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EVALUATION OF THE EFFECTIVENESS OF THE RESILIENT EDUCATORS SUPPORT PROGRAMME AMONG HIV AND AIDS AFFECTED EDUCATORS IN GAUTENG

BY

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Submitted in partial fulfilment of the requirements for the degree

Master in Social Work with specialisation in Employee Assistance Programmes

IN THE

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY

FACULTY OF HUMANITIES

AT THE

UNIVERSITY OF PRETORIA

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April 2010 **Pretoria**

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ACKNOWLEDGEMENTS

- I would like to bring thanks to God for giving me the passion for people, resources, knowledge and motivation to complete my studies. To Him be the Glory!

- I would like to thank my loving, wonderful husband, Willem, for the emotional support, motivation, inspiration, love, household chores, cooking dinner and thousands of cups of coffee! :o) . Thank you for your encouraging me when I got tired, for believing in me when I did not and for understanding when I had to work. Thank you for being there every step of the way. You made this study a manageable journey.

- I would like to thank my mother, Martie, for supporting and encouraging me every step of the way. Thank you introducing me to EAP, and for believing in me. Thank you for the computer that you gave me after mine was stolen – without that resource this would not have been possible.

- I want to thank my dad, Johan for believing in me! Thank you for encouraging and assisting me when I needed a fresh eye on the statistics.

- I would like to thank Marzanne for her professional and effective proofreading of this dissertation.

- To the following people: Cynthia, Jacob, Kees, Christien, Hendrik, Marga, and my home cell, thank you for your support and encouragement!

- To Prof. Delport, my supervisor, thank you for including me in this study, and for your guidance and encouragement. Thank you for sharing your professional knowledge and time with me.

- To Prof. Theron, REds project leader, it was a pleasure to be part of the REds team.

- To Regina Molokomme, the observer in the group sessions, thank you for your diligence and participation.

- The warmth, openness and contributions of the principal and educators of the Diepsloot Combined School, Johannesburg, who formed the experimental group is highly appreciated. Thank you for attending the sessions, and for completing the pre- and post-test. Thank you for sharing your hearts with me, and for being open about your experiences. It has been an enriching journey for me. I am very thankful towards you, because without your willing participation, this study would not have been possible.

- Thanks are also due to the Principal and educators of the Emfundiswene Primary School in Alexandra, Johannesburg, for participating as a comparison group.

- The financial sponsorship from the National Research Foundation of South Africa made a valuable contribution towards the cost of the study. The conclusions and recommendations of the study are solely that of the researcher and not necessarily endorsed by the National Research Foundation.

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ABSTRACT

EVALUATION OF THE EFFECTIVENESS OF THE RESILIENT EDUCATORS SUPPORT PROGRAMME AMONG HIV AND AIDS AFFECTED EDUCATORS IN GAUTENG

by

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Supervisor: Prof. C.S.L. Delport

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY

DEGREE: MSD (EMPLOYEE ASSISTANCE PROGRAMMES)

The Resilient Educators support programme (REds) for HIV and AIDS affected educators was initiated by the University of the Northwest in 2006, following a research project in 2005 that highlighted the need for a support programme that addresses the challenges of educators affected by HIV and AIDS, as existing support structures were found to be inadequate.

The REds programme is implemented in phases, and after the completion of each phase, the programme is modified to meet the needs of a broader audience of educators. Since 2006, the REds programme has been implemented by independent researchers in four South African provinces, Gauteng, Mpumalanga, the Northwest province and the Free State.

This round of implementation included a comparison group, to allow researchers to compare data. The 2009 implementation of the REds programme was aimed at gathering comparative data to prove that the programme has a positive impact on the quality of life and resilience of educators. This was 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.

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.

For the purpose of this research study, the researcher used applied and evaluative research. The mixed methods research approach was used, followed by the concurrent triangulation design. 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 prove or disprove the hypothesis. 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. For the qualitative part of the study, the researcher used a collective case study design.

Quantitative data was collected through two group administered standardised questionnaires, the Professional Quality of Life Screening (ProQol) and the Resilience Scale for Adults (RSA). Qualitative data was collected by using a narrative, drawings and observations. Pre-test data was collected from the experimental and comparison groups prior to exposure to the REds programme. The experimental group participated in the programme and afterwards, both the experimental and comparison groups participated in a post-test. The participants were recruited from the Diepsloot Combined School and the Emfundiswene Primary School in Alexandra, Johannesburg, Gauteng, by using non-probability volunteer sampling.

The quantitative empirical research findings in the experimental group data showed minimal differences between the pre- and post-test data for the ProQol test, and trivial differences in the RSA screening. The comparison group data also showed minimal differences, but the differences were in a downward trend. When comparing the experimental and comparison group findings, the experimental group's results were slightly more positive than the comparison group, but not enough to draw valid conclusions. However, the qualitative findings showed that the participants in the experimental group found that the programme addressed their support needs as HIV and AIDS affected educators and they felt empowered with knowledge and skills that they lacked, thus making them more resilient. The researcher did not mark any changes in the comparison group data, thus indicating that they did not feel empowered.

The researcher hypothesised the following: If the Resilient Educators support programme (REds) were implemented among HIV and AIDS affected educators, their quality of life and resilience will be increased. Conclusions drawn from the qualitative research findings indicated that the REds programme met the support needs of HIV and AIDS affected educators, as the experimental group indicated that they felt empowered and the comparison group did not indicate this. The quantitative data results were not significant enough to prove or disprove the proposed hypothesis, and thus the researcher recommends that the reasons for the insignificant test results from the questionnaires be investigated.

Key words:
Evaluation
Resilient Educators Support Programme
HIV
AIDS
HIV and AIDS affected
Educators
HIV and AIDS affected educators
Empowered
Support
Resilience
Quality of life
Education system

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OPSOMMING

EVALUERING VAN DIE DOELTREFFENDHEID VAN DIE RESILIENT EDUCATORS SUPPORT PROGRAMME VIR MIV- EN VIGS- GEAFFEKTEERDE OPVOEDERS IN GAUTENG

deur

Wya Aike van der Waal

Studieleier: Prof. C.S.L. Delport

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GRAAD: MSW (WERKNEMERHULPPROGRAMME)

Die Resilient Educators Support Programme (REds), ’n ondersteunings program vir MIV-en VIGS-geaffekteerde opvoeders, is in 2006, deur die Noordwes-Universiteit ontwikkel. Die projek spruit uit navorsing wat in 2005 gedoen is en getoon het dat die uitdagings wat MIV-en VIGS-geaffekteerde opvoeders in die gesig staar nie aangespreek word deur die huidige ondersteuningstrukture nie, en dat daar ’n daadwerklike behoefte aan ’n ondersteuningsprogram bestaan.

Die REds-program word in fases geïmplementeer, en in elke fase, word die program heraangepas om aan die behoeftes van ’n breër teikengehoor van opvoeders te voldoen. Sedert die begin van die projek in 2006, is die REds-program deur verskeie onafhanklike navorsers, in vier Suid Afrikaanse provinsies, Gauteng, Mpumalanga, Noordwes en die Vrystaat geïmplementeer.

Die 2009-implementering van die REds-program, het ’n vergelykende groep ingesluit, wat navorsers instaat stel om die data wat ingesamel word te vergelyk met ’n groep wat nie ’n intervensie ontvang het nie. Die 2009-implementering van die REds-program se doel was om vergelykbare data in te samel, en sodoende te bewys dat die program ‘n positiewe impak op die lewensgehalte en veerkragtigheid van opvoeders het.

Die doel van hierdie studie was om te evalueer hoe doeltreffend die 2009-weergawe van die REds-program die lewenskwaliteit en veerkragtigheid van MIV-en VIGS-geaffekteerde opvoeders in Gauteng verbeter.

Vir die doeleindes van hierdie navorsing het die navorser toegepaste en evaluerende navorsing benut. Die gemengdemetode-navorsingsbenadering en die samewerkende triangulasie-ontwerp is benut. Die kwantitatiewe en kwalitatiewe data dra ewe veel gewig in die resultate van die studie. Datastelle is ook saamgevoeg tydens die interpretasie daarvan ten einde deeglik gestaafde gevolgtrekkings te maak. Tydens die vergelyking van die voor- en na-toetsresultate, is die kwantitatiewe en kwalitatiewe data benut om die hipotese te bewys of te weerlê. Vir die kwantitatiewe deel van die studie het die navorser ‘n kwasi-eksperimentele ontwerp, genaamd die groep-vergelykende voor-toets-na-toets-ontwerp benut. Die kwalitatiewe deel van die studie is gedoen met behulp van die kollektiewe gevallestudie-ontwerp.

Kwantitatiewe data is verkry deur twee groepgeadministreerde gestandaardiseerde vraelyste, die Professional Quality of Life Screening (ProQol) en die Resilience Scale for Adults (RSA), te gebruik. Kwalitatiewe data is ingesamel deur gebruik te maak van ’n narratief, tekeninge en observasies. Voor-toets-data is ingesamel by die eksperimentele en vergelykende groep. Die eksperimentele groep het die die REds-program deurloop en beide groepe het daarna deelgeneem aan die na-toets.
Die deelnemers van die Diepsloot gekombineerde skool en die Emfundiswene laerskool in Alexandra, Johannesburg is by wyse van ’n nie-waarskynlikheids-steekproeftrekking gekies, deur van die vrywillige steekproeftegniek gebruik te maak.

Die kwantitatiewe navorsingsbevindinge van die eksperimentele groep het minimale verskille tussen die voor- en na-toets-data getoon vir die ProQol-toets, en niksbeduidende verskille is opgemerk in die RSA-toets. Die vergelykende groep se data het ook minimale verskille tussen die voor- en na-toets getoon, maar hierdie veranderings was negatief. In ’n vergelyking tussen die eksperimentele en vergelykende groep se resultate, is bevind dat die eksperimentele groep se uitslae meer positief van aard was as die van die vergelykende groep. Hierdie verskil is egter so klein dat geen werklike gevolgtrekkings gemaak kan word nie.

Desnieteenstaande het die kwalitatiewe bevindinge getoon dat die program wel aan die eksperimentele groep se ondersteuningsbehoeftes voorsien het. Die deelnemers het aangedui dat hulle bemagtig is met die kennis en vaardighede wat hul benodig om hul veerkragtigheid te verhoog. Die navorser het egter geen veranderinge in die vergelykende groep se data waargeneem nie, wat dus beteken dat die vergelykende groep nie bemagtig is nie.

Die navorser het die volgende hipotese geformuleer: Indien die Resilient Educators support program (REds) onder MIV-en VIGS-geaffekteerde opvoeders geïmplimenteer word, sal hul lewenskwaliteit en veerkragtigheid verbeter. Gevolgtrekkings gemaak na gelang van die kwalitatitewe navorsingsbevindinge toon aan dat die REds-program wel die ondersteuningsbehoeftes van die opvoeders aanspreek, aangesien die eksperimentele groep aangedui het dat hulle bemagtig voel, in teenstelling met die vergelykende groep wat nie bemagtig voel nie. Die kwantitatiewe navorsingsbevindinge was egter van so 'n aard dat die navorser dit nie kon benut om die hipotese waar of vals te bewys nie. Na gelang van hierdie bevinding beveel die navorser onder andere aan dat die rede(s) vir die niksseggende kwantitatiewe toetsresultate verder ondersoek word.

Sleutelwoorde:
Evaluering
Resilient Educators Support Programme
MIV
VIGS
MIV-en VIGS-geaffekteerde
Opvoeders
MIV-en VIGS-geaffekteerde opvoeders
Bemagtig
Ondersteuning
Veerkragtigheid
Lewensgehalte
Opvoedingstelsel

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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.

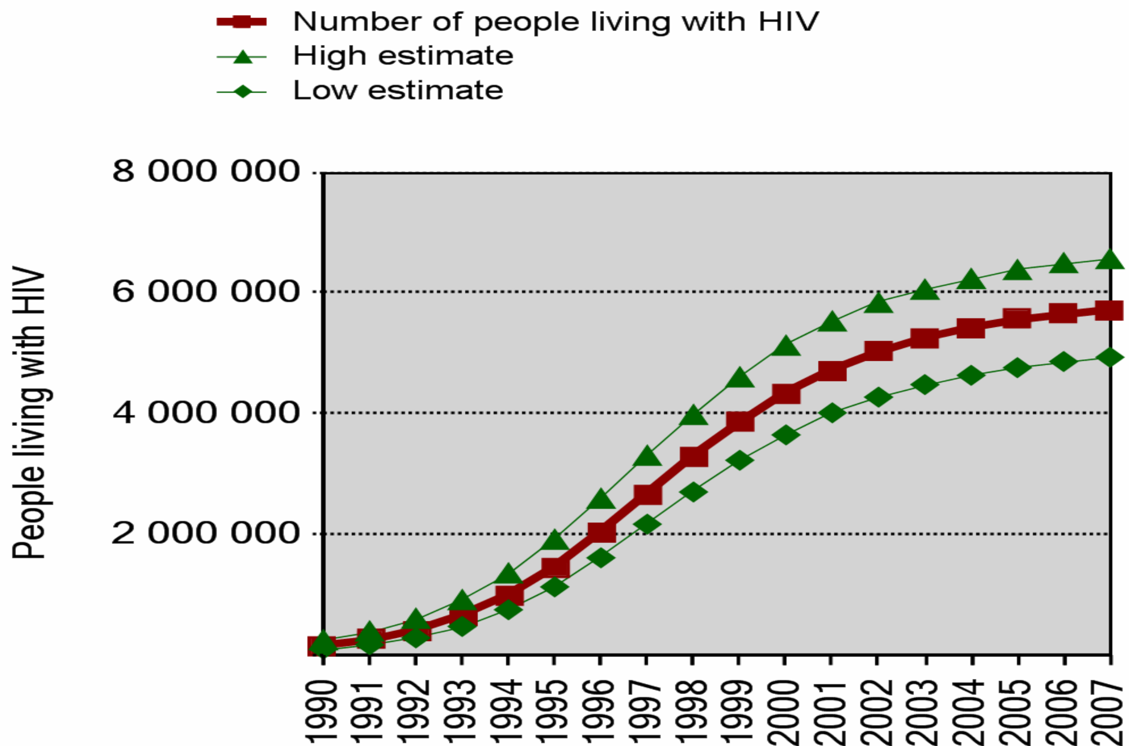

Figure 1-1 People living with HIV and AIDS in 1990 – 2007 in South Africa

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 were 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.

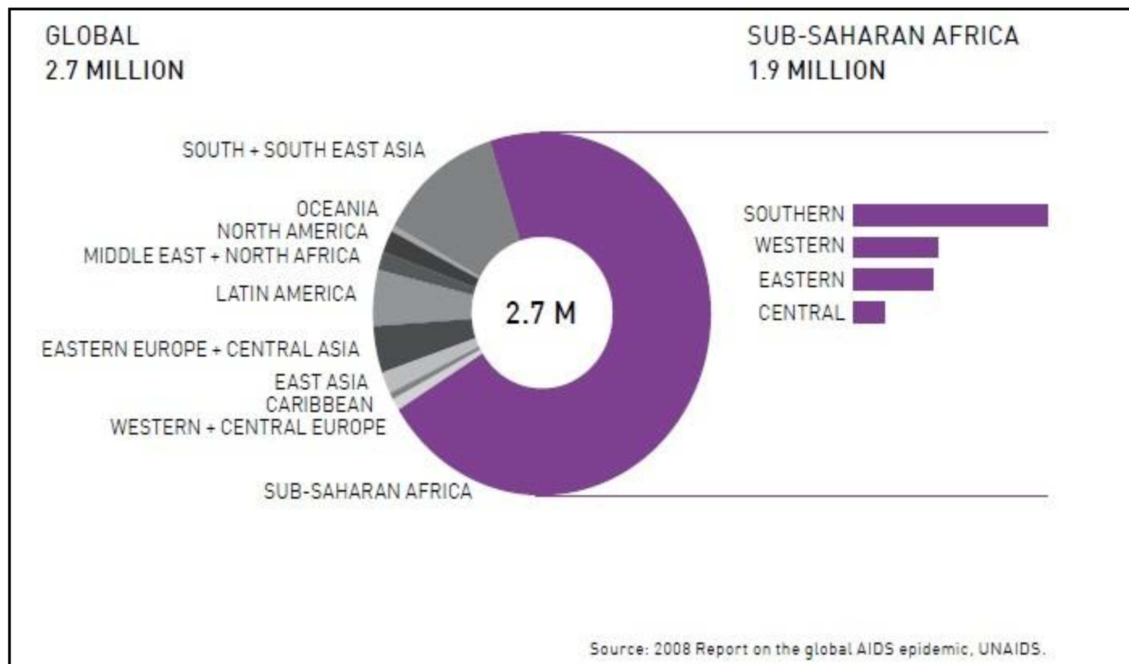

Figure 2-1: Global distribution of new HIV infections in 2007.

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.

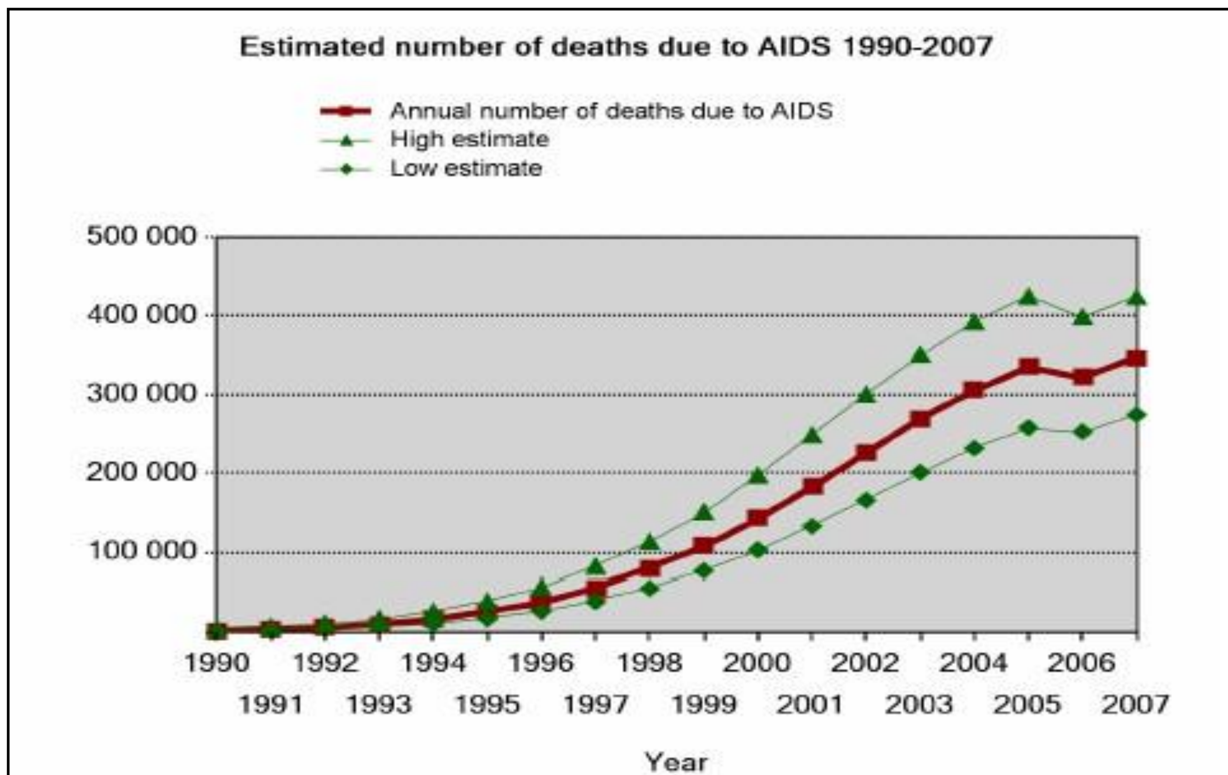

Figure 2-2: Number of deaths due to AIDS in South Africa 1990 - 2007

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.

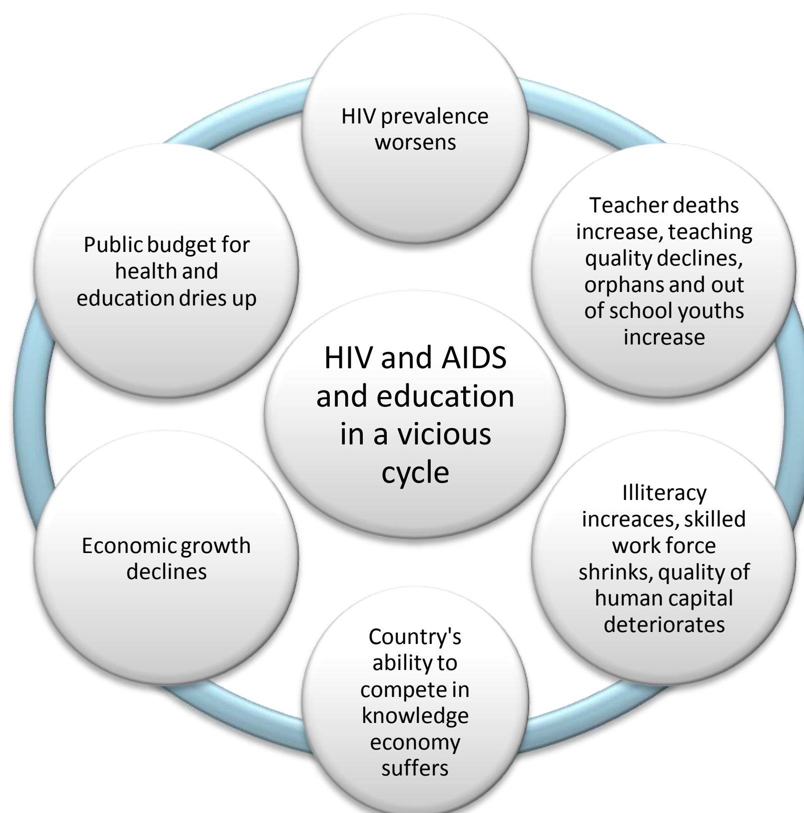

Figure 2-3: The vicious cycle of HIV and AIDS in the education system.

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.

CHAPTER 4

THE RESILIENT EDUCATORS SUPPORT PROGRAMME (REds) FOR HIV AND AIDS AFFECTED EDUCATORS

1. INTRODUCTION

Educators are expected to respond to trends and changes in society (Hall 2004:4-12). Educators' tasks have intensified and one of the consequences of these changes is that educators are left in need of a concurrently advanced repertoire of skills (Hall, 2004:3). The skills that Hall (2004:3) mentions include caring for children, even more so when the social reality is impacted by the negative effects of HIV and AIDS. As previously discussed, it seems as if South African educators do not have the necessary skills to cope effectively with the extra load, and according Bhana *et al.* (2006:6) there are many unacknowledged demands that the pandemic makes upon teachers to care for learners. Specific challenges educators are faced with, according to Bhana *et al*. (2006:7), are raising awareness and preventing infection, assisting the infected and affected and dealing with the trauma of illness and death of significant others. Other authors (Hall *et al*., 2005:27; Schulze & Steyn, 2007:691; Theron, 2007c:175) note that South African educators report similar stressful and burdening experiences. The burden is so severe that Hall *et al*., (2005:27) report that many South African educators who are considering quitting the teaching profession mention the challenges of teaching in an HIV-altered reality as one of the factors motivating their wearing away.

As concluded in Chapter Three, the researcher emphasises the need for a comprehensive support programme to assist HIV and AIDS affected educators to cope better with the pandemic. As Bhana *et al. (*2006:20) puts it: "Planning for professional development and support programmes in schools and the education system needs to [be taken] into consideration. As such, strategies that support and encourage all teachers … in their everyday care work in schools need to be developed and implemented." Kupa (2008:58) defines support as "being there" for one another in a time of need.

The Resilient Educators support programme (REds) for HIV and AIDS affected educators was compiled by the University of the North-West in 2006 to address the support needs of HIV and AIDS affected educators.

According to Theron *et al.* (2008:84), the REds programme has the express aim of empowering affected educators to cope more resiliently with the challenges of the pandemic by supporting educators to respond adaptively to a teaching context that demands responses more typical of counsellors, social workers or medical personnel trained to prevent HIV.

In short, the REds programme aims to equip educators with information and skills to assist them to cope with being HIV and AIDS affected. The programme also aims to empower participants to support other people who are HIV and AIDS affected or infected, irrespective of whether they are in a school environment or not. This means that all HIV and AIDS affected and infected people can benefit from the knowledge imparted by participating in the programme. The programme was developed in 2006, and since then, it was repeatedly implemented in various provinces. The rationale for implementing the programme various times was to create a database of knowledge that would provide sufficient proof and motivation for the REds programme to be implemented nationally. The programme was also a work in progress, and Theron *et al*. (2008:84) state that the programme was changed and adapted after each implementation, according to participant and facilitator feedback. Some of the changes made to the programme 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. (Theron *et al*., 2008:85).

In a personal interview, Theron (2009) said that the methodology of implementing the programme has also changed according to findings in previous rounds.

During the personal interview Theron (2009) explained that, based on previous implementations of the programme, two recommendations were made pertaining to cultural sensitivity and cultural preferences. These recommendations were incorporated as changes in the current REds programme. Theron (2009) also said that some recommendations after the pilot tests were that the pre- and post-test

media (e.g. questionnaires; incomplete sentences) can 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) noted 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 forms part of a third phase of implementation, and one of the changes in this phase of implementation of the programme, was that the research will make use of a quasi-experimental design namely the comparison group pre-test – post-test design. Previously no comparison group was involved, which meant that the researchers could not attribute positive change in measures to the participation in the REds programme.

In this chapter, the researcher will focus on the content of the REds programme and will provide an overview of the implementation process of the Resilient Educators support programme (REds) for educators affected by the HIV and AIDS pandemic.

2. CONTENT OF THE REDS PROGRAMME

The REds programme is, as indicated in Chapter One, an interactive programme, that is to say its success depends on both the facilitator and participants' full engagement in the programme. Theron *et al.* (2008:84) states that the REds programme endorses a participatory approach. The REds programme participant activities includes reflection, compiling and sharing inventories of community resources, art therapy, music therapy, gestalt work, role-play, visualisation, debate

and discussion. The facilitator is allowed to work with a group of 8 to 10 members at a time for meaningful impact.

The programme consists of nine sessions, covering seven modules, with each session lasting about two hours. The modules cover the following themes: health promotion; the psychosocial impact of HIV on educators and learners; supporting infected and affected people; stigma and discrimination; HIV related education policy and resilience (Theron *et al.,* 2008:84). In order to keep the programme from becoming a lecture, the programme is set up in such a way that the concepts are explored within the participants' context. Theron *et al.* (2008:84) notes: "instead of informing participants about the impacts of the pandemic on educators, they are encouraged to define how the pandemic impacts them and their communities. Participant knowledge and experiences are then supplemented by documented definitions, theories and recommended practices compiled from existing literature, therapeutic programmes and online resources." The pre- and post-tests form part of the programme, which brings the total number of meetings to eleven. The themes that the REds programme addresses are presented in different modules. In order to clarify and discuss the themes, each session will be discussed according to the following components:

- Objectives of the session;
- Facilitation material; and
- Content and process of implementation.

2.1 Session 1: Informed consent and pre-tests

The objectives of session one is:

- To discuss ethical issues and explain informed consent forms with the group;
- To facilitate the signing of informed consent; and
- To complete a pre-test.

