play an integral part in being the support system. If educators are affected, the education system as a whole will be affected. It is necessary to consider the impact that HIV has on the education system.

6. IMPACT OF HIV AND AIDS ON EDUCATION

UNICEF argues, "Although HIV affects all sectors, its most profound effects are concentrated in the education sector" (UNICEF, 2000:10). This is alarming to say the least. Cohen (2002:10-18) found that the whole education system is being slowed down by HIV and AIDS, which can lead to higher levels of illiteracy.
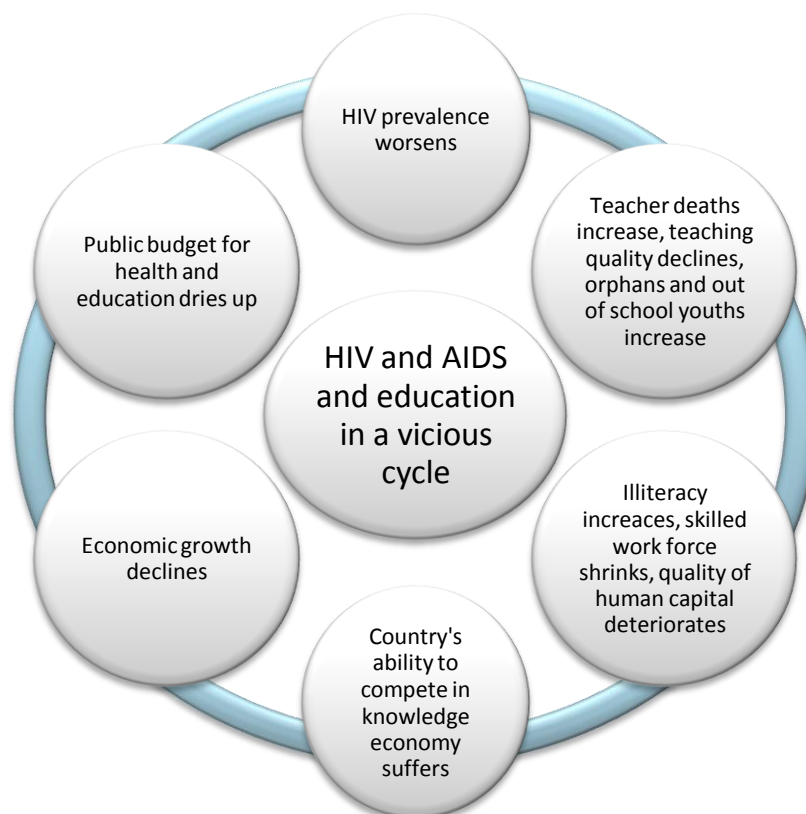
Figure 2-3: The vicious cycle of HIV and AIDS in the education system.

The World Bank has defined definite consequences of inaction as portrayed in Figure 2-3. This figure shows the vicious cycle that can potentially ruin the education system if no action is taken, it illustrates that HIV and AIDS affects the education

system in various areas, and that the decrease in education actually causes HIV prevalence to worsen.

The vicious cycle of HIV and AIDS in the education system as highlighted in Figure 2-3 shows only a few areas where HIV affects the education system. The impact is far more serious. Research done by Kelly (2000:45) and other researchers found that HIV and AIDS have many far-reaching consequences for the education system. In the following sub-sections, the researcher will discuss a few ways in which HIV and AIDS affect the education system.

6.1 Supply and demand of education

The impact of HIV and AIDS on education regarding the supply and demand of education has been researched by many. Researchers differ – some argue that the supply and demand will increase – some argue that it will decrease. The following arguments were investigated by the researcher:

6.1.1 Demand of education

The demand of education is defined by the researcher as the number of children who are in need of formal education. It is important to look at the demand for education, because, as noted in Figure 2-3, the lower enrolment rates in schools will unavoidably lead to lower literacy rates, and that can lead to an increase in the spread of HIV and AIDS.

The World Bank (2002:14) argues that AIDS mortality does not have its primary effect on school-age children, since the majority of children dying of AIDS are young children who have contracted the disease from mother to child transmission. However, the researcher argues that even though there might be fewer children, it does not necessarily mean the enrolment in school will reduce. Bennell (2003:493) argues that there is a projected explosion in the numbers of children directly affected by the pandemic, in particular children caring for sick relatives and orphans. This can result to a decrease in the demand of education, especially in high HIV prevalence countries (HPC's). According to Kelly (2000:24), HIV/AIDS appears to be in the ascendancy and to have virtually overcome education, swamping it with a wide range of problems. One of these problems is the supply and demand of education.

The demand and supply of education will now be explored, and the way in which HIV and AIDS impacts it will be discussed.

Kelly (2000:46) notes that the demand for education will be reduced. He reasons that, due to high mortality rates, lower fertility rates, and a reduction in births due to premature death of women in their childbearing years, there will be fewer children to educate. Bennell (2005:467) agrees with these reasons of Kelly (2000:46) and adds the increased poverty among AIDS affected households as a reason why the demand will be lower. The World Bank (2002:16) however argues that studies are inconclusive, but the demand appears to be adversely affected among poorer families, particularly at secondary and tertiary levels. The argument also states that most children who are born uninfected are unlikely to become infected until they reach adolescence. Thus, it is postulated that for most countries, the demand for primary school education might increase.

In South Africa, and specifically KwaZulu-Natal, Ramranthan, Khan, Khan and Reddy (2007:178) found that learner enrolment patterns suggest that lower grades currently have the highest enrolment figures. Factors that contribute to this pattern include an increase in live births within the country, and a decrease in mortality rates. There has been a slight decrease in enrolment in 1999, but projections show that the rates will not decrease dramatically. However Ramranthan *et al.* (2007:178) also state that as learners progress to higher grades, the enrolment decreases, due to an increased dropout rate in higher grades, which could be related to economic, health and social reasons. For the reason that HIV and AIDS have serious economic, health and social implications, one can thus argue that HIV and AIDS have a negative impact in the enrolment of school-age children in schools. In this regard, Kelly (2000) explored the impact HIV and AIDS has on the demand for education in detail.

Kelly (2000:48) highlights that one important aspect regarding the impact HIV has on the demand for education is the fact that fewer children want to be educated. Because of HIV and AIDS in a family, many children do not want to attend school. The deterrents include: fear of stigmatisation and scorn, fear of other children who have parents, exclusion, the reduced availability of money and external signs of

increasing poverty, or the trauma of seeing a loved one suffering and dying (Kelly, 2000; ILO, 2006; Poulsen, 2006, Theron, 2005; Theron *et al.,* 2008). The researcher is of the opinion that the demand for education will continue to decrease if these issues are not addressed.

Kelly (2000:50) states another important consequence of HIV on the demand of education, namely that fewer children will be able to afford education, and fewer children will be able to complete their schooling, due to some unavoidable direct and indirect costs of tuition. Educational materials, school-related activities, levy for development and uniforms all cost money. Where HIV is prevalent, cash may not be available, and it may have a negative impact on the enrolment of children in schools. Poulsen (2006:50-52) and Robson and Sylvester (2007:426) postulated that the costs related to education can be one of the reasons why children do not enrol in school or drop out of school early.

6.1.2   Supply of education

The supply of education according to Kelly (2000:56) refers to the number of trained educators available to do the job of educating. According to researchers, there is a broad consensus that educators are themselves a high-risk group (Kelly, 2000; Cohen, 2002; Theron, 2005). Zungu-Dirwayi, Shisana, Louw, and Dana (2007:1301) agree with the researchers and further assert that in the teaching profession, HIV/AIDS is likely to rewrite the educator supply-and-demand and the implications will evidently be very expensive. Bennell on the other hand (2003:295) asserts that there is little hard data that supports the contention that educators in Africa are a "high-risk" group with regard to HIV infection, however that this does not mean that the pandemic will not have serious consequences on the teaching profession in sub-Saharan Africa. The researcher agrees with Bennell (2003:295) in this regard. If one considers the factors influencing the supply of educators, one has to consider teacher infection and teacher mortality rates, as these two factors directly influence the availability of educators.

