

**AN EVALUATION OF THE EFFECTIVENESS OF RESILIENT EDUCATORS
(REDS) SUPPORT PROGRAMME AMONG HIV AND AIDS AFFECTED
EDUCATORS IN MPUMALANGA**

BY

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solemnly that of the researcher and not necessarily endorsed by the National Research Foundation.

ABSTRACT

AN EVALUATION OF THE EFFECTIVENESS OF *RESILIENT EDUCATORS (REDS) SUPPORT PROGRAMME* AMONG HIV AND AIDS AFFECTED EDUCATORS IN MPUMALANGA

by

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DEGREE: MSW (HEALTH CARE)

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

REds is implemented in phases, and with each phase it is modified to meet the needs of a broader audience of educators. The first phase was implemented in the Gauteng Province in 2006. Recommendations made from this phase were used to modify it for phase two, that is, implementation in Mpumalanga Province and two additional provinces.

The goal of the research project was to evaluate the effectiveness of the Resilient Educators Support Programme (REds) in empowering and supporting HIV and AIDS affected educators in Mpumalanga.

Programme evaluation research was adopted, using the dominant-less dominant model of combining both quantitative and qualitative research approaches, with the quantitative approach being the dominant approach. The research design for the quantitative research approach was the quasi-experimental one group pre-test post-test design whilst the collective case study design was used for the qualitative research approach.

Quantitative data was collected through a group administered standardized questionnaire, the Professional Quality of Life Scale (ProQOL) and for qualitative data, a non-standardized questionnaire with drawings, semi-structured interviews, observation and field notes were used. Data was collected before and after the respondents were exposed to REds. The respondents, ten educators from Sozama High School in Middelburg, were recruited using non-probability volunteer sampling method.

Additional qualitative data was collected from the five members of school management team using semi-structured interviews, after the respondents were exposed to REds.

Although the quantitative empirical research findings showed no significant differences between the pre- and post-test data, it seems from the qualitative approach as if the respondents found the programme addressing their support needs as HIV and AIDS affected educators and they felt empowered with knowledge and skills that they lacked and thus making them resilient.

Conclusions drawn from the qualitative research findings indicated that REds Support Programme was effective in meeting the support needs of HIV and AIDS

affected educators in Mpumalanga. From a quantitative perspective, it is recommended that the reason/s for the non-significant test results from the standardized questionnaire be investigated.

Key words:

Evaluation

Resilient Educators Support Programme

HIV

AIDS

HIV and AIDS affected

Educators

HIV and AIDS affected educators

Empowerment

Support

OPSOMMING

‘n EVALUASIE VAN DIE DOELTREFFENHEID VAN *RESILIENT EDUCATORS SUPPORT PROGRAMME* VIR MIV EN VIGS GEAFFEKTEERDE OPVOEDERS IN MPUMALANGA

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Resilient Educators Support Programme (REds), ‘n ondersteuningsprogram vir opvoeders wat deur MIV en VIGS geaffekteer word, is in 2006 deur die Noordwes-Universiteit geïnisieer. Hierdie program is ontwikkel nadat ‘n navorsingsprojek in 2005 uitgewys het dat bestaande ondersteuningstrukture vir MIV en VIGS geaffekteerde opvoeders onvoldoende is.

REds word in fases geïmplementeer, en met die implementering van elke fase aangepas om aan die behoeftes van ‘n breër gehoor van opvoeders te voldoen. Die eerste fase is in 2006 in die Provinsie Gauteng geïmplementeer. Aanbevelings wat uit hierdie fase voortgevloei het, is gebruik om die program vir fase twee – implementering in die Provinsie Mpumalanga en twee bykomende provinsies – aan te pas.

Die doel van die navorsingsprojek was dus om die doeltreffendheid van REs om opvoeders in Mpumalanga wat deur MIV en VIGS geaffekteer te bemagtig, te evalueer.

Daar is van progamevalueringnavorsing gebruik gemaak. Die “dominante–minder dominante” model – ’n kombinasie van kwantitatiewe en kwalitatiewe navorsingsbenaderings, met die kwantitatiewe benadering as die dominante een – is gebruik. Vir die kwantitatiewe navorsingsbenadering is die kwasi-eksperimentele navorsingsontwerp naamlik die een groep voor-en-ná-toets ontwerp gebruik, terwyl die kollektiewe gevallestudie ontwerp in die kwalitatiewe navorsingsbenadering gebruik is.

Kwantitatiewe data is met ’n groepgeadministreerde gestandaardiseerde vraelys, naamlik die Professional Quality of Life Scale (ProQOL), ingesamel. Vir die insameling van kwalitatiewe data is ’n nie-gestandaardiseerde vraelys met tekeninge, semi-gestruktureerde onderhoude, waarneming en veldnotas gebruik. Data is voor én nadat die respondente aan REs blootgestel was, ingesamel. Die respondente – tien opvoeders van die Hoërskool Sozama in Middelburg – is by wyse van nie-ewekansige steekproeftrekking gekies deur van die vrywillige steekproeftegniek gebruik te maak.

Bykomende kwalitatiewe data is by wyse van semi-gestruktureerde onderhoude by vyf lede van die Hoërskool Sozama se bestuurspan ingesamel nadat die respondente aan REs blootgestel was.

Hoewel die kwantitatiewe navorsingsbevindings nie ’n beduidende verskil tussen die voor- en na-toets getoon het nie, het die kwalitatiewe navorsingsbevindings getoon dat die respondente bevind het dat die program aan hulle ondersteunings behoeftes voldoen het en dat dit kennis en vaardighede wat by hulle ontbreek het aan hulle oorgedra het, waardeur hulle weerbaarder geword het.

Die navorsingsbevindinge lei tot die gevolgtrekking dat die REds-ondersteuningsprogram op doeltreffende wyse aan opvoeders in Mpumalanga wat deur MIV en VIGS geaffekteer is se behoefte aan ondersteuning en bemagtiging voldoen het. Vanuit 'n kwantitatiewe benadering word daar aanbeveel dat die rede(s) vir die nie-beduidende resultate van die gestandaardiseerde vraelys ondersoek word.

Sleutelwoorde:

Evaluering

Resilient Educators-ondersteuningsprogram

MIV

VIGS

MIV en VIGS geaffekteer

Opvoeder

Opvoeders wat deur MIV en VIGS geaffekteer word

Bemagtiging

Ondersteuning

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CHAPTER 1

GENERAL ORIENTATION

1.1 INTRODUCTION

When HIV and AIDS first became known through both print and audio-visual media in the early 1980s, an assumption was made that it would take a long time to reach South Africa. Unfortunately, ever since infection rates have continued to increase.

According to Noble (2007:3), the South African National HIV Survey 2005 reported that an estimated 10,8% of South Africans over the age of 2 were living with HIV in 2005. Among those between 15 and 49 years old, the HIV prevalence was 16,2% in 2005. The researcher is of the opinion that these statistics give an indication of the extent of the problem of HIV and AIDS in South Africa and why it is regarded as a pandemic.

The researcher assumes that because HIV and AIDS are regarded as a pandemic, it is bound to affect all important structures (social, economic, political, health, educational, etc.) in the community which ensure that communities function optimally.

The researcher is particularly interested in the implications of the HIV and AIDS pandemic in the school environment as an educational setting that is representative of the community it is situated in. In a school environment one expects to find both learners and educators who are affected by the pandemic, because of the general high prevalence rate in the larger community.

The educators, in the researcher's opinion, may be more affected by the pandemic as in addition to being community members, they also act as an adult

support system for learners who are orphaned and vulnerable due to HIV and AIDS in the school setting. The researcher focused on the educators, as it appeared that a lot is expected from them in terms of coping and supporting others regarding the HIV and AIDS pandemic.

Van Dyk (2005:355) explained that because of the general increase in HIV and AIDS infection rates in South Africa, learners, students and educators with HIV and AIDS will increasingly form part of the population of schools and institutions.

Pelser, Ngwena and Summerton (2004:299) add that according to Education International, HIV and AIDS threaten to destroy the teaching profession in Africa within the next 10 years. The same applies to South Africa as an African country.

Furthermore, Pelser *et al.* (2004:299) highlighted the fact that according to UNAIDS (2000), Bollinger and Stover (1999), and De Souza (2002), the education sector is affected by HIV and AIDS in the following ways:

- AIDS related illnesses and death are reducing the supply of skilled and experienced teachers.
- AIDS reduces family budget, increasing pressure on children to drop out of school to work in order to supplement family income.

This information shows that the education sector is among the essential public service sectors that are seriously affected by the pandemic. Van Dyk (2005:355) added that because of the increasing prevalence of HIV and AIDS in schools, it is imperative for each school to have a planned strategy to cope with the pandemic.

The *National Policy on HIV/AIDS for learners and educators in public schools and students and educators in further education and training institutions (1999)* is, according to Van Dyk (2005:355-361), a guideline that can be used by educators, counsellors and caregivers to:

- Discuss managing HIV and AIDS in the school environment; and
- Support learners and educators living with or affected by HIV and AIDS.

The researcher came to the conclusion that the focus of the mentioned policy, as summarized by van Dyk (2005:355-361), is mainly on the prevention and management of the disease in the school environment and the humane treatment of educators and learners infected with HIV and AIDS.

Theron (2006:35) reported that research conducted among 457 Gauteng HIV and AIDS affected educators in 2005 to determine what measures of support they required to cope with the pandemic, suggested that the affected educators were in need of comprehensive support and that they did not report adequate support to date.

A support programme, “Resilient Educators” (REds), was then compiled by the University of North West, Vaal Triangle Campus in 2006, focusing specifically on support and empowerment of HIV and AIDS affected educators.

REds, a seven module interactive HIV and AIDS Support Programme, was implemented in two Gauteng schools in 2006 and then modified based on action research findings, and prepared for implementation in three additional provinces, including Mpumalanga. The seven modules cover the following topics:

- Giving and gaining support
- How to remain psychologically well – coping with stress
- How to cope with stigma
- Educator rights with regard to the HIV and AIDS pandemic
- Health education – staying healthy despite the HIV and AIDS pandemic
- Health education – nursing ill loved ones
- Resilient in the face of the HIV and AIDS pandemic

For the purposes of this study, the researcher wanted to evaluate the effectiveness of REs in Mpumalanga because of the following reasons:

- Mpumalanga is a province with the second highest prevalence of HIV and AIDS (Shisana, Pelzer, Zungu-Dirwayi & Louw, 2005:119).
- The REs Support Programme has never been implemented in the province before.
- It was an opportunity for educators to be empowered with skills to cope with the psychosocial implications of being affected by HIV and AIDS.
- Data gathered from the research project will assist in refining REs to meet the needs of a broader audience of educators.

1.2. PROBLEM FORMULATION

Hall, Altman, Nkomo, Pelzer and Zuma (2005:4) explained that South African educators are seen as a high risk group in terms of HIV and AIDS because of the matches between the profiles of people living with HIV and AIDS and those of South African educators; both being mostly African, female and of younger age (an average of 32).

Educators, who are not infected with HIV, are affected. Coombe (2003:3) suggested that no educators are exempt from the inimical impact of the HIV and AIDS pandemic and that policy makers endanger the future of education in South Africa should they ignore the escalating support needs of affected educators.

Central to the recent studies focusing on educators and the HIV and AIDS pandemic is a call for practical and urgent educator support if excellence and sustainability are to be secured in education, despite the inimical impact of the pandemic (Hall *et al.*, 2005:30; Shisana *et al.*, 2005:xxi; Simbayi, Skinner, Letlape & Zuma, 2005:134-139).

The general response to the impact of the HIV and AIDS pandemic on education has been to launch preventative programmes and to write policy. An international study (UNAIDS Inter Agency Task Team on Education, 2006:6-7) on the readiness of the education sector (including the South African education sector) to cope with the impact of the pandemic suggests that although HIV and AIDS management structures are generally in place, there is a continued need for more holistic and comprehensive responses to the management of the pandemic, along with increased support for educators confronted by the pandemic.

Theron (2005:60) cited the fact that the reality is the attrition and morbidity rates of learners and educators, and the negative impact thereof for educator and school wellness. In the face of HIV and AIDS, it is inadequate to focus only on containing the epidemic; educators must be empowered to cope with the pandemic.

Ultimately, according to Theron (2005:59), educator empowerment is a choice. Educators cannot choose to nullify the impact of HIV and AIDS on education, but they can choose their responses to this reality. The same applies to Mpumalanga, which has the second highest prevalence of HIV and AIDS in South Africa (Sishana *et al.*, 2005:119).

Theron (2005:59) then concluded that there is a need to promote acceptance among new and experienced educators of the reality of the HIV and AIDS pandemic by empowering them with the knowledge and skills to cope with it.

The Resilient Educators (REds), an interactive HIV and AIDS Support Programme, was modified and prepared to empower and support educators in Mpumalanga to cope with the challenges of being affected by the HIV and AIDS pandemic.

Thus, the problem in this context was the lack of a support programme for HIV and AIDS affected educators in Mpumalanga. Therefore, the focus of this study was to implement the Resilient Educators Support Programme (improved version) in Mpumalanga in order to evaluate the effectiveness of the programme.

1.3. GOAL AND OBJECTIVES OF THE STUDY

Fouché and De Vos (2005:104) explain that the terms goal, purpose and aim are commonly used interchangeably as they have a similar meaning. In the context of this study the term goal was used. According to the mentioned authors the goal of a research study refers to that which you want to achieve; the end result.

According to Fouché and De Vos (2005:104), an objective is the steps that one has to take realistically at grassroots level in attaining the purpose or aim. The researcher is of the opinion that an objective answers the what, when and how questions of achieving the goal. The objectives of the research have to clearly explain how the goal is going to be achieved, what is involved and, where possible, indicate time frames.

1.3.1 GOAL OF THE RESEARCH

The goal of the research was to evaluate the effectiveness of the REds Support Programme in supporting and empowering HIV and AIDS affected educators in Mpumalanga.

1.3.2 OBJECTIVES OF THE RESEARCH

The researcher identified the following objectives for the research project:

- To conceptualize theoretically the phenomenon of HIV and AIDS and the impact thereof on the school environment as an educational setting with specific focus on HIV and AIDS affected educators.
- To implement the improved version of the REds Support Programme to HIV and AIDS affected educators in Mpumalanga.
- To evaluate the effectiveness of the improved version of REds Support Programme in supporting and empowering HIV and AIDS affected educators in Mpumalanga.
- To make recommendations based on the research findings to improve the REds Support Programme in order to implement it on a national basis.

1.4. RESEARCH QUESTION

Fouché and De Vos (2005:103) state that three factors determine the manner in which research problems, questions or hypotheses are formulated: the unit of analysis, the research goal and the research approach.

Black (1999:30) clarified that research questions and hypotheses describe potential relationships between and among variables. A research question should in general be potentially testable. Black (1999:30) added that even the most practical research question may require refinement in the light of contemporary knowledge, previous research and existing theories.

The researcher is of the opinion that the cited literature highlights the important qualities of a good research question and that it has to be specific to be able to yield the relevant data.

In the light of the aforementioned problem formulation, the research question is therefore stated as follows:

- How effective is the improved version of the Resilient Educators (REds) Support Programme in supporting and empowering educators affected by HIV and AIDS in Mpumalanga?

1.5. RESEARCH METHODOLOGY

The following are discussed in this section:

Research approach

Thomas (2003:1-2) explains that in qualitative research researchers study phenomena in their natural settings, attempting to make sense of or interpret phenomena in terms of the meaning people bring to them. Quantitative research, on the other hand, involves seeking explanations and predictions that will generalize to other persons and places.

De Vos (2005:360) explains that the mixed methods approach combines both qualitative and quantitative approaches into the research methodology of a single study. Most of the mixed method studies use triangulation as a way of combining the qualitative and quantitative approaches.

De Vos (2005:361) elaborated on the point made by Creswell (1994) that the concept of triangulation is based on the assumption that any bias inherent in a particular data source, investigator and method, would be neutralized when used in conjunction with other data sources, investigators and methods.

The researcher thus deemed the dominant-less-dominant model of combination of quantitative and qualitative approaches (Cresswell in De Vos, 2002:365-366) as the most appropriate for this research, and used the quantitative approach as the primary approach and the qualitative approach as the less dominant approach.

The reason for this choice is that although the research project is primarily quantitative in nature, it is necessary to neutralize any bias that may arise from this approach, and thus the qualitative approach is used as triangulation.

Type of research

Fouché and De Vos (2005:105) explain that basic research seeks empirical observations that can be used to formulate and refine theory. Applied research, on the other hand, is about formulating or generating solutions to problems experienced in social work practice, including policy problems.

Patton (2002), as cited in De Vos (2005:369), defines programme evaluation as the systematic collection of information about activities, characteristics and outcomes of programmes to make judgments about the programme, improve its effectiveness and/or inform decisions about future programming.

In this study, the researcher used programme evaluation research in the context of applied research. The researcher chose evaluation research as a type of applied research, because research data gathered has a specific purpose for practice; it will enable modification of the programme to ensure relevance.

Research design and procedures

Yegidis and Weinbach (1996:89) explain that a research design is a plan for conducting research. As this study will make use of both quantitative and qualitative research procedures, two different designs are applicable:

- **Quantitative design:** Newman (in Fouché & De Vos, 2005:133) cites quantitative designs as experiments, surveys and content analysis. Types of experiments are the classical experimental design, pre-experimental design and quasi-experimental design.