Facilitation materials:

- Informed consent letters as approved by the Ethical Committee of the University of Pretoria; and.
- Pre-test consisting of two quantitative measuring instruments and two qualitative data collection instruments.

Content and process:

- The informed consent letters are thoroughly explained and signed by all participants prior to participation in the pre-tests.
- The participants are asked to complete a pre-test consisting of the following:
    - Professional Quality of Life Screening (ProQol) developed by Stamm (2005). This measure has been internationally used to determine quality of life with specific emphasis on the variables satisfaction, burnout and fatigue among school personnel (Stamm, 2005:9).
    - The Resilience Scale for Adults (RSA) developed by Hjemdal (2007) to test a person's level of resilience.
    - The writing of a narrative. In the context of this study, the probe for the writing of a narrative requests a participant to write about his/her life as a teacher in the era of HIV and AIDS. The objective of the narrative is to assist the researcher in contextualising how life is when teaching people infected and affected with HIV and AIDS.
    - A free drawing, with the probe "draw something that symbolises how HIV and AIDS have affected you" also form part of the pre-test. The participant is also requested to briefly explain his/her drawing with two sentences.

2.2 Session 2: Introduction

The objectives of session two are:

- For group members to get to know one another;
- To explore the key concepts related to the REds programme;
- To explore the ethical boundaries governing the REds programme; and
- To determine group rules for the REds programme.

Facilitation materials:

- The symbolic worksheets;
- A narrative of Yulia and Mukasa;
- A poem by P. Nelson; and
- Reflective worksheets.

Content and process:

An icebreaker is used to get all participants relaxed and introduced to one another. The impact that the pandemic has on each individual is explored by making use of a symbolic handout. Participants are asked to explain the impact HIV and AIDS has on them by choosing a symbol, and explaining what it signifies.

The concepts of being infected and affected are explored, by making use of a narrative. The following core concepts are explored:

- What it means to be affected by HIV and AIDS;
- What support is; and
- What resilience is.

The participants' understanding of the concepts is supplemented by facilitation.

The purpose of the REds programme is discussed, and expectations of each participant from the REds programme explored. The session is concluded by establishing group rules and times when the meetings would take place. A reflective worksheet asking feedback of the session completes the session, and a poem is read to the participants.

2.3 Session 3: Health education on staying healthy despite the HIV and AIDS pandemic

The objectives of session 3 are:

- To be knowledgeable on the facts of HIV and AIDS;
- To be less afraid of HIV regarding myths about transmission; and
- To feel more confident and comfortable because individuals are more able to help themselves and others.

Facilitation materials:

- Narrative of Yulia and Mukasa;
- Common myths;
- Facts about HIV and AIDS as per the REds programme manual;
- Preventing HIV transmission at home as per the REds programme manual;
- Phases of HIV and AIDS as per the REds programme manual; and
- Reflection worksheets.

Content and process:

The narrative of Yulia and Mukasa is used to illustrate the facts of HIV transmission. Common myths that participants are aware of is discussed next, and the myths are dispelled by making use of the facts of HIV and AIDS, as per the REds programme manual.

The participants are asked to list methods of prevention of HIV transmission at home, which are elaborated on based on the REds programme manual.

The different phases of HIV and AIDS are discussed by making use of the content of the manual.

The session is ended with the completion of a reflection worksheet.

2.4 Session 4: How to give and gain support

The objectives of session four are:

- To provide information regarding resources for educators:
- To provide information regarding supportive resources for orphans and vulnerable children (OVC's);
- To provide some grief and bereavement skills for educators; and
- To provide grief and bereavement skills for learners who are confronted with death and coping with grief.

Facilitation materials:

- Handouts on how to support and help OVC's;
- Crayons and poster paper for resource's list;
- Example of a memory box;
- Clay; and
- Reflection worksheets

Content and Process:

The session is started with an icebreaker to illustrate trust. The facilitator and the participants share ideas on what can be done to give support to each other, what support resources are available in the community for HIV and AIDS affected and infected people. Participants compile a list of local support structures and services available. This list is distributed to all participants.

Grieve and bereavement skills are discussed. Participants are asked to share personal testimony of how they each deal with grief, and in this manner awareness is created for the unique grieving process of each individual.

Orphans and vulnerable children are discussed, and ways to support vulnerable children are discussed. How to deal with a grieving child is examined, and solutions like making a memory box are discussed. Other ways to deal with grieving children are discussed, and a case study is used to explain to participants how the concept of death can be explained to a child.

The session is concluded by the completion of the reflection worksheet.

2.5 Session 5: Health education on staying healthy despite the HIV and AIDS pandemic and nursing loved ill ones

The objectives of session five are:

- To be less afraid of HIV and AIDS regarding
  - Caring for the sick at home;
  - Infection comparison at home;
  - Use of medication – basic principles;
- To learn to do things which will help infected to stay healthy;
- To care for the dying;
- To know how to identify and manage common AIDS-related health problems in the home;
- To recognise danger signs and learn when and how to seek for help; and
- To assist educators to feel more confident and comfortable by enabling them to help themselves and their family members.

Facilitation materials:

- Facilitator's and participants' manuals; and
- Reflection worksheets.

Content and process:

Caring for the sick at home is addressed according to the REds programme manual. Participants are asked to share their own knowledge and discussion and participation is encouraged.

Tips on infection comparison are shared, and various aspects, like universal precaution, basic hygiene as well as the use of medication are explained. Care for the dying is also addressed.

The management of common AIDS-related health problems are discussed. The REds programme manual contains 21 common health problems – the facilitator can decide to discuss all, or ask the participants to choose those they want to discuss.

The session is concluded by the reflection worksheet.

2.6 Session 6: How to cope with stigma

The objectives of session six are:

- To explore the concept of stigma;
- To explore options for addressing stigma; and
- To explore some coping skills regarding stigma.

Facilitation materials:

- Handout with seven pictures depicting stigma;
- Old magazines; crayons; glue; scissors and pencils for making collages about a school/community without stigma;
- Handout on inspiring thoughts by an unknown author; and
- Reflection worksheets.

Content and process:

Sessions 1-5 are recapped. The concept of stigma is introduced. Seven pictures depicting stigma are discussed in terms of the type of stigma each picture depicted. Participants are asked to define stigma.

The session focuses on secondary stigma, and examples of secondary stigma is given out of participants' own lives. The fact that stigma is fuelled by fear is discussed, and strategies are addressed to tackle stigma. Participants are asked to recognise ways in which they themselves are stigmatising others.

Finding a common language for stigma is discussed and encouraged by the words of Doro, as used in the REds programme manual developed by Theron (2007a:86).

Participants are asked to create a collage from old magazines and drawings to depict a world/school where no stigma exists. The pictures are discussed with the group afterwards.

Participants also work with some ideas brought about by the Change Project (2005:64) on addressing stigma on a personal and community level.

The session is concluded by the completion of the reflection worksheet.

2.7 Session 7: Workplace policies on HIV and AIDS

The objectives of the session seven are to provide information on:

- Legislation on HIV and AIDS in education;
- Educators rights with regard to discrimination in the context of HIV and AIDS;
- Educators rights with regard to absenteeism and leave in the context of HIV and AIDS;
- Educators rights with regard to protection at school against HIV and AIDS; and
- A supportive environment in the context of HIV and AIDS.

Facilitation materials:

- Quiz 1 on educators' rights with regard to discrimination in the context of HIV and AIDS;
- Quiz 2 on educators' rights with regard to leave;
- A plastic cup;
- Handout on "put the glass down" from an unknown author; and
- Reflection worksheets.

Content and process:

The concept of rights are introduced to the group by using an icebreaker that involved giving each participant a glass of water to hold in the air for about 10 minutes, and observing their reaction. The reactions are then discussed, highlighting the right to choose to keep holding the cup or not.

Participants are asked to fill out Quiz 1 on educators' rights with regard to discrimination in the context of HIV and AIDS. Their answers are discussed, and

that formed a platform for discussion of the *Department of Education's workplace policy on HIV and AIDS (1999).*

The second activity involves completing Quiz 2 on educators' rights with regard to leave. The responses are discussed, and additional clarifications can be made using the REds programme manual.

The next topic of discussion is how to protect people potentially exposed to HIV and AIDS. The availability, content and current state of first aid kits are explored, and participants are asked to take charge of the first aid kits at school.

A supportive school environment is discussed, as well as the Educator Support Team and the Health Advisory Team. If the above-mentioned are lacking at the school, the participants are encouraged to take the necessary steps to ensure that it is established at the school to assist in creating a supportive school environment.

The session concludes with the reading of an inspirational text "Put the glass down" and the completion of reflection worksheets.

2.8 Session 8: How to cope with stress

The objectives of session eight are:

- To explore the concept of stress; and
- To explore mechanisms for addressing stress.

Facilitation materials:

- Clay;
- Tape recorder;
- Relaxation music and exercise; and
- Reflection worksheet.

Content and process:

Participants are each given a ball of clay, and are instructed to make something out of the clay that symbolises stress to them. Relaxing music is played, talking discouraged, and each person is encouraged to be busy with his or her own emotions and stressors. Participants are requested to share their symbol with the rest of the group.

A stress list is then completed, and compared with that of another participant. Participants are asked to define stress in their own words, and to discuss their personal stress symptoms. Feedback is given to the larger group.

Steps to manage stress are discussed next, and participants are asked to write a modified response to three items on their individual stress list. Irrational beliefs that cause stress are discussed, and participants are asked to identify common irrational beliefs that they have, and to formulate arguments to combat these beliefs. Feedback is given to the larger group in this regard. Participants are then reminded of tips to manage stress, and are asked to draw up a joy list.

Work stress is discussed next, and ways to reduce environmental stress is considered. Time management is a crucial aspect that increases work stress, and an exercise on time management should be completed. Time wasters must also be explored.

The session is concluded by completing a relaxation exercise, and completing reflection worksheets.

2.9 Session 9: Being resilient in a pandemic

This is the second last session of the programme, and the objectives are:

- To contemplate participant resilience;
- To contemplate further steps towards resilience;
- To emphasise our connectedness to others for the purposes of resilience; and
- To conclude resilience.

Facilitation materials:

- Reflection worksheets.

Content and process:

As an icebreaker, participants are asked to think of the most resilient person they know, and to discuss why they viewed the person as being resilient.

The definition for resilience is revisited, and six steps towards resilient functioning are discussed. Do the following activities: ask participants to think of ways to manage the impact of HIV and AIDS in their own communities; ask participants to make a list of people and organisations that they can connect to and ask them to visualise hope.

Participants are encouraged to share their personal steps and experiences towards gaining resilience. They are also invited to share with the group how they think their own resilience might have grown because of their participation in the REds programme.

Participants are reminded that they are busy with the second last session of the REds programme, and that the next session will be the last.

The session is concluded by an inspirational reading of "the A – Z of resilience" and the completion of reflection sheets.

2.10 Session 10: Conclusion and Post-tests

The objective of the last session:

- To conclude the REds programme and conduct the post-tests.

Facilitation materials:

- Attendance certificates;
- REds questionnaires; and
- Post-tests.

Content and process:

Participants are requested to list things that empower them to do things for their community to help limit the impact of the pandemic, and to think of steps they themselves can take to start coping better. They are encouraged to implement the knowledge gained and to learn from it.

- Participants are debriefed.

- The participants are asked to complete a post-test consisting of the following:
    - Professional Quality of Life Screening (ProQol) developed by Stamm (2005). This measure has been internationally used to determine quality of life with specific emphasis on the variables satisfaction, burnout and fatigue among school personnel (Stamm, 2005:9).
    - The Resilience Scale for Adults (RSA) developed by Hjemdal (2007) to test a person's resilience.
    - The writing of a narrative. In the context of this study, the probe for the writing of a narrative requests a participant to write about his/her life as a teacher in the era of HIV and AIDS. The objective of the narrative is

to assist the researcher in contextualising how life is when teaching people affected with HIV and AIDS.

- A free drawing, with the probe "draw something that symbolises how HIV and AIDS have affected you" also forms part of the post-test. The participant is also requested to briefly explain his/her drawing with two sentences.

3. CONCLUSION

As earlier mentioned, the REds programme is an interactive programme, and it endorses a participatory approach (Theron *et al.,* 2008:84). Therefore, it is crucial that the programme is presented in such a way that all participants are involved. The researcher should use group work facilitation techniques and strategies such as probing, brainstorming, and discussions to assist in the presenting of the REds programme. The use of these techniques will encourage participants to share their views and give input. This can lead to very interesting discussions, which in turn can lead to the dispelling of various myths and misconceptions about HIV and AIDS. The fact that the participants can take part actively increases their own learning experiences.

Collins (2004:1485) clarifies the following principles that apply in adult learning: "Adults have accumulated a foundation of life experiences and knowledge, and adults learn best when they are active participants in the learning process." This implies that when teaching or empowering adults, one has to capitalise on their life experiences and knowledge, which is exactly what the REds programme achieves by its participatory approach.

The researcher plays the role of facilitator in the group, and according to Drower (2005:113), the role of the facilitator is to support the development of group identity through emphasising commonality and encouraging inter-member communication. This role is utilised in every session, and it aims to assist group members to become a mutual aid system in which members are facilitated to lend their resources and strengths to each other.

The next chapter will deliberate on the research results, analysis and interpretation of qualitative and quantitative data gathered from participants and the comparison group before and after exposure to the REds programme.

CHAPTER 5

EMPIRICAL RESEARCH FINDINGS

1. INTRODUCTION

The goal of Chapter Five is the analysis and interpretation of qualitative and quantitative data gathered from the participants. The aim is to establish, using data gathered, whether or not the Resilient Educators support programme (REds) for HIV and AIDS affected educators was effective to enhance the quality of life and resilience of HIV and AIDS affected educators in Gauteng.

The researcher will firstly list the goal and objectives of the research study, after which the research methodology will be discussed. This will be followed by an analysis and interpretation of both qualitative and quantitative research findings. The researcher will discuss the two types of data gathered separately.

2. 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. 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 support programme in order to implement it on a national level.

4. RESEARCH METHODOLOGY

The following research methodology was used:

4.1 Research approach

According to Thomas (2003:7) qualitative and quantitative research methods are each suitable to answer a certain type of question. The researcher agrees with Thomas (2003:7) when he states that it is sometimes necessary to utilise both methods in order to achieve certain research outcomes. The mixed methods approach was suitable to address the research problem of this study. Creswell and Plano Clark (2007:5) define mixed methods research as an approach to collect, analyse and mix both quantitative and qualitative data in a single study or series of studies. It aims to use the quantitative and qualitative approaches to understand a research problem more completely. Ivankova, Creswell and Plano Clark (2007:261) further note that the researcher collects both numeric information (e.g. scores on survey instruments) and text information (e.g. drawings and narratives). 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.

The quantitative data assisted in determining the participants' quality of life and resilience before and after the implementation of the programme. By making use of standardised tests, the researcher was able to statistically compare the results of the pre- and post-tests.

The qualitative data assisted the researcher in determining which emotions the participants experienced when they were asked to think of the impact HIV and AIDS has had on them personally. By using narratives and drawings before and after the implementation of the programme, the researcher was able to identify themes that also assisted in validating the hypothesis.

4.2 Type of research

Fouché and De Vos (2005a:105) describe applied research as the scientific planning of induced change in a troublesome situation. This description is relevant to the researcher's study, as part of the goal was to identify possible solutions to the proposed problem of resiliency of HIV and AIDS affected educators.

In the context of applied research, the researcher used evaluative research. Evaluative research is used to assess the design, implementation and applicability of social research (Fouché & De Vos, 2005a:108). Babbie and Mouton (2001:334) state that evaluation research refers to a research purpose rather than a research method. Babbie (2001:333) as cited by Fouché and De Vos (2005a:108) also notes that evaluation research can be regarded as "the process of determining whether a social intervention has produced the intended result." A key element of all evaluation studies is the intervention or programme that is being evaluated. This statement supports the researcher's choice, because the evaluation of the effectiveness of the REds programme was the main theme of this research project.

4.3 Research design

A research design is, according to Mouton (2001:55), the blueprint according to which the research is done. According to Fouché and De Vos (2005b:132) the definitions for research design are ambiguous. Therefore, for the purpose of this study, the researcher will concur with the view of Fouché and De Vos (2005b:133), who state that the term research design will be used for worked out formulas from which researchers can select a design suitable for the proposed project.

As previously mentioned the researcher used a mixed methods research approach. Creswell and Plano Clark (2007:59) define four major types of mixed methods research designs. These designs are the triangulation design, the embedded design, the exploratory design, and the explanatory design. For the purpose of this research, the researcher has chosen the concurrent triangulation design. The design can graphically be displayed as shown in Figure 5-1:

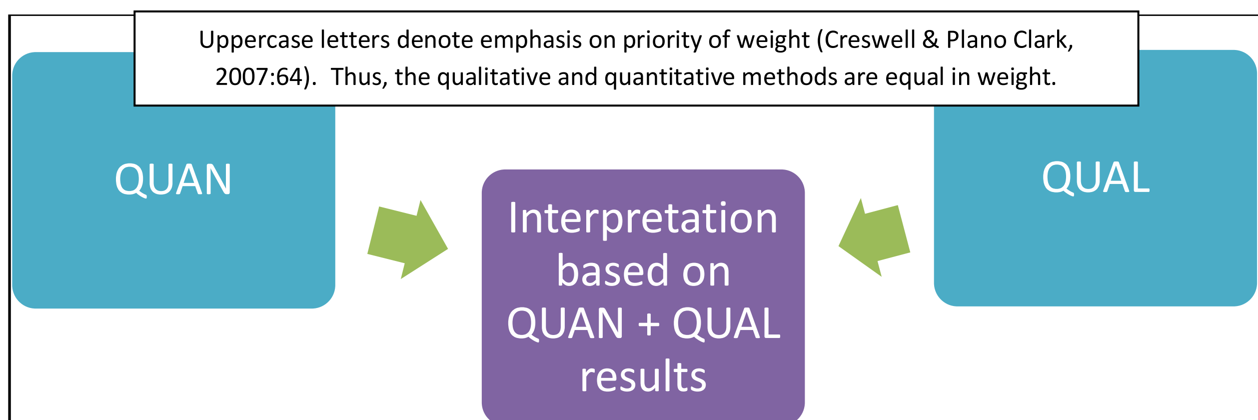

Figure 5-1: Concurrent triangulation design

According to Creswell and Plano Clark (2007:62), this design is relevant when researchers implement the quantitative and qualitative methods during the same timeframe and with equal weight in the same study. The REds programme is designed to give equal weight to the qualitative and quantitative measures. The pre-test and post-test include two quantitative measures and two qualitative measures. Creswell and Plano Clark (2007:64) note that the researcher attempts to merge the two data sets, by typically bringing the separate results together in the interpretation. Cherlin *et al.* (2005) as cited by Ivankova *et al.* (2007:272) state that triangulation can be used to compare quantitative and qualitative data sets to produce well-validated conclusions. The REds programme does exactly this – the qualitative and quantitative 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 prove or disprove the null hypothesis.

Embedded in the triangulation mixed methods design the following quantitative and qualitative designs were respectively utilized:

4.3.1 Quantitative research design

For the quantitative part of the study, the researcher used a quasi-experimental design namely the comparison group pre-test – post-test design.

The comparison group pre-test – post-test design is, according to Fouché and De Vos (2005b:140), an elaboration on the one group pre-test – post-test design, by adding a comparison group. Fouché and De Vos (2005b:139) state that with a pre-test – post-test design the researcher is attempting to measure the dependent variable/s when no independent variable is present. For the purpose of this study the dependent variables (HIV and AIDS affected educators' quality of life and resilience) were tested with a pre-test (O_1), using standardised measuring instruments, namely the Professional Quality of Life screening (Stamm: 2005) as well as the Resilience Scale for Adults (RSA) (Hjemdal, 2007:307), administered to both the experimental and the comparison groups. After the pre-test, the independent variable X (the REds programme) was introduced to the experimental group. After the implementation of the programme, a post-test (O_2) 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 then compared to determine if the independent variable X (the REds programme) 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.

As the focus of this study is on HIV and AIDS affected educators, the researcher selected two groups of educators from similar demographic and socio-economic contexts. The schools were not too close to one another, to ensure that the participants in the comparison group were not able to have contact with those in the experimental group. Thus, to prevent the contamination of data, the participants were selected from two different districts with the same basic demographics. Eleven educators volunteered from a school in Alexandra (district 9) in Johannesburg (comparison group) and another group of seven educators from a school in Diepsloot (district 12) in Johannesburg (experimental group) volunteered. The participants were not randomly selected – they were asked to volunteer. According to Babbie and Mouton (2001:351), this sampling method is valid because in evaluation research it is often impossible to select participants randomly.

After the post-test has been conducted, the REds programme will be implemented with the comparison group. This will be done to comply with ethical standards set out by the University of Pretoria. The data that was gathered from the comparison group after the implementation of the programme did not form part of this specific study. This data were used as data in the greater REds programme.

4.3.2 Qualitative research design

For the qualitative part of the study, the researcher was interested in the participants' experiences and feelings about their lives in the era of HIV and AIDS, and how they felt this pandemic has affected them. In order to gain this information, the researcher needed to do a collective case study. A case study is defined by Babbie and Mouton (2001:640) as an intensive investigation of a single unit while Fouché (2005:272) cites Creswell (1998:61) in saying that a case study can be regarded as an exploration or in-depth analysis of a bounded system. Fouché (2005:272) further notes that when multiple cases are involved it is referred to as a collective case study.

Mark (1996:219) as cited by Fouché (2005:272) defines a collective case study as follows:

> The collective case study furthers the understanding of the researcher about a social issue or population being studied. The interest in the individual case is secondary to the researcher's interest in a group of cases. Cases are chosen so that comparisons can be made between cases and concepts and so that theories can be extended and validated.

The researcher utilised the collective case study design in order to understand the experiences of HIV and AIDS affected educators as a specific population as well as the fact that the researcher would like to explore the influence that the REds programme had on the wellbeing of the group rather than that of the individual.

5. DATA COLLECTION METHODS

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.

5.1 Quantitative data collection method

The choice of quantitative data collection methods is listed by Delport (2005:166) as questionnaires, checklists, indexes and scales. For the purpose of this study, the REds programme stipulates making use of two questionnaires and specifically group administered standardised questionnaires to collect quantitative data.

A questionnaire is defined by Babbie and Mouton (2001:646) as a document containing questions and other types of items designed to solicit information appropriate to analysis. Thomas (2003:66) notes that questionnaires are used to obtain two types of information: facts and opinions. The group-administered questionnaire is defined by Delport (2005:169) as a method where participants who are present in a group each complete a questionnaire on their own. The field worker is present to answer questions or to clarify items in the questionnaire.

The REds programme developer included two standardised questionnaires in the programme that were used to collect quantitative date. The first questionnaire was called the Professional Quality of Life Screening (ProQol), and was developed by Stamm (2005) (see Annexure 6 & 10). This measure has been internationally used

to determine quality of life with specific emphasis on the variables compassion satisfaction, burnout and secondary trauma among school personnel (Stamm, 2005:9). The variables were defined in Chapter 3. The other standardised questionnaire was the Resilience Scale for Adults (RSA) developed by Hjemdal (2007:307) (see Annexure 7 & 11). The RSA tests a person's level of resilience. The factors used to measure resilience were discussed in Chapter 3. The ProQol and RSA were used before and after programme implementation with HIV and AIDS affected educators in the experimental group. The tests were also conducted in the comparison group, but they did not participate in the programme. The results of the pre- and post-test 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.

5.2 Qualitative data collection

The researcher used a narrative, drawings and observation to collect qualitative data.

Creswell (1998) as cited by Fouché (2005:269) states that a biography refers to any biographical writing or biographical research. Woodgate (2006:9) notes that illness narratives are variants of biographical writing or biographical research that describe special events of self-stories. According to Morgan (2000:5), humans seek to attach meaning to their daily experiences. Human beings' life stories are written by linking certain events together in a particular sequence, across a time-period, and finding a way of explaining and making sense of them. A narrative, according to Morgan (2005:5), is like a thread that weaves events together, forming a story. Hyden (1997) as cited by Woodgate (2006:9) says that the creation of the families' narratives helped to confirm the paradigmatic relationships of the emerging theoretical categories as they provided a basis for understanding how illness affects the children's and families' biographies by contextualizing cancer-related events. The researcher is of the opinion that even though this research (Woodgate, 2006) was conducted with cancer patients, it is also valid with HIV and AIDS affected people because AIDS is also a terminal illness, and narratives of people working with HIV and AIDS will provide a basis for understanding how the virus and syndrome affects the educators and children.

In the context of this study, the probe for the writing of a narrative asked the participants to write about their life as an educator in the era of HIV and AIDS – this (see Annexure 9 & 13) assisted in contextualising how life is when educating people affected with HIV and AIDS.

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 (see Annexure 8 & 12). Kellman (1995) as cited by Ahn and Filipenko (2007:280) notes that drawing, painting and three-dimensional art not only allow children's narratives to emerge naturally, but permit researchers to use these visual narratives as a way to interact with children, thus serving as a catalyst allowing children to communicate thoughts and concerns. According to Ray, Perkins and Oden (2004) as cited by Ahn and Filipenko (2007:282) drawings give a child an opportunity to speak in another language, one that allows him or her to communicate via images rather than language alone. The researcher is of opinion that this technique can also be used successfully with adults. This opinion is supported by research done by Rober (2009).

Rober (2009) used relational drawings in couple therapy. Rober (2009:117) explained that the drawings are used as tools to offer partners a special kind of lens through which they can observe themselves in their relationship from a distance. In the REds programme, the participants were asked to make drawings in order for them to communicate on another level, as well as to assist in observing their experiences from a distance. 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 2-3 sentences to explain the drawings. From these explanations, the researcher was able to identify themes. The aim of using the drawings was to ensure that all possible data is collected, and that the research findings reflect the true effectiveness of the REds programme.

The researcher also used an observer to make observations during the implementation of the REds programme. The observer formed part of the group and she observed the behaviour, verbal and non-verbal communication in the group. After each session, the researcher discussed the observations made by the observer

with her. The researcher found that the observer's comments were valuable, as she understood the context of the participants, and was able to give very practical input, because she is part of the lives and daily routine of the participants. This correlates with the view of Strydom (2005:277) who describes the role of the participant observer as "becoming part of their lives." The observer still actively participated in the group, and thus her role of observer did not interfere with her role as participant. The researcher used a person who spoke the same language as the participants to assist in this task. Observation was utilised to monitor the interaction of group members – both verbal and non-verbal. Rosnow and Rosenthal (1999:97) define observation as looking at events in an unobtrusive way, without trying to change or affect the event one is observing.

6. DATA ANALYSIS

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

6.1 Quantitative data analysis

Kruger, De Vos, Fouché and Venter (2005:218) clarify that data analysis in quantitative research means ordering, categorising, manipulating and summarising of data to obtain answers to research questions. The purpose of analysis is to reduce data to an interpretable form, so that relations can be identified and conclusions can be drawn.

The quantitative data generated from the standardised questionnaire (ProQol) and the Resilience Scale for Adults (RSA) were marked and analysed by the Statistical Services of the Vaal Triangle campus of the University of the North-West. The statistical analysis was conducted according to the manual for the ProQol (Stamm, 2005) and focused on comparing the results of the pre- and post-tests, and then displaying it by means of tables and graphic presentations. The statistical analyst made use of univariate analysis, which means that the variables are analysed, mainly with the view to describe the variables (Kruger, De Vos, Fouché & Venter, and 2005:222). The statistical analysis for both the ProQol (Stamm, 2005) and the RSA were descriptive. The RSA has a similar way of statistical analysis as described by Hjemdal *et al.* (2006:87).