Kelly (2000:64) asserts that there is a high rate of infection among educators, and therefore a high risk of mortality, which will lead to educators needing to be replaced. Due to a lack of availability of educators, schools resort to using services of

unqualified educators, or spread the load to other educators in the school (Kelly 2000:65). It is important to note that the lack of availability of educators is due to not only HIV and AIDS. The ILO (2006:32) states that there has been a shortage in quality educators, even before the HIV pandemic was taken into account. Bennell (2005:448) reports that the overall levels of teacher attrition in sub-Saharan Africa are high. Ramranthan (2003:182) reports a deficit of 4397 educators per annum in South Africa. However, this is due to not only HIV and AIDS. Ramranthan (2003:182) notes that reduced enrolment in tertiary institutions, as well as employment conditions may contribute to this shortage of educators, but the pandemic has aggravated the situation considerably. From these facts, it can be concluded that it seems as if HIV and AIDS have a negative effect on the supply of educators to the educational system.

The impact of HIV and AIDS on the educational system is however not only on the demand and supply of education but also on other important aspect liked to the education system namely those who are potential clients of the education system; the organisation of education; the nature of the role of education; the process of education; the quality of education and the quality of learning. These aspects will be briefly discussed in the following sections.

6.2   Profile of potential clients of the education system

Due to HIV and AIDS, the profile of children attending school is in a state of change. According to Kelly (2000:56), the potential clientele for education is affected by HIV and AIDS due to the rapid growth in the number of orphans. Orphanhood places strain on the extended family and the public welfare services, which can also affect the potential clientele for education. The increase in street children and child-headed households are also noted as clients affected by HIV and AIDS. The World Bank (2002:16) notes that the increase in orphans represents one of the largest impacts of HIV and AIDS, but states that the impact of orphaning on school enrolment is unclear due to inconclusive studies, and variability of data from different countries. The researcher is of the opinion that even if one child did not go to school due to HIV and AIDS, it is still one child too many. The impact of HIV and AIDS on the learner will be more thoroughly discussed later in this chapter.

6.3   The organisation of education

Kelly (2000:78) notes that due to HIV and AIDS, there is a need to adapt the organisation of education in order to adopt a flexible timetable that will be more responsive to the income-generating burden many students need to shoulder. In this regard Kelly (2000:78) mentions that attention should be given to factors and strategies such as decentralising school to homes instead of a central location, adapting the development of student responsibility and examining certain assumptions about schooling, such as the age of going to school, or the practice of bringing large numbers of young people living in relatively high-risk circumstances together. The researcher is of the opinion that it is important to consider these facts in order to try to increase the number of children attending school, and to address some of the burdens these children need to face.

6.4   The nature of the role of education

The role of education is also affected by HIV and AIDS. According to research, schools are adapting an important role as the locus for sexual and reproductive-health education (Kelly, 2000; Cohen, 2002; ILO, 2006; Poulsen, 2006). Kelly (2000:83) emphasises the need for schools to disseminate messages about HIV and AIDS as another change in the traditional role that the education system plays. The researcher is of the opinion that the education system has a vital role to play in the community to convey truths and messages about HIV and AIDS.

Different authors (Kelly, 2000; Theron, 2005; Theron *et al.*, 2008; Poulsen, 2006) mention the role of counselling that educators need to fulfil as well as the need for schools to be transformed into a multi-purpose development and welfare institution. The ILO (2006:25) report that generations of surviving orphans do not have the support, guidance and education they need to gain skills, pursue opportunities for decent work, and contribute to their societies and their economies. The researcher draws the logical conclusion that due to the fact that many children are orphaned, the children will look to their educators for the skills and support they would normally receive at home. This can have a negative effect on the quality of education children receive, because their educators not only teach them, but also emotionally support the children.

The researcher is of the opinion that these role changes will have a significant effect on the educators and educational system. Therefore, the researcher is of the opinion that educators need to be empowered to deal effectively with these changes in role fulfilment. If this role transition is not properly managed, the levels of attrition may rise very fast.

6.5   The process of education

HIV and AIDS affect the process of education in schools, as people need to learn how to deal with HIV infected individuals in school (Kelly, 2000; Poulsen, 2006). The high rate of infection among educators also affects the process of education, because it influences teaching activities, and if a teacher is affected by HIV and AIDS, it brings forth more responsibilities that dilute their focus from education (Kelly, 2000; Theron 2005; Theron *et al.* 2008). Kelly (2000:75) also states that children from AIDS affected families show erratic school attendance, which in turn has an influence on the process of education – educators need to deal with children who are absent very often.

The researcher is of the opinion that the education system is affected in all aspects, and there is pressure on the system to look at ways to adapt to the rapidly changing state of the education system. One of these ways is the content of education.

6.6   The content of education

In order to combat HIV and AIDS, knowledge about it as a phenomenon is crucial. The most logic place to start imparting this knowledge is at school level. This naturally has an impact on the content of the education curriculum.

Kelly (2000:70) notes that HIV and AIDS impacts on needs to be incorporated into the curriculum in order to impart knowledge, attitudes and skills that may help to promote safer sexual behaviour. There is also the need to develop life skills that equip learners for positive social behaviour, and for coping with negative social pressures. Consequently, educators need to teach children another set of skills, which according to the researcher can cause more stress to the educators.

On the area of life skills, Van Dyk (2008:79) states that in South Africa, the Department of Health and the Department of Education have developed national life skills and HIV/AIDS education programmes for South African schools. The goal of these programmes is to offer age-appropriate education on HIV/AIDS as part of life skills education to increase knowledge, develop skills, promote positive and responsible attitudes, and provide motivational support to HIV infected and affected schoolchildren. The results of such a programme varied. Van Dyk (2008:89) found that children who said they did learn about HIV/AIDS at school had a more comprehensive understanding of HIV transmission and prevention; they also had significantly fewer misconceptions about HIV and AIDS, and were more prepared to have social contact with a child with HIV. The problem according to the researcher is that many schools still need to implement the programme, and the time and effort takes its toll on the educator – yet another responsibility they need to shoulder that might contribute to their burnout and resignation.

6.7   The quality of education

The quality of education is another factor that is influenced by HIV and AIDS, according to Kelly (2000). Kelly (2000:64) and Theron (2005:56) state that the performance of children at school is directly linked to the quality of education they are receiving. The quality of education is defined by the researcher as the quality of what is being taught, as well as the time that is spent teaching, and the ratio of children to educators. Cohen (2002:15) states that the HIV pandemic is indeed eroding the capacity of the educational sector to undertake its primary tasks. This means that the quality of education is negatively affected, because educators cannot do their basic tasks due to educators' absenteeism and the loss of educators.

Absenteeism of educators is a big problem. Zungu-Dirwayi *et al.* (2007:1299) articulate that learners lose out on quality education because of the fact that HIV infected educators are frequently absent and can lose up to 6 months of professional time before developing full-blown AIDS. According to Zungu-Dirwayi *et al.* (2007:1298-1300) nearly 13% of all educators in South Africa are HIV positive and the prevalence of HIV is the highest among educators aged 25 to 35 years. Zungu-Dirwayi *et al.* (2007: 1301) notes that this will result in AIDS-related absenteeism and in-service mortality as well as an increase in early retirement and lower productivity.

The factor of educators' absenteeism is also confirmed in a study in Zambia, which found that schools experience high levels of educator absenteeism due to the attendance of funerals and family responsibility. Schools also reported having educators absent with persistent illness, healthy educators' workloads increased, and teacher-pupil ratio ranged from 1:50 to 1:120 (Robson & Sylvester, 2007:424). This can negatively influence the quality of education, because the educators are not focused on their task. In support of this, Theron (2005:57) asserts that ill educators cannot model good health and cannot devote themselves to their profession; therefore, they cannot provide the same quality of teaching as before. The absence of educators also lead to other educators taking the ill educators' learners into their classes when they are absent, an undesirable learner-educator ratio of one educator to fifty or more learners is reached which impacts negatively on the quality of education (Theron 2005:57).

According to the WHO/UNAIDS (2001:2) it has been estimated that in 1999 alone approximately 860 000 children in sub-Sahara Africa lost their educators to AIDS. Theron (2005:57) notes that a hundred thousand South African learners have lost educators to AIDS. Coombe (2000:17) found that as experienced educators are lost, poorer quality could be expected with regard to creating, presenting and explaining learning material (especially important subjects such as mathematics and science) to learners. This, in turn, is likely to result in less capable future students and subject specialists in relevant subjects, which suggests a long-term decline in the quality of education.

