

THE PSYCHOSOCIAL CHALLENGES EXPERIENCED BY HIV-INFECTED EDUCATORS IN MPUMALANGA

by

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**Submitted in partial fulfilment of the requirements for the degree
MSOSCI EAP**

**In the
DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY
FACULTY OF HUMANITIES**

**at the
UNIVERSITY OF PRETORIA**

**SUPERVISOR: PROFESSOR C.S.L. DELPORT
2014**

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude and give recognition to the following persons for their unconditional assistance and support while I completed this study:

- Firstly, God Almighty for the guidance and strength given to me throughout this study.
- My mother and my brother for their continuous love, support and encouragement, and instilling in me the belief that I can achieve anything that I set out to do.
- My son, Thando, for giving me hope and encouraging me that anything is possible.
- My daughter, Khanyisile, for her support and patience.
- To all the educators who voluntarily participated in this study, thank you all. May God bless you and your families. Without you I wouldn't have finished this study.
- The Department of Education, Mpumalanga, for giving me permission to conduct the study and making available the necessary support and required resources.
- My supervisor, Professor C.S.L. Delport, for her guidance, patience, support and encouragement throughout this study. May you be blessed and be a blessing to others.
- My colleagues and friends for their professional guidance and support.

Thank you all.

ABSTRACT
THE PSYCHOSOCIAL CHALLENGES EXPERIENCED BY HIV-INFECTED
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The impact of HIV and AIDS has threatened to destroy the education sector in South Africa. The aim of this study was to explore and describe the psychosocial challenges that HIV-infected educators experienced in Nkangala District, Mpumalanga.

The objectives of this study were the following:

- To describe theoretically the phenomenon of HIV and AIDS with specific reference to the effect thereof on the education system, more specifically on infected educators.
- To explore the emotional challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To explore the social challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To determine the spiritual challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- Based on the results, to make recommendations to the Department of Education in Mpumalanga in order to address the psychosocial challenges experienced by HIV-infected educators in the educational sector and to enhance further research.

Against this background the study was guided by the following research question:

- What are the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga?

A qualitative research approach was used to investigate the psychosocial challenges that the HIV-infected educators experienced. In this study applied research was applicable due to the fact that it focuses on problem solving in practice and emphasises the participation of the people who are experiencing a problem by involving them in finding a solution to the problem.

In this study the researcher wanted to make recommendations based on the results of the project, to address the psychosocial challenges experienced by HIV-infected educators in Mpumalanga.

In the context of qualitative research the phenomenological research design was utilised as the most appropriate research design, because the researcher wanted to understand and interpret the meaning that HIV-infected educators gave to the psychosocial challenges they experienced in their everyday lives.

Because the use of a phenomenological design was applicable in this study, the researcher collected information through unstructured, in-depth interviews. There was no interview schedule with a compilation of predetermined questions, because the questions emerged from the immediate context and the researcher was able to facilitate the process as such.

The researcher utilised a probability sampling technique, namely systematic sampling to select a sample. The first participant was randomly selected from the list of HIV-infected educators and thereafter every second name on the list was selected until a sample of 12 participants had been selected. Using De Vos (2005:333) method of data analysis away from the site, the researcher analysed data primarily off-site. The findings of the research confirmed that HIV-infected educators are experiencing psychosocial challenges. Finally, recommendations were made to address the identified challenges.

The goal of the study was definitely achieved as the study revealed that there is a need for an urgent response by the Department of Education to develop and implement treatment, care and support programmes for HIV-infected educators. Furthermore, it was recommended that the Department of Education should revise and reformulate HIV and AIDS policies and programmes to cater for the needs of HIV-infected educators.

Key Words:

HIV

AIDS

Psychosocial

Infected

Educators

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CHAPTER 1

GENERAL BACKGROUND OF STUDY

1.1 INTRODUCTION

HIV and AIDS are by far one of the most devastating diseases the world faces today and, in the words of UNAIDS (2001), “it will get worse before it gets better”. In relation to this assertion, Otaal (2008:2) postulated that the UNAIDS statement was prophetic as the disease is believed to have originally spread from a few homosexuals in California to people of all ages, sexes, races and classes, including unborn babies around the world. Its rapid spread has led to increased morbidity and mortality among young adults in all parts of the world.

Although HIV and AIDS have affected all sectors of society, the education sector has been a particular centre of attention and controversy (Kelly, 2000:10). HIV/AIDS has had a far-reaching effect on the systems of education in the world in general and Africa in particular, where it has sown havoc among learners and educators alike. Schools have often found it difficult to function properly owing to the sickness, absence or deaths of their educators (Theron, 2005:56; Coombe, 2003:3). The illness or death of educators has been especially devastating in rural areas where schools often depend heavily on one or two educators (Van Dyk, 2008:165). The higher prevalence of HIV and AIDS among educators in rural areas as opposed to urban areas has also been confirmed by Shisana, Peltzer, Zungu-Dirwayi and Louw (2005:viii).

In the school context, the disease sent a message about the number of educators who would die and be hard to replace and also about the number of learners who failed to show up because of the toll of infant mortality. Furthermore, the disease also pointed to the number of affected educators, learners and parents (Jansen, 2006:12).

Different authors (Wilkinson, 2002:240; Shisana et al., 2005: viii; Pelser, Ngwenya & Summerton, 2004:299) warned that HIV and AIDS could disrupt the teaching and

learning process and destroy the teaching profession in Africa within the coming decades. This perception claimed that the education sector was among the essential public sectors to be seriously affected by the pandemic. In fact, HIV and AIDS have had an extremely negative effect on educators, the schools and the community at large. In the context of this study, however, the focus was specifically on an exploration of the psychosocial challenges experienced by HIV- and AIDS-infected educators in the area of their work.

The concept “psychosocial” used in this study refers to the emotional, spiritual and social implications that influence the mental health of HIV-infected educators (Delport, Strydom, Theron & Geyer, 2011:123). This was echoed by Bezuidenhout, Elago, Kalenga, Klazen, Nghipondoka and Ashton (2006:18) who referred to “psychosocial” as “those thoughts, feelings, emotions that affect the mental state and well-being of the infected and affected persons”. Although the psychological or internal challenges a person with HIV and AIDS faces vary from individual to individual and not every person experiences all of the emotional responses, it seems that the following psychosocial effects of HIV and AIDS are generally prevalent: fear, loss, grief, guilt, denial, anger, anxiety, low self-esteem, depression, suicidal behaviour and thinking, social isolation, discrimination, stigmatisation, stress, grief, withdrawal, aggression and socio-economic issues (World Bank Report, 2002:13).

This research explored the nature of the psychosocial challenges that HIV-infected educators experience in Mpumalanga. The context within which the study was specifically conducted is the Nkangala District in the Mpumalanga Province where the prevalence of HIV infections amongst educators was said to be high (Education Labour Relation Council, 2005: 2).

1.2 PROBLEM FORMULATION

According to Brouard and Maritz (2010:2), the Human Sciences Research Council (HSRC) recently estimated South Africa was home to approximately 5, 2 million people living with HIV and AIDS (PLHA). However, the HSRC found that HIV prevalence in the population between 2002 and 2008 had stabilised at around 11%.

Furthermore, among South Africans aged two years and older, the estimated prevalence rate (13.6%) in females was higher than the rate for males (7.9%).

In the education sector, Jansen (2006:15) highlighted that AIDS-related deaths among educators stood at 1% in 2000 with this rate being expected to reach 5% by 2010. This scholar referred to specific studies that had found an increase of 70% in educators' deaths between 1999 and 2000, and projected a cumulative attrition rate that required as many as 60,000 new educators by 2010. Rehle and Shisana (2005:13) also conceded that the number of projected AIDS deaths in the education sector was estimated at 3976 in 2004, with almost 50% of the AIDS deaths occurring in the 34 - 44 age groups.

The above estimates suggested that 8.3% of the HIV-infected educators, or 1.1% of the total education population, had died of AIDS in 2004 (Education Labour Relation Council, 2005:2).

These statistics were elaborated on by Shisana et al., (2005: xvi) who mentioned that the 2004 HIV prevalence rate among educators in public schools stood at 12.7%. These scholars further postulated that educators working in schools located in urban formal settlements had a significantly lower HIV prevalence (with a rate of 6.3%) than those working in urban informal settlements (13.9%) and rural areas (16.8%). Educators employed in KwaZulu-Natal and Mpumalanga had the highest HIV prevalence (more than 19%) when compared to all other provinces.

These statistics provided an indication of the extent of the problem of HIV and AIDS among educators in South Africa and, in the process, offered a rationale as to why HIV and AIDS should be regarded as a pandemic. As such, it was worth noting that this pandemic not only had serious physical consequences, but also carried with it an intense psychosocial effect on educators (Delpont et al., 2011:123). The psychosocial effect of HIV and AIDS on the educational sector has been visible in an increase in absenteeism, requests for leave, emotional problems, changes in attitudes, overloaded educators, overcrowded classes as the result of a shrinking supply of educators, unexpected deaths and increasing demands being made on

medical aid schemes (Van der Waal, 2010:33; Delpont et al., 2011:123; Shisana et al., 2005:115).

The negative psychosocial effect of HIV and AIDS on the educational sector in the Nkangala District in Mpumalanga, both in rural and urban areas, has not only been professionally observed by the researcher as an Employee Health and Wellness practitioner in Mpumalanga's Department of Education, but was also confirmed by Mhlabane (2011), the Deputy Director of Human Resources in the Mpumalanga Department of Education. According to him, educators who were HIV-infected went absent for different reasons. The first reason was stress and depression; educators developed a negative complex and felt embarrassed because they believed that their colleagues were aware of their status. The second reason was that they were absent from work owing to sickness and the need for medical care. In the absence of these educators, the remaining staff members usually took over their workload. The whole education system thus became negatively affected because the production levels went down and educators had to be imported from other countries to fill vacancies left by those educators who died or retired as a result of AIDS. In the Nkangala district alone, 96 foreign educators had been employed to teach Mathematics and Science in 2011.

Thus the problem under investigation could be summarised as follows: The standard of education was deteriorating because of the physical and psychosocial effect of HIV and AIDS. Literature showed that much research had been carried out on the effect of HIV on the education system in general (Pelser et al., 2004:299), as well as the psychosocial effect thereof on HIV-affected educators (Delpont et al., 2011:2). In Mpumalanga, no formal research in this regard was being done. For these reasons, this study sought to explore the psychosocial challenges experienced by HIV-infected educators in the Nkangala District of Mpumalanga.

Information gathered from this study was thought likely to be significant to the Mpumalanga Department of Education as it provided the department with valuable empirical information to assist the HIV-infected educators and, in the process, enhance the Employee Health and Wellness programmes on HIV and AIDS issues. Furthermore, by documenting the voices of HIV-infected educators in regard to the

psychosocial challenges and effects of HIV on their personal and professional lives, the study could increase the awareness of senior managers in the education sector, and could lead to colleagues and other role player's better understanding the issue.

1.3 GOAL AND OBJECTIVES OF THE RESEARCH STUDY

1.3.1 Goal of the study

The goal of this study can be formulated as follows:

To explore and describe the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga.

1.3.2 Objectives

For the study to attain its projected goal, the following objectives were formulated:

- To describe theoretically the phenomena of HIV and AIDS with specific reference to the effect thereof on the education system, more specifically on infected educators.
- To explore the emotional challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To explore the social challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To determine the spiritual challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- Based on the results, to make recommendations to the Department of Education in Mpumalanga in order to address the psychosocial challenges experienced by HIV-infected educators and to enhance further research.

1.4 RESEARCH QUESTION

Given the explorative nature of this study, the following research question was formulated:

What are the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga?

1.5 RESEARCH METHODOLOGY

For the purpose of this study, a qualitative approach was used in order to understand, from the point of view of the participants (HIV-infected educators) (Flick, Von Kardorff & Steinke, 2004:3), the psychosocial challenges HIV caused in their lives. The study sought to develop a holistic picture through the collection of non-numerical data in the field and at the worksites (Creswell, 2007:37) where HIV-infected educators experienced the psychosocial challenges of HIV and AIDS.

The study can also be classified as applied research due to the fact that the research focussed on a problem in real practice; the research sought to show that the results could be used to address a problem or issue in the “real world” (Jupp, 2006:9). The researcher wanted to make recommendations based on the results of the project, to address the psychosocial challenges experienced by HIV-infected educators in Mpumalanga.

The researcher used a phenomenological research design in order to understand and interpret the meaning that these HIV-infected educators gave to the psychosocial challenges experienced in their everyday lives (Fouche, 2005:270). By using this design the researcher aimed to provide an in-depth description of the essence of the participants’ experiences, as voiced by them.

The population or unit of analysis (Jupp, 2006:271) of this study comprised all the members of a well-defined class of people (Strauss & Myburgh, 2000:69), namely all the HIV-infected educators who had disclosed their HIV status to the Employee Health and Wellness practitioner in the Nkangala District, Mpumalanga.

While making certain attempts to represent the population of this study, the researcher randomly selected a sample of 12 participants using a probability sampling technique, namely systematic sampling, from the list of HIV-infected educators who had disclosed their HIV status to the Employee Health and Wellness practitioner in Nkangala District, Mpumalanga .

According to Lynn (2004:1111), systematic sampling involves selecting units at a fixed interval. The researcher did so by randomly selecting the first participant from

the list of HIV-infected educators and thereafter every second name on the list, until a sample of 12 participants had been selected.

In this study a phenomenological design was applicable; the researcher collected information through unstructured, in-depth interviews. There was no interview schedule with a compilation of predetermined questions (Patton, 2002:349), because the questions emerged from the immediate context and the researcher was able to facilitate the process as such. The interview process extended and formalised the conversation between the interviewer and interviewees; this is referred to as a “conversation with a purpose” (Greeff, 2005: 292).

Through the use of unstructured interviews as a data collection method, the study attempted to understand the meaning of the participants’ everyday lives. The purpose was not to get answers to questions, test the hypotheses, or “evaluate” in the usual sense of the term (Greeff, 2005:292-293), but only to understand the psychosocial challenges experienced by HIV-infected educators and the construction of meanings pertaining to that experience. The study employed unstructured interviews because this method was focused and discursive, and it would also allow the researcher and the participants to explore issues (Greeff, 2005:293).

In order to analyse the collected information, the researcher used Creswell’s model as described in De Vos (2005:334-339). Briefly summarised, it means that the researcher read the transcripts over and over again to familiarise her with it. While reading the transcripts the researcher performed minor editing, such as doing away with information that is not relevant to the study. The information that was gathered was categorised by themes, described, classified and interpreted. A coding system was utilised to analyse the information and to identify similarities and differences.

1.6 LIMITATIONS OF THE STUDY

The study has been restricted in the following ways:

- Money and time have restricted this study to 12 HIV-infected educators as a result of the stigma and discrimination attached to HIV and AIDS.

- Due to the small sample size findings cannot be generalised to the whole population of HIV-infected educators.