To ensure the reliability and validity of the quantitative data, the researcher used standardised questionnaires. The fact that the questionnaires were standardised, means that the reliability and validity are already tested. The researcher also used a triangulation research design (Creswell & Plano Clark 2007:64), which also ensures that the data is both reliable and valid, because more than one method of data collection was used.

6.2 Qualitative data analysis

The narratives, drawings and observation field notes were studied and the researcher used content analysis to identify themes and seek to understand meaning.

The narratives were analysed by making use of content analysis. Content analysis is, according to Dane (1990:170), a research method that can be used to make objective and systematic inferences about theoretically relevant messages. This means that content analysis assists the researcher in understanding the meaning of communication. Berg (2007:303) defines content analysis as a careful, detailed, systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases and meanings. According to Babbie and Mouton (2001:492), this method is used to make inferences by objectively and systematically identifying messages and characteristics in data. Berg (2007:304) cites Maxfield and Babbie (2006) in saying that content analysis is chiefly a coding operation and a data interpreting process.

The following methods were used:

- Coding, this is defined by Berg (2007:235), as a process of identifying central issues, themes or theories that emerge during the course of data analysis, and tagging them. In this study, the researcher tagged words and phrases from each narrative to indicate that a certain theme has been identified.
- Data interpreting – the process in which the researcher took the themes derived from the coding process, and searched for patterns, relationships and commonalities in the codes.

The drawings were analysed using face value interpretation without any theoretical frame of reference.

The following methods were used to ensure trustworthiness in the qualitative data analysis:

- Triangulation (Creswell & Plano Clark, 2007:64) was used as a research design and multiple methods of data collection were used.
- The method of drawings and narratives were discussed with colleagues and modified prior to commencement of research.
- Experienced colleagues were asked to "audit" identified themes in data and the interpretation thereof (Glesne, 2006).
- The drawings were clarified by the participants, by asking them to write one or two sentences about the meaning of their drawings. This means that the researcher interpreted the drawings of the participants based on their description of the drawing.

7. DESCRIPTION OF THE POPULATION, SAMPLE AND SAMPLING METHOD

7.1 Research population

A universe, according to Arkava and Lane (1983) as quoted by Strydom (2005b:193) is defined as all the potential subjects who possess the attributes in which the researcher is interested. Due to the type of study, all HIV and AIDS affected educators in Gauteng formed the universe of the study.

A population on the other hand is defined by Babbie and Mouton (2001:173) as the theoretically specified aggregation of study elements. The population of this study was all the HIV and AIDS affected educators in the Teaching Districts 9 and 12 in Johannesburg, Gauteng.

District 9 includes the whole of Alexandra in Johannesburg. Alexandra is a township, situated on the banks of the Jukskei River. According to the City of Johannesburg Alexandra Renewal Project (2009), the township covers an area of more than 8 km² and has an estimated population of 470 000 people. In addition to its original,

reasonably well built houses, it also has a large number (estimated at more than 20 000) of informal dwellings or shacks. Alexandra is one of the poorest urban areas in the country. The school participating is only one of many schools in Alexandra.

District 12 includes the whole of Diepsloot. Diepsloot is in the north of Johannesburg. According to the City of Johannesburg Diepsloot Development Program (2009), Diepsloot is a sprawling, densely populated settlement made up of formal and informal settlements. The formal townships of Diepsloot comprise about 7139 households. However, it is in the informal settlements where the largest numbers of people live: about 15 900 families. Diepsloot is home to about 250,000 people; many of them live in 3m-by-2m shacks. City officials estimate that half the population in the settlement is unemployed. The two districts are similar in demographics – both have very large informal settlements, and poverty and unemployment rates are high in both areas. Thus, the researcher concluded that due to the similarity of the populations, they could be included in the population without compromising the validity of the study.

A sample is defined by Fouché and Delport (2005:82) as a small representation of the whole. In the context of this study, one sample of 11 HIV and AIDS affected educators from one school in district 9 in Johannesburg, Gauteng, volunteered to participate in the study. This group was the comparison group. The experimental group consisted of a sample of 7 volunteer HIV and AIDS affected educators from one school in district 12 in Johannesburg, Gauteng.

7.2 Sampling method

As earlier stated, the researcher did not randomly assign subjects for the study. Thus, she used non-probability sampling. Non-probability sampling is defined by Babbie and Mouton (2001:644) as a sample selected in some fashion other than any suggested by probability theory.

The researcher used a combination of volunteer and 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. Due to attrition, the researcher only used the data of 7 HIV

and AIDS affected educators in the experimental group, and 11 HIV and AIDS affected educators in the comparison group. The fact that participants dropped out is one of the limitations of this study. The researcher discussed the limitations in Chapter One. Volunteer sampling is described by Strydom and Delport (2005:330) as a method that is used in qualitative research, where volunteers come forward to participate in the study. Strydom and Delport (2005:330) cite Silverman (2000) who notes that volunteer sampling works well when the participants are known to one another or at least aware of one another and can encourage one another to become involved in the study. In a school environment, this type of sampling works well, because educators motivate one another to participate. Strydom (2005b:202) defines purposive sampling as a sample that is based entirely on the judgement of the researcher, and it is composed of elements that contain the most characteristic, representative or typical attributes of the population. For this study, the participants consisted of volunteers purposively selected by volunteer sampling. The following criteria were used to select the participants for this study:

- They should be teachers 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.

8. EMPIRICAL FINDINGS

This section will focus on the biographical profile of the participants as well as the actual analysis and interpretation of both quantitative and qualitative research findings. The researcher has divided the information in terms of Section A (Biographical profile), Section B (Quantitative findings) and Section C (Qualitative findings) to ensure that the data is presented in a format that is structured and easy to follow.

SECTION A: BIOGRAPHICAL PROFILE OF PARTICIPANTS

The research project consisted of two groups of participants, namely the experimental group, consisting of 7 HIV and AIDS affected educators, and the comparison group, consisting of 11 HIV and AIDS affected educators. The profile of both groups will be presented separately.

9. BIOGRAPHICAL PROFILE OF THE HIV AND AIDS AFFECTED EDUCATORS

The biographical profile of the experimental and comparison groups encompasses gender and age. These are displayed as follows:

9.1 Gender

The data is presented in Figure 5-2.

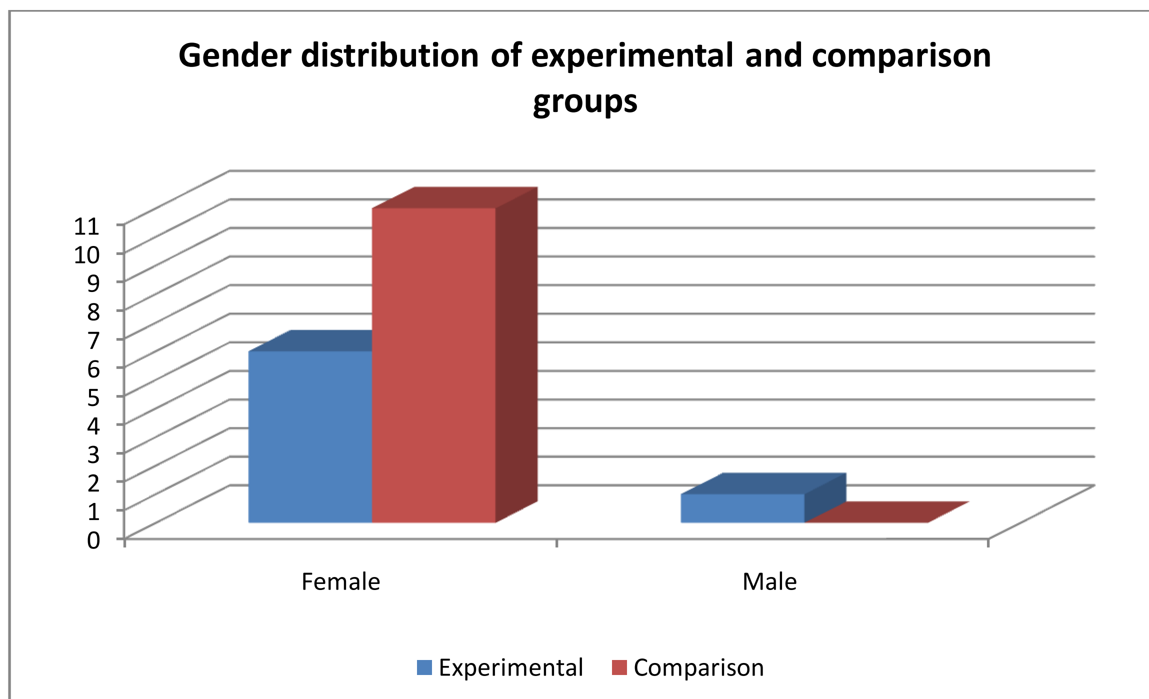

Figure 5-2: Gender distribution of experimental and comparison groups

The experimental group consisted of 7 participants. Six of the seven participants were female and one was male. The comparison group consisted of 11 participants, of which all were female.

9.2 Age

The following graph depicts the age distribution of both the experimental and comparison groups. From Figure 5-3, it is clear that the average ages of the experimental group is much younger than that of the comparison group. This might have an influence on their pre-and post- test results.

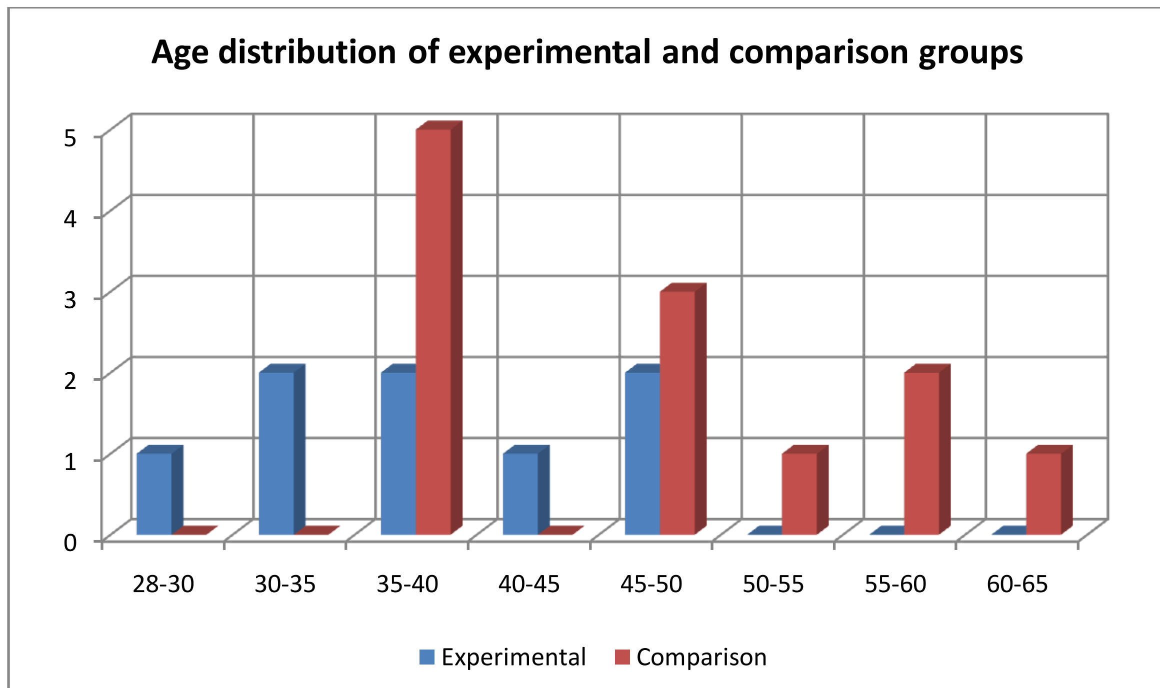

Figure 5-3: Age distribution of the experimental and comparison groups

The next section will focus on the quantitative research findings.

The researcher will firstly analyse the data gathered from the experimental group. The data gathered from the pre-test will be compared to the data gathered from the post-test and a conclusion will be drawn. This will be done for the quantitative and qualitative data. Thereafter the data gathered from the comparison group will be analysed. Once again, the data gathered from the pre- test will be compared to the data gathered from the post-test and a conclusion will be drawn. The last step will be to compare the conclusions derived from the experimental and comparison groups with one another, in order to draw a logical conclusion.

SECTION B: QUANTITATIVE RESEARCH FINDINGS

In this section, the results from the quantitative research data will be discussed. The quantitative research findings consists of two components, namely data gathered from the Professional Quality of Life (ProQol) measuring instrument developed by Stamm (2005) and the Resilience Scale for Adults (RSA) developed by Hjemdal (2007). Each of these components will be discussed separately.

10. THE PROQOL MEASURING INSTRUMENT

Quantitative data were gathered from the participants in the experimental and comparison group using the ProQol standardised questionnaire, before (pre-test) and after (post-test) exposure to the REds programme (see Annexure 6 & 10). The questionnaire consisted of thirty questions that the participants had to answer. The following instruction was given:

"As a teacher you help many people. Circle the answer that honestly shows how often you felt like this in the last 30 days."

For each question, there were five responses, ranging from never to very often, from which the participants had to choose. These responses were coded 1 to 5 to enable proper statistical analysis.

Within the context of this study one of the dependent variables, namely quality of life was measured with ProQol based on the following three constructs: compassion satisfaction, burnout and secondary trauma. The following definitions are given:

- **Compassion satisfaction (CS)** is about the pleasure an individual derives from being able to perform work well. You may feel positive about your colleagues or your ability to contribute to society or your workplace (Stamm, 2005:5).

- **Burnout (BO)** is defined as feelings of hopelessness and difficulties in dealing with work or doing a job effectively. These feelings normally gradually increase, until an individual feels that their contribution makes no difference. These feelings can also be associated with an unsupportive work environment (Stamm, 2005:5).

- **Secondary trauma** is defined as work-related, secondary exposure to extremely stressful events, for instance being exposed to others' traumatic events because of doing a job, for example working with abused women. These symptoms of secondary trauma are usually rapid in onset and associated with a particular event. The person experiencing them may also feel afraid, have trouble sleeping, or have relived the situation in their minds. (Stamm, 2005:5).

Data gathered will reflect on these three constructs.

Quantitative data were gathered from the participants in the comparison group using the ProQol standardised questionnaire, at the same time as the experimental group (pre-test) and after four months (post-test) with no exposure to the REds programme (see Annexure 6 & 10). This was done to enable the researcher to compare the results of the experimental group to the comparison group that has not been exposed to the REds programme.

10.1 Statistical techniques used for analysis of ProQol data

The statistical analyst utilised the SPSS (Statistical Package for the Social Sciences) programme to analyse the data. The analyst used the codebook provided with the ProQol manual to list the variables and the meanings of these variables. The analyst then proceeded to analyse the data by making use of the programme.

10.2 Quantitative results as collected from ProQol.

10.2.1 Pre- and Post-test Experimental

Stamm (2005:12) states that *compassion satisfaction* is the pleasure one derives from being able to do work well. A higher score on the scale represents greater satisfaction related to a person's ability to be an effective caregiver in a job. The average score for CS is 37. If a person scores under 33, the probability is that the person is finding the job troublesome.

Burnout is associated with feelings of hopelessness and difficulties in dealing with work or doing work effectively. A higher score on the scale means that a person is at a higher risk of burnout. The average score for BO is 22. If a score is under 18, it

probably means that a person is positive about their work. If a person scores above 22, it can mean that a person needs to be concerned about burnout.

Secondary trauma is about work-related secondary exposure to stressful events. The average score according to Stamm (2005:13) is 13. If a person scores above 17, it might indicate that a person works in a highly strenuous environment.

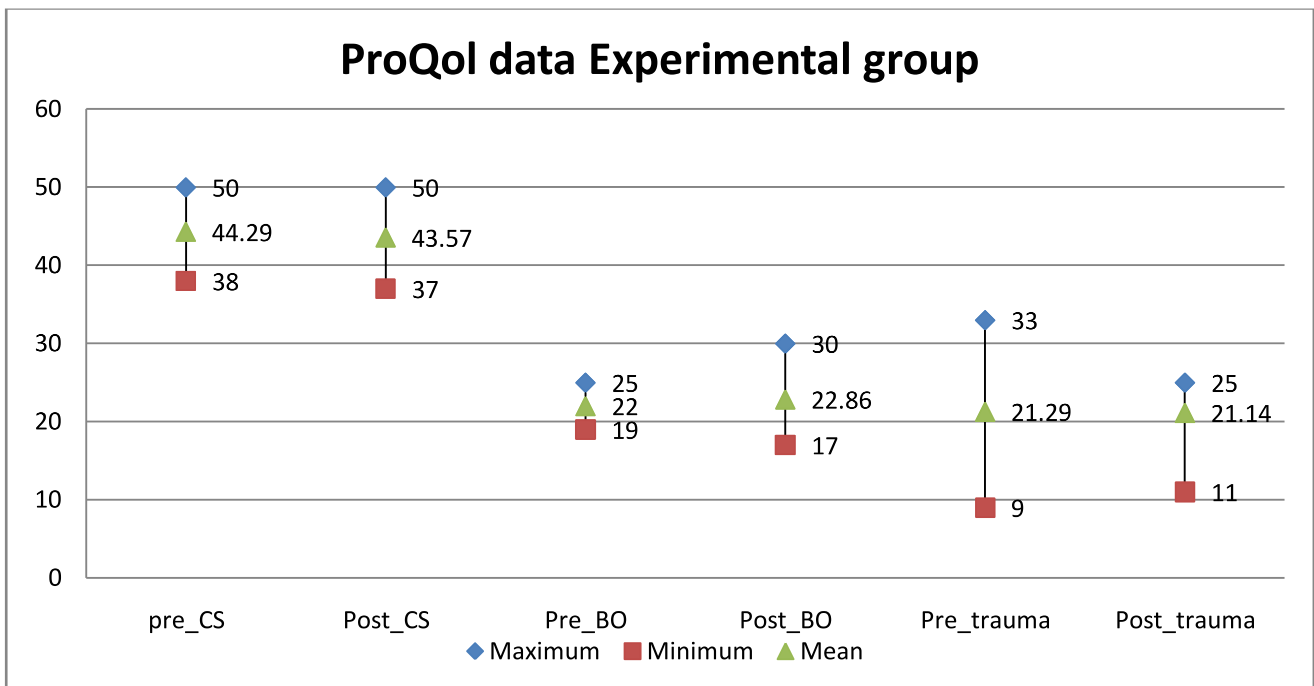

Figure 5-4: ProQol results for the experimental group

From Figure 5-4, it can be concluded that:

- Most participants found their work very satisfying. There is no significant difference between the pre- and post-test results for the CS measure.
- The mean score on the BO measure are above 22 in both the pre- and post-test results. It is worrisome that the maximum scores are 25 in the pre-test and 30 in the post-test. The average BO measure was higher by almost one point in the post-test. This may be significant considering the fact that only 7 people participated in the study and it might mean that participants scored on average higher on the burnout scale.
- On the trauma measure, the average score were 21. This is much higher than the average mentioned by Stamm (2005:12). It is noticeable that in the group participants scored lower in the post-test than in the pre-test. It might mean that there was an improvement in the participants' exposure to

secondary trauma, but because the average score is so high, the improvement may be irrelevant.

10.2.2 Pre- and Post-test Comparison group

By making use of Stamm (2005:12-13) the following can be concluded about the results for the comparison group, as displayed in Figure 5-5.

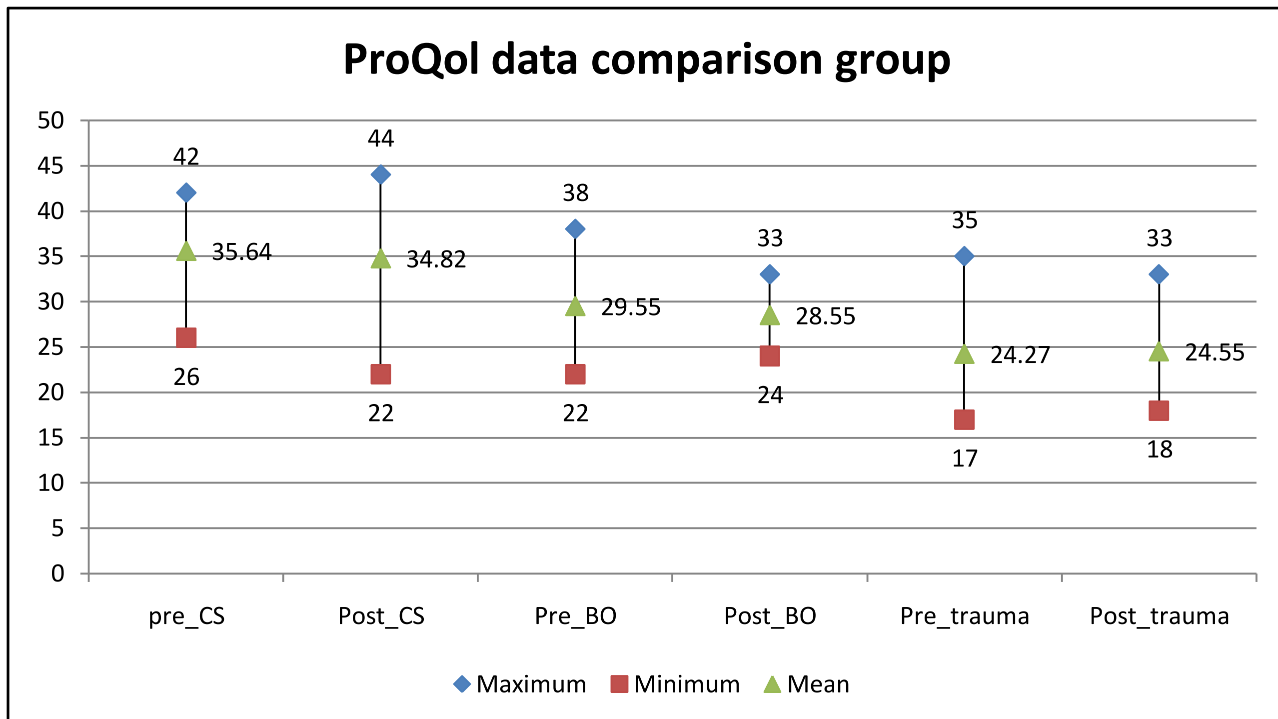

Figure 5-5: ProQol data for the comparison group

From Figure 5-5, the following is apparent:

- The average score on CS is 35.64 and 34.82 respectively for the pre- and post-tests. According to Stamm (2005:12), a person might be very unsatisfied with their work if they score below 33. If one considers the high and low scores, it can be concluded that more people in the group were unsatisfied with their work. There is also a difference between the pre- and post-tests scores. The post-tests score is also on average lower than the pre-tests score.
- On the BO scale participants scored much higher than the average of 22 noted by Stamm (2005:12). The minimum scores on both the pre- and post-tests were 22 and 24, which means, according to Stamm (2005:12) that

participants should be cautious of burnout. A slight improvement in the BO scores from the pre- and post-tests is noted. Taken into consideration that the average score is still above 22, this improvement is not significant – participants are still risking burnout.

- On the trauma scale, the average scores were 24.27 and 24.55 – much higher than the indicated average of Stamm (2005:13) of 13. There has been a slight improvement if one compares the pre -and post-test results, but once again, because the average score is so high, the improvement may be irrelevant.

10.2.3 Comparison between experimental and comparison group's test results

It is necessary to compare the experimental and comparison group's test results, in order to conclude if the REds programme had any influence on the ProQol test score of the experimental group. This comparison is shown in Figure 5-6

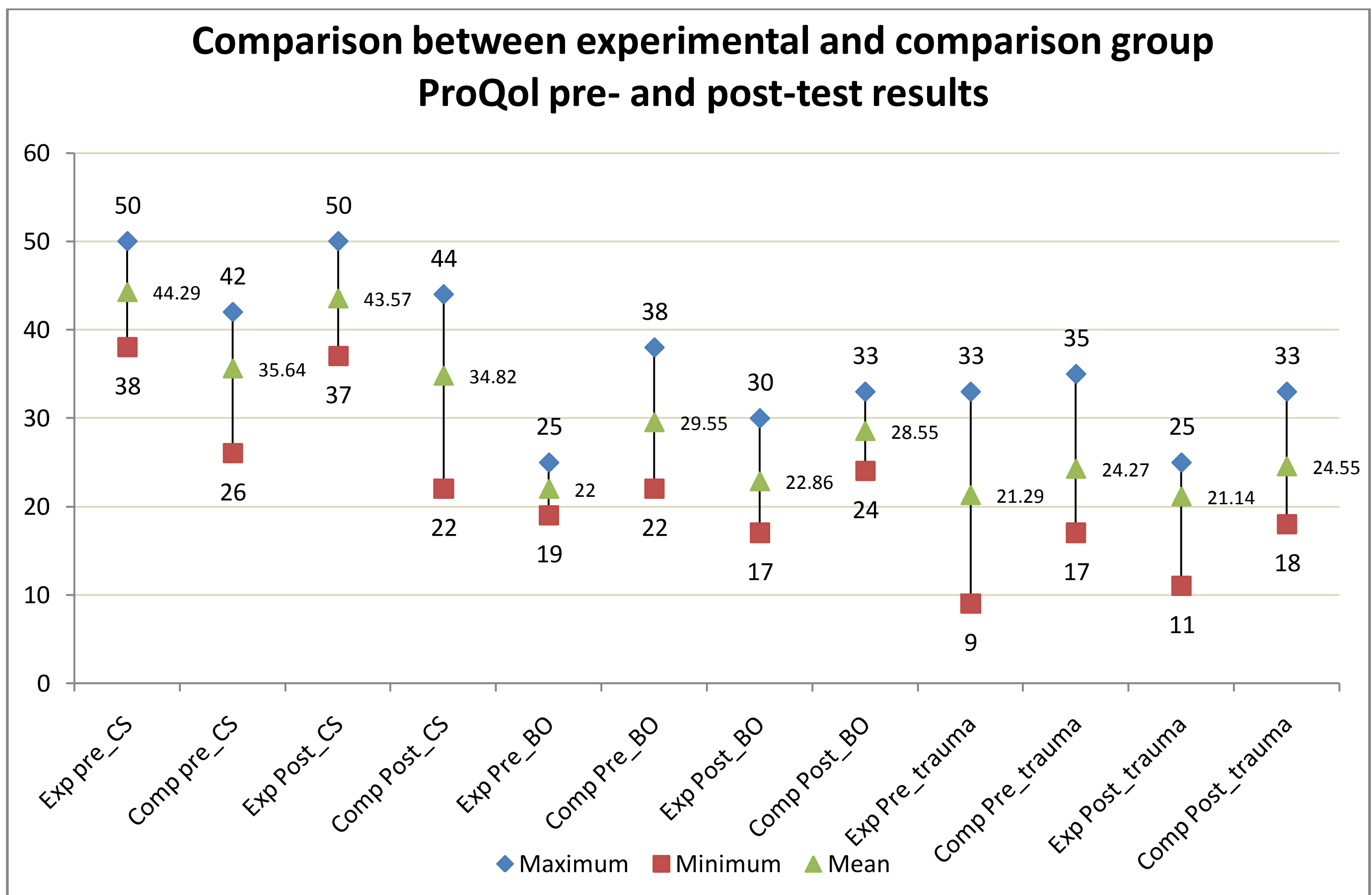

Figure 5-6: Comparison between experimental and comparison group ProQol pre- and post-test results

In Figure 5-6, it is shown that:

- During the pre-tests, the experimental group scored overall better than the comparison group. The researcher finds it difficult to explain why the experimental group's pre-test results were better than the comparison group's results, as both samples came from similar schools in similar areas.
- The experimental group reported higher CS, slightly less BP and less secondary trauma than the comparison group.