For the quantitative approach, the researcher adopted the quasi-experimental, one-group pretest-posttest design because the respondents were a group of 10 educators (experimental group) and there was no control group. In this design, there was a measurement of the dependent variables, support and empowerment, where there was no independent variable, REds Support Programme, present. Subsequently the independent variable (REds) was introduced followed by a repeated measurement of the dependent variables (support and empowerment). Measures of the dependent variables, pre-test and post-test were then compared to evaluate the effectiveness of the independent variable on the respondents.

- **Qualitative design:** Cresswell (in Fouché & De Vos 2005:269) mentioned that the following qualitative designs can be used: biography, phenomenology, grounded theory, ethnography and case study. The researcher then chose the collective case study. The collective case study, according to Punch (2005:144), is where the instrumental case study is extended to cover several cases, to learn more about the phenomenon, the population being studied or the general condition.

The researcher was of the opinion that this is in line with what the research project aimed to achieve, namely to understand the support needs of HIV and AIDS affected educators as a social issue.

Methods of data collection

- **Quantitative data collection method:** Data were collected using a group administered, standardized questionnaire, namely the Professional Quality of Life Scale (Stamm, 2005) consisting of 30 questions, before (pre-test) and after (post-test) the respondents were exposed to REds (see

Appendix D & G). The results of the pre and post-tests were then compared in order to evaluate the effectiveness of the programme.

- **Qualitative data collection methods:** The researcher used a non-standardized questionnaire with drawings, interviews, observations and field notes.

The **non-standardized questionnaire** was administered to the respondents before and after exposure to REs. It consisted of five open-ended questions in a form of incomplete sentences and a section for drawing of symbols showing how the HIV and AIDS pandemic had affected the respondents (see Appendix E & H).

The researcher also used **semi-structured face-to-face interview schedule** to collect data from both the respondents (10 educators) and the five members of the school management team (principal, deputy principal and three heads of departments). The respondents were interviewed before and after exposure to REs, whilst the school management team was only interviewed after the respondents (10 educators) had completed REs.

The pre-test semi-structured interview schedule consisted of seven open-ended questions which aimed to elicit data from the respondents on how the pandemic affected them and what coping mechanisms they used, if they were coping at all (see Appendix F). The post-test semi-structured interview schedule, on the other hand, consisted of two open-ended questions and a third item, where respondents were expected to write a short narration on how the REs Support Programme had impacted them (see Appendix I).

The semi-structured interview schedule for the school management team consisted of four open-ended questions which aimed to gather data on whether or not the team had observed any difference in the respondents regarding empowerment and support for themselves and others who are HIV and AIDS affected, after exposure to REs (see Appendix K).

Observation and field notes during implementation of REs were taken as additional methods of qualitative data collection. Observation of group members' interaction and discussions during the training sessions were noted by the researcher and the research assistant. The field notes were taken by the researcher using a tape recorder and writing notes after each session to capture data on the group process and any other data that were relevant for the evaluation of the programme.

All these methods of data collection were employed to ensure that any limitation arising from one method is covered by another.

Data analysis

Quantitative data analysis: The analysis of data from the Professional Quality of Life Scale (Stamm, 2005) was done by a statistician from the Statistical Services of the Vaal Triangle Campus of the North West University. Data from this study were analyzed through statistical procedures using computer application software, and then displayed by means of tables and graphic presentations.

Qualitative data analysis: Data gathered from the non-standardized questionnaire, interviews and field notes were content analyzed. Content analysis is a method of qualitative data analysis that is defined by Palmquist (1993) in Babbie and Mouton (2001:491-492) as a method that examines words

or phrases within a wide range of texts. It is a technique for making inferences by objectively and systematically identifying specified characteristics of messages.

Punch (2005:199) clarifies that coding and memoing are two basic operations to get data analysis going in qualitative research.

The researcher thus used coding and memoing to content analyze the questionnaire responses, interviews, observations and field notes. In practical terms it means that, based on coding and memoing, the researcher categorized the information in themes and sub-themes with the aim to identify patterns, relationships and commonalities or disparities.

The drawings on the other hand were analyzed using face value interpretation, without any theoretical frame of reference.

Pilot study

Only the feasibility of the study and suitability of the procedure for data collection is discussed, as the REds Support Programme has already been piloted before.

Feasibility of the study: The pilot testing of REds in Gauteng during 2006 gave evidence that the goal and objectives of the study, as well as the procedures of data collection and analysis, were clear and feasible. Resources needed for this study were mainly time, administrative support and transport, and these were feasible.

The researcher received a National Research Fund bursary to conduct the study in Mpumalanga and this covered the financial resources needed for administrative support and transport. The researcher's employer granted study leave whenever necessary.

The researcher was granted written permission by the Kwa-Mhlanga district office of the Mpumalanga Department of Education to pursue the research project at Sozama High School, Middelburg. After the recruitment process, 10 respondents volunteered to participate in REs.

The research took place at Sozama High School, the respondents' place of work, which was a venue that the respondents were comfortable with, as it was familiar and easily accessible.

Testing the data collection instruments:

- **Quantitative measuring instrument:** The Professional Quality of Life Scale (Stamm, 2005) is a standardized questionnaire with a manual and thus there was no need to pilot test it.
- **Qualitative data collection methods:** Both the interview schedules and questionnaire were used during the first phase of REs in the Gauteng province and thus there was no need to pilot test them.

Description of the population, sample and sampling method

Description of the population: Strydom (2005a:193) cites Arkava and Lane's (1983) distinction between a universe and a population. Universe is said to be all the potential subjects who possess the attributes in which the researcher is interested. In this study the universe is all HIV and AIDS affected educators in Mpumalanga.

The population, on the other hand, refers to individuals in the universe who possess specific characteristics the researcher is interested in (Strydom, 2005a:193). In the context of this study, the population is all the HIV and AIDS

affected educators in Sozama High School in Middelburg (where the research took place).

Description of the sample and sampling method: Yegidis and Weinbach (1996:115) explain that a sample is a subset of individuals selected for the study among people within the population. Strydom (2005a:198) clarifies that there are two major groups of sampling, namely probability sampling which is based on randomization and non-probability sampling which is based on the absence of randomization.

For the purpose of this study, the researcher chose the non-probability sampling method. Volunteer sampling (Saunders, Lewis & Thornhill, 2003:177) was used to compose the group of 10 research respondents, that is to say the HIV and AIDS affected educators in Sozama High School in Middelburg, Mpumalanga.

No sampling method was applicable to select the school management team, because the whole team (population) was interviewed.

The identified management team members and the educators were informed about the purpose and procedures of the study and the reasons for recruiting them as respondents.

1.6. LIMITATIONS OF THE STUDY

The following limitations of the research project were identified:

- Only one quantitative measuring instrument was used, as compared to the qualitative approach that used several data collection methods and thus gathered rich data.
- The research project had prescribed data collection methods which made it difficult for the researcher to make or propose modifications.

- The sample was small; it consisted of only 10 respondents and there was no control group. The findings of the research project could, therefore, not be generalized to the population.
- The research project took place immediately after the Public Service strike action in 2007. The school management team therefore focused on ensuring that the backlog is attended to, rather than monitoring that the respondents implemented what they were learning through REs.

1.7. ETHICAL ISSUES

Research in social work is mainly about people and therefore a researcher could not ignore the ethical issues that are involved. Strydom (2005b:58-67) mentions a number of ethical issues. The following were applicable to this study:

- **Avoidance of harm:** According to Strydom (2005b:58), research can harm respondents physically and/or emotionally. Respondents should be fully informed in time about the possible harm the research is likely to cause and, in addition, be given the opportunity to withdraw from the research if they choose to. The researcher explained the goal, objectives and research procedures of the research project to all respondents before she distributed consent forms.

The researcher did not observe any physical or emotional harm done to the respondents by the research. Any painful experiences that were discussed in the sessions were dealt with within the group context and respondents felt comfortable with this as they provided support to each other. It became part of the group process.

Furthermore, the researcher followed up with individual respondents to assess the need for referral to a social worker from the Department of Social Development in the area, but there was no need.

- **Informed consent:** This implies that all possible information on the goal of the investigation, procedures, possible advantages and disadvantages, dangers to which respondents might be exposed to, as well as the credibility of the researcher be clearly explained to the respondents in a language that they understand to ensure that there are no misunderstandings (Strydom, 2005b:59). In addition, respondents have to be legally and psychologically competent to give consent.

The researcher provided background information on the research before distributing consent forms and obtaining consent verbally and in written form.

As the researcher had to record the sessions, an explanation of the reasons for using the tape recorder was given and consent requested. The researcher clarified that the tape recorder was only for recording purposes, as she could not facilitate and record at the same time, and to ensure that accurate records on the process during sessions and interviews were captured. The respondents gave their written consent.

- **Deception of respondents:** Rosnow and Rosenthal (1999:68) explain that two broad types of deception have been used in social research; active and passive. In active deception respondents are actively misled, such as when they are given false information about the research. In passive deception certain information is withheld from the respondents.

The researcher did not deceive the respondents because she is bound by the social work profession and research ethics to treat clients with dignity and respect. This was also explained to the respondents.

Respondents were given an opportunity to ask questions about the research in a group setting to clarify any misconceptions. All questions raised were answered satisfactorily.

- **Violation of privacy, anonymity and confidentiality:** Confidentiality and anonymity of respondents in data collection cannot be over-emphasized. The social work profession stresses the client's right to self-determination and, most importantly, the principle of confidentiality. Strydom (2005b:61) states that, according to Singleton *et al.* (1988:454) the right to privacy is the individual's right to decide when, where, to whom and to what extent his or her attitudes, beliefs and behaviour can be revealed.

The researcher assured the respondents when recruiting them for the research that their identities would not be revealed, meaning that they would remain anonymous and that she was bound by the oath of confidentiality that she took as a social worker to always respect the clients', in this case respondents', right to privacy. The researcher also explained that the research assistant, who was a social worker, is bound by the same oath of confidentiality. Cassettes, field notes, drawings and questionnaires were kept in a secure place that only the researcher had access to and which was kept locked at all times.

No space for names was allocated on the questionnaires and field notes were numbered for administrative purposes.

- **Actions and competence of researcher:** Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation (Strydom, 2005b:63). The researcher is a registered social worker with extensive experience working in the health care field and Employee Assistance Programme. This

background has prepared her to work with the respondents and with sensitive social issues such as HIV and AIDS.

Even though the respondents did not have a relationship with the researcher, the fact that she was working through the provincial/district office of the Department of Education gave her credibility, as the respondents knew that the Department follows protocol in such cases.

- **Release of findings:** Strydom (2005b:65) explains that the findings of the research must be disseminated to the public through a written report. The researcher has to ensure that the results of the research are reported accurately and that no one is deceived by the findings. The researcher asked the research supervisors and an independent researcher to proofread the research report to check the accuracy of the information contained in the report.

The researcher will make a copy of the research available to the provincial/district office of the Department of Education for their own record keeping, as a source of information and a product of their participation.

The researcher will also submit the research report to be published in appropriate academic journals. Another way of releasing research findings will be through presentations in relevant professional conferences or seminars. The main aim is sharing scientific information and creating awareness on the research findings.

- **Debriefing of respondents:** Rosnow and Rosenthal (1999:72) clarify that debriefing sessions after the study give the researcher an opportunity to address any misconceptions and anxieties the respondents might have,

so that their sense of dignity remains intact. Debriefing does not have to take place only after the data collection is complete.

The researcher did not enlist an external social worker to debrief respondents as they felt comfortable with the researcher and a rapport was already established.

The debriefing was done as the need arose during sessions. The formal debriefing was done immediately after the last session of REds. Both the researcher and respondents terminated on a good note and nothing was left unattended.

For the researcher, adhering to the mentioned ethics is an indication of the respect one has for the research, the profession you represent and, most importantly, the respondents.

1.8. DEFINITION OF KEY CONCEPTS

The research topic, “evaluation of the effectiveness of the Resilient Educators Support Programme among HIV and AIDS affected educators”, implies the following key concepts: evaluation, the Resilient Educators Support Programme, HIV and AIDS affected educators, support and empowerment.

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

Flanagan and Finger (2000:299) describe evaluation as holding debriefings about the project to review problems and successes, and to make recommendations for future projects. For the researcher, evaluation is a process

of assessing if the goal of the project has been attained. In this context, it means assessing if the REds Support Programme has been effective in supporting and empowering HIV and AIDS affected educators in Mpumalanga.

1.8.2 Resilient Educators Support Programme: The researcher found it difficult to define the Resilient Educators Support Programme as there was no available literature to source a definition from because the programme was new (developed in 2006) and is still in the process of being refined and adapted for a broader audience of educators.

The researcher is of the opinion that the support programme is in line with Theron's (2005:59) recommendations that empowerment of educators in the light of HIV and AIDS should be facilitated in three ways, as mentioned by Scriven and Stiddard (2002), namely:

- Facilitation of skills to empower educators to cope with the anticipated adjustments by providing staff development plans and cognitive-behavioural workshops focusing on resilience and coping skills.
- Facilitation of the acquisition of assertiveness, interpersonal competence and cognitive knowledge.
- Facilitation of positive psychological perception.

The researcher thus views the Resilient Educators Support Programme as a training programme that aims to support and empower educators to cope with the challenges of the HIV and AIDS pandemic, which in turn achieves an improved level of social functioning both at work and at home.

1.8.3 HIV and AIDS affected educators: This concept is divided into the following sub-concepts:

1.8.3.1 **HIV:** HIV is defined by Butterworth and Pearsall (2003:644) as an abbreviation for human immunodeficiency virus, a retrovirus that causes acquired immunodeficiency syndrome, AIDS. *The National Policy on HIV/AIDS for learners, educators in public schools, students and educators in further education training institutions* (RSA, 1999) cites a similar definition of HIV: HIV means the human immunodeficiency virus. For the researcher, HIV means a virus that progressively weakens a person's immune system.

1.8.3.2 **AIDS:** Van Dyk (2005:3-4) mentions that AIDS is short for Acquired Immune Deficiency Syndrome. It is a collection of many different conditions that manifest in the body because of the HIV virus which has so weakened the body's immune system that it can no longer fight the disease-causing agents that are constantly attacking it and thus has the ability to kill the infected person in the final stages of the disease.

Kelly (2000:17), on the other hand, defines AIDS as a condition that is caused by HIV and which works in conjunction with opportunistic infections, making the body susceptible to a variety of infections, weakening the immune system to such an extent that the potential of the body to recover from the infections is reduced. Thus in the great majority of cases the person becomes steadily weaker and eventually dies.

In the context of this research, AIDS is a result of a weakened immune system, whereby the person's health deteriorates to the point where he/she becomes dependent on others for care and eventually dies because of the body's inability to fight disease.

1.8.3.3 **HIV and AIDS affected:** Van Dyk (2005:218) explains that HIV and AIDS affected refers to the significant others in the life of a person living with HIV and AIDS. Significant others include friends and family members. Another definition of HIV and AIDS affected is cited by Hall *et al.* (2005:23), which is specific to the

education setting, namely referring to those educators that are either HIV positive or have colleagues, learners and relatives that are living with HIV and AIDS.

The researcher's understanding of HIV and AIDS affected is more in line with the description by Hall *et al.* (2004:23), namely persons who are HIV positive and/or have loved ones, significant others, friends or colleagues who have died from AIDS and/or are living with HIV and AIDS.

1.8.3.4 **Educator:** The *National Education Policy Act* (RSA, Department of Education, 1996) defines an educator as any person who teaches, educates or trains other persons at an educational institution or assists in rendering education services or education auxiliary or support services provided by or in an education department, but does not include any officer or employee as defined in Section 1 of the Public Service Act, 1994 (Proclamation No. 103 of 1994).

Another definition of an educator is by Hornby (2005:468) and it is: "a person whose job is to teach or educate people."

For the purposes of this research project, an educator is a person who is professionally qualified to teach, educate and train learners and students in a formal education institution.

An HIV and AIDS affected educator is then a professionally qualified teacher in a formal education setting, who is HIV positive and/or has loved ones, significant others, friends, colleagues and learners that have died from AIDS and/or are living with HIV and AIDS.

1.8.4 **Empowerment:** It is defined by Potgieter (1998:216) as "a process of increasing personal, interpersonal and collective power which allows individuals, families, groups and communities to maximize their quality of life."

Another definition is by the *New Dictionary of Social Work* (1995:21), which states that empowerment is a process whereby individuals or groups attain personal or collective power which enables them to actively improve their living conditions.

For the researcher, empowerment is a process of capacitating individuals, groups or communities with the knowledge, skills and resources to improve their level of functioning.

1.8.5 Support: The *New Dictionary of Social Work* (1995:64) defines support as a technique in social work used to assist a client, through, amongst others, encouragement and acceptance, to reduce tension and promote self-confidence. According to Hornby (2005:1416) support is to encourage and/or to give help to those who need it.

The researcher conceptualise support as the unconditional outreach to others to strengthen their self-esteem.

1.9. DIVISION OF THE RESEARCH REPORT

The research report is divided as follows:

Chapter 1: General orientation

Chapter 1 gives a brief overview of what the research is about, the goals and objectives, research question and approaches, research design and procedures, pilot study, sampling procedures, research limitations, ethical issues and the definition of key concepts.

Chapter 2: HIV and AIDS in the education sector

Chapter 2 focuses on an in-depth literature review on HIV and AIDS in the education sector. The purpose of literature review is familiarization with concepts to gain insight into what is being investigated.

Chapter 3: Resilient Educators Support Programme for HIV and AIDS affected educators

A description of the REds Support Programme, including contents of the seven modules, is discussed in this chapter to inform the reader about what the programme entails.