6.7.1 Quality of learning

Theron (2005:57) found that learners find it difficult to observe HIV positive educators' health decline, their absenteeism and eventual death and as such, it has a negative impact on learners' quality of learning. The value of educators as positive role models to learners become thus lessened and this also impacts negatively on the quality of learning and education. If these children have already lost a loved one or family member to HIV, the emotional effect of seeing an educator suffer can be even bigger.

From the above discussion, it is thus clear that HIV and AIDS have a tremendous impact on education per se. It is however furthermore important to consider the impact that HIV and AIDS has on the learner in order to contextualise the impact on the educator as the focus of this study.

7. IMPACT OF HIV AND AIDS ON THE LEARNER

Bennell (2005:468) notes three groups of schoolchildren whose lives are most directly affected by the AIDS pandemic and whose education is, therefore, potentially at greatest risk. These groups are children who are HIV positive, children in households with sick family members and children whose parents or guardians have died of AIDS. Each group will be briefly discussed.

7.1 The impact on the education of children who are HIV positive

The first group of children that will be discussed is children who are HIV positive. Where children are infected by HIV, their quality of education is also influenced. Franks, Miller, Wolff and Landry (2004:230) note that absenteeism due to medical treatment can result in lowered academic performance and intolerance by classmates. Scholastic performance is linked closely to the adequate functioning of the brain. When symptoms of AIDS develop in a child or adolescent with HIV infection, central nervous system dysfunction can occur and cause a decrease in cognitive functioning followed by a decline in academic performance and impairment of motor, cognitive and emotional activities. In relation to areas of the brain being affected, infected learners may experience educational difficulties that include: seizures; confusion; memory loss; disturbances in speech, vision and thought; inattentiveness; and apathy, as well as various emotional, social and educational difficulties, not only due to areas of the brain being affected, but also because of exhaustion, aching body parts, weakness and the negative stigma surrounding the pandemic (The American Academy of Paediatrics, 2000:1358; Naudé & Pretorius, 2003:138-142; Franks *et al.,* 2004:232). Naudé and Pretorius (2003:141) note that the above symptoms make optimal learning difficult. In other words, when educators teach infected learners, teaching may be more complicated, thereby further burdening educators. Esterhuizen (2007:42) mentions that it is difficult to teach ill learners, because the learners will find it difficult to concentrate, co-operate, and develop. Ill learners are also often absent from school and may be faced with

learning disabilities. Therefore, Naudé and Pretorius (2003:140) advise that educators would benefit from additional training to provide for the needs of infected learners. Sick and suffering children also have a negative impact on the educators.

According to Theron (2006:18), the declining health and suffering of learners may be devastating for an educator, in the sense that these educators may become extremely involved in assisting these learners, whether financially, emotionally or physically. This involvement may consequently affect their performance as professional educators, because they cannot find enough time or energy to perform as expected (Theron, 2006:15). This can negatively influence the quality of education for the learner, and it places additional pressure on the educator to cater for the needs of these children.

7.2 The impact on the education of children living in households with sick family members

The second category of children is children who live in a household where a person is sick due to HIV infection. The ILO (2006:26) reports that the destructive impact of HIV/AIDS on children begins when a parent becomes ill. Often, they are already living in a poor household. When the parent becomes ill, children are expected to shoulder new responsibilities, and their ages and capabilities may be ignored when they are pushed before they are ready to take over household responsibilities. Robson *et al.* (2007:419) notes that girls as young as ten may carry heavy responsibilities such as caring for younger siblings and sick parents. Tasks children engage in can include domestic chores that they would take on eventually anyway, such as fetching water or firewood, preparing food or cooking, as well as childcare for younger siblings, but they may have to take on this work when younger than usual. The researcher postulates that the children engage in these activities out of love for their parents, but also because they feel responsible. Poulsen (2006:51) notes that the children need to take on these tasks because there is no one else who can do it.

The tasks of the children may also include care-giving activities for sick relatives. Esterhuizen (2007:31) state that children or young people in AIDS-stricken homes may need to care for or stay with the sick and even accompany sick persons to

health-care centres so that other adults in the household can go to work to generate an income. Others must liberate an adult from domestic or economic activities so that the adult can care for the sick. This might cause children to drop out of school, or it may result in infrequent school attendance, which in turn, can have a negative impact on literacy and the quality of education the children receive.

The ILO (2006:27) found that when a parent becomes so ill that she or he is unable to work inside or outside the home, the income of the household diminishes. Another adult may be able to assist at this time, including grandparents. Often there are no options however, and children then need to work in agricultural or other income-generating activities that enable the household to pay medical expenses and to provide subsistence. In settings where school fees are required, children may work at first only to pay school fees (Poulsen, 2006:51). School attendance becomes more difficult however, as the time dedicated to work increases, and children in households living with HIV and AIDS often ultimately drop out (Poulsen, 2006; Robson *et al.,* 2007). The result is that children find themselves prematurely out of school, engaged in income-earning activities at a time when they are developmentally and educationally ill prepared for these activities and at the same time facing the loss of one or both parents.

7.3 The impact on the education of orphans and vulnerable children whose parents or guardians have died of AIDS

The third group of children that will be discussed is children whose parents or guardians have died from AIDS. Poulsen (2006:49) reported that children whose parents are sick or dying from AIDS would not attend school for some time. Quite often, however, they will return to school three or four weeks after their parents' death. This suggests that with a supportive school environment, a child can continue his or her schooling after the parent's death. The researcher is of the opinion that supporting grieving children does however put more pressure on educators. Robson *et al.* (2007:419) notes that the fact that the number of mortalities increase, leads to increasing numbers of children who live in disrupted family situations. That is, they are living with grandparents, stepparents, extended families or in Child-headed households. This may be because their parents are ill or have died from AIDS, but it may also be for other reasons.

Poulsen (2006:49) reports the following effect on the children whose parents have died from HIV and AIDS:

- Children experience bereavement and loss at the death of a parent. In some cases, this is compounded by neglect by step- or foster parents. Some grandparents, who may themselves be old or infirm, struggle to look after children who are recently bereaved or separated from their parents.

- Children often described the pressure of taking on financial responsibilities, particularly children in child-headed families.

- Some of the implications for children's education of shifting and disrupted home lives were lack of money, lack of support from home, the need to work (either domestic or wage-earning), worry about what is happening at home, neglect or abuse from foster families and poor parenting skills of foster families. All of these factors could contribute to dropping out of school. Children are put in a more vulnerable position by fluctuating and shifting family forms (i.e. foster families or living with grandparents). The change in family forms is intensified by HIV and AIDS.

- If children are in child-headed households, and they do come to school, they struggle. Robson *et al.* (2007:424) report that, especially in orphans, the participation and quality of learning was affected because orphans often came to school poorly dressed, hungry, sleep-deprived, and psychologically and emotionally traumatised. Robson *et al.* (2007:424-426) and Poulsen (2006:49-52) noted the following factors negatively impacting the school performance of orphans: being absent in order to care for siblings, anxiety and the need to dedicate time (usually spent on school tasks) on income-generating activities, bullying or being accused of having HIV or AIDS and not having the necessary materials (i.e. books and stationary) to complete school tasks.

Taking into consideration the fact that researchers like Ramranthan *et al.* (2007:178) and others found an increase in learner enrolment, means that the educators have children in their classes that experience these circumstances, and this means that educators are confronted with disrupted homes, neglect, abuse as well as tired and disrupted children. It implies that the roles of the educators may be conflicted. The

role conflict is confirmed by Theron *et al.* (2008:84) who emphasise that educators need to do grief counselling, solve family problems and find resources – responses that are not part of the educator's role. These responses are typical to that of social workers, trained counsellors and health care professionals, not of educators.

The other side of the situation is that children whose parents have died from AIDS may be taken out of school by their new guardian, or they decide to drop out of school due to economic stress. Robson *et al.* (2007:423) found that the financial strain or orphaned families increase the likelihood that children will drop out of school.   The ILO (2006:29) state that orphans are more likely than other children to be removed from school, although the degree of poverty of the household, the age of the orphan, the child's stage of development and the orphan's relationship with the guardian all influence school attendance. In certain countries, like Botswana, the ILO (2006:29) found that there was a very strong schooling culture, and dropouts from school occurred less frequently.