In the post-test, however, the experimental group again scored better than the comparison group, but the following was evident:

- The BO scores for the experimental group showed a slight increase (approximately 1 point) whilst the comparison group's results showed a slight decrease (approximately 1 point). It is important to note that the BO scores for both groups are high, and thus an increase or decrease of 1 point can be considered trivial. The researcher notes this because the experimental group was supposed to improve in their scores after intervention (the REds programme) took place.
- The secondary trauma results for both groups decreased. Once again, the decrease seems minor, but since the comparison group showed a decrease without intervention, the researcher thinks it should be noted.

11. THE RSA MEASURING INSTRUMENT

In order to measure resilience, the RSA measuring instrument (see Annexure 7 & 11) is used in the same way as the ProQol for both the experimental and comparison groups.

The questionnaire consists of thirty-three questions that the participants had to answer. The following instruction was given:

"Please think of how you usually are, or how you have been in the last month, how you think and feel about yourself, and about important people surrounding you.

For each question there were two options (a or b), that describes how the person usually is, or what is mostly true.

11.1 Statistical techniques used for analysis of RSA data

The statistical analyst utilised the SPSS (Statistical Package for the Social Sciences) programme to analyse the data. The analyst used standard coding procedures to list the variables and the meanings of these variables. The analyst then proceeded to analyse the data by making use of the programme.

11.2 Quantitative results as collected from RSA

11.2.1 Pre- and post-test experimental group

Hjemdal (2007:312) indicated that the RSA scale consists of a six-scale measure that measures the following constructs: perception of self; planned future; social competence; structured style; family cohesion; and social resources.

According to Hjemdal (2007:312), a high score on a measure indicates high resilience. The results are depicted in Figure 5-7.

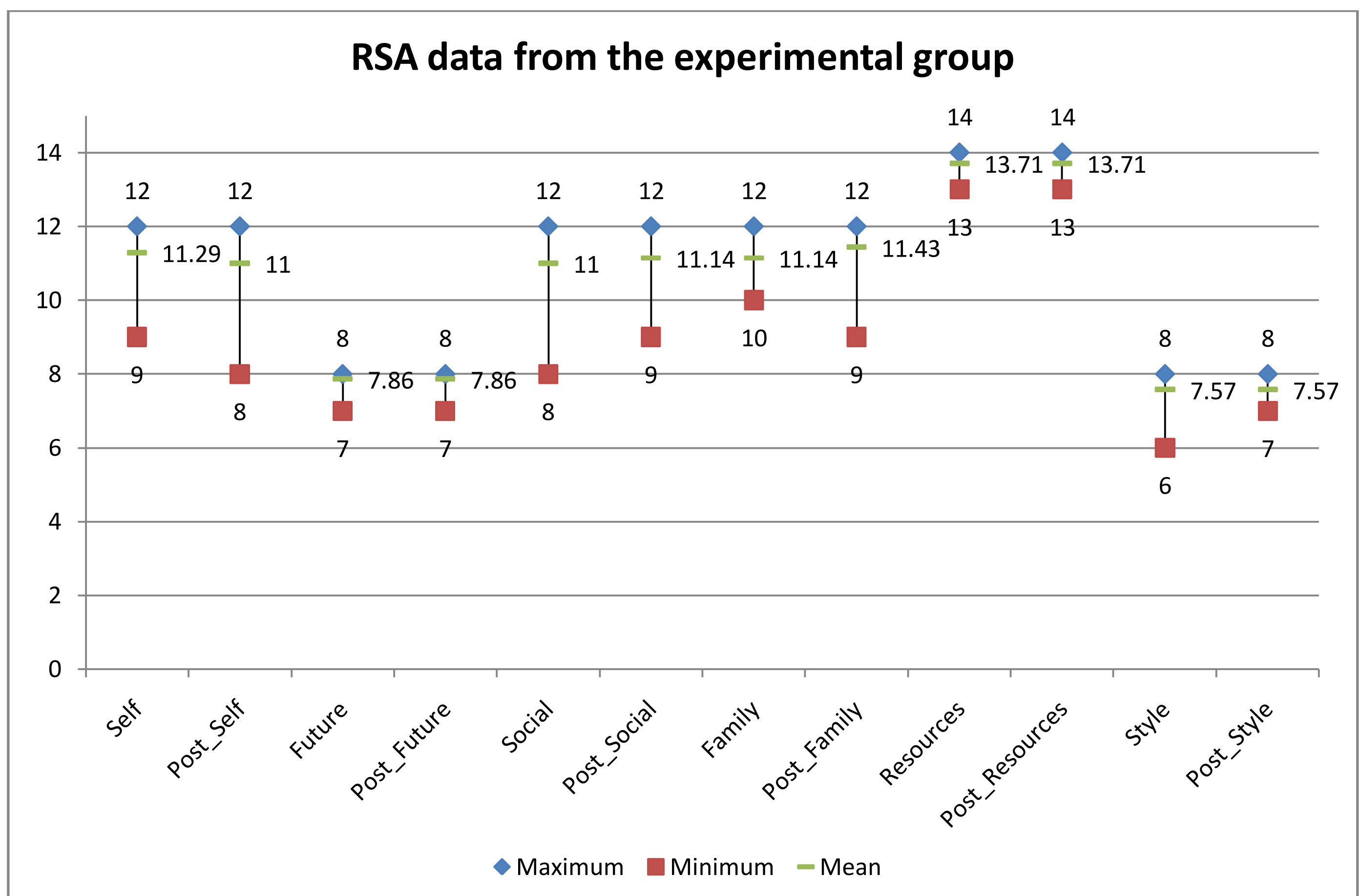

Figure 5-7: RSA data from the experimental group

From Figure 5-7, it is clear that:

- There was little difference between the pre- and post-test results. The participants scored overall lower in the measures on planned future and structured style. The participants scored the highest on resources. The differences in pre- and post-test result can be considered insignificant.

11.2.2 Pre- and post-test Comparison

In the comparison group, the results were also analysed in the same manner.

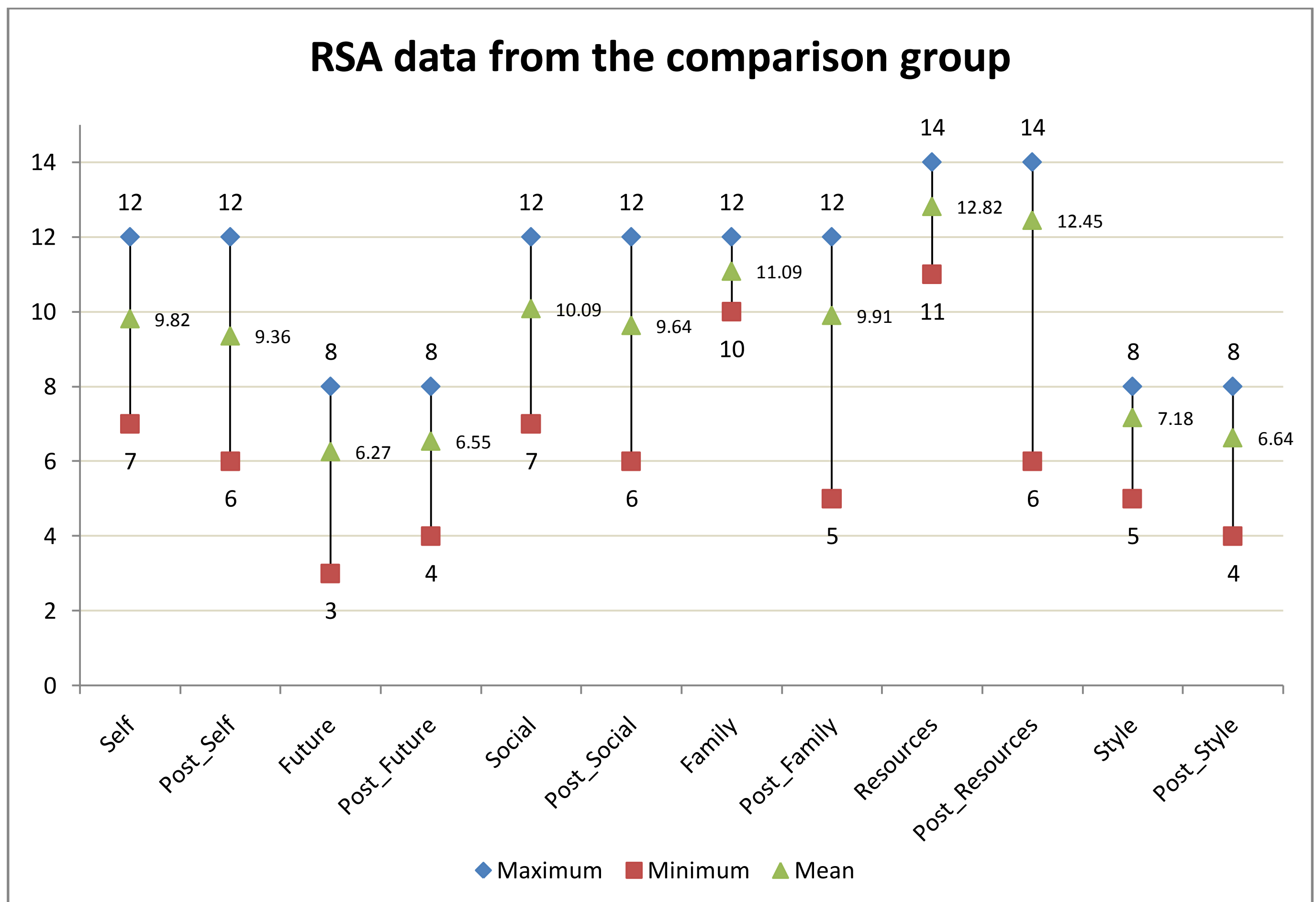

Figure 5-8: RSA data from the comparison group

From Figure 5-8, it can be concluded that:

- There was no major difference between the pre- and post-test results. The post-test results seem to have lower minimums than those of the pre-tests, but if one considers the mean result, the conclusion can be made that the lower scores were those of individuals and not of the group as a whole.

- Similar to the results of the experimental group, the comparison group also scored lower on future and style. Once again, the differences between the pre- and post-test results are insignificant.

11.2.3 Comparison between experimental and comparison group test results

Due to the magnitude of information, the comparison between the experimental and comparison groups will be split into pre- and post-test results. The comparison between the pre-test results for the experimental and comparison groups is shown in Figure 5-9.

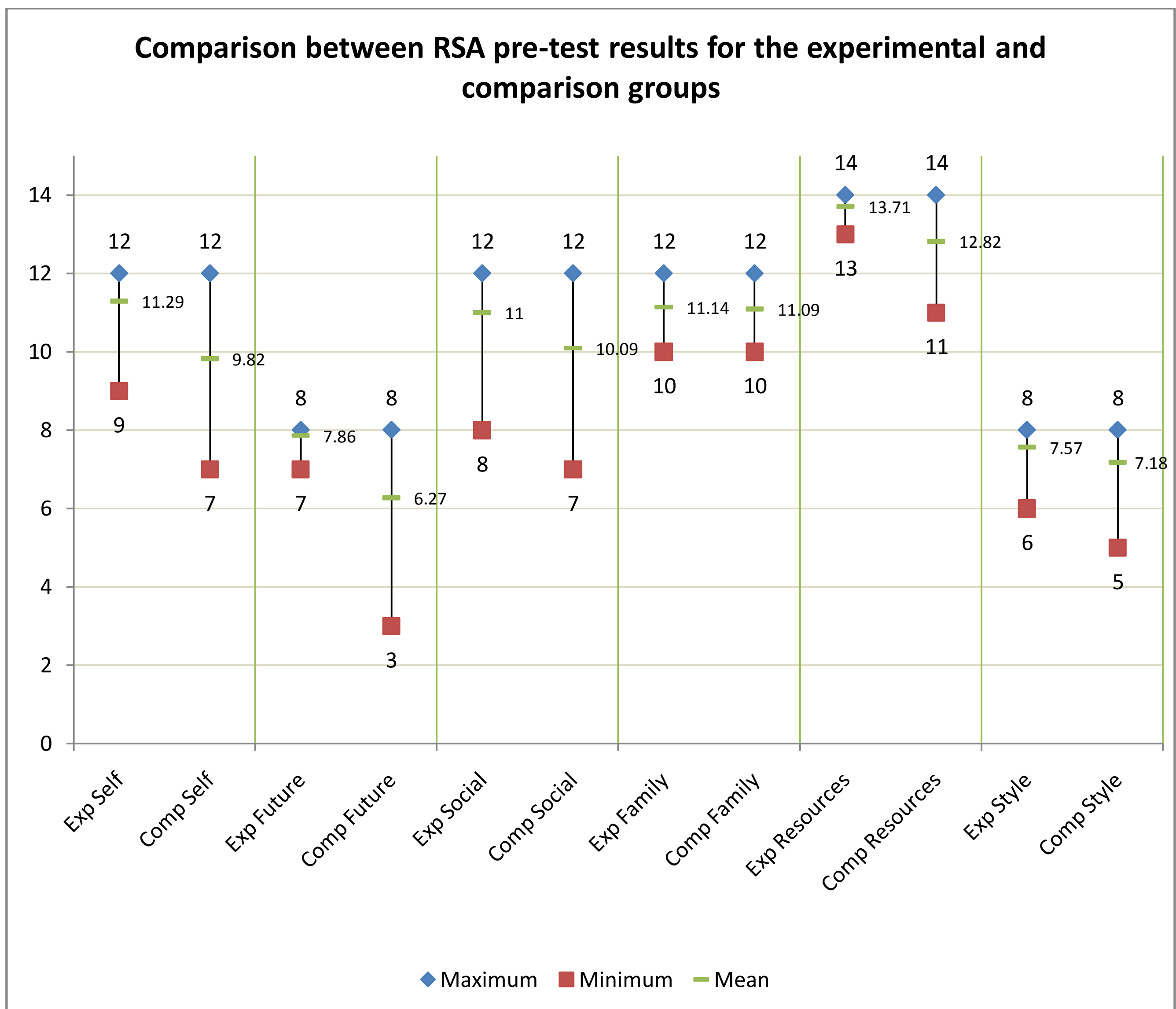

Figure 5-9: Comparison between RSA pre-test results for the experimental and comparison groups

From Figure 5-9, it is seen that

- The experimental and comparison groups scored roughly the same in the pre-tests. The differences shown are statistically insignificant. On face value, it seems as if the comparison group's minimum scores are lower than those of the experimental group are, but if one compares mean scores, the conclusion is that the largest number of participants scored the same.

The comparison between the RSA post-test results for the experimental and comparison groups is shown in Figure 5-10.

From Figure 5-10, it is apparent that:

- There is no significant difference between the results of the experimental and comparison groups. The researcher expected the experimental group to perform better on all measures than the comparison group. This was not the result. The differences shown are insignificant.

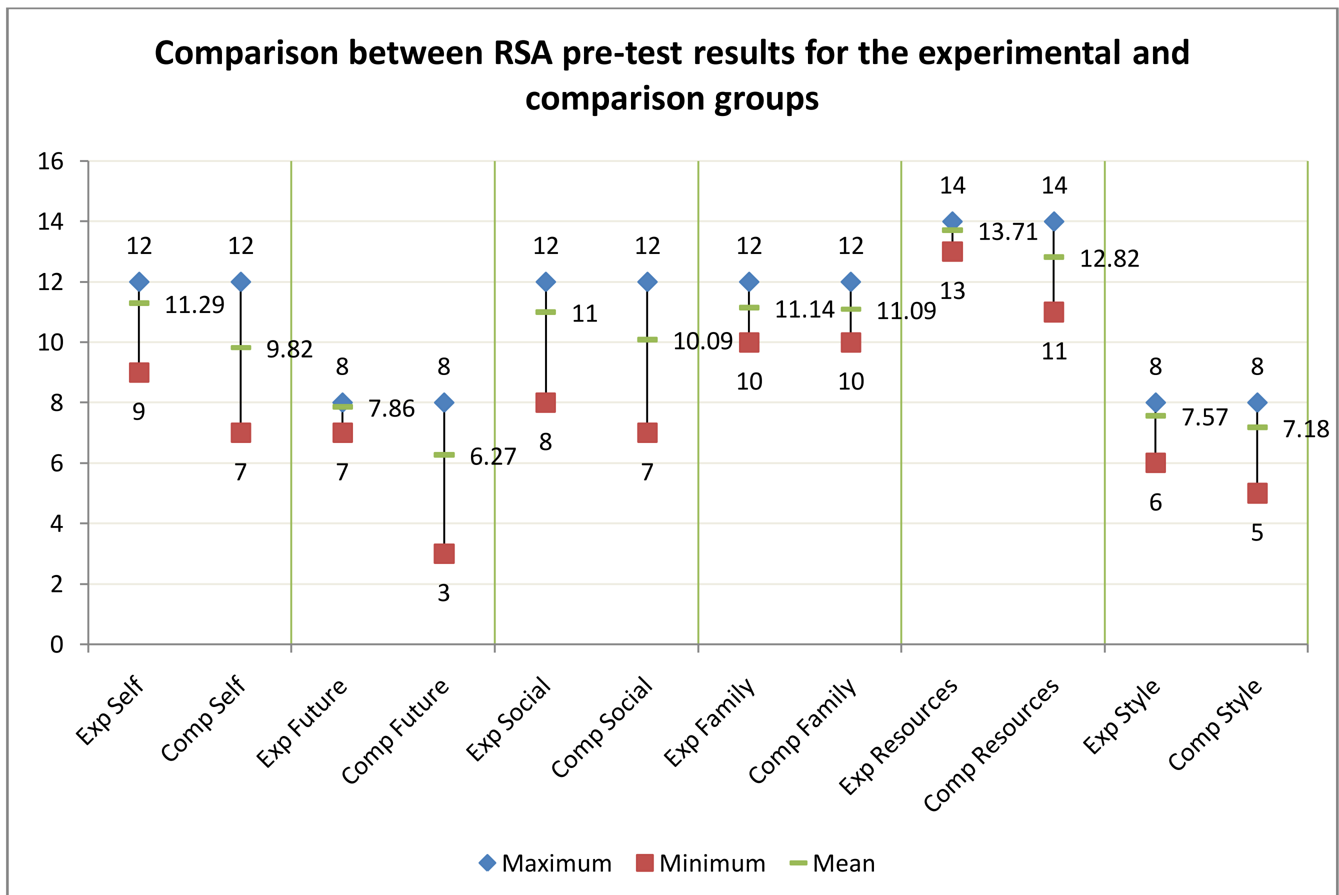

Figure 5-10: Comparison between RSA post-test results for the experimental and comparison groups

12. DISCUSSION AND INTERPRETATION OF QUANTITATIVE RESULTS

The researcher did not find any conclusive proof in the experimental group's quantitative research results that the REds programme made any difference to the dependent variables (participant's quality of life and resilience). The differences between the pre- and post-test results were insignificant. The comparison group pre-test results were also not different from the results of the post-test and comparing the experimental and comparison group results, the researcher came to the same conclusion. Based on the quantitative research results, it seems as if the REds programme did not make a difference to the quality of life or resilience of participants.

SECTION C: QUALITATIVE RESEARCH FINDINGS

Qualitative data were gathered from 7 participants in the experimental group through a narrative that they wrote (see Annexure 9 & 13) before and after exposure to the REds programme. The narrative aimed to explore how HIV and AIDS affected the educators. 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 from a qualitative approach.

Qualitative data were also gathered from 11 participants in the comparison group at the same time as the experimental group (pre-test) and after four months (post-test) with no exposure to the REds programme (see Annexure 9 & 13). This was done to enable the researcher to compare the results of the experimental group to a group that has received no intervention.

Additional data sources were observations and field notes that were compiled by the researcher and the observer during the implementation of the REds programme

Data were also gathered from drawings, which were analysed using face value interpretation without any theoretical framework.

13. QUALITATIVE FINDINGS FROM NARRATIVES

According to Apsalan and Mabutho (2005:282), data analysis should include examination, categorising, tabulating or otherwise recombining the evidence to address the research question.

The researcher conducted the analysis in the following manner:

- The researcher read all the narratives and made notes in the margin of possible categories and themes.
- The researcher then repeated the process to cluster together categories that emerged most prominently.

- The categories that emerged from the narratives were then identified and written down separately.
- Information from the narratives that fitted into each of the categories was recorded in these categories.
- The researcher then searched for commonalities or contradictions in these categories.
- The categories were hereafter clustered together, and from this clustering, the themes emerged. Five main themes with sub-themes were identified, and these themes were used to categorise the data gathered from the narratives. The themes and sub-themes, in both the experimental and comparison groups are summarised in Table 2.

Table 1: Summary of themes and sub-themes

Experimental group		Comparison group	
Theme 1: The impact of HIV and AIDS on the school environment		**Theme 1: The impact of HIV and AIDS on the school environment**	
Pre-test sub-themes	**Post-test sub-themes**	**Pre-test sub-themes**	**Post-test sub-themes**
• Negative teaching environment • Poor performance • Child-headed households • Role changes	• Negative teaching environment • Poor performance • Child-headed households • Social problems • Role of the educator	• Child-headed households, orphans and poverty • Poor performance from learners • Learners at school are infected and affected	• Child-headed households and orphans • Poor performance from learners
Theme 2: The personal impact of HIV and AIDS on the educators		**Theme 2: The personal impact of HIV and AIDS on the educators**	
Pre-test sub-themes	**Post-test sub-themes**	**Pre-test sub-themes**	**Post-test sub-themes**
• Having loved ones infected by HIV and AIDS • The emotional impact of HIV and AIDS on the educator	• Work environment • The emotional impact of HIV and AIDS on the educator • Empowerment	• Role changes • The emotional impact of HIV and AIDS on the educator	• Role changes • The emotional impact of HIV and AIDS on the educator
Theme 3: The impact of HIV and AIDS on the community		**Theme 3: The impact of HIV and AIDS on the community**	
Pre-test sub-themes	**Post-test sub-themes**	**Pre-test sub-themes**	**Post-test sub-themes**
• Poverty • Lack of resources • Fear to disclose • Loss of life and opportunities	• Poverty • Fatalism and ignorance • Social grants	• HIV and AIDS cause death • Substitute care	• Fatalism about HIV and AIDS • The economic and social impact of HIV and AIDS

Experimental group		Comparison group	
Theme 4: Thoughts of educators on HIV and AIDS		**Theme 4:Thoughts of educators on HIV and AIDS**	
Pre-test sub-themes	**Post-test sub-themes**	**Pre-test sub-themes**	**Post-test sub-themes**
• Untruths about HIV and AIDS • Importance of knowledge regarding HIV and AIDS • God is the only answer • AIDS is cruel	• Untruths about HIV and AIDS • AIDS is a deadly disease	• Life before HIV and AIDS • Untruths about HIV and AIDS	• HIV and AIDS is deadly • Importance of knowledge regarding HIV and AIDS
Theme 5: Action plans educators devise to cope with the impact of HIV and AIDS		**Theme 5: Action plans educators devise to cope with the impact of HIV and AIDS**	
Pre-test sub-themes	**Post-test sub-themes**	**Pre-test sub-themes**	**Post-test sub-themes**
• Faith as a means to cope with HIV and AIDS • Knowledge of HIV is power • Support by educators	• Faith as a means to cope with HIV and AIDS • Knowledge of HIV is power • Support by educators	• Utilisation of community resources • Support by educators	• Support by educators • Faith as a means to cope • Utilisation of community resources

The data sets that were used consisted out of pre- and post-tests from experimental and comparison groups. For clarity purposes, the researcher will firstly visually present each theme. This visual presentation consists of a mindmap drawing that shows the different sub-themes that were found for every theme in both the pre- and post-tests. This will be done for all five themes in the experimental group. The themes and sub-themes are then discussed by verbatim quotes from the narratives followed by supporting citations from relevant literature. Thereafter the researcher will write a summary for each theme. This process will be repeated for the comparison group. Thereafter the researcher will compare the differences between the experimental and comparison groups, visually. Lastly, conclusions will be compared, and a last conclusion will be made. An example of a narrative is shown in Annexure 14.

14. RESULTS FROM THE NARRATIVE FOR THE EXPERIMENTAL GROUP

The following themes were extracted from the narratives:

- The impact of HIV and AIDS on the school environment;
- The personal impact of HIV and AIDS on the educators;
- The impact of HIV and AIDS on the community;
- Thoughts of educators on HIV and AIDS; and
- Action plans educators devise to cope with HIV and AIDS.

The sub-themes that were derived from each one of these themes will now be discussed in detail.

14.1 Theme 1: The impact of HIV and AIDS on the school environment

This theme and its sub-themes dealt with the educators' experience of how HIV and AIDS have an impact on the school environment. Figure 5-11 shows how the theme is divided into sub-themes.

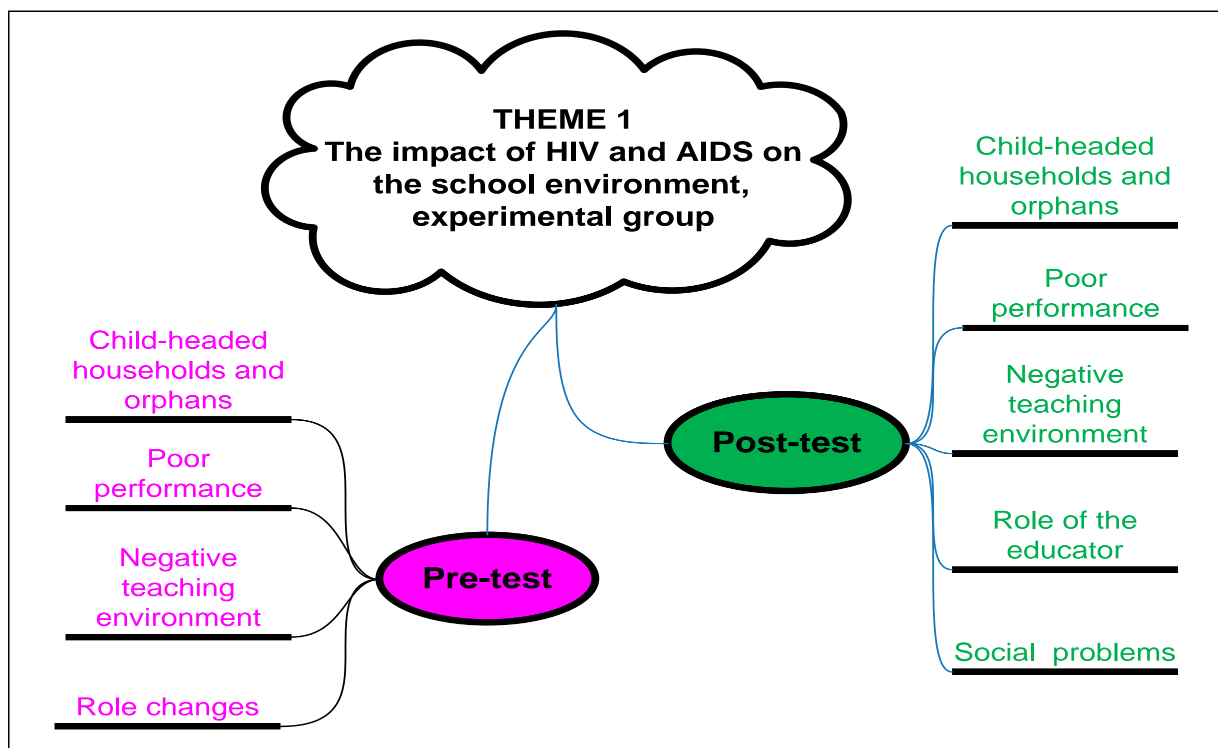

Figure 5-11: Theme 1: The impact of HIV and AIDS on the school environment

14.1.1 Pre-test results for theme 1

In the pre-test, this theme was divided into the following sub-themes:

- Child-headed households and orphans;
- Role changes;
- Poor performance; and
- Negative teaching environment.

