

Resilient Educators Support Programme for HIV and Aids affected educators in the Northern Cape: an evaluative study

by

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University of Pretoria

Faculty of Humanities

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ABSTRACT

Resilient Educators Support Programme for HIV and AIDS affected educators in the Northern Cape: an evaluative study

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DEGREE: MSW (Employee Assistance Programme)
INSTITUTION: University of Pretoria

The Resilient Educators (REds) Support Programme was compiled by the North West University in 2006. The aim of the REds Programme is to promote the quality of life of HIV and AIDS-affected educators. It is therefore geared towards assisting educators to cope more effectively with the challenges of the pandemic by supporting them to respond adaptively to a teaching context that demands responses more typical of counsellors or social workers, or medical personnel trained to prevent HIV (Theron, Geyer, Strydom & Delpport, 2008:84).

The content of the REds Programme is grouped into nine modules. Each module provides thematic structure, background information and interactive activities. Since its conception in 2006 and subsequent implementation, REds has continued to evolve, being continually informed by empirical research, with the future aim of disseminating REds to the National Department of Basic Education in South Africa (Theron et al., 2008:84-85). Continual refinement and development of REds have thus been occurring to the extent that the fourth version has been implemented in 2009. REds has to date been implemented in four South African provinces, namely Gauteng, Mpumalanga, Free State and North West Provinces, but not in the Northern Cape. However, its extended implementation in the Northern Cape may deem invaluable to the standardisation of the programme for the South African educational context.

The goal of the research project was to determine the effectiveness of the REds Support Programme (fourth version) in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape.

The researcher embarked upon programme evaluation as a type of applied research. The study utilised the triangulation mixed methods research design, as this study combines qualitative and quantitative research methods. The research design for the quantitative research approach was the quasi-experimental comparison group pre-test post-test design, whilst the collective case study design was used for the qualitative research approach.

Quantitative data were collected through a group standardised questionnaire, the Professional Quality of Life Scale (ProQOL) and for qualitative data different methods were used including narratives and drawings. The same standardised questionnaire was administered at both the pre- and post-test level with both the experimental and comparison groups. Narratives and drawings were also utilised for both groups before and after exposure to REds. The experimental group consisted of 11 respondents from a specific primary school in Kimberley, Northern Cape, while 10 respondents, from another primary school in Kimberley, participated as part of the comparison group.

The quantitative research results suggested that even though a significant difference was indicated between the comparison group and the experimental group as it relates to the measure of burnout at the post-test level, it cannot be certain that this difference is as a result of the experimental group having been exposed to the REds programme, given that a significant difference between these groups already existed at the pre-test level. Qualitative research results, on the other hand, evidently indicated that participants have profited from the REds programme and that there was a positive mind shift in the post-exposure of respondents to the programme. This could be substantiated when comparing post-exposure findings of the comparison group and the experimental group.

Based on the data obtained through ProQOL, the REds programme did not adequately address the support needs (Quality of Life) of participants.

The qualitative results gathered through narratives and drawings seem to have given a better representation of the impact of the REds programme on participants when compared to the quantitative results. It is recommended that the qualitative component of the research project be elevated as the data gathered through this research method was much richer than the quantitative data. The impact of the programme is evident using this data collection method. It is recommended that other possible standardised questionnaires be explored or a self-structured questionnaire be compiled in order to identify a more applicable measuring instrument. It is also recommended that the possibility of excluding a quantitative measuring instrument be explored.

Key Concepts:

- Educator
- Evaluation research
- HIV and AIDS affected
- Northern Cape Province
- Quality of life
- Resilient Educators Support programme

OPSOMMING

Resilient Educators Ondersteuningsprogram vir MIV en Vigs-geaffekteerde onderwysers in die Noord-Kaap: 'n evaluatiewe studie

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GRAAD:	MMW (Werknemerhulpprogramme)
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Die *Resilient Educators Support Programme* (REds) was deur die Noordwes-Universiteit gedurende 2006 saamgestel. Die doel van hierdie ondersteuningsprogram was om die lewenskwaliteit van MIV geaffekteerde opvoeders te bevorder. Die program het dus ten doel om opvoeders (leerkragte) beter toe te rus om meer effektief die uitdagings wat hierdie pandemie inhou, te hanteer deur hulle te ondersteun met aanpasbare response tot die opleidingskonteks wat response soortgelyk aan voorligters of maatskaplike werkers of medies-opgeleide personeel vereis om die verspreiding van MIV te bekamp (Theron, Geyer, Strydom & Delpport, 2008: 84).

Die inhoud van die REds is in nege modules/afdelings verdeel. Elke module voorsien 'n tematiese struktuur, agtergrondinligting en interaktiewe aktiwiteite. Sedert die totstandkoming van die program in 2006 en sy gevolglike implimentering, het hierdie program gegroei en is voortdurend onderwerp aan empiriese navorsing met ten doel die toekomstige verspreiding van hierdie program aan die Nasionale Departement van Basiese Onderwys in Suid-Afrika (Theron, Geyer, Strydom & Delpport, 2008:84).

Voortgesette verfyning en ontwikkeling van hierdie program het meegebring dat die vierde weergawe reeds in 2009 geïmplimenteer is. Die REds program is reeds al in

vier (4) provinsies, naamlik Gauteng, Mpumalanga, Vrystaat en Noordwes provinsies, geïmplimenteer. Die implimentering van hierdie program in die Noord-Kaap mag van onskatbare waarde wees vir die standaardisering van die program vir die Suid-Afrikaanse opvoedkundige konteks.

Die doel van die navorsingsprojek was om die effektiwiteit van die REds program (vierde weergawe) in die bevordering van die lewenskwaliteit van MIV/VIGS geaffekteerde opvoeders in die Noord-Kaap Provinsie, te bepaal.

Die navorser het program-evaluering as die tipe navorsing gebruik. Hierdie studie het beide kwalitatiewe en kwantitatiewe navorsingsontwerpe ingesluit. Die ontwerp tot die kwantitatiewe navorsing het 'n kwasi-eksperimentele vergelykende groep met voor-en-na-toets behels, terwyl die kollektiewe gevallestudie ontwerp gebruik was as deel van die kwalitatiewe ondersoek.

Kwantitatiewe data was deur 'n gestandaardiseerde vraelys ("*Professional Quality of Life Scale*") ingesamel, terwyl die kwalitatiewe data deur middel van narratiewe en tekeninge ingevorder is. Die vraelys was vóór en ná blootstelling aan REds op beide die eksperimentele en vergelykende groep geadministreer. Narratiewe en tekeninge was ook op dieselfde beginsel toegepas. Die eksperimentele groep het uit elf (11) deelnemers vanaf 'n spesifieke Primêre skool in Kimberley bestaan, terwyl tien (10) deelnemers vanaf 'n ander Primêre skool in Kimberley die vergelykende groep verteenwoordig het.

Die kwantitatiewe data dui daarop dat, alhoewel betekenisvolle verskille aangedui word tussen die groepe ten opsigte van uitbranding (burnout) tydens die na-toets, dit nie duidelik is dat dié resultaat aan die program toegeskryf kan word nie. Die eksperimentele groep het, reeds tydens voor-toetsing, betekenisvolle verskille aangetoon. Kwalitatiewe resultate dui daarop dat deelnemers baat gevind het by die program en dat 'n positiewe ingesteldheid in die na-toets van deelnemers gerapporteer was. Gebaseer op die data verkry vanaf die ProQOL, het die REds nie die ondersteuningsbehoefte van deelnemers verbeter nie.

Die kwalitatiewe resultate wat deur middel van narratiewe en tekeninge verkry is, gee 'n beter verteenwoordiging / verklaring van die impak van die program as dit met die kwantitatiewe resultate vergelyk word. Dit word aanbeveel dat die kwalitatiewe komponent van die navorsingsprojek vergroot word om 'n ryker databasis aan die studie te verleen. Die impak van die program is veral sigbaar as hierdie metode van ondersoek gevolg word. Voorts word ook aanbeveel dat ander gestandaardiseerde vraelyste of 'n self-gestruktureerde vraelys ontwikkel word en by die studie ingesluit word. Daar word ook aanbeveel dat die moontlike uitsluiting van die kwantitatiewe navorsing verder ondersoek word.

Sleutelwoorde:

- Evaluering
- Lewenskwaliteit
- MIV/VIGS-geaffekteer
- Opvoeder
- Resilient Educators Support Programme

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CHAPTER 1

GENERAL INTRODUCTION

1.1 INTRODUCTION

Just over thirty years ago, HIV and AIDS was discovered and since then the scale of the HIV and AIDS pandemic has exceeded all expectations. During 2009, 370 000 children became newly infected with HIV globally and an estimated 42 000-60 000 pregnant woman died because of HIV (UNAIDS, 2010:6)

It appears that the African region most affected by the pandemic is sub-Saharan Africa. At the end of 2000, there were an estimated 25.3 million people living with HIV, with this region also accounting for almost three-quarters of the global death toll (Piot, Bartos, Ghys, Walker & Schwartander, 2001: 969). Approximately 10% of the world's population lives in sub-Saharan Africa, but the region is home to approximately 64% of the world's population living with HIV.

Most epidemics in sub-Saharan Africa, such as HIV, have stabilised, although at very high levels of prevalence, especially in South Africa. Even though the HIV prevalence stabilised in sub-Saharan Africa, the actual number of people infected continues to grow because of ongoing new infections and increasing access to antiretroviral therapy (UNAIDS, 2008:17). The decrease and stabilisation of the number of HIV infections in sub-Saharan Africa are noticeable, though the effects of the damage done by the pandemic are still vigorously felt by abandoned families, orphaned children and poverty-stricken communities.

It is estimated that South Africa has the sixth highest prevalence of HIV in the world, with an estimated 15% - 28% adult prevalence rate of the population being infected (UNAIDS, 2008: 5).

According to the Department of Health (2006: 20), the Northern Cape Province has the second lowest rate of HIV and AIDS in South Africa, with the age group 20 to 29 years accounting for the highest proportion of HIV-positive people in the province. The HIV prevalence estimate for the Northern Cape has declined from 18% in 2005 to 15.6% in 2006. The South African average in 2006 was 29.1%. No exponential increase in HIV prevalence has been noted in South Africa since 1998. In July 2006, statistics for the Northern Cape reported that 6.9% of the population was newly infected with HIV. It was further estimated that 30% of all deaths in the same year were AIDS-related in the Northern Cape.

Even though the prevalence rate for HIV and AIDS in the Northern Cape is lower than other provinces, it does not mean that the province is safe or that the problem is not as severe. It remains crucial to ensure that these statistics do not increase. According to the Budget Speech by Ms E.D. Peters, former Northern Cape MEC for Health (Northern Cape Health Budget Vote, 2002: 16), it was predicted that, without significant intervention, 54% of the population of the Northern Cape would be infected with HIV by 2010. It was further estimated that if there was no commitment to bring about the necessary behavioural changes to curb the spread of the disease, the population in the Northern Cape would be reduced dramatically, leaving millions of children orphaned and the province stripped of its human resources.

According to the *AIDS Foundation* (2005: 1), there were 1.2 million orphans as a result of AIDS in South Africa by the end of 2005. Orphans are defined as children under the age of 17 years, whose mothers have died - this being the average age of school-going children (*AIDS Foundation*, 2005: 8). These children's social circumstances and emotional burdens might impact negatively on their schoolwork. The education system thus becomes the playground for the social, health, emotional and other problems experienced by learners, with educators bearing the brunt of having to deal with these issues hands-on (*AIDS Foundation*, 2005: 10). HIV and AIDS appears to be exhausting the supply of education, eroding its quality, weakening demand and access, drying up countries' pools of skilled workers and increasing the sector costs (*Science in Africa*,

2002: 1). HIV and AIDS has radically transformed the world, including the world of education, while the contents, structures and programmes that responded to the needs of a world without AIDS are no longer adequate in a world with AIDS.

Bhanna, Morrell, Epstein and Moletsane (2006: 14) note that in under-resourced schools, given the overwhelming needs of learners, educators often have to assume various professional roles for which they were not formally trained (for example, counsellors, social workers, advisors, etc.). The nature of the work and the role of educators has therefore changed dramatically in response to the impact of, and challenges posed by HIV and AIDS. Hall, Altman, Nkomo, Peltzer and Zuma (2005: 23-24) argue that HIV and AIDS has radically altered the teaching experience of educators in that they are affected by their colleagues, learners and/or family members who are HIV-positive or dying from AIDS-related illnesses. Teaching learners made vulnerable as a result of the HIV and AIDS pandemic has had the same effect (Hall et al., 2005: 23-24). Bhanna et al. (2006: 6) purport that in an HIV and AIDS-affected context the role of educators is extended to that of HIV prevention agents, counsellors, social workers and even surrogate parents. Theron, Geyer, Strydom and Delpont (2008: 77) contend that, despite numerous calls to empower educators to cope with the relentless challenges posed by the pandemic, very little has been done to date to empower and support educators. Despite these major challenges, educators are still expected to cope and adequately perform the role of instilling the necessary knowledge and values in children.

Theron et al. (2008: 83) further assert that the implication for educational practice in South Africa is comprehensible in that educators need broad support to cope with the challenges of a professional role that has been escalated to encompass HIV prevention and counselling. According to Theron et al. (2008: 83), there is no form of comprehensive support for affected educators, although some South African research initiatives have empowered participating educators and their communities. This shortcoming, based on scientific evidence, prompted their compilation of an interactive participatory programme entitled Resilient Educators (REds).

The express aim of the REds Programme is to promote the quality of life and of HIV and AIDS-affected educators (Theron et al., 2008: 83). It is therefore geared toward assisting educators to cope more effectively with the challenges of the pandemic by supporting them to respond adaptively to a teaching context that demands responses more typical of counsellors or social workers, or medical personnel trained to prevent HIV (Theron et al., 2008: 84). The content of the REds Programme, which was informed by a multidisciplinary team of professionals, is grouped into nine modules. Each module provides thematic structure, background information and interactive activities. Themes that are explored include: health promotion; the psychosocial impact of the HIV pandemic on learners and educators; psychosocial support (resources and skills); stigma and discrimination; HIV-related education policy and resilience.

To date, REds has been implemented in four South African provinces with small groups of volunteer educator-participants, who further form part of continued integrative intervention research to both effectively empower and support educators, and to standardise REds within the South African educational context. The facilitators of REds have been trained by experienced researchers to facilitate the content and participatory group process of REds, after which its further development was, and continues to be, informed by participant and facilitator feedback. REds has therefore continued to evolve since its conception and subsequent implementation in 2006, being continually informed by empirical research, with the future aim of disseminating REds to the National Department of Basic Education in South Africa (Theron et al., 2008: 84-85). Continual refinement and development of REds have thus been occurring to the extent that its fourth version was implemented in 2009.

To date, REds has not been implemented in the Northern Cape. However, its extended implementation in the Northern Cape may deem invaluable to the standardisation of the programme for the South African educational context. It may also avail the much needed support and aid in the empowerment of educators as it relates to the associated problems of HIV and AIDS in the Northern Cape.

1.2 PROBLEM FORMULATION

As alluded to earlier, the education system in South Africa has not made adequate provision to address the challenges faced by HIV and AIDS-affected educators in the South African school setting. There remains, therefore, a crucial need to support and empower educators to deal effectively with the problems they experience as a result of the HIV and AIDS pandemic, more particularly in the Northern Cape where a dearth of resources and limited interventions geared particularly toward this end exists. REds attempts to address this gap through a programme for educators with the express aim of promoting the quality of life of HIV and AIDS-affected educators.

Quality of life is the degree to which a person enjoys the important possibilities of his/her life. The study aims to promote the degree to which HIV and AIDS-affected educators enjoy the important possibilities of their lives (Theron et al., 2008: 86).

As mentioned above, REds has not been implemented in the Northern Cape yet, and its extended implementation deems invaluable for the standardisation of the programme in the South African educational context. Its extended implementation will furthermore avail the much needed support and aid, to enhance the quality of life of HIV and AIDS-affected educators who continuously face problems associated with HIV and AIDS. Ultimately, the implementation of REds in the Northern Cape will bridge the gap with regard to its implementation in all the provinces of South Africa, thus assisting in completing the national study.

The rationale of this study, therefore, is to address the challenges faced by HIV and AIDS-affected educators in the school setting by implementing the REds Programme and determining its effectiveness in the Northern Cape. According to the Life Skills and HIV and AIDS Coordinator of the Northern Cape Department of Education, Ms T. Saul (2009), the Department of Education is implementing HIV-related education for educators. But, according to her, this is not enough and does not include information on how to deal with and support HIV affected learners and educators. Mr E. Kistoo (2009),

Director of Curriculum, Life Skills and HIV and AIDS at the Department of Education, agrees and admits that although various programmes have been implemented to support educators to deal with the impact of HIV and AIDS in schools, monitoring and evaluating the impact of these initiatives is non-existent.

In summary, REds has not been implemented in the Northern Cape yet. Furthermore, it was found that the nature of support to HIV and AIDS-affected educators in the Northern Cape is not sufficient. Therefore, the intended study will not only make a contribution in terms of standardising REds on a national basis, but will also potentially benefit HIV and AIDS-affected educators in the Northern Cape, who often lack support services to cope within their HIV and AIDS-altered working environment.

1.3 GOAL AND OBJECTIVES

1.3.1 Goal

The goal of the study was to determine the effectiveness of the REds Support Programme (fourth version) in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape.

1.3.2 Objectives

The specific objectives of the study were as follows:

- To theoretically conceptualise the phenomenon of HIV and AIDS with specific emphasis on its impact on the educational sector;
- To implement the fourth version of REds for HIV and AIDS-affected educators in the Northern Cape;

- To evaluate the effectiveness of the improved fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape; and
- To reach conclusions and make recommendations based on the research findings, to standardise REds for ultimate implementation on a national basis.

1.4 RESEARCH QUESTION AND HYPOTHESES

1.4.1 Research question

The qualitative part of the study was guided by the following research question:

“How effective is the fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape?”

1.4.2 Hypothesis

The quantitative part of the study was guided by the following hypotheses:

(H₀) “After exposure to REds the quality of life of the experimental group and the comparison group does not differ statistically significantly on the $p < 0.05$ level.”

(H₁) “After exposure to REds the quality of life of the experimental group does differ significantly ($p < 0.05$) better than the comparison group.”

1.5 RESEARCH METHODS

The research approach utilised for the purpose of this study was the mixed methods research approach, a combination of both quantitative and qualitative research methods (Ivankova, Creswell & Plano-Clark, 2007:261).

Applied research was utilised for this study. Applied research will be used for the purpose of this study, as it is aimed at solving specific problems in practice and helping practitioners (*viz.* HIV and Aids affected educators) accomplish tasks (Neuman, 2000:23). In the context of applied research, programme evaluation was therefore embarked upon. The REds programme was thus evaluated to determine its effectiveness as it related to quality of life of HIV and AIDS-affected educators in the Northern Cape.

The overall research design was the concurrent triangulation mixed methods research design. Quantitative and qualitative data were collected and analysed at the same time. The specific research design allowed the researcher to reach an answer to the research question and hypotheses from both a qualitative and quantitative perspective (Ivankova et al., 2007:266).

The specific quantitative design used was the quasi-experimental comparison group pre-test/post-test design. The two groups, namely the experimental group and the comparison group were involved in the study, and both groups completed the data collection instrument at the pre- and post-test level.

The qualitative research design used was the case study, specifically the collective case study. The collective case study was the most appropriate qualitative research design, as it could be conducted with a group of individual HIV and AIDS-affected educators participating in the REds Programme.

The sampling method used was the non-probability sampling method. With this type of sampling the odds of selecting a particular individual are not known. Volunteer sampling was utilised which meant that respondents could offer their participation voluntarily (Gravetter & Forzano, 2003:118). The criteria that were used for recruiting of volunteer HIV and AIDS-affected educators in Kimberley, Northern Cape, for both experimental and comparison groups were that participants had to:

- be educators;
- all be affected by HIV and AIDS;
- volunteer their participation for this study through signing an informed consent form.

Both quantitative and qualitative data collection methods were utilised in this study.