Chapter 4: Empirical research findings

In this chapter, data gathered is analyzed and interpreted.

Chapter 5: Summary, Conclusions and Recommendations

The researcher summarizes and makes concluding statements and recommendations based on research findings regarding the effectiveness of REds as a support programme for HIV and AIDS affected educators.

1.10. CONCLUDING REMARKS

The researcher is of the opinion that HIV and AIDS affect people from every sphere of life and therefore cannot be ignored. Educational institutions are more vulnerable to the pandemic because of the demographics of people normally found in such settings.

The research project aims to contribute in the fight against the pandemic by looking at ways to enhance the coping mechanisms of educators who are affected by HIV and AIDS.

The next chapter focuses on a theoretical discussion of HIV and AIDS in the education sector.

CHAPTER 2

HIV AND AIDS IN THE EDUCATION SECTOR

2.1 INTRODUCTION

This chapter focuses on a literature review of HIV and AIDS in the education sector. The aim of the review is to gain insight into the issue under investigation which was clarified in the previous chapter.

The conceptualization of HIV and AIDS, its stages, the difference between being HIV and AIDS affected and HIV and AIDS infected, the extent of the pandemic in the education sector and available support structures for HIV and AIDS affected educators will be discussed.

The researcher recognizes that HIV and AIDS are not only a South African problem, but a global problem. Thus the prevalence of the pandemic globally and in Sub-Saharan Africa, of which South Africa forms part, will be dealt with.

2.2 CONCEPTUALIZATION OF HIV AND AIDS

The researcher has observed from literature studied that the concepts HIV and AIDS are defined differently by authors and this is largely dependent on the discipline they represent. It then becomes important for the researcher to clarify HIV and AIDS in the context of this research project.

Gant (1998:4) defines HIV as an acronym for “human immunodeficiency virus”, the virus that leads to AIDS. According to Hornby (2005:31) HIV is the virus that causes AIDS.

Pelser et al. (2004:277) explain that HIV is closely related to several Simian (monkey) Immunodeficiency Viruses (SIVs) found in Africa; that crossed the species barrier at some stage to enter human beings. Precisely when and how HIV entered human populations has been fiercely debated. There are a number of hypotheses, but none are conclusive. The fact remains that the HI-virus continues to infect the human population and a cure is still to be discovered.

Van Dyk (2005:10-11) adds that, like other viruses, HIV can reproduce itself only by becoming a “parasite” inside a living cell. It cannot live and multiply outside human cells. What makes HIV so effective in destroying human lives is that our immune system has no way of defending us against the HI-virus.

For the researcher, HIV is a parasitic virus which, once it enters the human body, is primarily responsible for the progressive weakening of a person’s immune system and with time leads to AIDS.

AIDS, on the other hand, is defined by Hornby (2005:31) as an abbreviation for “Acquired Immune Deficiency Syndrome”, an illness which attacks the body’s ability to resist infection and which usually causes death. Gant (1998:4) also defines AIDS as an acronym for “acquired immune deficiency syndrome”, a progressive weakening of the immune system with primary cause of infection identified as HIV.

Whiteside and Sunter (2000:1) add that the acronym AIDS needs to be explained as follows:

- The ‘A’ stands for acquired. This means that the virus is not spread through casual or inadvertent contact, like flu or chicken pox. In order to be infected, a person has to do something (or have something done to them) which exposes them to the virus.

- The 'I' and 'D' stand for Immuno-Deficiency. The virus attacks the person's immune system and makes it less capable of fighting infections. Thus the immune system becomes deficient.
- The 'S' is for syndrome. AIDS is not just one disease, but it presents itself as a number of diseases that come about as the immune system fails. Hence it is regarded as a syndrome.

From the cited definitions, the researcher views HIV and AIDS as parts of a continuum; beginning with an HIV infection and ending with AIDS. A person starts with being infected with the HI-virus, which over a number of years rapidly replicates and in the process weakens the immune system. Opportunistic infections then take advantage of the compromised immune system and attack the body. The body cannot fight these infections and thus the person presents with AIDS and eventually death.

2.3 THE DIFFERENT STAGES OF HIV AND AIDS

The HI-virus is indiscriminate in terms of whom it infects. It cuts across age, gender, race, nationality, socio-economic status, religion and culture. HIV, according to Orr and Patient (2007:19), is mainly transmitted in the following ways:

- Through unprotected sexual intercourse (vaginal, anal or oral) with an infected person.
- From infected mother to child during pregnancy, the birth process or breastfeeding.
- Through contact with infected blood (e.g. blood transfusion or sharing of needles).

Once infected with the virus, the person goes through a progressive deterioration of the immune system that has a number of stages. The researcher is of the

opinion that progression from one stage of the disease to the other depends on a number of psychosocial factors ranging from health status, available support system, attitude towards the disease, internal motivation, to available community resources (Cogan, Klein, Magongo & Kganakga, 2005:2).

Evian (2003:28) adds that some patients may be rapid progressors to immune deficiency and AIDS. Others may be slow progressors, and a very small and lucky group are non-progressors, that is to say they remain well and free of immune-deficiency. It is the existing health status of an individual that largely influences how long it will take to develop immune-deficiency and symptomatic disease.

The researcher has observed from literature studied that there seems to be no uniform stages of HIV and AIDS and thus there is a difference from one author to another. For the purposes of this research, reference will be made to only two sources, namely Mather (2002) and Evian (2003). The aim is to discuss different points of view and at the same time capture the important points that need to be known at each stage.

Mather (2002), as cited in Vilakazi (2005:14-15), mentions the following stages of HIV and AIDS with each phase usually developing gradually and merging into the next:

- **Stage 1:** the asymptomatic or silent phase. After a person is infected with HIV, he/she would most likely “remain well” for approximately seven years. He/she would look healthy but might experience swollen lymph nodes.
- **Stage 2:** the phase of HIV and AIDS related conditions. After the initial asymptomatic phase, the HIV infected person commonly starts experiencing various medical problems, including skin rashes, fungal mouth infections, fatigue, swelling of lymph glands in the neck and

armpits, mild weight loss and occasional fevers. This phase does not yet signify the onset of AIDS.

- **Stage 3:** the AIDS phase. By this stage, the body's defences are becoming depleted and thus opportunistic infections increase. The person usually experiences various conditions ranging from those in the previous stage to more severe, life-threatening infections. Usually after repeated illnesses and the resultant weakening of the body, the body cannot fight the infections anymore and the person eventually dies.

The researcher views these three stages as giving a picture of the progression of the disease, including the physiological signs and symptoms of each stage. However, the stages mentioned here are not expansive enough and have omitted some of the crucial facts about each stage.

The researcher has found the following source (Evian, 2003) to be comprehensive and informative and it thus gives workable information in terms of what happens in each stage of HIV and AIDS.

Evian (2003:28-31) has identified the following five stages:

- **Stage 1:** Primary/early HIV infection. In the first three to six months after infection with the HI-virus the person may develop a flu-like illness known as "seroconversion illness". At this time, the viral load may rise to high levels and then drop to much lower levels thereafter. This means that the person becomes very infectious. Fever, headaches, sore throat, muscle and joint pain, swollen lymph glands, gastro-intestinal symptoms, skin rashes and tiredness may be noticed. These symptoms disappear within a week or two and are often mistaken for a simple cold or flu because the signs and symptoms are non-specific. Evian (2003:29) adds that in the

first few years after HIV infection, the HIV antibody test may be the only sign of HIV infection.

- **Stage 2:** Clinical latent or silent – the asymptomatic phase. This can last from three to seven years, sometimes up to 10, in which the person remains clinically healthy, but the virus is active in the body causing progressive damage to the immune system. Evian (2003:29) explains that the CD4 cell count (CD4 cells are helper T cells vital in the human immune system) will usually decrease by 40 to 80 cells/ml per year. For the researcher, this is a stage where the infected person appears healthy and thus may be resistant to voluntary HIV testing as he/she has no reason to suspect that he/she is infected.
- **Stage 3:** Minor symptomatic stage. Evian (2003:30) clarifies that minor symptoms and signs secondary to the HIV infection, between three and seven years after infection, may include chronic swelling of the lymph nodes which are commonly felt in the neck, axilla and below the jaw, as well as herpes zoster, occasional fevers, skin rashes, fungal nail infections, recurrent oral ulcerations, angular stomatitis and recurrent upper respiratory tract infections. The researcher's understanding is that these minor infections may be telling signs that the person is not as healthy as he/she thought and thus necessitates HIV testing. Though voluntary and usually accompanied by pre- and post-test counselling, for most people it remains a hurdle that they find difficult to overcome.
- **Stage 4:** Symptomatic stage. After about five to eight years following infection, the viral load increases progressively and the immune system continues to deteriorate. Evian (2003:30) further explains that these symptoms are usually due to an overgrowth of some of the body's natural flora with fungal infection, reactivation of old infections and uncontrolled multiplication of the HI-virus. The common signs and symptoms include

persistent and recurrent oral or vaginal thrush, hairy leukoplakia on the tongue, recurrent cold sores, shingles, acne-like bacterial skin infections, persistent herpes simplex infection, weight loss (more than 10% of the usual body weight) and persistent diarrhoea.

- **Stage 5:** AIDS, severe symptomatic phase. Evian (2003:31) explains that the symptomatic phase usually progresses over the next year or 18 months into the fully developed AIDS phase of the disease. The high viral load and severe immunodeficiency allows for, in addition to severe opportunistic infections, some cancers and HIV related organ damage. These conditions are referred to as AIDS defining illnesses and usually correspond with a CD4 cell count below 200.

The researcher perceives this stage as presenting a number of challenges not only for the infected and sick person, but also for his/her family. The family has to cope with taking care of a dying family member and come to terms with the eminent loss. The sick and dying person has to come to terms with dying and also ensure that wills and his/her wishes are communicated to the family on time.

The progression of the disease from HIV infection to AIDS takes years. During this period the person has a chance to change to a healthy lifestyle and slow down the replication of the virus and thus live longer. This is especially important for mothers/fathers with young children. Unfortunately this can only happen if the person knows his/her status. The researcher therefore sees it as her role to continually motivate people to “know their status”, as this will help people to realize that progression from one stage of the disease to the next can be managed.

2.4 THE DIFFERENCE BETWEEN BEING HIV AND AIDS INFECTED AND AFFECTED

HIV and AIDS, being a pandemic, affect almost all spheres of life. This means that even when you are HIV negative, you are affected by the pandemic. Cogan *et al.* (2005:2) add that there are many physical effects of HIV and AIDS, but perhaps the most profound effects of HIV are on the psychological, social and economic health of the person, their loved ones and the community.

Being infected with HIV, for the researcher, means having contracted the HI-virus. The infected person will progressively move from the primary infection stage to AIDS in about seven years, depending on their lifestyle, as explained by Evian (2003:29).

Rooth, Stielau, Plantagie and Maponyane (2006:96) highlighted the fact that because HIV and AIDS are everybody's problem, we are affected by what it does to the people we love, live and work with.

The researcher thus concludes that being HIV and AIDS infected means having the virus in your body and this is usually confirmed by a clinical HIV antibody test (normally used in public health services) or a test that detects the HI-virus.

Being HIV and AIDS affected, on the other hand, means that a person is affected by having a partner/spouse, family, neighbours, colleagues, friends or other loved ones that are infected with HIV and/or being infected yourself. This means that being HIV positive you are both infected and affected by HIV and AIDS.

2.5 THE EXTENT OF THE HIV AND AIDS PANDEMIC

The researcher's view is that HIV and AIDS grew to pandemic proportions because the initial media reports painted a picture that seemed to suggest that it affects mainly minority groups, such as homosexuals and migrant workers. The incubation period of the disease also added to this misconception, as infected people appeared physically healthy for a long time. This underplayed the significance of the high prevalence rate as only a few people were visibly sick and/or dying from the disease. In most instances the symptoms of the disease, like tuberculosis or some cancers, were cited as the cause of death rather than the underlying cause; HIV and AIDS.

In the meantime the infection rates were rising and today society is faced with a pandemic that, in spite of continued clinical trials, no cure has been found for. We only have drugs that slow down the replication of the HI-virus, that is to say antiretroviral drugs.

HIV and AIDS is a global pandemic affecting people mainly in their economically productive years and thus threatens the livelihood of all, both infected and affected. The researcher will thus discuss the prevalence of this pandemic globally, in Sub-Saharan Africa, in South Africa and lastly in Mpumalanga, one of the provinces in South Africa and the geographical area in which this study was conducted.

2.5.1 HIV AND AIDS WORLD-WIDE

Advances in technology have made the world a smaller place as we can communicate and commute between and among countries of the world much more easily than before. The flipside to this is that once there is an outbreak of an epidemic in one country or continent, it becomes difficult to contain and

prevent it from reaching pandemic proportions. This scenario seems applicable to the HIV and AIDS pandemic.

Marais (2005:25) supports this by mentioning that HIV spreads with stealth and hides its presence from casual observation for many years.

Evian (2003:20) maintains that HIV and AIDS have spread to all parts of the world and it is the most serious public health problem. Whiteside and Sunter (2000:37) add that in 1998 when the UNAIDS (Joint United Nations Programme on HIV/AIDS) issued a map showing the global infections, the caption was: “No place on earth untouched.” This shows how widespread the pandemic is and thus how challenging it is to contain.

According to Pelsler *et al.* (2004:276), HIV and AIDS have brought a global epidemic far more extensive than what was predicted a few decades ago. Still rapidly growing, the pandemic is reversing development gains, obliterating millions of lives, widening the gap between rich and poor, and undermining social and economic security.

The researcher’s view is that though it was clear that HIV and AIDS had the potential to be a pandemic if appropriate preventative and curative interventions were not implemented, its global socio-economic impact seemed to have been underestimated.

According to the *UNAIDS (Joint United Nations Programme on HIV/Aids) Annual Report* (2007:1), the global summary of the HIV and AIDS pandemic as at December 2007 is as follows:

- Number of people living with HIV and AIDS in 2007: 33.2 million. Of this number 30.8 million are adults, 15.4 million are women and 2.5 million are children under the age of 15 years.

- People infected with HIV in 2007: 2.5 million, of which 2.1 million are adults and 420 000 are children under the age of 15 years. The UNAIDS (2007:10) clarifies that there are over 68 000 new HIV infections a day and more than 96% are in low and middle income countries.
Foster (2007:1) adds that according to the annual report of the Joint United Nations Programme on HIV/AIDS, the number of new HIV infections a year is estimated to have peaked in the late 1990s at more than 3 million infections a year. This means that there is now a steady decline in the number of new infections.
- People who died from AIDS in 2007: 2.1 million of which 1.7 million are adults and 330 000 are children under the age of 15 years.

Cullinan (2007:9) comments that the UNAIDS estimate that 33.2 million people in the world are living with HIV and AIDS is over 6 million lower than estimates in 2006. The reason for this reduction is related to how numbers have been estimated, rather than effective prevention campaigns. Thus, the UNAIDS officials cautioned that the levelling off of HIV prevalence does not mean that HIV and AIDS are under control.

The mentioned global statistics of HIV and AIDS only serve to highlight, to the researcher, that this disease is still a pandemic and will continue to be for many years to come. Furthermore, statistics only give numbers of people infected with HIV and not how many are affected by the disease. An assumption can be made that every person that is living with HIV and AIDS has loved ones that are affected by the disease. This therefore implies that these statistics should preferably not be used as is. It is advisable to also factor in those that are affected by the disease, as this will give a more holistic picture of the impact of the pandemic.

2.5.2 SUB-SAHARAN AFRICA

The Sub-Saharan region consists mainly of developing countries (e.g. Zimbabwe and South Africa) which are faced with major political and socio-economic challenges that are related to the existing high levels of poverty.

Pelser *et al.* (2004:276) explain that the Sub-Saharan region is by far the worst infected region (with HIV and AIDS) in the world. HIV and AIDS have already surpassed malaria as the leading cause of death in the region and it kills more Africans than war does.

Skweyiya (2007:21) adds that it is significant to note that even though Sub-Saharan Africa constitutes slightly more than 10% of the world's population, it is home to more than 67% of people living with HIV and AIDS globally. It is thus important that Africans remain optimistic and determined to contain the pandemic. The researcher perceives dismantling the stigma against HIV and AIDS and proactive preventative programmes as important ingredients of a successful plan to curb the scourge of this disease.

The UNAIDS (2007:3) cites the following regional HIV and AIDS statistics in respect of the Sub-Saharan Africa as at December 2007:

- Adults and children living with HIV and AIDS in 2007: 22.5 million
- Adults and children newly infected with HIV and AIDS in 2007: 1.7 million
- Adult and child deaths due to HIV and AIDS in 2007: 1.6 million

These statistics, according to the researcher, indicate that the number of people living with HIV and AIDS is likely to stay the same for a while or increase, as the number of new infections is higher than that of those dying from the disease. This shows that there is minimal progress in turning the tide against HIV and AIDS

and this necessitates an on-going evaluation of existing preventative and intervention programmes, with specific focus on effectiveness and relevance.

2.5.3 SOUTH AFRICA

According to Evian (2003:20) South Africa was one of the last countries in Africa to be affected by the pandemic. Whiteside and Sunter (2000:59) add that, despite a relatively late start, HIV and AIDS have taken off in South Africa. The apartheid system may have delayed the onset of the epidemic, but its legacy provided a fertile environment for the rapid spread of HIV infection. This means that South Africa had time to plan strategically to manage the pandemic and contain it, but it seems the low prevalence rates in the late 1980s provided a comfort zone and more time was dedicated to changing the political landscape of the country. In the meantime the prevalence rates continued to increase.