Sub-theme 1: Child-headed households and orphans

In sub-theme one, educators dealt with the huge number of children in school who are orphans due to HIV and AIDS. Shisana *et al*. (2005b:21) define orphans as children who lost their parents through death. Orphans are also defined by UNICEF (2000) as children who have lost one or both parents. Vulnerable children on the other hand are defined as children who belong to high-risk groups who require access to basic social services or facilities. These orphaned and vulnerable children often do not have access to education. Many children are heading households, or are living in child-headed households. These children fend for themselves, and sometimes they are very poor, and have little or no resources to sustain them. They come to school inadequately dressed, and the educators are confronted with their poverty. Sometimes these children engage in lucrative income-generating activities, which is often to the detriment of the child.

Educators mentioned the following in this regard:

> *Participant 3: "There are many child-headed households where kids fend for themselves and become promiscuous for food."*
> *Participant 6: "Most new learners are AIDS orphans who are poor and have no food and there are no real parents caring for the kids. Kids care for siblings at home after the parents passed away. It is quite pathetic, kids are looking after other kids, and they come to school without proper uniform, barefooted, no books and pens. They are uncared for because they have no parents."*
> *Participant 10: "Many students are orphans because of AIDS."*

These findings concur with Brookes *et al*. (2004) as cited by Van Dyk (2008:79) who found that about 10% of children in South Africa had lost a parent or caregiver by age 9, and 15% had lost a parent or caregiver by age 14. Among children, aged 15 to18 years, almost 25% had lost at least one parent or caregiver, and 3% of children

aged 12–18 years said that they were the head of their household. These deaths are mostly AIDS-related.

Sub-theme 2: Poor performance

The second sub-theme focused on the way educators experienced how HIV and AIDS affect the children's performance. Many participants reflected that children who are affected by HIV struggle in school – the children struggle to concentrate, and start performing poorly due to being affected and infected by HIV and AIDS. Some learners even drop out of school. Educators also noted that learners manifest behaviour problems, which the educators link to the loss of parents due to HIV and AIDS.

The following confirmation was found in the narratives in support of this sub-theme:

> *Participant 3: "Learners lose concentration, become withdrawn, become bullies and show bad performance because their parents are HIV positive. It is disappointing to see performance and behaviour of children change to worse because they are affected by HIV."*
> *Participant 6: "Kids feel inferior and drop out of school, others care for siblings at home after the parents have passed away, or they look after their ill parents. The result of so many responsibilities at home is poor performance, and thus the pass rate is affected by HIV and AIDS."*
> *Participant 11: "Children performed well, then their performance went down, and I found that either parents or children were sick or the parents were late."*

Poor performance of HIV and AIDS affected children is confirmed in literature.

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) note 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.

Sub-theme 3: Negative teaching environment

This sub-theme highlights educators' description of the negative teaching environment HIV and AIDS creates. The learners come to school ill, or they are very traumatised if one of their classmates passes away due to HIV and AIDS.

The following proof was derived from the narratives in support of the sub-theme:

> *Participant 3: "Learners are infected because of poverty. Their parents can't supply them with what they need and then they get involved with bad people."*
> *Participant 6: "HIV positive children come to school, educators don't know the status of these children, and they don't know how to handle the sick children."*
> *Participant 6: "There is a high mortality rate among children due to this disease. When a pupil dies, this disturbs other kids and has a negative impact on the teaching environment."*

Naudé and Pretorius (2003:141) indicate that physical symptoms that HIV positive children or children with AIDS-related diseases show 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 they 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.

Sub-theme 4: Role changes

This sub-theme dealt with the change in roles the educators experienced. They play different roles in the classroom – not only educating the learners, but also emotionally supporting the learners. The educators spend many valuable teaching hours addressing emotional and social issues, and many times the educator uses their own means to assist the children, as there are no other means of support. The problems that exist in the community enter the classroom, and the educators need to deal with these problems.

The following evidence was found in the narratives to support that this was indeed a valid sub-theme:

> *Participant 1: "Teacher's roles change – social issues impact the classroom, and the community becomes your class."*
> *Participant 6: "Educators spend more time dealing with social issues than they teach. We [educators] give our lunch to the kids and buy pens and books for the children from our own pocket, because the kids come to us for support."*

> *Participant 8: "Children whose parents have died need counselling and help."*
> *Participant 10: "I am a teacher, parent, mother, sister and a friend - HIV touches me."*

This is also reflected in literature. As earlier mentioned, different authors (Kelly, 2000; Theron, 2005; Theron *et al*., 2008; Poulsen, 2006) note 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 role conflict is confirmed by Theron *et al.* (2008:84) who found that educators do grief counselling, solve family problems, find resources – responses that are not part of the educator's role.

14.1.2 Post-test results for theme 1

In the post-test, some of the sub-themes were repeated. In the post-test, the impact of HIV and AIDS on the school environment was divided into the following sub-themes:

- Child-headed households and orphans;
- Poor performance;
- Negative teaching environment;
- Role of the educator; and
- Social problems.

Sub-theme 1: Child-headed households and orphans

This sub-theme also dealt with the impact child-headed households and orphans have on the school. It also noted the impact the absence of parents has on the children. The emphasis was once again on the lack of resources that exists because children are growing up as orphans. It is noticeable that participants did not change in their views on the impact orphans have on the classroom after participation in the REds programme. It seems as if they are still unsure of how to deal with the orphans, and this is still an issue for them. The following was said by participants:

> *Participant 3: "There are an increased number of orphans as parents die and leave young children behind. In most cases, the children have no one to look after them or to teach them the facts of life. These children tend to be unruly in class. This affects their performance as well."*
> *Participant 11: "Many learners are now orphans and many families from which they come are child-headed families whereby in the end, resources are scarce for them as there will be no breadwinner."*

From literature, the ILO (2006:27) asserts that children running or living in child-headed households must generally fend for themselves and manage their own activities without the supervision of an adult. These children face unusual hardship emotionally, materially and educationally and children who are raised by other children, or who themselves raise children, are exceptionally disadvantaged. In some cases children receive regular visits and support from relatives, but research shows that in communities severely stressed by AIDS, a large proportion of child-headed households known to have living relatives do not receive material support from them. Thus, it can be concluded that the opinion of the participants is also reflected in literature.

Sub-theme 2: Poor performance

This theme was prevalent in the pre-test as well as in the post-test. This theme elaborated on the impact HIV and AIDS has on the performance of children in school. Educators not only noted that the academic results deteriorate, but it also placed the magnifying glass on the behaviour of the HIV and AIDS affected child. Once again, when comparing the pre-test with the post-tests, it is observed that the participants did not change in their views on the performance of learners after participation in the REds programme. It seems as if the performances of the learners are still a concern for them.

The following was written in the post-test narrative to support of this theme:

> *Participant 1: "Orphans tend to be unruly in class, and this affects their performance as well."*
> *Participant 6: "Poor results because of absenteeism of educators and pupils due to illness or death in the family because of AIDS."*
> *Participant 8: "Orphans who are heading the families are affected by the circumstances in which their school performances tend to deteriorate."*

These findings concur with Bennell (2005:467) who holds that the educational performance of orphans, child-carers, and children with AIDS-related illnesses is also expected to deteriorate markedly with higher repetition and dropout rates and generally poorer learning outcomes. Franks *et al.* (2004:230) cite Wishnietsky & Wishnietsky (1996), who state that absenteeism due to medical treatment can result in lowered academic performance and intolerance by classmates.

Sub-theme 3: Negative teaching environment

This sub-theme was also prevalent in the pre-test results. The sub-theme refers to the impact HIV and AIDS has on the teaching environment, and how the educators are negatively affected by learners and staff being affected, and by the duty educators have to emotionally support and assist learners. All these issues contribute to create a negative teaching environment. It appears as if the educators' perception of the work environment did not change after participation in the REds programme. In the pre-test, they also experienced the work environment as negative.

The following was said by participants in this regard:

> *Participant 1: "we need to cope as teachers with all that is coming to us in the classroom."*
> *Participant 10: "The environment I work in impacts my life."*
> *Participant 11: "I have seen my peer staff and learners being affected. AIDS has taken these learners' parents from them, and now we educators have the duty to protect and comfort children from the harsh world."*

Once again the experiences of the participants is supported by Sackney, Noonan and Miller (2000:45), who found that classroom teachers are affected greatly by their working environments, and the daily increased expectations related to their jobs. Bennell (2005:486) also notes that most teachers do not have sufficient time, resources and incentives to be able to support students properly. Most already feel heavily over-burdened by a crowded curriculum and other work-related commitments. Consequently, the right enabling environment has to be created so that they can perform this key function effectively.

Sub-theme 4: Role of the educator

This sub-theme dealt with the different roles the educators need to fulfil, such as that of a mother, counsellor and survivor.

The following was noted by participants in the post-test narratives:

> *Participant 1: "My role is that of a survivor – all these changes affecting my life should not break me at all, but rather should make me feel stronger."*

Participant 6: "Most of my time is spent counselling learners instead of teaching and visiting sick learners as well."
Participant 12: "This time needs a person to be strong enough to face life on both angles with passion and goals. You must share with people, especially in difficult times. You must pass what you have learned to the learners and their families. Take these learners as your kids or family and accept them as a good mother who loves her family."

From literature, Theron *et al*. (2008:84) clarifies that the current teaching context demands educators to respond with roles such as grief counselling, solving family problems, and finding resources – these responses are not part of the educators' role. Robson and Sylvester (2007:425) found that many of the school staff participates in various unofficial support and monitoring activities (supplying food, clothes, keeping orphan registers, soliciting for bursaries and so on) that go beyond traditional educational roles.

Sub-theme 5: Social problems

This theme was not prevalent in the pre-tests. The theme dealt with the social and behavioural problems that exist due to people becoming infected and affected by HIV and AIDS. These problems focus around teenage pregnancy, and the tendency for young girls to fall pregnant in order to gain access to a child support grant. The issues also focus on children who engage in risky behaviour due to the effect HIV and AIDS has on them. It is noted by educators that social and behavioural problems often go hand in hand with poverty, HIV and AIDS. In communities with high HIV prevalence, HIV/AIDS exacerbates existing problems, including poverty, and social and educational inequalities (UNAIDS 2008b). The following was noted by participants in this regard:

Participant 3: "People want easy money, and then learners get pregnant, because by having kids you are entitled to a child support grant, where they will use the money to take care of their own needs instead of those of the children. The parents do not care about the future of the kids – they just know that the more children, the more money they will get from the grant. The other problem is sugar daddies. They pamper young women with lots of gifts in exchange for sex. They move from one person to another, and they do not want to condomise."
Participant 11: "Some children even end up committing crimes, dropping out of school as they lack proper guidance at home concerning the importance of going to school."

Participant 8: "The same orphans become pregnant at an early age. Pregnancies also brought poverty in their homes. Once the learner become pregnant, they quit school and start to live on their own. What causes pregnancy? The girls are eager to become independent; they bend under peer pressure and because of poverty. As a result our learners become drunkards and prostitutes, and they themselves become contaminated and then the spread the virus."

In literature the problems noted by the participants is supported by the following authors:

The ILO (2006:44) reports that youth who live in households that are affected by HIV and AIDS are dropping out of school and starting to work when too young, too unskilled and too inexperienced. With poor education and training, these young people are less likely to have access to decent work and face a high risk of under- and unemployment.

With regard to social issues, the ILO (2006:42-44) found that orphaned adolescents become exposed to many risks when they experiment with sexual initiation, alcohol or tobacco use, and sometimes experience violence and drug use. The consequences of their risk taking behaviours can be grave, including sexually transmitted diseases and HIV, as well as unwanted pregnancy.

14.1.3 Summary on theme 1

Theme 1 dealt with the impact HIV and AIDS has on the school, the educators and learners. In both the pre- and post-tests, it was noted that HIV and AIDS influences the performance of children and a negative teaching environment is created at school. Orphans and child-headed households was also a central theme, and in both the pre- and post- tests, participants concluded that the death of parents negatively influences the school. The roles of educators were also discussed. In the pre-tests, it was noted how the role of the educator has changed due to HIV and AIDS. In the post-test, the focus was more on the role they assumed in order to cope. In the post-tests, participants elaborated on the social problems that are caused by poverty and how that influences the school environment.

14.2 Theme 2: The personal impact of HIV and AIDS on the educator

This theme dealt with the personal impact HIV and AIDS has on educators. Figure 5-12 illustrates how the theme is divided into sub-themes, which will be discussed below:.

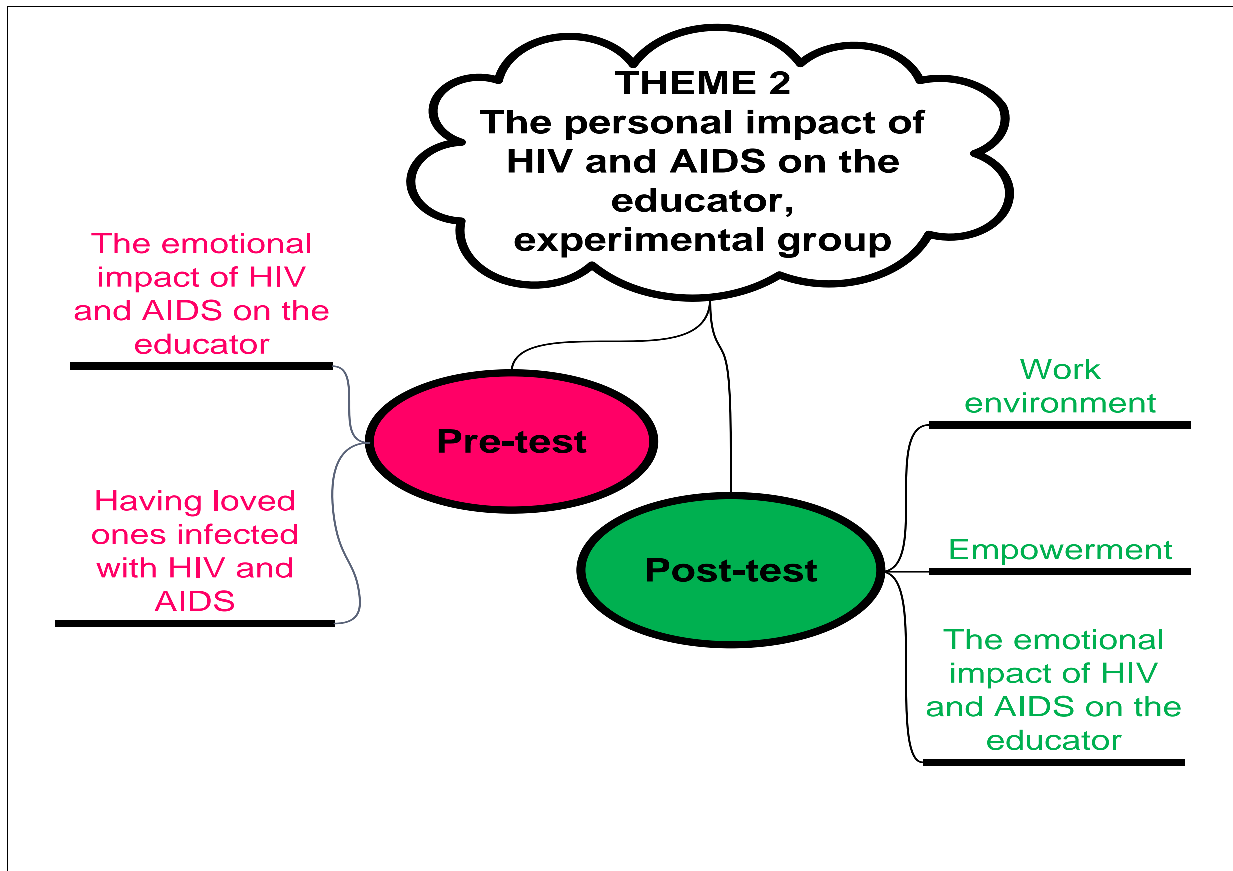

Figure 5-12: Theme 2: The personal impact of HIV and AIDS on the educator

14.2.1 Pre-test results for theme 2

In the pre-test theme 2 was divided into the following two sub-themes:

- Having loved ones infected by HIV and AIDS; and
- The emotional impact of HIV and AIDS on the educator.

Sub-theme 1: Having loved ones infected with HIV and AIDS

This sub-theme explored how having loved ones who are infected with HIV and AIDS has an impact on the educator. Educators mentioned they experience pain, and that it takes emotional energy to support loved ones. In the narratives, the following was obtained:

> *Participant 1: "It was after the death of someone close to me that I became concerned. It filled me with pain and regrets. Now I have lost three loved ones from this terrible disease. I felt destroyed inside."*
> *Participant 10: "My younger sister is sick with AIDS and I need to support her. I went with her to clinic for treatment and encouraged her to disclose her status. At night when she was in pain, I used to spend sleepless nights sitting by her bedside praying and comforting her."*

From literature, it is clear that having loved ones who is infected with HIV and AIDS has a negative impact on the educator.

Van Dyk (2005:218) explains that the term HIV and AIDS affected refer to the significant others in the life of a person living with HIV and AIDS. 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 and AIDS, or have died from 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.

Sub-theme 2: The emotional impact of HIV and AIDS on the educator

This sub-theme dealt with the emotional impact HIV and AIDS has on educators. Educator's experiences emotional pain, they were scared, they were traumatised, stressed and they felt sad.

The following was noted in the narrative:

> *Participant 3: "As a teacher it is very difficult and challenging… It is very painful to see learners becoming orphans at an early age, with no relatives to look after them. It is very sad to bury a child knowing he has been suffering from AIDS"*
> *Participant 8: "It is painful to see kids who cry because their parents have died."*
> *Participant 10: "The mothers had passed away, and I was very shocked as the learners were crying bitterly and I also started to cry."*
> *Participant 11: "Watching all this happen around me is a nightmare, and it is very painful." I had aspirations of nurturing children, but now I wonder if there is going to be any children left to teach. I am scared – I wonder if I will escape it?"*
> *Participant 12: "I must start making home visits for the learner who collapses in class because they had not eaten for three days, when you get there you will find a disaster in children's houses. That thing traumatises me for a long time, and then I end up being stressed about the learners I need to help – this causes my health to deteriorate. I need to go to the doctor to get some medication."*
> *Participant 12: "Learners end up being my burden."*

The responses of participants concur with Esterhuizen (2007:38) who indicates 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.

14.2.2 Post-test results for theme 2

In the post-test, the theme was divided into the following sub-themes:

- Work environment;
- The emotional impact of HIV and AIDS on the educator; and
- Empowerment.

Sub-theme 1: Work environment

This sub-theme dealt with the negative personal experience of educators of their work environment in the era of HIV and AIDS.

> *Participant 1: "In dealing with learners, especially at my school, I realise that the environment has a great influence. As a teacher, my life has to adapt to all the conditions I work in."*
> *Participant 6: "I need to teach hungry filthy kids, because their parents are dead."*

In literature, Cohen (2002:20) points out that government have the task of facilitating an open dialogue and discussion about difficult issues that require a supportive environment. In most countries in Sub-Saharan Africa, these conditions are not present and have to be created. Thus, teachers need to feel that the government and their communities will support them in their attempts to address HIV prevention within schools. It is thus clear that the educators work in a difficult work environment. The evidence from the narratives support that educators indeed find their work environment to be troubling.

Sub-theme 2: The emotional impact of HIV and AIDS on the educator

This sub-theme dealt with the emotional impact that HIV and AIDS has on educators. This impact included feeling frustrated, being emotionally disturbed and saddened. The emotional impact was eminent whether educators are infected or affected by the pandemic. From the narratives, it seemed as if there was not a lot of change in the

emotional experiences of educators after the implementation of the REds programme. This theme was also prevalent in the pre-tests.

The following was cited in the narrative:

> *Participant 6: "I am personally affected by child-headed households and poor results due to absenteeism and death."*
> *Participant 10: "As a teacher I experience frustrations in my classroom when interacting with my learners or orphans caused by HIV and AIDS. These learners are very intelligent in my class, but they are transferred to other schools because the mother died of HIV and AIDS. I get troubled by my work; it is hurting and emotionally disturbing."*

Hargreaves (1994) and Crossman (1996) as cited by Sackney *et al.* (2000:46) report that many emotional and societal problems have placed increasing demands on teachers; teachers are only human, and therefore they bring to their jobs their own personal problems and frailties.

Sub-theme 3: Empowerment

This sub-theme dealt with empowerment. From the narrative, it was marked that some of the educators were empowered by the REds programme. The following was found in the narrative to show how the participants were empowered:

> *Participant 1: "How does one cope? I must gain my strength so that AIDS cannot control or determine my life. I am in control. I cope by accessing necessary information and enskilling myself with important skills where possible."*
> *Participant 1: "We can't divorce AIDS from education, it is vital for us to realise that, and this Resilience course has just cemented that."*
> *Participant 10: "Since I attended REds, I am aware of many things that will help our people, e.g. families, learners, neighbours etc. which also helped me to deal with serious situations around me."*

Theron *et al.* (2008:84) confirmed that the REds programme has the express aim of empowering affected educators to cope more resiliently with the challenges of the pandemic by supporting educators to respond adaptively to a teaching context that demands responses more typical of counsellors, social workers, or medical personnel trained to prevent HIV. The programme also aims to empower participants to support other people who are HIV and AIDS affected or infected. Theron *et al.* (2008:83) state that there is no form of comprehensive support for

affected educators, although some South African research initiatives (like REds) have empowered participating educators and their communities.

14.2.3 Summary of theme 2

This theme dealt with the personal impact HIV and AIDS has on the educator. In the pre-test, the participants noted that they are personally affected by HIV and AIDS, by having lost loved ones to HIV and AIDS. Another sub-theme that was indicated was the emotional effect HIV and AIDS had on the educators, and the difficulty educators experienced to deal with the issues they face. In the post-test, it was also noted that HIV and AIDS had a negative emotional effect on the educators. In the post-test, the educators noted that their work environment negatively influenced their emotions – a sub-theme that was not prominent in the pre-tests. In the post-test, it is detected that the educators noted growth and some positive feelings after the implementation of the REds programme. Two educators indicated that they felt empowered by the REds programme to deal better with their situation. This was not the case in the pre-tests.

14.3 Theme 3: The impact of HIV and AIDS on the community

This theme focused on the impact that HIV and AIDS has on the community. Most of the educators who work at the experimental group's school also live in the community.

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. From literature, it is clear that HIV and AIDS negatively affect communities. In this theme, the researcher will explore the areas the participants highlighted. Figure 5-13 illustrates how this theme is divided in sub-themes. Each sub-theme will be discussed

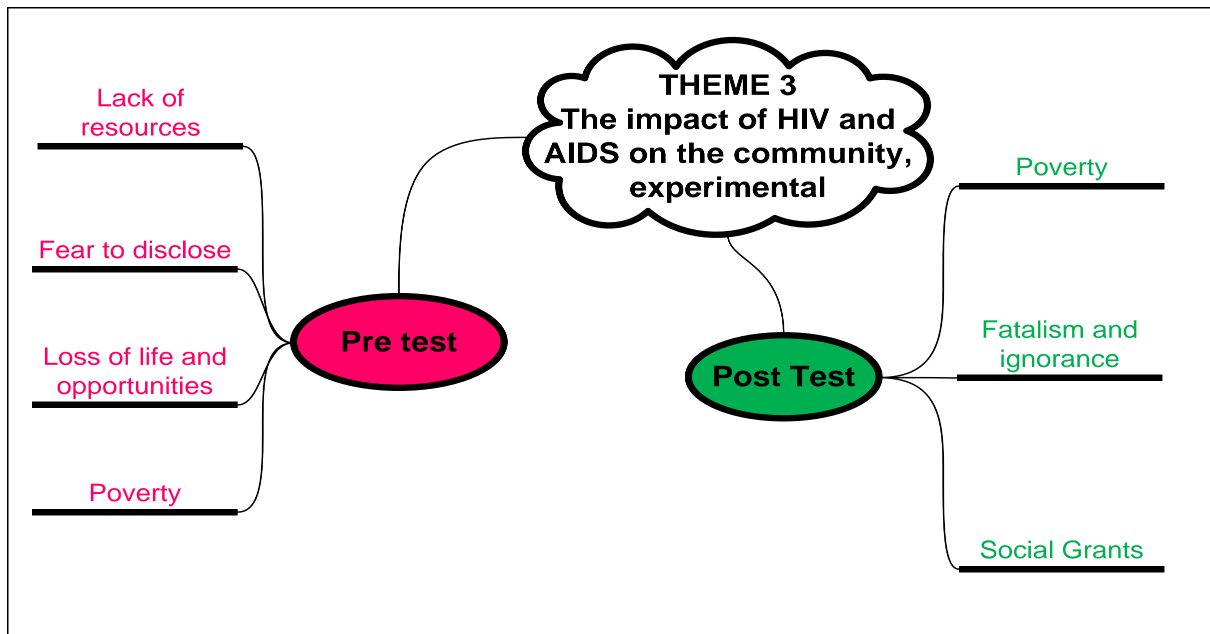

Figure 5-13: Theme 3: The impact of HIV and AIDS on the community

14.3.1 Pre- test results for theme 3

In the pre-test, the theme was divided into the following 4 sub-themes:

- Poverty;
- Lack of resources;
- Fear to disclose; and
- Loss of life and opportunities

Sub-theme 1: Poverty

A lot has been said about poverty and HIV and AIDS. This specific sub-theme dealt with the poverty that is created by HIV and AIDS, as well as the poverty it creates and fuels. The following was noted by participants in this regard:

> *Participant 3: "Some of the learners get infected because of poverty. Their parents are not able to supply them with basic needs and they get involved with anyone who they think has money in order to maintain a good lifestyle."*
> *Participant 8: "AIDS orphans live with grandparents in poverty."*

The link between poverty and HIV and AIDS is emphasised by Cohen (2002:vii) who notes that the HIV pandemic has its origins in conditions of poverty, gender inequality and patterns of development that intensify the mechanisms through which

HIV transmission takes place. Simultaneously, the HIV pandemic, through its impact on development, exacerbates poverty and gender inequality and undermines the organizational capacity and human and social capital essential for development.

Sub-theme 2: Lack of resources

This theme centres on the lack of community resources that is created by HIV and AIDS infection, as well as illness due to AIDS. This lack can be summarised as a deficit in household income, as the child becomes the breadwinner. AIDS also pressurises government to increase its social support towards people affected by HIV and AIDS.