The quantitative data collection method used was a standardised questionnaire, namely the Professional Quality Of Life [ProQOL] (Stamm, 2005:26). The same standardised questionnaire was administered on both the pre- and post-test level to participants of the experimental group and the comparison group.

The data collection methods for the qualitative part of the study were narratives and drawings.

Quantitative data were analysed, using descriptive statistics, by statisticians from the North West University (NWU). The data of both the comparison and experimental groups at the pre- and post-test level were compared to determine whether the programme was effective or not.

Qualitative data were analysed using the Creswell (in De Vos, 2005a:335) qualitative data analysis process.

Data collection methods used for the study were piloted when utilised previously with empirical studies that evaluated REds. There was, therefore, no need to pilot the data collection instruments again before embarking on the empirical study. Considering the fact that this is the fourth version of REds, it is fair to say that the data collection methods have been tested and can thus be considered suitable for this study.

A detailed description of research methods used in this study will be provided in Chapter 4.

1.6 LIMITATIONS OF THE STUDY

Within the context of this research study the following limitations are acknowledged and should be taken into account when interpreting the content:

- The study was only conducted at two schools in the Northern Cape, thus results cannot be generalised for the entire province.
- Respondents were predominantly Coloured people, which limit the researcher to one racial group; thus it is unknown how other racial groups might respond to the programme.
- Respondents from the experimental group were all female and as a result it is not possible to determine if males would respond the same to the programme.
- The Northern Cape Province is predominantly rural and this might have an impact on results in comparison with studies done in other more urban areas.

1.7 KEY CONCEPTS OF THE STUDY

The following key concepts are used in this study and should be interpreted as follows:

- **Evaluation**

According to Merk, Van der Weijden, Oostveen, Van den Besselaar and Spaapen (2007:1), evaluation is “the process of examining a subject and rating it based on its important features.”

Evaluation in the context of this study is therefore the systematic determination of the effectiveness of REs to enhance the quality of life of HIV and Aids affected educators in the Northern Cape.

- **Educator**

In education an educator is a person who educates/teaches. The role of an educator is often formal and ongoing, carried out by way of occupation or profession at a school or other place of formal education (Kelly, 2000: 29).

“A person or organisation with responsibility for developing, managing or delivering learning resources” (Schilling, 1997:174).

Educator in the context of this study refers to the individual employed by the Department of Basic Education, Northern Cape, to educate learners.

- **HIV/AIDS affected**

HIV is the acronym for Human Immunodeficiency Virus (*Aids Foundation SA*, 2005: 1)

AIDS is the acronym for Acquired Immunodeficiency Syndrome (*Aids Foundation SA*, 2005:1)

Affected refers to the “experience of feeling or emotion which is a key part of the process of an organisms interactions with certain stimuli” (*Aids Foundation SA*, 2005: 2)

HIV/AIDS affected in this study refers to individuals who have been acted upon, influenced or changed in any way (emotionally, psychologically, socially,) by HIV and AIDS.

- **REds**

REds is the acronym for Resilient Educators, which is a programme designed with the aim of empowering HIV/AIDS-affected educators to cope more effectively with the challenges of the pandemic by supporting them to respond adaptively to a teaching context that demands responses more typical of counsellors or social workers, or

medical personnel trained to prevent HIV to ultimately improve their quality of life (Theron et al., 2008: 84).

- **Quality of life**

Quality of life is “the degree to which a person enjoys the important possibilities of his/her life” (Stamm, 2005:23).

Quality of life refers “to a person’s general well-being, including mental status, stress level, sexual function, and self-perceived health status” (*Stedman's Medical Dictionary*, 2006: 10).

Quality of life is therefore the holistic health and wellness of an individual in order to experience an ultimate satisfaction of emotional peace of mind.

1.8 COMPOSITION OF THE RESEARCH REPORT

The content of the research report is as follows:

Chapter 1: General introduction

The introduction introduced and contextualised the study. In addition, it provides an overview of the research methods and limitations of the study and conceptualises key concepts.

Chapter 2: HIV and AIDS in the Education sphere of the Northern Cape

This chapter covered literature related to the context of the study extensively, dealing with contextualising, the phenomenon of HIV and AIDS, and specifically its impact on the educational sector.

Chapter 3: Content of the REds Programme

This chapter described the REds Programme, its content and its ultimate purpose.

Chapter 4: Research methodology, empirical research findings and interpretation

This chapter covered the research process as well as the results of the research findings and the interpretation thereof.

Chapter 5: Summary, conclusion and recommendations

This chapter concluded the findings of the study and provided recommendations.

CHAPTER 2

HIV AND AIDS IN THE EDUCATION SPHERE OF THE NORTHERN CAPE

2.1 INTRODUCTION

One of the greatest bio-psychosocial and economic challenges threatening the human race in our time is the HIV and AIDS pandemic. This pandemic has put the survival of the African continent at stake.

It has been estimated that worldwide, more than 15 million children under the age of 18 years are orphaned as a result of AIDS (UNAIDS, 2006:2). An estimated 11.6 million of these children live in sub-Saharan Africa, with South Africa being one of the worst affected countries (UNAIDS, 2006:2). Most orphans are scholars/learners, as called in the South African context, or will become learners at a later stage. These orphans ultimately become part of the education sector. Teachers/educators become responsible for these affected/infected orphans and all other learners affected by the pandemic. Educators, therefore, need to be empowered in order to deal effectively with these learners and their specific needs.

This chapter will be focusing on HIV and AIDS as a concept, its origin and the stages which are associated with the disease. It will also zoom in on the prevalence of the pandemic globally, in sub-Saharan Africa, in South Africa, as well as in the Northern Cape. Lastly, the chapter will reflect on HIV and AIDS in the education sector in South Africa, specifically the Northern Cape where the study is conducted.

2.2 ORIGIN OF HIV AND AIDS

In order to conceptualise HIV and AIDS the researcher has investigated these concepts in great depth and has come to the conclusion that a discussion concerning the origin of this pandemic is imperative. Sharp and Hahn (2006:2), researchers from Nottingham University, reveal that in their search for the origin of HIV, it seems as if the original source can be traced to two colonies of chimpanzees in a corner of Cameroon. The findings represent the culmination of a 10 year search for the source of the pandemic and provide a crucial link between HIV, which causes AIDS in humans, and the Simian Immunodeficiency Virus (SIV), a similar virus that infects monkeys and chimpanzees. It is believed that, as far back as the 1930s, in South East Cameroon, the HI-virus first transferred from chimpanzees to humans, resulting in the subsequent spreading of the infection among people (Sharp & Hahn, 2006:3).

Chimpanzees and humans are said to be very similar genetically, but the virus, which seems to be harmless in chimpanzees, when carried over to humans has the potential to cause AIDS (Sharp & Hahn, 2006:3). The most widely held theory of how the virus was transmitted from chimpanzees to humans is that hunters caught infected chimpanzees, slaughtered them to eat, and as lots of blood is involved in this type of slaughtering, if hunters had any open wounds they could easily be infected with SIV. From this theory regarding the origin of HIV and AIDS it can thus be concluded that the pandemic derived from the chimpanzee, although the researcher acknowledges that other theories about the origin of HIV and AIDS may exist, discussing the numerous theories are beyond the scope of this study.

2.3 CONCEPTUALISATION OF HIV AND AIDS

In order to understand how HIV and AIDS is conceptualised it is imperative to understand its makeup, what it is, how it is transmitted and the characteristics thereof.

2.3.1 HIV

According to Theron (2009:15), the acronym, HIV, can be described as follows: the 'H' stands for 'Human', because it only occurs only in humans. 'I' stands for 'Immunodeficiency', because it causes a deficiency of the human system. 'V' stands for 'Virus', because it is a virus.

The immune system is weakened over time by the HI-virus. The strength of the immune system is measured by the CD4 count and the penetration of the virus into the blood system is measured by the viral load (Sharp & Hahn, 2006:7). The CD4 count of a person determines how healthy the immune system is. In adults without HIV a CD4 count is usually more than 500 (Van Dyk, 2005:21). An HIV infected person is said to have AIDS when CD4 count becomes 200 or less.

Viruses, according to Theron (2009:14), are very small living organisms that cause many different diseases in humans, animals and even plants. Viruses are so small that even if thousands of them are put together they cannot be seen with the naked eye. Viruses cannot reproduce on their own but depend on the animal or human they prey on to act as a host. HIV reproduces in certain cells in human blood, called white blood cells (WBCs). WBCs are a very important part of the immune system, because WBCs defend the body against infections. They attack all things which they do not recognise and which are foreign.

When a person becomes infected with HIV the virus reproduces in the white blood cells, multiplying until millions of viruses are present. The virus gradually damages the WBCs so they can no longer protect the body from infection. It is when these infections occur that humans are said to have AIDS (Theron, 2009:14).

2.3.2 AIDS

In order to describe the meaning of the concept AIDS, Theron (2009:14) explains it as follows 'A' stands for 'Acquired', because it is acquired rather than occurring spontaneously. The 'I' stands for 'Immuno', because it attacks the immune system. The 'D' stands for 'Deficiency', because it causes the immune system to become deficient. While 'S' represents 'Syndrome', because it results in a collection of diseases called opportunistic diseases.

The researcher views HIV and AIDS as a progressive disease that starts off with HIV, which leads to AIDS, which can ultimately reach a point of no return. In order to understand the progressive nature of the pandemic, the researcher will outline the stages of HIV and AIDS.

2.3.3 Stages of HIV and AIDS

All humans have the potential to contract HIV. There are predominantly three ways in which to contract this disease (Theron, 2009:14), namely:

1. Through unprotected sexual intercourse (anal, vaginal, or oral) with an infected human.
2. Through blood transfusion or contact with contaminated blood (sharing needles).
3. Mother to child transmission through breast feeding or the process of giving birth.

The human being goes through different stages while being HIV infected before reaching the stage of having full-blown AIDS. According to Evian (2003: 28-31) and Van Dyk (2005:40-45) the stages can be described as follows:

Stage 1: Early (Primary) HIV infection

In the first few years after HIV infection, the HIV antibody test result, if positive, is the only sign of HIV infection referred to as sero-conversion illness. During this stage the person may present with symptoms similar to influenza.

Stage 2: Asymptomatic stage (clinically silent infection)

During this stage the infection is clinically silent although the virus is active in the body. Persons are able to spread the virus during this stage. This stage can last between three to seven years.

Stage 3: Minor Symptomatic stage (Minor HIV-related symptoms)

After three to seven years this stage can commence, when the person with HIV antibodies presents, amongst others, with symptoms like: lymph nodes, occasional fevers, shingles, skin rashes, chronic itchy skin, oral ulcerations and weight loss.

Stage 4: Symptomatic stage (HIV-related disease)

More serious symptoms and opportunistic diseases begin to appear and the immune system continues to deteriorate. The CD4 cell count becomes very low (200-250). It is important to note that the CD4 count determines how healthy the immune system is.

Stage 5: Severe Symptomatic stage (Severe HIV-related disease)

This is the final stage of HIV; at this stage the disease is called AIDS. Symptoms which can occur during this stage are diarrhoea, nausea and vomiting, cold sores and thrush in the mouth.

From the outline above it is evident that the pandemic is made up of systematic stages which ultimately result in full-blown AIDS. In the next section the researcher will

deliberate on the extent of the pandemic, globally, in sub-Saharan Africa, South Africa and ultimately in the Northern Cape.

2.4 EXTENT OF HIV AND AIDS

The extent of the HIV pandemic has affected all spheres of life. The following section will deliberate on the extent of the pandemic in more depth.

2.4.1 HIV and AIDS globally

Just over thirty years ago HIV and AIDS was discovered, and since then the scale of the HIV and AIDS pandemic has exceeded all expectations. Globally, in 2008, it was estimated that 33.4 million people were living with HIV, while more than 25 million had already died due to AIDS-related diseases since 1981, giving a cumulative total number of HIV infections in excess of 58.4 million people (UNAIDS, 2009:1) - almost as many as the population of the United Kingdom (Piot et al., 2001: 968).

Table 1 below illustrates the extent of the pandemic globally in the year 2009.

Table 1: Global epidemiology of HIV/AIDS in 2009

During 2009	Estimated number
People living with HIV/AIDS	33.3 million
Adults living with HIV/AIDS	30.8 million

Woman living with HIV/AIDS	15.9 million
Children living with HIV/AIDS	2.5 million
People newly infected with HIV	2.6 million
Children newly infected with HIV	370 000
AIDS deaths	1.8 million
Child AIDS deaths	260 000

Source: UNAIDS (2009:2)

From **Table 1** it becomes evident that in 2009 the amount of people living with HIV and AIDS in the world exceeded 33 million. The amount of adults living with the pandemic exceeded that of children by far, which ultimately explains the huge number of orphans, which will be discussed later in the chapter. It is important to have a global picture of the effect of the pandemic, but in order to have a better understanding of its effects, deeper investigation is needed.

The number of people living with HIV has risen from around 8 million in 1990 to 33 million today, and is still growing. An estimated 67% of people living with HIV are in sub-Saharan Africa (UNAIDS, 2010:3). Countries on the African continent are especially of great concern with regards to the HIV and AIDS pandemic. Just as the spread of the disease has been greater than predicted, so too has been its impact on social capital, population structure and economic growth. This pandemic is viewed as one of the most serious crises facing human development (Piot et al., 2001: 969).

Table 2 illustrates the different regions globally, in relation to the amount of adults and children living with HIV and AIDS, the amount of newly infected adults and children, as well as the number of deaths amongst adults and children as a result of the pandemic.

Table 2 Regional epidemiological breakdown of HIV and AIDS in 2009

Region	Adults and children living with HIV/AIDS	Adults and children newly infected	Deaths of adults and children
Sub-Saharan Africa	22.5 million	1.8 million	1.3 million
North Africa and Middle East	460 thousand	75 thousand	24 thousand
South & South East Asia	4.1 million	270 thousand	260 thousand
East Asia	7700 thousand	82 thousand	58 thousand
Oceania	57 thousand	4 500	1 400
Central & South America	1.4 million	92 thousand	58 thousand
Caribbean	240 thousand	17 thousand	12 thousand
Eastern Europe & Central Asia	1.4 million	130 thousand	76 thousand
North America	1.5 million	70 thousand	26 thousand
Western & Central Europe	820 thousand	31 thousand	8 500
Global Total	33.3 million	2.6 million	1.8 million

Source: UNAIDS (2010:4)

Table 2 reveals that in comparison to all regions mentioned sub-Saharan Africa has by far the most infected adults and children. While the global number of adults and children living with HIV/AIDS amounts to 33.3 million, 22.5 million live in sub-Saharan Africa. This figure is alarming and is a cause for serious concern.

During 2009 more than two million adults and children became infected with HIV, by the end of the year an estimated 33.3 million people worldwide were living with HIV and AIDS. The year also saw 1.8 million deaths from AIDS, despite recent improvement in access to antiretroviral treatment. As **Table 2** above reveals, most of the infections and deaths occurred in sub-Saharan Africa. It is therefore important to have a closer look at the impact thereof in this region.

2.4.2 HIV and AIDS in sub-Saharan Africa

It appears that the African region that has been most affected by the pandemic is sub-Saharan Africa where, at the end of 2000, there were an estimated 25.3 million people living with HIV, with this region also accounting for approximately three-quarters of the global death toll (Piot et al., 2001: 969). More recent statistics illustrate that by the end of 2008 more than 22 million people in sub-Saharan Africa were estimated to be living with HIV and AIDS (UNAIDS, 2009). Approximately 10% of the world's population lives in sub-Saharan Africa, but the region is home to approximately 64% of the world's population living with HIV. Transmission is primarily through heterosexual contact, and more women are HIV infected than men (World Health Organization, 2006:1). More recent statistics from the *Report on the global AIDS epidemic* (UNAIDS, 2008:5) reveals that an estimated 1.9 million people were newly infected with HIV in sub-Saharan Africa in 2007. In total, 22 million people are living with HIV in the region, which is two-thirds (67%) of the global population of people with HIV.

Even though the HIV prevalence stabilised in sub-Saharan Africa, the actual number of people infected continues to grow because of ongoing new infections and increasing

access to antiretroviral therapy (UNAIDS, 2008:6). The decrease and stabilisation of the number of HIV infections in sub-Saharan Africa is noticeable, although the effect of the damage done by the pandemic is still very vigorously felt by abandoned families, orphaned children and poverty-stricken communities. Foster and Williamson (2000:62) reported that of children orphaned by AIDS throughout the world, 95% have occurred in Africa where the numbers of orphans will continue to rise throughout the next decade reaching an estimated 40 million by 2010. Long-term solutions need to be crafted for these children as the impact will remain for decades after the pandemic begins to fade. The importance of the most recent statistics regarding the pandemic is imperative but it does not mend the real impact and effect on those who are at the receiving end.

Worldwide, it is estimated that more than 1.5 million children under 18 years of age have been orphaned as a result of AIDS. Around 11.6 million of these children are estimated to live in sub-Saharan Africa. In countries badly affected by the epidemic, such as Zambia and Botswana, it is estimated that 20% of children under 17 years of age are orphans – most of whom have lost one or both parents to AIDS (UNAIDS, 2008: 16).

According to the UNAIDS (2008:16) report, even with the expansion of antiretroviral treatment access, it is estimated that by 2015, the number of orphaned children will still be devastatingly high. The number of orphans living in South Africa due to AIDS in 2007 was estimated at 1.4 million; the highest compared to all other sub-Saharan countries.

The statistics of orphans on the continent is overwhelmingly high. With South Africa being the worst affected country it has an adverse effect on all spheres of life. Orphans are more often than not either learners or would ultimately become learners in the education system. The circumstances of each and every orphan in the school setting ultimately becomes the responsibility of the educator, who needs to deal with these very unique learners on a daily basis. It must be borne in mind that these educators are not adequately trained to deal with this type of child (UNAIDS, 2006:4).

From the above it is clear that educators affected by HIV are in need of support structures to cope resiliently in their HIV and AIDS–altered reality. As will be debated in Chapter 3, the REds programme aims to address this need. The programme ultimately aims to address the gap of educators who need to teach learners infected with or affected by HIV. Simultaneously, various HIV affected educators need to cope with work-related stress due to colleagues who are HIV-positive, and live in communities severely affected by the pandemic (Theron et al., 2008:6).

Now that we have looked more closely at sub-Saharan Africa, it is noteworthy that South Africa is the country with the highest HIV and AIDS prevalence in the region.

2.4.3 HIV and AIDS in South Africa

It is estimated that there were 5.3 million South Africans infected with the virus in 2008, of which 3 million were woman above 15 years and 220,000 were children (UNAIDS, 2008:3). The impact of deaths due to AIDS–related illnesses is a tragic reality experienced by families, communities and the nation at large (Motsoaledi, 2010:vi).

The antenatal HIV and syphilis prevalence survey is one of the epidemiological tools used by the Department of Health to monitor the epidemic trend. This survey has been conducted annually in South Africa since 1990. It is one of the most vigorous HIV surveillance methods that targets the 15 to 49 year old antenatal women who come for a first booking at an antenatal care facility in the public health sector (AIDS Foundation SA, 2005: 1). When it is taken into consideration that these statistics originate from antenatal clinics only, it raises a question about the accuracy of the actual prevalence rate in South Africa. Can this really be viewed as a true reflection of the prevalence rate or is it far beyond or far below the true rate?

It is estimated that South Africa has the sixth highest prevalence of HIV in the world, with an estimated 18.8% of the population being infected (AIDS Foundation SA, 2005:

1). Furthermore, recent statistics show that approximately, 5.7 million South Africans were living with HIV in 2007, making this the largest epidemic in the world (UNAIDS, 2008:6).

Evian (2003:20) purports that South Africa was one of the last countries in Africa to be affected by the pandemic. But even though this was the case the pandemic has intensified in South Africa. Motsoaledi (2010:iv) supports this by stating that South Africa, with so many millions of people living with HIV, faces both institutional and human resource capacity challenges to provide treatment, care and support. This is compounded by the simultaneous resurgence of the TB epidemic and drug resistant pathogens.