1.7 DEFINITIONS OF KEY CONCEPTS

The following concepts were relevant in the context of this study:

1.7.1 Human Immunodeficiency Virus (HIV)

According to Brouard and Maritz (2010:7), HIV stands for “Human Immune-deficiency Virus”. This is the virus that causes AIDS. The immune system is the body’s defence system, which protects the body from diseases. The virus in question attacks the immune system and weakens it. HIV infection makes the immune system deficient and the infected person becomes sick. Hornby (2010:738) also concurred that HIV is the virus that can cause AIDS. Hornby further contended that the body’s natural ability to fight illness is called the immune system. It is the body’s defence against infection. Therefore, HIV attacks the immune system and reduces the body’s resistance to all kinds of illness, including flu, diarrhoea, pneumonia, TB and certain cancers, and eventually makes the body so weak that it cannot fight sickness, thus leading to death.

1.7.2 Acquired Immunodeficiency Syndrome (AIDS)

AIDS is an epidemic caused by HIV. It is an illness that occurs in the body when it’s immune or defence system is weakened. AIDS is the final stage of infection with HIV, and this is what causes a person to die (Healthology, 2002:1). According to Van Dyk (2008:4), AIDS is the abbreviation for “Acquired Immune Deficiency Syndrome”. It is caused by a virus (the human immunodeficiency virus or HIV) that enters the body from outside. Immunity is the body’s natural ability to defend itself against infection and disease. A deficiency is a shortcoming, thus it means the weakening of the immune system so that it can no longer defend itself against passing infections. A syndrome is a medical term for a collection of specific signs and symptoms that occur together and that are characteristic of a particular condition. According to the researcher, AIDS is the end of HIV infection; it is when the body can no longer fight various illnesses and, eventually, death occurs.

1.7.3 HIV-Infected

Barker (2003:197) defined HIV-infected as “a result of a blood test that had determined the existence of antibodies to the human immune-deficiency virus (HIV)”. This view was also shared by Van Dyk (2008:492) who pointed out that the phrase meant “the antibodies to HIV were present in the bloodstream... an indication that the person concerned had been exposed to, and was therefore infected with, HIV”. In the context of this research, the researcher’s understanding of HIV-infected is when the blood of a person shows the existence of antibodies to HIV.

1.7.4 Educator

While Hornby (2010:486) understood an educator to be “a person whose job was to teach or educate people”, the *Collins English Dictionary* (2006:523) defines an educator as “a person who educates, a specialist in education, and a school teacher”. Apart from these two definitions, *The National Education Policy on HIV and AIDS* (Department of Education, 1999) presents an educator as “any person who teaches, educates or trains other persons at an educational institution or assists in rendering education services or education auxiliary or support services provided by or in an education department, but does not include any officer or employee as defined in Section 1 of the Public Service Act, 1994 (Proclamation No. 103 of 1994)”. In this study, the concept ‘educator’ will be used to refer to the person who provides knowledge and skills to learners in a school setting.

1.7.5 Psychosocial

According to the *Collins English Dictionary* (2006:1307), psychosocial relates to “processes or factors that are both social and psychological in origin”. This term emphasises social and cultural influences on mental health, personality development and behaviour of an individual. It is used to describe the influence of social factors on the mental health and behaviour of a person; such influences include social situations, relationships and pressures. In the context of this study, the concept of psychosocial refers to the emotional, spiritual, and social implications and experiences that influence the mental health of HIV-infected educators.

1.8 CONTENTS OF THE RESEARCH REPORT

Chapter 1: General background of the study

Chapter 1 presents a brief overview of what the research is about, namely: the research problem; the goal and objectives of the research study; the research question; the research methods used in the study; research limitations and the definition of key concepts.

Chapter 2: Literature Study

Chapter 2 comprises an in-depth literature review describing the phenomena of HIV and AIDS with specific reference to the effect on the education system, more specifically on infected educators.

Chapter 3: Empirical Study

This chapter describes the research methodology used in this study as well as the empirical findings.

Chapter 4: Conclusions and Recommendations

This chapter draws the conclusions and formulates recommendations based on the research findings.

CHAPTER 2

HIV AND AIDS IN THE EDUCATION SECTOR

2.1 INTRODUCTION

This chapter offers a literature review surrounding the impact of HIV and AIDS on the education sector. The aim of the review is to gain insight into the phenomenon under investigation as discussed in the previous chapter. The chapter explores the concepts of HIV and AIDS and, in the process, provides a clear distinction between a person who is HIV- and AIDS-infected, and a person who is affected by the pandemic. Furthermore, it investigates the extent of the HIV and AIDS pandemic worldwide, in particular in Sub-Saharan Africa and in South Africa, with specific focus on the Mpumalanga Province, where the study was conducted. Most importantly, the chapter discusses the HIV and AIDS pandemic in the South African education sector with specific reference to the challenges facing HIV-infected educators and their support systems.

2.2 CONCEPTUALISATION OF HIV AND AIDS

The concepts of HIV and AIDS are defined differently by various scholars. While HIV, on the one hand, is understood as an abbreviation for human immunodeficiency virus, AIDS, on the other, stands for Acquired Immunodeficiency Syndrome (Mulaudzi, 2009:320; Cichocki, 2007:1). Balkwil and Rolph (2002:18) as well as Boyles and Joska (2009:28) reveal that HIV is different from other viruses, because it attacks an infected person's immune system. Informed by this, it is important for the researcher to clarify the concepts of HIV and AIDS in the context of this research project.

2.2.1 HIV

According to Van Dyk (2002:43) and the Department of Labour (2003: vii), HIV causes AIDS through the weakening of the immune system; an indication that a person has been exposed to the virus and is therefore infected with HIV. The virus is detected through the presence of antibodies to HIV in the blood stream. These

antibodies are special protein complexes produced by the immune system that attacks and neutralise specific disease-causing organisms. The antibodies created by the body in response to the HI-virus become powerless to protect the body against the long-term destructive effects of the virus.

In relation to this, Evian (2000:13-17) explains that the virus is spread or transmitted through bodily fluids via unprotected sexual intercourse, contact with HIV-infected blood and mother to child transmission during pregnancy, childbirth and via breast feeding. The presence of other sexually transmitted diseases makes the sexual transmission of HIV easier. To this end, the most infectious phases in which an infected person is likely to pass on the HI-virus are the first 4-8 weeks (symptomatic phase during sero-conversion) in which there is a high HIV viral load, as well as during the later phase of infection when the AIDS symptoms appear. This is because there are larger quantities of virus in the blood stream at these times, although it is important to note that it is possible to transmit HIV at anytime once infected (Van Dyk, 2002:23).

2.2.2 AIDS

Van Dyk (2005:3-4) furthermore reveals that AIDS is a collection of many different conditions that manifest in the body because of the HIV virus which has so weakened the body's immune system that it can no longer fight the disease by itself and, as such, the virus is able to kill the infected person in the final stages of the disease. Evian (2000:09) claims that at this stage "a person is described as having AIDS when the HIV-related immune-deficiency is so severe that various life threatening, opportunistic infections and/or cancers occur."

On the basis of the above, it is clear that 'HIV' and 'AIDS' are two confusing phenomena that are closely related, such that people often use them interchangeably as if to suggest that they refer to the same thing. As such, it is important to clarify that HIV and AIDS do not refer to the same phenomenon. In fact, HIV is a virus while AIDS refers to a syndrome. Accordingly, once a person is infected with the HI-virus, his/her illness progresses through different stages until it reaches a full blown AIDS status. In relation to this, Service SETA (UNAIDS, 2011) points out that there is no specified duration of life after infection, because the

disease affects people differently. Factors contributing to these differences can be, but are not limited to, age, genes, and type of strain of virus, re-infection, and contact with other infections, prevention, and early treatment of infections (Evian, 2000:9).

2.2.3 The difference between being ‘infected’ and ‘affected’ by HIV and AIDS

While the purpose of this study is to explore the psychosocial challenges that HIV-infected educators experience, it is important to make a clear distinction between one who is HIV- and AIDS-infected and the other who is affected. In their study, Rooth, Stielau, Plantagie and Maponyane (2006:96) contend that while “HIV and AIDS are everybody’s problem, we are affected by what it does to the people we love, live and work with”. Similarly, Cogan, Klein, Magongo and Kganakga (2005:2) add that there are many physical effects of HIV and AIDS, however, the most profound effects of HIV are on the psychological, social and economic health of the infected person, his/her loved ones and the community. Informed by this, the researcher concludes that being HIV-infected, on the one hand, means the presence of the virus in one’s body as confirmed by a clinical HIV antibody test (normally used in public health services) or a test that detects the HI-virus. On the other hand, being HIV and AIDS affected means that a person is affected by being infected themselves, or because that person has a partner/ spouse, family member, neighbour, colleague, friend or other loved ones that are infected with HIV. This simply means that by being HIV-positive, one is both infected and affected by HIV and AIDS.

2.3 THE EXTENT OF THE HIV AND AIDS PANDEMIC

Brouard and Maritz (2010:1) highlight that since the discovery of AIDS in 1981, more than 60 million people have been infected with HIV and it is estimated that more than 24 million people have died. In addition, approximately 2 million people lived with HIV worldwide in 2008, while an estimated 2.7 million people were newly infected with the disease worldwide. Furthermore, it is also recorded the number of people currently living with the virus is approximately 33.4 million (Brouard & Maritz, 2010:1). From these statistics, it could be argued that HIV and AIDS are a global pandemic affecting people mainly in their economically productive years and thus threatening the livelihood of all, both infected and affected. Therefore, the researcher

will discuss the prevalence of this pandemic globally, in Sub-Saharan Africa, in South Africa and lastly in Mpumalanga – the context within which this study was conducted.

2.3.1 HIV and AIDS worldwide

UNAIDS (2011:6) states that at the end of 2010 an estimated 34 million people (31, 6 million to 35, 2 million) were living with HIV worldwide, up to a 17% increase from 2001. This clearly reflects the continued large number of new infections. However, the number of people dying of AIDS-related causes fell to 1.8 million (1.6 million-1.9 million) in 2010, down from a peak of 2.2 million (2.1 million-2.5 million) in the mid-2000s, while a total of 2.5 million deaths were averted in low- and middle-income countries since 1995 due to the introduction of antiretroviral therapy. It needs to be noted that much of this success has come in the past few years when a rapid increase in access to treatment occurred in 2010 alone, thus leading to the prevention of approximately 700,000 AIDS-related deaths. It is interesting to note that the number of people becoming infected with HIV is continuing to fall more rapidly in some countries than others. HIV incidence has fallen in 33 countries, 22 of them in Sub-Saharan Africa; the region most affected by the AIDS epidemic (UNAIDS, 2011:6).

Although the above-mentioned global statistics of HIV and AIDS highlight that more people than ever are managing HIV mainly due to the greater access to treatment, this disease is still a pandemic and will continue to be for many years to come. Furthermore, statistics only give numbers of people infected and dying of HIV and AIDS, but not how many are affected by the disease. Within the context of this study, it is important therefore to focus also on those who are affected by the disease as this will give a more holistic picture of the effects and/or challenges of the pandemic.

2.3.2 Sub-Saharan Africa

Different scholars (Skweyiya, 2007:21; Pelsers et al., 2004:276) explain that the Sub-Saharan region is by far the worst infected region with HIV and AIDS in the world. The Sub-Saharan region is seen as home to more than 67% of people living with HIV and AIDS globally. This view is also confirmed by UNAIDS (2011:7) that Sub-Saharan Africa remains the region most heavily affected by HIV. According to

UNAIDS (2011:7), in 2010, about 68% of all people living with HIV resided in Sub-Saharan Africa, a region with only 12% of the global population. Furthermore, AIDS claimed at least one million lives annually in Sub-Saharan Africa since 1998 and Sub-Saharan Africa accounted for 70% of new HIV infections in 2010. Interesting to note, though, is that the total number of new HIV infections in Sub-Saharan Africa dropped by more than 26%, down to 1.9 million from the estimated 2.6 million at the height of the epidemic in 1997, and that research in 22 Sub-Saharan countries confirms that HIV incidence declined by more than 25% between 2001 and 2009. These statistics, according to the researcher, indicate that the number of new HIV infections in Sub-Saharan Africa has dropped.

2.3.3 South Africa

Evian (2003:20), Foster (2007:1) and Marias (2005:7) share the view that South Africa has the highest prevalence of HIV and AIDS and is experiencing one of the most intense and probably the largest HIV and AIDS epidemic in the world. Shisana et al. (2005: viii) support this by stating that South Africa has a severe HIV and AIDS epidemic. According to this claim, about 5.6 million South Africans, the majority of whom are in the economically active age group, are currently living with the virus. This claim is further echoed by a UNAIDS (2011:7) report, which reveals that the epidemic continues to be most severe in Southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world. However, the annual HIV incidence in South Africa, though still high, dropped by a third between 2001 and 2009 from 2.4% to 1.5%.

The assumed decline in HIV prevalence may indicate that the fight against the disease is finally having some impact. To elaborate on these encouraging statistics, Pembrey (2007a:7) attests that the future of the pandemic at least partially depends on the direction of the government's HIV and AIDS policies. Although the government has been criticised in the past for its HIV and AIDS policies, recent events, including the development of a new framework to guide the national response to HIV and AIDS from 2007 until 2011, suggest a gradual improvement in the treatment of HIV and AIDS.

2.3.4 Mpumalanga Province

According to the Department of Health's National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa (2010:62-64), the Mpumalanga Province has the second highest prevalence rate in South Africa with an overall prevalence greater than 30%, and with an increase in the number of new infections. This view is also shared by Masinga (2007b:12) who asserts that, according to an antenatal survey conducted in 2007, Mpumalanga was found to have the second highest HIV prevalence rate. In the context of this study, the high prevalence of the pandemic in the Mpumalanga Province has become a crisis and should be attended to by both the community and the government.

Nkangala is one of the three districts that constitute the Mpumalanga Province. Although there are booming mining and agricultural sectors in the district, this section of the province is characterised by high rate of poverty and unemployment. With regard to the pandemic, Gert Sibande and Ehlanzeni districts of the Mpumalanga Province have both registered a decrease in the HIV and AIDS prevalence rate when compared to Nkangala district, which recorded an increase in its prevalence rates between 2007 and 2009; an increase of 4.3% from 27.5% in 2007 to 31.8% in 2008, and a further increase of 0.8% in 2009 to 32.6%. The number of people who are HIV-positive in Mpumalanga Province is estimated at just below half a million. This is estimated to be 21.8% of the general provincial population (Department of Health's National Antenatal Sentinel HIV and Syphilis Prevalence Survey, 2010:62-64).

Mpumalanga Province is predominantly rural with a high level of poverty. Poverty is well documented as being among the primary drivers of HIV and AIDS (Department of Health's National Antenatal Sentinel HIV and Syphilis Prevalence Survey, 2010:62-64). This simply suggests that the province could do very little to avoid the pandemic. The pandemic also puts more pressure on the education sector, to which the researcher will turn in the next section, and in the process impacts on the broader society.