Children who are orphaned by HIV and AIDS are also more likely to become HIV positive themselves. Poulsen (2006:51) states that parental death is a major cause of disruption of children's home lives (although not the only one). Illness, death and disruption at home make families poorer and children more vulnerable to HIV infection themselves. These children need money and thus they are more likely to engage in risky behaviour, and are more likely to drop out of school. Poulsen (2006:51) notes that gender has an impact on the kind of risky behaviour children engage in. She (Poulsen, 2006:51) found that boys are more likely get involved in promiscuity and drug taking. Girls are likely to get pregnant or engage in sex work or sexual relationships with older men in exchange for money or food. This means that the trauma and home circumstances of children can lead to them becoming victims of HIV. This vicious circle increases the spread of HIV.

8. IMPACT OF HIV AND AIDS ON THE EDUCATOR

Although the impact of HIV and AIDS on educators was already mentioned in previous sections, it is of utmost importance to discuss the issue in more detail, due to the context and focus of this study. Educators are faced with HIV and AIDS on a daily basis. In many areas, schools are the primary support system for many

orphans and vulnerable children. Poulsen (2006:52) states that schools face particular challenges in terms of educating children in areas of high HIV prevalence. Many schools have implemented a number of supportive strategies as suggested by Poulsen (2006:53). These strategies include for instance feeding schemes and grants for orphans, but still the need is increasing. The reality is that schools are confronted to do a lot more to support affected children, although it is equally clear that they cannot do everything. Given available resources, schools are very constrained in taking on additional responsibilities in support of these children with the effect that educators withstand the worst of dealing on a daily basis with the pandemic. This situation becomes worse when educators are also affected personally by HIV and AIDS. It implies that educators may be affected personally and professionally by the impact of HIV and AIDS.

8.1 The impact of HIV and AIDS when educators are personally affected

Educators who are personally affected by HIV and AIDS are defined by Theron (2007a:5) as educators who have loved ones in their family who are infected with HIV, have AIDS, or have died from AIDS. When educators are personally affected, their psychological wellbeing also suffers. Theron (2005:57) found that educators who are personally affected report being psychologically affected because of the death of loved ones and friends as well as being depressed by the stigma of AIDS. According to Shisana *et al.* (2005a:115), educators are tormented emotionally when relatives, colleagues and learners are suffering from HIV and AIDS. They experience feelings of depression, sadness and hopelessness (Theron, 2005:57). These feelings may lead to low educator morale, which can lead to more educators leaving the profession (Hall *et al.*, 2005:23-25). Esterhuizen (2007:38) confirms that affected educators cannot cope emotionally and financially with sickness and death among family, friends, colleagues and learners, and are concerned about the uncertainty of their own future and that of their dependents. According to Theron (2005:57) such circumstances do not only impact depressingly on the quality of teaching, but also plays a negative role in the health status of uninfected but affected educators, due to anxiety, trauma and constant worry that they experience. The trauma and worry educators experience influences negatively on their ability to perform their role as educators, and can lead to low teacher morale, higher rates of absenteeism and

burnout. This is confirmed by Bennell (2005:450) who found that low teacher morale and motivation is a serious problem in many, perhaps the majority, of schools in Africa. Negativity and stress follows and a comprehensive physiological response (including mental, emotional, behavioural and physical components) is provoked. Chronic stressful responses are at loggerheads with emotional wellness or resilience (Ross & Deverell, 2004: 302).   HIV and AIDS and the impact on the individual increase all these emotional responses, and it can cause great disruption to the educational system if not addressed.

8.2   Professional impact of HIV and AIDS on educators

The professional sphere of educators includes aspects such as productivity, work-related commitments and the educators' professional growth.   This professional sphere can be influenced negatively by colleagues and learners being infected and affected by HIV and AIDS.   Both the impact of colleagues and learners being infected and affected by the pandemic will be discussed in the following sections.

8.2.1   The impact of colleagues affected and infected by HIV and AIDS on educators

When colleagues are affected or infected by HIV and AIDS, it has an impact on the rest of the teaching staff.   Different people react differently to the situation.   Theron (2005:56) notes that many educators choose to relocate once they are visibly ill, or simply disappear, leaving classes without educators. Rural areas are especially affected, as infected educators require urban medical services.   This will lead to healthy educators taking over the responsibilities of the educators who are absent or gone. Hall *et al.* (2005:23-25) found that infected colleagues, infected learners and infected relatives lead to increasing workloads and heightened responsibilities as affected educators have to witness HIV positive colleagues, learners and relatives dying.   All of these impact negatively on the psychological wellness of educators. The following emotions are noted by Shisana *et al.* (2005a:115): shock, unacceptableness, self-blame, denial, fear, relief, anger, guilt, decreased self-esteem, loss of identity, loss of personal comparison, sadness, depression and hopelessness. These feelings, if not dealt with properly, can lead to negative emotional reactions which impacts negatively on professional performance. Shisana *et al.* (2005a:115) report the following reactions to these feelings: people have

multiple behaviour changes like alcoholism, misuse of drugs and social withdrawal, which in their turn lead to isolation and deprivation. Esterhuizen (2007: 41) says that affected educators are often concerned about the well-being of their infected colleagues, trying to help them to cope with their health status. This can be emotionally draining, leaving the affected educator with feelings of despair. Furthermore, when psychological wellness declines, physical health is often also affected.

According to Shisana *et al.* (2005a:114) HIV and AIDS play a major role in the health status of uninfected educators. Many illnesses diagnosed in the past five years among educators have been stress-related, which indicate that educators may be working under extremely high levels of stress. The following illnesses were most frequently diagnosed among affected educators in the past five years (Shisana *et al.*, 2005a:114):

- Depression;
- High blood pressure;
- Ulcers; and
- Diabetes.

These physical illnesses are only some of the external impacts HIV and AIDS have on educators.

Educators who are ill, are increasingly absent from class and it is often difficult to find relief cover for them. Ill educators who remain in their posts cannot provide the same quality of teaching; therefore, there is reduced productivity of sick educators. Educators who are not ill have to cover for those who are (Theron, 2005:58). In other words, when healthy educators have infected colleagues, they face extra teaching loads. Most educators will have to take on additional teaching and other work-related duties in order to cover for sick colleagues (Coombe, 2000:17). This will affect their psychological wellness. The impact of working with HIV and AIDS affected and infected colleagues is traumatic and many educators experience it very negatively. However, it is not their colleagues' situation that affects them the worst – research has shown that the impact is worse when the learners are affected. Thus, the impact

HIV and AIDS has on educators, when they teach learners who are affected and infected by HIV and AIDS will be discussed.

8.2.2 The impact of learners affected and infected by HIV and AIDS on educators

In a study by Robson *et al.* (2007:425), educators reported that they are most affected when learners are infected. As mentioned earlier learners who are HIV affected and infected, can show the following psychological distress signs: depression, anxiety, peer problems and post-traumatic stress symptoms (Cluver *et al.,* 2007:756). These symptoms can have a negative impact on the educator. Robson *et al.* (2007:425) found that educators report having comforted children who seemed particularly distressed. Due to the high emotional impact HIV has on the learners, many educators are willing to do more than is expected of them. This causes the role confusion stated earlier, and it adds to extra stress and emotional burnout.

According to Shisana *et al.*(2005a:114) educators feel that they cannot effectively guide HIV and AIDS affected learners, and they are constantly in need of support and training to make it possible for them to cope with this aspect of their work. It is necessary to understand why educators are negatively impacted when they become involved with HIV affected and infected children.

When educators become involved with children who are affected by HIV and AIDS, they go through a cycle of trauma. This cycle of trauma is described by Shisana *et al.* (2005a:113) as follows: educators are required to become involved in cases where children are exposed and abandoned or neglected by parents who are infected with HIV. These educators have to report the affected child to social workers or police and nearly all of them want to make sure that the child is taken care of or placed in a place of safety. According to Shisana *et al.* (2005a:113) educators feel responsible for the learners' school attendance. However, these learners may become troubled and depressed, which may affect their learning negatively. Educators, in turn, will be affected by witnessing the circumstances in which these learners are growing up, some of whom are heading households, or whose parents are mobile workers and only return once a month or during holidays. In many

circumstances, educators take care of orphans in their own homes, and provide for needy relatives (Shisana *et al.*, 2005b:23). This cycle can be very destructive if educators do not have the emotional capability and skills to cope with the emotional effects on themselves.   The researcher is of the opinion that the cycle includes human kindness and empathy, and it needs to take its' course. The educator is one of the few people that have a trusting relationship with the learners, and they are often the first people that take note of these troubles.   It is however imperative to teach the educators to care for themselves emotionally and not to become so involved that they themselves become emotionally wanting and deprived.   It is necessary to teach them much needed resilience and to explore what supportive strategies are already in place to support the educators.   The existing supportive strategies will now be discussed.