Marais (2005:7) states the fact that South Africa is experiencing one of the most intense and probably the largest HIV and AIDS epidemic in the world. The epidemic in South Africa and several of its neighbours is unique in at least two respects: the national adult HIV prevalence in Southern Africa has soared to heights not seen anywhere else in the world. Secondly, with the exception of Zimbabwe, there is no sign yet of a nationwide decline in any of the national epidemics.

Foster (2007:1) supports this by stating that South Africa has the highest prevalence of HIV and AIDS in the world according to the annual United Nations report on the pandemic released recently. For the researcher, this means that the pandemic has reached a crisis point and it should be treated as such by both civil society and government.

Dickinson (2006:6) clarifies that the HIV and AIDS epidemic presents a major social and developmental challenge in South Africa. With a cure still remote, it is

anticipated that the country will have to deal with the epidemic for decades to come. The researcher agrees with Dickinson (2006), because HIV and AIDS in South Africa have become a reality of daily life. An average adult (in South Africa) knows someone who is either infected with HIV and AIDS or affected by it. It is true that a cure is still remote, but antiretroviral drugs have gone a long way to prolong the lives of those living with HIV and AIDS thus reducing the negative effects of the disease on individuals, families and communities.

Mail and Guardian's HIV/AIDS barometer (2007:34) states the fact that the Department of Health (using the 2006 National HIV and Syphilis Survey) estimates that 5.41 million South Africans are living with HIV; slightly lower than the previous estimate of 5.54 million. This could mean that the country's HIV prevalence may finally have entered a phase of decline.

According to the *HIV and AIDS and STI Strategic Plan for South Africa* (RSA, Department of Health, 2007:46), additional HIV and AIDS prevalence estimates for 2006 indicate that:

- 1.8 million AIDS deaths have occurred in South Africa since the start of the pandemic.
- 71% of all deaths in the 15 to 49 age groups were due to AIDS.

The assumed decline in HIV prevalence may indicate that the fight against the disease is finally having some impact. For the researcher, the impact is not significant enough and thus more needs to be done to seriously reduce these prevalence rates.

The UNAIDS (2007:16), in the AIDS epidemic update, states that the epidemic in South Africa varies considerably between provinces, from 15% in Western Cape to 39% in Kwa-Zulu Natal (Department of Health South Africa 2007). Dorrington, Johnson, Bradshaw and Daniel (2006:i) further mention that projections show

that the prevalence in most provinces is reaching a plateau, with Kwa-Zulu Natal the highest (estimated antenatal plateau of around 40%), the Western Cape the lowest (estimated plateau of around 17%) and the Northern Cape and Limpopo slightly higher than the Western Cape. The other provinces are expected to level off or peak at an antenatal prevalence of 30 to 35%.

The researcher is of the opinion that these statistics are not conclusive as they are based only on those who utilize public health facilities. Those who do not use these facilities will remain unaccounted for. However, these statistics remain important as they assist in giving an indication of the magnitude of the HIV and AIDS pandemic and inform relevant stakeholders in the HIV and AIDS field as to whether or not their policies and programmes address the needs of people living with HIV and AIDS.

Pembrey (2007a:7) adds that the future of the pandemic at least partially depends on the direction of the government's HIV and AIDS policies. Although the government has been criticized in the past for its HIV and AIDS policies, recent events, including the development of a new framework to guide the national response to HIV and AIDS from 2007 until 2011, suggest that they are now more committed to improving the situation.

2.5.4 MPUMALANGA

Mpumalanga, like other provinces in South Africa, has not been spared from the HIV and AIDS pandemic. It is predominantly rural with high levels of poverty, despite the fact that it is a major tourist attraction because of the Kruger National Park and other interesting sites. Poverty is well documented as being among the primary drivers of HIV and AIDS, meaning that the province had very little chance of not being affected by the pandemic.

Masinga (2007b:12) explains that according to an antenatal survey conducted in 2007, Mpumalanga was found to have the second highest HIV prevalence rate among pregnant women who use state health facilities at 32.1%. The district with the highest prevalence, a rate of 38.9%, is the Gert Sibande district which is in Secunda and covers the southern Highveld.

Masinga (2007b:12) adds that people between the ages of 20 and 24 are the most affected by the HIV and AIDS pandemic. This group should therefore be the primary target group of intervention programmes in the province.

Masinga (2007a:12) further states the fact that the Treatment Action Campaign (TAC) estimates that there are 400 000 people living with HIV in Mpumalanga, of which at least 160 000 need antiretroviral drugs. The Mpumalanga Provincial Government programmes supply antiretroviral drugs to only 14 700. The reason for this is said to be the Provincial Health Department's human resources, infrastructure and management problems.

The researcher finds this situation unacceptable as there are resources to minimize the impact of the pandemic to those infected and their families, and government officials are not taking responsibility for improving poor service delivery. This is contrary to the *Draft White Paper on Transforming Public Service Delivery: Batho Pele – People First* (RSA, Department of Public Service and Administration, 1997:7), which motivates treating public service users (including health services) with consideration and respect, and making sure that the promised level and quality of service is always of the highest quality.

Dorrington *et al.* (2007:75-76) cite the following HIV and AIDS indicators for Mpumalanga as at mid-2006:

- Total number of people living with HIV and AIDS: 446 000
- Accumulated AIDS death by mid-year: 189 000

The high prevalence of HIV and AIDS in this province calls for concern. The researcher concurs with Mahlangu's (2001:2) statement that:

To overcome the challenge that this disease poses, every one of us must play an active part. If you are a member of a church or non-governmental organization or a school that does not have a HIV/AIDS programme, see to it that you come together to draw up such a programme.

This implied that everyone had to work in partnership to address the challenges of HIV and AIDS in the community. Those who were more experienced in the field of HIV and AIDS were encouraged to capacitate novices for the benefit of service users.

2.6 THE HIV AND AIDS PANDEMIC IN THE EDUCATION SECTOR

HIV and AIDS is a worldwide pandemic and thus expected to affect the education sector. Kelly (2000:10) explained that HIV and AIDS affect the education sector just as it affects the body. For years the effects of the sickness remain unnoticed, then slightly more teachers began to be absent and some died, but no deaths were attributed to HIV and AIDS. Suddenly statistics start to show that the number of infected teachers was higher than the rest of the population and there was also a decline in the number of pupils and students. Then it sends a clear message that the sector could afford to remain silent, but needed to speak and do something about the pandemic.

Kelly (2000:45) adds that HIV and AIDS affect the education sector in the following ways:

- The demand for education
- Those who are its potential clients
- The sufficiency of its personnel to supply education services
- The content of what is being taught

- The process involved in the teaching
- How schools are organized
- The nature of the role of education
- The funds needed for education
- Aid agency involvement in the system
- Sector-wide planning and management.

The researcher is of the opinion that this means that the HIV and AIDS pandemic is pressuring the education sector to carefully look at the way they have been doing business and find ways to adapt to the rapidly changing needs of the sector.

The researcher's interest is not in the global education sector, but the South African education sector, especially the Mpumalanga province, as the focus of the research project is addressing the support needs of HIV and AIDS affected educators in the province. The researcher will thus deliberate on this with the aim of understanding how the pandemic affects the school community which in turn impacts on the broader society.

2.6.1 HIV AND AIDS: SOUTH AFRICAN EDUCATION SECTOR

The education sector plays a vital role in the socialization of children and, more specifically, provides the intellectual stimulation that assists the child to map the route to responsible adulthood.

Shisana *et al.* (2005: viii) maintain that the new millennium has ushered in several challenges to educators and education in general. However, none have been as daunting as the HIV and AIDS pandemic. Education is one of the most powerful weapons against HIV and AIDS. However, it is also a sector that is labour-intensive and therefore most vulnerable to the disease.

Simbayi *et al.* (2005:2) add that existing problems in the education sector, such as inadequately trained teachers, lack of infrastructure and high dropout rates, are longstanding problems now compounded by teacher shortfalls due to sickness, absenteeism and early death.

The researcher understands this to imply that the education sector has existing challenges that they had to deal with, one of them being the transformation from apartheid to an all-inclusive and democratic education department. Whilst trying to formulate a working plan HIV and AIDS hit and consequently the education sector has to re-strategize.

Shisana *et al.* (2005:xvi) report that research results showed that 12% of educators (from a sample of 24 200) who tested for HIV were HIV positive. The prevalence was the same for males and females (21.4%). The highest prevalence was among educators aged 25 to 34 years, followed by those aged 35 to 44 years.

Differences were observed when the analysis was restricted to women and men aged between 25 and 34 years, with women having a higher HIV prevalence. Shisana *et al.* (2005:115) clarify the fact that the combination of biology, gender construction, socio-economic status and behaviour contribute to high rates of HIV in women of this age group.

This is in line with the statement by Dorrington *et al.* (2006:9) that HIV and AIDS prevalence is higher in women than men for the 15 to 34 age group. Among women, the rate is highest (32.5%) for the age group 25 to 29 years. Pembrey (2007a:1) adds that in 2006, it was estimated that 21% of educators in South Africa were living with HIV and AIDS.

These statistics highlight the fact that the education sector is truly experiencing a crisis, because it is among the professions that are female dominated. So, the

high prevalence rate among female teachers in the age group 25 to 34 years suggests that this is not likely to decrease, because they are in the childbearing years and thus not using any protection because they want to procreate. This then makes them vulnerable to HIV infection.

Pelser *et al.* (2004:299) mention that it is also anticipated that HIV and AIDS will lead to declining school enrolments and delayed enrolments, due to household impacts of the epidemic. These are attributed to an increase in infant mortality, whereby the numbers of children entering school at age six or seven are reduced. This means that the demand for education is also affected by the pandemic.

Kelly (2000:10) concludes that responding to the challenges of designing and managing education in a world with HIV and AIDS requires more than piecemeal approaches. It requires mobilization of all sectors of society, flexibility, openness to change, willingness to loosen bureaucratic procedures and constraints, and sensitivity to the needs of those infected and affected by HIV and AIDS.

2.6.2 HIV AND AIDS: MPUMALANGA EDUCATION SECTOR

Mahlangu (2002:2), at the launch of the Mpumalanga traditional leaders HIV and AIDS task team, mentioned that:

We will eventually defeat this scourge when all of us as youth, as women, as business people, as workers, as religious people, as parents and teachers, as farmers and farm workers, as the unemployed, as professionals, as the rich and poor join hands. We are all invaluable allies in the fight against HIV/AIDS.

The researcher perceives this as emphasizing that it is only through a collective effort that HIV and AIDS will be managed in the province, meaning that it is not only the education sector's problem, but everybody's problem.

Shisana *et al.* (2005:119) claim that research regarding HIV prevalence among educators by province showed that Kwa-Zulu Natal and Mpumalanga had the highest prevalence. These findings suggest that more resources for HIV prevention, treatment and care would be needed by these provinces to reduce the impact of HIV on education. Unfortunately, according to Masinga (2007a:12), the Mpumalanga Provincial Government seems not to be fully committed to use available resources to manage the pandemic. The Auditor-General reported that 25% of the Provincial Health Department's HIV/AIDS conditional grant was returned unspent in the previous financial year, whilst there were clinics that regularly ran out of antiretroviral drugs. This means that patients were left without lifesaving medication and nobody was held accountable.

Masinga (2007a:12) further mentioned that it was not only the health department that was not performing. The Auditor-General found that the province was also failing to properly spend grants for feeding schemes in poor rural schools; children were thus going hungry unnecessarily. The feeding scheme mainly services orphaned and vulnerable children and it is the responsibility of the education department. Again no explanation was forthcoming from the relevant provincial department.

The *Mpumalanga Provincial Government Department of Education Annual Report* (2006:111-112) explains that systems have been put in place to address the pandemic among educators. The Department participates in the Prevention, Care, Treatment and Access Programme (for HIV and AIDS infected educators), a trade unions' initiative pilot project. Amongst others, the Programme provides access for educators to undergo voluntary counselling and testing, and receive free treatment. The Department of Education has also established an Employee Assistance Programme Unit in March 2006 which provides psychosocial support for HIV and AIDS affected and/or infected educators in the province.

For the researcher, these support services must be easily accessible to the educators otherwise they will just be strategies on paper.

2.7 HIV AND AIDS AFFECTED EDUCATORS

The education sector is staffed primarily by teachers and thus any intervention programme to mitigate the impact of the HIV and AIDS on the supply of education needs to identify educators as the primary target group, especially women in the age group between 25 and 34 years.

Theron (2005:56) maintains that HIV and AIDS sabotage education in the following ways:

- Educators are dying
- The quality of education is compromised because of fewer experienced teachers
- The demand for education is decreasing because few children are entering and/or remaining at school
- Education costs are going up because substitute and temporary teachers have to be employed.

The healthy teachers then have to fill in for their sick colleagues, resulting in high workloads and added responsibility. This thus taxes their psychological wellbeing and can lead to stress. The researcher is of the opinion that if the stress is not managed through relevant support services it can lead to increased absenteeism, thus compromising the number of teachers available to provide education.

Kelly (2000:69) elaborates that teachers are deeply affected personally by the incidence of HIV and AIDS among their relatives and colleagues, and by the fear and uncertainty about their personal infection status. Though these are major

causes of concern, they are areas in which little support is received. The unresolved HIV-related stresses that teachers experience in the classroom and at home need to be acknowledged and resolved. If not, it will be much more difficult for the teacher to incorporate HIV and AIDS issues into teaching encounters in a way that will enlighten students and help them adopt behaviour that will protect them against the likelihood of infection.

For the researcher, this means that even though the primary role of teachers is to teach, they cannot ignore societal/environmental issues that impact on them and their learners as members of families and communities. The success of an educational institution depends largely on whether it is situated in a well-resourced community, in terms of both material and human resources, or not. The educational institution cannot disconnect from its community and thus shares the challenges, achievements and problems of the community; it is part of the rhythm of the community it is situated in. The researcher therefore assumes that if there is a pandemic like HIV and AIDS affecting the community, it automatically affects the education sector serving that community.

Hall *et al.* (2005:23) cite research findings that indicate that educators were emotionally affected by HIV and AIDS: 6% were depressed because of colleagues who were living with or had died from HIV and AIDS, 13% were emotionally affected through HIV positive/affected learners, and 11% experienced feelings of sadness and depression because of relatives who had passed away or were living with HIV and AIDS. Therefore, being HIV and AIDS infected and/or affected impacted on them in the practice of their profession.

For those educators that are HIV and AIDS infected, Rehle, Shisana, Glencross and Colvin (2005:1) explain that the National Department of Health has released national guidelines for antiretroviral treatment to provide comprehensive care and treatment for people living with HIV and AIDS. The programme responds to the

needs of all people at all stages of HIV infection and attempts to slow progression and maintain the person at the highest functional level.

Simbayi *et al.* (2005:2-3) further explain that the South African Department of Labour requires that each workplace develop a policy to deal with HIV and AIDS. This also applies to the education sector employer. The policy is expected to include:

- The organization's position on HIV and AIDS
- An outline of the HIV and AIDS programme
- Details on employment policies
- Express standards of behaviour expected of employees and employers
- Stated means of communication within the organization on HIV and AIDS issues
- Details of employee assistance available to persons affected by HIV and AIDS
- Details of implementation responsibilities
- Monitoring and evaluation mechanisms

Simbayi *et al.* (2005:3) clarify that the entire National Department of Education has been undergoing transformation for at least 10 years and there are still challenges. In addition, there is a scarcity of resources. This is a really difficult context in which to formulate and implement policy.

The Department of Education therefore had to formulate HIV and AIDS policies to comply with the Department of Labour's directive. A number of policies were then formulated with the most important being, according to the researcher, the *National Policy on HIV/AIDS for learners and educators in public schools, students and educators in further education and training institutions of 1999* (RSA, Department of Education, 1999). It is a comprehensive policy that gives guidelines on what should be done to manage the impact of HIV and AIDS at all

levels of the education department, especially at local level where the impact is more direct.

Furthermore, it does not only focus on educators but all parties in the education sector, including learners, parents and the broader community (RSA, Department of Education, 1999). It basically covers most of the points that the Department of Labour expects an HIV and AIDS policy to cover.

The researcher perceives the HIV and AIDS treatment plan by the Department of Health (RSA, Department of Health, 2007) and the *National Policy for educators and learners in public schools, students and educators in further education and training institutions* (RSA, Department of Education, 1999) as providing a comprehensive framework for support structures for educators and learners that are HIV and AIDS affected and/or infected.

Furthermore, through the *HIV and AIDS and STI Strategic Plan for South Africa* (RSA, Department of Health, 2007:8,11), the national government has committed itself to a multi-sectoral response to the challenges of the HIV and AIDS pandemic and its widespread impact. It flows from the National Strategic Plan of 2000 to 2005 as well as the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment. It is informed by the nature, dynamics and character of the epidemic, as well as developments in medical and scientific knowledge. Provinces, local authorities, the private sector and a range of community based organizations are the main implementing bodies of the Strategic Plan. Each government department has a focal person and team responsible for planning, budgeting, implementing and monitoring HIV and AIDS interventions.

With all the strategic and implementation plans in place, the researcher's concern is whether or not they will make a real difference to the lives of those infected and/or affected by HIV and AIDS, specifically in the education sector. The

mentioned plans need to ensure that there are working support structures for educators that are HIV and AIDS affected and/or infected.