The following was mentioned by participants in the narrative:

> *Participant 6: "There is a lack of resources by the social government and this means that there is an increase in children that need assistance."*
> *Participant 8: "At school we give them food parcels, but we can only do it once a week – the rest of the time they go hungry with nobody to help them*
> *Participant 12: "Children are left without parents. The child becomes the breadwinner"*

In this regard, 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. Cohen (2002:9) also states that the largest number of those infected with HIV, are poor and that the pandemic emphasizes the fault lines in society. The poor are in a situation which make it hard for them to avoid behaviour that lead to infection and they have few of the resources needed for coping with the consequences of HIV and AIDS.

Sub-theme 3: Fear to disclose

This sub-theme dealt with people's fear of disclosure. The fear of disclosure often causes them not to take an HIV test, and then they pose a risk of infecting others knowing or unknowingly in the community. Some people refuse to take a test because they still believe untruths about HIV and AIDS. The following was said by participants:

> *Participant 3: "Children die and people are afraid to disclose their status and get tested – this causes loss of life."*

> *Participant 6: Beliefs hinder people from living positively. People don't want to be tested and they think they are bewitched."*
> *Participant 6: "People deny that they are infected and their denial kills family and the infected person, in actual fact commits suicide. People know they are infected but continue to infect others who are innocent."*

Literature confirms that, due to the immorality associated with AIDS, educators are less likely to disclose their status or their loved ones' status (Boler & Jellema, 2005:6). Although discrimination is prohibited, infected as well as affected people (educators included) are stigmatized, due to the following unfair perceptions: sexual taboos; immoral behaviour, God punishes sexual sin; sorcery and witchcraft; easy transmission; and painful death (Theron 2005:6).

Sub-theme 4: Loss of life and opportunities

This sub-theme focused on loss associated with HIV and AIDS. AIDS causes loss of life and of opportunities for children to develop in a healthy environment. The participants wrote the following:

> *Participant 3: "AIDS leaves behind orphans, parents lose children and community loses economic struggles."*
> *Participant 12: "Children are deprived of youth, or do not enjoy being young they lose many opportunities".*

Cohen (2002:3) indicates the following on loss: In the worst affected countries, there is a steep loss in life expectancy. There are presently an estimated 12 million children who have lost their mother or both parents to the epidemic, and this appalling number of orphaned children is projected to more than double over the next ten years. Loss of life can also lead to a loss in human capital which, according to Cohen, (2000:4) causes all kinds of problems, like for instance loss of specific knowledge due to labour losses.

14.3.2 Post-test results for theme 3

In the post-test, the following sub-themes were identified:

- Poverty;
- Fatalism and ignorance; and
- Social grants.

Sub-theme 1 Poverty

In this theme, it was discussed how HIV causes poverty, and how poverty-stricken environments stimulate HIV and AIDS. The following was noted by participants in support of this sub-theme:

> *Participant 1: "A poverty-stricken environment creates an avenue for AIDS to prevail."*
> *Participant 3: "There are so many people who use poverty as a reason to be promiscuous. People engage themselves in dangerous life by selling their bodies to anyone who has money. Using protection is the last thing on their minds."*

The ILO (2006:16) highlights that in developing economies, poverty remains the most persistent and severe economic and social problem facing the majority of the population. It aggravates all other human problems and is an important root cause of conflict and of diseases, including malaria, HIV and tuberculosis. At the same time, HIV/AIDS is an obstacle to poverty reduction in most resource-poor settings as it ultimately impoverishes households through slowed economic growth and loss of jobs as well as by directly depriving households of their main providers.

Sub-theme 2: Fatalism and ignorance

This sub-theme focused on people's attitude with regard to HIV and AIDS. It elaborates on how people tend to be fatalistic – they believe that there are many ways of dying, and dying of AIDS is just another option. They are also not afraid of being infected with HIV, and once they have acquired the virus or the syndrome, they do not mind infecting others with it. The following was derived from the narratives:

> *Participant 3: "Some people are of the opinion that no one is immortal, we will all die and there are many ways of dying. They tell themselves that God brought them on this earth so that they can enjoy life. They do not mind how they enjoy their lives as they say life is too short, so they want to live life to the fullest. They tell themselves that death has always been there so why should they worry about it. They say there is time for everything and we will all die in a different way."*
> *Participant 3: "There are people who think that they are immune to AIDS, and when they discover that they have the virus they become angry and they want revenge by infecting others so that they do not die alone."*

Literature, confirmed this theme. During a qualitative study by Meyer-Weitz and Steyn (1998), people expressed a fatalistic attitude towards HIV prevention and were of the opinion that it was senseless to try and protect themselves from HIV and AIDS because of the high prevalence in their communities and also because of the difficulties involved in using condoms consistently (Meyer-Weitz 2005:76). According to Meyer-Weitz, (2005:77) youth further argued that it was quite possible that they might die because of violence and crime, and therefore they did not see the need to protect themselves from an infection from which they might die in ten years' time.

These opinions and responses were not the simple result of ignorance. Instead, they seem to be an outcome of the manner in which medical, political and religious discourses have actively, but not always intentionally, constructed AIDS as a condition between life and death.

Sub-theme 3: Social grants

This sub-theme focused on the role that social grants play in the community, and how people will go to great extents to obtain these grants. Participants had the following comments on this issue:

> *Participant 3: "People do not want to work, they want easy money – this is a cause for teenage pregnancy in order to get the child grant."*
> *Participant 6: "There is wastage of resources because when one is educated and he/she dies before even working or paying back the loans. Burden the government with giving free medication and grants."*

Naidu and Harris (2007:426) found that social grants that were eminent in HIV and AIDS affected households were largely disability grants, old age pensions and child support grants. (The proportions of HIV-affected households receiving these grants were much greater than the proportions of non-affected households). For affected households, these grants contributed 30% of annual household income compared with 11% for non-affected households. It is also stressed that social grants have been crucial in compensating for the lower incomes and higher expenditures that HIV and AIDS imposes on households.

14.3.3 Summary on theme 3

This theme highlighted the impact HIV and AIDS has on the community, and how that had influenced the educators In the pre-tests, the participants noted that the largest problems were poverty, lack of resources, fear of disclosure and loss. All these themes correlate with literature. In the post-tests, the participants discussed fatalism, social grants and poverty as the big impact that HIV and AIDS has on the community. It seems as if the participants were more aware of the negative behaviour of people in the post-tests.

14.4 Theme 4: Thoughts of educators on HIV and AIDS

This theme centred on the educators' thoughts on HIV and AIDS. It explored their emotional response when they are thinking about how HIV and AIDS had affected them as educators.

It is important to note that these thoughts are not necessarily in line with literature. The researcher will provide evidence from literature where possible. Figure 5-14 shows how the theme was divided into sub-themes. Each sub-theme will be discussed.

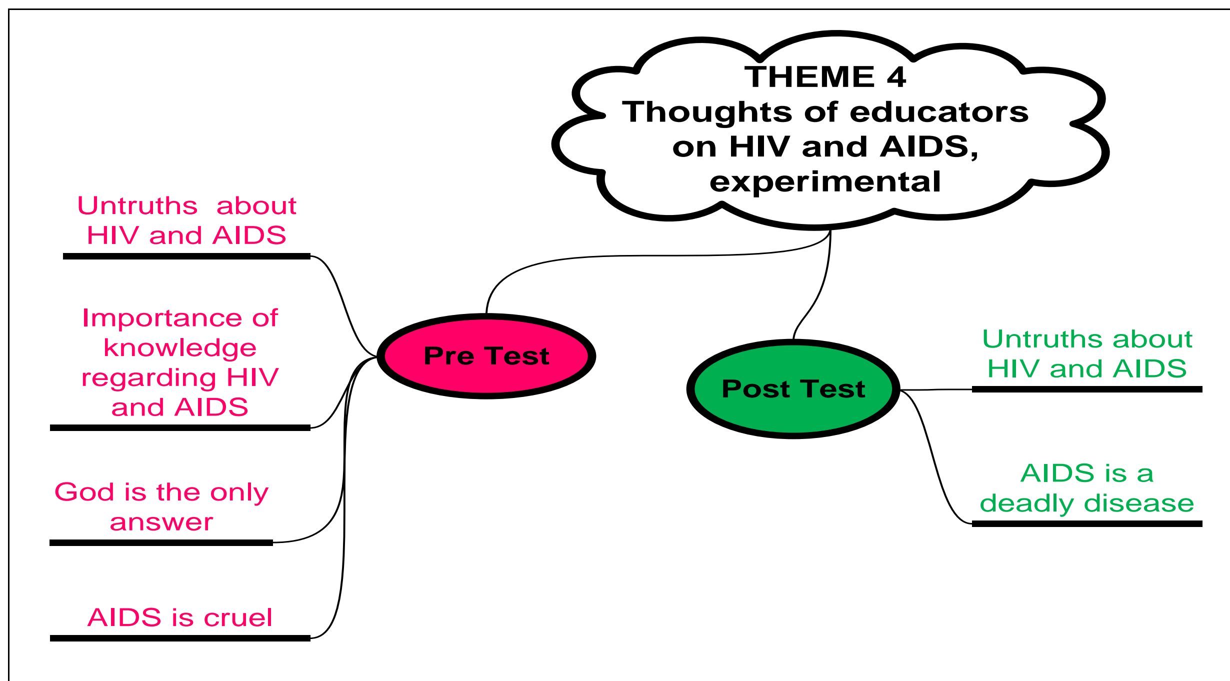

Figure 5-14: Theme 4: Thoughts of educators on HIV and AIDS

14.4.1 Pre-test results for theme 4

The following sub-themes were found:

- Untruths about HIV and AIDS;
- Importance of knowledge regarding HIV;
- God is the only answer; and
- AIDS is cruel.

Sub-theme 1: Untruths about HIV and AIDS

This theme dealt with the fact that people still believe untruths about HIV and AIDS. Examples of these untruths are that AIDS is only a disease for the uneducated, or that HIV does not exist. Participants mentioned the following untruths:

> *Participant 1: "I had always thought that if you are educated you will be distanced from the impact of HIV and AIDS, but I was wrong."*
> *Participant 3: "People don't believe that HIV exists. They wrongly believe it won't happen to them."*

From literature it is clear that people are still of the opinion that HIV and AIDS is a myth. Theron (2005:79) stresses the fact that there were still educators who had misperceptions on HIV and AIDS. In an article on educators' perceptions on HIV and AIDS, Theron (2005:56) found that the stigma surrounding AIDS is complex. She cites Coombe (2000) who found that, whilst discrimination is prohibited, stigmatisation of infected persons is an entrenched response. It is primarily caused by inadequate knowledge, fear of death and disease, sexual mores and poor acknowledgement of stigma. The stigma surrounding AIDS includes prejudiced perceptions.

Sub-theme 2: Importance of knowledge regarding HIV

This sub-theme emphasised the fact that educators realised the importance of knowledge regarding HIV and AIDS. Participants noted the following:

> *Participant 1: "Lack of knowledge about HIV makes one not realise the seriousness of HIV and AIDS."*
> *Participant 1: "Lack of knowledge about HIV makes one fear HIV and AIDS."*

The importance of knowledge regarding HIV and AIDS is also emphasised by Kelly (2000:70) who notes that HIV and AIDS needs to be incorporated into the school curriculum in order to impart knowledge, attitudes and skills that may help to promote safer sexual behaviour.

Sub-theme 3: God is the only answer

This theme noted that faith and God is the only comfort that educators had in the face of the pandemic. Participants wrote:

> *Participant 10: "… what I like most was the confidence I have that God will heal her one day. I hope for miracles to happen in her life. I believe that God is the healer who heals the hearts of those that who are troubled."*
> *Participant 10: "I still believe in God for miracles to bring a cure"*

Sub-theme 4: HIV is cruel

This theme dealt with the views educators had on HIV and AIDS. Educators saw HIV as a monster that kills and destroys lives. HIV is also portrayed as a very cruel disease. The following excerpts noted their feelings towards HIV and AIDS:

> *Participant 10: "AIDS is a barbaric monster that brings cries of woes and pain."*
> *Participant 12: "AIDS is cruel."*

From literature, it is indicated that HIV and AIDS kills. One only has to consider the statistics to know that this is true and real. As noted in Figure 1-1, the UNAIDS Epidemiological Fact Sheet on HIV and AIDS (2008:4) state that approximately 5 400 000 people above the age of 15 are living with HIV and AIDS in South Africa. UNAIDS (2008a:3) reports an estimated 2 million deaths due to HIV and AIDS in 2007. In 2005 alone, AIDS claimed between 2.4 and 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 9 million people in Africa, resulting in a minimum estimate of 18 million orphans.

14.4.2 Post-test results for theme 4

The following sub-themes were found:

- Untruths about HIV and AIDS; and
- AIDS is a deadly disease.

Sub-theme 1: Untruths about HIV and AIDS

This sub-theme was also identified in the pre-test and highlighted that there are still people who believe untruths about HIV. The following was noted:

> *Participant 3: "Some people think AIDS is something invented by government to stop people from enjoying their lives."*

This view is supported by findings of Niehaus (2007:851) who reported in a study done in rural Mpumalanga that villagers frequently blamed powerful outsiders for creating and spreading HIV. Some of these outsiders included Dr Wouter Basson, former head of the apartheid government's chemical weapons programme, and Americans who allegedly manufactured the virus; white farmers who distributed HIV-infected sweet potatoes and oranges; and funeral undertakers and corrupt government officials who blocked the AIDS cure. Within the domestic domain, women accused men of purposefully infecting others with the virus.

Sub-theme 2: AIDS is a deadly disease

This theme once again underlined that HIV is a deadly disease, and that people die because of it. As explicitly noted by participants:

> *Participant 11: "AIDS is a deadly pandemic, and it caused havoc in people's lives, both those that are infected and affected."*

This finding concurs with the UNAIDS (2008a:6) which points out that the estimated number of deaths from HIV and AIDS have increased significantly from 1990, and in 2007, the UNAIDS (2008a:6) reported that approximately 350 000 people have 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 fifteen die of AIDS on a daily basis.

14.4.3 Summary on theme 4

Theme 4 dealt with the thoughts of educators on HIV and AIDS. In both the pre- and post-tests, participants commented on the fact that people still believe untruths about HIV and AIDS, and that HIV and AIDS is deadly and cruel. In the pre-test, participants elaborated on the fact that knowledge of HIV is important, and that God is the only answer.

14.5 Theme 5: Action plans devised by educators to cope with the impact of HIV and AIDS

The following theme aimed to explore which action plans educators devised to assist them with coping with HIV and AIDS. Figure 5-15 shows how the theme was divided into sub-themes:

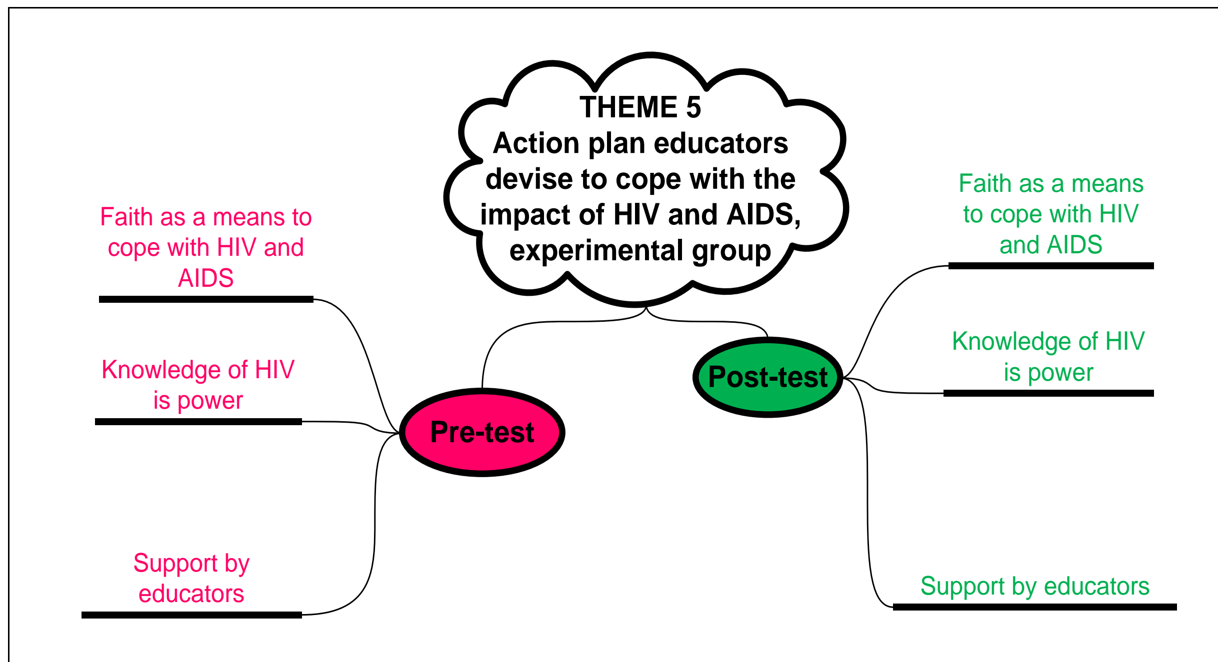

Figure 5-15: Theme 5: Action plans educators devise to cope with the impact of HIV and AIDS

14.5.1 Pre-test results for theme 5

This theme explored the actions that educators undertook to help themselves to cope with the impact HIV and AIDS has on their lives. Once again, because these actions were implemented by individuals to solve individual problems and lack of coping, these actions cannot necessarily be supported by literature. Where possible the researcher will support the sub-themes from other sources.

The following sub-themes were found:

- Faith as a means to cope with HIV and AIDS;
- Knowledge of HIV is power; and
- Support by educators

Sub-theme 1: Faith as a means to cope with HIV and AIDS

Faith is one of the means that a participant used to cope. She firmly believes in God, and in His power to heal, so she used her faith to give the learners hope.

The following was noted to support this theme:

> *Participant 10: "I pray and believe in God and miracles, and when a learner grieves, I involve learners in prayer as means of consolation. I ask God for strength and for help for the learners and to help me to overcome this problem."*

Sub-theme 2: Knowledge of HIV is power

This sub-theme dealt with the use of knowledge to empower the individual to cope. The following was brought up:

> *Participant 1: "I resigned my job to learn more about HIV and AIDS, so that I can teach others about HIV so that they will not die of ignorance. I have learnt that fear is taken away by knowledge. Knowledge about HIV and AIDS empowers."*

Literature confirms this. Campbell, Foulis, Maimane and Sibiya (2005:473) cite (Crossley, 2000) who stresses that the accurate knowledge about health risks is an important precondition for health-enhancing behaviour change.

Sub-theme 3: Support by educators

This sub-theme showed how educators tried to cope by helping and encouraging learners and other HIV infected people. The educators were the people who took initiative. Some examples were encouraging learners to look after one another and to respect the elders. The following was noted in the narratives:

> *Participant 1: "I can offer good things to those who are infected."*
> *Participant 10: "I encourage learners to look after one another and to respect the elders caring for them."*
> *Participant 8: "I started a vegetable garden to supplement food parcels that are given out once a week…. I worked in the garden myself, and sometimes learners and other staff members assisted."*
> *Participant 12: "I do home visits and find disasters at home, then I try to organise social workers to help learners."*

Mrs Mothibe (2008), headmaster of a primary school, noted that the educators in her school tend to become very involved with the children – the 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 HIV-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.

14.5.2 Post-test results for theme 5

The following sub-themes were found

- Faith as a means to cope with HIV and AIDS;
- Knowledge of HIV is power; and
- Support by educators

Sub-theme 1: Faith as a means to cope with HIV and AIDS

As identified in the pre-test faith was once again a lifeline for participants. The following was noted:

> *Participant 10: "Prayed to God to give a solution, and He did. Disclosure brought freedom, and support."*

Sub-theme 2: Knowledge of HIV is power

As noted previously, knowledge is seen as a solution to cope with HIV and AIDS. The following was said in the narrative.

> *Participant 8: "Sex education is needed."*
> *Participant 11: "Deal with HIV cautiously by learning about preventative measures and deal with being infected in order to live longer."*

Sub-theme 3: Support by educators

Once again, the educators noted that they are prepared to assist in any way possible. The following was mentioned in the narrative:

> *Participant 8: "These children are poor, and we need to give them food parcels"*
> *Participant 10:" I am prepared to campaign to parents to take HIV seriously and know their status."*
> *Participant 11: "School needs to intervene and give food parcels."*

14.5.3 Summary on theme 5

In both the pre- and post-tests, educators listed that faith is a means to cope. They also expressed the importance of adequate knowledge on HIV and AIDS in the pre- and post-tests. The actions that participants took themselves to support people who need it were also eminent in the pre- and post-test. It seems as if these actions were sometimes motivated by educator's own empowerment, and sometimes by their exasperation.

14.5.4 Conclusion for experimental group qualitative narrative

The data gathered from the experimental group's narratives showed that the educators are negatively influenced by HIV and AIDS. Their stories reflected a lot of pain and frustration. The pre-tests showed some desperation – the educators were confronted with many problems, and they try to deal with them.

The post-test was more positive. Participants did note some empowerment, and two participants referred explicitly to the REds programme as a positive influence in their lives.

The comparison data will now be discussed.

15. COMPARISON GROUP QUALITATIVE DATA

For clarity purposes, the researcher will firstly visually present each theme. This visual presentation consists of a mind map drawing that shows the different sub-themes that was found for every theme in both the pre- and post-tests. This will be done for all five themes in the comparison group. The themes and sub-themes are then discussed by verbatim quotes from the narratives followed by supporting citations from relevant literature Thereafter the researcher will write a summary for each theme and then compare the differences between the experimental and comparison groups visually. In the last instance, conclusions will be compared, and an overall conclusion will be made.

15.1 Theme 1: Impact of HIV and AIDS on the school environment

This theme and its sub-themes dealt with the experience of the educators on how HIV and AIDS have an impact on the school environment. Figure 5-16 visually sets out how the theme is divided into its different sub-themes:

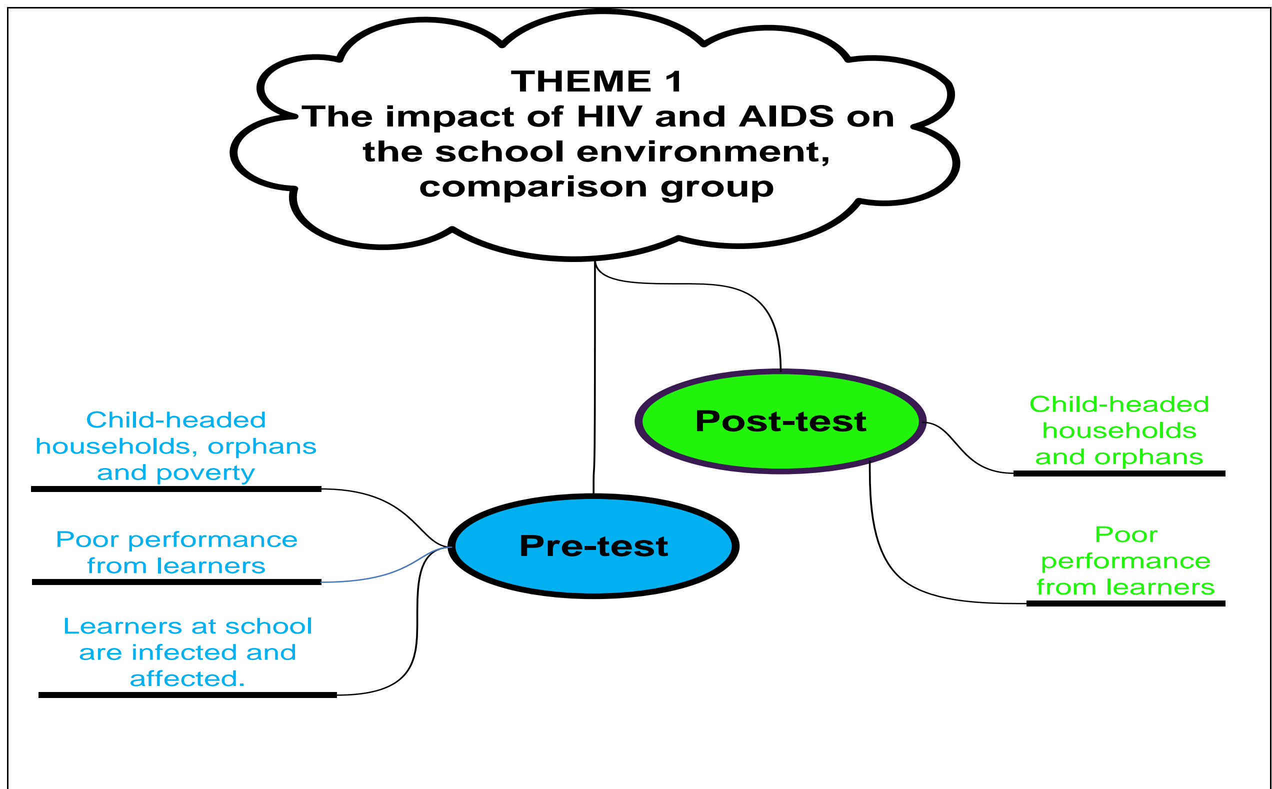

Figure 5-16: Theme 1: The impact of HIV and AIDS on the school environment

15.1.1 Pre-test results for theme 1

The following sub-themes were derived from the pre-test narratives

- Child-headed households, orphans and poverty;
- Poor performance from learners; and
- Learners at school are infected and affected.

Sub-theme 1: Child-headed households, orphans and poverty

This sub-theme was very central in the narratives. Participants summated that many of the learners attending the school are orphans or live in child-headed households. These children live in circumstances that force them to care for siblings or their ill parents. Sometimes the situation is worsened by extreme poverty. Poverty sometimes results from a breadwinner dying of an AIDS-related disease. The participants emphasised the following:

> *Participant 11: "Learners lose both their parents and have no one to look after them. Then these children beg in the streets for food or come to school hungry to receive the meal from school – this is all they eat in the day."*

Participant 4: "Most of our learners lost their parents after the long illness. Most of them are the ones helping their parents while they are sick until the end. These children are orphans. Some of the family end up headed by the child."
Participant 5: "Learners feel inferior when compared to other learners because they are always in tatters, no clothes, no food, no one to care for them because they have lost the breadwinners."
Participant 12: "I experience massive absenteeism and hunger among the children."
Participant 15: "Some learners are leaders of the family…These families are poverty stricken because no-one is working."

Robson *et al.* (2007:419) highlights the fact that as the number of mortalities increase, it leads to increasing numbers of children who live in disrupted family situations. This disrupted family situation includes living with grandparents, stepparents, extended families or in child-headed households. Cohen (2002:16) found clear evidence that shows that intensified poverty, in part the result of the erosion of the asset base of households and other pressures on current resources, has the effect of reducing school enrolment and attendance.

Sub-theme 2: Poor performance from learners

This theme elaborated on the way HIV and AIDS affects the performance of learners. The learners are orphans and come from poverty-stricken homes. Sometimes the family is so poor that the children do not know where the next meal will come from. Some children have the responsibility to care for their sick parents or sibling, which causes them to worry. The situations at the homes of the children often lead to absenteeism, poor concentration and a decrease in scholastic performance. In the narratives, the following was articulated:

Participant 4: "Being orphans and caring for sick parents affect performance."
Participant 5: "Learners can't concentrate because their parents are dead or they have no one to care for them."
Participant 12: "Children are sleepy in classes... they are tired and crying because they worry about the situation at home."
Participant 13: "Affected learners struggle to concentrate or do well. They are always absent, and this makes progress difficult "
Participant 15: "Learners are sick and absent, I need to visit them at home to bring them catch-up work – learners fail because they fall behind in their school work."