South Africa, with its nine provinces, has different prevalence rates in each province. The Northern Cape has been shown to have one of the lowest prevalence rates. Since the REds programme was implemented in the Northern Cape Province it is important to report on the prevalence of HIV in this province.

2.4.4 HIV and AIDS in the Northern Cape

According to the Budget Speech by Ms E.D. Peters, former Northern Cape MEC for Health (Northern Cape Health Budget Vote, 2002: 16), it was predicted that by 2010, without significant interventions, 54% of the population of the Northern Cape would be infected with HIV. It was further estimated that if there is no commitment to bring about the necessary behavioural changes to curb the spread of the disease, the population in the Northern Cape would be reduced dramatically, leaving millions of children orphaned and the province stripped of its human resources.

It is, however, important to mention that HIV was not even mentioned in the Budget Speech of the Northern Cape Department of Education (2008:7). The researcher is of the opinion that it is in vain that the Department of Health is making significant

contributions to combat HIV and AIDS while other departments, such as Education, which has as a significant role to play in this struggle, fail even to mention their contributions. The focus seems too often to be more on the infected while the affected are in most cases left vulnerable.

A more recent study done by Nicolay (2008:1) found that the Northern Cape Province has the second lowest rate of HIV and AIDS in South Africa, with the age group 20 to 29 years accounting for the highest proportion of HIV-positive people in the province. It is further mentioned that the HIV prevalence estimate for the Northern Cape has declined from 18% in 2005 to 10% in 2008 –a much lower rate compared to the rest of South Africa which had an average HIV infection rate of 29.1% in 2006.

The study done by Nicolay (2008:7) also highlighted that the Northern Cape has the lowest number of HIV-positive people living in any single province (67 000). Approximately 7% of the population, and one in every 10 adults, was estimated to be HIV-positive in 2008. However, it is emphasised that the epidemic in the Northern Cape has not reached a mature phase yet and is still growing; with new infections almost double the number of AIDS-related deaths. An estimated 11 000 people were in need of antiretroviral treatment in 2008, with approximately 53% having taken up treatment. It is thus clear that although the prevalence rate for HIV and AIDS in the Northern Cape is fairly lower than that of other provinces it in no way means that the province is safe or that the problem is not as severe. It remains crucial to ensure that these statistics do not increase.

Table 3 illustrates the prevalence rate of HIV and AIDS in the Northern Cape. It respectively looks at the whole population estimates for antenatal clinics as well as new infections and deaths over the year. It also looks at the total number of people in need of antiretroviral treatment.

Table 3 Prevalence of HIV and AIDS in the Northern Cape

Whole Population	7%
Antenatal clinic estimate	21%
Adults (ages 20-64)	12%
People living with HIV	67,000
New HIV infections (over the year)	7,000
AIDS deaths (over the year)	4,000
Total people in need of ART	11,000
Total people accessing ART	6,000
Accumulated AIDS deaths	22,000
New infections per day	19
Deaths per day	11

Source: Nicolay (2008:7)

From **Table 3** it is evident that there is a noticeable difference between the percentage of the whole population and that of the antenatal clinics. Approximately 7% of the population, and one in every 10 adults, is estimated to be HIV-positive. If this is the estimate of adults infected, their children, who are most probably of school going age, are either infected or affected. This then becomes a problem in the education sector.

This section focused on the extent of HIV and AIDS globally as well as the extreme extent thereof in sub-Saharan Africa. This section further highlighted the impact on South Africa and the impact on the Northern Cape, the largest province with the smallest population. Considering the amount of adults infected in the Northern Cape (one in every ten adults), the children of these adults are a cause for concern. They would either be infected or affected. Ultimately they become part of, or already are part of the education system. This can only put pressure on the educators as it will be discussed in the next section.

2.5 HIV AND AIDS IN THE EDUCATION SECTOR

Education in South Africa is both a key indicator and important facilitator of development (Statistics South Africa, 1996:2). Of all sectors it is accorded the single largest proportion of the national budget. In addition, many poor households spend a significant proportion of their income on education for their children in the hope and belief that this will ensure them a better life (Statistics South Africa, 1996: 3).

Factors affecting teaching and learning reveal significant disparities in conditions both within and between provinces, according to the Human Science Research Council (2005:2). Factors which hinder the teacher-learner environment include large class sizes with more than 46 learners per class and school fees such as the Northern Cape annual school fees of R800. HIV and AIDS becomes a problem as according to the study a slight majority of educators (52%) have attended HIV and AIDS training workshops and 48% have taught a class on HIV and AIDS according to the HSRC (2005:3).

According to Theron (2004:1) AIDS impacts on education in at least four ways, namely:

1. Increased educator morbidity and mortality.
2. The quality of education is being eroded.
3. The demand for education is decreasing.
4. Education sector costs are soaring.

Approximately 12% of South African education administrative personnel and educators are thought to be infected. Ill educators are often absent and lose up to six months of professional time before developing full-blown AIDS (Theron, 2004: 2). Many of these teachers disappear, leaving classes without educators. Rural areas, such as the Northern Cape, are especially affected as infected educators require urban medical services. Infected teachers have to seek medical care in Kimberley which is often thousands of kilometres from where they stay. Moreover, because of the stigma attached to the pandemic they would often disappear, as they want no one to know

what is wrong with them. This then leaves learners lagging behind, waiting for a new educator to take over and the confusion of not knowing what happened to their teacher. The implication for remaining educators is also bleak. Healthy educators will have to contend with increased workloads and heightened responsibilities. Their psychological wellness will be taxed as work demands escalate and as they witness HIV-positive colleagues and relatives die (Theron, 2004:2).

Learners observe HIV-positive educators' health decline, followed by their absenteeism and eventual death. In the process the value of educators as positive role models is severely diminished. However, absenteeism is not restricted to infected educators, as educators who have infected relatives have higher rates of absenteeism too, given that they are involved in caring for ill relatives or burying them (Theron, 2004: 2).

According to Kelly (2000:1), HIV and AIDS has radically transformed the world, including the world of education. The content, structures and programmes that responded to the needs of a world without AIDS no longer suffice in a world with AIDS. This appears in the way school participation can enhance the risk of HIV infection. Kelly (2000:1) also reiterates the fact that it surfaces in the way schools deal with HIV and AIDS in a traditional way as part of the curriculum and it does not seem to work.

HIV and AIDS not only attack individuals it also attacks systems. Until recently, HIV and AIDS has been perceived primarily as a health problem which can be contained. However, it continues to spread so widely that it is now having a profoundly adverse impact on communities and institutions. Government's health-focused HIV and AIDS plans must be deemed as failed when those very plans do not consider what must be done when the disease is out of control and state systems are themselves threatened. Coombe (2000:1) suggests that while working to limit the spread of the disease, it is necessary to recognise and manage the pandemic's impact on the education system.

Education could play a critical role in HIV and AIDS prevention, but the pandemic's devastating impact threatens to derail any such efforts. HIV and AIDS is draining the

supply of education, eroding its quality, weakening demand and access, drying up countries pools of skilled workers and increasing the sector costs (Coombe, 2000: 2). In the Central African Republic, 85% of teachers who died between 1996 and 1998 were HIV-positive, and they died 10 years before they were due to retire (Science in Africa, 2002:2).

According to an investigation done by the Education Labour Relations Council (HSRC, 2005:1) following worrying anecdotal reports about educators leaving the profession in large numbers, one of the prominent reasons which transpired was the prevalence of HIV and AIDS among educators. Based on a nationally representative sample of 17 088 educators who gave an oral fluid or blood sample specimen for HIV testing (response rate 83%), 12.7% were HIV-positive. If sex and age were taken into account, the figure would not be significantly different from that of the general population. When it is taken into consideration that these statistics date back to 2005, it becomes evident that the pandemic has been a cause for concern amongst teachers for more than 7 years now. It can thus be speculated that, because they do not have the necessary skills to deal with this problem, they opt out.

African educators were most likely to be HIV-positive compared with the other racial groups; they were also most likely to be of low economic status and more likely to be placed in rural areas without their families (HSRC, 2005:2). In considering the evidence of this study, which has been done nationally, it is evident that teachers in the Northern Cape can easily fit this type of description. Although there might not be sufficient provincial statistics, factors that can be identified will include low economic status and being placed in rural areas without their families. In addition to the problem of infected educators, there is also the very serious problem of the effects of HIV and AIDS on the education system, where our attention is turned to affected educators.

According to the *AIDS Foundation SA* (2005:1), there were 1.2 million orphans as a result of AIDS in South Africa by the end of 2005. Orphans are defined as children under the age of 17 years, whose mothers have died - this being the average age of

school going children (*AIDS Foundation, 2005:8*). These children's social circumstances and emotional burdens might impact negatively on their school work. The education system thus becomes the playground for the social, health, emotional (and other) problems experienced by learners, with educators bearing the brunt of having to deal with these issues hands-on (*AIDS Foundation, 2005:10*). HIV and AIDS appears to be exhausting the supply of education, eroding its quality, weakening demand and access, drying up countries' pools of skilled workers and increasing the sector cost (*Science in Africa, 2002: 1*). HIV and AIDS has radically changed the world, including the world of education, while the contents, structures and programmes that responded to the needs of a world without AIDS are no longer adequate in a world with AIDS.

Bhanna et al. (2006:14) noted that in under-resourced schools, given the overwhelming needs of learners, educators often have to assume the role of various professionals for which they were not formally trained (for example counsellors, social workers, advisors, etc.). The nature of the work and the role of educators have therefore changed dramatically in response to the impact of and challenges posed by HIV and AIDS. Hall et al. (2005:23-24) argue that HIV and AIDS has radically altered the teaching experience of educators in that educators have now become affected by their colleagues, learners and/or family members being HIV-positive or dying from AIDS-related illnesses. Bhanna et al. (2006: 6) purport that in an HIV and AIDS-affected context the role of educators is extended to that of HIV-prevention agents, counsellors, social workers and even surrogate parents. Theron et al. (2008:77) contend that, despite numerous calls to empower educators to cope with the relentless challenges posed by the pandemic, very little has been done to date to empower and support these educators. Despite these major challenges, educators are still expected to cope and adequately perform the role of instilling the necessary knowledge and values in children.

Theron et al. (2008: 83) further assert that the implication for educational practice in South Africa is comprehensible in that educators need broad support to cope with the challenges of a professional role that has been escalated to encompass HIV prevention and counselling. There is, therefore, no form of comprehensive support for affected

educators, although some South African research initiatives have empowered participating educators and their communities.

There is a dearth of research focusing specifically on HIV and AIDS in the Northern Cape education sector, and it can be speculated that the implication for educational practice resulting from HIV and AIDS can be generalised to include the Northern Cape.

2.6 CONCLUSION

The war against the HIV and AIDS pandemic has been around for decades; to date the battle has not been won and the enemy has not been defeated. More than 33 million people in the world are living with this disease (UNAIDS, 2009:1), with sub-Saharan Africa the most affected by this pandemic and South Africa one of the worst affected countries (UNAIDS, 2009:2).

South Africa also has the highest rate of orphaned children as a result of this disease (UNAIDS, 2008: 16). These orphans are learners or will eventually become learners at a later stage, and as such will ultimately become part of the education sector. Educators become responsible for these affected/infected orphans and all other learners affected by the pandemic.

This chapter focused on HIV and AIDS as a concept, its origin and the stages which are associated with the disease. It zoomed in on the prevalence of the pandemic globally, in sub-Saharan Africa, South Africa as well as in the Northern Cape. The chapter also reviewed HIV and AIDS in the education sector in South Africa and specifically the Northern Cape where the study was conducted.

Chapter three will describe the content of the REds programme, as well as its ultimate purpose, namely to empower educators who are HIV and AIDS-affected to become more resilient in the face of adversity.

CHAPTER 3

RESILIENT EDUCATORS SUPPORT PROGRAMME FOR HIV AND AIDS-AFFECTED EDUCATORS

3.1 INTRODUCTION

Educators are generally seen to have the responsibility to be there for their learners in more ways than merely educating them in aspects relating to teaching the syllabus. They are faced with challenges from their learners on a daily basis. More often than not, teachers are not only obligated to supporting their learners, but also their colleagues and the community. Often, in small communities, educators are regarded as being information agents who should know a little of everything.

Theron (2005:16) highlighted a need for a support programme for educators that would address the specific challenges of HIV and AIDS. This need was established by research as existing support structures were found to be insufficient.

The Resilient Educators (REds) Support Programme was compiled by the North West University in 2006. The aim of the REds Programme is to promote the quality of life of HIV and AIDS-affected educators. It is therefore geared towards assisting educators to cope more effectively with the challenges of the pandemic by supporting them to respond adaptively to a teaching context that demands responses more typical of counsellors or social workers, or medical personnel trained to prevent HIV (Theron et al., 2008: 84).

The contents of the REds Programme, which was informed by a multidisciplinary team of professionals (consisting of an Educational Psychologist, a Nursing Specialist, as well as an Educational Scientist), are originally grouped into nine modules. Each module provides thematic structure, background information and interactive activities. Themes

that are explored, include: health promotion; the psychosocial impact of the HIV pandemic on learners and educators; psychosocial support (resources and skills); stigma and discrimination; HIV-related education policy and resilience.

Since its conception in 2006 and subsequent implementation, REds has continued to evolve, being continually informed by empirical research, with the future aim of disseminating REds to the National Department of Basic Education in South Africa (Theron et al., 2008: 84-85). Continual refinement and development of REds have thus been occurring to the extent that the fourth version was implemented in 2009. To date REds has been implemented in four South African provinces, namely Gauteng, Mpumalanga, Free State and North West Provinces, but not in the Northern Cape. However, its extended implementation in the Northern Cape may deem invaluable to the standardisation of the programme for the South African educational context.

The aim of this chapter is to provide the content of the fourth version of REds as implemented by the researcher in the Northern Cape, Kimberley region.

3.2 CONTENT OF THE REDS SUPPORT PROGRAMME

Despite numerous calls for educator empowerment to cope with HIV-related challenges, little has been done to support educators. The Resilient Educators Support Programme has been introduced as one possible means of educator support.

The fourth version of the programme consists of eight sessions, covering seven modules. Every session lasts approximately two hours. The core modules and topics which form the REds programme include:

Module 1: HIV and AIDS manual for Educators (Part 1). Facts about HIV and AIDS.

Module 2: How to gain and give support.

Module 3: HIV and AIDS manual for Educators (Part 2-4). Care of the sick at home. Care of the dying and management of common AIDS-related health problems in the home.

Module 4: How to cope with stigma.

Module 5: Workplace policies on HIV and AIDS (guidelines for educators);

Module 6: How to cope with stress.

Module 7: Resilient in the HIV and AIDS pandemic.

The following section briefly outlines the sessions, adapted from and elaborated on in more depth in both the facilitator and participant manuals developed for the REds Support Programme (Theron, 2008:4-137).

Session 1: Introduction

The **objectives** of the session were:

- To get to know each other;
- To explore the key concepts related to REds;
- To explore the ethical boundaries governing REds; and
- To determine group rules for REds.

Facilitation material included:

- The symbol worksheets;
- Informed consent forms;
- Copies of “I walk down the street”, a poem by P. Nelson from Covey’s book, The Seven Habits of Highly Effective Teens; and
- Reflection worksheets (evaluation forms after each session).

Content included the following:

The symbol worksheet was the icebreaker the facilitator utilised to start the session. The purpose of the worksheet was to explore the impact of the pandemic on the participants.

A discussion about the key concepts, namely “what [words missing] being HIV and AIDS-affected means”, followed. The facilitator and participants gave inputs on using the manuals as a guide.

The purpose of REds was then discussed with participants and their participation was encouraged. This opportunity was also utilised to explore the expectations of participants as well as the development of group rules for the duration of the programme. Group rules such as confidentiality, respect for each other’s opinion, as well as being on time, were discussed and adopted.

The discussions that followed related to ethical clarifications. Ethical issues, such as informed consent, avoidance of harm and deliberately misleading subjects (deception of respondents) were discussed. Other ethical issues discussed and clarified with participants included the violation of privacy. The competence of the researcher was clarified and the publication of the research findings was made known to the respondents. Respondents were also informed about the debriefing session which would be made available to those participants who would like to talk about their experience. This matter was discussed and clarified with participants. The discussions were exhausted to ensure that participants conceptualised the importance of the ethics underlying the research process. Only after this was achieved the consent forms were handed out for completion and signing by participants, as written proof that they consented to participating in the study.

Session 2, Module 1: HIV and AIDS manual for educators (Part 1) - Facts about HIV and AIDS

The **objectives** of the session were:

- To be knowledgeable about the correct facts concerning HIV and AIDS;
- To be less afraid of HIV and AIDS with regard to the myths about its transmission; and
- To feel more confident and comfortable because of increased understanding and consequent ability to help themselves and their family members.

Facilitation material included:

- Visual aids and additional information on antiretroviral treatment and the CD4 cell count;
- Story of Yulia and Mukasa (family affected by HIV) from the REds manual (Theron, 2008:142);
- Reflection worksheets.

Content included the following:

The facilitator started the session by reading the story about Yulia and Mukasa. Participants were encouraged to follow in their manuals. The story relates how a person can be infected, how the virus spreads and its effects on family and community life. Information from the story was utilised to demonstrate how HIV and AIDS is spread, its make-up and transmission, how to avoid infections in the home and avoidance of other infections.

Participants were given the opportunity to go through the section in their manuals to familiarise themselves with the information. The facilitator then asked probing questions such as, “what is an opportunistic infection,” to test their knowledge. This was a very

informative session for both participants and facilitator as clarity-seeking questions from participants had stimulated critical thinking amongst group members.

The session was concluded by completing the reflection worksheets.

Session 3, Module 2: How to gain and give support

The **objectives** of the session were:

- To provide information regarding supportive resources for educators;
- To provide information regarding supportive resources for orphaned and vulnerable children (OVCs);
- To provide some grief and bereavement skills; and
- To provide some grief and bereavement skills for learners coping with grief and death.

Facilitation material included:

- Handouts and/or booklets on how to support and help orphaned and vulnerable children;
- Crayons and poster paper for resources list;
- Two case studies about orphaned school-going children, as well as a case study of a grieving learner that had lost a parent. These stories were from personal experiences of the researcher;
- Tape recorder and inspirational song; and
- Reflection worksheets.

Content included the following:

The facilitator broke the ice with a blindfolding exercise. A volunteer was blindfolded and, during the exercise, was completely at the mercy of the participants, who had to ensure that she did not stumble or fall.

The discussion which followed related to support and the importance thereof. Participants shared ideas around the kind of support resources available in the community for HIV and AIDS-infected and affected people (educators and learners included representatives of LoveLife, Right to Care, Biophelo place of safety, local clinics, Pathfinder and many other community resources). Information regarding these resources, including where the resources could be located, were shared among facilitator and participants.

Participants were then divided into two groups to create a poster showing all the available resources relating to support services in the province and in the community that assist HIV and AIDS-infected and affected people. After completion it was to be displayed at a central place in the school for all learners and educators to see.

'Orphaned children' was the next topic of the discussion. The facilitator used a case study to explore the needs of orphaned and vulnerable children, such as the need to gain access to child support grants. Participants then divided into smaller groups and discussed these needs further. These discussions sparked a lot of interest among participants and the information regarding orphans was very important. One of the other aspects discussed related to how orphans could obtain exemption from paying school fees. Participants also read from their manuals how to support grieving learners, and how to cope with loss and bereavement.

Participants completed their reflection worksheets before concluding the session.

Session 4, Module 3: HIV and AIDS manual for educators (Parts 2 to 4): Care of the sick at home; Care of the dying and Management of common AIDS-related health problems in the home

The **objectives** of the sessions were:

- To be less afraid of HIV and AIDS regarding:
 - the care of the sick at home,
 - infection control at home,
 - use of medicine,
 - basic principles;
- To learn to do things which will help the infected and affected to stay healthy;
- To learn how to care for the dying;
- To know how to identify and manage common AIDS-related health problems at home;
- To learn to recognise danger signs, and to learn when and how to seek assistance; and
- To feel more confident and comfortable because of increased understanding and consequent ability to help themselves and their family members.