2.8 AVAILABLE SUPPORT STRUCTURES FOR HIV AND AIDS AFFECTED EDUCATORS

The school environment, though primarily an educational institution, has characteristics of a community. It has its own norms and values that are informed by the National Department of Education and the society in which it is situated. What makes it unique is that it consists of learners, educators, support staff and parents who have contact almost daily. This results in relationships forming and therefore it becomes difficult not to get involved when a member or members of this community is/are hurting.

This community finds itself faced with the HIV and AIDS pandemic, like other communities in the country. Members are expected to give support to each other and be united against the pandemic, but secrecy and stigma surrounding the disease make it difficult to openly talk about it and deal with it head on. Everyone is affected by the pandemic; containing it and coping with its psychosocial implications is the challenge.

Page, Louw and Pakkari (2006:112) highlight the fact that organizations and other places of work, civil or government entities, in South Africa are not doing enough to intervene in the pandemic. This includes the education sector as a place of work. Page *et al.* (2006:113) therefore propose an HIV and AIDS workplace programme that educates employees to deal with the pandemic, teaching them what to do to reduce the risk of infection and how to reduce ignorance and prejudice against those that are living with HIV and AIDS. Furthermore, education must also help reduce the potential fear or disruption of work among employees who have HIV positive colleagues and enhance the coping mechanisms of all employees.

The National Department of Education is therefore expected, as an employer of educators, to develop HIV and AIDS workplace policies and ensure that it is properly implemented.

According to Simbayi *et al.* (2005:2), since 1994 the National Department of Education has developed a number of policies to address the education needs of the new democratic South Africa. HIV and AIDS policies were also developed in this process. The researcher will briefly discuss two policies, namely the *National Policy on HIV/AIDS for learners and educators in public schools and students and educators in further education and training institutions* and the *Department of Education Workplace Policy for HIV/AIDS*. These policies directly inform the National Department's and provincial education departments' response to the HIV and AIDS pandemic.

Simbayi *et al.* (2005:31) summarize the mentioned policies as follows:

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

The core elements of the policy deal with issues of rights as entrenched in the country's Constitution, including the right to education, protection from discrimination, privacy, basic freedoms, a safe environment and the best interest of the child. Through this policy the Department of Education acknowledges that there are learners and educators in its institutions that are infected or affected by HIV and AIDS and empowers institutions to be proactive in their response to the pandemic. The policy also recommends that each school have a strategic plan, accompanied by an implementation plan, to cope with the pandemic. Furthermore, it calls for a concerted struggle against HIV and AIDS by all organs of the society and

that schools should work closely with local communities to provide information and support.

The researcher is of the opinion that the policy is all-inclusive, but still lacks specific guidelines regarding support for HIV and AIDS affected educators. It appears that this is left to the formulators of the school based strategic plan. Theron (2005:59) adds that the mentioned National Policy on HIV/AIDS has succeeded in inculcating civilized attitudes, but does not address the systemic ramifications that educator attrition and morbidity hold. There is a need for an education policy that specifically gives guidelines to the education systems for the management of the reality of HIV.

- **Department of Education Workplace Policy for HIV/AIDS:**

Simbayi *et al.* (2005:34) explain that its main objectives are to create a supportive environment for employees living with and affected by HIV and AIDS, to eliminate discrimination against persons with HIV and AIDS, inform employees about their rights, and protect persons potentially exposed to HIV at work. The content of the policy addresses the practical needs of employees and includes issues such as employee benefits, HIV/AIDS workplace programmes, ill-health retirement, universal precautions and advocacy.

The researcher's view about this policy is that it primarily caters for the needs of educators as employees of the Department of Education and gives guidelines on how to support HIV and AIDS infected and/or affected educators. It appears though it is again left to the provincial education departments and educational institutions to implement the policy. The education institution's primary role is to educate learners/students and

thus there is a tendency to put other important issues happening in the institution aside, including HIV and AIDS.

For the researcher, both policies have to be implemented, together with proper and regular monitoring and evaluation, to be able to address the true realities and support needs of educators affected by HIV and AIDS.

Simbayi *et al.* (2005:121) report that research findings indicated that a slight majority of educators mentioned that they receive proportionally more support from their trade union, the Department of Education and religious groups in the community for their role in HIV and AIDS work and education. This means, according to the researcher, that the Department of Education has some shortcomings with implementation of the mentioned policies and therefore organized labour unions stepped in to provide the needed support to their members.

McElligott (2005:1) elaborates on the trade union involvement by explaining that four South African teachers' unions joined with the United States of America and South African partners to save the lives of teachers through an innovative programme combining peer education, HIV testing, counselling and antiretroviral treatment to those who need it.

The programme is called "Prevention, Care, Treatment Access for South African educators" (PCTA). The programme was piloted for two years (2005-2007) and ought to train 7 500 peer educators and provide antiretroviral treatment to 2 300 educators and their spouses in the Kwa-Zulu Natal, Mpumalanga and Eastern Cape provinces. The programme focused on educators who are HIV positive and their spouses; affected educators were not accommodated.

Theron (2006:35) recommends, from research findings, a comprehensive support programme to ensure the overall wellness of HIV and AIDS affected educators. The programme should focus on the following:

- Learning and teaching about HIV and AIDS
- Education environment support (for example, Employee Assistance Programmes)
- Support for educator wellness (for example, health workers at schools)
- Social sector support (for example, social workers, lay counsellors and school based support groups)

The researcher's understanding is that the recommendations by Theron (2006) suggest that the support needs of HIV and AIDS affected educators are still unmet, in spite of the mentioned policies of the Department of Education and the trade unions' Prevention, Care, Treatment Access (PCTA) project.

In 2006 the University of North West (Vaal Triangle Campus) took the initiative of addressing this gap through compiling a support programme called "Resilient Educators (REds) Support Programme," focusing specifically on the identified support needs of HIV and AIDS affected educators. The support programme is an interactive, seven module programme that empowers educators with, amongst others, information about HIV and AIDS, how to give and gain support and manage stress. As the focus of this study is the evaluation of the effectiveness of REds in supporting and empowering HIV and AIDS affected educators, the programme will be discussed in detail in the next chapter.

The researcher concludes that the combined effort of the Department of Education's policies, the trade unions' PCTA and the REds Support Programme will empower educators to cope with the pandemic as individuals, as employees, as colleagues, as family members and as members of the community. They will become assets in the education sector and in the society at large.

2.9 CONCLUSION

The HIV and AIDS pandemic has been around for more than two decades and to date the war against it is still being fought in many sectors, including the education sector, seemingly without much success.

Statistics on the prevalence of the pandemic continue to remind society that no one is really winning this war. The fact that there is still no cure has implications for all, HIV and AIDS infected and affected. This includes the education sector and therefore a lot of effort and resources needs to be put in place to ensure that the prevalence of HIV and AIDS in the sector decreases significantly.

In trying to manage the HIV and AIDS pandemic in the education sector, the Department of Education may consider equipping educators with information and skills to cope with the challenges of being HIV and AIDS affected and/or infected. The knowledge gained will empower and support educators to feel confident in engaging in HIV and AIDS school based programmes and thus be resourceful to their colleagues and learners. The REds Support Programme for HIV and AIDS affected educators is relevant in this context, as one of its goals is to empower educators to cope with being HIV and AIDS affected and be resilient in the face of the pandemic.

The next chapter focuses on a detailed account of the REds Support Programme which aims to support and empower educators that are HIV and AIDS affected in order to achieve and maintain resilience.

CHAPTER 3

RESILIENT EDUCATORS SUPPORT PROGRAMME FOR HIV AND AIDS AFFECTED EDUCATORS

3.1 INTRODUCTION

Support is explained in different ways depending on the context, but it is commonly understood as “being there” for one another in a time of need. Educators are expected to be there for their learners, colleagues and in some instances even for the community, because they are regarded as enlightened and therefore assumed to be resourceful in many respects.

In as much as educators are expected to act as support systems for others, they also need support, especially in light of the HIV and AIDS pandemic. Theron (2005), based on research findings, highlighted a need for a support programme that addresses the specific challenges of educators affected by HIV and AIDS, as existing support structures were found to be inadequate.

The Resilient Educators (REds) Support Programme was then compiled by the University of North West in 2006 to address the support needs of HIV and AIDS affected educators. The aim of REds is therefore to equip educators with information and some skills to cope with being HIV and AIDS affected and support others who are HIV and AIDS affected and/or infected, irrespective of whether they are in the school environment or not.

The REds Support Programme is implemented in phases; with each phase it is modified to meet the needs of a broader audience of educators. The first phase was implemented in 2006 in a school in the Gauteng province. Recommendations made from the first phase were used to modify it for a phase

two implementation in the Mpumalanga, North West and Free State provinces. The researcher therefore participated in the phase two implementation of the programme in Mpumalanga.

The aim of this chapter is to provide the content of the second version of REds as implemented by the researcher.

3.2 CONTENTS OF REDS SUPPORT PROGRAMME

The REds Support Programme, as indicated in Chapter 2, is an interactive programme, that is to say its success depends on both the facilitator's and the participants' full engagement in the programme. The facilitator is allowed to work with a group of 8 to 10 members at a time for meaningful impact. For the purposes of this research project, the researcher worked with 10 respondents/participants.

The programme consists of eight sessions, covering seven modules, with each session lasting about two hours. The modules and topics which form the core of the REds programme are:

- Module 1: How to gain and give support
- Module 2: How to cope with stigma
- Module 3: How to cope with stress
- Module 4: Workplace policies on HIV and AIDS
- Module 5: Health education: staying healthy despite the HIV and AIDS pandemic (HIV/AIDS manual for educators Part 1 & 2)
- Module 6: Health education: nursing ill loved ones (HIV/AIDS manual for educators Part 3 & 4)
- Module 7: Resilient in a pandemic

In brief the sessions, as extracted from both the facilitator's and participants' manuals, entail the following:

Session 1: Introduction

The **objectives** of the session were:

- To get to know each other
- To explore the key concepts related to REs
- To explore the ethical boundaries governing REs
- To determine group rules for REs

Facilitation materials used:

- 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*.
- Reflection worksheets (session evaluation forms)

Content

The facilitator started with an icebreaker, the symbol worksheet, which was used to explore the impact of the pandemic on the participants.

This was followed by a discussion of key concepts, namely what "being HIV and AIDS affected" means, and what is meant by "support" and "resilience". The facilitator and participants gave input using the manuals as a guide.

Once the participants had a common understanding of these core concepts, the facilitator facilitated a discussion on the purpose of REs, what participants could expect from the programme and the rules of participation.

Ethical clarification, for example, protection of privacy and anonymity of the participants, was then discussed with the facilitator explaining the ethics she had to adhere to as a researcher and how participants were protected by these ethics. When the facilitator was convinced that the participants understood the ethics, she issued consent forms for completion and signing by the participants as written proof that they voluntarily consent to participate in the study.

The facilitator ended the session by summarizing what had transpired in the session and distributed copies of, and read a poem by Portia Nelson.

The last activity was the completion of the reflection worksheets (session evaluation form).

Session 2, Module 1: How to give and gain support

The **objectives** of the session were:

- To provide information regarding resources for educators
- To provide information regarding supportive resources for Orphaned and Vulnerable Children
- To provide some grief and bereavement skills for educators
- To provide some grief and bereavement skills for learners coping with grief and death

Facilitation materials used:

- Handouts and/or booklets on how to support and help orphaned and vulnerable children (OVCs)
- Crayons and poster paper for resources' list
- Two case studies
- Tape recorder
- An inspirational song
- Reflection worksheet

Content

The facilitator started the session with the blindfolding icebreaker that explored the issue of trust. A volunteer was blindfolded and had to rely on other participants to ensure that she did not stumble and fall.

Support for ill loved ones was next, with both facilitator and participants sharing ideas on what could be done to give support and what support resources were available in the community for HIV and AIDS affected and infected people, educators and learners included.

Participants then compiled, as a group, a list of local support structures and services for HIV and AIDS affected and/or infected people on the poster and decorated it with the crayons. The participants took responsibility to put up the poster at a central point in the school where everyone could see it.

This was followed by a discussion on support for orphaned and vulnerable children, looking at available resources locally, provincially and nationally.

The discussion was facilitated through the use of the case studies to explore the needs of orphaned and vulnerable children in small groups, and concluded with reading guidelines from the participants' manual on how to support grieving learners and/or colleagues, including skills on how to assist learners to cope with loss and bereavement.

The facilitator played an inspirational song to end the session followed by the completion of reflection worksheets.

Session 3, Module 2: How to cope with stigma

The **objectives** of this session were:

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

Facilitation materials used:

- Handout with seven pictures depicting stigma
- Pencils for drawing a school/community without stigma
- Handout on “Inspiring Thoughts” by an unknown author
- Reflection worksheets

Content

An icebreaker, a handout with seven pictures depicting stigma, was used to introduce the concept of stigma. Stigma is explained in the participants’ manual as labelling someone and seeing them as inferior because of an attribute they have (Change Project, 2005:12).

The participants, in pairs, had to choose two pictures that best represented stigma. This was then shared with the rest of the group and the participants gave reasons why they chose specific pictures.

The facilitator led the group to a discussion on what stigma entails, types of stigma, how to tackle stigma using text and an exercise from the participants’ manual. Brainstorming was used to facilitate discussion.

Participants then drew a picture of a school/community without stigma as a group.

The session was concluded with the reading of an inspiring text by an unknown author to participants and the completion of reflection worksheets.

Session 4, Module 3: How to cope with stress

The **objectives** of the session were:

- To explore the concept of stress
- To explore coping mechanisms for addressing stress

Facilitation materials used:

- Clay
- Tape recorder
- Relaxation music
- Reflection worksheet

Content

The session started with a stress relieving icebreaker. The facilitator gave each participant a piece of clay to make something that symbolized stress. Participants displayed their creativity and humour with this icebreaker. For example, one of the participants made a woman with a heavy pot on her head which she struggled to put down. Participants then shared amongst themselves what each participant made and why.

The discussion on stress then continued, using text from the participants' manual, with a definition of stress, the identification of stress and stress management. Furthermore, ways of combating work stress, such as reducing environmental stress and time management, were explored. The facilitator used questioning skills to encourage the full participation of all participants, including the quiet group members.

In addition, participants were given an exercise from the manual to practice good time management. Most of the participants used examples from their work environment.

The facilitator played her own choice of relaxation music to conclude the session, and then reflection worksheets were issued and completed.

Session 5, Module 4: Workplace policies on HIV and AIDS

The **objectives** of the session were to provide up-to-date information on:

- The provisions of legislation on HIV and AIDS in education
- Educator rights with regard to discrimination in the context of HIV and AIDS
- Educator rights with regard to absenteeism and leave in the context of HIV and AIDS
- Educator rights with regard to protection at school against HIV and AIDS
- A supportive school environment in the context of HIV and AIDS

Facilitation materials used:

- Quiz 1 on educators' rights with regard to discrimination against HIV and AIDS
- Quiz 2 on educators' rights with regard to leave
- A plastic cup
- Copies of handout "Put the glass down" from an unknown author
- Reflection worksheets

Content

The facilitator introduced the notion of rights using an icebreaker which involved giving each participant a cup of water and asking them to hold it in the air for

about 10 minutes and then observing their reaction. Their reactions are then discussed highlighting the right to choose to keep holding the cup or not.

A discussion on the Department of Education's workplace policies on HIV and AIDS followed. Quiz 1 was used to assess the participants' familiarity with the policies. Participants' knowledge on the policies was good. However, they requested more information on labour laws governing incapacity and/or chronic disease in the workplace, which the facilitator provided. The facilitator also referred them to the relevant resources.

Participants were quizzed again with Quiz 2 on educator rights in relation to leave provision. After their responses were discussed, additional clarifications were made using the manual.

Protection against HIV infection in the school was the next topic addressed, using the manual as a guide.

Then focus moved to a discussion covering the following: what participants needed to do to create or maintain a supportive school environment for those that are HIV and AIDS affected and/or infected, a proposal for an **Educator Support Team** and **Health Advisory Committee**, and how to eliminate all forms of discrimination against people who are HIV and AIDS affected and/or infected. The facilitator used probing to ensure that all participants understood the concepts as explained in the manual.

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

Session 6 and 7, Module 5 and 6: Health education on staying healthy despite the HIV and AIDS pandemic and nursing ill loved ones

The **objectives** of Module 5 and 6 were:

- To be knowledgeable on the facts about HIV and AIDS
- To acquire knowledge on how to help the infected and affected to stay healthy
- To care for the dying
- To know how to identify and manage common AIDS-related health problems in the home
- To recognize danger signs and learn when and how to seek more help
- To assist educators to feel more confident and comfortable, by enabling them to help themselves and their family members

Facilitation material used:

- Facilitator's and participants' manuals
- Reflection worksheets

It was recommended, in the facilitator's manual, that the two sessions/modules be presented on the same day for continuity purposes. The modules consists of four parts with part 1 and 2 being module 5 (session 6) and parts 3 and 4 being module 6 (session 7).

Content

Part 1: Facts about HIV and AIDS

The facilitator started by reading a case study, the story of Yulia and Mukasa (Addendum A in the participants' manual), which illustrated how one can be infected, how the virus spreads and its effects on family and community life. The facilitator used the story and information from the participants' manual to facilitate a discussion on what HIV and AIDS are, how HIV is transmitted, how to use a

condom, preventing transmission of HIV in the home, avoiding other infections and ending with a discussion on the stages of HIV and AIDS.

Part 2: Care for the sick at home

Topics discussed included nutrition and HIV and AIDS, what foods to eat and how to prepare them at home, personal and environmental hygiene, infection control at home and lastly, a general guide on the use of medicines.