Poor academic performance by learners is confirmed by Robson *et al.* (2007:424) who report that the participation and quality of learning was affected, especially in

orphans, because they often came to school poorly dressed, hungry, sleep-deprived after long hours of household labour, and psychologically and emotionally traumatised.

Sub-theme 3: Learners at school are infected and affected

This sub-theme reflects on the manner in which learners are infected and affected by HIV and AIDS. Learners are affected by parents who are ill from an AIDS-related disease, or by parents who passed away. Sometimes the learners are ill, and they come to school sick, or they are absent. In the narratives, the following was indicated:

> *Participant 3: "Learners need to take care of sick parents, who eventually die."*
> *Participant 4: "Sick learners are staying with grandparents who struggle to care for them."*
> *Participant 9: "Mondays are frustrating because learners are always sick on Mondays and you find out they don't have food at home."*
> *Participant 11: "Learners are sick, and don't get proper treatment from their guardians or they are neglected by their guardians."*

In a study by Robson *et al.* (2007:425), educators reported that they are most affected when learners are infected. Robson *et al.* (2007:425) found that teachers report having comforted children who seemed particularly distressed.

15.1.2 Post-test results for theme 1

In the post-test, the following sub-themes were noted:

- Child-headed households and orphans; and
- Poor performance from learners.

Sub-theme 1: Child-headed households and orphans

As in the pre-test, educators repeatedly mentioned the impact of child-headed households and orphanhood on learners.

In the post-test, the comparison group noted the following:

> *Participant 9: "Children are late and absent because there is no-one to take care of them. The children tell you they are orphans and there is no food in the home. It is quite a challenge – children come to school without food, clothes,*

> *and they are not bathed. When you ask for a reason you hear that the parents died and the neighbours are looking after the kids."*
> *Participant 12: "They need food, because they don't have parents. Most of them are orphans because of this disease."*

The World Bank (2002:16) emphasises that the increase in orphans represents one of the largest impacts of HIV and AIDS. 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.

Sub-theme 2: Poor performance from learners

As earlier noted, poor performance is one of the results of HIV and AIDS. The participants noted the following in support of this sub-theme:

> *Participant 4: "Most of the learners are not performing well because of the difficulties they are facing."*
> *Participant 6: "If they are infected it is difficult for them to produce good results. During teaching time, these learners cannot focus and pay attention. Sometimes they do not get food or medication… they fall asleep during teaching and learning. They are affected because their parents are sick at home so they have to take care of their parents and that gives them less or no time to do their homework and nobody helps them at home. They have to cook for their siblings and have to do everything at home. Obviously they are going to produce poor results because they didn't have enough time for their school work."*

15.1.3 Summary of theme 1

The educators noted that children are suffering most severely due to HIV and AIDS. They noted the same issues as the experimental group, namely child-headed households and orphans, poverty, poor performance and issues affecting the learners specifically. The researcher is of the opinion that the pre- and post-test results did not show any significant difference – the post-tests actually had a more negative tone than the pre-tests. This could possibly be because the participants received no intervention.

The following theme will discuss the personal impact of HIV and AIDS on educators.

15.2 Theme 2: The personal impact of HIV and AIDS on educators

This theme explored the personal impact HIV and AIDS have on the educators. Figure 5-17 depicts how the main theme was divided into sub-themes:

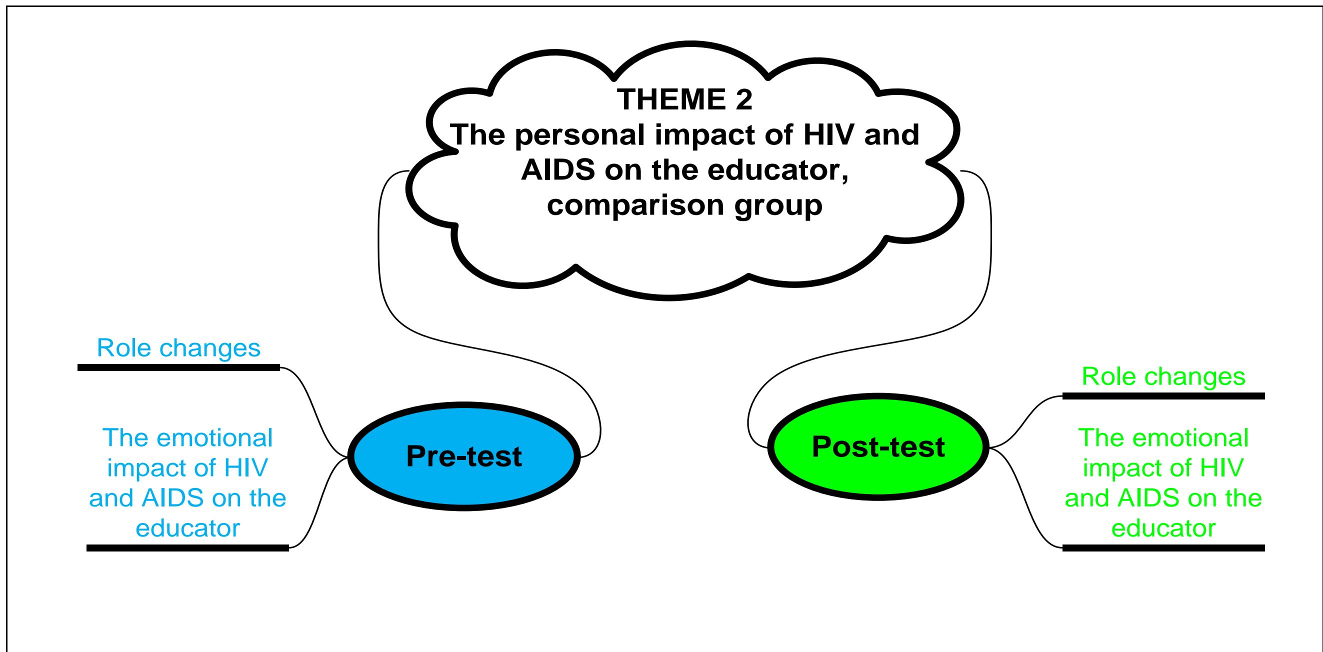

Figure 5-17: Theme 2: The personal impact of HIV and AIDS on the educator

15.2.1 Pre-test results for theme 2

This theme shows that educators are personally impacted by HIV and AIDS the following sub-themes were identified:

- Role changes; and
- The emotional impact of HIV and AIDS on the educator.

Sub-theme 1: Role changes

This sub-theme highlights how the roles that educators play have changed since HIV and AIDS came into the education system. Educators need to fulfil roles of support, caring and solving problems.

The following was noted by participants:

> *Participant 3: "Teachers are burdened – they need to identify and support affected learners."*
> *Participant 15: "I am a social worker, a psychologist, a paramedic and a pastor."*

This is confirmed in literature. Theron *et al.* (2008:84) spell out that the current teaching context demands educators respond with roles such as grief counselling, solving family problems and finding resources.

Sub-theme 2: The emotional impact of HIV and AIDS on the educator

This sub-theme noted the emotional impact that HIV and AIDS had on the participants. This sub-theme was very central in the narratives.

The following was said:

> *Participant 5: "Each day you are faced with struggling learners, you are heartbroken by this. You try to help, but you feel that you are not doing enough."*
> *Participant 8: "I started to worry when one of my family members died – it was very painful."*
> *Participant 10: "The thing that saddens me the most is to see a child who is HIV infected."*
> *Participant 12: "Dealing with these children is not easy – you have to be sensitive and supportive, because they have very hard lives."*

According to Shisana *et al*. (2005a:115) educators are tormented emotionally when relatives, colleagues and learners are suffering from HIV and AIDS

15.2.2 Post-test results for theme 2

The following sub-themes were identified:

- Role changes; and
- The emotional impact of HIV and AIDS on the educator.

Sub-theme 1: Role changes

Role changes were again highlighted by educators. It was expressed in the narratives that educators are faced with the problems that learners have and that the educators need to find solutions for the problems. Often the educator needs to fulfil roles of counselling, being sympathetic and listening to the learners.

From the narratives, it was derived that the educators do exactly this:

> *Participant 4: "… it is then when we as educators take our role as leaders and as social workers…"*

Participant 12: "Being a teacher is challenging. It is not about being a teacher but you will become a mother, social worker and nurse. You need to love those who are close to you."
Participant 13: "I am faced with problems of learners that I need to deal with."
Participant 15: "As a teacher, I need to practice love, patience, sympathy, empathy, be accommodating at all times, I need to hear them, because most of the kids are affected. You have to counsel those that are affected, and the same time you become worried and filled with anxiety when you see them cry. After you have heard their story, you even have to visit their homes to monitor how bad the situation is. If there is a need, you even go to the extent of providing them with what they need."

In literature, Robson and Sylvester (2007:425) also stress the point that many of the school staff participate in various unofficial support and monitoring activities (supplying food, clothes, keeping orphan registers, soliciting for bursaries and so on) that go beyond traditional educational roles.

Sub-theme 2: Emotional impact of HIV and AIDS on the educator

HIV and AIDS have an overwhelming emotional impact on the educator. It causes feelings of confusion, sadness, grieving, uncertainty, fear and desperation. In the narratives, the following was noted:

Participant 5: "Living in this era makes one to have feelings of confusion and broken heartedness. The confusion comes because you do not know if you have solved the child's problems. I am broken-hearted because I don't know what to say to grieving children, and I feel as if I don't trust my own judgement when interacting with a learner – even if the learner is grieving, I still have to reprimand him if he is disobedient, but then I distrust myself. When I go home at night, I feel as if I am not doing enough. I have feelings of guilt and I want to do more."
Participant 7: "It is difficult living in this world nowadays. Sometimes I wish I was never born, because we are watching innocent children die."
Participant 12: "I lost everybody close to me because of HIV and AIDS"
Participant 13: "I just become scared sometimes to face the situation."
Participant 15: "At times you promise them that things are going to be fine, knowing very well that everything is not going to be fine, just because you don't know what else to do."

15.2.3 Summary of theme 2

The educators are affected by their emotional experiences, as well as the different roles that they need to perform in school and in their community. The researcher once again did not detect big differences between the pre- and post-tests. The next theme will explore the impact HIV and AIDS have on the community.

15.3 Theme 3: The impact of HIV and AIDS on the community

This theme focuses on the impact HIV and AIDS have on the community. Figure 5-18 shows how the theme is divided into sub-themes:

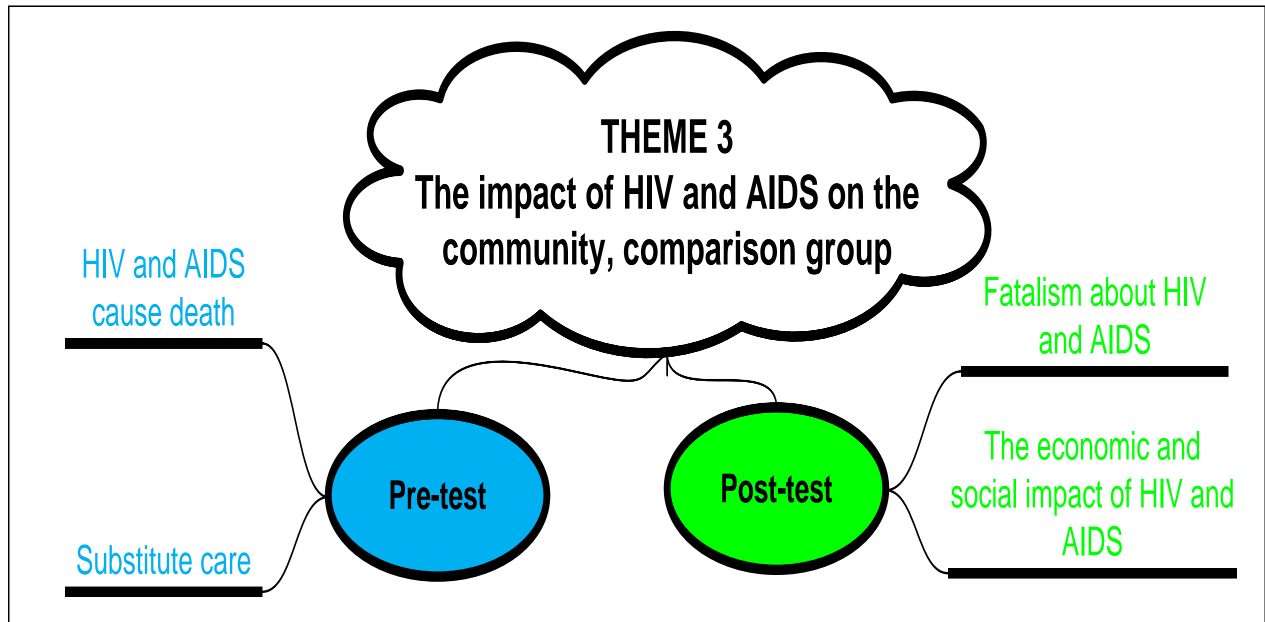

Figure 5-18: Theme 3: The impact of HIV and AIDS on the community

15.3.1 Pre-test results for theme 3

This theme explored how the impact of HIV and AIDS on the community affects the educator. Most of the educators live in the community where they work, so they are very familiar with the problems in the community, and it touches them in a direct manner.

The following sub-themes were extracted:

- HIV and AIDS cause death; and
- Substitute care.

Sub-theme 1: HIV and AIDS cause death

Educators referred specifically to the death toll of HIV and AIDS. The following comment illustrated this sub-theme:

Participant 3: "Our community is affected because our cemeteries are full"

UNAIDS 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 (UNAIDS, 2008a:4).

Sub-theme 2: Substitute care

According to educators, many children are placed in substitute care, which is not necessarily to the benefit of the child. Some of the participants noted the following:

> *Participant 3: "The parents die and grannies need to look after children."*
> *Participant 4: "Children are orphans and they are staying with grannies. The grandmothers are old and they are not working, these learners become ill, and the granny can't take care of them."*
> *Participant 9: "Many children are orphans and are placed in substitute care or with family members or in children's homes. When you look at them, they are not happy.*
> *Participant 11: "Some of my learners lost both of their parents, and they have no-one to look after them, they are placed in centres where they don't get proper care, they are ill-treated or sometimes they don't have food to eat. Some of them are taken care of by old weak grannies… they are neglected by their guardians"*

In literature, Poulsen (2005:50) mentions that an increasing number of children are living in disrupted and shifting family situations. Children 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. Family and social structures were already shifting and fluid in both study areas and HIV and AIDS has aggravated this tendency.

15.3.2 Post-test results for theme 3

In the post-test, the following sub-themes were extracted:

- Fatalism about HIV and AIDS; and
- The economic and social impact of HIV and AIDS

Sub-theme 1: Fatalism about HIV and AIDS

This theme was also mentioned by the experimental group. The theme dealt with the people's attitude of fatalism towards HIV and AIDS.

The following was said:

> *Participant 3: "People or children growing up in this time seem to be reckless with their lives because government also provides them with disability grants. From the look of things, teenage pregnancy is now very high because of grants and disability grants."*

According to Meyer-Weitz and Steyn (1998) people expressed a fatalistic attitude towards HIV prevention and were of the opinion that it was senseless to try to protect themselves from HIV and AIDS because of the high prevalence in their communities and also because of the difficulties involved in using condoms consistently (Meyer-Weitz 2005:76).

Sub-theme 2: The economic and social impact of HIV and AIDS

Educators mentioned that HIV and AIDS have serious economical and social impacts on society. Family structures are disrupted, and people struggle economically due to AIDS.

The following was noted by the participants:

> *Participant 3: "It affects us economically and socially, because of the number of orphans caused by HIV and AIDS, and it causes trauma to most families."*
> *Participant 4: "Grandmothers need to look after children, while they themselves are not well and they also need to be helped and looked after."*

According to the ILO (2006:25), the impact of HIV undermines the process of human capital formation. The ILO (2006:25) affirms 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 economical and social effects, and that can lead to higher HIV infection rates, due to issues such as child labour.

15.3.3 Summary on theme 3

The participants noted that HIV and AIDS have a negative impact on the community. Death causes trauma, and the children need to be placed in substitute care. Those in substitute care are not necessarily cared for. HIV and AIDS also cause people to become fatalistic and it causes economic and social problems.

The thoughts on HIV and AIDS of educators will now be discussed.

15.4 Theme 4: Thoughts of educators on HIV and AIDS

This theme dealt with the thoughts participants had on HIV and AIDS. Figure 5-19 illustrates how the theme was divided into sub-themes.

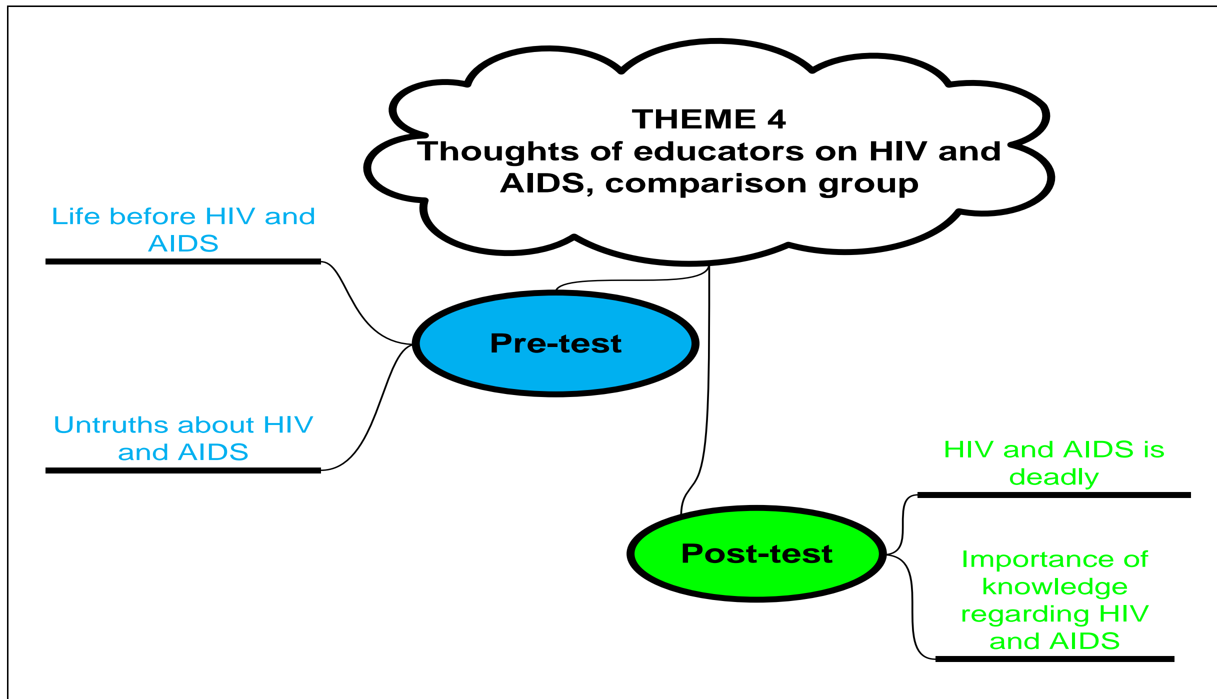

Figure 5-19: Theme 4: Thoughts of educators on HIV and AIDS

15.4.1 Pre-test results for theme 4

This theme explored what educators think of HIV and AIDS. It was divided into the following sub-themes:

- Life before HIV and AIDS; and
- Untruths about HIV and AIDS.

Sub-theme 1: Life before HIV and AIDS

This sub-theme reminisced on how educators experienced life before HIV and AIDS.

The following was noted:

Participant 5: "Before HIV came into being, learners were full of life, happy and loved one another. Now they are sickly, with a low self esteem, and unsure of what the future holds for them."
Participant 7: "Long ago you could sleep around and only get STD's. Now you have to think about this terrible disease."

> *Participant 8: "Life was so good before the HIV pandemic. I never thought it would stay with us and kill us and our families."*

The researcher is not aware of any literature that supports this theme.

Sub-theme 2: Untruths about HIV and AIDS

The participants noted the following untruths that people still believed:

> *Participant 6: "Parents think sick children are bewitched."*
> *Participant 7: "First we thought it [AIDS] was a joke."*

This view is supported by findings of Niehaus (2007:851) who reported in a study done in rural Mpumalanga that villagers frequently blamed powerful outsiders for creating and spreading HIV.

15.4.2 Post-test results for theme 4

In the post-test, the following sub-themes were articulated:

- HIV and AIDS is deadly; and
- Importance of knowledge regarding HIV and AIDS.

Sub-theme 1: HIV and AIDS is deadly

As also indicated by the experimental group, participants postulated that AIDS kills. The following was said:

> *Participant 8: "AIDS makes people sad and thinks they will die young."*
> *Participant 12: "Firstly I thought HIV is not a killing disease, but now I am affected by all the deaths."*

Statistics that were previously noted support these findings.

Sub-theme 2: Importance of knowledge regarding HIV and AIDS

Participants articulated that knowledge about HIV is important. It was noted that:

> *Participant 13: "If people have no education on HIV, it makes people scared. Knowledge is empowerment."*

15.4.3 Summary on theme 4

In the pre-test, participants noted that people still believed many untruths about HIV and AIDS, and that life was better before HIV came into existence. In the post-test

participants articulated that HIV is a killer disease, and that knowledge about HIV and AIDS is important.

15.5 Theme 5: Action plans educators devise to cope with the impact of HIV and AIDS

This theme explores the actions that educators took in order to cope with HIV and AIDS. Figure 5-20 aims to illustrate how the sub-themes were derived.

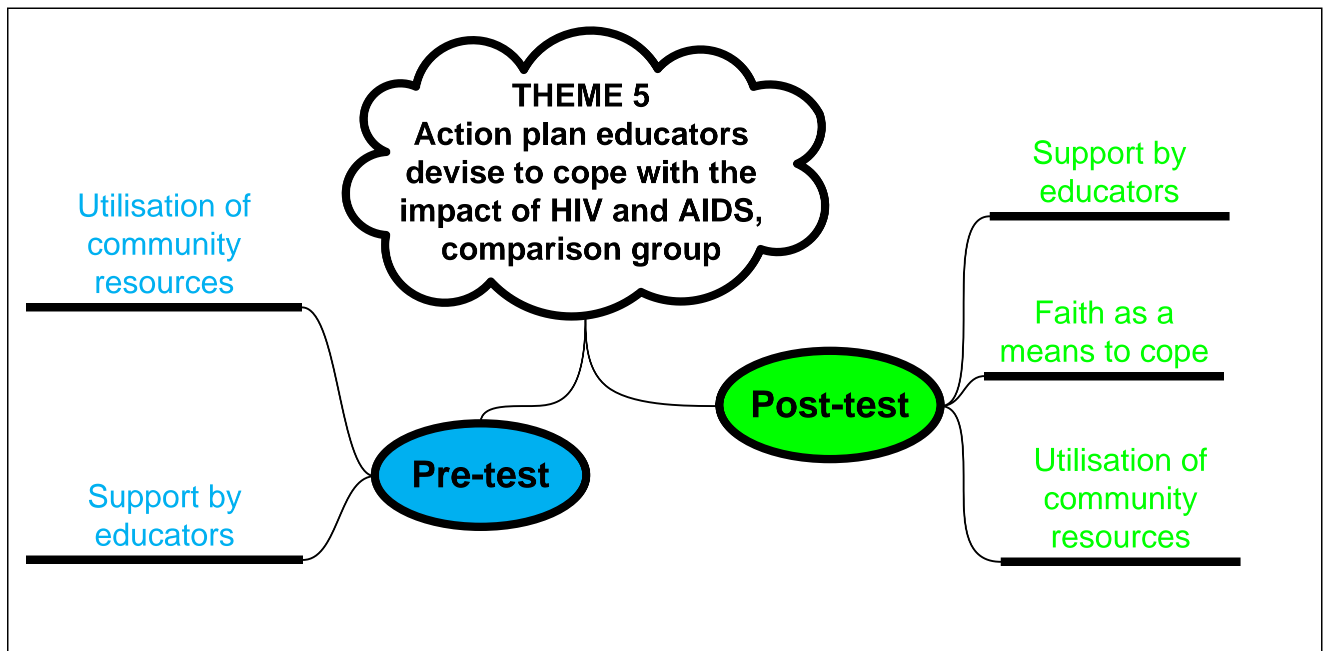

Figure 5-20: Theme 5: Action plan educators devise to cope with the impact of HIV and AIDS

15.5.1 Pre-test results for theme 5

The theme aimed to articulate how educators tried to cope with the impact of HIV and AIDS in their personal lives. Once again, the theme is focused on individual's actions, and is not necessarily supported by literature.

The following sub-themes were identified:

- Utilisation of community resources; and
- Support by educators

Sub-theme 1: Utilisation of community resources

Some of the participants used outside resources like social workers and health institutions to assist those infected and affected by HIV and AIDS. The following was noted:

> *Participant 6: "When I realised the child was sick, I called the parents for help… but later I had to contact the social worker."*
> *Participant 12: "We are involved in many campaigns in the community to assist those who are affected and infected with HIV and AIDS."*
> *Participant 12: "We refer children to the social workers for help, attend workshops, visit hospitals and provide food"*

Sub-theme 2: Support by educators

This theme showed that educators assisted the children and supports the community themselves. The following was said:

> *Participant 4: "As a teacher it is my duty to help learners who suffer. I need to get food and help for the grannies."*
> *Participant 9: "In the end, I play UBUNTU and try to counsel the granny and empower her to see a social worker and get help, but sometimes I need to intervene to help children who do not have food at home."*
> *Participant 10: "I always need to help everyone who is infected by means of advising, food and health. Sometimes I help learners from my own pocket."*
> *Participant 15: "There is such a big need. Sometimes I provide food and clothes, for learners, and sometimes even shelter."*

15.5.2 Post-test results for theme 5

In the post-test, the following sub-themes were central:

- Support by educators;
- Faith as a means to cope; and
- Utilisation of community resources

Sub-theme 1: Support by educators

In this sub-theme, the participants once again noted that they assisted and supported the children and HIV and AIDS affected people in the community themselves. The following was mentioned:

Participant 12: "I feel great to help and am willing to take care of others. I help children by attending workshops and then sharing the knowledge with them."
Participant 7: "We must take responsibility as people and young generation to Abstain till Marriage (ATM)."
Participant 4: "I do home visits like social workers and refer families to the NGO called Friends for Life. Educators need to help people; it is part of our job."
Participant 15: "I provide food for the children, and monitor the children."

Sub-theme 2: Faith as a means to cope with HIV and AIDS

Some participants referred to faith as a means to help people cope with HIV and AIDS.

Participant 4: "… and I ask God to give them more time in this world."
Participant 15: "…put them to your chest and comfort them. Tell them how important they are and that their being on earth is not a mistake and that God has a purpose for them. Give them love."

Sub-theme 3: Utilisation of community resources

Some of the participants highlighted how they used resources in the community to help people to cope with HIV and AIDS. They noted the following:

Participant 8: "We need more workshops to teach us about HIV and AIDS so that we can help more parents and children."
Participant 9: "In order to help the children I involve social workers."
Participant 12: "I participate in awareness campaigns preaching words of safety to all who need to hear it."

15.5.3 Summary on theme 5

This theme dealt with the actions that participants took in order to help them cope with the pandemic. In the pre- and post-tests, a lot of emphasis was on helping and supporting the children and people in the community themselves. It seems as if the participants have a great sense of responsibility, and they care very much about the children. Once again, there was no significant difference between the pre- and post-tests.