Facilitation materials included:

- Visual aids, charts and booklets on care of the sick at home, how to care for the dying and how to manage common HIV-related problems in the home (Uys & Cameron, 2003:207). Material (booklets) was obtained from Love Life.
- Poster paper for resource list in the province.
- Reflection worksheets.

Content included the following:

This session consisted of information from which participants could learn how to care for the sick and dying as well as how to manage AIDS-related problems in the home. Handouts on basic care for the dying as well as information on AIDS-related problems and how these can be managed were given to participants. The facilitator acquired these handouts from Love Life as well as Pathfinder International, as these organisations are considered to be experts on HIV and AIDS.

The session included Parts 2 to 4 in the HIV and AIDS manual for educators.

Part 2: Care for the sick at home

Aspects discussed under this topic included nutrition whilst infected. This topic explored the different kinds of food which should be eaten and how it should be prepared, e.g. eating body-building foods, energy-giving foods, as well as foods that protect the body from infection (vitamin rich foods). Food like vegetables should not be cooked for too long and should be lightly steamed to retain its nutritional value. Personal and environmental hygiene and infection control at home, e.g. wash sick people every day and also, when coughing or sneezing cover the mouth with the hand. This topic also considered a general guide on the use of medicines, such as following the instructions for safe and effective use. Medication not taken according to instructions could be useless or even harmful.

Part 3: Care for the dying

The facilitator initiated this topic by drawing the correlation between HIV and death. Death is a given when talking about HIV and AIDS and it is part of the process when it comes to the pandemic.

The participant manual was used to note the guidelines concerning what to do when caring for a dying person. Guidelines such as giving comfort, allowing the person independence and preparing the person for death were explored. The facilitator also referred back to the story of Yulia and Mukasa to illustrate the support needs during the terminal stages of the disease and the management process thereof.

Part 4: Management of common AIDS-related health problems in the home

This section focused on the general symptom management of the following HIV and AIDS-related health problems, including:

- Anxiety: constant worrisome thoughts and tension experienced, amongst others, tight muscles, headaches, breathing problems, irritability or trouble in sleeping;
- Constipation: taking days before passing a stool;
- Different types of coughs;
- Depression: feeling low, sad, or “blue,” normally associated with trouble in sleeping and loss of appetite;
- Diarrhoea: three or more watery stools per day;
- Dizziness: blackouts when trying to stand;
- Fever: abnormally high body temperatures often accompanied by chills and shivering;
- Forgetfulness: poor memory or difficulty in concentrating ;
- Fatigue: feeling weary or tired;
- Nausea: upset stomach, heaving or loss of appetite;
- Night sweats during the day or night, not related to exercise;
- Pain in arms, hands, legs and feet;
- Shortness of breath;
- Skin abscesses: painful swollen and closed boils on any part of the body;

- Painful skin blisters: itchy discharging, irritating and painful blisters with a burning sensation;
- Skin rash or changes in skin condition that may last for a short or long time;
- Swelling arms, hands, legs and feet;
- Trouble in sleeping ;
- Weight loss of 10% of usual body weight when not intending to lose weight;
- Oral thrush: painful whitish or reddish sores in the mouth that make eating difficult; and
- Vaginal itching, burning and discharge: a profuse, slimy, offensive and yellowish discharge.

The facilitator used reflection skills to ensure that participants understood these health conditions. In this process participants were, for example, asked to summarise the three different types of nutritious foods and to mention one vitamin rich food. Probing questions, such as how to make water safe to drink, were also asked. It was emphasised that although the manual gave advice on how to manage the sick at home, public or private health services should be used first for proper medical diagnosis, treatment and care. Self care should be used for hygiene purposes and to manage the disease.

The session was concluded with the completion of the reflection worksheet.

Session 5, Module 4: How to cope with stigma

The **objectives** of this session were:

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

Facilitation material included:

- Paper, crayons, old magazines and scissors;
- Handouts with pictures depicting stigma;
- Pencils for drawing a school community without stigma;
- Handout with inspiring thoughts by an unknown author; and
- Reflection worksheets.

Content included the following:

According to the Change Project (2005: 12) stigma is explained as labelling someone and seeing them as inferior because of an attribute they have. A handout with seven pictures depicting stigma was used to introduce the concept of stigma as defined above.

Pairs of participants were then requested to choose two pictures which they thought best presented stigma. They all then shared their pictures with the rest of the group explaining why they chose those specific pictures.

The group discussed what stigma entails in reality and how it affects everyday life. By using the participant manual, participants learnt more about the different types of stigma and how to deal with it.

The group as a whole had to draw a picture of a school without stigma. The group as a whole reflected on the picture, and the session concluded with the completion of reflection worksheets.

Session 6, Module 5: Workplace Policies on HIV and AIDS

The **objectives** of this session were:

- To focus on legislation concerning HIV and AIDS in education;
- To focus on educator rights with regard to discrimination in the context of HIV and AIDS;
- To provide information about educator rights with regard to absenteeism and leave in the context of HIV and AIDS;
- To provide information on educator rights with regard to protection at school against HIV and AIDS; and
- To provide a supportive school environment in the context of HIV and AIDS.

Facilitation material included:

- Quiz 1 on educator rights with regard to discrimination against HIV and AIDS;
- Quiz 2 on educator rights with regard to leave;
- A plastic cup;
- Copies of a handout, “Put the glass down,” from an unknown author; and
- Reflection worksheets.

Content included the following:

Each participant was given a cup of water and was instructed to keep it in the air. This ice-breaker was used to demonstrate the notion of rights. Their reaction was then discussed after having held the cup for ten minutes. The facilitator used the opportunity to discuss the right to choose, in this example holding the cup as instructed. The topic was discussed at length through exploring the relationship between your rights as a human being and the information at your disposal.

Quiz 1 is an assessment of the familiarity of participants with workplace policies of the Department of Education. We moved on to Quiz 1 which related to discrimination. Participants were divided into two teams and were expected to give a verdict on the question, “Are learners and educators with HIV and AIDS protected from unfair discrimination?”

Quiz 2 was related to educator rights in relation to leave provision. Information provided in the participant manual assisted participants in gaining a better understanding of educator rights. Rights discussed, amongst others, included the right to fair labour practices, according to the Constitution of the Republic of South Africa, 1996.

The next topic related to HIV infection in schools. The knowledge of participants was tested first before consulting the guide for more concrete information.

The group explored ways of maintaining a supportive school environment for those that are HIV and AIDS-affected or infected. A discussion on the HIV and AIDS committee, which already existed in the school, as well as the establishment of a Health Advisory Committee unfolded. The group also shared ideas such as how to revive the already existing committee, the importance of training the Advisory Committee and how to eliminate forms of discrimination against people who are HIV and AIDS-affected or infected.

The session was concluded with an inspirational text, “Put the glass down”, followed by completion of reflection worksheets.

Session 7, Module 6: How to cope with stress

The **objectives** of the session were:

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

Facilitation material included:

- A medium-sized ball of clay/play dough for each participant ;
- Stress list (Theron, 2008:111);
- Tape recorder for relaxation music;

- Joy list to be completed; and
- Reflection worksheets.

Content included the following:

The session started off with a stress relieving exercise. Each participant received a piece of clay to mould something that would symbolise stress. Participants then discussed what each one had made, what it meant to them and why.

The participant manual was utilised to initiate the discussion on stress. A definition of stress was given, namely that stress “is our emotional and physical response to stressors with multiple physical, cognitive and behavioural symptoms” as well as ways of identifying stress and stress management. The facilitator used these discussions to explore ways of combating work stress. The facilitator used the skill of questioning to ensure that all participants participated, even those who are normally quiet.

Time management was one of the ways discussed in combating stress and an exercise relating to this was executed from the participant manual. In this exercise participants had to demonstrate good time management. They were requested to make a group list of time management techniques, some of the techniques included getting started on a job as soon as you can as well as making a list of tasks that needed to be attended to, divided into “must”, “should” and “want to” categories.

A relaxing song was played after the last exercise and participants were requested to close their eyes while listening. On this very relaxing note the session was concluded by completing the reflection worksheets.

Session 8, Module 7: Resilient in a pandemic

This was the last session of the programme and the **objectives** were:

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

Facilitation materials used included:

- Television;
- Video cassette focusing on promoting resilience in the face of the pandemic or adverse circumstances in the South African context;
- Video player;
- Reflection worksheets; and
- Participants' attendance certificates.

Content included the following:

The facilitator was supposed to access a television to demonstrate the video on resilience in the face of the pandemic, instead the facilitator brought along twigs for each participant in order to demonstrate the concept of resilience. Participants played around with the twigs and realised that though they were bent they did not break. The group then used the example in relation to people affected and infected by HIV and AIDS.

The group also looked more in-depth at ways of maintaining resilience. During this session we explored resilience and the six steps toward resilience which includes, as described in the participant manual, accepting the situation, seeing the situation as manageable, connecting with others, using the pandemic to promote self-growth, staying hopeful and self care. This session also looked at the A-Z of resilience which can be used when you are unsure if you are on the right track when it comes to resilience (described in same manual).

The remainder of the session was used to debrief participants and to discuss with them a follow-up session for the issuing of certificates. Reflection worksheets were then completed.

In conclusion the participants discussed the implementation of what they had learnt from the training about the pandemic, as well as being a source of support for others in the school environment and the community.

3.3 CONCLUSION

Facilitation techniques assisted the researcher to draw as much information and participation from participants. Each session was interactive and this allowed participants and facilitator to learn from each other. Other skills utilised by the researcher often included probing and clarification. The process as far as possible assisted in rectifying misconceptions and myths regarding the pandemic.

The aim of working in small groups includes the development of intellectual understanding, abilities and skills. It also enhances communication, cooperative and teamwork skills such as planning, management, leadership and peer support.

The aim of REds is therefore to develop the intellectual understanding of participants regarding the HIV and AIDS pandemic. The programme also allows for optimal communication and teamwork skills, such as leadership and peer support with regard to the pandemic within the school setting, as well as within the family and community setup.

Chapter 4 will focus on how the 11 participants (educators from a Primary school in Kimberley, Northern Cape) experienced the REds Support Programme, as well as to compare the results with a comparative group. The chapter which will follow would thus

analyse and interpret the data gathered from participants, pre- and post- exposure to REds.

CHAPTER 4

RESEARCH METHODOLOGY, EMPIRICAL RESEARCH FINDINGS AND INTERPRETATION

4.1 INTRODUCTION

This chapter is aimed at giving an overview of the research findings of this study. Among other things, it will be zooming in on the goal and objectives of the study, as well as the research methodology used in this study. This chapter will also outline the step-by-step notion of the data analysis process, both quantitative and qualitative. Ethical issues will also be described, followed by the interpretation of results.

4.2 GOAL AND OBJECTIVES OF THE RESEARCH

4.2.1 Goal of the study

The goal of the study was to determine the effectiveness of the REds Support Programme (fourth version) in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape.

4.2.2 Objectives of the study

The specific objectives of the study were as follows:

- To theoretically conceptualise the phenomenon of HIV and AIDS with specific emphasis on the impact of HIV and AIDS on the educational sector;

- To implement the fourth version of REds for HIV and AIDS-affected educators in the Northern Cape;
- To evaluate the effectiveness of the improved fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape; and
- To reach conclusions and make recommendations based on the research findings; to standardise REds for ultimate implementation on a national basis.

4.3 RESEARCH QUESTION AND HYPOTHESES

4.3.1 Research question

The research question stresses the importance of the specific problem, while the remainder of the research process will endeavour to answer the research question (Fouché & De Vos, 2005:100).

The study was guided by the following research question:

“How effective is the fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape?”

4.3.2 Hypotheses

A method of inferring from sample to population is hypothesis testing. This is a process that starts with the researcher having certain ideas or beliefs about the properties of some of the study variables in the population (Pietersen & Maree, 2007a:203).

The ideas or beliefs of the researcher have to be put into a format that lends itself to statistical testing. It thus has to be put in terms of random variables that will be

measured during the survey. For the purpose of this study two hypotheses are formulated; a null hypothesis and an alternative hypothesis (Pietersen & Maree, 2007a:203). The hypotheses of this study are as follows:

- (H₀) “After exposure to REs the quality of life of the experimental and comparison group does not differ statistically significantly on the $p < 0.05$ level”
- (H₁) “After exposure to REs the quality of life of the experimental group does differ statistically significantly ($p < 0.05$) better than the comparison group”

4.4 RESEARCH METHODS

The research methods will encapsulate the research approach and the type of research, as well as the research design and procedures that were used.

4.4.1 Research approach

The researcher adopted a mixed methods research approach, which is a combination of both quantitative and qualitative research methods. In mixed methods research, the researcher constructs knowledge about real-world issues based on pragmatism, which places more emphasis on finding the answers to research questions than relying on only one research paradigm (Ivankova, Creswell & Plano Clark, 2007:261). The mixed methods research approach was suitable for the intended study, as the utilisation of both qualitative and quantitative methods ensured that the optimal amount of information from participants had been gathered in order to obtain answers to the research question and test the formulated hypotheses.

4.4.2 Type of research

The researcher embarked upon programme evaluation as a type of applied research. Programme evaluation is defined as, “the systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgements about the programme, better programme effectiveness, and/or inform decisions about future programming” (Patton, 2002:10). With regard to the conducted research study, the REds programme was evaluated to determine its effectiveness as it relates to the quality of life of HIV and AIDS-affected educators in the Northern Cape.

4.4.3 Research design and procedures

This research study utilised the triangulation mixed methods research design, as this study combines qualitative and quantitative research methods. The latter is one of four mixed method research designs, and is said to be the most utilised and popular (Creswell & Plano Clark, 2007:261). This design exploits both a quantitative and qualitative research approach to ultimately have a better understanding of the phenomenon of interest.

This study dually employed both quantitative and qualitative research procedures, thus two different designs were applied:

4.4.3.1 Quantitative research design

Neuman (2000:121) describes the quantitative research design as being inclusive of experiments, surveys and content analysis. The specific experiment that was embarked upon for the purpose of this study was the quasi-experimental comparison group, pre-test, post-test design (Neuman, 2000:121). Two groups, namely an experimental and

comparison group were involved in the study, and both groups completed the same data collection instruments at the pre- and post-test level (Fouché & De Vos, 2005:140).

This study included the measurement of the dependent variable, namely 'quality of life' of HIV and AIDS-affected educators in the Northern Cape, with the independent variable being the REds programme (fourth version). Both the experimental and comparison group completed the same data collection instrument at the pre-test and post-test level. However, the comparison group was not exposed to the independent variable, but merely completed the data collection instrument at the pre-test and the post-test level. This enabled the researcher to compare the measurement of the dependent variable at the pre-and post-test level. However, to comply with the ethical standards of research the comparison group was exposed to the programme after the completion of the empirical study.

One of the limitations of the quasi-experimental research design is the allocation of subjects. Subjects are not randomly selected, this could allow for bias to slip in, which can cause results to be less valid (Fouché & De Vos, 2005:138). In an effort to guard against this type of bias, respondents were all given an equal opportunity to volunteer their participation in the research endeavour.

4.4.3.2 Qualitative research design

Babbie and Mouton (2001:270) define the qualitative research design as describing and understanding human behaviour rather than explaining it. The specific design utilised for the study was the case study. The case study is described as an intensive investigation of a single unit (Babbie & Mouton, 2001: 270).

The specific type of case study used in this research study was the collective case study design (Fouché, 2005:273). The collective case study has been the most appropriate qualitative research design, because the researcher was interested in

describing the outcomes REds had on the group of affected educators as a unit, instead of the individual group members. Fouché, (2005:272) support this notion that the collective case-study promotes the understanding of the researcher in relation to a social issue or population (e.g. whole group) being studied.

4.4.4 Description of the population, sample and sampling method

4.4.4.1 Description of the population

According to Arkava and Lane (in Strydom, 2005:193), a population refers to individuals in the universe who possess specific characteristics. The population for this study was HIV and AIDS-affected educators at two different schools in Kimberley in the Northern Cape Province.

4.4.4.2 Description of the sample and sampling method

The sampling method utilised was the non-probability sampling method. In non-probability sampling the odds of selecting a particular individual are not known (Gravetter & Forzano, 2003:118). In this study, volunteer sampling was utilised. Volunteer sampling is a method by which the respondents offer their participation to the research study voluntarily (Silverman, 2000:44). Silverman, (2000:44) also asserts that volunteer sampling works well when the respondents are known to one another or are aware of one another.

The criteria that were used for recruiting of volunteer HIV and AIDS-affected educators in Kimberley, Northern Cape, for both experimental and comparison groups were that participants had to:

- be educators;

- all be affected by HIV and AIDS;
- volunteer their participation for this study through signing an informed consent form.

Eleven respondents, of the experimental group were from a specific Primary school in Kimberley, Northern Cape, while ten respondents, from another Primary school in Kimberley, participated as part of the comparison group.

4.4.5 Methods of data collection

Data collection methods utilised during the study included both quantitative and qualitative methods. The quantitative data collection method used in the study was a standardised questionnaire, namely the Professional Quality of Life (ProQOL); the qualitative method included narratives and drawings. The data collection methods are discussed separately.

4.4.5.1 Quantitative data collection method

The quantitative data collection method, utilised in this study was one standardised questionnaire, namely the ProQOL (Stamm, 2005: 26) (See Addendum A). ProQOL developed by Stamm, is used to measure 'quality of life' through the constructs compassion satisfaction, compassion fatigue as well as burnout (Stamm, 2005:26). In terms of reliability, the early returns on test-retest data suggest good reliability across time with a small standard error of estimate. The construct validity upon which the test is based is well established with over 200 articles noted in the peer-review literature (Stamm, 2005:8-9).

The same standardised questionnaire was administered at both the pre- and post-test levels with both the experimental and comparison groups.

4.4.5.2 Qualitative data collection methods

The researcher used narratives and drawings to collect qualitative data. The following gives a brief outline of these data collection methods.

4.4.5.2.1 Narratives

Narratives are the collection of individual stories of people's experiences, as well as a discussion of the meaning of these experiences (Gay, Mills & Airasian, 2008:22). Participants were requested to respond to a specific question which was used consistently, both prior to and after exposure to REs. The question asked read as follows: Write 1 ½ -2 pages about your life as a teacher in the age of HIV and AIDS...."; (See Addendum. B).

4.4.5.2.2 Drawings

Drawings encourage reflexivity and have to have written explanations (Theron, 2008:7). Drawings were completed by participants with notes to explain the context of the picture. One of the prompts to stimulate participants in drawing was: "When you think of how the pandemic has affected you, what symbol comes to mind? Draw the symbol in the space below." (See Addendum. C).

4.4.6 Data analysis

In the next paragraph the data analysis process pertaining to both the quantitative and qualitative part of this study will be described separately.

4.4.6.1 Quantitative data analysis

Data analyses of the ProQOL were undertaken making use of descriptive statistics, by a statistician from the North West University (NWU). The reason for utilising a statistician from NWU is that the founder and developer of the REds programme are from this university. Furthermore, NWU is the central point where data, collected from the implementation of REds throughout the various provinces in South Africa, are sent for combined analysis.

Descriptive statistics is the area of statistics concerned with organising and summarising data (Pretorius, 1995:14). The data of both the comparison and experimental groups at the pre-and post-test level were compared to determine whether the programme is effective or not. The variable analysed was, "quality of life".

Non-parametric significance tests were used to analyse the data. Non-parametric methods are used when very little is known about the variables distribution in the population (Pietersen & Maree, 2007b:225). This leaves room for a degree of objectivity. Objectivity remains one of the core qualities that differentiate the quantitative research approach from others. The non-parametric test utilised in this study was the Mann-Whitney U test. This test evaluates whether the medians on a test variable differ significantly between two groups (Green & Salkind, 2008:1).

4.4.6.2 Qualitative data analysis

Content (thematic) analysis was used to analyse qualitative data. The latter involves a process designed to condense raw material into categories or themes based on valid inference or interpretation (Cresswell in De Vos 2005a:334). The qualitative data have been analysed using Creswell's qualitative data analysis process as outlined by Creswell (in De Vos, 2005a:334). The steps followed were as follows:

Step 1: Planning for recording of data

As described by Creswell (in De Vos, 2005a: 335), the researcher will plan for the recording of data in a systematic way that would be appropriate to the setting and the participants. Therefore, the participants were requested to complete all data collection tools during sessions. This was collected by the researcher at the end of each session.