2.4 HIV AND AIDS PANDEMIC IN THE EDUCATION SECTOR

Shisana et al. (2005: viii) point out that education is one of our most powerful weapons against HIV and AIDS. However, it is also the sector that is labour-intensive and thus most vulnerable to the disease. Coombe (2002:4) also supports this view when he points out that HIV and AIDS affect the supply and quality of education, its management, as well as its capacity to respond to new and complex demands. Within the context of this study, the above claims are particularly important as they attest to the fact that the HIV and AIDS pandemic is one of the most serious challenges currently facing the education sector as it affects both educators and learners severely.

According to Kelly (2000:45), HIV and AIDS affect the education sector in the following ways: it affects the demand for education – those who are its potential clients; the sufficiency of its personnel to supply education services; the content of what is being taught; the processes involved in teaching and learning; how the schools are organised; the nature of the role of education; the funds needed for education; aid agency involvement in the system; and sector-wide planning and management. Baxen and Breidlid (2004:13) share the same view when they state that HIV and AIDS will affect the education sector in the following ways: there will be less demand for education as AIDS orphans leave school; educators will leave the education system due to their own ill-health or the need to look after significant others; and the quality of education will be compromised.

In the context of this study, the researcher will focus on the South African education sector, especially the Mpumalanga Province; thereby looking at the psychosocial challenges experienced by HIV-infected educators in the province.

2.4.1 HIV and AIDS: South African education sector

As mention in the previous section, Shisana et al. (2005: xvi) as well as Bisgard and Copozza (2001:24) refer to the fact that the education sector is thought to be particularly affected by HIV and AIDS because both the demand for and the supply of educators are affected. In this regard, not only do children drop out of school because of HIV and AIDS, thus reducing the demand for education, but educators,

school managers and education policy makers are also said to be dying of AIDS and thus affecting the supply. Simbayi, Skinner, Letlape and Zuma (2005:2) add that existing problems such as inadequately trained educators, lack of infrastructure and high dropout rates in the education sector are longstanding challenges now compounded by educator shortfalls due to HIV sickness, absenteeism and early death.

Shisana et al. (2005:xvi) continue to emphasise that research results show 12% of educators in South Africa (from a sample of 24,200 who tested for HIV) are HIV-positive. The prevalence was the same for males and females (21.4%). The highest prevalence was among educators aged 25 to 34 years, followed by those aged 35 to 44 years. These differences were observed when the analysis was restricted to women and men aged between 25 and 34 years, with women having a higher HIV prevalence. Dorrington, Johnson, Bradshaw and Daniel (2006:9) concur with these claims and state that the HIV and AIDS prevalence is higher in women than men for the 15 to 34 age group. Among women, the rate of infection is reported as the highest (32.5%) for the age group 25 to 29 years. This could be attributed to the fact that females are more vulnerable and susceptible to HIV infection as they often have limited choices when it comes to using prophylactic protection during sex, due to patriarchy and gender inequality.

Pembrey (2007a:1) states that in 2006 it was estimated that 21% of educators in South Africa were living with HIV and AIDS, and educators represented the country's largest workforce of 4 million personnel. Calitz, Fluglestad and Lillejord (2002:151) also estimated that between 88,000 and 133,000 educators would have died from AIDS-related illnesses by 2010. This is confirmed by the Department of Education (2003:3-4) which indicates that since the outbreak of HIV and AIDS, educators specifically are not performing according to their capability; they are adversely affected by the HIV and AIDS epidemic which weakens their performance. This situation does not only affect the personal and professional lives of educators; learners are also equally affected by the pandemic. On these bases, the researcher believes that the education sector plays an important role in the socialisation of children and that these statistics highlight the fact that the education sector is facing challenges that need to be dealt with concerning HIV and AIDS.

Rajagopaul (2008:116), Buchel (2006:68) and Xaba (2003:287) explain that HIV and AIDS impact negatively on learners because when educators become ill, learning is affected since learners are often left without consistent teaching. Educators affected by or infected with HIV and AIDS cannot provide quality education to the learners because of their inability to cope with their daily duties. This problem is made worse by educators' attrition, which disrupts schooling. It becomes more difficult when infected educators leave the profession during the academic year whilst engaged in the teaching of critical subjects such as mathematics and physical science. Often there is no continuity when these educators leave the profession and learners fall victim to poor quality of learning.

2.4.2 HIV and AIDS: Mpumalanga education sector

Shisana et al. (2005:119) claim that research regarding HIV prevalence among educators in the provinces showed that KwaZulu-Natal and Mpumalanga had the highest prevalence. This is supported by the Education Labour Relation Council (2005:2), which states that the two provinces with the highest number of HIV-positive educators were KwaZulu-Natal and Mpumalanga, with rates of 21.8% and 19.1% respectively. The key drivers of the epidemic within the educator population are believed to be lack of condom use, multiple partnerships, alcohol use and intergenerational sex. Educators residing in rural areas and working in rural schools had a higher HIV prevalence than their urban counterparts (Education Labour Relation Council, 2005:2). These findings suggest that more resources for HIV prevention, treatment and care are needed by these provinces to reduce the impact of HIV on education.

The Department of Education Annual Report (Mpumalanga Provincial Government, 2006:111-112) explains that systems have been put in place to address the pandemic among educators. For instance, the Mpumalanga Provincial Government Department of Education established an Employee Health and Wellness programme unit in March 2006, which provides psychosocial support for HIV- and AIDS-infected and/or affected employees in the province. The trade unions under the Department of Education also initiated a pilot project, namely: the HIV Prevention, Care and Treatment Access (PCTA) meant for all the employees in the Department (PCTA,

2007:6). The programme provides free HIV testing and counselling, free treatment, one's own private doctor for free, as well as a privacy and confidentiality guarantee. The combined effort of the Employee Health and Wellness programme and the trade Unions' PCTA have the potential to empower educators to cope with the pandemic as individuals, employees, colleagues, family members and as members of the community and, in this way, they become assets to society. The next section will look at the HIV- and AIDS-infected educators.

2.5 HIV- AND AIDS-INFECTED EDUCATORS

Jansen (2006:25) gives a negative picture of the effect of HIV and AIDS on infected educators. He describes the effect as follows:

AIDS is currently the main cause of death among educators. Educators die while in school. Educators fall ill and drop in and out of school as their health deteriorates. Educators with HIV and AIDS face a terrible stigma when they do come to school in a society that has yet to come to terms with HIV/AIDS prejudice. Educators who are infected face an excessive drain on their basic health care coverage, and further health care demands on an income long stripped of any notion of 'disposable income'. Infected educators grow weaker at the very point that the administrative demands of teaching grow stronger. Educators who need to have the emotional capacity not only to care for themselves, but to care for increasingly vulnerable children who are also infected and affected by HIV/AIDS.

Different authors (Hall, 2003:36; Calitz et al., 2002:151; Coombe, 2000:15; Kelly, 2000:65) refer to the problem of educators infected with HIV and AIDS and point out that it is made worse by the fact that more educators are leaving the system than entering, and if a replacement is not available or not budgeted for, the situation will pose a strain on other educators who will have to assume the duties of sick or deceased educators. From this discussion, it is clear that schools depend on educators; an absence or death of an educator affects the education of children and may cause burnout and stress among educators who have to take up the workload left behind by colleagues inflicted with AIDS-related diseases. If the stress is not managed through relevant support systems it can lead to increased absenteeism, thus compromising the number of educators available to provide education.

Moreover, recurring absenteeism of HIV-infected educators is apparent in many schools. This is directly attributed to opportunistic diseases to which immune-compromised individuals are susceptible. The HIV-infected educators become weak and unable to fully concentrate on their work, and therefore tend to be unproductive and/or perform their work poorly. The consequence thereof is that those educators who are not sick have their work load increased, because they have to divide the work of the sick educator among themselves. Also, the educators who have family members or relatives who are HIV-infected are very likely to be absent from school due to attendance of funerals or taking care of sick loved ones (Kelly, 2000:67-68; World Bank Report, 2002:13). This increase in workload reduces the effectiveness of teaching and learning in the classroom. As a result, the conditions of educator shortages decrease the remaining educators' desire, morale and the motivation to teach. As a solution to this, however, Theron, Geyer, Strydom and Delport (2008:78) argue that the professional demands should encompass raising HIV and AIDS awareness, teaching prevention, aiding infected and affected learners (and even colleagues), shouldering increased teaching loads left by increasingly absent colleagues, and coping with the ordeal of HIV-related sickness and death in significant others.

2.6 PSYCHOSOCIAL CHALLENGES FACING HIV-INFECTED PERSONS

This section offers a discussion on the psychosocial challenges facing HIV-infected persons. This is due to the fact that HIV and AIDS, according to the researcher, are seen to pose psychosocial challenges among people infected and affected by the pandemic. These psychosocial challenges include, amongst others, the emotional, spiritual and social well-being of the infected in their day-to-day life experiences. In relation to this, Bezuidenhout et al. (2006:18) state that the psychosocial challenges a person with HIV and AIDS faces vary from individual to individual. In other words, not everyone will experience all the stages of the emotional responses in the same way. Thus, it is important to explain the psychosocial challenges experienced by HIV-infected educators, thereby looking at how these challenges manifest themselves in their various types.

2.6.1 Emotional challenges

The *Oxford English Dictionary* (2002:696) as well as Ross and Deverell (2010:400) describe stress as “a mental or emotional strain or tension; a psychological condition that is caused by demanding and frustrating situation that exceeds a person’s means, and can result in mental, emotional, physical and behavioural problems”. Coombe (2002:18) and Kelly (2000:65) explain that educators are deeply affected personally by the incidence of HIV and AIDS. HIV impacts on educators’ emotional status, and their morale becomes low where the impact of HIV is high. This is an area where educators receive little support. But this is no longer the case; the Department of Education has come up with different programmes to support the HIV-infected educators and as a result HIV-infected educators receive a lot of support. Van Dyk (2005:225-226) concurs with Coombe and Kelly’s views and states that “people infected with HIV frequently experience depression because of day-to-day difficult situation such as social ostracism by significant others.” As such, people infected with HIV are also prone to stress and depression.

In the context of this study, it is important to note that an HIV-infected educator who is in denial and angry about contracting HIV may have feelings of stress and depression and may resort to alcohol and substance abuse in order to avoid thinking about being HIV-positive. Furthermore, HIV-infected educators may need to deal with their HIV and AIDS as well as their day-to-day duties, which may lead to physical, mental and spiritual tiredness.

Apart from the above, Newman and Newman (2006:548-549) offer another emotional response to the case of HIV and AIDS infected people. They differentiate between bereavement and grief as common behavioural responses to HIV- and AIDS-related cases. While the former is understood as a long-term process of adjusting to the death of a loved one, the latter is seen as an emotional reaction that follows after a person has lost a loved one because of death. Grief as an emotional reaction is also part of HIV-infected educators’ experience, as they are also exposed to the deaths of significant others or loved ones such as family members, relatives, or colleagues due to AIDS on a daily basis.

Writing about the effects of HIV and AIDS on educators, Van Dyk (2005:227) bemoans that “people living with HIV and AIDS are 36 times more likely to commit suicide than those who do not have the disease.” In this case, suicide contemplation is influenced by difficult situations such as lack of treatment, care and support experienced by people living with HIV and AIDS. This means that HIV-infected educators are also possibly susceptible and vulnerable to suicide ideation as educators who have feelings of guilt and shame for contracting HIV may not cope with life and may thus resort to ending their lives.

2.6.2 Social challenges

One of the most serious consequences of being HIV-infected is that the infected person experiences stigma, discrimination and isolation. Kelly (2000:29) as well as Bennel, Hyde and Swainson (2002:86) confirm this by stating that “it is generally agreed that educators living with HIV and AIDS are seriously discriminated against by the school managers, colleagues, students and community members. This is often due to the belief that they deserve to be punished for their promiscuous sexual behaviour.” Ross and Deverell (2010:106) observe that “HIV and AIDS with its discreditable stigma and disclosure are often avoided as a result of both felt and enacted stigma.” HIV-infected mine workers, like educators, are afraid to disclose their HIV status because people hold a signatory and discriminatory attitude towards them. In other cases, HIV-infected educators stigmatise and discriminate themselves before other people do and, as a consequence, their situation worsens once others get to know that they are infected. Also, relations with colleagues, students and parents become strained, making it difficult for the infected educator to come to school thus affecting teaching and learning, as well as the productivity of the school (Ross & Deverell, 2010:106).

According to the researcher stigmatisation, discrimination and social isolation of HIV-infected educators have the potential to increase their stress and trauma. These educators can experience a decrease in self-esteem as they are no longer confident in themselves or what they can achieve. Commenting on the effects of HIV and AIDS on educators, Kelly (2000:30) contends that HIV and AIDS are often associated with fear due to lack of knowledge about the disease. Thus, the stigma relating to HIV and AIDS is an obstacle to accessing prevention, treatment, care and support

services due to rejection, discrimination and shame attached to HIV and AIDS. From Kelly's observation, one can say that this is no longer the case. Many HIV-infected educators who choose not to disclose their HIV status, on the one hand, are able to access prevention, treatment, care and support services available in public health care facilities and, on the other hand, HIV-infected educators who choose to disclose their HIV status also face discrimination and stigmatisation by their colleagues, learners and community members with whom they live. In relation to this, Kelly (2000:30) reveals that there are authenticated cases of people being denied medical care, employment or job promotion because of their HIV-positive status.

As far back as 1993 Cameron (1993:1) argues that there have been cases of unfair discrimination against educators infected with HIV in South African educational institutions. Educators infected with HIV have been denied employment, promotion and dismissed on grounds of their HIV-positive status. Thus, this situation shows that HIV-infected educators are also subjected to these unfair practices in their day-to-day life experiences. Cameron's argument relates to Maile's (2004:116) view that HIV-infected educators choose to disclose their status to officials and colleagues. However, other colleagues may use this opportunity to disempower HIV-infected educators as a stepping stone to gaining privileges from managers. Some HIV-infected educators, therefore, are regarded as useless in the school because they are perceived to be there just to pass time awaiting death. These educators are seen as unfit to perform responsible duties in the school. According to the researcher this is no longer the case.

There are HIV-infected educators who might face sudden changes in their personal relationships, jobs, physical bodies, self-images and self-esteem and, as a result, their behaviour also changes. These educators may become withdrawn, aggressive and rude to colleagues and friends (Bezuidenhout et al., 2006:18). According to the researcher, this happens because an HIV-infected educator may feel or imagine him/herself victimised. Bezuidenhout et al. (2006:19) further state that "a person with HIV and AIDS may be forced to see themselves as undesirable by others who view them as "contagious". The most destructive stressor is that of feeling isolated. This isolation can have many effects which may include, amongst others, the loss of support by lovers, family and friends. Additional feelings of isolation may result from

the need to change their sexual practices and take more precautions to protect themselves and others.

2.6.3 Spiritual challenges

According to Maile (2004:114), people often hear others passing the following comments despite HIV and AIDS education interventions:

Our priest said that this disease is punishment for sinners. AIDS is God's way of punishing sinners. Nobody should have sex with anyone else outside marriage. It's those moffies who have unnatural sex that get it. AIDS will clean them out. There are too many people on this planet. AIDS is nature's way of controlling the population. The government wants us to wear condoms to control the size of our families.