9. SUPPORTIVE STRATEGIES

Support can be defined as providing another person with comfort, recognition, approval and encouragement. There are multiple forms of support, but they share a general aim, namely to ensure a better wellbeing and a general feeling of wellness (Reber & Reber, 2001:726). If one looks at the detrimental impact HIV and AIDS has on the education system, it is imperative that supportive strategies are developed to support the education system and the educator.

According to Theron *et al.* (2008:81), the African continent is under pressure to respond to the international community's decision to adopt social development as a strategy to address social problems such as HIV and AIDS and inadequate education.   In response, Africa developed programmes to try to address these problems. According to Theron *et al.* (2008:81) the success of these programmes is dubious should educators not be empowered to provide quality education notwithstanding the challenges they experience daily owing to, among other things, the AIDS pandemic.

In South Africa, Page, Louw and Pakkari (2006:112) highlight the fact that organisations and government are not doing enough to intervene in the pandemic. Kupa (2008:53) notes that two policies were developed in South Africa to assist in supporting these educators. They are:

- ***The National Policy on HIV/AIDS for learners and educators in public schools and students and educators in further education and training institutions of 1999***

- ***The Department of Education Workplace Policy for HIV/AIDS (****1999)*

The above-mentioned policies are summarised by Simbayi, Skinner, Letlape and Zuma (2005:31) as follows:

- ***The National Policy on HIV/AIDS for learners and educators in public schools and students and educators in further education and training institutions of 1999***

The policy deals with issues of rights as entrenched in the country's Constitution, including the right to education, protection from discrimination, privacy, basic freedoms, a safe environment and the best interest of the child. Through this policy the Department of Education acknowledges that there are learners and educators in its institutions that are infected or affected by HIV and AIDS and empowers institutions to be proactive in their response to the pandemic. The policy also recommends that each school have a strategic plan, accompanied by an implementation plan, to cope with the pandemic. Furthermore, it calls for a concerted struggle against HIV and AIDS by all organs of the society and that schools should work closely with local communities to provide information and support. In reaction to this policy, Kupa (2008:54) states that the policy is all-inclusive, but lacks specific guidelines to assist HIV affected educators. The researcher agrees with her.

- ***The Department of Education Workplace Policy for HIV and AIDS (1999)***

The Department of Education Workplace Policy for HIV and AIDS (1999) is summarised by Simbayi *et al.* (2005:34) as a policy that has the main objective to create a supportive environment for employees living with and affected by HIV and AIDS, to eliminate discrimination against persons with HIV and AIDS, inform employees about their rights, and protect persons potentially exposed to HIV at work. The content of the policy addresses the practical needs of employees and includes issues such as employee benefits, HIV/AIDS workplace programmes, ill

health retirement, universal precautions and advocacy. Kupa (2008:55) is of the opinion that the Workplace Policy of the DoE does give guidelines, but the implementation of this policy is decentralised to the different provincial departments of education, and therefore it is not implemented. The researcher agrees with this statement. Theron *et al.* (2008: 82) cite Hartel and Maile (2004) in saying that policy guiding supportive and non-discriminatory practices was not always effectively implemented or monitored. Theron *et al.* (2008:83) summarises that our national response is largely limited to pre-service and in-service training and to the provision of policy. They note that South African educators need comprehensive support to cope with the challenges of a professional role that has been escalated to encompass HIV prevention, counselling and social work. Theron *et al.* (2008:83) concludes that there is no form of comprehensive support for affected educators, although some South African research initiatives have empowered participating educators and their communities.

10. CONCLUSION

Chapter Two discussed the impact of HIV and AIDS on South Africa, and specifically on the education sector. This pandemic has been known since 1981, and now, 29 years later, there is still no cure. The good news is that the world realises the seriousness of the situation, and measures are being taken to try to rectify the problems.

The researcher is of the opinion that the time for "damage control" has passed – we are well aware of the magnitude of HIV, and we can predict the impact it will have in future. What we need to do now is implement strategies that will prevent further damage – the cures and ways to improve the life expectancy and quality of life is well on its way, but we are seriously lacking in preventative measures that will comparison and rectify the ripple effect HIV has on the economic, social and emotional sector of this country. The education sector is one of the sectors that need to empower and teach the future generation of this country, but the people doing this important work are not empowered to deal with the effect of HIV and AIDS – educators need to become emotionally strong. They need to become resilient.

The next chapter will discuss the much-needed skill of resilience. This skill will empower people who are affected by HIV and AIDS to cope better with the pandemic.

CHAPTER 3

RESILIENCE AND HIV AND AIDS

1. INTRODUCTION

HIV and AIDS is negatively influencing society. All people are affected by it in some way, and as Hjemdal, Friborg, Stiles, Rosenvinge and Martinussen (2006:84) put it: "Times of trouble accentuate differences between triumph and misery and draw attention to individual differences when facing adversity."

People deal with adversity in different ways, and according to research, resilience is one of the factors that enable people to deal with adversity in a positive way (Hjemdal *et al.*, 2006:84). The goal of this study is to evaluate the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng. In order to attain this goal, it is important to theoretically explain and explore resilience in the context of HIV and AIDS and the educational sector. Chapter Three will therefore focus on defining resilience as a construct; looking at different ways to measure resilience; exploring the correlation between resilience and quality of life; explaining the connection between HIV and resilience, as well as between education and resilience.

2. CONCEPTUALISATION OF RESILIENCE

There are various definitions for the concept resilience, and the researcher will now discuss these various definitions in order to clarify the meaning of resilience in the context of this study.

According to Hjemdal (2007:305), resilience is a relatively new construct, and it is difficult to define it, because several different theoretical approaches and definitions exist. Therefore, the researcher has attempted to categorise the definitions and approaches of resilience as follows:

2.1 Resilience defined as a personal characteristic or ability

The earliest definitions of resilience was coined in the 1980's, and according to Hjemdal (2007:306) the main focus of these definitions was to describe resilience by referring to personal characteristics. In this regard, Rutter (1985:599) defines

resilience as "Firstly, a sense of self-esteem and self-confidence; secondly, a belief in one's own self-efficacy and ability to deal with change and adaptation; thirdly, a repertoire of social problem-solving approaches." Earvolino-Ramirez (2007:73) summarises Rutter's definition as "the ability to bounce back or cope successfully despite substantial adversity." Rutter (1999:119) later explains resilience as a term that "describes relative resistance to psychosocial risk experiences." Earvolino-Ramirez (2007:73) found that the definition from Rutter received acknowledgement and was built on. Hjemdal (2007:306) acknowledges Earvolino-Ramirez (2007), and calls it a second class of definition that emphasises the power of recovery and re-adjustment. An example of such a definition is given by Hjemdal (2007:306) as he cites Wolin and Wolin (1993) who defined resilience as "the ability to bounce back, defy challenges and repair oneself in the face or hardship." These definitions mainly define resilience as a personal characteristic or a learned skill. Other authors define resilience as a process.

2.2 Resilience defined as a process

As time progressed, resilience was redefined as a dynamic, modifiable process. Dyer and McGuinness (1996:277) describe resilience as a global term describing a process whereby people bounce back from adversity and go on with their lives. According to them, resilience is a dynamic process highly influenced by protective factors. The researcher will elaborate on protective factors later on in this chapter.

Rutter (1999:135) further builds on the definition of Dyer and McGuiness (1996:277) remarking that resilience does not constitute an individual trait or characteristic, but involves a range of processes that bring together diverse mechanisms to assist a person to cope.

The theme of coping with adversity is used by a couple of authors to define resilience. Luthar, Chichetti and Becker (2000:543) define resilience as "a dynamic process encompassing positive adaptation within the context of significant adversity." In developing countries, Koller and Lisboa (2007:342) define resilience as "a dynamic and complex process through which a person thrives/copes/deals with events and risks in the context of her or his personal characteristics, ecologic cohesion, and familial, social, and cultural history. Masten (2007:923) states that

resilience usually refers to positive adaptation during or following exposure to adversities that have the potential to harm development. Hjemdal (2007:307) summarises the definitions of abovementioned authors into a different and widely used definition of the construct resilience as "the individuals' positive adaptation or demonstration of a pattern of normal development despite significant risk and adversity." Hjemdal (2007:308) is of the opinion that one problem with this definition of resilience is that it leaves little room for prediction. Hjemdal (2007:308) says that the definition defines the outcome, but not what contributes to the outcome.