Step 2: Managing and organising data

At an early stage in the analysis process the researcher organised the data into file folders Creswell (in De Vos 2005a: 336). Each and every piece of data was coded with the initials and first letter of the surname of a participant as soon as it had been collected. It was then filed respectively.

Step 3: Reading and writing memos

After the organisation and conversion of the data the researcher continued the analysis by getting a feeling of the whole database Creswell (in De Vos, 2005a:337). The researcher read the narratives and studied the drawings, several times to get a sense of the data as a whole before formal analysis started.

Step 4: Generating categories, themes and patterns

This process involved noting regularities in the setting or noting settings that had internal convergence. The researcher identified the salient, grounded categories of meaning held by participants in the setting. This step involved interpretation, and

making sense of the data, through the identification of categories, themes and sub-themes Creswell (in De Vos, 2005a:338).

Step 5: Coding the data

Coding is the formal representation of analytic thinking. The tough intellectual work of analysis was generating categories and themes. The researcher coded and categorised themes and thoroughly marked passages in the data using the codes. A coding scheme was applied to categories and themes marking passages in the data using the code Creswell (in, 2005a:338). Both the researcher and the research assistant were involved in this process. Narratives and drawings were coded per theme discovered. The codes were applied using the coloured dots to systematically distinguish between them.

Step 6: Testing emergent understandings

During this process the researcher started the process of evaluating the plausibility of her understandings and exploring it through the data. This involved a search through the data while the researcher challenged her understanding of the patterns as well as negative instances and incorporated themes into larger constructs. Creswell (in De Vos 2005a:338). This understanding was explored in the narratives and drawings.

Step 7: Searching for alternative explanations

Discovering categories and patterns in the data motivated the researcher to critically challenge the very patterns that seemed so apparent. Alternative explanations always exist; the researcher searched for these and explained the most plausible Creswell (in De Vos, 2005a:339). The researcher looked for alternatives to the common themes

found in the narratives and drawings. The drawings were analysed using face value interpretation, without theoretical framework.

Step 8: Writing the report

The researcher presents the data in this step. This is a representation of what was found in the text and drawings. This was done in a visual representation, for example, through tables and figures (Creswell in De Vos, 2005a:339). The data analysis is presented in report form after all the drawings and narratives have been examined.

However, to merely follow the process as described above does not ensure the trustworthiness of the research findings. The trustworthiness of the qualitative study was ensured as described below.

4.4.6.2.1 Trustworthiness in qualitative research

Trustworthiness is imperative in qualitative research. Assessing trustworthiness is the acid test of data analysis, findings and conclusions. Procedures for assessing the trustworthiness of the data analysis need to be constantly considered (Nieuwenhuis, 2007:113). These include using multiple data sources, verifying raw data, keeping notes of research decisions taken, greater trustworthiness in coding data, stakeholder checks, verifying and validating findings, controlling for bias, avoiding generalisation, choosing quotes carefully, maintaining confidentiality and anonymity and stating the limitations of the study upfront.

In order to ensure the trustworthiness of the qualitative analysis the researcher constantly conducted consistency checks as described by Nieuwenhuis, (2007:113). Namely, verifying raw data, by way of reading through notes after every session and

clarifying uncertainties with participants. Communicating with the research assistant constantly to verify information.

Other measures used to enhance trustworthiness involved the verification of raw data, this was done through asking participants to rectify or clarify information unclear to the researcher.

One other method used to ensure greater trustworthiness was coding data. According to Nieuwenhuis (2007: 114), qualitative research is more defensible when multiple coders are used. In the study the research assistant served as an independent coder and coded some of the data.

Furthermore, more than one data source was utilised through the combination of quantitative and qualitative measures.

Therefore, the researcher is of the opinion that through the utilisation of these various strategies, the qualitative research findings of this study could be considered trustworthy.

4.5 ETHICAL CONSIDERATIONS

Babbie and Mouton (2001:520) note that ethics is typically associated with morality, as both deal with matters of right and wrong. Ethical issues arise out of interaction with other people, other beings and the environment, especially where there is potential for conflict of interest.

4.5.1 Avoidance of harm

The responsibility for protecting respondents against harm reaches further than mere efforts to repair, or attempt to minimise, such harm afterwards. Respondents should be thoroughly informed beforehand about the potential impact of the investigation. Such information offers respondents the opportunity to withdraw from the investigation if they wish to do so (Strydom, 2005:58).

At the onset, participants were informed about the impact of the study and that it will be a process where emotions will be expressed. They were also further informed that the researcher will at all times attempt to ensure that the process is harmless. Participants were also given the option to withdraw from the study at anytime should they feel that the process evokes harm.

4.5.2 Informed consent

Informed consent becomes a necessary condition rather than a luxury or an impediment. Emphasis must be placed on accurate and complete information, to ensure that respondents fully understand the investigation, and consequently are able to make a voluntary and informed decision about their possible participation (Hakim, 2000:59). Informed consent was received in writing by all participants at the very first meeting (see Addendum F). The research assistant also completed the informed consent form and will be bound in terms of confidentiality.

4.5.3 Deception of respondents

Deception of respondents relates to deliberately misleading subjects to believe that which is not true. Respondents participating in the research study were informed by

means of information what the study is all about. The content of the research study was transparent (Loewenberg & Dolgoff, in Strydom, 2005:60).

Respondents were given comprehensive information, so that they were able to understand what the research process would entail. The process was as transparent as possible.

4.5.4 Violation of privacy, anonymity and confidentiality

The right to privacy is the individual's right to decide when, where, to whom and to what extent his/her attitudes, beliefs and behaviour will be revealed (Strydom, 2005:61). Supplying information anonymously ensured the privacy of subjects. The researcher ensured and safeguarded the privacy and identity of respondents at all times. For the purpose of the study the researcher upheld the anonymity of respondents asking them to identify themselves by drawing a symbol or picture on their test, and to keep on using that symbol as a means of identifying themselves. This was done to enable the researcher to compare the pre- and post-tests without linking a person to a test. The qualitative part of the data also had to be protected, but it was difficult to keep it anonymous, as the participants were asked to share their pictures with the group. Therefore, the researcher had to focus on protecting their confidentiality. Confidentiality was protected by the following steps:

The participants had to sign a consent form that has given the participant the assurance that the results of the pre- and post-test will be kept confidential. The researcher also contracted with the group members during the first session, to ensure that they keep the discussions in the group confidential. The researcher also explained the concepts to the participants, and ensured that they understand it.

4.5.5 Actions and competence of researcher

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation (Babbie, 2001: 475).

The researcher successfully completed the theoretical component of the Research Methodology module and underwent training in the REds Programme. Thus, she is equipped to undertake this research study and will be guided by two competent study leaders throughout the research process.

4.5.6 Publication of findings

The findings of the study must be introduced to the reading public in written form, otherwise even highly scientific investigation will mean very little and will not be viewed as research (Strydom, 2005:65). The report was compiled as accurately and objectively as possible. The research results will also be presented at a congress and will be submitted for possible publication in an accredited journal. To comply with UP Policy, all raw data will be stored for a period of 15 years in the Department of Social Work and Criminology. This aspect is dealt with in the informed consent form.

4.5.7 Debriefing of respondents

Debriefing sessions, during which subjects get the opportunity, after the study, to work through their experience and its effects, are a possible way in which researchers can assist their respondents and minimise harm (Salkind, 2000:38). Respondents had the opportunity to require debriefing. However, no participant requested debriefing.

4.6 EMPIRICAL FINDINGS

This section will present the biographical profile of the respondents as well as the actual analysis and interpretation of both the quantitative and qualitative research findings.

4.6.1 Biographical profile of respondents

The research project consisted of two groups of respondents, namely an experimental group, which consisted of 11 HIV and AIDS-affected educators, and a comparison group consisting of 10 HIV and AIDS-affected educators.

The following sub-sections outline the profiles of both groups of respondents.

4.6.1.1 Age of respondents

The age distribution of respondents is displayed in **Table 4**

Table 4 Age distribution of participants

Age	Comparison Group	Experimental Group	Total Number per Age Group
31-40 years	3	2	5
41-50 years	5	7	12
51-60 years	2	2	4
Total	10	11	21

From **Table 4** it is evident that the age group 41-50 years was dominant in both comparison and experimental groups

4.6.1.2 Gender

The gender distribution of respondents is displayed below:

Table 5 Gender distribution of participants

Gender	Comparison Group	Experimental Group	Total
Male	2	0	2
Female	8	11	19
Total	10	11	21

It is evident that females were the dominant gender involved in this study. There were no male participants in the experimental group.

4.5.2 Quantitative research findings

The following section reports on the quantitative research findings.

4.5.2.1 The measuring instrument

The ProQOL standardised questionnaire was administered as the quantitative measuring instrument in this study (See Addendum A). This instrument was administered to the 11 respondents of the experimental group as well as to the 10 respondents of the comparison group (pre-test). The same test was conducted with both groups after (post-test) the REds Programme had been implemented with the 11 respondents of the experimental group and with the 10 respondents of the comparison group.

The ProQOL standardised questionnaire consists of thirty questions that had to be answered by all respondents. The instruction for answering the questionnaire reads as follows:

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

For each question there were five responses, ranging from never to very often. Respondents had to choose one of the responses. These responses were coded 1 to 5 to ensure proper statistical analysis.

An example of a question:

I am happy

- never
- not often
- quite often
- often
- very often.

The dependent variable used for the purpose of this study through this measuring instrument was 'quality of life'. Within the context of this study 'quality of life' was measured with the following three constructs: compassion satisfaction, burnout and secondary trauma. The ProQOL manual (Stamm, 2005:5) defines these constructs as follows:

Compassion Satisfaction: Relates to the pleasure you derive from being able to do your work well. You may feel good about your colleagues or your ability to contribute to the greater good of society or your work setting. Higher scores on this scale signify a greater satisfaction related to your ability to be an effective caregiver in your work environment.

Burnout: Is linked to feelings of hopelessness and the inability to do your work effectively. Burnout can reflect the feeling that your efforts make no difference. They can also be associated with a high workload or a non-supportive environment. High scores on this scale signify high risk for burnout.

Secondary Trauma: Relates to work-related, secondary exposure to extremely stressful events. It is the exposure to traumatic events of others as a result of your work, such as working with child protection services. The symptoms of secondary trauma are rapid in onset and associated with a particular event. Symptoms include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or evading things reminding you of the event.

Data gathered from respondents reflected their scores per group on these constructs.

4.5.2.2 Statistical techniques used for data analysis

Both the pre- and post-test data results of the ProQOL were captured and analysed by a statistician from the Statistical Services of the Vaal Triangle Campus of North West University.

The Mann-Whitney U test was used to analyse the data. The Mann-Whitney U test evaluates whether the medians on a test variable differ significantly between two groups (Green & Salkind, 2008:1). To conduct the Mann-Whitney U test, each case must have scores on two variables, the grouping variable. The grouping variable divides cases into two groups or categories and the test variable assesses individuals on a variable with at least one ordinal scale (Green & Salkind, 2008:1).

4.5.2.3 Quantitative results

The results, as per the statistician's report, are presented in **Table 6**

Table 6 Results from the Mann-Whitney U Test for the ProQOL

			Sum of Ranks	U (test scores)	Z	p-level
Compassion Satisfaction	Pre-test	Comparison group	148.00	17.000	-2.685	0.007
		Experimental group	83.00			
	Post-test	Comparison group	125.00	40.000	-1.060	0.289
		Experimental	106.00			

		group				
Burnout	Pre-test	Comparison group	75.50	20.500	-2.452	0.014
		Experimental group	155.50			
	Post-test	Comparison group	82.00	27.000	-1.981	0.048
		Experimental group	106.00			
Secondary Trauma	Pre-test	Comparison group	91.50	36.500	-1.024	0.306
		Experimental group	118.50			
	Post-test	Comparison group	93.00	38.000	-1.201	0.230
		Experimental group	138.00			

With regard to the ProQOL, the results of the Mann-Whitney U test (as indicated in **Table 6**) indicate significant differences between the comparison and experimental groups as they relate to the pre-test measures of both compassion satisfaction and burnout. However, only burnout at the post-test level, tested statistically significantly different when the probability values are at $p < 0.05$.

4.5.2.4 Discussion

Given that a significant difference already exists between the comparison and experimental groups in the pre-test measures of compassion satisfaction and burnout, it is difficult to determine, given the use of the chosen statistical procedure (namely the Mann-Whitney U test), whether a significant result on their post-test measures would be an indication of the effect of the REds programme. Therefore, even though a significant difference is indicated between the comparison and experimental groups as it relates to

the measure of burnout at the post-test level, it cannot be certain that this difference is as a result of the experimental group having been exposed to the REds programme, given that a significant difference between these groups already existed at the pre-test level.

However, given the significant difference between the comparison and experimental groups on the measure of compassion satisfaction at the pre-test level, the non-significant result at the post-test level on this measure may indicate the effect of the REds programme on the experimental group.

The null hypothesis is thus seen to be true. It is therefore not possible to reject it. The alternative hypothesis is thus rejected. In essence, REds did not succeed to improve the “quality of life” of the experimental group in a statistically significant manner when compared to the comparison group.

Therefore, REds seems ineffective in terms of improving the quality of life of HIV and AIDS-affected educator respondents when interpreted from a quantitative paradigm.

4.5.3 Qualitative research findings

Qualitative data were gathered from the 21 respondents in the experimental as well as comparison group, through narratives and drawings before and after exposure to the REds programme.

Narratives

The question relating to the narrative read as follows:

Write 1½ - 2 pages about your life as a teacher in the age of HIV and AIDS.

Drawings

The question related to the drawing read as follows:

When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below (remember: it is not how well you draw but about what you draw).

The question which followed the drawing requested respondents to write 2-3 sentences explaining their symbols or drawings. A drawing means very little without an explanation.

Data gathered by the researcher, in the form of narratives and drawings, will present the experience of the respondents in both the experimental and the comparison group before and after exposure to REs.

Data gathered from the narratives and drawings will be presented as follows:

- Narratives experimental group¹ (before and after exposure to REs)
- Narratives comparison group
- Comparing the narratives of the two groups
- Drawings: experimental group (before and after exposure to REs)
- Drawings: comparison group
- Comparing the drawings of the two groups

¹ Although the reference is before and after exposure to REs within the context of this study it merely indicate representation of the experimental group. The comparison group has not been exposed to the programme.

4.5.3.1 Narratives: Experimental Group: before exposure to REds

The narrative was administered to all 11 participants of the experimental group before exposure to REds thematic analysis followed.

Themes and sub-themes were extracted from the narratives and are displayed in **Table 7** below:

Table 7 Themes and sub-themes from narratives of experimental group before exposure to REds

THEMES	SUB-THEMES
1. Emotional involvement	1.1 Hopelessness 1.2 Sadness 1.3 Sense of loss
2. Role ambiguity	
3. Feelings of incompetence	3.1 Lack of knowledge 3.2 Uncertainty
4. Fear	

Discussion of themes

Theme 1: Emotional involvement: The participants had different experiences as educators in the age of HIV and AIDS. However, their emotional involvement was

evident and three sub-themes could be identified, namely hopelessness, sadness and a sense of loss.

Sub-theme 1.1: Hopelessness

With regard to **hopelessness** one participant, representing the consensus amongst the group, stated, *“In my teaching career I have lost learners as a result of the pandemic. I really feel hopeless to help or talk to these little ones.”*

Sub-theme 1.2: Sadness

Two respondents portrayed **sadness** by stating, *“As a teacher it is sad to see how many children are affected by this pandemic I really feel sorry for these children that has to suffer because of their parents’ doings.”* Another respondent stated, *“It breaks your heart when children are orphaned, because in most cases there was not a big gap in the time of death of parents.”*

Sub-theme 1.3: Sense of loss

A **sense of loss** was depicted by one participant who stated, *“As a teacher I am dealing for 17 years with HIV and AIDS. During this time I had to bury several of my learners and parents as a result of HIV and AIDS.”*

In support of these statements by respondents, Hall et al. (2005:23) purport that educators affected by the pandemic do not portray wellness, their experiences are exemplified by sadness and depression. Coombe (2003:11), also reports that many teachers bury loved ones, colleagues and learners and this results in trauma and grief.

Coombe (2003:11) continues that educators who are not infected by HIV are affected; no educator is exempt from the impact of the HIV pandemic. He also mentions that policy makers jeopardise the future of South African education by ignoring the escalating support needs of affected educators.

Theme 2: Role ambiguity

Two participants expressed the amplification of their roles since the pandemic. One respondent stated, *“Teachers are forced to be counsellors, social workers, care givers, doctors, etc.”* *“Teachers are emotionally drained because they take the problems home with them.”*

This is supported by Delpont, Strydom, Theron and Geyer, (2011:121) who states that the pandemic has led to increased responsibility and distress for educators. Educators have to provide preventative education for learners, because education is considered a fundamental means of preventing new HIV infections. Many educators are uncomfortable with this additional professional role arising from the curricula of prevention. The pandemic impacts professionally and emotionally on educators, seeing that multiple roles, such as caregiver, counsellor and social worker, for which they are not trained are imposed on them (Delpont et al., 2011:121).

Theme 3: Feelings of incompetence

Numerous participants portrayed feelings of incompetence due to a **lack of knowledge**. One participant reported that, *“As a teacher I have very little knowledge and experience in the field of HIV and would like to learn more.”*

Another respondent portrayed **uncertainty** as a result of feeling incompetent, stating, *“Can I confront the parents when I see signs of HIV?”*

In support of this an international study of the readiness of the education sector to cope with the impact of the pandemic suggests that although HIV and AIDS management structures are generally in place, there is continued need for more holistic and comprehensive responses to the management of the pandemic along with the increased support for educators confronted by the pandemic (UNAIDS, 2006:7).

Theme 4: Fear

Two participants expressed their fear in different ways. One participant expressed the fear that *“Parents do not disclose their child’s HIV and AIDS status, and consequently place the health and safety of other children at risk”*. Another respondent expressed fear for the learners in that *“... the high mortality rate of children (learners) is putting learners at risk”*.

Theron (2005:59) supports this by stating that educators also report high levels of fear both in terms of personal safety and the future viability of South Africa, given the pandemic.

The responses of participants describing their experiences as teachers in the age of HIV and AIDS reflected unique lived experiences. However, specific trends could be identified.

4.5.3.2 Narratives: Experimental Group: after exposure to REds

Themes were extracted from the narratives and are displayed in **Table 8** below:

Table 8 Themes and sub-themes from narratives of experimental group after exposure to REds

THEMES	SUB-THEMES
1. Feeling competent	1.1 Helpfulness 1.2 Hopefulness 1.3 Feeling equipped
2. Role acceptance	
3. Mindset change (mind shift)	

Discussion of themes

Theme 1: Feeling competent

It is clear that after the implementation of REds the themes and sub-themes which surfaced are different to those of before the implementation of REds, **in the sense that the participants became positive.** Participants seemed to feel much more confident than they did before the implementation of the programme. Hopefulness, helpfulness as well as feeling better equipped were feelings and perceptions that arose. A participant who portrayed **helpfulness** responded as follows, *“I would offer my support to affected families and share the knowledge I have gained through the sessions.”* Another who shared **hopefulness** stated, *“As educator I know I will be able to assist those who are suffering from the disease to the best of my ability.”* A positive statement which portrayed the **better equipped** read as follows: *“I am very positive about assisting colleagues, learners or members because of the knowledge I gained and I am stronger emotionally and believe I can make a difference in somebody’s life.”* One other participant stated, *“As a teacher I was and still am affected by the pandemic of HIV and AIDS but now I am better equipped to cope with the situation.”*

The content of the REds Programme, which was informed by a multidisciplinary team of professionals (consisting of an Educational Psychologist a Nursing Specialist as well as Educational Scientist), are grouped into nine modules. Each module provides thematic structure, background information and interactive activities. Themes that are explored include: health promotion; the psychosocial impact of the HIV pandemic on learners and educators; psychosocial support (resources and skills); stigma and discrimination; HIV-related education policy and resilience (Theron et al., 2008: 84-85). Thus it is evident that the impact which these explored themes had on the participants had a positive psychological impact of the HIV pandemic on the educators, and that they feel better equipped as they are aware of the resources available. They are also now more sensitised around stigmatisation as well as discrimination.