From the above remarks, it is clear that HIV-infected persons may experience ethical and spiritual challenges in their day-to-day life experiences. For example, educators are believed to be at the forefront of HIV and AIDS education; if they are found to be HIV-positive, society regards them as deceivers and liars. They may be viewed by the society as bad role models, sexual predators and terrible examples to their children, and as such not fit to perform their school duties. In addition to this, the stigma and discrimination attached to HIV and AIDS make communities blame people living with HIV for becoming infected. These infected people are perceived to have done something wrong and therefore deserve punishment for their actions. These unfavourable day-to-day experiences and scenarios inevitably may create psychosocial challenges among HIV-infected people.

2.6.4 Financial challenges

According to Buchel (2006:60), the impact of HIV and AIDS is most certainly felt in the education sector as more and more resources have to be channelled to cope with the health impact. Schools and the Department of Education feel the direct and indirect cost of HIV and AIDS. As a result, many schools are crippled by the impact of HIV and AIDS when HIV-infected educators become sick or die; schools suffer disruption which hampers the provision of quality education. Apart from this, Jansen (2006:29) also mentions that more educators require care and treatment, and the

cost of maintaining health is very high for poor educators whose salaries are low compared to other professionals. Informed by these observations, the researcher shares the same view that educators are some of the lowest paid in South Africa. For HIV-infected educators, this poses a great challenge because they have to live a healthy lifestyle with all the basic commodities provided for. They spend a lot of money on medication and may therefore face financial crisis, making the situation very difficult for them to function properly as educators.

2.7 HIV AND AIDS POLICIES AND PROGRAMMES IN THE EDUCATION SECTOR

Page, Louw and Pakkiri (2006:112) postulate that organisation and other places of work and civil or government entities in South Africa are not doing enough to intervene in the HIV pandemic. This includes the education sector as a place of work. The researcher believes that the prevention of HIV and AIDS should not centre on a single strategy. Several strategies should be adopted by the South African Government in an attempt to combat the HIV and AIDS pandemic. This was confirmed by Kofi Annan (The Former Secretary of the United Nations) during the launch of the Global media AIDS initiative, who acknowledged (Kofi Annan in Kruger, 2005:125): “When you are working to combat a disastrous and growing emergency, you should use every tool at your disposal. HIV and AIDS is the worst epidemic humanity has ever faced”.

In the context of South Africa, Simbayi et al. (2005:2) state that the Department of Labour requires that each institution develop an HIV and AIDS workplace policy and programme to address the problems and needs of employees infected and/or affected by HIV and AIDS. Simbayi et al. (2005:2) further quote the Code of Good Practice on key aspects of HIV and AIDS of the Employment Equity Act (Act No. 55 of 1998), which declares that “every workplace should develop a specific HIV and AIDS policy in order to ensure that employees infected/affected by HIV and AIDS are not unfairly discriminated against in employment policies and practices.”

Also, the Department of Education is obliged and compelled to develop and implement HIV and AIDS policies and programmes to address the problems and

needs of educators infected and/or affected by HIV and AIDS. The researcher will briefly discuss different policies and programmes that inform the National Department and Provincial Educational Departments' responses to the HIV and AIDS pandemic.

2.7.1 National Policy on HIV and AIDS for learners and educators in public schools, students and educators in further education training institutions

The *National Policy on HIV and AIDS for learners and educators in public schools, students and educators in further education training institutions* was published in 1999 by Kader Asmal (former Minister of Department of Education). In this policy, the Minister of Education acknowledges the seriousness of the HIV and AIDS epidemic and provides guidelines to be used by learning institutions where increasing numbers of educators and students are HIV-positive (Republic of South Africa, 1996:1; Govender, 2003:15; Simbayi et al., 2005:31). The HIV and AIDS policy and guidelines document stipulates:

- The constitutional rights of learners and educators must be protected equally.
- There should be no compulsory disclosure of HIV status in schools.
- The HIV testing of learners as a prerequisite for attendance at an institution is prohibited.
- The HIV testing of an educator as a prerequisite for employment at an institution is prohibited.
- No HIV-positive learner or educator may be discriminated against; they must be treated in a just, humane and life-affirming way.
- No learner may be denied admission to or continued attendance at an institution because of his or her actual or perceived HIV status.
- No educator may be denied appointment to a post because of his or her actual perceived HIV status.
- Learners and educators who are HIV-positive should lead as full a life as possible.
- HIV-related infection control measures must be applied universally to ensure a safe institutional environment.

- Learners must receive education about HIV and AIDS in the context of Life Skills Education as part of the curriculum.
- Educational institutions should ensure that learners acquire age and context appropriate knowledge and skills to enable them to behave in ways that will protect them from HIV infection.
- Educators need more knowledge of, and skills to deal with HIV and AIDS, and should be trained to give guidance on HIV and AIDS (Coombe, 2000:28).

Theron (2005:59) argues that the above-mentioned National Policy on HIV and AIDS has succeeded in inculcating civilised attitudes, but does not address the systemic ramifications that educator attrition and morbidity hold. According to her, “there is a need for an education policy that specifically gives guidelines to the education systems pertaining to the management of the reality of HIV.” Also commenting on the policy, Simbayi et al. (2005:31) assert that this policy emphasises the needs of learners more than those of educators. Furthermore, the policy pays particular attention to educators and learners infected with HIV and neglects those affected by HIV and AIDS. They also critique the policy’s focus on biomedical aspects of the disease by stating that “it pays less attention to psychosocial challenges experienced by educators and learners infected and/or affected by HIV and AIDS.”

On the basis of the above, the researcher claims that the policy advocates the rights of educators and learners infected with HIV in educational institutions. It is, however, important that the policies and guidelines of this nature are visibly enforced in educational institutions in order to address the challenges and needs of HIV-infected educators and, in the process, help in the eradication of HIV-related stigmatisation and discrimination.

2.7.2 Department of Education Workplace Policy for HIV and AIDS and TB Management in the workplace

The Department of Education’s *Policy on HIV/AIDS and TB management in the Workplaces* aimed at providing guidelines for all Department of Education employees to manage HIV and AIDS in their place of work. The main objective of the policy is to create a supportive working environment for employees infected with and

affected by HIV and AIDS, thereby eliminating discrimination and protecting the rights of these employees (Simbayi et al., 2005:34). Drawing from the policy's objective as outlined above, it is the researcher's view that this policy primarily caters for the needs of educators as employees of the Department of Education and gives guidelines on how to support HIV- and AIDS-infected and/or affected educators. This view is also shared by Simbayi et al. (2005:65-66) who criticise the policy by pointing out that "the policy seems to over-emphasize the elimination of discriminatory practices and attitudes, and neglects the issues of prevention, treatment, care and support for employees infected with HIV and/or affected by HIV and AIDS." It is thus against this background that the policy needs to be reviewed and revised.

2.7.3 The Department of Education's strategy and programme 'Tirisano'

The above strategic programme was developed in July 1999 by the former Minister of Education, Prof. Kader Asmal, in his *Call for Action: 'Tirisano'* ('Tirisano' is Setswana for working together). Coombe (2000:29-33) points out that this programme pays particular attention to the health and well-being of learners and educators infected and/or affected by HIV and AIDS. The HIV and AIDS strategy also looks at ways to deal with the impact of the AIDS epidemic on the education sector. Coombe (2000:29-33), furthermore, points out that the programme addresses issues such as HIV and AIDS awareness and the integration of HIV and AIDS in the school curriculum by implementing the following three HIV and AIDS projects:

Project 1: HIV and AIDS awareness, information and advocacy

There is a need for awareness, advocacy and information about HIV and AIDS in schools given to the educators, students and learners at all levels of education.

Strategic Objectives:

- To raise awareness and the level of knowledge of HIV and AIDS amongst all educators and learners;
- To promote values, which inculcate respect for girls and women and recognize their right to free choice in sexual relations.

Anticipated Outcomes:

- Increase awareness, understanding, knowledge and sensitivity concerning the causes of HIV and AIDS, its consequences and impact on individuals, communities and the society in general;

- Eradication of discriminatory practices against individuals infected with HIV and/or affected by HIV and AIDS;
- Development and implementation of HIV and AIDS policies and programmes for the education system;
- Change of attitude and behaviour towards sexuality.

Outputs:

- Copies of HIV and AIDS policies and programmes to be distributed to all educational institutions;
- HIV/AIDS information materials to be available at all educational institutions;
- Gender sensitivity and equality to form part of all learning programmes in educational institutions.

Performance Indicators:

- Myths about HIV and AIDS are eradicated;
- Increased acceptance of the need to practice safe sex;
- Establishment of non-discriminatory practices in all educational institutions;
- Visible change of attitude towards girls and women.

This project clearly indicates that there is a need for ongoing dissemination and inculcation of HIV and AIDS information amongst educators and learners in schools. It advocates for gender equality by treating women and girls with dignity and respect if the nation is to combat the spread of HIV and AIDS in the education sector.

Project 2: HIV and AIDS within the curriculum

According to Visser (2005:206) this project aims to increase knowledge and skills needed for healthy relationships, effective communication, to promote positive and responsible attitudes and provide motivational support. In addition, the project seeks to integrate HIV and AIDS within the curriculum to ensure that life skills and HIV and AIDS education are included into the curriculum at all levels of education.

Strategic Objectives:

- To ensure that Life Skills and HIV and AIDS education are integrated into the curriculum at all school levels

Anticipated Outcomes:

- Every learner to understand the causes and consequences of HIV and AIDS;
- All learners to lead healthy lifestyles and make responsible decisions about their sexual behaviour.

Outputs:

- HIV and AIDS training materials to be developed for educators to facilitate Life Skills and sexuality education.

Performance Indicators:

- Life Skills and HIV and AIDS education are integrated across all learning areas and subjects;

- Increase in knowledge of, and changed attitudes towards, sexuality and HIV and AIDS amongst educators and learners;
- Reduction in the prevalence and incidence rates of HIV and AIDS amongst educators and learners.

In effect, this programme is designed to advocate for the integration and inclusion of HIV and AIDS knowledge in the school curriculum. It emphasises the need to include HIV and AIDS education in all learning areas and as a subject at all school levels in order to increase HIV and AIDS knowledge amongst educators and learners.

Project 3: HIV and AIDS and the education system

This project sees the need to have knowledge about the impact of HIV and AIDS on education and training system.

Strategic Objective:

- To develop planning models for analysing and understanding the impact of HIV and AIDS on the education system.

Anticipated Outcomes:

- Plans and strategies to respond to the impact of HIV and AIDS on the sustainability of the education system, and the human resource needs of the education system in particular;
- Establishment of treatment, care and support systems for learners and educators infected with HIV and/or affected by HIV and AIDS.

Outputs:

- National plan to deal with the impact of HIV and AIDS on the education system;
- Impact studies and reliable statistical databases on the impact of HIV and AIDS on the education system.

Performance Indicators:

- Improved data and planning models on the impact of HIV and AIDS on the education sector are implemented

As presented above, this project emphasises the need to implement the surveillance and monitoring of the impact of the AIDS epidemic on the education sector in order to develop strategies aimed at mitigating the effects of the disease on educators and learners.

Although the programme with its projects is a good initiative, it was found that the programme was not implemented as envisaged in schools, due to organisational problems, educators and principals' lack of commitment, mistrustful relationships between educators and learners, lack of resources and conflicting goals in the education systems. However, in schools where the programme was implemented and monitored, there seemed to be a remarkable success. Learners' and educators'

knowledge of HIV and AIDS increased and sexual behavioural changes in learners and educators were reported (Visser, 2005:203).

Visser (2005:2003) and Ngcobo (2002:97) highlight that the programme has been in existence for a while, but many educators at school level argue that they know nothing about the programme. They argue that the programme is formulated and drafted by the Department of Education at national level without consulting educators at school level. Therefore, educators infected with HIV and/or affected by HIV and AIDS feel that the programme is not effective in addressing their problems and needs. The Department of Education should have involved them in the formulation of the programme because they possess a greater knowledge of the day-to-day challenges faced by learners and educators infected with HIV and/or affected by HIV and AIDS at school level. It is probably against these grounds that Ngcobo (2002:97) calls for further research on the effectiveness of these programmes. The current situation is that the researcher has also visited schools and observed that the programme has been in existence for a while, but it is not being implemented, educators at school level know nothing about the programme, and no research has been conducted.

2.7.4 The HIV/AIDS emergency: guidelines for educators

The fourth important document is the *HIV/AIDS guidelines for educators*, which clearly indicates that educators should be at the forefront of disseminating HIV and AIDS education and information programmes in schools. According to Coombe (2000:33), these documents stipulate the following roles and responsibilities for educators:

- Exemplify responsible sexual behaviour;
- Spread correct information about HIV and AIDS;
- Lead HIV- and AIDS-related discussions among learners and parents;
- Create a school environment that does not discriminate against those who are infected with HIV and/or affected by HIV and AIDS;
- Support those who are ill because of AIDS-related diseases; and
- Make the school a centre of hope and care in the community.

In summary, these guidelines have been distributed to all schools by the Department of Education. They outline the role of educators in reducing the impact of HIV and AIDS on education. They also focus on exemplifying responsible sexual behaviour, spreading correct information and leading discussions amongst learners and parents. The guidelines also make provision for the creation of a work environment which does not discriminate against those who are infected. In terms of these guidelines, schools are seen as centres of hope and care in the community (Department of Education, 2000:5-13; Govender, 2003:16). Moreover, the guidelines emphasise that educators should create a caring and supporting environment for other educators and learners infected with HIV in schools. In doing so, HIV-infected educators would feel comfortable and welcomed in the school. The researcher observed in visiting schools that currently not all schools are implementing these guidelines.

McElligott (2005:1) states that four South African educator unions joined with the United States of America and South African partners to save the lives of educators through an innovative programme combining peer education, HIV testing, counselling and antiretroviral treatment to those who need it. The programme is called the *HIV and AIDS Prevention, Care, Treatment Access (PCTA) for South African educators*. In addition, in 2004, an alliance of South African and U.S. NGOs with experience in the management of HIV and AIDS programmes for educators proposed a two-year pilot project designed to mitigate the impact of HIV and AIDS on the education sector in general and on educators specifically. The project was in response to the findings and recommendations of a comprehensive study of the impact of AIDS on educators conducted by the Human Science Research Council for the Education Labour Relations Council (ELRC) (PCTA, 2007:6). To do this, PCTA used a comprehensive, integrated approach to prevention, care, and treatment of educators in Kwa-Zulu Natal, Mpumalanga and the Eastern Cape. It directly addressed three areas: prevention of HIV transmission, ART treatment services, and palliative care for HIV-infected educators. The programme was piloted for two years (2005-2007) and focused on educators who are HIV-infected. PCTA's (2007:35) final evaluation report reveals the following overall findings about the PCTA programme:

- **Significant awareness of the PCTA among educators**

Educators in the intervention site learned about the project from union meetings, peer educators, brochures, posters and newspapers. Over 80% of this group found the sessions were held at an appropriate time and they were satisfied with the information they received.