16. COMPARISON BETWEEN THE EXPERIMENTAL AND COMPARISON GROUP'S NARRATIVES

When comparing the experimental and comparison group pre-test narratives, the researcher identified that both groups wrote down negative issues that they experienced as educators in the era of HIV and AIDS. This is a list of some of the correlating sub-themes: poor performance of learners; child-headed households; role changes the educator experienced; the emotional impact of HIV and AIDS on the educator; poverty; HIV and AIDS causes death; lack of resources; untruths people believe about HIV and AIDS; and educators as a support system for children and people in the community.

In the post-test, the experimental group wrote down negative issues, but some of the participants shared their feelings of hope and empowerment. The negative issues listed were a statement of the realities that they face due to the impact that HIV and AIDS has. The participants noted their own empowerment as an answer to some of the problems they face. In the comparison group, the narratives did not differ from those in the pre-test, and when put side by side with the experimental group, these narratives seem more negative than the experimental group's narratives.

Considering this, the researcher can conclude that the REds programme did empower the participants in the experimental group by addressing their support needs as HIV and AIDS affected educators. These educators felt empowered with knowledge and skills that they lacked. They were more resilient after participation in the REds programme.

17. QUALITATIVE DATA ANALYSIS OF DRAWINGS

The participants were requested to make drawings as another method of collecting qualitative data. The following probe was given: "When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below." The participants were also asked to explain their symbol by writing two or three sentences that explained the symbol. An example can be seen in Annexure 15

17.1 Experimental group drawings

17.1.1 Pre-test drawings

The following was drawn by the experimental group in the pre-tests:

- Participant 1 drew HIV like **arrows**. These arrows come from nowhere, and all of a sudden, a person feels overwhelmed – emotionally, physically, psychologically, spiritually, and economically. A person experiences the following feelings: hopelessness; anxiety; loneliness; regret; tiredness; thoughtlessness; feeling strained; disturbed and scared.
- Participant 3 drew a **grave**, and said that if we continue to be ignorant, and not take the necessary precaution, we will all perish.
- Participant 6 drew the **vicious cycle of HIV and AIDS**. Her cycle says that death causes poverty and child-headed households, which leads to absenteeism at school, sick kids and grandparents looking after sick children. An increased death rate leads to loss in the community.
- Participant 8 drew the **grave** of people who had unprotected sex and died of AIDS.
- Participant 10 drew an **AIDS ribbon**, and noted that her friend with HIV will always be her friend.
- Participant 11 drew **green trees bearing fruit** that symbolises life before HIV and AIDS, and **dried-up trees, like a desert**, symbolising life after HIV and AIDS, and this life is hopeless.
- Participant 12 drew an **AIDS ribbon**, and noted that a person with HIV is still a person.

17.1.2 Post- test drawings

The following was drawn by the experimental group in the post-test:

- Participant 1 drew **a person standing at the top of a mountain** feeling that this person is a source of strength for all life. Moreover, this person has the ability to give these qualities to others. The person is experiencing the

following: wisdom; love; embrace; freedom; goodbyes; faith; human dignity; hope; kindness; warmth; life; strength; and being caring.

- Participant 3 drew **people holding hands**, their arms forming a star – this means that with the knowledge that we have about HIV and AIDS, we can conquer the disease, and look forward to a bright future by helping, supporting, respecting and loving one another. We now look forward to an HIV free generation. TOGETHER WE CAN!
- Participant 6 drew **stakeholders** from the economic, business, social welfare, educational, medical and social society, **holding hands**. These stakeholders are working together to fight HIV and AIDS. This disaster has affected everyone.
- Participant 8 drew a **tombstone** that covers the grave of a person that has died from HIV and AIDS.
- Participant 10 drew an **AIDS ribbon**, and noted that a friend with HIV will always be a friend.
- Participant 11 drew **the map of Africa that cries**. The drawing means that Africa is the biggest victim of the pandemic, and people are suffering due to a lack of knowledge and resources.
- Participant 12 drew a **candle that burns brightly**, indicating hope.

17.1.3 Comparison between the experimental group's pre- and post-tests:

The probe for writing the narrative was to think how the pandemic has affected you, and to draw the symbol that comes to mind. In the pre- and post- tests, the following themes were identified, as shown in Table 3.

Table 2: Summary of experimental group themes derived from drawings.

Pre-test experimental group themes	Post-test experimental group themes
Feelings of being overwhelmed.	Feelings of victory and of being able to cope
Pre-occupation with death and warnings	People and stakeholders are working

that HIV kills and without precaution, we will all perish.	together and holding hands, fighting the pandemic together.
A person with HIV is still a person worthy of love and kindness	Feelings of hope, and people with HIV is still worthy and should be treated with dignity.
HIV has changed the world, and has made people hopeless	Africa as a continent suffers due to a lack of resources.
HIV has a vicious cycle that affects everybody and everything.	Pre-occupation with death

The post-test themes were more positive than that of the pre-test. The participants seem to have a more positive outlook of how HIV and AIDS have affected them after participation in REds.

17.2 Comparison group drawings

17.2.1 Pre-tests drawings

The following was drawn by the comparison group in the pre-test:

- Participant 3 drew **black heavy clouds** on a person's shoulders.
- Participant 4 drew a **world that is dark and scary**.
- Participant 5 drew a **person crying and feeling heartbroken** and sad because of AIDS orphans and children suffering from mother to child transmission.
- Participant 6 drew a **tired and exhausted person**, who is tired due to stress, and is feeling sad and sorry.
- Participant 7 drew **AIDS as a monster that is eating children**, friends and family alive, and AIDS as a devil who is hungry for our lives.
- Participant 8 drew a **heart with an arrow right through** it, indicating that HIV causes a lot of pain.
- Participant 9 drew a **person crying**, and noted that HIV makes her sad and makes her cry.
- Participant 11 drew **graves** – the person wishes he/she were dead, because he/she struggles to cope with losing three loved ones in three years.

- Participant 12 drew **a dead person** with a priest praying over the corpse, and people crying.
- Participant 13 **drew a dark night without light or stars**, with a heavy storm over the person's life.
- Participant 15 drew **HIV as a snake**, and **a spear**, piercing lives and killing people.

17.2.2 Post-test drawings

In the post-tests, the following was drawn by the comparison group:

- Participant 3 drew **a person crying**, and being very sad. The person does not know how to describe the feelings.
- Participant 4 drew **a big snake** – AIDS is like a big snake with a big mouth.
- Participant 5 drew **a person crying** and being fearful.
- Participant 6 drew a **person with a painful bleeding heart**. This person feels like crying, and is very confused. The person also is exhausted and under stress.
- Participant 7 drew **people burning in a fire**, and bystanders being very sad and afraid. This person describes the world as a place at the brink of catastrophe, as if we are all going to hell, and all people are faced with the devil, which is HIV.
- Participant 8 drew an **axe striking rock**.
- Participant 9 drew a **family where the mother is sick** and not able to help her, the children are all younger than ten are and they cannot look after themselves.
- Participant 11 drew a **crying person** who is scared to lose family members.
- Participant 12 drew **a broken heart**, a grave with a cross on it, and a mother crying, holding a baby and a child's hand. The person is sad because he/she lost loved ones to HIV and she is left with their children to care for.
- Participant 13 drew a **person crying** and looking at a coffin.
- Participant 15 drew a **person crying** and groaning.

17.2.3 Comparison between the comparison group pre- and post-tests

There was little difference between the drawings made in the pre- and post-tests. The following themes were identified, as shown in Table 4.

Table 3: Summary of comparison group themes derived from drawings.

Pre-test comparison group themes	Post-test comparison group themes
Hopelessness, the world is dark, scary and without hope.	People are sad, crying and broken-hearted
Pre-occupation with death and dying.	AIDS is a monster that destroys lives
People are sad, crying and broken-hearted, and tired of suffering.	Pre-occupation with death and dying.
AIDS is a monster that kills and we are helpless victims.	AIDS is a vicious cycle that affects all people.

The comparison group participants depicted hopelessness. In the post-test, these symbols come to mind when they thought of HIV and AIDS: people burning in a fire, people crying; people with broken hearts; death, HIV and AIDS as a snake or a monster that kills. Thus, the pre- and post-test, symbols of the comparison group did not change to positive symbols.

18. COMPARISON BETWEEN EXPERIMENTAL AND COMPARISON GROUP'S DRAWINGS

The experimental group's drawings depicted hope and people overcoming obstacles. As seen in the summary of themes in Table 3, the experimental group showed an improvement in the way they thought about how HIV and AIDS affected them. The comparison group's pictures did not differ much, as shown in Table 4. The group's post-test drawings showed hopelessness, fear, sadness and viewing HIV and AIDS as a monster. The researcher can conclude that the experimental group's symbols of how HIV and AIDS affects them had changed from negative to positive, whilst those in the comparison group did not show any change.

Taken this into consideration, the researcher can conclude that the REds programme did empower the participants in the experimental group by addressing their support needs as HIV and AIDS affected educators. These educators felt

empowered with knowledge and skills that they lacked. They were more resilient after participation in the REds programme.

19. CONCLUSION

Research results from both quantitative and qualitative approaches have been analysed, interpreted and discussed.

The quantitative research results suggests that the REds programme (independent variable) seems not to have had a significant effect on the dependent variables (HIV and AIDS affected educators' quality of life and resilience), as no significant differences were detected in the pre- and post-test results of the experimental group, or the comparison group. The quality of life measure showed definite signs that participants were on the verge of burnout, and that they were exposed to secondary trauma. The post-test results for the experimental group did not indicate that the REds programme addressed these issues, which once again made it difficult to conclude that the REds programme increased the quality of life of the participants. The researcher found it difficult to equate the content of the REds programme with the protective factors tested with the RSA. The results from the RSA were also insignificant, which made it difficult to say that the programme increased the resilience of the participants. Furthermore, the researcher could not detect noteworthy differences when contrasting the results of the experimental and comparison groups. This further supports the lack of quantitative findings.

The qualitative research results, on the other hand, indicate that the participants in the experimental group have gained some skills and knowledge that had increased their resilience. The experimental group had shown a positive difference prior to and after exposure to the REds programme, which was not the case with the comparison group. This implies that the participants experienced the REds programme as supportive and empowering.

The researcher is of the opinion that the discrepancy between the quantitative and qualitative research results may be because the standardised questionnaires limit the responses of participants. They need to choose an answer, and if they could clarify the answer, one might have attached different meaning to it. The narratives and drawings were effective because the participants could share their own

experiences. Muller (1999:221) clarifies that narratives are stories that relate the unfolding of events, human action or human suffering from the perspective of an individual's lived experience.

The researcher also found it difficult to see how the REds programme will increase the protective factors measured by the RSA, as these protective factors are general attributes that a person does or does not have. Thus, the researcher doubts the applicability of the RSA in an African context. The Resilience Scale for Adults was developed in Norway, which is a developed country. The questions and protective factors measured in this scale are not necessarily relevant for a developing country such as South Africa. This is supported by Theron (2007b:373) who notes that African people embrace *ubuntu*, and a scale that focuses on the individual might not bring the same results as when applied in a western context.

In the next chapter, the researcher will draw conclusions and make recommendations on the implications of both the quantitative and qualitative research results on the effectiveness of REds as a support programme for HIV and AIDS affected educators.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

Chapter Five focused the reader's attention on the empirical findings from both the quantitative and qualitative approaches. The implications of these research results with regard to the goal and objectives of the research and the future of the REds programme were not discussed.

In this chapter, summarised conclusions and recommendations will be made from literature and the empirical findings. The purpose of the study, testing of the goal and objectives as well as the hypothesis will be evaluated and discussed. Chapter Six will refer to the goal of the study, stated in Chapter One, namely to evaluate the effectiveness of the REds programme to enhance the quality of life and resilience of HIV and AIDS affected educators. The aim is also to make recommendations for the REds programme.

2. EVALUATION OF THE GOAL AND OBJECTIVES OF THIS STUDY

The aim of this chapter is firstly to provide an explanation on whether the following goal and objectives of the research project have been met:

2.1 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.*

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 has been successfully evaluated. The empirical findings primarily from the qualitative approach confirmed that the REds programme has equipped participants with valuable information and skills, which enhanced their quality of life and resilience.

However, the same conclusion cannot be obtained from the quantitative research findings.

2.2 Objectives of the study

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

2.2.1 Objective one

The first objective was:

- *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.*

This objective was achieved through an elaborate discussion of HIV and AIDS. The researcher investigated the extent of the HIV pandemic, globally, and in Africa and South Africa. The impact of HIV on the education system was also discussed extensively (see Chapter Two). Resilience was defined and conceptualised according to literature (see Chapter Three), and different factors influencing resilience in adults and children were explored. HIV and resilience, as well as education and resilience were explained and examined. The correlation between resilience and quality of life were also discussed briefly.

Based on the above discussion, the researcher succeeded in achieving the first objective.

2.2.2 Objective two

The second objective was:

- *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.*

This objective was successfully achieved as explained in Chapter 5, from both the quantitative and qualitative approaches.

2.2.3 Objective three

The third objective was

- *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.*

This objective was accomplished through conclusions and recommendations on the future of the REds programme, as deliberated in this chapter, Chapter Six.

2.3 Testing the hypothesis

The hypothesis of this study was:

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**.**

The following null hypothesis was set

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

Based on the quantitative research findings, the null hypothesis cannot be confirmed or refuted, because the standardised questionnaires did not produce results that can be used to generalise. However, based on the qualitative research results, the researcher can prove the null hypothesis to be false, as it seems as if there is an association between the Resilient Educators support programme and quality of life and resilience.

The researcher will now give an overview of the entire research project and each chapter of the dissertation will be discussed according to the following headings:

- Summary
- Conclusions
- Recommendations

3. RESEARCH METHODOLOGY

3.1 Summary

The research methodology was briefly explained in Chapter One, and discussed in detail in Chapter Four. Chapter One started with an introduction and a general overview of the study. The researcher elaborated on the problem of HIV and AIDS, and the need for a support programme. The goals, objectives and hypothesis of the study were discussed next. The researcher further briefly explained the research approach, research design, data collection methods for the quantitative and qualitative approaches, the pilot study and the sampling methods used in this study.

The remainder of the Chapter One was used to elaborate on the ethical issues that were relevant to the study. Chapter One concluded with a discussion on the limitations of the study, the definition of key concepts, and an overview of the subsequent chapters of the research report.

3.2 Conclusions

The researcher draws the following conclusions from the research methodology:

- The mixed methods approach was suitable to address the research problem of this study, as the mixed methods research is an approach used to collect, analyse and mix both quantitative and qualitative data in a single study or series of studies. It aims to use the quantitative and qualitative approaches to understand a research problem more completely.
- In the context of applied research, the researcher used evaluative research. Evaluative research is used to assess the design, implementation and applicability of social research. This approach guided the researcher to adequately evaluate the effectiveness of the REds programme to improve the quality of life and resilience of HIV and AIDS affected educators.
- Data collected in the experimental group, before and after exposure to the REds programme, as well as the comparison group's pre- and post-tests results, provided the researcher with rich data from a variety of sources that facilitated the effective evaluation of the REds programme.

3.3 Recommendations

- The study was carried out in an urban area, which is better resourced than rural areas. The researcher therefore recommends that the study also be targeted in the rural areas in the future.
- The researcher suggests that the study use primarily qualitative data collection methods, as it allows participants to open up and provide meaningful data about their perceptions and experiences of the programme, which would be difficult to obtain if the quantitative approach is used.

4. LITERATURE REVIEW ON HIV AND AIDS AND THE EDUCATION SYSTEM

4.1 Summary

The literature review in Chapter Two focused on an in-depth discussion of HIV and AIDS and the educator. It deliberated the impact that HIV has on the different spheres of the education system.

Saunders, Lewis and Thornhill (2003:75) clarify that a literature review sets your research in context by critically discussing and referring to work that has already been undertaken, drawing out key points and presenting them in a logically argued way, and highlighting those areas that the researcher will provide fresh insights in.

The researcher therefore discussed the following to put the research project into context:

- Conceptualisation of HIV and AIDS;
- HIV and AIDS worldwide and in South Africa;
- The difference between being HIV and AIDS infected and affected;
- The impact of HIV and AIDS on the education system;
- The impact of HIV and AIDS on the learner;
- The impact of HIV and AIDS on the educator; and
- Supporting strategies.

4.2 Conclusions

The researcher, based on the literature review, draws the following conclusions

- HIV and AIDS affect all people. It is a global problem, with sub-Saharan Africa, and South Africa being especially affected according to the WHO and UNAIDS.
- The education system suffers particularly, as UNICEF argues: "Although HIV affects all sectors its most profound effects are concentrated in the education sector." The education system is affected in the following spheres: the supply and demand of education changes; the profile of potential clients of the education system changes; the organisation of education needs to adjust; and AIDS places a premium on the nature of the role of education to adjust to meet other needs. The process, content and quality of education is negatively affected by HIV and AIDS, and the quality of learning is negatively affected. HIV and AIDS also affect the learner and the educator negatively.
- Different support strategies launched by the National Department of Education were discussed, and HIV and AIDS affected educators found these strategies inadequate in meeting their support needs.
- The University of the North-West took the initiative of addressing the lack of appropriate support structures by compiling the Resilient Educators support programme for HIV and AIDS affected educators.

4.3 Recommendations

- The researcher recommends the implementation of 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 compare and rectify the ripple effect HIV and AIDS has on the economic, social and emotional sector of this country.
- The researcher recommends that the education sector needs to be empowered to deal with the effect of HIV and AIDS. The educators need to become emotionally strong – they need to become resilient.
- It is further suggested that the National Department of Education establish a properly structured, accessible, user-friendly and confidential Employee Assistance Programme that focuses specifically on HIV and AIDS. This programme needs to address some of the issues that educators face, like their exposure to trauma and risk of burnout.

5. LITERATURE REVIEW ON RESILIENCE AND HIV AND AIDS

5.1 Summary

The literature review of Chapter Three focussed on theoretically explaining and exploring resilience in the context of HIV and AIDS and the educational sector.

Chapter Three elaborated 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; and
- Explaining the connection between education and resilience.

5.2 Conclusions

The following conclusions are made from the literature review on resilience and HIV and AIDS.

- Little consensus exists among researchers around central terms used within models of resilience, and 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. The researcher therefore 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.
- Different scales exist to measure resilience. The Resilience Scale for Adults (RSA) is based on the following six factors: perception of self; planned future; social competence; structured style; family cohesion; and social resources.
- The connection between quality of life and resilience must be understood. 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. Resilience on the other hand, can improve the individual's quality of life, and ability to cope better with the impact HIV and AIDS has on human functioning.

- 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. HIV and AIDS affected educators need support to cope with the altered job description. 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.
- 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.
- 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. 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, but not resilience training. This apparent shortcoming prompted the compilation of an interactive, participatory support programme to enhance resilience and quality of life, entitled the Resilient Educators (REds) programme.

5.3 Recommendations

The researcher recommends the following:

- Resilience is a fluctuating concept, and there are many different views on resilience. However, there is little literature available on resilience in a South African context. The cultural aspects that make the South African context unique should be incorporated in a study on resilience in South Africa. The

researcher therefore recommends that resilience in a South African context should be further researched in order to contribute to the existing body of knowledge.

- The researcher further recommends that a resilience scale applicable to the South African context be developed.
- There is also little literature available specifically on resilience and HIV and AIDS. The researcher therefore recommends that this should be researched further.

6. *THE RESILIENT EDUCATORS SUPPORT PROGRAMME (REDS) FOR HIV AND AIDS AFFECTED EDUCATORS*

6.1 Summary

Chapter Four discussed the REds programme in detail. The following summary applies:

The Resilient Educators support programme (REds) for HIV and AIDS affected educators was compiled by the University of the North-West in 2006 to address the support needs of HIV and AIDS affected educators. The REds programme has the express aim of empowering affected educators to cope more resiliently with the challenges of the pandemic by supporting educators to respond adaptively to a teaching context that demands responses more typical of counsellors, or social workers, or medical personnel trained to prevent HIV.

The REds programme is an interactive programme that endorses a participatory approach. The programme consists of nine sessions, covering seven modules, with each session lasting about two hours. The modules cover the following themes: health promotion; the psychosocial impact of HIV on educators and learners; supporting infected and affected people; stigma and discrimination; HIV related education policy; and resilience.

6.2 Conclusions

The following conclusions are drawn on the facilitation of the programme

- The REds programme manual has relevant information, which can empower educators to cope better with the pandemic and to assist them in supporting others.
- The participatory and interactive nature of the programme can facilitate the discussion of HIV and AIDS-related matters and problems that participants might have in a spontaneous manner.
- The programme is run after school, so the time to discuss pertinent matters is limited.
- The presenter should make use of the role of the facilitator to support the development of group identity through emphasising commonality and encouraging inter-member communication. This role should be utilised in every session, to assist group members to become a mutual aid system in which members are facilitated to lend their resources and strengths to each other.
- The researcher should use group work facilitation-techniques and strategies such as probing, brainstorming, and discussions to assist in the presenting of the REds programme. By making use of these techniques, it will encourage participants to share their views and to give input. This can lead to very interesting discussions, which in turn can lead to the dispelling of various myths and misconceptions about HIV and AIDS. The fact that the participants can actively participate increases their own learning experiences.
- When teaching or empowering adults, one has to capitalise on their life experiences and knowledge, which is exactly what the REds programme achieves by having a participatory approach.

6.3 Recommendations

- The researcher recommends that the REds programme should be made available to all educators. This can be done as an in-service training. It should also be presented to student educators whilst they are still in the forming phase of their careers.
- The researcher also recommends that session 5, [module 3 (part 2-4)] that focuses on health education and nursing ill loved ones be shortened. The participants noted that the information in this session was irrelevant to them.

- After the completion of this programme, participants should form a committee that will oversee the establishment of proper support structures for the specific school.
- It is also recommended that session 6 should include more knowledge on burnout and exposure to trauma. From the quantitative research results, it is clear that there is a need for the participants to deal with burnout and exposure to trauma, but the content of the REds programme does not address these specific issues.

7. EMPIRICAL RESEARCH FINDINGS

7.1 Quantitative research findings

7.1.1 Summary

The quantitative data were collected by making use of two group administered standardised questionnaires, namely the Professional Quality of Life Scale (ProQol) and the Resilience Scale for Adults (RSA). The questionnaires were administered to participants in the experimental group prior to, and after exposure to the REds programme. The comparison group also completed a pre- and post-test, but they had no exposure to the REds programme.

7.1.2 Conclusions

The researcher draws the following conclusions from the quantitative research findings:

- The findings indicated that no statistically significant results were found.
- The researcher then concluded that, according to the quantitative results based on the ProQol and the RSA, the REds programme did not succeed in improving the quality of life and resilience of the participants.
- The researcher concludes that there must be a reason for the insignificant results. The reasons might be that the ProQol and RSA measures are not appropriate in the context of the REds programme and/or in the South African context. This might mean that the programme should be adjusted to address the issues tested by the measuring instruments, or other instruments should be used or developed.

- The possibility also exists that participants try to manipulate the measuring instrument in order to “look good.”

7.1.3 Recommendations

- The researcher recommends that the reason for the non-significant test results from the ProQol and RSA should be investigated.
- The quality of life measure showed definite signs that participants were on the verge of burnout, and that they were exposed to secondary trauma. The post-test results did not indicate that the REds programme addressed these issues, which once again made it difficult to conclude that the REds programme increased the quality of life of the participants. Therefore, the researcher recommends that the programme should include content that aims to address these issues. This might make a difference to the ProQol results.
- The researcher found it difficult to equate the content of the REds programme with the protective factors tested with the RSA. The results from the RSA were also insignificant, which made it difficult to say that the programme increased the resilience of the participants. The researcher recommends that these protective factors should be addressed in the programme content. This might have a positive impact on the RSA results.
- If the RSA is to be used in future, attention needs to be given to syntax, as some of the statements were translated incorrectly and this caused confusion.
- The researcher further recommends that other possible standardised questionnaires be explored or a self-structured questionnaire be compiled in order to provide a more applicable measuring instrument.
- The participants experienced the two questionnaires to be very long and tiring. Therefore, the researcher recommends that only one effective quantitative measure be included in the pre- and post-tests.

7.2 Qualitative research findings

7.2.1 Summary

The researcher used a narrative, drawings and observation to collect qualitative data. The probe for the writing of a narrative asked the participants 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 affected with HIV and AIDS.

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 2-3 sentences to explain the drawings. From these explanations, the researcher was able to draw conclusions. 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 also used a co-researcher to make observations during the implementation of the REds programme. The co-researcher formed part of the group and she observed the behaviour, verbal and non-verbal communication in the group. After each session, the researcher discussed the observations made by the co-researcher.

7.2.2 Conclusions

The researcher draws the following conclusions from the qualitative research findings:

- When comparing the experimental and comparison group's pre-test narratives, the researcher marked that both groups wrote down negative issues that they experienced as educators in the era of HIV and AIDS. This is a list of some of the correlating sub-themes: poor performance of learners; child-headed households; role changes the educator experienced; the emotional impact of HIV and AIDS on the educator; poverty; HIV and AIDS causes death; lack of resources; untruths people believe about HIV and AIDS;

and the educator as a support system for learners and people in the community.

- In the post-test, the experimental group wrote negative issues, but some of the participants shared their feelings of hope and empowerment. The negative issues listed were a statement of the realities that they face due to the impact that HIV and AIDS has. The participants noted their own empowerment as an answer to some of the problems they face. In the comparison group, the narratives did not differ from those in the pre-test, and when put side by side with the experimental group, these narratives seem more negative than the experimental group.
- Considering this, the researcher can conclude that the REds programme did empower the participants in the experimental group by addressing their support needs as HIV and AIDS affected educators. These educators felt empowered with knowledge and skills that they lacked. They were more resilient after participation in the REds programme.
- The experimental group's drawings depicted hope and people overcoming obstacles. Some of the participants drew themselves as having succeeded in climbing a mountain. This shows an improvement in the way the experimental group thought about HIV and AIDS.
- The comparison group's pictures did not differ much, and they still showed hopelessness, fear, sadness and viewing HIV and AIDS as a monster. The researcher can conclude that the experimental group's symbols of how HIV and AIDS affects them had changed from positive to negative, whilst those in the comparison group did not show any change.

7.2.3 Recommendations

- The researcher recommends that the narrative be shortened, and/or that the probe asks respondents to focus more specifically on their own experiences. The researcher received some narratives that did not focus on the experience of the educator at all.
- The researcher also recommends that the data collection method be shortened. Four measuring instruments takes very long to complete, and the participants become tired and negative if they have to complete so many tests.

8. CONCLUDING REMARKS

The HIV and AIDS pandemic continue to affect the education sector and therefore educators need working support structures to cope with the pandemic. Through the REds programme, participants received hands-on, correct information on the facts of HIV and AIDS, and much of their fears, misconceptions and worries were addressed. The programme also supplied much-needed knowledge on how to support children who are affected by HIV and AIDS, what the current policies on HIV and AIDS are, as well as information on how stigma and discrimination can be addressed. The programme also focuses the attention of participants on caring for themselves, and assisted them with skills and knowledge to be resilient in the face of the pandemic.

The researcher believes that this programme can assist participants in living resiliently, and the participants can be ambassadors of the REds programme by reaching out to others that need support. They can also contribute to combating the spread of HIV and AIDS by sharing their newly gained knowledge. Participants are also empowered to make a difference in the lives of children, and loved ones, by sharing knowledge on grieving with them. The participants also have the responsibility to care for themselves, so that they can continue to care for others.

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