Theme 2: Role acceptance

In the post-exposure to the REds programme phase, participants portrayed a sense of responsibility through understanding the role they need to play in response to the pandemic faced. A sense of acceptance of their multiple roles was clearly present. One respondent stated, *“We must not only teach children to read and write, but also moral values and life-skills to survive.”* The same participant also revealed that, *“As an educator I can no longer separate myself from this pandemic, learners and parents infected and affected are put on my path daily.”*

The REds programme is geared towards assisting educators to cope more resiliently with the challenges of the pandemic by supporting them to respond adaptively to a teaching context that demands responses more typical of counsellors or social workers, or medical personnel trained to prevent HIV (Theron et al., 2008: 84). The aim of the programme, in this context, has been attained through the rise of this theme. Participants are accepting their multiple roles in aid of the pandemic.

Theme 3: Mindset change

The shift in the understanding and attitude of participants is clear when compared to the experimental group before exposure to REds. Participants reported more positively in the narrative. One participant reported, *“I now look at my learners with different eyes and am curious to know what is happening in their homes.”*

A positive attitude is eminent as a result of the new knowledge and understanding gained as respondents reported on their ability to offer better support to affected learners and their families after having undergone the REds programme.

Delport, Strydom, Theron and Geyer (2011:125), support this notion by stating that affected educators who experienced the REds programme reported that REds capacitated them professionally and personally. It is further emphasised that if affected teachers are to bounce back from the challenges of the pandemic, protective resources such as REds must be made accessible to teachers, and the latter should make the most of and navigate supportive resources (Delport et al., 2011:125).

4.6.3.3 Comparing narratives of the experimental group before and after exposure to REds

The narratives gave respondents the opportunity to explore and write freely about their experiences as teachers in the age of HIV and AIDS. Themes could be depicted from the narratives and in this way certain similarities and differences could be classified. Themes from the experimental group before and after exposure to the REds programme were radically different. A positive change is evident in the themes depicted. During the pre-test (before exposure) participants felt overwhelmed by the responsibility of HIV and AIDS in the workplace (role ambiguity), while during the post-test, and after having being exposed to the REds programme, they accepted the role of being responsible for the aspects related to HIV and AIDS in the workplace. Initially

participants felt incompetent and this was a theme from the pre-test (before exposure), however, after the programme participants felt more competent. The conclusion drawn from this is that the value of the information shared during the programme enhanced the understanding of participants to such an extent that they now want to be more involved and take responsibility for the HIV and AIDS pandemic. The experimental group, who received the REds programme, revealed positive change in their themes. It is thus clear the REds programme to a certain extent enhanced the quality of life of respondents, in that they became much more positive about HIV and AIDS-related issues after having received the REds programme.

4.6.3.4 Narratives: Comparison Group: before exposure to REds

The researcher extracted the main themes from each participant's narration.

Themes extracted from the narratives are displayed in **Table 9** below

Table 9 Themes and sub-themes from narratives of comparison group (pre-exposure)

THEMES	SUB-THEME
1. Feelings of incompetence	
2. Emotional involvement	2.1 Helplessness
3. Role ambiguity	

Three different themes were identified in **Table 9** which represents the feelings of participants in the comparison group before as part of the pre-exposure. The discussion follows below:

Discussion of themes

Theme1: Feelings of incompetence

A participant declared her feeling of incompetence by stating, *“As a young teacher in this age I have not experienced HIV and AIDS in my classroom....I am confused and will probably not know how to react or comfort someone affected by this.”*

There are several challenges that many teachers face. Younger teachers who have not experienced HIV in the classroom feel that they need more training to deal with the pandemic. Compared to older educators, they view the disease as impacting negatively on innocent children.

Coombe (2003:10) supports this notion when he states that educators feel they lack knowledge, training and support in this regard or they struggle to not become overly involved with needy learners.

Theme 2: Feelings of helplessness

It is evident that several participants were emotionally involved with their learners when it came to HIV and AIDS. The participants had different experiences as teachers, however helplessness was a dominant emotion that frequently surfaced, and was identified as a sub-theme. One participant stated, *“Seeing that I teach such a lot of years I have seen these heartbreaking circumstances that are killing out communities.”* Another participant similarly stated, *“As an educator it is not easy to work with infected learners as at times the learner will need special attention, as a teacher what the learner is going through also affects you as a teacher mentally and emotionally.”*

Even the principal of the school, who was also a participant portrayed feelings of helplessness when he stated, *“As a principal who have to deal with poverty, unemployment and the different diseases impact on the life of innocent kids.”*

These statements emphasise that the educational system has “become the playing field for the social, health, emotional and other difficulties experienced by learners, with educators bearing the brunt of having to deal with these issues hands-on” (*AIDS Foundation, 2005:10*).

Theme 3: Role ambiguity

The acceptance of multiple roles in the age of HIV and AIDS has become very common and this has been accepted as normal in many instances, as several respondents reported in this group. One respondent reported, *“In the beginning of my career, I enjoyed the carefree days, because it was just expected of me to do the primary tasks of educating children in academics. Now I have to be a nurse, priest, ambulance etc., to be successful in my calling.”* Another respondent reported, *“Daily I am confronted with issues that are related to HIV and AIDS. Most of the children at our school know someone that is diagnosed with HIV and AIDS.”*

Bhanna et al. (2006:6) purport that in an HIV and AIDS-affected context the role of educators is extended to that of HIV prevention agents, counsellors, social workers and even surrogate parents.

Older educators are of the opinion that prior to HIV their primary function was teaching. But now their roles have changed to being social workers, nurses etc.

4.5.3.5. Narratives: Comparison Group: after exposure to REds

After the experimental group completed REds, the researcher extracted the main themes from each respondent's narration of the comparison group.

Themes are displayed in **Table 10** below

**Table 10 Themes from narratives of comparison group after exposure to REds
(post-exposure)**

THEMES
1. Emotional involvement
2. Feelings of incompetence
3. Role ambiguity
4. Fear and anger

Discussion of themes

Theme 1: Emotional involvement

Participant's sharing their emotional involvement as educators in the age of HIV and AIDS was prominent with three participants. One participant stated, *"Children are affected by the loss of a mother/father through this disease. Some children drop by the kerb, because they feel abandoned and not loved."*

Another participant, sharing her personal view, stated, *"..... is that schools who serve the poorest of the poor encounter most of these social ills."* Another participant shared her helpless feeling when she stated, *"You are so scared and you feel helpless when looking at the future of the children."*

Similarly to the narrative before exposure to REds, very little change could be perceived by the same participant. As supported by the *AIDS Foundation (2005:10)* educators are bearing the brunt of having to deal hands-on with the social, health, emotional and other problems experienced by learners in the education sector.

Theme 2: Feelings of incompetence

Three participants reported on feelings of incompetence. One participant stated, *“In the beginning it was hard to accept that I have to work with children who are infected. At that time as educator no one trained us to explain how to handle the situation,”* while another said, *“It is important to know what support you as a teacher can give the family.”* Another participant said, *“HIV and AIDS has affected me so much that I wish I could do more.”*

This theme also surfaced in the comparison group before exposure to the REds programme, and is confirmed by Coombe, (2003:10) who supports the notion, that educators feel they lack knowledge, training and support or they struggle to become overly involved with needy learners.

Theme 3: Role ambiguity

One participant mentioned the multiple roles that teachers are expected to play in the age of HIV and AIDS, *“Teachers are a model of all in one that is being a mother, teacher, social worker, nurse etc.”*

This theme has been common amongst all groups. The feeling that the role of the teacher has changed is a common feeling amongst most participants. This is supported by Bhanna et al. (2006:6) who states that in an HIV and AIDS-affected context the role of educators is extended to include HIV-prevention agents, counsellors, social workers and even surrogate parents.

Theme 4: Fear and anger

These themes came up twice in this group, one participant feared that, *“Parents are not being open with us, maybe fearing rejection or being the topic at school.”* Another participant expressed anger towards government for the intensification of the pandemic, by stating *“I blame government for the HIV Aids situation”*.

Theron (2005:59) supports this by stating that educators report high levels of fear both in terms of personal safety and the future viability of South Africa, given the pandemic.

In comparison to the before-exposure level of the same group very few changes are evident in the narration of the comparison group, who did not receive the REds training.

4.5.3.6 Comparing narratives of the comparison group before and after exposure to REds

The comparison group who did not receive the REds programme showed very little change from their pre-test. Themes were very similar and remained unchanged to a large extent. Themes that were similar, emerging from both tests, were feelings of incompetence as participants felt disabled in dealing with issues of HIV and AIDS as they do not have the skills to deal with the pandemic. Emotional involvement was the other theme that surfaced both before and after exposure to the programme. It could be assumed that participants became emotionally involved because they were overwhelmed by issues of the pandemic which they were not trained to deal with. The theme of role ambiguity also surfaced strongly as participants felt they were expected to take on different roles in dealing with a phenomenon which is foreign to them. Fear and anger came up after exposure to the programme, participants portrayed fear and anger toward government, parents and the intensification of the pandemic. It is clear that the similarities in responses of the two tests are as a result of non-implementation of the REds programme for the comparison group.

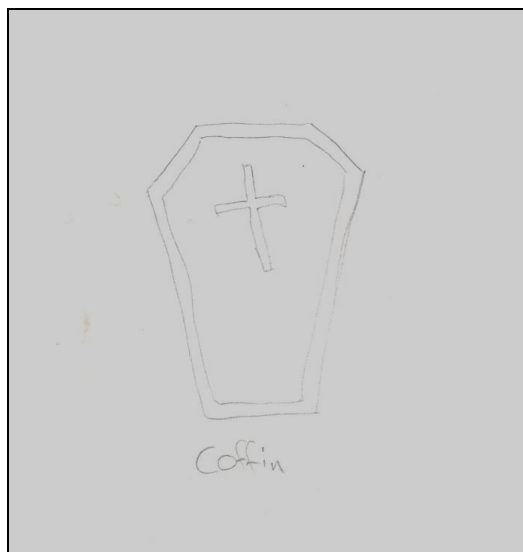
South Africa is likely to lose multiple educators due to low morale, stress, depression, de-motivation and the general challenges associated with the rampant impact of the pandemic (Shisana, Peltzer, Zungu-Dirwayi, & Louw, 2005:121).

It can be concluded from a qualitative paradigm, that the fourth version of REds enhanced the quality of life of affected educators in that those who underwent the programme showed a mindset change, evident in their narratives when compared to the comparison group who did not undergo the programme. Educators displayed a more hopeful and positive attitude toward the pandemic after the implementation of the REds programme.

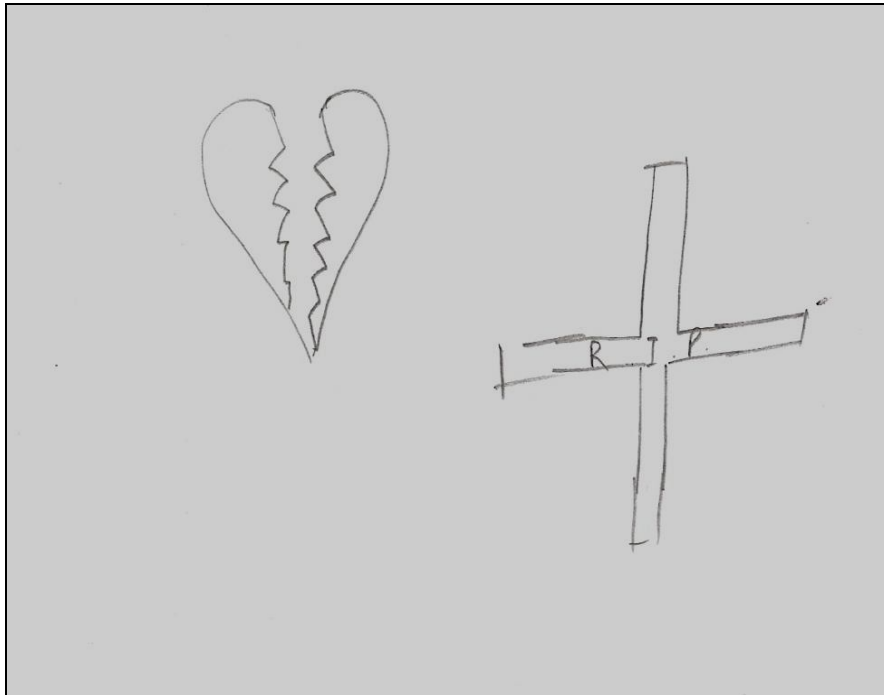
4.5.3.7 Drawings: Experimental Group: before exposure to REds

The following examples depict drawings of two of the participants in the experimental group before exposure to REds:

Example 1:



Example 2:



Drawings from participants included the following:

- A dark hole, symbolising darkness and hopelessness.
- A grave, children and a school, symbolising loss and punishment.
- A heart and tombstone, symbolising death and loss.
- A graveyard, symbolising death.
- A broken heart and a grave, symbolising sadness, death and loss.
- A coffin, symbolising death and loss.
- Tears rolling down a face and an empty hole, symbolising sadness and helplessness.
- Tears rolling down a face and a grave, symbolising sadness death and loss.
- A broken heart, symbolising sadness.
- A coffin and a broken heart, symbolising death, loss and sadness.

Discussion

Drawings were analysed using face value interpretations.

As with the narratives more or less the same themes emerged from the drawings. The researcher's view is that approximately four participants depicted the theme of death in their drawings. Drawings describing this included those of a coffin, graveyard and tombstone. Death in these pictures can be related to loss.

The other four participants depicted sadness and death in their drawings. Drawings describing this included those of broken hearts and tears rolling. These could symbolise loss and sadness.

The remaining two participants depicted 'hopelessness' in their drawings by way of a dark hole.

Foster and Williamson (2000:15) report that 95% of children orphaned by AIDS throughout the world live in Africa, where numbers of orphans will continue to rise throughout the next decade, reaching an estimated 40 million by 2010. This to a certain extent clarifies the association of the drawings of participants. The amount of orphaned children can be symbolic of the loss of their parents and the sadness they must be going through. It could also be related to the loss educators feel when losing learners, colleagues or family members through death.

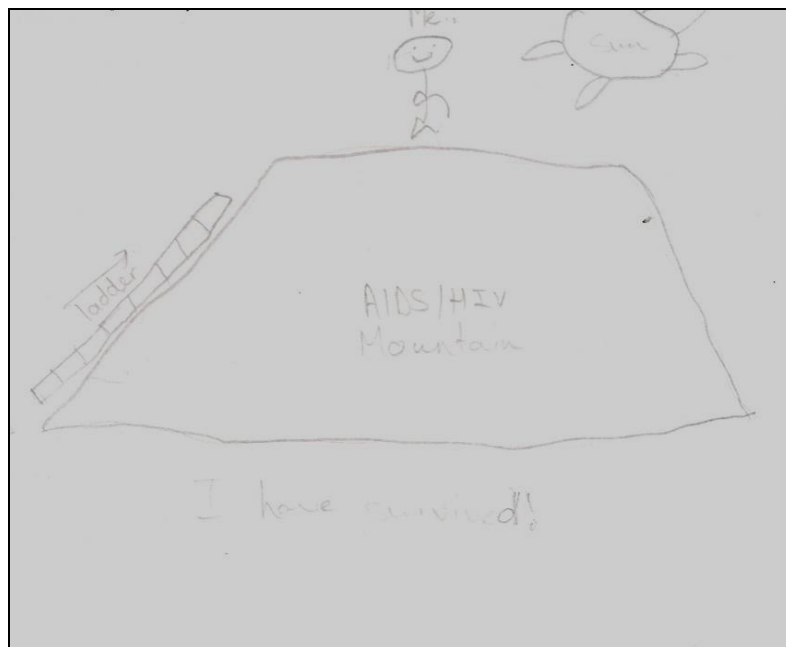
4.5.3.8. Drawings: Experimental Group: after exposure to REds

After exposure to the REds programme participants from the experimental group showed a significant change in the depiction of the symbolic drawings from that of before their exposure. The following examples of (before and after exposure) drawings from two respondents depict this change.

Example 1:

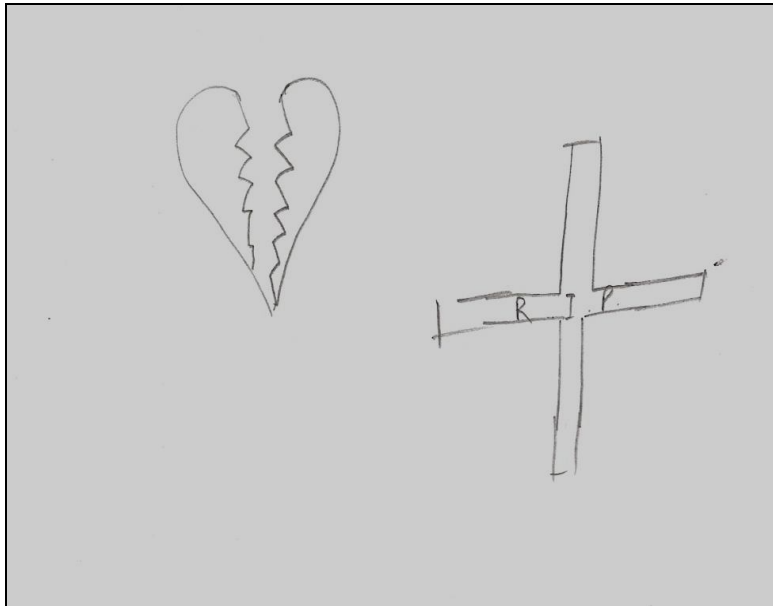


Before exposure

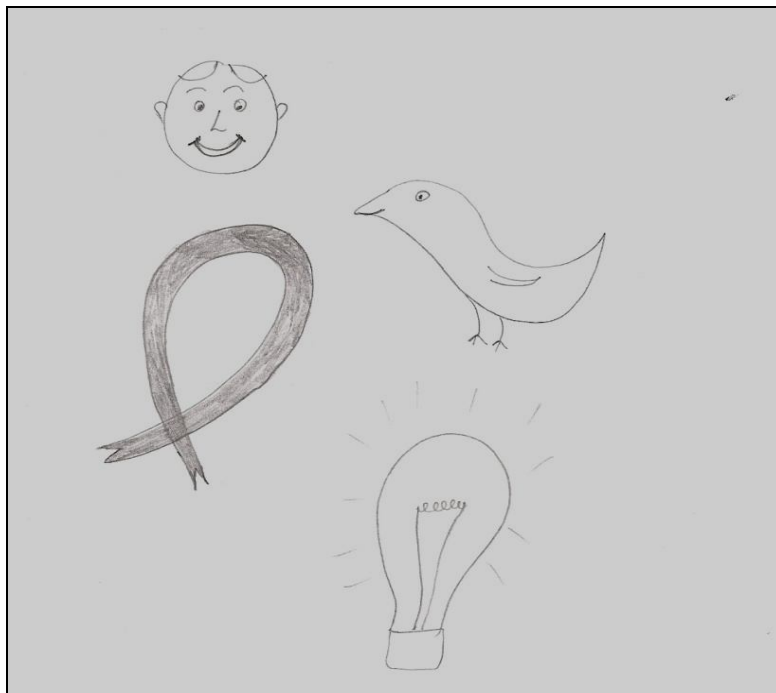


After exposure

Example 2



Before exposure



After exposure

Drawings from participants included the following:

- Big heart.
- Candle burning.
- Racetrack with person smiling while crossing the finishing line.
- Burning light bulb and people holding hands.
- A dark cloud with a silver lining and a sun shining brightly.
- A smiling face.
- Happy people going to church.
- A tall tree with the sun shining brightly through the clouds.
- A person climbing a mountain and reaching the top smiling.
- Sun shining brightly.
- A dove and a light bulb with a smiling face.