- **PCTA had a positive effect on HIV knowledge**

The odds of an educator answering all HIV transmission-related questions correctly were almost twice that of an educator responding correctly to all questions at baseline.

- **PCTA had no significant impact on HIV attitudes among educators**

Stigma remains as an important emotional factor that hampers educators' willingness to openly access testing and treatment. Fear of rejection by family and colleagues continues to surface as an issue with educators. Loss of employment, although protected by unions, is also a common concern.

- **PCTA had no effect on uptake of VCT**

One of the objectives of the PCTA intervention was to increase voluntary HIV testing and counselling among educators. Consequently, educators had to be made aware of the services available to them and the intervention succeeded in doing so. The proportion of educators who were tested at least once seemed to have decreased at the follow-up period when compared to baseline. Reasons for not accessing VCT included fear of a negative result, fear of being stigmatised for seeking a test, and concerns about confidentiality.

- **PCTA did not have a significant impact on educators' intention to use ART services**

A number of complex issues prevented educators from accessing ART service providers by PCTA. Confidentiality and concerns about people finding out their status remain some of the major obstacles to educators getting tested and obtaining treatment.

The PCTA was originally designed to be a pilot project to encourage educators to be tested and treated for HIV and AIDS. The project was successful in creating

awareness and encouraging educators to attend peer education sessions. These sessions had a direct impact on knowledge about HIV and AIDS. According to PCTA (2007:38-39):

Educators did not feel the environment was safe for accessing testing and treatment services. Fears related to being 'found out to be HIV-positive', losing one's job, and being shunned by the community emerged as the 'elephant in the room' for educators. Based on the above observation, confidentiality was a crucial factor for educators to be sure of, prior to using the services promoted through the project.

2.7.5 Employee Health and Wellness Programme

In 2006 the Department of Education in Mpumalanga came up with a comprehensive support programme to ensure the overall wellness of HIV- and AIDS-infected/affected educators (Mpumalanga Department of Education, 2007). The Department of Education initiated the programme in response to the findings of the research conducted by the Education Labour Relation Council, Human Science Research Council and Medical Science Research Council on three provinces to determine the impact of HIV and AIDS on the supply and demand of educators, namely: Mpumalanga, Eastern Cape and KwaZulu Natal (Policy on Employee Health and Wellness Programmes, 2007:2). The programme is called the Employee Health and Wellness Programme (EHWP). The EHWP acknowledges the seriousness of the HIV, AIDS and TB pandemic and commits itself to the following support programme:

- The implementation of an HIV, AIDS and TB workplace programme to ensure continuous service delivery and minimise the impact of HIV and AIDS at all levels in the workplace;
- The creation of a supportive and healthy working environment to enable employees living with HIV and AIDS to continue working for as long as they are fit to do so;
- The active and visible participation and involvement of senior management, line managers and supervisors and unions in HIV, AIDS and TB matters; and
- The creation of a non-discriminatory work environment to enable management, trade unions and all employees to actively contribute towards the prevention, control and management of the disease. The Superintendent

General or the delegated authority will also support its employees by ensuring that:

- an HIV, AIDS and TB workplace strategy is in place;
- managers support HIV and AIDS programmes, and that attendance at HIV and AIDS-related training is compulsory for all employees including management;
- a work environment that responds to the workplace challenges created by HIV and AIDS infection is maintained;
- the concerns of employees who may request management assistance are attended to;
- the medical information of employees is treated confidentially;
- there is continuous training programmes for employees, union representatives and managers;
- there are adequate annual financial and logistical investments to ensure that the HIV, AIDS and TB programmes run efficiently and are effectively provided for; and
- partnerships are entered into with NGOs and other stakeholders to negotiate for user-friendly and cost-effective service to all affected and infected employees and their families (Mpumalanga Department of Education, 2007:8-9).

According to the researcher's professional involvement and experience in the Employee Health and Wellness field, the Employee Health and Wellness Programme is making a big impact on HIV-infected educators. It seems as if many HIV-infected/affected educators are supported by the programme and are using the programme.

The researcher concludes that the Department of Education's Policies and Programmes as well as the Trade Unions, PCTA and Employee Health and Wellness Programmes have the potential to empower HIV-infected/affected educators to cope with the pandemic as individuals, employees, colleagues, family members and as members of the community. Furthermore, the programmes provided by the Department of Education can only play a significant role in reducing

the impact of HIV and AIDS on the education sector provided that they are coordinated and closely monitored by school principals.

2.8 CONCLUSION

This chapter has reviewed the literature pertaining to the psychosocial challenges as experienced by HIV-infected educators. It reviewed the HIV and AIDS policies and programmes implemented in the education sector to address the challenges and needs of the infected and/or affected educators. From the discussion, the chapter revealed that HIV and AIDS affect a large number of educators in Mpumalanga. It pointed out that many schools are confronted with the absence of educators, because they are either infected with or affected by HIV and AIDS. As such, it is the researcher's belief that school principals and the Department of Education should accept the challenge of HIV and AIDS and manage it with the same responsibility and commitment they do in other areas of their schools. School principals also have a great responsibility to manage HIV-infected educators and meet all the challenges imposed by the HIV and AIDS pandemic in order to reduce the rate of HIV transmission among educators.

Most importantly, the knowledge gained by these educators will possibly help to empower them to feel more confident in dealing with HIV and AIDS. Since there is no known cure yet, school based intervention by school principals supported by the Department of Education is key in reducing the impact of HIV and AIDS on the education sector (Calitz et al., 2002:142). The next chapter will describe the research methodology used in this study as well as the empirical findings, regarding the psychosocial challenges experienced currently by HIV-infected educators in Mpumalanga.

CHAPTER 3

RESEARCH METHODOLOGY AND RESEARCH FINDINGS

3.1 INTRODUCTION

Rayners (2007:1) and Finhaber and Michelow (2009:1) postulated that the Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome (HIV/AIDS) were global issues. AIDS was one of the biggest killers in the world today, and South Africa has more HIV-positive individuals than any other country in the world (Education Labour Relation Council 2005:1; Hofmeyr, Georgion & Baker, 2009:3).

As a result, the impact of HIV and AIDS on the education sector is profound and is eroding the delivery of learning, teaching and development to an unprecedented degree (Edusource, 2002:1). This is confirmed by Van Wyk and Lemmer (2007:303), who stated that HIV and AIDS affected a large number of educators and their deaths impact both the supply of and demand for educators.

While the previous chapter focused on a literature review with regard to HIV/AIDS as a social phenomenon, this chapter will focus on research methodology used in this study as well as the empirical findings of the study.

3.2 GOAL AND OBJECTIVES OF THE STUDY

3.2.1 Goal of the study

The goal of this study was formulated as follows:

To explore and describe the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga.

3.2.2 Objectives of the study

For the study to obtain its projected goal, the following objectives were formulated:

- To describe theoretically the phenomena of HIV and AIDS with specific reference to the effect thereof on the education system, more specifically on infected educators.

- To explore the emotional challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To explore the social challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To determine the spiritual challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- Based on the results, to make recommendations to the Department of Education in Mpumalanga in order to address the psychosocial challenges experienced by HIV-infected educators in the educational sector and to enhance further research.

Against this background the study was guided by the following research question:
What are the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga?

3.3 RESEARCH METHODOLOGY

In this section there will be a thorough discussion on the following: research approach, type of research, research design, population, sample and sampling method, data collection method, data analysis and trustworthiness.

3.3.1 Research approach

For the purpose of this study, a qualitative approach was used in order to understand the psychosocial challenges that HIV brought to the lives of the participants (HIV-infected educators) (Flick, Von Kardorff & Steinke, 2004:3). The study sought to develop a holistic picture, through collecting non-numerical data in the field at the site (Creswell, 2007:37) where HIV-infected educators experienced the psychosocial challenges of HIV and AIDS.

3.3.2 Type of research

The study could be classified as applied research due to the fact that the research focused on a problem in real practice; the research sought to show that the results could be used to address a problem or issue in the “real world” (Jupp, 2006:9). In the context of this study, the researcher wanted to make recommendations based on the

results of the study, to address the psychosocial challenges experienced by HIV-infected educators in the educational sector in Mpumalanga.

3.3.3 Research design

In the context of this study, the researcher used a phenomenological research design in order to understand and interpret the meaning that HIV-infected educators gave to the psychosocial challenges they experienced in their everyday lives (Fouche & Schurink, 2011:316). By using this design the researcher aimed to give an in-depth description of the essence of the participants' experiences as voiced by them.

3.3.4 Population, sample and sampling method

3.3.4.1 Population

The population or unit of analysis (Jupp, 2006:271) of this study was all the members of a well-defined class of people (Strauss & Myburgh, 2000:69), namely all the HIV-infected educators who had disclosed their HIV status to the Employee Health and Wellness practitioner in the Nkangala District, Mpumalanga, during the period 2008-2012. The Department of Education Mpumalanga gave permission that Employee Health and Wellness practitioners provided a list of HIV infected educators to the researcher.

3.3.4.2 Sample

To represent the population of this study, the researcher randomly selected a sample of 12 participants from the list of HIV-infected educators who had disclosed their HIV status to the Employee Health and Wellness practitioner in Nkangala District, Mpumalanga, during the period 2008-2012.

3.3.4.3 Sampling technique

To select a sample of 12 participants randomly for this research study, the researcher made use of a probability sampling technique, namely systematic sampling. According to Lynn (2004:1111), systematic sampling involves selecting units at a fixed interval. In the context of this study, the researcher randomly selected the first participant from the list of HIV-infected educators and thereafter every second name on the list until a sample of 12 participants had been selected.

3.3.5 Data collection method

Due to the applicability of using a phenomenological design in this study, the researcher collected information through unstructured in-depth interviews. There was no interview schedule with predetermined questions (Patton, 2002:349) as the questions emerged from the immediate context, and the researcher intended to facilitate the process as such. The interview process extended and formalised the conversation between the interviewer and interviewees: this has been referred to as a “conversation with a purpose” (Greeff, 2005:292).

Through the use of unstructured interviews as a data collection method, the study attempted to understand the meaning of everyday life for the participants. The purpose was not to get answers to questions, nor to test any hypothesis, and also not to “evaluate” in the usual sense of the term (Greeff, 2005:292-293), but only to understand the psychosocial challenges experienced by HIV-infected educators and from this construct meanings pertaining to that experience. The study employed unstructured interviews because this was focused and discursive, and it would also allow the researcher and the participants to explore issues (Greeff, 2005:293). The researcher conducted interviews at the school after hours as well as in the researcher’s office.

3.3.6 Data analysis

Qualitative data analysis involves organising, accounting for and explaining the data. In short, this involves making sense of the data in terms of the participants’ definitions of the situation, noting the patterns, themes, categories and regularities (Cohen, Manion & Morrison, 2007:22). For the sake of this study, the collected data was analysed according to Creswell’s model as described by Shurink, Fouche and DeVos (2011:404-419), thereby focusing on the following steps:

3.3.6.1 *Planning for recording data*

According to Schurink et al. (2011:404), the researcher should plan for the recording of data in a systematic manner that is appropriate to the setting, the participants, or both. The researcher used a tape recorder to record the interviews. She also

designed an interview summary form to record details such as biographical information, time, place, duration of the interview, and other relevant field notes.

3.3.6.2 *Data collection and preliminary analysis*

Data analysis in a qualitative inquiry necessitates a twofold approach. While the first phase deals with data analysis at the research site during data collection, the second phase involves data analysis away from the site, following a period of data collection (Schurink et al., 2011:405). For the purpose of this research, the researcher primarily analysed data away from the site.

3.3.6.3 *Managing the data*

This is the first step in data analysis away from the site (Schurink et al., 2011:408). The researcher took notes while listening to the recorded interviews in private and then transcribed the information in the form of written transcripts. She labelled tapes with the dates and the locations of the interviews and also compiled backup copies of recorded data. The researcher kept the data locked away for safety purposes, to ensure the participants' confidentiality.

3.3.6.4 *Reading and writing memos*

After organising the data the researcher familiarised herself with the data by reading the transcripts. During the reading process, the researcher wrote memos and looked for similarities and differences. Memos took the form of short phrases, ideas or key concepts. After reading the data intensively the researcher identified key concepts.

3.3.6.5 *Generating categories, themes and patterns*

The researcher went through the responses given by participants in order to understand their meaning. The researcher generated the main themes and sub-themes from transcripts, examined the transcripts of all interviews, and classified the responses according to the identified themes and sub-themes.

3.3.6.6 *Coding Data*

The researcher used different colours to highlight the themes from the collected data, because the key process in the analysis of qualitative social research data involves coding, classifying or categorising individual pieces of data (Babbie,

2007:384). The researcher assigned codes to the information collected to help her present the information in a tabular or figure form during the process of interpretation.

3.3.6.7 *Testing emergent understandings*

As described by Schurink et al. (2011:415), the researcher needed to search through the data for possible negative instances of the emerging patterns and then, if necessary, incorporate these into larger constructs. The researcher evaluated the data and sought to find how useful and central that data was to the unfolding story.

3.3.6.8 *Searching for alternative explanations*

The researcher critically challenged the obvious apparent patterns in order to search for alternative explanations. The researcher sought for other plausible explanations for the data and the linkages between them.

3.3.6.9 *Writing the report*

The researcher wrote the research report by discussing the emerged themes and sub-themes. The researcher used quotations to verify the evidence obtained, and went back to the literature and contextualised this with the data.

3.3.7 Trustworthiness

The trustworthiness of the qualitative study was ensured through the “external audit” of data and the interpretation thereof by experienced colleagues, as well as by “member checking” where the interpretation of results was verified with research participants (Glesne, 2006:38; De Vos, 2005:362).

3.4 ETHICAL ASPECTS

Ethics is defined as “a set of moral principles suggested by an individual or group, which is subsequently widely accepted, and offers rules and behavioural expectations about correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students” (Strydom, 2005:57). The considered ethical issues are discussed below.

3.4.1 Avoidance of harm

In the course of this study the researcher was sensitive to the possible harm and upset her study might cause participants (Gibbs, 2008:8). The researcher tried to protect the participants from any form of physical or emotional harm. Participants were fully informed in time about the possible emotional harm the research was likely to cause and were given the opportunity to withdraw from the research if they so desired. In the event that any emotional harm was observed, the researcher stood ready to refer the participant to an appropriate therapist in the Department of Social Development in the specific area. With regard to this study, the study did not stir any emotions or cause any physical harm as such.

3.4.2 Informed consent

The principle of fully informed consent means that participants in research should know exactly what they are letting themselves in for, what will happen to them during the research, and what will happen to the data they provide after the research has been completed (Gibbs, 2008:7-8). They should be made aware of this before they take part in a research study and they should be given the option to withdraw from the study at any time.