2.3 Resilience defined in terms of the presence or influence of protective factors

To include the predictive perspective as well as to facilitate the idea of processes, resilience was alternatively defined as "the protective factors and processes that contribute to a good outcome despite experiences with stressors shown to carry significant risks for developing psychopathology" (Luthar *et al.*, 2000; Masten & Reed, 2002; Rutter, 2000) as cited by Hjemdal (2007:308). In order to understand this definition and the meaning of "protective factors," it is necessary to elaborate in this regard.

Protective factors can be defined as specific attributes or situations that are necessary for the process of resilience to occur (Dyer & McGuinness, 1996:277). Luthar, Sawyer and Brown (2006:106) later define protective factors as something that modifies the effects of risk in a positive direction, clearly has positive connotations, and is referring to something that is helpful or beneficial. Sumison (2003:145) mentions that in broad terms, protective factors can be clustered into three groups:

- personal qualities and characteristics (e.g. motivation, internal locus of comparison, determination, interpersonal awareness, self-esteem, problem-solving skills);
- environmental factors (e.g. caring for others, effective support systems); and
- person–environment interactional processes (e.g. the contribution by individuals to the creation of supportive communities that in turn sustain them).

To summarise the view of Sumison (2003:145) one can deduct that protective factors are actually a combination of personal characteristics and processes.

Hjemdal (2007:309) highlights the following attributes as the protective factors to measure resilience: perception of self; planned future; social competence; structured style; family cohesion; and social resources. The researcher is of the opinion that the protective factors noted by Hjemdal (2007:309) are more inclusive. From the above descriptions, protective factors seem to refer to personal characteristics, skills and processes that assist an individual to cope with life.

However, Hjemdal (2007:307), states that the presence of protective factors is not sufficient alone to explain individual differences in adapting to adversity. He (Hjemdal, 2007:307) states that individuals who positively projected some of the protective factors did not necessarily have resilience. This means that resilience is a fluctuating concept. This view correlates with that of Kumpfer (1999) and Sumison (2003:143) who see resilience as fluid, not fixed, and involving ongoing "negotiation through life."

2.4 Summary on the conceptualisation of resilience

Thus it seems as if, in the words of Luthar *et al.* (2000:546), "little consensus exists among researchers around central terms used within models of resilience". This is confirmed by Hjemdal (2007:306), who acknowledges that there were changes in the understanding of the construct, and efforts to identify personal characteristics were supplemented with an awareness of social external factors playing an important part in negotiating the effects of adversity and facilitating resilient adaptation. Hjemdal (2007:306) further cites Fonagy, Steele, Steele, Higgitt, and Target (1994), who state that many of the definitions of resilience are not theoretically founded, and most are linked to a collection of empirical findings, resulting in new definitions to account for the empirical findings. These definitions all convey aspects of resilience. Some definitions focus on personal or family characteristics, whereas others focus on processes and mechanisms involved in resilience or on outcome.

Therefore, Hjemdal (2007:309) defines resilience as "the protective factors, processes and mechanisms that, despite experiences with stressors shown to carry

significant risk for developing psychopathology, contribute to a good outcome." The researcher agrees with the definition of Hjemdal (2007:306) because it incorporates all the mentioned elements of resilience and further defines resilience as the presence of protective factors, processes and mechanisms (including cultural history) that enable an individual to cope despite the occurrence of risk and negative factors and the presence of multiple adverse factors and circumstances.

It is clear from the above discussion that resilience is a difficult construct to define, and therefore it will be difficult to measure resilience. Nevertheless, in order to understand the existing level of resilience that an individual possesses, and in order to improve resilient functioning, it is necessary to measure resilience. Hjemdal *et al.* (2006) have done a lot of research on resilience scales. In the following section, the different ways of measuring resilience will be discussed.

3. MEASUREMENT OF THE CONCEPT RESILIENCE

Delport (2005:160) cites Monette, Sullivan and DeJong (2000) who define measurement as the process of describing abstract concepts in terms of specific indicators, by the assignment of numbers or other symbols to these indicators in accordance with specific rules. When considering measurement, Delport (2005:160) notes that particular characteristics or properties of a concept or phenomenon are measured and not the phenomenon per se. This view is relevant in the measurement of resilience, as resilience is constructed by the presence of protective factors, processes and mechanisms. For the purpose of this study, the researcher is interested in evaluating the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng. In order to accomplish that, it is necessary to measure resilience before and after the support programme has been implemented.

Although different scales exist to measure resilience (e.g. The Resilience Scale by Wagnhild & Young, 1993; The Connor Davidson Resilience Scale, 2003; The Brief Resilience Scale by Smith, Dalen, Wiggins, Tooley, Christopher & Bernard, 2008) the researcher will, due to the fact that this research study utilises the Resilience Scale for Adults (RSA), only concentrate on the RSA by Hjemdal (2007:308). The results derived from this measure are discussed in Chapter 5 of this study.

Hjemdal (2007:308) notes that he and Friborg attempted to develop a scale to measure resilience. After much research, Hjemdal (2007:308) reports that only one measurement scale directly related to resilience among adult populations was located. The scale they located was the Resilience Scale developed by Wagnhild and Young in 1993. This scale was based on interviews with 24 elderly women who had adapted successfully to various losses typical of old age. From this material, they developed a scale that consisted of 25 items covering two factors: personal competence and acceptance of self and life. The scale was found highly reliable with an elderly sample and showed initial construct validity.

In critique of the Wagnhild and Young Resilience Scale (1993), Hjemdal (2007:308) cites Aroian, Schappler-Morris and Neary (1997), who found the scale was tested on a restricted range of stressors (single traumas) and a sample not representative of the total age range of the adult population. They further established that the scale of Wagnhild and Young (1993) included only one of the three overarching categories of resilience namely dispositional positive attributes and none of the two social dimensions of resilience namely social networks and a supportive family environment. Based on this finding, Hjemdal (2007:308) ascertains the scale not appropriate for measuring adult resilience.

Hjemdal (2007:308) states that he and Friborg then developed the Resilience Scale for Adults (RSA) that are based on empirical resilience research and measure protective factors in accordance with the three overarching categories of resilience factors namely:

- positive characteristics and resources of the individual;
- a stable and supportive family environment marked by coherence, and
- external social networks that support and reinforce healthy adaptation.

Hjemdal (2007:307) note that recent findings indicate substantial support for the reliability of the RSA concerning internal consistency and test-retest reliability. The RSA is based on the following six factors:

- perception of self;
- planned future;

- social competence;

- structured style;

- family cohesion, and

- social resources.

These six factors cover the three overarching categories previously mentioned and as such include the social aspects of protective factors associated with resilience. These factors are measured in RSA developed by Hjemdal (2007:307). The scale can be seen in Annexure 7.

The researcher's study is based in South Africa, which is a developing country. In developing countries, Koller and Lisboa (2007:342) defines resilience as "a dynamic and complex process through which a person thrives/copes/deals with events and risks in the context of her or his personal characteristics, ecologic cohesion, and familial, social, and cultural history". South Africa is a developing country, and therefore it is important to consider the "risks and context of the person" when studying resilience.

Although little research on resilience has been done in South Africa, Theron (2007b:358) utilised a locally developed resilience scale to study resilience among township youth in South Africa. Theron (2007b:358) emphasises the importance of context when measuring resilience. Ungar (2005) and Rutter (2001) as cited by Theron (2007b:358) emphasised that resilient functioning varies according to the context where it is measured. Therefore it is important to realise that resilient functioning in a developing country would not necessarily mirror resilient functioning among developed countries (Theron 2007b:358). Koller and Lisboa (2007:341) also emphasise the fact that the context in which an individual functions has a direct influence on the measures used to measure resilience. In her study among township youth in South Africa, Theron (2007b:368) found that the personal competence factors that were measured by their resilience measure were not responded to by the youth. They responded to the other measures, but not to the personal competence factors. Theron (2007b:358) attributed this to the fact that in an African culture, the communal self is more emphasised than the individual self is. This fact might affect the outcome of the study, and it is possible that more research

should be done to develop a resilience scale that is appropriate to the African context.

This study focuses on both resilience and quality of life as attributes that the REds programme should improve. Thus, it is important to explore the connection between quality of life and resilience, and why it is important in the context of HIV and AIDS affected educators. The next section will focus on exploring the connection between quality of life and resilience.