Discussion

In evaluating the drawings of the experimental group, on face value it is clear that there has been a uniform change in their drawings after exposure to REs. All the respondents depicted the themes of 'hope', 'life' and 'positivity'. One of the participants also included the theme of 'faith', or the belief in a Higher Power or Being. It can thus be assumed that the REs programme had a positive impact on the experimental group respondents when comparing their drawings to before exposure.

It is clear that the REs Support Programme assisted participants to cope better with the challenges of the pandemic. Their drawings after exposure to the programme depicts hope, light and positivity as they now have a better understanding of the pandemic and how to deal with it more effectively.

4.5.3.9 Comparing Drawings of Experimental Group before and after exposure to REds

Drawings from the experimental group before exposure to REds revealed that four participants depicted the theme of death in their drawings. Drawings describing this theme included a coffin, graveyard and tombstone. Death in these pictures can be related to loss.

The other four participants depicted sadness and death in their drawings. Drawings describing this theme included those of broken hearts and tears rolling. These could symbolise loss and sadness

The remaining two participants depicted 'hopelessness' in their drawings by way of a dark hole.

In evaluating the drawings of the experimental group, on face value it is clear that there has been a uniform change in their drawings. All the respondents depicted the themes of 'hope', 'life' and 'positivity'. One of the participants also included the theme of 'faith', or the belief in a Higher Power or Being. It can thus be assumed that the REds programme had a positive impact on the respondents if compared to the pre-test drawings of the experimental group.

It is evident that there is a significant difference between the attitudes of participants in that those from the experimental group who received the programme seemed to have undergone a mindset change which is more hopeful and positive compared to the participants of the comparison group who did not receive the REds programme. Based on the drawings it is evident that the REds programme had a positive impact on the experimental group.

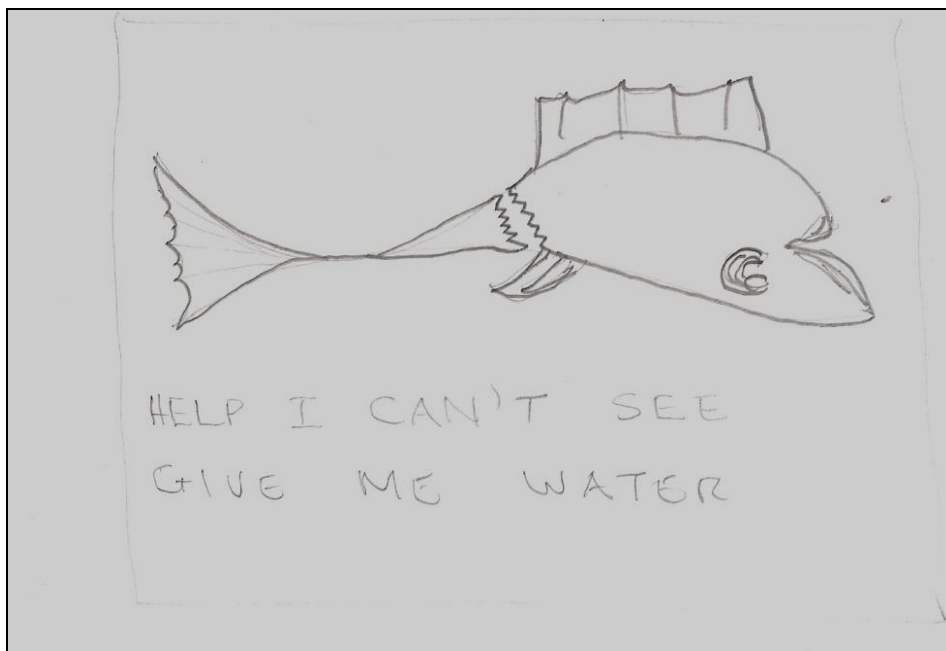
It can be concluded that the fourth version of REds enhanced the quality of life of affected educators in that those who received the programme showed a mindset change, evident in their narratives and drawings when compared to the comparison

group who did not receive the programme. Educators displayed a more hopeful and positive attitude toward the pandemic after the implementation of the REds programme.

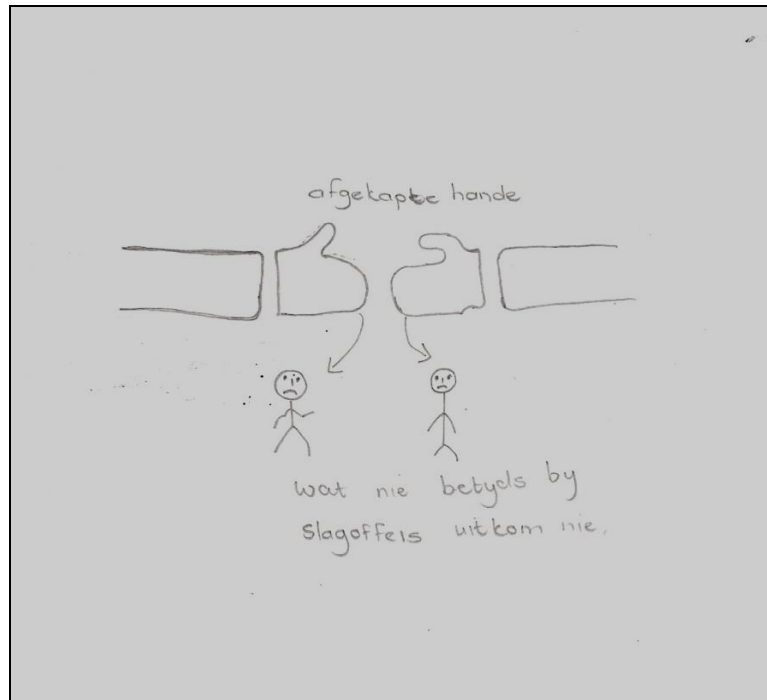
4.5.3.10 Drawings: Comparison Group: before exposure to REds

The following example depicts the before-exposure drawings of two of the participants in the comparison group:

Example 1:



Example 2:



Drawings from the respondents 'before- exposure' included:

- A broken heart with a sad face and dark clouds surrounding. Two hands breaking a chain.
- Man standing crying in the dark.
- Bleeding heart with hands chopped off.
- Coffin with a crying family.
- Big heart with a cross inside.
- A sad face of a child with begging hands.
- Fish out of water suffering.
- A bright sun shining on a church.
- Church cross.

Discussion

Drawings were analysed using face value interpretations.

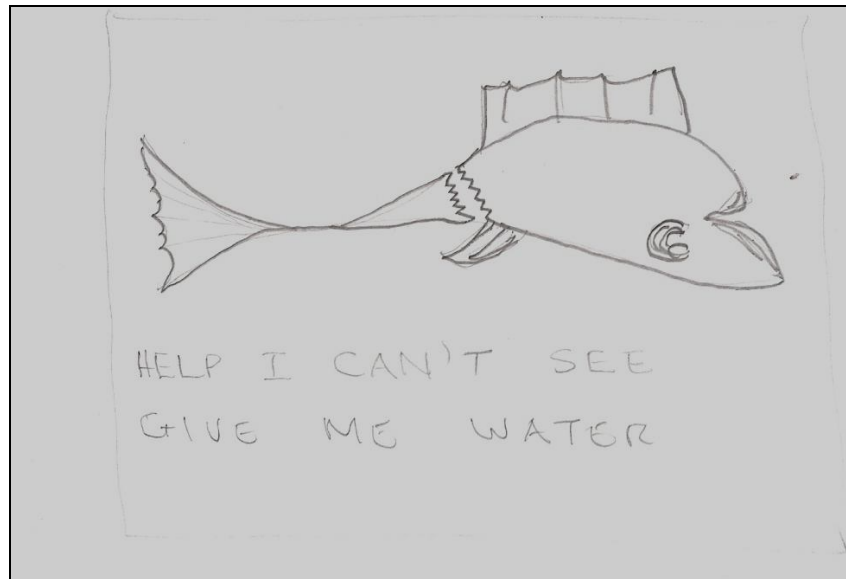
The researcher's view with regard to the comparison group's before-exposure drawings is that four participant's drawings depicted the theme of death, loss and sadness (Man standing crying in the dark, Coffin with a crying family, Church cross and a Fish out of water suffering). Three participants from the comparison group drew pictures related to helplessness and sadness (Bleeding heart with hands chopped off, A sad face of a child with begging hands, A broken heart with a sad face and dark clouds surrounding). Two participants expressed their thinking by drawing a symbol depicting a theme describing faith (drawing strength from a Higher Power). Only one participant depicted a theme of suffering, drawing a fish out of the water.

Just as the spread of the disease has been greater than predicted, so too has been its impact on social capital, population structures and economic growth. This pandemic is viewed as one of the most serious crises facing human development (Piot et al., 2001:969). As serious as the author claims the pandemic to be, so too do the drawings depict, by way of helplessness, sadness and a fish dying because it is out of the water, how participants feel as educators in the face of this greater than predicted disease. A certain percentage of participants also reverted to drawings which related to the theme of faith. This describes turning to a Higher Power for guidance and peace because, as humans, the fight against this pandemic is like fighting a losing battle.

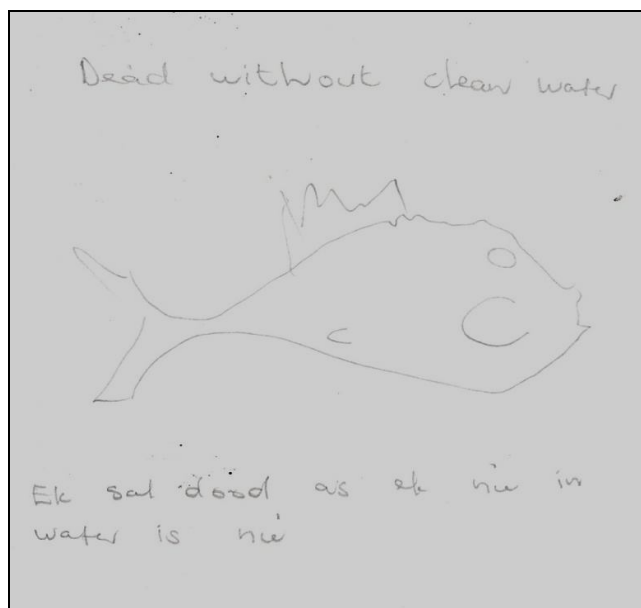
4.5.3.11. Drawings: Comparison Group: after exposure to REds

Participants from the comparison group showed a minimal change in their depiction of their symbolic drawings after exposure to the REds programme from that of their drawings before exposure. The following pre- and post-test drawings from two participants depict this.

Example 1

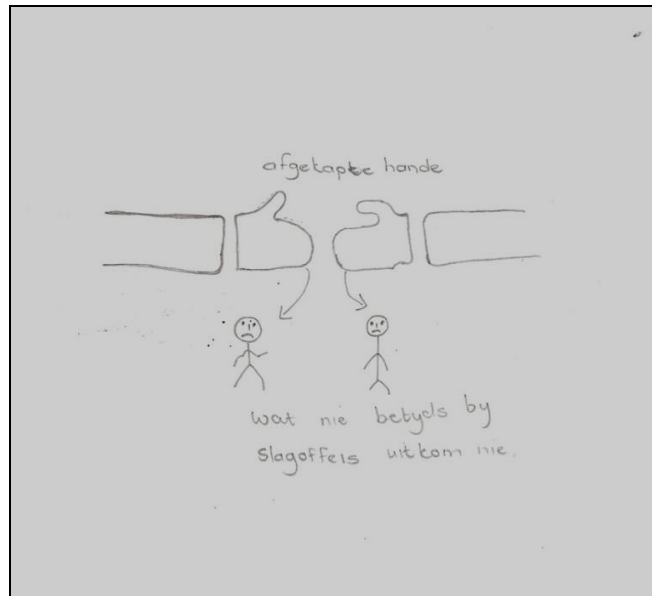


Before exposure

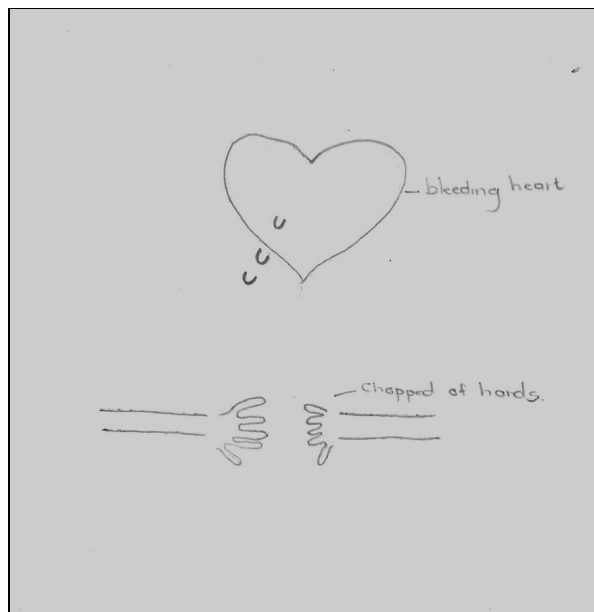


After exposure

Example2



Before exposure



After exposure

Drawings from participants in the comparison group 'after exposure' included:

- A tombstone with a watch.
- Clinic, family and teachers.
- A sad family.
- Two people breaking a chain.
- A fish out of water.
- A crying family at a funeral.
- An open hand.
- Hands chopped off.
- A coffin with a broken heart.
- A group of people standing with their backs turned and mouths closed.

4.5.3.12 Comparing Drawings of Comparison group before and after exposure to REds

The researcher's view with regard to the comparison group's drawings before exposure is that four participant's drawings depicted the theme of death, loss and sadness. Three participants from the comparison group drew pictures related to helplessness and sadness. Two participants expressed their thinking by drawing a symbol depicting a theme that described faith (drawing strength from a Higher Power). Only one depicted a theme of suffering, drawing a fish out of the water.

Most of the themes in the drawings done before exposure to the REds programme were similar for both groups, with pictures of death, coffins, broken hearts and sadness. Some also depicted the theme of hopelessness.

Just as the spread of the disease has been greater than predicted, so too has been its impact on social capital, population structures and economic growth. This pandemic is viewed as one of the most serious crises facing human development (Piot et al., 2001:969). As serious as the author claims this pandemic to be, so too do the drawings

depict, by way of helplessness, sadness and a fish dying because it is out of the water, how participants feel as educators in the face of this greater than predicted disease. A certain percentage of participants also reverted to drawings which related to the theme of faith. This describes turning to a higher power for guidance and peace because, as humans, fighting the pandemic is like fighting a losing battle.

This can be considered a hopeless situation without any positivity or different way of viewing the pandemic. With the limited knowledge of respondents their views could be as a result of their lack of information and education related to the subject.

4.5.3.13. Comparing drawings of both experimental groups and comparison groups

It is comprehensible that the two groups (experimental and comparison) encompassed similarities initially before exposure to the REds programme. Drawings such as broken hearts, coffins, tears and sad faces were symbolised by both groups during this process. This could represent the negative impact the pandemic has on educators as a result of lack of information, training and support. However after exposure to REds a noticeable difference could be perceived between the experimental and comparison groups. The comparison group, who did not undergo the REds programme, had very little difference in comparison to their responses before exposure to the programme. Drawings related to coffins, crying and sad faces, as well as tombstones were portrayed by this group. The experimental group, however, was exposed to the REds programme and portrayed significant change in their drawings after exposure to the programme. Participants showed a positive transition in their symbolic drawings; a burning light bulb, the sun shining brightly and smiling faces, are some of the drawings of those who experienced the REds programme. Ultimately this serves to prove that the programme indeed assisted in the development and empowerment of educators in the age of HIV and AIDS.

4.6 CONCLUSION

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

The quantitative research results suggest that even though a significant difference is indicated between the comparison and experimental groups as it relates to the measure of burnout at the post-test level, it cannot be certain that this difference is as a result of the experimental group having been exposed to the REds programme, given that a significant difference between these groups already existed at the pre-test level.

Qualitative research results, on the other hand, evidently indicate that participants profited from the REds programme and that there is a positive mind shift in participants subsequent to exposure to the programme. This can be further substantiated when comparing post-tests of the comparison group and the experimental group. Very little difference exists in the before- and after-exposure of the comparison group; who did not receive the REds programme.

The qualitative results, gathered through narratives and drawings, seem to have given a better representation of the impact of the REds programme on participants when compared to the quantitative results.

In the next chapter, the researcher will draw recommendations and conclusions concerning, amongst others, the implication of both the quantitative and qualitative research results on the efficacy of REds as a support programme for HIV and AIDS-affected educators.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The focus of this chapter is to give a general summary of the research project and to reach conclusions and make recommendations, based on the research findings, of the effectiveness of REds as a support programme for HIV and AIDS-affected educators in the Northern Cape Province.

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

Goal:

To determine the effectiveness of the REds Support Programme (fourth version) in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape.

Objectives:

- To theoretically conceptualise the phenomenon of HIV and AIDS with specific emphasis on the impact of HIV and AIDS on the educational sector;
- To implement the fourth version of REds to HIV and AIDS-affected educators in the Northern Cape;
- To evaluate the effectiveness of the improved fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape, and;

- To reach conclusions and make recommendations based on the research findings; to standardise REds for ultimate implementation on a national basis.

Secondly, the aim of this chapter is to give an answer to the research question:

“How effective is the fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape?”

with hypotheses namely:

(H₀) “After exposure to REds the quality of life of the experimental group and the comparison group does not differ statistically significantly on the $p < 0.05$ level”

(H₁) “After exposure to REds the quality of life of the experimental group is statistically significantly ($p < 0.05$) better than that of the comparison group”

Thirdly, the researcher will give an overview of the research project and each chapter of the mini-dissertation will be discussed under the following headings:

- Summary;
- Conclusions; and
- Recommendations.

5.2 RESEARCH METHODOLOGY

5.2.1 Summary

The research methodology was explained briefly in Chapter 1 and a more detailed description was provided in Chapter 4. The introduction, covered in Chapter 1, provided a general overview of the nature of the study. The problem formulation was then discussed, giving background of the circumstances that led to the investigation of the problem situation.

The goal and objectives of the research project were stated, including the research question and hypotheses. The researcher further briefly explained the research approach (i.e. mixed methods research) and type of research (i.e. applied research) followed by research design and methods of data collection. For the quantitative approach the data collection instrument was a standardised questionnaire called ProQOL while qualitative data were collected by means of narratives and drawings. The sampling method used to select the participants for the project was non-probability sampling (i.e. voluntary sampling).

Ethical considerations were also addressed by the researcher in Chapter 4. Chapter 1 concluded by highlighting the limitations of the research, the definition of key concepts of the study and a brief description of how the subsequent chapters of the research report are divided, including what each chapter covers.

5.2.2 Conclusions

The researcher draws the following conclusions, based on the research methodology:

- The overall research design was the concurrent triangulation mixed methods research design. Quantitative and qualitative data were collected and analysed at

the same time. This specific research design allowed the researcher to reach an answer to the research question from both a qualitative and quantitative perspective.

- Programme evaluation research, in the context of applied research, proved to be relevant as it guided and enabled the researcher, during the research process, to evaluate the effectiveness of REds as a support programme for HIV and AIDS-affected educators adequately.
- The sampling method selected was non-probability sampling and specifically volunteer sampling which is a method by which the respondents offer their participation to the research study voluntarily. This type of sampling worked well because respondents were known to one another.
- Data collection instruments were completed by both the comparison group and the experimental group. ProQOL was the quantitative instrument while the narratives and drawings were the qualitative instruments. The data collection methods provided the researcher with valuable data to evaluate the effectiveness of REds.

5.2.3 Recommendations

It is recommended that in future qualitative data collection methods be the dominant method of collecting data. This method allows participants to express themselves in more detail and bring richer research findings to the fore. Data collection, regarding people's perceptions and experiences of a programme in relation to whether their exposure to the programme has resulted in an improved quality of life, or not, is difficult when using a quantitative approach. Standardised measuring instruments are particularly troublesome if the language is not the mother tongue of the participants.