In line with Gibbs' suggestion, the researcher informed the participants about the goal of the study and all the procedures involved, via an informed consent letter. She described the goal, objectives, advantages, disadvantages, duration, possible risks and the benefits of the study. She also indicated to the participants that all the information would be stored for 15 years within the Department of Social Work and Criminology at the University of Pretoria. The research participants were also informed that their involvement in the study was voluntary. This allowed them to decide whether or not they wanted to take part in the study and, in the process, gave them the opportunity to withdraw at any stage without any pressure to stay. The researcher also mentioned that she intended to record the sessions, explained her reasons for using the tape recorder, and assured participants that the information recorded would be kept confidential and that accurate records of the interview sessions would be captured. The participants were asked to sign a consent form if they agreed to take part in the research.

3.4.3 Deception of subjects

Deception takes the form of a lapse or calculated misrepresentation in the process of informing participants that research is taking place and as to its nature, purpose, and consequences. In other words, deception of participants is a deliberate misrepresentation of facts in order to make another person believe what is not true (Homan, 2004:241). The researcher provided correct information to the participants and did not mislead them in any way.

3.4.4 Violation of privacy/anonymity/confidentiality

Seal, Gobo, Gubrium and Silverman (2004:233) stated that researchers “are obliged to protect the participants’ identity, places, and the location of the researcher.” In the context of this study, anonymity and confidentiality were ensured by not referring to any individual’s name or publishing any means of identifying the participants. The researcher ensured that the information gathered from the participants was kept confidential. Cassettes, field notes and transcripts were held in a secure place to which only the researcher had access.

3.4.5 Action and competence of researcher

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. The researcher was competent and adequately skilled in this respect. As a professional counsellor herself, the researcher has had extensive experience in dealing with sensitive social issues and specifically when it comes to working with people with HIV and AIDS. This background prepared her to work in a sensitive manner with the participants. The researcher also ensured that the research project ran its course in an ethically correct manner.

3.4.6 Release or publication of the findings

The researcher compiled a final report that was honest, accurate, objective and clear. She avoided misinterpretation and plagiarism, and stood ready to admit shortcomings and errors. The researcher reported back to the participants about the findings of the study and will make a copy of the research available to the Provincial/District office of the Department of Education for their own record keeping, as a source of information and as a product of their participation. The researcher will

also make a presentation, releasing the research findings to the Senior Management of the Department of Education and to all the Employee Health and Wellness practitioners in Mpumalanga to assist in creating HIV awareness based on the research findings.

3.4.7 Debriefing of respondents

According to Sieber (2004:239), debriefing refers to a conversation between the investigator and the subject that occurs after the research session. In the context of this study, the researcher planned a formal debriefing session immediately following each interview. The researcher rectified any misperceptions and gave the participants an opportunity to work through their feelings, emotions, thoughts and experiences.

3.5 EMPIRICAL FINDINGS

The researcher presented, analysed and interpreted the qualitative data collected by using individual interviews with 12 HIV-infected educators. Data analysis is the process of bringing order, structure and meaning to the mass of collected data as noted by Creswell (in De Vos, 2005:333).

All the interviews were first recorded on audio tapes, then transcribed and finally analysed by carefully going through all the transcripts utilising a coding system. Themes and sub-themes were then identified, interpreted and verified against the appropriate literature.

The presentation of the findings of the study has been done according to the following outline:

- **Section A:** Biographical profile of the research participants. Twelve HIV-infected educators from Nkangala District, Mpumalanga Province took part in this study. The biographical profile of the participants is discussed in terms of the following variables: age, gender, marital status, highest qualification, teaching experience and residential area.
- **Section B:** A presentation of the themes and sub-themes that emerged from the process of data analysis. Each theme and sub-theme is discussed

according to a summary of findings, quotations to verify the findings, and an integration of the relevant literature.

3.5.1 Section A: biographical profile of participants

The biographical profile of the participants will be discussed in terms of the following variables: gender, age, marital status, highest qualification, teaching experience, residential area.

3.5.1.1 Gender of participants

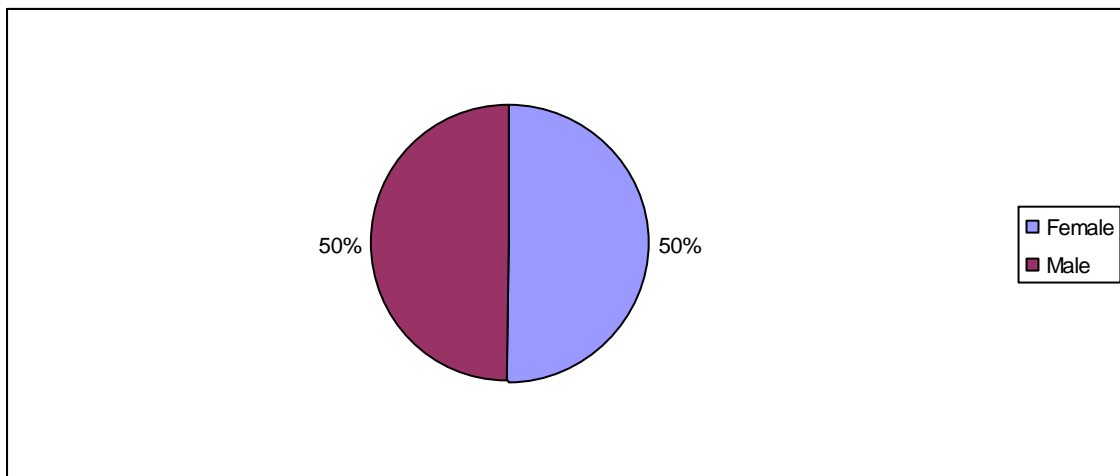


Figure 1: Gender of participants

Figure 1 illustrates that 50% of the participants were female and 50% were male.

3.5.1.2 Age of participants

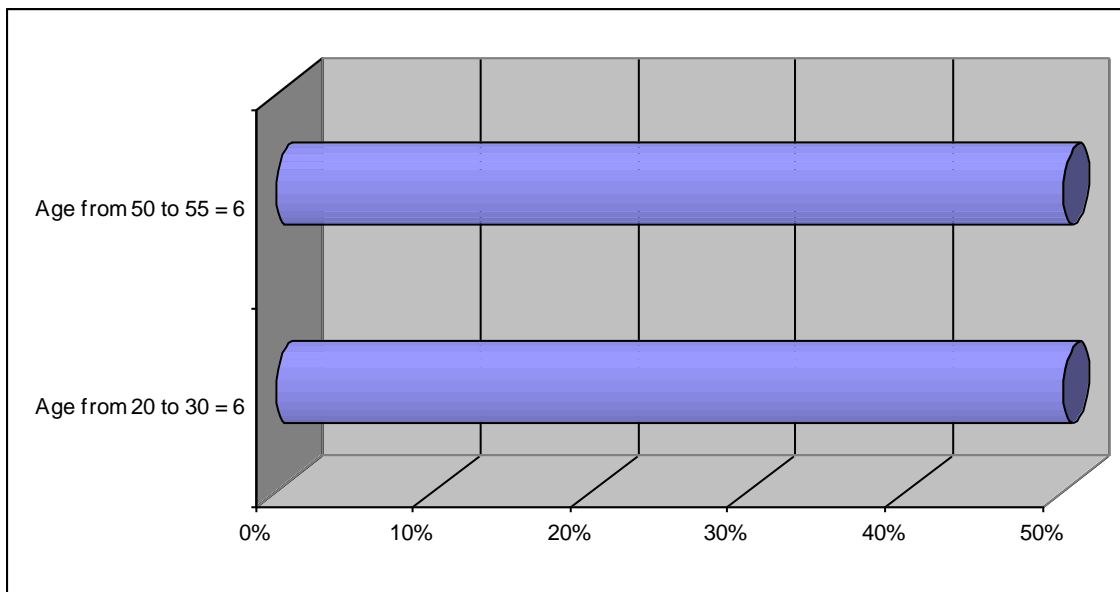


Figure 2: Ages of participants

Figure 2 highlights that the age of participants is between 55 and 20. Six participants (50%) were between the ages of 50 and 55 years, while the other six (50%) were between the ages of 20 and 30 years. None of the participants were between the age range of 31-49 years.

3.5.1.3 Marital Status

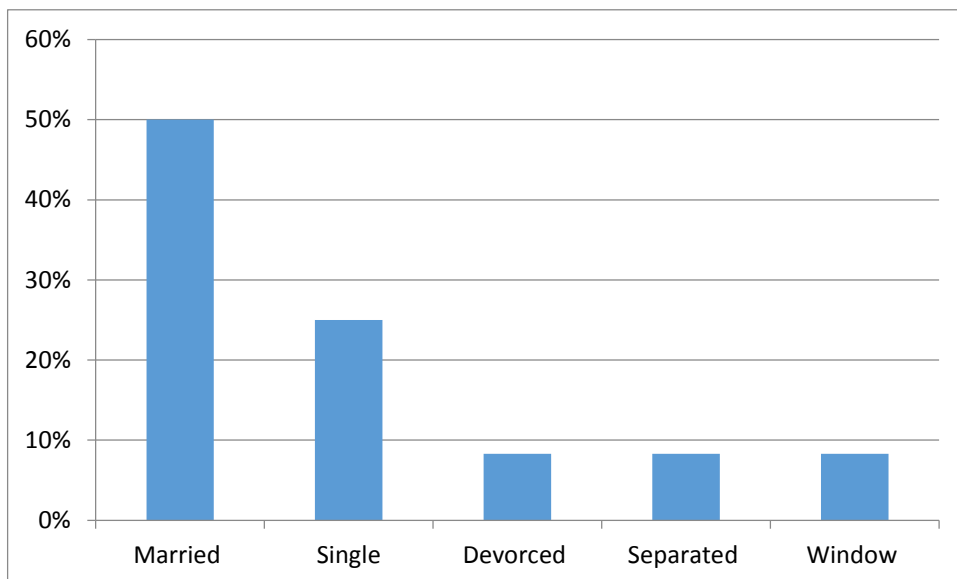


Figure 3: Marital Status of participants

Figure 3 indicates the marital status of the participants. It is interesting to note that half of the participants were married (50%), while 25% were single, 8.3% divorced, 8.3% separated and 8.3% widowed.

3.5.1.4 Highest qualification of participants

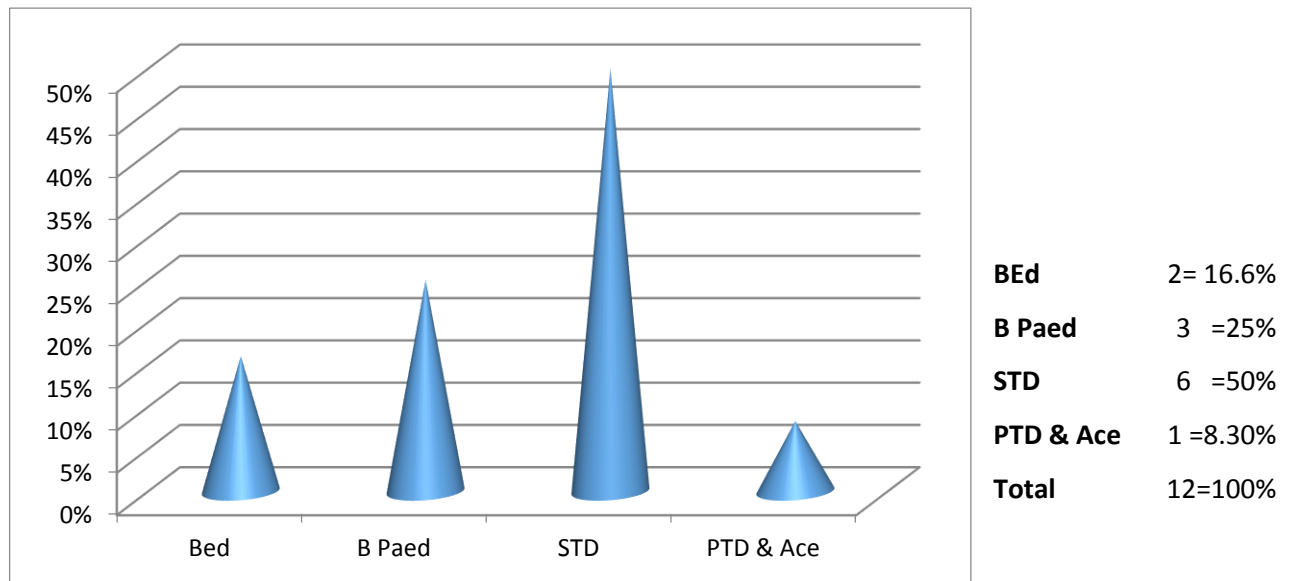


Figure 4: Highest qualifications held by participants

Figure 4 shows that six (50%) participants hold a Secondary Teachers Diploma (STD), three (25%) hold a BPaed degree, two (16.6%) hold BEd honours in education and one (8.3%) has a Primary Teachers Diploma (PTD) and an Advanced Certificate in Education (ACE). This shows that the participants are well educated and likely to be well-informed on the issues of HIV and AIDS.

3.5.1.5 Teaching Experience

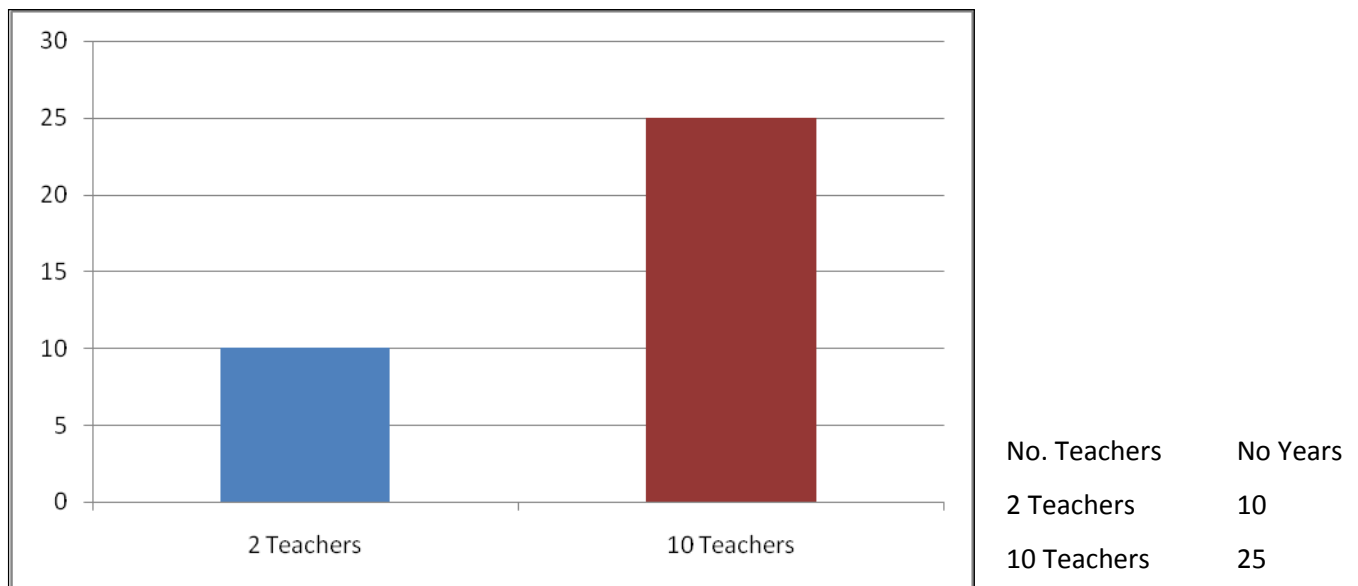


Figure 5: Teaching experience

Figure 5 indicates that 10 (%) participants have had 25 years' experience in the teaching field, while two (%) have had 10 years' experiences.