4. THE CONNECTION BETWEEN RESILIENCE AND QUALITY OF LIFE

In the context of this study two scales are used to assist in evaluating the REds programme – the one scale measures quality of life (The ProQol Manual by Stamm 2005:4-6), and the other resilience (The Resilience Scale for Adults developed by Hjemdal *et al.,* 2006:84). As mentioned in Chapter Two, HIV and AIDS have a detrimental impact on the individual. HIV and AIDS negatively affect the quality of life and resilience of the individual who is infected, but also those who are affected by HIV and AIDS. The aim of the research is to evaluate whether the REds programme increases the quality of life and resilience of HIV and AIDS affected educators. Therefore, it is important to understand the connection between quality of life and resilience. The researcher will however firstly define "quality of life" and then briefly discuss the differences and similarities between quality of life and resilience.

Similarly, to the concept of resilience, there is no clear-cut definition for the concept "quality of life." Koot (2001:12) as well as Lawford and Eiser (2001: 210) mention that no consensus exists on what "quality of life" means. According to Lawford and Eiser (2001:210), "the concept quality of life becomes a kind of umbrella term under which are placed many different indexes dealing with whatever the user wants to focus on." The following definitions are examples thereof:

- According to the WHO/UNAIDS (2001), quality of life refers to an individual's physical health, psychological states, and level of independence, social relationships and their relationship to salient features of their environment. This definition is however very broad, and it is difficult to measure quality of life if you need to consider all these factors.

- Calman (1987:7) offers an alternative definition of quality of life, defining it as the "perceived differences between an individual's hopes and expectations and his/her present experience." Calman (1987:7) states that a good quality of life is achieved by a match between the hopes of an individual and his/her present experience, and a poor quality of life occurs when hopes are not matched by experience. The researcher agrees with Calman (1987:7) but is of the opinion that hopes and experience are not quantifiable, and thus thinks that it can be difficult to measure quality of life using this definition.

- Lawford and Eiser (2001:211) also refer to Bergner (1989) who extended the ideas of Calman and argues, "quality of life is enhanced when the distance between the individual's attained and desired goals is less." The researcher is of the opinion that the abovementioned definition is relevant.

In the context of this study, the researcher defines quality of life as the individual's psychological state, social relationships, and the individual's ability to relate to their environment. In this study, the researcher will utilise the ProQol Manual by Stamm (2005:4-6) to assert the quality of life of participants. The ProQol developed by Stamm (2005:4-5) specifically measures the quality of life of professionals in the work environment. All participants in this study are educators who work in a school environment. The applicability of the ProQol in a work environment was tested and verified by Sprang, Clark and Whitt-Woosley (2007:259). The ProQol by Stamm (2005:4-6) tests quality of life in relation to three concepts, namely compassion satisfaction, burnout and secondary trauma. The following definitions are given:

- Compassion satisfaction is about the pleasure an individual derives from being able to perform work well (Stamm, 2005:5).

- Burnout is defined as feelings of hopelessness and difficulties in dealing with work or doing a job effectively (Stamm, 2005:5).

- Secondary trauma is defined as work-related, secondary exposure to extremely stressful events, like for instance being exposed to others' traumatic events as a result of doing a job (Stamm, 2005:5).

The researcher discusses the ProQol (Stamm, 2005:5) in detail in Chapter 5.

According to Alriksson-Schmidt, Wallander, and Biasini (2006:370) two approaches of studying quality of life have emerged, namely disease-specific quality of life and generic quality of life.

The disease-specific quality of life approach is applicable only to individuals with a given disease and typically addresses symptoms, functional status and psychological and social functioning (Alriksson-Schmidt *et al.*, 2006:370). It is often used in medical/healthcare to measure burden from specific diseases in patients; however, according to Koot (2001:9), such a clinical approach prevents quality of life comparisons among different diseases and with healthy individuals.

According to Koot (2001:10) a generic view of quality of life refers to a broader view of life, including, for example, considerations for relations with family and friends, job or school situations, and goals in life. Alriksson-Schmidt *et al.* (2006:370) quote Wallander (2001), who is of the opinion that generic quality of life can and should be applied to both healthy and ill individuals to express the notion that ill individuals are more than their illness.

For the purpose of this study, the researcher agrees with Koot (2001:9) as she is interested in HIV and AIDS affected educators' quality of life – they are still healthy individuals, but their exposure to HIV and AIDS can have a negative impact on their quality of life. When a person is affected by HIV and AIDS, they are exposed to other people's trauma, and often they are asked to do something to relieve the trauma. This can lead to secondary trauma, a lack of compassion satisfaction and burnout as defined by Stamm (2005:5).

Alriksson-Schmidt *et al.* (2006:370) cites Cummins (2001) who distinguishes between subjective and objective components to measure quality of life. This distinction addresses the content of the measure, not the source of the information per se. Alriksson-Schmidt *et al.* (2006:371) explain that subjective measures typically tap into one's satisfaction with life, whereas objective measures request factual information about one's life. Measures of quality of life therefore can vary on a dimension from subjective to objective. The measuring instrument in the context of this study, namely the Professional quality of life (ProQol) developed by Stamm (2005:5), measures both subjective and objective measures, and is therefore a valid measure for the purpose of the research project.

When one compares the two concepts, quality of life and resilience, one has to look at both definitions. Lawford and Eiser (2001:211) state that the key ideas in quality of life research – coping within the context of adversity - have previously been identified as central in the resilience literature. This means that both resilience and quality of life deals with an individual's capacity to cope within the context of adversity. Lawford and Eiser (2001:211) define resilience as a dynamic process encompassing positive adaptation within the context of significant adversity.

According to Lawford and Eiser (2001:211), resilience can be divided into two types. The first type refers to resilience as *stress-resistance*, i.e. children showing competent functioning despite considerable stress and threat, thus they effectively cope in order to maintain normal functioning. The second type refers to resilience in the context of *recovery from trauma*, i.e. where children recover once the stressor is removed, and often benefit from this early stress later in their lives. These concepts were used when Lawford and Eiser looked for correlation between resilience and quality of life.

For the purpose of this study, three relevant similarities, as found by Lawford and Eiser (2001:211), are identified between resilience and quality of life, which support the comparability of these two concepts. These areas of similarity can be briefly explained as follows:

- First, resilience and quality of life have both been defined as **multidimensional** (Lawford & Eiser, 2001:212). Quality of life measures usually include a variety of different domains or spheres of an individual's life. Similar items are aggregated into groups, which reflect the chosen dimensions of quality of life. For example, quality of life is deduced from measures of physical functioning and emotional functioning. Resilience measures are also defined to include measures of various aspects of life for example both the academic performance and the social competence of an individual's life.

- Second, Lawford and Eiser (2001:212) found that both quality of life and resilience are considered **latent constructs** which are difficult to quantify, and that leaves researchers with the problem of defining and quantifying concepts that can only be inferred. This means that the researcher needs to quantify and define resilience and quality of life based on evidence or reasoning. This again

concurs with Luthar *et al.* (2000:546) who highlighted the fact that the theoretical and research literature on resilience reflects little consensus about definitions, with substantial variations in operationalisation and measurement of key constructs.

- Third, within individuals, both resilience and quality of life have been shown to have high **internal variability** between different dimensions for any individual. Reports of high or low quality of life do not necessarily mean that individuals function similarly across all dimensions (Lawford & Eiser, 2001:211). For example, a high score on a social domain does not necessarily mean a high score on a physical functioning domain. This internal variability is typical in quality of life assessment, and highlights the fact that illness affects some aspects of individuals' lives more than others do.

However, there are some differences that can also be identified between the concepts quality of life and resilience.

Lawford and Eiser (2001:212) note the following differences:

- Quality of life researchers have attempted to **show how, and in what ways, a child's quality of life can be compromised by illness experiences**. They have not attempted to explain exactly why quality of life is compromised, or tried to explain those factors that contribute to a child's appraisal of their quality of life. On the other hand, the emphasis in resilience work has been in **identifying underlying protective factors that mediate a child's reaction to adversity, with the aim to explain any better-than-expected outcomes.** These protective factors are overarching and research on resilience has expanded to include multiple adverse conditions from parental mental health and maltreatment to socio-economic disadvantage and catastrophic life events.
- Second, there has been considerable debate about the **stability** of both concepts. Longitudinal studies have shown that competent children are likely to remain so throughout life. Masten (1999) as cited by Lawford and Eiser (2001:213) has found that resilience has a high predictive validity, and remains relatively stable over an individual's lifetime. However, Lawford and Eiser (2001:213) assert that the stability of quality of life over time has not been

investigated and, therefore, no clear conclusions can be made about the predictive validity of this concept.