Participants were then issued with reflection worksheets to complete as evaluation for session 6.

Part 3: Care for the dying

The facilitator started by discussing the concept of death and highlighted that, when dealing with HIV and AIDS, this issue has to be dealt with because it is an eventuality.

The story of Yulia and Mukasa was used to illustrate the support needs during the terminal stages of the disease and what can be done to manage the process. A number of guidelines were read from the participants' manual on what to do to care for a dying person.

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

This section focuses on general symptom management of the following HIV and AIDS related health problems:

- Anxiety: constant worrisome thoughts and tension experienced as, amongst others, tight muscles, headaches, breathing problems, irritability or trouble sleeping
- Constipation: taking days before passing stools
- Different types of coughs

- Depression: feeling low, sad or “blue” normally associated with having trouble sleeping and a loss of appetite
- Diarrhoea: three or more watery stools per day
- Dizziness: black outs when trying to stand
- Fever: abnormally high body temperature often accompanied by chills and shivering
- Forgetfulness, poor memory or difficulty 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 sleeping
- Weight loss of 10% of your usual body weight when you did not intend to lose weight
- Oral thrush: painful whitish or reddish sores in the mouth that may make eating difficult
- Vaginal itching, burning and discharge: a profuse, slimy, offensive and yellowish discharge

The facilitator used clarification, reflection of content, advice giving, and questioning skills to ensure that participants understood these health conditions and emphasized that although the manual gave advice on how to manage them at home, they have to use public or private health services first for proper

medical diagnosis, treatment and care. Self-care strategies should be used for hygiene purposes and to facilitate speedy recovery.

The session ended with the completion of reflection worksheets.

Session 8, Module 7: Resilient in a pandemic

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

- To contemplate participant resilience
- To contemplate further steps towards resilience
- To emphasize our connectedness to others for the purposes of resilience
- To conclude REds

Facilitation materials needed:

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

An icebreaker in the form of a video is used to illustrate resilience in the face of the pandemic.

The facilitator did not have access to a television and had to find an alternative. The facilitator read a text, in summarized form, from the book "*I have life: Alison's journey*". The story is about the quest for survival against all odds by a South African woman. The story was thus used to illustrate resilience in the face of the pandemic. The participants found the story relevant and inspirational.

The group re-visited the concept of resilience and compared their responses to those given at the first session. The comparison revealed that their understanding of resilience had improved.

This was followed by brainstorming on ways to maintain resilience and a discussion on the six steps towards resilience, as well as the A to Z of resilience as explained in the participants' manual.

The remaining part of the session was used to debrief participants, contract for a follow-up session (in approximately three months), complete the reflection worksheets and set a date for issuing of certificates.

The participants, after completing the programme, are expected to implement what they have learned to cope with the pandemic and also be a source of support for others in the school environment and the community.

3.3 CONCLUSION

The researcher used group work facilitation techniques and strategies such as probing, brainstorming and role-play to equip participants with practical information on what to do in the face of the pandemic. Because of its interactive nature input from participants made it very interesting, as different points of view were discussed and myths and misconceptions about HIV and AIDS clarified.

Drower (2005:113) adds that, in group work, the function of the facilitator is to support the development of group identity through emphasizing commonality and encouraging inter-member communication. The group becomes a mutual aid system in which members are facilitated to lend their resources and strengths to each other. The group as a whole and its individual members are both the means to and the ends of growth and change.

The aim of REds is therefore to create the mutual aid system for participants, which should in turn benefit their colleagues, learners, significant others and the broader community.

In the next chapter the researcher will deliberate on how the participants, 10 educators from Sozama High School in Middelburg, Mpumalanga, experienced the REds Support Programme. The focus of Chapter 4 is therefore on the analysis and interpretation of qualitative and quantitative data gathered from the participants, before and after exposure to REds. Qualitative data gathered from the school management team on the observed difference among participants after completion of the REds programme will be included in the chapter.

CHAPTER 4

EMPIRICAL RESEARCH FINDINGS

4.1 INTRODUCTION

The focus of this chapter is the analysis and interpretation of qualitative and quantitative data gathered from the respondents. The aim is to establish, using data gathered, whether or not the Resilient Educators (REds) Support Programme was effective in supporting and empowering HIV and AIDS affected educators in Mpumalanga.

The researcher will firstly mention the goal and objectives of the research and the research question. Thereafter, a discussion of the research methodology will be cited. This will be followed by an analysis and interpretation of both qualitative and quantitative research findings. The researcher will discuss the two types of data gathered separately.

4.1.1 GOAL OF THE RESEARCH

The goal of the study was to evaluate the effectiveness of the Resilient Educators (REds) Support Programme in supporting and empowering HIV and AIDS affected educators in Mpumalanga.

4.1.2 OBJECTIVES OF THE RESEARCH

In order to achieve the goal of the study, the following objectives were formulated:

- To conceptualize theoretically the phenomenon of HIV and AIDS and the impact thereof on the school environment as an educational setting, with specific focus on HIV and AIDS affected educators
- To implement the improved version of REds to HIV and AIDS affected educators in Mpumalanga
- To evaluate the effectiveness of the improved version of REds in supporting and empowering HIV and AIDS affected educators in Mpumalanga
- To make recommendations based on the research findings to improve REds, in order to implement it to a broader audience of educators.

4.1.3 RESEARCH QUESTION

The study was guided by the following research question:

“How effective is the improved version of REds in supporting and empowering educators affected by HIV and AIDS in Mpumalanga?”

4.2 RESEARCH METHODOLOGY

The following research methodology was used:

Research approach

The researcher adopted the dominant-less-dominant model, a combination of quantitative and qualitative approaches (Cresswell in De Vos, 2002:365-366), as the most appropriate approach for this research, with the quantitative approach as the primary approach and the qualitative approach being the less dominant approach.

Although the research project was primarily quantitative in nature, it was necessary to neutralize any bias that might arise from this approach, and thus the qualitative approach was used as triangulation (Cresswell in De Vos, 2005:361).

Type of research

In this study, the researcher used programme evaluation research in the context of applied research. The researcher chose evaluation research, as a type of applied research, because research data gathered has a specific purpose for practice; it will enable modification of the programme to ensure relevance (Patton in De Vos, 2005:369).

Research design and procedures

Research design: This study used both quantitative and qualitative research procedures; therefore two different designs were applicable:

- **Quantitative design:** For the quantitative approach, the researcher used the quasi-experimental, one-group pretest-posttest design (Neuman in Fouché & De Vos, 2005:133) because the respondents were a group of 10 educators (experimental group) and there was no control group to compare the results with. In this design, there was a measurement of the dependent variables, namely support and empowerment, when there was no independent variable, REds Support Programme, present. Subsequently the independent variable (REds) was introduced, followed by a repeated measurement of the dependent variables (support and empowerment). Measures of the dependent variables pre-test and post-test were then compared to evaluate the effectiveness of the independent variable on the respondents.

- **Qualitative design:** The researcher utilized the collective case study design. The collective case study, according to Punch (2005:144), is where the instrumental case study is extended to cover several cases to learn more about the phenomenon, the population being studied or the general condition. The researcher was of the opinion that this is in line with what the research project aimed to achieve, namely to understand the support needs of HIV and AIDS affected educators as a social issue.

Methods of data collection

- **Quantitative data collection method:** Data were collected using a group administered standardized questionnaire, namely the Professional Quality of Life Scale, referred to as ProQOL (Stamm, 2005), consisting of 30 questions. The questionnaire was administered before (pre-test) and after (post-test) the respondents were exposed to REs (see Appendix D & G). The results of the pre- and post-tests were then compared in order to evaluate the effectiveness of the programme.
- **Qualitative data collection methods:** The researcher used different data collection methods, namely a non-standardized questionnaire with drawings, interviews, observations and field notes. Each one is briefly discussed as follows:
 - The **non-standardized questionnaire** was administered to the respondents (the educators) before and after exposure to REs. It consisted of five open-ended questions in the form of incomplete sentences and a section for the drawing of symbols, showing how the HIV and AIDS pandemic had affected the respondents (see Appendix E & H).

- The researcher also utilized **semi-structured face-to-face interview schedules** to collect data from both the respondents (10 educators) and the five members of the school management team (principal, deputy principal and three heads of departments). With the respondents (10 educators), interviews were conducted pre- and post-exposure to REds, whilst with the school management team interviews were only conducted after the respondents (10 educators) had completed REds.

The pre-test, semi-structured interview schedule consisted of seven open-ended questions which aimed to elicit data from the respondents (10 educators) on how the pandemic affected them and what coping mechanisms they used, if they were coping at all (see Appendix F). The post-test semi-structured interview schedule, on the other hand, consisted of two open-ended questions and a third item, in which respondents were expected to write a short narration on how the REds Support Programme has impacted on them (see Appendix I).

The semi-structured interview schedule for the school management team consisted of four open-ended questions which aimed to gather data on whether or not the team had observed any difference among the respondents (10 educators) after exposure to REds (see Appendix K) regarding empowerment and support for themselves and others .

- **Observations and field notes** during implementation of REds were taken as additional methods of qualitative data collection. Observations of group members' interaction and discussions during the training sessions were noted by the researcher and the research assistant. The research assistant was a qualified social

worker and a first year Social Work Masters degree student (at the University of Pretoria) and therefore knowledgeable in research. The researcher briefed him about the role of a research assistant in the context of this research project, which was mainly that of a non-participant observer, and the important role of group work skills in observation. The field notes were taken by tape recorder and note taking after each session, in order to capture data on the group process and any other data that were relevant for the evaluation of the programme.

All these methods of data collection were employed to ensure that any limitation that arose from one method was covered by another.

Data analysis

Quantitative data analysis: The analysis of data from the Professional Quality of Life Scale (Stamm, 2005) was done by a statistician from the Statistical Services of the Vaal Triangle Campus of the North West University. Data from this study was analyzed through statistical procedures using computer application software and then displayed by means of tables and graphic presentations.

Qualitative data analysis: Data gathered from the non-standardized questionnaire, interviews and field notes were content analyzed. The researcher used coding and memoing to content analyze the questionnaire responses, interviews, and observation and field notes. In practical terms it means that, based on coding and memoing, the researcher categorized the information in themes and sub-themes with the aim of identifying patterns, relationships and commonalities or disparities.

The drawings on the other hand were analyzed using face value interpretation, without any theoretical frame of reference.

Description of the population, sample and sampling method

Description of the population: The universe, in this study, was all HIV and AIDS affected educators in Mpumalanga. The population, on the other hand, was all the HIV and AIDS affected educators in Sozama High School in Middelburg, Mpumalanga.

Description of the sample and sampling method: For the purpose of this study, the researcher adopted a non-probability sampling method, namely volunteer sampling (Saunders *et al.* 2003:177), to compose the group of research respondents, that is to say the HIV and AIDS affected educators at Sozama High School in Middelburg, Mpumalanga.

The researcher approached the principal of Sozama High School and negotiated the implementation of the research project at the school. After consent was granted, the principal arranged several meetings with all the educators in the school where the researcher recruited respondents for the research project. Eventually 10 educators volunteered to participate in the project.

No sampling method was applicable to select the school management team, because the whole team (population) was interviewed.

The identified management team members and the educators were informed about the purpose and procedures of the study and reasons for recruiting them as respondents.

4.3 EMPIRICAL FINDINGS

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

4.3.1 SECTION A: BIOGRAPHICAL PROFILE OF THE RESPONDENTS

The research project consisted of two groups of respondents, namely the 10 HIV and AIDS affected educators as the primary respondents and the five members of the school management team as the secondary respondents.

The profile of both groups of respondents is presented separately in the next heading.

4.3.1.1 Biographical profile of the HIV and AIDS affected educators

The biographical profile of the 10 primary respondents (educators) encompasses gender, age, ethnicity, marital status, educational qualifications and years of experience as educators. These are presented as follows:

Gender

The group consisted of nine females and one male. The researcher is of the opinion that this is expected as the teaching profession is dominated by females.

Age

Table 1: Age of the respondents

30 – 34 years	3
35 – 39 years	2
40 – 44 years	5

The age of the respondents indicates that 70% are in the developmental stage of middle adulthood, that is to say 35 to 44, whilst 30% are in early adulthood (Santrock, 1997:20).

Ethnicity

Table 2: Ethnicity of the respondents

Sotho (Pedi, S. Sotho)	3
Nguni (Zulu, Ndebele, Swati)	7

The majority of the respondents are Nguni and they communicate in iSiZulu with an influence of Ndebele language, which is the dominant language in Middelburg, followed by SePedi as the second dominant language.

Marital status of the respondents

The marital status of the respondents is as presented in Diagram 1; five respondents are married, three are single and two are divorced. This implies that 50% of the respondents are married.

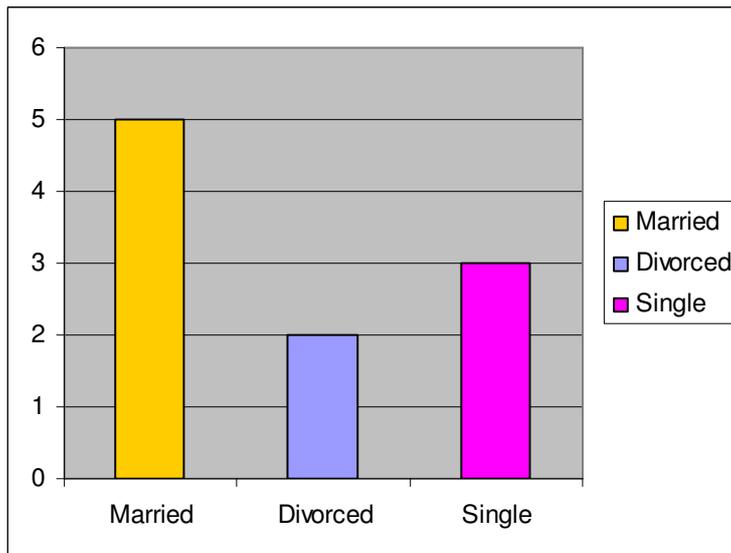


Diagram 1: Marital status of the respondents

Educational qualifications

Eight respondents have a junior Diploma in Education only, whilst two respondents have junior Degrees in Education and post-graduate qualifications.

Years of experience as educators

Table 3: Years of experience as educators

< 1 year	0
2 – 6 years	2
7 – 11 years	3
12 – 16 years	3
17 – 21 years	2

Table 3 shows that none of the respondents are new in the profession, with more than 50% having more than 10 years experience as educators.

The profile of the 10 educators has given background information on the identity of the primary respondents. In the next heading the researcher focuses on the profile of the school management team.

4.3.1.2 Biographical profile of the school management team

For the school management team, namely the five secondary respondents, the biographical profile will focus on gender, years of experience as educators and their position/title in the school.

Gender

The school management team consisted of three males and two females.

Years of experience as educators

Table 4: Years of experience as educators

< 14 years	0
15 – 19 years	3
20 – 24 years	2

The researcher observed that the team consists of educators that have more than 15 years experience as educators, which implies that they have professional knowledge and experience to mentor and guide other educators in the school.

Position/title in the school

The school management team consisted of three Heads of Departments, the Deputy Principal and the Principal. These are all senior staff members.

The biographical profile of the school management team has highlighted the experience that they have to lead the staff and learners, including the primary respondents, that is to say the 10 HIV and AIDS affected educators.

The next heading focuses on the quantitative research findings.

4.3.2 SECTION B: QUANTITATIVE RESEARCH FINDINGS

4.3.2.1 The measuring instrument

Quantitative data were gathered from the 10 respondents (HIV and AIDS affected educators) using the ProQOL standardized questionnaire, before (pre-test) and after (post-test) exposure to REs (see Appendix D & G). As indicated earlier, the questionnaire consisted of thirty questions that the respondents had to answer. The only instruction given was:

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

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

An example of a question is:

1. I am happy

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

Within the context of this study the dependent variables, namely support and empowerment were measured with ProQOL based on the following three constructs: compassion satisfaction, burnout and secondary trauma. These constructs are defined in the ProQOL Manual (Stamm, 2005: 5) as follows:

Compassion satisfaction: it is about the pleasure you derive from being able to do your work well. You may feel positive about your colleagues or your ability to contribute to the work setting or even the greater good of society.

Burnout: from a research perspective, it is associated with feelings of hopelessness and difficulty in dealing with work or doing your job effectively. These feelings normally have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very large workload or a non-supportive work environment.

Secondary trauma: it is about your work-related secondary exposure to extremely stressful events. It is exposure to others' traumatic events as a result of your work, such as working with child protection services. The symptoms of secondary trauma are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop in your mind or avoiding things that remind you of the event.

Data gathered from the respondents, therefore, reflected their scores, as group, on the three constructs.

Kruger, De Vos, Fouche and Venter (2005:220) clarify that in quantitative research, after data have been collected, it is transformed through coding into numerical values for statistical calculation, which most statistical programmes require.

The pre- and post-tests scores were then compared to establish if the REds Support Programme was effective in supporting and empowering the sample of 10 HIV and AIDS affected educators.

4.3.2.2 Statistical techniques used for analysis of data

The pre- and post-test scores from ProQOL were analyzed by a statistician from the Statistical Services of the Vaal Triangle Campus of the North West University. The analysis was conducted according to the Manual for the ProQOL (Stamm, 2005) and focused on comparing the respondents' compassion satisfaction, burnout, and secondary trauma levels prior to and following exposure to REds (see Appendix M).