3.5.1.6 Residential area

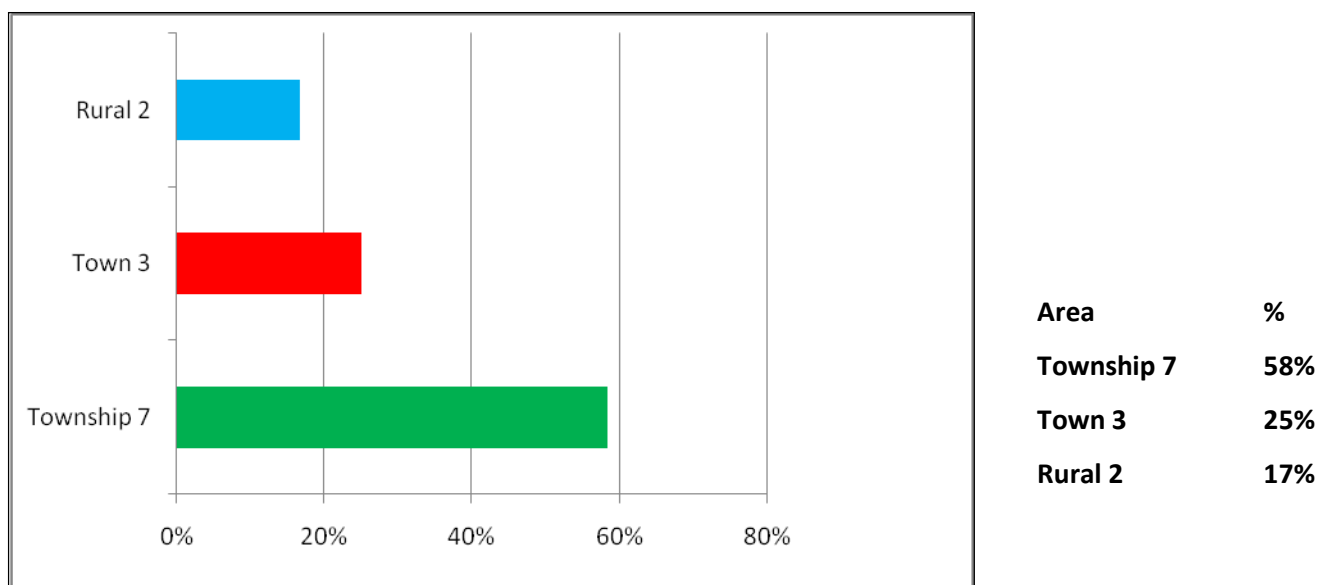


Figure 6: Residential area of participants

Figure 6 highlights that seven (58%) of the participants live in a township, three (25%) in town and two (17%) come from a rural area.

3.5.2 Section B: Qualitative findings

Section B will focus on the themes and sub-themes that emerged from the process of data analysis.

Table 1 displays a summary of the identified themes and sub-themes in this study.

Table 1: A summary of identified themes and sub-themes

Theme	Sub-Theme
Theme1: Participants' experiences of social challenges	1.1: Stigma and discrimination 1.2: Violation of confidentiality 1.3: Absenteeism affects colleagues and learners 1.4: Lack of support
Theme2: Participants' experiences of financial challenges	2.1: Exhausted Medical Aid 2.2: Health care services and ART 2.3: Maintenance of a healthy life style
Theme3: Participants' experiences of emotional challenges	3.1: Stress and depression 3.2: Isolation
Theme4: Participants' experiences of spiritual challenges	

Each of the above themes and sub-themes will be discussed according to a summary of findings, quotations to verify the findings and an integration of relevant literature.

3.5.2.1 Theme1: Participants' experiences of social challenges

The participants reported that they have been stigmatised and discriminated against by their family members, principals, partners and their colleagues which in turn created social challenges. Other prominent social challenges identified by the participants were violation of confidentiality, the effect of absenteeism on colleagues

and learners as well as lack of support. Each of these social challenges will be discussed as sub-themes.

Sub-theme1.1: Stigma and discrimination

All the participants experienced stigma and discrimination attached to their HIV and AIDS status. Some participants mentioned that they had lived a life of denial and secrecy with regard to their HIV status for fear of being stigmatised and discriminated against by their colleagues. The following comment illustrates this:

- *“There are so many challenges that we do experienced, firstly you know the case of discrimination, the stigma that we always have especially in our staff rooms. For instance when you want to borrow a cup of a colleague, you will experience that someone will make rules that you must not touch her things. You then feel as if maybe they know your status, but I never disclose my status to my colleagues.”*

Participants also mentioned that some colleagues still thought that by sharing utensils, shaking hands or hugging an HIV-positive person they were at risk of infection. One of the participants remarked about this as follows:

- *“After I disclosed there was a change, they use to put away their utensils, meaning cups, during lunch or during break, so now I always have to use my own things.”*

Bennel et al. (2002:86) confirm this findings by referring to the fact that school managers, colleagues, students and community members seriously discriminated against educators living with HIV and AIDS.

One participant also mentioned that she was discriminated against by her partners: she remarked about this as follows: *“We all want to be loved, to belong to a certain group but living with a virus is difficult to socialize. Like I told you when my husband died, it was difficult for me to find a partner, because once I have explained that I’ve got a virus, that person will leave me and will never call me again. That gives me a pain of being reminded that this is in me and it will never go away and then I feel*

being rejected, because I cannot take it away. As much as I want to have a partner it is difficult for me because they are afraid.

Kelly (2000:30) supports this statement by saying that the stigma relating to HIV and AIDS is an obstacle to accessing care and support services due to rejection, discrimination and shame attached to HIV and AIDS.

Stigmatisation and discrimination also created job insecurity among HIV-infected educators. One participant mentioned that she had been absenting herself, which resulted in the School Governing Body looking for a volunteer from the community to replace her. The participant voiced this experience as follows:

- *“I heard the school governing body is complaining and they are thinking of replacing me with a volunteer because sometimes I was sick for a month, they say I’m a cheque collector.”*

This was corroborated by Bennel et al. (2002:86), Kelly (2000:30) and Maile (2004:114) who pointed out that educators infected with HIV were discriminated against by their employers and might face dismissal from their jobs.

From the participants’ responses it was clear that people still thought that if one was HIV-infected it was because one had been doing wrong things by either being promiscuous or being unfaithful to one’s partner and that one deserved the punishment. Bennel et al.(2002:86) confirmed that stigma and discrimination attached to HIV and AIDS directly and indirectly killed HIV-positive educators; they were stigmatised and discriminated against by their colleagues, principals and families and ended up feeling rejected, blaming themselves and isolating themselves at the workplace or in the community. As a result, this engendered loneliness for these educators.

Sub-theme:1.2: Violation of confidentiality

A serious social challenge experienced by the majority of participants was violation of confidentiality. In this regard some educators mentioned that after they had revealed their HIV status to their principals, confidentiality was not maintained. All

their colleagues at the school would soon know their HIV status, as one participant noted:

- *“I never disclosed to anyone for the past two years, only this year I started to inform my supervisor, the principal, because most of the time I am absent from work because I was sick. I heard that he was complaining about my absence. So I decided to disclose to him, but since I have disclosed my status to him, seemingly now all my colleagues know my status.”*

Another participant remarked in this regard as follows:

- *“I used to be absent from work and sometimes there were submissions that I had to submit so I feel that it’s about time that the principal must know about my status; maybe it will be much better between me and him in terms of the working situation, that if maybe I didn’t submit some of my duties, he will understand that I was sick. However I feel he has disclosed my status because like during closing parties and if we are assigned duties among ourselves, they won’t allow me to touch, spice a meat, or to prepare snacks. So obvious things make me to suspect that they know my HIV status.”*

This links with the literature, which stated that HIV-positive educators were not afforded sufficient protection because they might sometimes be pressured by their supervisors to reveal their status, for example, when they had to explain their absence from school (Simbayi et al., 2005:55).

Sub-theme:1.3: Absenteeism affects colleagues and learners

One of the most serious consequences of being HIV-infected is that educators are on a regular basis absent from school due to the deterioration of their health. This situation poses a strain on other educators and influences relationships with colleagues and learners in a negative way.

When HIV-infected educators become ill, colleagues becomes overloaded with work of sick educators and that makes them angry and demotivated. On the other hand, the quality of learning is also affected; learners start complaining, as a result this influences relationships between the HIV-infected educators, colleagues and learners negatively.

Buchel (2006:343) as well as Rajagopaul (2008:287) confirm that when HIV-infected educators become ill, learning is affected because learners are often left alone in the classroom without any consistent teaching.

Some of the participants were in agreement that as a result of their HIV status they were absenting themselves from school. One participant noted the following:

- *“We are multigrading school. We teach more than one grade in one class. When I absent myself due to illness, it is really frustrating to educators and learners because of the kind of teaching that will take place under these circumstances.”*

It was confirmed by Calitz et al. (2002:151) and Rajagopaul (2008:116) that prolonged absenteeism was a serious problem in schools.

Sub-theme 1.5: Lack of support

Another social challenge that the majority of participants highlighted is the fact that they experienced a lack of support from the school management and the Department of Education. One participant voiced this challenge as follows:

- *“There is lack of support from the school management and the Department of Education to support HIV-infected educators. We are treated the same as healthy educators and given a lot of work we cannot manage. We need to be given reasonable compassionate sick leave to heal for the sake of our health. We cannot pretend to be healthy and work ourselves to death in order to keep our jobs. It is not fair.”*

The findings are in line with the literature, which maintains that HIV-infected educators need all kinds of support to play their meaningful role as educators (Calitz et al., 2002:160). This is also supported by Buchel and Hoberg (2006:17) who refer to the fact that the school management and the principal need to play a significant and vital role in supporting educators infected with HIV and/or affected by HIV and AIDS.

The majority of participants also experienced a lack of support from family members. One participant voiced this lack of support as follows:

- *“I can’t talk about HIV with my family, with them it’s a no-no area. I remember one day I went to a church, so it was so nice, they say people must come to give testimony, and then I went forward to testify. I looked at my mother, she was saying no, no, no, you know, she thought maybe I’m going to talk about my illness, and I could see even my sisters they were crossing fingers that I must not talk anything with regard to HIV.”*

This situation shows that HIV-infected educators are subjected to these unfair social practices in their day-to-day life experiences. Furthermore, these responses and lack of support from family members may lead to the fact that a person with HIV and AIDS may be forced to see themselves as undesirable by others who view them as “contagious” (Bezuidenhoudt et al., 2006:19).

3.5.2.2 Theme 2: Participants’ experiences of financial challenges

Educators are some of the lowest-paid professionals in South Africa; this causes financial challenges for HIV-infected educators, because they need care and treatment and they have to maintain a healthy lifestyle. In terms of financial challenges participants referred specifically to exhausted Medical Aids, expensive health care services and the maintenance of a healthy life style. Each of these aspects will be discussed as sub-themes.

Sub-theme 2.1: Exhausted Medical Aid

Some participants mentioned that HIV-infected educators could not meet their bills, because their Medical Aid became exhausted early in the year. As a result they had to pay medical bills from their own pockets with serious financial implications. This financial challenge is expressed by participants as follows:

- *“I have to go for my check-ups twice per month and sometimes I need to consult more than twice and then the funds will be exhausted and I had to pay from my own pocket.”*
- *“When the Medical Aid is exhausted, I use cash most of the time, so sometimes you will find that there are only four tablets in the packet and they will tell you that it’s 500.”*

Some participants referred specifically to the fact that they spend a lot of money on buying medication and healthy food and may therefore face a financial crisis, making the situation very difficult for them to function properly as educators. One participant remarked:

- *“I was refer by my Doctor to see a dietician, as a result it means I must change my menu, change the way you eat, and some of the food are expensive, you have to adjust your budget., you have to travel, like I said we are in a rural area, some of the food they recommend is not there. So we must travel to town.”*

It is understandable that these participants experienced financial challenges, because they have been extremely affected by the recent period of economic recession where expenses have sky rocketed, including medical costs and food prices. Hence being HIV-infected aggravates the situation and this in turn creates financial challenges. Hall, Altman, Nkomo, Peltzer and Zuma (2005:13) and Van Dyk (2005:218) concur that many people living with HIV and AIDS experience financial difficulties.

Sub-theme 2.2: Health care services and ART

Some of the participants mentioned the fact that they cannot financially afford ART because they are underpaid and cost of ART is expensive. This challenge was confirmed by a participant who said:

- *“My medical aid is exhausted at the moment, so we are using cash most of the time and ART are expensive”.*

The demand for ART exceeded the supply of treatment for HIV-infected people. This meant that HIV-infected educators would find it difficult to access ART at public health care facilities. This is confirmed by Rehle et al. (2005:9) who found that the participants (educators) in their study mentioned that there was a need for adequate and sufficient medical aid benefits in order for them to be able to afford health care services such as ART and the treatment of HIV and AIDS-related opportunistic infections.

Most of the participants highlighted that they found it difficult to access Anti-Retroviral Treatment (ART) at public health care facilities, because they didn't want people to know that they were HIV-positive. Some of the health care facilities lacked privacy, so that when one went for treatment everybody would know that one was there to access ART.

One participant mentioned the following:

- *“At the government clinic, wellness is split at the outskirt of the hospital, so when you turn there, immediately everybody knows that you are going to wellness and that you are infected with the HIV virus.”*

Due to the stigma the participants avoided public health facilities to get ART which poses a financial burden for them to go and buy it somewhere else.

Sub-theme 2.3: Maintenance of a healthy life style

Another prominent financial challenge highlighted by participants was the financial implications regarding the maintenance of a healthy life style. In this regard a participant mentioned the following:

- *“HIV-infected educators could not meet their financial expenses, because the type of food that they needed to buy is expensive. Others were consulting dieticians so that they could learn how to eat correctly. One educator said he was teaching in a rural area and most of the time there was no water. As a result he had to buy water and that was costly for him.”*

Another participant voiced this challenge as follows:

- *“We are using olive oil full time, we used to buy olives for the salads, and the salad is there every day in the house. I would say its financial consuming”.*

Participants emphasised the fact that having insufficient income posed a great financial challenge, because they had to live a healthy lifestyle with all the basic commodities provided for. They spent a lot of money on buying medication, making it very difficult for them to function properly and thus faced financial crises.

This was confirmed by Jansen (2006:29) who mentioned that more educators required care and treatment, and the cost of maintaining good health was very high for educators whose salaries were low when compared to other professionals.