5.3 LITERATURE REVIEW

5.3.1 Summary

The literature review in Chapter 2 focused on a comprehensive discussion of HIV and AIDS in the education sector. The chapter analysed HIV and AIDS as a concept, explored its origin and explained the stages which are associated with the disease. It zoomed in on the prevalence of the pandemic globally, in sub-Saharan Africa, South Africa as well as in the Northern Cape. The chapter also reviewed HIV and AIDS in the education sector in South Africa, and specifically in the Northern Cape where the study was conducted.

5.3.2 Conclusions

Based on the literature review, the researcher depicts the following conclusions:

- The HIV and AIDS pandemic is one of the greatest bio-psycho-social and economic challenges threatening the human race in our time. This pandemic places the survival of the African continent at stake.
- The study done by Nicolay (2008:7) highlighted that the Northern Cape has the lowest number of HIV-positive people living in any single province (67 000). Approximately 7% of the population and one in every 10 adults is estimated to be HIV-positive in 2008. However, it is emphasised that the epidemic in the Northern Cape has not reached a mature phase yet and is still increasing, with new infections equalling almost double the number of AIDS-related deaths. An estimated 11 000 people are in need of antiretroviral treatment in 2008 with around 53% having commenced treatment. It is thus clear that although the prevalence rate for HIV and AIDS in the Northern Cape is lower than other provinces it does not guarantee that the province is safe or that the problem is not as severe. It remains crucial to ensure that these statistics do not increase.

- Approximately 12% of the South African education department's administrative personnel and educators are thought to be infected. Education could play a critical role in HIV and AIDS prevention but the pandemic's devastating impact threatens to derail any such efforts. HIV and AIDS is draining the supply of education, eroding its quality, weakening demand and access, drying up countries pools of skilled workers and increasing the sector costs.
- The University of North West (Vaal Triangle Campus) took the initiative in addressing the lack of appropriate support structures for HIV and AIDS-affected educators by compiling the "Resilient Educators Support Programme for HIV and AIDS-affected educators".

5.3.3 Recommendations

- In order for the statistics of the Northern Cape not to increase, the Health Department, as well as other structures responsible for combating HIV and AIDS, should become more proactive instead of treatment focused. Focusing on prevention and education would more likely ensure fewer infections.
- It is further suggested that the National Education Department establish a properly structured Employee Assistance Programme, in order to address the wellness needs of employees which have emerged through the implementation of the REds programme. The REds programme should be introduced to more schools to equip educators with the necessary skills to cope and survive within an age of HIV and AIDS

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

5.4.1 Summary

REds is a support programme which aims to equip educators with skills and knowledge to cope with being HIV and AIDS-affected and offers support to others who are HIV and AIDS-affected and/or infected. The content of the REds programme was informed by a multidisciplinary team of professionals and is grouped into seven modules. Each module provides thematic structure, background information and interactive activities. Themes that are explored include: health promotion; the psychosocial impact of the HIV pandemic on learners and educators; psychosocial support (resources and skills); stigma and discrimination; HIV-related education policy and resilience. The seven modules are facilitated over eight sessions. The core modules and topics which form the REds programme include:

Module 1: HIV and AIDS manual for Educators (Part 1). Facts about HIV and AIDS.

Module 2: How to gain and give support.

Module 3: HIV and AIDS manual for Educators (Part 2-4). Care of the sick at home. Care of the dying and management of common AIDS-related health problems in the home.

Module 4: How to cope with stigma.

Module 5: Workplace policies on HIV and AIDS (Guidelines for educators).

Module 6: How to cope with stress.

Module 7: Resilient in the HIV and AIDS pandemic.

5.4.2 Conclusions

The following conclusions are drawn from the content of the programme:

- The REds programme allowed educators the opportunity to empower themselves to understand and to a certain extent deal with the pandemic which they face on a daily basis.
- The interactive nature of the programme allowed for active participation and sharing of information. This enhanced teamwork and group cohesion.
- The different modules of the manual followed in a logical order, introducing new information systematically.
- The first session of Module 1 specifically focused on HIV and the facts thereof, thereby to a large extent eradicating many of the myths related to the pandemic, consequently making educators more knowledgeable about the disease.
- The second module related to how to give support. Support can only be given to an infected or affected person if the person giving the support has a proper understanding of the pandemic.
- The third module offered in depth understanding and guidance of how, practically, to care for the sick and the dying.
- The fourth module related to coping with stigma. It is the researcher's opinion that this module could have been introduced earlier, as module two, for example, following the discussion around the understanding of HIV and AIDS in Module 1. The two topics seem more related.
- The fifth module related more to the working environment and the importance of policies as an integral part of the fight against the pandemic.
- Module six was crucial and of great importance to all educators and, because of the impact of stress on affected and infected educators, this session could have been presented over two sessions and a debriefing aspect could be built into this module to ensure that it is well encapsulated.

- The last module related to resilience contemplation of participant as well as connectedness with others for the purpose of resilience.

5.4.3 Recommendations

- It is recommended that the REds programme be incorporated as part of in- service training for all educators on a national basis in order to ensure that educators are empowered and well equipped to deal with the HIV and AIDS pandemic.
- The themes of the seven modules are crucial; however, it is recommended that the module on stigma be introduced much earlier in the programme as it related more to module one which clarifies what HIV and AIDS is. Similarly, the position in the overall sequence of the seven modules of module six, on coping with stress, should be reconsidered. Stress is an aspect which is experienced by most educators, not only as a result of the HIV and AIDS pandemic, and needs more time and effort. It is thus recommended that an extra session be created to deal with this very important aspect.
- The fourth module related to coping with stigma. It is the researcher's opinion that this module could have been introduced earlier, as module two, for example, following the discussion around the understanding of HIV and AIDS in Module 1. The two topics seem more related.
- The fifth module related more to the working environment and the importance of policies as an integral part of the fight against the pandemic.
- Module six was crucial and of great importance to all educators and, because of the impact of stress on affected and infected educators, this session could have been presented over two sessions and a debriefing aspect could be built into this module to ensure that it is well encapsulated.

5.5 EMPIRICAL RESEARCH FINDINGS

5.5.1 Quantitative Research Findings

5.5.1.1 Summary

The specific experiment that was embarked upon was the quasi-experimental comparison group pre-test, post-test design. Two groups, namely an experimental group and a comparison group were involved in the study, and both groups completed the same data collection instruments at the pre- and the post-test level. The Professional Quality of Life Scale (ProQOL), as a standardised questionnaire, was administered to obtain quantitative research data. The latter was administered to 11 participants in the experimental group and 10 participants in the comparison group, pre- and post-exposure to REs, in determining and comparing whether the programme improved the quality of life of respondents.

This study included the measurement of the dependent variable, namely 'quality of life' of HIV and AIDS-affected educators in the Northern Cape, with the independent variable being the REs programme (fourth version). Both the experimental group and the comparison group completed the same data collection instrument at the pre-test and post-test level. However, the comparison group was not exposed to the independent variable, but merely completed the data collection instrument at the pre-test and the post-test level. This enabled the researcher to compare the measurement of the dependent variable at the pre- and post-test level through a non-parametric statistical test, i.e. Mann Whitney U test.

5.5.1.2 Conclusions

The following conclusions are drawn by the researcher with regard to quantitative research findings:

- Findings indicated that no statistically significant results were found for either the experimental or the comparison group.
- According to the quantitative results, the researcher concludes that, based on the data obtained through ProQOL, the REds programme did not adequately address the support needs (quality of life) of participants.
- The ProQOL, in the researcher's opinion, does not seem to be the most applicable measuring instrument in the context of the REds programme.
- The ProQOL is limited to measuring quality of life through predetermined constructs namely compassion satisfaction, burnout and secondary trauma which limits the scope for measuring other variables associated with the construct.
- ProQOL is proven to be a valid and reliable test, however in terms of the specific study it could not adequately address the scope because of its limited constructs.
- A significant difference already exists between the comparison and experimental groups as they relate to pre-test level measures of both compassion satisfaction and burnout.

5.5.1.3 Recommendations

- The researcher recommends that other possible standardised questionnaires be explored or a self-structured questionnaire be compiled in order to identify a more applicable measuring instrument.
- The possibility of excluding a quantitative measuring instrument from the programme evaluation should be strongly considered.
- Based on the results from both quantitative, as well as qualitative results, it is clear that the qualitative results had more valuable data which indicated a much clearer impact of the REds programme, while quantitative results were limited through the scope of the standardised testing instrument.

5.5.2. Qualitative Research Findings

5.5.2.1 Summary

Qualitative data were gathered from the 21 respondents in the experimental as well as the comparison group, through the narratives and drawings before and after exposure to the REds programme. Participants were requested to respond to a specific question which was used consistently both prior to, and after exposure to REds. The question asked as a prompt for the narrative was: “Write 1 ½ -2 pages about your life as a teacher in the age of HIV and AIDS”. With regard to the drawings participants had to complete a drawing with notes to explain the context of the picture. The prompt used to stimulate the participants to commence drawing was: “When you think of how the pandemic has affected you, what symbol comes to mind?”

The qualitative data were analysed using Creswell’s qualitative data analysis process as outlined in De Vos (2005a:334).

5.5.2.2 Conclusions

The following conclusions are drawn by the researcher with regard to qualitative research findings:

- The narratives of both groups in the pre-test phase (before exposure to REds) revealed similar statements after the emergence of the pandemic. Their primary function as educators was no longer teaching, but that of being social workers and nurses, etc.
- Most of the themes in the drawings of the pre-test phase (before exposure to REds) were similar for both groups, depicting pictures of death, coffins, broken hearts and sadness. Some also mentioned the theme of hopelessness.

- The post-test phase (after exposure to REds) of the experimental group reveals a clear shift in the understanding and attitude of participants. Participants reported more positively in the narrative. A sense of acceptance of their multiple roles was clearly present.
- Based on the drawings, it is evident that the REds programme had a positive impact on the experimental group. In comparing the post-test results of the comparison group with those of the experimental group (who received the REds training) it is evident that there was a distinct difference between the attitudes of participants. Participants from the experimental group, who received the REds training, seemed to have undergone a mindset change which was more hopeful and positive compared to the participants of the comparison group, who did not receive the REds training. Some symbols in support of this conclusion include people holding hands, a burning candle, a smiling face and a person climbing a mountain and reaching the top smiling.

5.5.2.3 Recommendations

- It is recommended that the qualitative component of the research project be elevated as the data gathered through this research method were much richer than the quantitative data. The impact of the REds programme is evident using this data collection method.

5.6 ACCOMPLISHMENT OF THE GOAL AND OBJECTIVES OF THE STUDY

The accomplishment of the objectives of the study will be discussed by the researcher, followed by the goal of the study. The representation of the accomplishment of the objectives of the study will be presented below in **Table 11**

Table 11 Accomplishment of objectives

Objective	Achievement
1. To theoretically conceptualise the phenomenon of HIV and AIDS with specific emphasis on the impact of HIV and AIDS on the educational sector.	This objective was achieved through extensive discussions on HIV and AIDS in the education sector in Chapter 2, focusing on the global picture and narrowing it down to the Northern Cape.
2. To implement the fourth version of REds to HIV and AIDS-affected educators in the Northern Cape.	This objective was achieved through the discussion in Chapter 3 relating to the REds programme and how it was facilitated.
3. To evaluate the effectiveness of the improved fourth version of REds in enhancing the quality of life of HIV and AIDS-affected educators in the Northern Cape.	This objective was achieved as described in Chapter 4 from both a quantitative and qualitative approach.
4. Based on the research findings, to reach conclusions and make recommendations to standardise REds for ultimate implementation on a national basis.	This objective was accomplished through conclusions and recommendations on the future of REds as deliberated in Chapter 5.

The goal of the study:

The effectiveness of the REds Support Programme has been successfully determined. It has enhanced the quality of life of HIV and AIDS-affected educators in the Northern

Cape. If interpreted from a qualitative paradigm the goal has been accomplished through the objectives as discussed above. The empirical findings confirmed primarily from the qualitative approach, that the REds Support Programme has enhanced the quality of life of the respondents with valuable information and skills to cope with being HIV and AIDS-infected and/or affected. The programme also empowered them to support others who are affected and infected. The same conclusion can, unfortunately, not be reached from the quantitative research findings.

5.7 CONCLUDING REMARKS

In the face of adversity the pandemic of HIV and AIDS continues to affect the education sector and the need for support of educators is inevitable. This became clear after implementation of the programme when new hope was born in those who participated in the REds programme. The training enhanced the quality of life of every participant in that, whereas they once viewed the pandemic with a mindset of total hopelessness, they could now view the pandemic as a situation which is more hopeful than hopeless.

The researcher's expectation of the respondents is that they become leaders and ambassadors of REds by reaching out to others who are affected and infected by the pandemic by doing the following:

- Providing them with correct information about HIV and AIDS;
- Offering support; and
- Referring them to relevant resources.

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ADDENDUM A

Pre-Test Questionnaire 1

As a teacher, you help many people.

Circle the answer that honestly shows how often you felt like this *in the last 30 days*.

1. I am happy.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

2. I am worried about more than one person I help.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

3. I get satisfaction from being able to help.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

4. I feel connected (joined) to others.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

5. I jump or am nervous when hearing unexpected sounds.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often

e. Very Often

6. I feel re-energized after working with those I help.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

7. I find it difficult to separate my personal life from my life as a helper.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

8. I am losing sleep over experiences of people I help.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

9. I am affected by the disturbing experiences of those I help.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

10. I feel trapped by my work as a helper.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

11. Because of my helping, I feel nervous about various things.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

<p>12. I like my work.</p> <ul style="list-style-type: none">a. Never / Not at allb. Not oftenc. Quite oftend. Oftene. Very Often
<p>13. I feel depressed as a result of my work as a helper.</p> <ul style="list-style-type: none">a. Never / Not at allb. Not oftenc. Quite oftend. Oftene. Very Often
<p>14. I feel as if I am experiencing the trauma of those I help.</p> <ul style="list-style-type: none">a. Never / Not at allb. Not oftenc. Quite oftend. Oftene. Very Often
<p>15. I have beliefs that support me.</p> <ul style="list-style-type: none">a. Never / Not at allb. Not oftenc. Quite oftend. Oftene. Very Often
<p>16. I know how to use different helping techniques.</p> <ul style="list-style-type: none">a. Never / Not at allb. Not oftenc. Quite oftend. Oftene. Very Often
<p>17. I am the person I always wanted to be.</p> <ul style="list-style-type: none">a. Never / Not at allb. Not oftenc. Quite oftend. Often

e. Very Often

18. My work makes me feel satisfied.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

19. Because of my work, I feel exhausted.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

20. I have happy thoughts and feelings about those I help.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

21. I feel overwhelmed by the amount of work I have to deal with.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

22. I believe I can make a difference through my work.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

23. I avoid some situations because they remind me of disturbing experiences of people I've helped.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often

e. Very Often
24. I plan to be a helper for a long time. a. Never / Not at all b. Not often c. Quite often d. Often e. Very Often
25. As a result of my helping, I have disturbing thoughts. a. Never / Not at all b. Not often c. Quite often d. Often e. Very Often
26. I feel frustrated by the system. a. Never / Not at all b. Not often c. Quite often d. Often e. Very Often
27. I think I am a success as a helper. a. Never / Not at all b. Not often c. Quite often d. Often e. Very Often
28. I can't remember important parts of when I've helped others. a. Never / Not at all b. Not often c. Quite often d. Often e. Very Often
29. I am a very sensitive person. a. Never / Not at all b. Not often c. Quite often d. Often

e. Very Often

30. I am happy that I chose to do this work.

- a. Never / Not at all
- b. Not often
- c. Quite often
- d. Often
- e. Very Often

ADDENDUM B

4. Write 1 ½ - 2 pages about your life as a teacher in the age of HIV and AIDS.

ADDENDUM C

3. When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below (remember: it is not about how well you draw but about what you draw):



ADDENDUM D

100
1908 - 2008



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Postgraduate Committee

13 October 2009

Dear Prof Lombard,

Project: Resilient Educators Support Programme for HIV and Aids
affected educators in the Northern Cape: an evaluative study
Researcher: E Braaf
Supervisor: Dr LS Geyer
Department: Social Work and Criminology
Reference number: 2844054

Thank you for the application you submitted to the Postgraduate Committee, Faculty of Humanities.

I have pleasure in informing you that the Postgraduate Committee formally approved the above study on 7 October 2009. Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the candidate's actual research depart significantly from the proposed research (as sometimes happens for a variety of possible reasons), it would be necessary to apply for a new research approval and ethical clearance.

The Committee requests that you convey this approval to Ms Braaf.

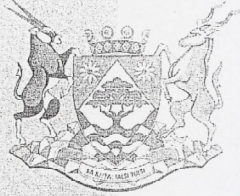
We wish you success with the project.

Sincerely

Prof. John Sharp
Chair: Postgraduate Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: john.sharp@up.ac.za

Postgraduate Committee Members: Prof S Africa; Prof PJ Botha; Dr C Carbonatto; Prof E Dreyer; Dr A Gildenhuis; Prof AE Goslin; Ms H Kirstein; Prof L Kriel; Prof D Medalle; Dr S Ouzman; Prof I Pitikrayi; Prof M/MME Schoeman; Prof JS Sharp (Chair); Prof GJ Swart; Prof R Vally; Prof H van der Mescht; Prof A Wessels; Ms P Woest

ADDENDUM E



DEPARTMENT OF EDUCATION
DEPARTEMENT VAN ONDERWYS
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ISEBE LEZEMFUNDO

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Date : 26 August 2009
Leshupelo :
Umhla :
Datum :

Enquiries : A Ericksen
Dipatisiso :
Imibuzo :
Navrae :
Reference :
Tshupelo :
Isalathiso :
Verwysings :

2 Meathling Street
[REDACTED]
[REDACTED]
8301

Dear Ms. Braaf

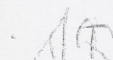
RE: Permission to use volunteer educators as research participants and as participants in the REds Programme

After having read your research proposal and after mindful deliberation with departmental heads, permission is hereby granted to you to use volunteer educators from Homevale and Venus Primary Schools as research participants in your proposed research (title: *Resilient educators support programme for HIV and Aids affected educators in the Northern Cape: An evaluative study*) and as participants in the REds Programme.

It is, however, expected that this office be furnished with a copy of the research report emanating from the said research on its completion.

The Northern Cape Department of Education wishes to thank you for your efforts to assist in our struggle against the devastating effects of HIV and Aids on our education system.

Sincerely,


.....
W. H. ESAU
CHIEF DIRECTOR: DISTRICT COORDINATION AND DEVELOPMENT

ADDENDUM F



Department of Social Work & Criminology

Researcher: Eldene Braaf

Tel. Number: [REDACTED] (mobile)

[REDACTED] (office)

[REDACTED] and [REDACTED] Primary Schools

Kimberley

Participant's Name:

INFORMED CONSENT

1. **Title of the study:** Resilient Educators Support Programme for HIV and Aids affected educators in the Northern Cape: An evaluative study
2. **Purpose of the study:** The purpose of the study is to determine the effectiveness of the REds Support Programme (fourth version) in enhancing the quality of life and resilience of HIV and Aids affected educators in the Northern Cape.
3. **Procedures:** I understand that I will be asked to complete a pre-assessment (before starting REds), a post-assessment (after completing REds) and a delayed post-assessment (three months after completing REds). During these sessions I understand that I will complete 2 questionnaires, make a drawing and write about being an educator in the age of HIV and Aids. This should take about two and a half hours each time and understanding that the facilitator will arrange to do this at a time and place that suits me.
4. **Risks and discomforts:** There are no known risks and discomforts associated with this study. If I, however, do experience distress I will inform the researcher, who will be prepared to provide me with information about community resources that can help me.
5. **Benefits:** I understand that there are no known direct benefits for me participating in this study. The results of the study will, however, assist the researcher to gain a better understanding of the effect of the REds support programme (fourth version) in empowering and supporting educators who are affected by HIV and Aids.
6. **Participant's rights:** I may withdraw from participating in the study at any time.