Non-parametric significance tests were used to analyze the data. Gerard (2007:3) clarifies that one of the important advantages of non-parametric tests is that they provide a certain degree of objectivity when there is no universally recognized scale for the original data. The researcher regards this assurance of objectivity as vital, because objectivity is one of the core qualities that differentiate the quantitative research approach from others.

Kruger *et al.* (2005:242) explain that:

These tests have been developed to ascertain whether the results obtained by data analysis are statistically significant, i.e. whether they are meaningful or not merely the result of chance. These tests are executed on what is called a level of significance.

Payne (1999:132) clarifies that the level of significance is determined by the researcher. Either the .05 or .01 level of significance can be selected, but the .05 level is usually preferred. In the context of this study, the .05 level of significance was selected.

The following non-parametric significance tests were then chosen for data analysis:

- Mann-Whitney U Test
- Kolmogorov-Smirnov Test
- Wald-Wolfowitz Runs Test

Gerard (2007:1) states that these are the commonly used non-parametric significance tests.

4.3.2.3 Quantitative results

The results, as per the statistician's report, present scores of the respondents (N=10) as a group in terms of the constructs of compassion satisfaction, burnout and secondary trauma. As described in 4.3.2.1 these constructs can briefly be summarized as follows:

- Compassion satisfaction: it is the pleasure you derive from being able to do your work well.
- Burnout: it is associated with feelings of hopelessness and difficulty in dealing with work or in doing your job effectively.
- Secondary trauma: it is work-related secondary exposure to extremely stressful events.

Stamm (2005:4) clarifies that each construct/scale is psychometrically unique and cannot be combined with other scores.

The results from the mentioned non-parametric significance tests are as follows:

Table 5: Results from Mann-Whitney U Test

	Rank sum	Rank sum	U (test scores)	Z	Z adjusted	p-level
	Pre-test	Post-test				
CS: Compassion satisfaction	394.5000	425.5000	163.5000	-0.975023	-0.978933	0.347514
BO: Burnout	451.0000	369.0000	179.0000	0.555221	0.556896	0.577599
Secondary trauma	451.0000	369.0000	179.0000	0.555221	0.556292	0.578012

Table 6: Results from Kolmogorov-Smirnov Test

	Max negative difference	Max positive difference	Pre-test mean	Post-test mean	Pre-test standard deviation	Post-test standard deviation	p-level
CS: Compassion satisfaction	-0.255639	0.032581	36.28571	38.15789	5.187898	4.645944	>.10
BO: Burnout	-0.102757	0.162907	26.85714	25.42105	4.819603	4.549918	>.10
Secondary trauma	-0.062657	0.150376	29.66667	28.05263	5.561774	6.987876	>.10

Table 7: Results from Wald- Wolfowitz Runs Test

	Valid N pre-test	Valid N post-test	Pre-test mean	Post-test mean	Z	Z adjusted	p-level
CS: Compassion satisfaction	21	19	36.28571	38.15789	0.337245	0.176652	0.859782
BO: Burnout	21	19	26.85714	25.42105	0.979616	0.819024	0.412774
Secondary trauma	21	19	29.66667	28.05263	-0.947498	0.786905	0.431338

The researcher's observation is that, although these tests are different, they measure the same data using the same approach and therefore there are similarities noted in the results. For example, the pre- and post-test means of both the Kolmogorov-Smirnov test and Wald-Wolfowitz Runs test.

In the next section the researcher will deliberate on interpretation of these results.

4.3.2.4 Discussion and interpretation of quantitative results

As non-parametric significance tests were used to analyze the pre-and post-test data, the next step is to establish if there is any significant difference between pre- and post-test data using levels of significance or probability.

The statistician determined significance of the results at $p < .05000$. This means that the results are significant only if the probability/significance level is less than .05000 that is $p < .05000$. Payne (1999:132) concurs with this by mentioning that the .05 level is usually selected. This means, for the researcher, that this is the preferred level of significance in this type of research.

The p (probability) level from the Mann-Whitney U test for compassion satisfaction (CS) is 0.347514, 0.577599 for burnout (BO) and 0.578012 for secondary trauma. All these p levels, 0.35, 0.58 and 0.58 are greater than 0.05, that is to say $p > .05$.

With the Kolmogorov-Smirnov test, the p levels for the three constructs/scales have been established at $p > 0.10$. Again the p levels are greater than 0.05.

The last test used, the Wald-Wolfowitz Runs test, yielded similar results. The p level for compassion satisfaction is 0.86, 0.41 for burnout and 0.43 for secondary trauma. All these p levels are greater than 0.05.

The researcher interprets the results as implying that there are no statistical significant results between pre- and post-test scores.

4.3.3 SECTION C: QUALITATIVE RESEARCH FINDINGS

Qualitative data were gathered from the 10 respondents through a non-standardized questionnaire with drawings (see Appendix E & H) and a semi-structured interview schedule (see Appendix F & I), before and after exposure to REs.

Additional data sources were observations and field notes that were compiled by the researcher and the research assistant during the implementation of REs.

Qualitative data were also gathered from the school management team after the respondents were exposed to REs, using a semi-structured interview schedule (see Appendix K) to determine whether or not they have observed any difference in the respondents regarding empowerment and support for themselves and others who are affected by HIV and AIDS, after they were exposed to REs.

Content analysis was used to analyze the qualitative data from the mentioned data sources, except for the drawings. The drawings were analyzed using face value interpretation, without any theoretical framework.

The qualitative data will be presented according to the following structure:

Part 1: Qualitative data gathered from the 10 respondents (HIV and AIDS affected educators) with the following data collection methods:

- Non-standardized questionnaire with drawings
- Semi-structured interview schedule
- Observations and field notes

Part 2: Qualitative data gathered from the school management team using the following data collection method:

- Semi-structured interview schedule

The researcher will present data gathered from the respondents before and after exposure to REs, from each data collection tool separately, using mainly themes and sub-themes and concluding with a discussion and interpretation of the results.

PART 1: QUALITATIVE DATA GATHERED FROM THE HIV AND AIDS AFFECTED EDUCATORS

1.1 DATA GATHERED FROM THE NON-STANDARDIZED QUESTIONNAIRE

After completion of the ProQOL, respondents had to complete the incomplete sentences on the non-standardized questionnaire and then conclude the questionnaire with a drawing that symbolizes how the HIV and AIDS pandemic had affected them (Appendix E &H). The same procedures were followed before and after the respondents were exposed to REs.

1.1.1 PRE-TEST RESEARCH RESULTS FROM THE NON-STANDARDIZED QUESTIONNAIRE

The non-standardized questionnaire contained five incomplete sentences which focused on the respondents' general perception about the future their hopes and their approach to daily challenges (see Table 8). The researcher analyzed data gathered through content analysis and identified themes and sub-themes for responses to each sentence.

The drawings were analyzed using face value interpretation, without any theoretical framework.

The incomplete sentences

The incomplete sentences and the identified themes and sub-themes are presented in a tabular form first, followed by a discussion of the individual themes.

Table 8: Pre-test incomplete sentences, themes and sub-themes

INCOMPLETE SENTENCES	THEMES	SUB-THEMES
1. When I think of the future.....	Thoughts about the future	Optimism, uncertainty, pessimism
2. Giving up.....	Perception of despair	Optimism, pessimism
3. I hope that.....	Hopefulness	Optimism
4. When things go wrong.....	Perception of adversity	Optimism, pessimism, realism
5. I can.....	View of own capabilities	Optimism

Discussion of the themes

- 1. Thoughts about the future:** The respondents had different views about the future. From their responses, three sub-themes were identified, namely optimism, uncertainty and pessimism. With optimism, four respondents mentioned that they foresee a future with opportunities despite the pandemic. One respondent explained her optimism by stating: “I always think very much positive concerning life as a whole. God will lift me up where I want to be.”

A Khomanani booklet, *I had an HIV test – now what?* (Sa:9), stresses the importance of optimism in its statement that everybody needs to live a healthy life, especially people infected with HIV and AIDS by firstly staying positive about life.

Two respondents were uncertain about the future, which one respondent expressed as: “I feel unhappy because I don’t know what the future holds for me.” The other four respondents were pessimistic about the future. This is captured in one of the respondent’s statement: “When I look back and count my loved ones that I have already lost I just see a dull future.”

To support these statements, van Rensburg, Fourie and Pretorius (1998:149) highlight the fact that HIV and AIDS certainly have far reaching, even catastrophic implications for the South African population, its social and economic dimensions and for health care and the health care system. The researcher concurs with this because HIV and AIDS are overwhelming, as the pandemic has been difficult to manage.

- 2. Perception of despair:** The respondents expressed their opinion about giving up. Two main sub-themes emerged from their responses; optimism and pessimism. Only two respondents were pessimistic and the rest were opposed to becoming despondent. One of the pessimistic respondents completed the sentence by stating: “I sometimes give upon life and feel that life is not fair, why children and why is everyone susceptible to this disease.” The researcher views this as implying that the respondent is not always pessimistic, but the reality of the pandemic invokes the feelings of despair.

The opinions of the optimistic respondents are captured in one of the responses as follows: “I will not give up until I find something that I want.” Additional input included the opinion that one has to be courageous, and that giving up makes one feel like a loser. Another opinion is that giving up is a problem and one has to seek solutions.

Whiteside and Sunter (2000:145) agree with maintaining optimism by saying that, although the HIV and AIDS pandemic is an enormous

challenge, people must not feel powerless. It is all about action on many different fronts.

3. Hopefulness: All the respondents responded in an optimistic manner.

There was an equal split between those who were hopeful about life in general and those who were hopeful that things will change for the better for those that are affected or infected by HIV and AIDS. This is supported by these quotations from the respondents:

“I hope that life will be precious as I wish and dream it to be” and “I hope that one day cure will be found so that we can stop losing people we dearly love.”

The respondents’ optimism is reiterated by Drower (2005:106) who stated that, although the HIV and AIDS pandemic presents a range of challenges, there is hope that the situation will improve.

4. Perception of adversity: Seven respondents thought that even when things go wrong, a positive outcome is possible. Two respondents felt that the situation had to be viewed realistically by examining why things went wrong. Only one respondent mentioned that he/she has a tendency to expect the worst, especially when a sick person is hospitalized.

The researcher is therefore of the opinion that the majority of the respondents perceive adversity in an optimistic manner and this is expressed by one of the respondents in this way: “When things go wrong I try again and again. I look for solutions and ideas from people in the same situation.”

Barolsky (2003:71) emphasizes the importance of a proactive approach to the pandemic by stating that we can allow families and communities to be overwhelmed by the pandemic or we can choose to think anew by

strengthening these social institutions to become centres of care for those infected or affected by HIV and AIDS. The researcher's view is that it is through the proactive approach that meaningful progress can be made in the fight against the pandemic.

- 5. View of own capabilities:** All the respondents, except one (female, who did not complete the sentence), expressed belief in the ability to take control of their own lives and reach out to others in need. For the researcher, this means that they are aware that they can make a difference in others. One of the respondents reiterated this by stating that: "I can be one of those who want to give positive support and strength to those that are already being infected, especially those around me, for example, learners, family and neighbours who lost hope for life."

Kaya (1999:45) adds that there is a need for greater commitment by the communities where those affected and infected by HIV and AIDS live, to support all efforts directed towards preventing the spread of the pandemic and caring for those who are already infected.

The researcher is of the opinion that the discussion of the themes highlights that, although each respondent had his/her own unique way of expressing how he/she is affected by HIV and AIDS, trends could be identified.

Drawings

The respondents were given the following instruction: "When you think of how the pandemic has affected you, what symbol comes to mind?"

The respondents were creative in their drawings and these are briefly described as follows (see Appendix L for an example):

- A coffin
- A big cross with “death” written next to it.
- Drawing of a person crying, isolated by friends
- An expressionless face
- Drawing showing the death of breadwinners, leaving children orphaned and living in poverty
- Drawing of a crying child with its mother with raised open hands looking desperate
- A sword dripping blood
- A hook with this message: “if we continue to ignore information on HIV and AIDS it is still going to claim more lives.”
- A worried face
- A drawing showing a teacher reaching out and supporting an infected learner.

The researcher, as earlier mentioned, analyzed the drawings using face value interpretation.

The researcher’s view is that all the drawings except one depicted a negative effect of the pandemic. Some drawings depicted helplessness, for example the coffin and expressionless face, others pain, for example the sword, and the in some instances despair, as in the case of the desperate mother with the crying child.

What is depicted in the drawings could be interpreted by Frohlich’s (2005:352) explanation that HIV and AIDS have emerged as an inescapably visible pandemic with devastating effects on vulnerable communities. More and more these communities experience frequent funerals, orphaned children, withdrawal of children from schools to care for ill family members and dwindling household incomes.

Only one respondent depicted caring in his/her drawing, which is supporting an infected learner.

Pre-test data from the non-standardized questionnaire have been analyzed and presented. In the next heading, the researcher will focus on the analysis and presentation of post-test data from the same non-standardized questionnaire.

1.1.2 POST-TEST RESEARCH RESULTS FROM THE NON-STANDARDIZED QUESTIONNAIRE

After exposure to REs, the respondents were asked to complete the non-standardized questionnaire again. The aim was to obtain post-test data that will assist in evaluating the effectiveness of REs.

The respondents completed the incomplete sentences again and also made drawings on how the pandemic had affected them.

The researcher will firstly present data from the five incomplete sentences with the accompanying themes and sub-themes that were identified through content analysis, and then the drawings.

The incomplete sentences

Table 9: Post-test incomplete sentences, themes and sub-themes

INCOMPLETE SENTENCES	THEMES	SUB-THEMES
1. When I think of the future.....	Thoughts about the future	Optimism, pessimism
2. Giving up.....	Perception of despair	Optimism
3. I hope that.....	Hopefulness	Optimism
4. When things go	Perception of adversity	Optimism, pessimism,

wrong.....		realism
5. I can.....	View of own capabilities	Optimism

Discussion of the themes

- 1. Thoughts about the future:** After exposure to REds, five respondents are optimistic about the future, whilst the other half is pessimistic. A noticeable difference in comparison with the pre-test, is that none are uncertain about the future. To illustrate this, the researcher quotes the respondents as follows: “When I think of the future I have positive thoughts that someday a cure will be found and people will get help.” The other respondent wrote: “When I think of the future I become worried about the young generation.”

McKee, Bertrand and Becker-Benton (2005:41) clarify that social scientists have recently recognized that HIV and AIDS communication programmes should not only focus on dissemination of practical information on transmission, prevention and risk reduction of HIV and AIDS, but should also consider the socio-cultural factors that strongly influence complex health behaviours.

The researcher is therefore of the opinion that there might be socio-cultural factors that had influenced most of the respondents not to change their perception about the future, in spite of new information they had received about the pandemic.

- 2. Perception of despair:** The results indicate that all the respondents stated that they will not despair in the face of the pandemic; giving up is not an option. One respondent wrote: “There are times when I was confronted with serious difficult situations, however, I stood firm and never gave up.”

Whiteside and Sunter (2000:135) stress that fighting the pandemic is about doing lots of little things better at grassroots level, with an emphasis on doing. The virus is fragile and can be beaten. The researcher understands that this means optimism needs to be maintained, in spite of the challenges of the pandemic.

- 3. Hopefulness:** All the respondents were optimistic. This is similar to pre-test results. Six respondents indicated that they are hopeful that a cure for HIV and AIDS will be found; whilst four respondents stated that they are hopeful about life in general. One respondent stated: “I hope that one day there will be a cure for this disease and that our people can take this pandemic seriously and play it safe.”

The researcher understands this to mean that the respondents have maintained their optimism despite having learned more about the grim realities of HIV and AIDS.

- 4. Perception of adversity:** Research results indicated a shift regarding the respondents' view of adversity. Only five respondents remained optimistic as compared to seven in the pre-test results. There were two pessimists as compared to one during pre-test. The remaining three respondents adopted a realistic approach to adversity, focusing on challenging it without attaching any meaning to it or its implications for the future.

The optimism was expressed by one respondent in this statement: “When things go wrong we need to accept and focus on the brighter side and always have faith and hope for positive outcomes.” Another respondent, who prefers a realistic approach, stated: “When things go wrong I stop and review the situation. Then I try to approach the situation in a different way.”

Van Rensburg *et al.* (1998:149) maintain that this threatening pandemic, HIV and AIDS, has introduced an enormously uncertain factor into the health profile of the South African population. For the researcher, this implies that the respondents were also challenged by the uncertain implications of the pandemic and this will from time to time affect their perception of adversity.

- 5. View of own capabilities:** Results showed a similar pattern as the pre-test results. The only difference is that all respondents completed the sentence and the message was similar, that is to say they believe in themselves and that they can reach out to others and offer assistance and support. The respondents' input was captured in this statement by one respondent: "I can be creative and come up with initiatives to take my work to the next level and be more involved in helping people."

Batson (1995:368) explains that there is considerable evidence that when faced with a social dilemma, many people do not only attend to their own welfare, but they also attend to others for whom they feel special concern. Under certain conditions, they even attend to the needs of the group or community. The researcher is of the opinion that this is applicable to the pandemic and thus explains the respondents' willingness to reach out to others.

Through discussion of the themes, the researcher has demonstrated how exposure to REs influenced the respondents when completing the five sentences. The next focus is on the drawings.

Drawings

The second portion of the questionnaire, as earlier mentioned, instructed respondents to draw a symbol that depicts how the pandemic has affected them.