3.5.2.3 Theme 3: Participants’ experiences of emotional challenges

According to Kelly (2000:65) educators are deeply affected personally by the incidence of HIV and AIDS. HIV impacts on educators’ emotional status, and their morale becomes low where the impact of HIV is high. The most important emotional challenges identified by the participants were stress and depression as well as isolation.

Sub-theme 3.1: Stress and depression

Ross and Deverell (2010:400) describe stress as “a mental or emotional strain or tension; a psychological condition that is caused by a demanding and frustrating situation that exceeds a person’s means, and can result in mental, emotional, physical and behavioural problems”.

During the interviews all the participants indicated that they experience stress and depression because of the difficulties they go through in their daily personal lives due to their HIV status. They referred specifically to stress that was caused by colleagues who isolated and rejected them as well as financial problems. The following quotations illustrate the emotional challenge of stress and depression:

- *“I do have a lot of stress; my stress at times is like when I am isolated by my colleagues I worked with. I realised that one get angry quickly, because it’s like when you want their sympathy and they are isolating you and you end up being depressed”.*
- *“I’m so stressed due to financial problems that I experience on a day-to-day basis. It makes me feel depressed”.*

The prevalence of stress and depression among people who are HIV-infected is confirmed by Van Dyk (2005:225-226) who notes that people infected with HIV frequently experienced depression because of day-to-day difficult situations such as social ostracism by significant others.

From the researcher’s point of view the problems of stress and depression could be detrimental to the health and wellbeing of HIV-infected educators, because stress and depression have the potential to suppress the immune system and speed up the rate of the disease.

Sub-theme 3.2: Isolation

It seems as if the majority of participants experienced rejection by their spouses, families, colleagues and friends; this in turn creates isolation and loneliness. The following quotations illustrate the emotional challenge of feeling isolated:

- *“When I am sick my kids know that my mother won’t come, my sisters won’t come, it will be me and them only. Sometimes I ask myself: ‘Is it only me who living with this virus in my family?’”*
- *“They [colleagues] sit at the back when I’m in front. When I am in front I don’t see them at the back, but I can feel that they are talking about me. “They don’t share anything with me. I feel isolated.”*

In this regard Bezuidenhout et al. (2006:19) postulate that the most destructive stressors are that of feeling isolated. This isolation can have many effects which may include, amongst others, the loss of support by lovers, family and friends.

3.5.2.4 Theme 4: Spiritual challenges

It was clear that participants experience serious spiritual challenges. Some of the participants commented that most church members considered HIV and AIDS as a sin and punishment from God. They revealed that they did not go to church anymore because they felt neglected and abandoned and had concluded that God “does not exist anymore”. The following quotation illustrates these feelings:

- *“In my church there are no programmes that accommodate HIV people. When you are not married you cannot talk about sex; they will tell you that sex before marriage is sin.”*
- *“In my church when they preach they say: “You see that all those who are not faithful, they will catch AIDS. When you are infected with HIV it means in your lifestyle you were cheating’.”*
- *“Our priest said that this disease is punishment for sinners. AIDS is God’s way of punishing sinners. Nobody should have sex with anyone else outside marriage.”*

The participants’ experiences of the above mentioned spiritual challenges was confirmed by Maile (2004:14) who also found that some church leaders refer to HIV and AIDS as Gods’ way of punishing sinners.

However, some participants expressed their spiritual feelings as follows: *“In terms of spiritual challenges, as the people of God we were supposed to be a family, to receive support when attending a church. HIV-infected people were supposed to come to church and be filled with love, support and comfort.”*

Maile (2004:114) confirms that HIV-infected persons may experience ethical and spiritual challenges in their day-to-day life experiences and argues that educators are believed to be at the forefront of HIV and AIDS education. If they are found to be HIV-positive, society regards them as deceivers and liars. They may be viewed by the society as bad role models, sexual predators and terrible examples to their children, and as such not fit to perform their school duties.

3.6 CONCLUSION

In this chapter, the researcher described the research methodology, ethical aspects as well as the most important empirical findings referring to social, financial, emotional and spiritual challenges experienced by HIV-infected educators.

The next chapter will focus on a discussion of the key findings, conclusions and recommendations.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The study revealed that HIV-infected educators experience different psychosocial challenges in their day-to-day personal lives. Based on the empirical findings it seemed as if there is a need for an urgent response from the Department of Education in terms of care and support for these educators.

This chapter presents the conclusions and recommendations of the dissertation. The goal of the study was to explore and describe the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga. It is therefore important to restate the objectives of the study and the research question in order to describe whether the study achieved the objectives it set out to meet.

The objectives of this research study were as follows:

- To describe theoretically the phenomenon of HIV and AIDS with specific reference to the effect thereof on the education system, more specifically on infected educators.
- To explore the emotional challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To explore the social challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- To determine the spiritual challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.
- Based on the results, to make recommendations to the Department of Education in Mpumalanga in order to address the psychosocial challenges experienced by HIV-infected educators in the educational sector and to enhance further research.

4.2 KEY FINDINGS AND CONCLUSIONS

4.2.1 Objective 1

The first objective was to describe theoretically the phenomenon of HIV and AIDS with specific reference to the effect thereof on the education system, more specifically on infected educators. The following key findings and conclusions based on the literature review are relevant:

- The HIV and AIDS pandemic is one of the serious challenges currently facing the education sector as it affects both educators and learners severely. It also affects the supply and quality of education, its management, as well as its capacity to respond to the new and complex demand (Coombe, 2002:4).
- It affects the education sector in the following ways: it affects the demand for education – those who are its potential clients; the sufficiency of its personnel to supply education services; the content of what is being taught; the processes involved in the teaching and learning; how the schools are organised; the nature of the role of education; the funds needed for education; aid agency involvement in the system; and sector-wide planning and management (Kelly, 2000:45).
- Among educators by provinces, HIV prevalence showed that KwaZulu-Natal and Mpumalanga had the highest prevalence with rates of 21.8% and 19.1%, respectively. From the literature it was clear that the key drivers of the epidemic within the educator population are believed to be lack of condom use, multiple partners, alcohol abuse and intergenerational sex. Educators residing in rural areas and working in rural schools had a higher HIV prevalence than their urban counterparts (Education Labour Relation Council, 2005:2; Shisana et al, 2005:119).
- HIV and AIDS affect many educators in Mpumalanga; many schools are confronted with the absence of educators, because they are either infected with or affected by HIV and AIDS.
- The school principals and the Department of Education should accept the challenge of HIV and AIDS and manage it with the same responsibility and commitment that they display in other areas of education.

- In the absence of either a cure or vaccine for HIV and AIDS, prevention and education must be made the focus of response in the educational context.

4.2.2 Objective 2

The second objective was to explore the emotional challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.

- Coombe (2002:18) and Kelly (2000:65) explain that educators are deeply affected personally by the incidence of HIV and AIDS. HIV impacts on educators' emotional status, and their morale becomes low where the impact of HIV is high.
- Participants infected with HIV indicated that they are prone to stress and depression because of the situations that they encounter in their day-to-day life experiences of being infected with HIV and AIDS. They are also rejected and isolated by their colleagues at work because of their HIV status. The emotional challenge of stress and depression is also highlighted in literature. According to Van Dyk (2005:225-226) "people infected with HIV frequently experience depression because of day-to-day difficult situation such as social ostracism by significant others."
- The majority of the participants postulated the challenge that they experience rejection by their partners, colleagues and families; this in turn creates loneliness for these educators.
- Another prominent emotional challenges identified by the participants was their experience of isolation. In this regard, Bezuidenhout et al. (2006:19) state the following: The most destructive stressors are that of feeling isolated. This isolation can have many effects which may include, amongst others, the loss of support by lovers, family and friends.
- For these reasons it is important that the Department of Education come up with different programmes to support the HIV-infected educators in order to eliminate AIDS-related emotional challenges.

4.2.3 Objective 3

The third objective was to explore the social challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.

- Participants indicated that one of the most serious consequences of being HIV-infected is that the infected person experiences stigma, discrimination and isolation. Kelly (2000:29) as well as Bennel et al. (2002:86) confirm this by stating that “it is generally agreed that educators living with HIV and AIDS are seriously discriminated against by the school managers, colleagues, students and community members.”
- Most of the participants indicated that they are afraid to disclose their status because people hold a signatory and discriminatory attitude towards them. HIV-infected educators sometimes stigmatise and discriminate themselves before other people do. It is clear that people still have the fear that they can be HIV-infected by associating with infected persons.
- A person’s HIV status is a private and confidential matter and disclosure is optional. The majority of the participants felt reluctant to reveal their HIV status because they fear that confidentiality will not be maintained, but some participants mentioned that after they had informed their principals of their HIV status, these principals ended up disclosing that status to other colleagues without their permission. This links with the literature which states that HIV-infected educators are not afforded sufficient protection because they may sometimes be pressured by their supervisors to reveal their status, for example, when they have to motivate their absence from school (Simbayi et al., 2005:55). The research shows that violation of confidentiality is still rife in some schools and has been cited as the major reason for HIV-infected educators’ reluctance to disclose their status.
- Participants felt that their HIV and AIDS status led to a high level of absenteeism in school. When HIV-infected educators become ill, learning is affected since learners are often left alone in the classroom without any consistent teaching and they also cannot be able to provide quality education to the learners because of their inability to cope with their daily duties (Buchel, 2006:343;Rajagopaul, 2008:287). It was confirmed by Calitz et al. (2002:151) and Rajagopaul (2008:116) that prolonged absenteeism was a serious problem in schools.

- During illness-related absences, colleagues were forced to take on double classes. Van Wyk and Lemmer (2007:303) have found that sometimes educators were overloaded with the work of sick educators; as a result they experienced higher stress levels and become demoralised.
- Another social challenge that was highlighted by the participant is a lack of support from the school management and the Department of Education for HIV-infected educators. It seems as if HIV-infected educators are treated the same as healthy educators. In this regard Buchel and Hoberg (2006:17) stated that the school management and the principal need to play a significant and vital role in supporting educators infected with HIV and/or affected by HIV and AIDS.
- The most prominent financial challenge mentioned by the majority of participants was the fact that they could not afford ART because they are underpaid and the cost of ART is expensive. It is also difficult for HIV-infected educators to access ART in public health facilities.

4.2.4 Objective 4

The fourth objective was to determine the spiritual challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.

- Participants experience serious spiritual challenges. The participants indicated that educators who were HIV-infected were treated differently and they felt neglected and abandoned and had concluded that God “does not exist anymore”. In most of the churches there are no programmes that accommodate HIV people. The participants’ experiences were confirmed by Maile (2004:114) who stated that it is clear that HIV-infected persons may experience ethical and spiritual challenges in their day-to-day life experiences.

4.3 RECOMMENDATIONS

Based on the empirical findings, the following recommendations can be made:

- Policies on HIV and AIDS should be implemented at schools to ensure that HIV-infected educators are not unfairly discriminated against. The policies should also deal with challenges faced by educators and learners and protect their rights.
- This study shows that there is a lack of education and information about HIV and AIDS in our schools. If educators were more knowledgeable about the disease, the instances of AIDS-related stigmatisation and discrimination would not occur. Therefore, educators need to educate each other about HIV and AIDS in order to dispel the myths and misconceptions surrounding the disease and eliminate HIV and AIDS-related stigmatisation and discrimination.
- The Department of Education must disseminate information and provide training pertaining to HIV and AIDS. Prevention programmes should also form part of the training.
- The Department of Education has to ensure that HIV-infected educators are able to access treatment, care and support such as ART, treatment of opportunistic infections, nutritional support, psychosocial support, as well as financial support.
- HIV-infected educators should be encouraged to disclose their status in order to be able to access treatment, care and support services. Disclosure would also encourage support by family members, colleagues and school management.
- HIV-infected educators need to form school-based support groups in order to be able to care, counsel and support each other in times of need.
- Schools are encouraged to consider hiring educator assistants to substitute absent educators who are ill due to AIDS-related diseases.
- The Department of Education needs to increase the salaries of educators in order for HIV-infected educators to be able to afford treatment, care and support services, medical expenses and proper nutrition.
- Schools must network with the community in order for HIV-infected educators to access NGOs, FBOs and CBOs which offer HIV and AIDS treatment, care and support services. Parents, Unions and the Department of Education should work together in the fight against HIV and AIDS through awareness and outreach campaigns.

- Educators should be encouraged to go for HIV Counselling and Testing (HCT) services in order to ascertain their HIV status and to make informed decisions based on the outcome of an HIV test.
- HIV-infected educators should be encouraged to continue using the Employee Health and Wellness programme and to rely on the services of the Prevention, Care, Treatment and Access (PCTA) which deals with issues of HIV and AIDS in schools.
- Further research should be done with regard to the development and implementation of support mechanisms for HIV-infected educators.

4.4 ACCOMPLISHMENT OF THE GOAL AND OBJECTIVES OF THE STUDY

Goal of the study: To explore the psychosocial challenges that HIV-infected educators experience in Nkangala District, Mpumalanga.

Table 2 below focuses on how the above goal and objectives of the study were accomplished.

Table 2: Accomplishment of the study objectives

Nr	Objectives	Objectives achievement
1.	To describe theoretically the phenomenon of HIV and AIDS with specific reference to the effect thereof on the education system, more specifically on infected educators.	This objective was achieved as reflected in the theoretical discussion presented in Chapter 2.
2.	To explore the emotional challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.	This objective was achieved as reflected in the discussion in Chapter 3.
3.	To explore the social challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.	This objective was achieved as reflected in the discussion in Chapter 3.

4.	To determine the spiritual challenges experienced by HIV-infected educators in Nkangala District, Mpumalanga.	This objective was achieved as reflected in the discussion in Chapter 3.
5.	To make recommendations, based on the research findings.	The objective was achieved through a summarised presentation of findings and recommendations in Chapter 4.

4.5 CONCLUDING REMARKS

This study aimed to explore the psychosocial challenges that HIV-infected educators experience. The research study has revealed that the level of awareness is still low. Everybody needs to gain a greater consciousness about the massive dangers that HIV and AIDS pose to the mankind as a whole.

Support systems for HIV-infected educators are an important workplace issue; even though the educators conceded that schools had insufficient capacity to provide these at present. HIV-infected educators are working/living under stressful conditions and support systems such as counselling, care and treatment would help them to cope. Provision of these support systems would help to promote positive attitudes in HIV-infected educators.

The general attitude of educators towards HIV in general showed that HIV literacy is high, but there are still some misconceptions which hamper the support of HIV-infected educators to a certain extent. Stigmatisation and discrimination still exist in the education sector and are much more evident when it comes to the HIV-infected educator.

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APPENDIX A

PERMISSION LETTER FROM THE MPUMALANGA DEPARTMENT OF EDUCATION

APPENDIX B

LETTER OF ETHICAL CLEARANCE

APPENDIX C

RESPONDENTS' LETTER OF INFORMED CONSENT

APPENDIX D

EDITORIAL LETTER