Although the abovementioned differences are based on studies done with children (Lawford & Eiser, 2001:213), other studies done on adults (Whitt-Sherman, Ye, Mcsherry, Parkas, Calabrese & Gatto 2006:948; Pentz, 2005:15) show the same differences.

These similarities and differences between the two concepts show why the researcher views it important that both scales are used in the study, as the presence of both resilience and quality of life is necessary to ensure coping. In the context of this study, it means that having resilience can improve the individual's quality of life, and ability to cope better with the impact HIV and AIDS has on human functioning. It is therefore necessary to explore resilience in the context of HIV and AIDS. This aspect will be discussed in the following section.

5. RESILIENCE IN THE CONTEXT OF HIV AND AIDS

As earlier noted, HIV and AIDS have a negative impact on humans, and they need resilience to enable them to cope better with this negative impact of HIV and AIDS. Research by Munro and Edward (2008:122-128) has shown that gay men who care for their partners dying of AIDS cope better if they have resilience. If resilience is defined as the presence of protective factors, processes and mechanisms (including cultural history) that enable an individual to cope despite the occurrence of risk and negative factors and the presence of multiple adverse factors and circumstances, one can reason that there may be a similarity between participants in Munro and Edwards' study (2008), and educators who also care for HIV and AIDS affected loved ones. It implies that HIV and AIDS affected educators can also possibly cope better if they have resilience.

In the study by Munro and Edward (2008:126), the following factors were identified as factors that helped the carer cope better with the situation: caring environments; self-efficacy; well-defined faith lives; the ability to reframe obstacles; support networks and relational/psychological factors. Munro and Edward (2008:126) note that the experience of resilience sprouted from exposure to risk and the consequent successful negotiation of these risks by successful problem solving. The researcher

is of the opinion that these factors correlate with the factors mentioned by Hjemdal (2007:309) as indicators of resilience, and this implies that the detrimental impact that HIV and AIDS has on people can also possibly be combated by increasing resilience.

In a study done by Lee, Lee, Kim, Song, Park and Park (2003:639) on chronic illnesses, the following aspects were found to attribute to individual and family resilience: flexibility; (stress) resistance; positive outlook; coping (problem solving); and sense of control (balancing); adaptation (adaptability); social integration; and resourcefulness. The key attributes of individual resilience were maturity, empowerment, creativity and sense of belonging. The research done by Lee *et al.* (2003:637) found that family resilience is an enduring force that leads families to solve problems when faced with chronic illness. Even though the research by Lee *et al.* (2003:637) was not done specifically on HIV and AIDS, it is relevant to this study, because AIDS is seen as a chronic illness. Lee *et al.* (2003:639) defined the following characteristics as attributes of family resilience: cohesion; commitment; communication; family strength; connectedness; meaningfulness; spirituality; and bouncing back. Lee *et al.* (2003:644) found that the presence of these factors in a family enabled them to cope better with chronic illness. Therefore, the researcher concludes that the presence of factors that characterises resilience may also enable people who are faced with chronic disease (like AIDS) to cope better with their circumstances.

The last part of this will therefore focus on the subject of resilience in the South African education system. As noted in Chapter Two, educators are affected personally and professionally by HIV and AIDS, the aim of this study is to evaluate the effectiveness of the 2009 version of the REds programme to enhance the quality of life and resilience of HIV, and AIDS affected educators in Gauteng. It is therefore necessary to briefly explore resilience in the context of the education system. The next section will discuss this.

6. RESILIENCE IN THE EDUCATION SYSTEM

Theron *et al.* (2008:78) state that HIV and AIDS have radically altered the job description of South African educators to include caring for children who most of the time have additional (often unmet) needs such as grief counselling, hunger,

accommodation and school fees; most need support to cope with discrimination, abuse, rejection, lost childhoods, and so forth (Bhana, Morrell, Epstein & Moletsane 2006:14-18; Coombe, 2000:17). Theron *et al.* (2008:78) state further that HIV and AIDS affected educators need support to cope with the altered job description.

Hall *et al.* (2005:23-25) directly link this change in the job description to educators being HIV and AIDS affected through colleagues, learners and/or family members being HIV positive, or dying from AIDS-related illnesses, or to teaching AIDS orphans and learners made vulnerable by the HIV pandemic. As earlier noted, educators withstand the worst of the HIV and AIDS pandemic, as they are responsible to assist learners and fellow educators to cope with the wide-ranging influence of HIV and AIDS. The support currently given is insufficient. Theron (2007a:13) states that educators affected by HIV and AIDS, whether directly (HIV-infected loved ones, colleagues or learners) or indirectly (aware of the pandemic, but do not have HIV positive loved ones, colleagues or learners), indicated that they do not experience sufficient support regarding the pandemic and that they are in need of a wide range of support. In other words, Esterhuizen (2007:73) states that educators feel that the current support is inadequate.

Support can be given by teaching educators resilience. Education and resilience is dualistic – the researcher is of the opinion that education can assist to create resilience among HIV affected learners. In her study Theron (2007b:372) states, "not only can education be harnessed as a vehicle for intervention, but education per se is linked to psychological well-being and resilience."

Educators need to be resilient. In this regard, Sumison (2003:152) notes that to focus on creating and instilling resilience in the workplace would provide a counter-foil to the current emphasis on teacher stress, burnout and attrition. To create resilience in the education system can prove to be quite a challenge, because resilience programmes differ from other support programmes based on policy. Xaba (2008: 112-114) states that affected educators are supported through policies that provides information regarding educator rights, encourages educator HIV awareness and healthy living, and promotes supportive working conditions. However, a study by Hartell and Maile (2004:198) noted that policy guiding supportive and non-discriminatory practices was not always effectively implemented or monitored.

Theron *et al.* (2008:81) cite Campbell and Lubben (2003) as well as Jacob, Mosman, Hite, Morisky and Nsubuga (2007) in noting that in Africa, the typical response to the HIV pandemic has included both curricular and extra-curricular learner focused educational initiatives that encourage HIV prevention with some emphasis on the need to provide educators with relevant training and policy to cope in this regard. This shows that the educators were given training and policy to support them to cope – not resilience training. Theron *et al.* (2008:81) state that the South African response has been to endorse educators doubling as caregivers and prevention agents, by producing policy and providing training. This strategy has proven insufficient, and Theron *et al.* (2008:81) quote Govender (2008) who found that schools report that a limited number of educators are trained, and remain uncomfortable to teach children about HIV and AIDS, and government does not spend grants earmarked for supporting educators and learners.

According to Ramranthan (2003:182), there is a deficit of 4397 teachers per annum in South Africa. This is due to not only HIV and AIDS, but the logical conclusion can be made that HIV and AIDS and the lack in current support can possibly increase the attrition of educators. Theron *et al.* (2008:83) state that there is no form of comprehensive support for affected educators, although some South African research initiatives have empowered participating educators and their communities. This apparent shortcoming prompted the compilation of an interactive, participatory support programme to enhance resilience and quality of life, entitled the Resilient Educators support programme (REds). The following chapter will discuss the REds programme as a supposed solution to develop resilience in educators, in detail.

7. CONCLUSION

Chapter Three focused on resilience as a concept, and the researcher the following is the researcher's definition of resilience: the presence of protective factors, processes and mechanisms that enable an individual to cope despite the occurrence of risk and negative factors and the presence of multiple adverse factors and circumstances. The ways to measure resilience has been discussed, and the researcher has concluded that the RSA of Hjemdal (2007:308) can be used, but it has been noted that the scale might not be entirely appropriate for an African context. The correlation between resilience and quality of life has also been

explored, and the researcher has concluded that both constructs are important when trying to improve the coping skills of an individual, as they both measure different aspects of an individual's ability to cope with dire circumstances. Resilience in the context of HIV and AIDS and in the context of the education system has also been explored, and the researcher concludes that resilience can be a positive way to address the detrimental impact that HIV and AIDS has.

The next chapter will focus on the aims, content and processes of the Resilient Educators support programme (REds) for HIV and AIDS affected educators.