The respondents drew the following:

- A mass funeral
- An angel, at the bottom written “an angel of hope”
- A hanging rope with a loop
- A sick person with a box of tablets leaving the clinic
- A coffin, with writing at the bottom “loss of economically active members of the population”
- Two people crying over a person suffering from vomiting and diarrhoea
- Sick person
- A man and an HIV positive woman, with writing at the bottom “live longer by taking care of yourself”
- A cross with a caption “death”
- A smiling face

Using face value interpretation, the drawings seem to indicate that, after the respondents were exposed to REs; only six respondents associated the pandemic with pain and/or helplessness as, compared to nine respondents in the pre-test results. The other four respondents depicted hope that there is life after an HIV positive diagnosis.

Lewis (2004:2) emphasizes that the defining characteristic of the HIV and AIDS pandemic has been the needless loss of life, and even as we inch towards hope, lives continue to be lost on a daily basis. The researcher agrees that HIV and AIDS are still claiming many lives, but keeping hope alive will assist in the fight against the pandemic.

1.1.3 DISCUSSION AND INTERPRETATION OF THE PRE- AND POST-TEST RESULTS FROM THE NON-STANDARDIZED QUESTIONNAIRE

The researcher has observed a difference between the pre- and post-test results with both the incomplete sentences and the drawings. The differences can be described as follows:

- Discussion of the themes revealed that from the pre-test results, the respondents' **perception about the future** seemed more inclined towards pessimism, though not with a huge margin. With the post-test results, there was a clear split in the group, with five respondents being optimistic and the other half being pessimistic.
- A similar pattern was observed with the theme on **perception of despair**. The pre-test results showed two respondents being pessimistic and the post-test results presented all respondents as being optimistic, not allowing themselves to be easily discouraged.

The researcher attributes the positive change to a statement by Kaya (1999:44) that it is through being well-informed about the pandemic that relatives, friends and communities will be able to convert, for those that are HIV and AIDS affected, fear into hope and uncertainty into confidence.

- The pre- and post-results for the themes **hopefulness and view of own capabilities** remained the same. All respondents were optimistic and believed in their ability to reach out to those in need.
- An interesting development was on the theme of **perception of adversity**. The pre-test results showed seven respondents being optimistic, one pessimistic and two respondents having adopted a realistic approach. The post-test results on the other hand indicated a reduction in the optimistic respondents to four. Those who adopted realism increased to three and

respondents who were pessimistic increased to two. It appears that after exposure to REds respondents were more realistic about HIV and AIDS.

The researcher interprets the change as typical of what Aronstein (1998:293) meant with the statement that many people experience HIV and AIDS as isolating, confusing, complex and posing serious challenges in terms of coping with the emotional and psychosocial aspects of a life-threatening disease.

- The pre- and post-test drawings indicated some positive change. Prior to exposure to REds, all the drawings, except one, depicted pain and/or helplessness. The one respondent depicted a positive message; caring. With the post-test drawings, six respondents depicted pain and/or helplessness, whilst three depicted hope in the face of the pandemic.

The researcher attributes this to Theron's (2005:58) statement that educators are realistic about the impact of HIV and AIDS in education. The negative implication of HIV and AIDS for school wellness is not as a result of negative educator perception, but as a result of the grim reality of the pandemic. The researcher is of the opinion that REds has made them more aware of the realities of the pandemic.

The researcher concludes that there is significant difference in the pre- and post-test results from the non-standardized questionnaire. It appears REds positively impacted on the respondents' perception of the pandemic.

1.2 DATA GATHERED FROM THE SEMI-STRUCTURED INTERVIEW SCHEDULE

The semi-structured interview schedule was used as another qualitative data collection tool (see Appendix F & I) to collect data from the 10 HIV and AIDS

affected educators (respondents). There were two different semi-structured interview schedules used, one for the pre-test interview and the other for the post-test interview. The data gathered were content analyzed.

The respondents opted to complete the interview schedules themselves, both pre- and post-test, because of time constraints. The researcher only interviewed respondents who needed clarification on the questions asked and took notes of their responses.

1.2.1 PRE-TEST RESEARCH FINDINGS FROM THE SEMI-STRUCTURED INTERVIEW SCHEDULE

The purpose of the pre-test interview, as earlier indicated, was to gain deeper understanding of how the HIV and AIDS pandemic had affected the respondents and what coping mechanisms they were using, if they were coping at all.

Seven open-ended questions were asked which the respondents had to answer. The researcher used content analysis to identify themes from responses for each question.

The questions on the interview schedules and the identified themes are presented in Table 10, followed by a discussion of the themes.

Table 10: Pre-test interview schedule questions and themes

QUESTION	THEMES
1. How has the pandemic affected you emotionally?	Emotional impact
2. How has the pandemic affected you spiritually?	Spiritual impact

3. How has the pandemic affected you physically?	Physical impact
4. How has the pandemic affected you socially?	Social impact
5. How has the pandemic affected you professionally?	Professional impact
6. How has the pandemic changed your daily routine as an educator?	Impact on daily routine
7. What has helped you cope with teaching whilst the pandemic rages on?	Coping mechanisms

Discussion of the themes

1. Emotional impact: Three respondents indicated that they were not emotionally affected by the pandemic. One of them mentioned: “I have to take it as it comes like any other disease that kills.”

Seven respondents expressed how the pandemic has affected them emotionally. Their responses included being scared, depressed, angry, hurt and stressed. This is captured in one respondent’s statement: “I feel sorrow and emotionally down. I am sometimes angry when thinking about our brothers and sisters who left this world as a result of AIDS.”

The researcher is of the opinion that these responses imply an overall negative emotional effect of the pandemic, which is in line with a comment by Page *et al.* (2006:106) that fear creates a world view where HIV and

AIDS and everything surrounding it are seen with varying degrees of anxiety, unease, danger or stigma. It is awareness and knowledge that can remove the fear.

- 2. Spiritual impact:** Four respondents mentioned that they are not affected spiritually by the pandemic. One respondent attributed this to the knowledge he/she has about HIV and AIDS and others attributed it to their faith in God. One respondent wrote: “HIV and AIDS doesn’t affect me spiritually because the more it kills people the more I believe in God that one day he will send us the cure.”

The other six respondents were spiritually affected by the pandemic. Their responses included having lost hope, worried and questioning faith in God. To express how they felt, one respondent stated: “I sometimes lose hope in God and ask myself why? Because we believe he can cure every sickness.”

Van Dyk (2005: 249) clarifies that HIV and AIDS create a need for spiritual comfort, consolation and understanding for those infected and presumably those affected by HIV and AIDS. Ironically, many of the most urgent and troubling spiritual questions remain unanswered at a time when the need is more acute than it has ever been at any time in their lives. The researcher is of the opinion that this highlights the importance of taking cognizance of the spiritual impact of the pandemic on those affected and infected and addressing the identified needs in a non-judgmental manner.

- 3. Physical impact:** Two respondents mentioned that they did not experience any physical effects when in contact with or thinking about those who are HIV and AIDS infected or affected. The remaining eight respondents, on the other hand, mentioned that they did experience physical effects, especially after having contact with someone who shows

symptoms of the disease. Their responses included being stressed, having a poor appetite, having difficulty sleeping and thinking too much about the pandemic. One respondent wrote: “I sometimes lose appetite after visiting the hospital and homes of those who have AIDS.”

Pratt, Stephens and Gibson (2003:264) explain that HIV and AIDS are no different to any other chronic disease with periods of acute exacerbations. It just seems different because of the complexity of external factors associated with it such as stigma, fear of contagion, judgmental attitudes towards sexual orientations, and various cultural and moral issues. The researcher’s view is that maybe if the respondents could perceive HIV and AIDS like any other chronic disease, the physical effect would be reduced.

- 4. Social impact:** All respondents, except for one, indicated that the pandemic impacted on their social relations. Some respondents mentioned that they have become cautious about whom they interact with, whilst others mentioned that they are careful about what they say to others, especially about the pandemic. The social impact is captured in this response: “One is always afraid and has to be very careful. You do not know how to react when you come across someone showing the signs of the virus.”

McKee *et al.* (2005:76) clarify that such responses are expected because denial, stigma and discrimination against people living with HIV and AIDS prevent communities from normalizing the disease and integrating it into shared problem-solving strategies. This implies that unless the stigma and misconceptions about HIV and AIDS are properly tackled, the social impact of the pandemic will prevail.

- 5. Professional impact:** All respondents, except one, stated that the pandemic has affected them as educators. Most of the respondents

indicated that in addition to their core tasks as educators, they have to make time to support learners that are HIV and AIDS affected and even educate them about the disease. This results in an increased workload.

One respondent mentioned: “I began to see myself as a person who must take the lead in giving guidance on issues of HIV and AIDS, mainly because educators are more influential in the community.”

Frohlich (2005:359) argues that the morale of children affected by HIV and AIDS can be raised through the provision of recreational activities and most especially by keeping them in school. The researcher’s interpretation is that educators are expected to be affected professionally by the pandemic, as they have a responsibility to act as support systems for learners that are affected or/and infected with HIV and AIDS.

- 6. Impact on daily routine:** For two respondents, their routine remained unaffected. One respondent attributed this to the fact that he/she does his/her support work after hours. For the rest of the group, their work routine changed. The respondents felt that the normal work day has become unpredictable. One respondent stated: “Daily routine is affected a little, but what worries me is that we bury parents almost every day and more learners become orphaned.”

Pembrey (2007b:2) stresses that schools depend on a variety of individuals, which include learners, teachers and support staff. If anyone involved with the school is affected by HIV and AIDS, it is likely to affect the ability of that school to function.

- 7. Coping mechanisms:** All respondents explained the coping mechanisms they use to keep them going despite the pandemic. Their responses were as follows:

- “I always hope and believe that one day things will be okay.”
- “Take each day as it comes and tackle the challenges as they come.”
- “My religion and involvement in discussion groups help me cope.”
- “I have hope that ARVs do help a person to recover and live a healthy life.”
- “I have hope and faith.”
- “By reading and associating with people who have more knowledge about the pandemic.”
- “The understanding or knowledge I have about the pandemic helps me cope.”
- “Support from my colleagues and principal.”
- “Seeking guidance and information on how to support affected learners.”
- “The testimony of those affected and how they cope keeps me going.”

Frohlich (2005:357) supports statements by the respondents by citing that interventions to address the challenge of HIV and AIDS must include helping people to understand that it is possible to live with HIV and AIDS and that treatment and wellness management promises real hope for the future, an important step in dissipating fear and anxiety about the disease. For the researcher this means that though challenging, HIV and AIDS can be beaten by focusing on what can be done to manage its impact rather than what cannot be done.

The pre-test results seem to indicate that all the respondents were affected by the pandemic in some way and they used various mechanisms to cope.

1.2.2 POST-TEST RESEARCH FINDINGS FROM THE SEMI-STRUCTURED INTERVIEW SCHEDULE

The purpose of the interview was to find out how REds impacted on the respondents personally and professionally. The semi-structured interview schedule had two open-ended questions and with the last question the respondents were requested to write a narration on what REds meant to them (see Appendix I).

Content analysis was again used to analyze the data. The open-ended questions and themes are displayed in Table 11. The researcher will first discuss the open-ended questions with themes and conclude with the respondents' narration.

The open-ended questions

Table 11: Post-test open-ended questions and themes

QUESTION	THEME
1. How has REds impacted on you as a person?	Personal impact
2. How has REds impacted on you as a professional?	Professional impact

Discussion of themes

- 1. Personal impact:** All the respondents mentioned that REds had a positive personal effect. Some mentioned that it encouraged them to support others, whilst others mentioned that they are now confident about discussing HIV and AIDS matters as they are equipped with the right information. One respondent mentioned: "The programme has helped me to gather courage and to deal with the issues of HIV and AIDS at various levels; as a mother, wife and member of the community."

Kaya (1999:43) emphasizes that, according to Martin (1996), relatives, friends and the community at large have the capacity to change attitudes about HIV and AIDS. This though can only happen if they are provided with adequate information about the disease, especially its modes of infection and prevention.

The researcher is of the opinion that REds equipped the respondents with adequate information, which enabled them to feel confident in participating in HIV and AIDS related activities.

- 2. Professional impact:** All respondents indicated that REds had positively impacted on them as professionals. Some mentioned that they are inspired to make a difference, whilst one respondent mentioned that he/she feels well-equipped to support grieving learners and colleagues. Another respondent wrote: “It equipped me with factual knowledge to help my learners in different ways. It also equipped me to handle stress and be able to help my colleague to cope with stress.”

Pembrey (2007b:2) adds that whilst the education sector is seriously threatened by the pandemic, it is also an invaluable tool in the fight to establish an environment where people living with HIV and AIDS are well supported and new infections are prevented. For the researcher this implies that the REds Support Programme has capacitated respondents to work towards making their school a supportive environment to those affected and infected by HIV and AIDS.

The narrative

The respondents were requested to respond to the following statement:

“In your own words, write a story describing what REds means to you, the role it played in your life.”

The respondents were asked not to exceed three paragraphs.

The researcher extracted the main points from each respondent’s narration as follows:

- “The programme made me aware that as an educator, I am also a community member. I should be involved in the control and battle to fight the pandemic. It has enabled me to see the need to create an environment that is supportive to learners and educators who are living with and affected by the pandemic.”
- “I have learnt the skills to be more resilient in many ways of providing support, comforting others and encouraging my learners. It has also opened my eyes in as far as educator’s rights regarding the pandemic are concerned.”
- “I was one with little knowledge about HIV and AIDS. Since I attended REds I’ve gained more knowledge and I am well equipped about the pandemic.”
- “REds helped me to believe in myself. I can now encourage infected people to accept and live with the pandemic by teaching them to live positive and ignore those who try to discourage them. REds taught me not to fear death.”
- “REds taught me to be strong; I must stand very firm and maintain my well being. It has taught me to read about everything important in my life.”

- “I was able to gain more information relating to HIV and AIDS. It also taught me to manage stress. REds means a lot to me and I wish that it should continue to grow.”
- “It helped a great deal, especially where we were made to understand that a person living with HIV can take care of himself to live longer.”
- “REds has made it easy for me to understand HIV and AIDS related problems, to cope with increased workload due to teacher absenteeism because of HIV and AIDS and be supportive to learners.”
- “The little knowledge I had about this pandemic is now being integrated to a highest level. REds taught me about resilience, that you can survive for as long as you want, AIDS is not a life sentence.”
- “REds means a lot to me. With this knowledge that I got, I won’t hide it under the bed, but I will spread it to help others. It helped me a lot and it was very supportive to me, it was as if I am attending counselling about HIV and AIDS.”

The comments by the respondents on the positive impact of REds are, according to the researcher, supported by Kaya (1999:44) in the statement that it is through being well-informed about the nature of the pandemic that the relatives, friends and communities can convert, for those affected and infected by HIV and AIDS, fear into hope, rejection into acceptance, and uncertainty into confidence.

The next section will focus on the discussion and interpretation of these research results.

1.2.3 DISCUSSION AND INTERPRETATION OF PRE- AND POST-TEST RESULTS FROM THE SEMI-STRUCTURED INTERVIEW SCHEDULE

The researcher is of the opinion that the pre-test semi-structured interview gave the respondents the opportunity to fully express themselves regarding the way in which the pandemic has affected them.

The discussion of themes gave a picture of how most of the respondents were affected by the pandemic emotionally, spiritually, physically, socially, and professionally. The impact on their daily routine and the coping mechanisms they used were also explored.

The researcher's opinion is that the pre-test results indicate that the respondents experienced the pandemic as stressful and challenging and therefore difficult to cope with. Input on the professional impact illustrated how they are expected to participate in HIV and AIDS activities, irrespective of whether or not they have the time or knowledge to do so.

The researcher, on the other hand, has noted from the post-test research results that there is a repeated mention of the following statements: "Encouraged to support others, gained valuable information and knowledge, confidence to deal with HIV and AIDS and empowered with life skills."

This led the researcher to assume that prior to REEds; the respondents lacked the mentioned knowledge and information about HIV and AIDS. After acquiring the knowledge, their confidence is boosted and they are in a better position to support others in the school environment and the community.

Pembrey (2007b:3) highlights the fact the important role played by educators in the fight against HIV and AIDS by emphasizing that schools have always been more than just places that education takes place. They are often the focal point of local community activity and this gives them the enormous potential to act as a base from which local responses to the pandemic can be coordinated and strengthened. Teachers who expand their knowledge of HIV and AIDS can use the school setting to pass this information on to adults and pupils.

The researcher concludes from comparing the pre-and post-test research findings from the interview schedule, that the REds Support Programme seems to have impacted positively on the respondents.

1.3 DATA GATHERED FROM OBSERVATIONS AND FIELD NOTES

The researcher took field notes after every session and all sessions were tape-recorded, except the first session as the respondents had not yet given consent. In addition, there were observation notes from the research assistant. After every session the researcher and the research assistant compared and discussed their notes. After reaching consensus, they compiled process reports that were reflective of what had transpired at the group sessions. The researcher took responsibility for cross-checking the process reports with the recorded version of the sessions and making changes where necessary.

Content analysis of all the data gathered from the tape records, as well as observation and field notes revealed that during the first sessions, that is to say session 1 to 3, the respondents mentioned the following regarding the HIV and AIDS pandemic:

- They are scared
- They associate the pandemic with death
- They lack relevant information on HIV and AIDS
- They do not know what to do, especially how to give support to grieving learners and colleagues

From the fourth session both the researcher and research assistant started to observe that the respondents were shifting from feeling helpless to feeling confident about the knowledge they were acquiring from the programme. The questions they asked indicated that they are beginning to clear up some of the

misconceptions they had about the pandemic and wanted to know more.

Examples of some of the questions asked are:

- “How can I offer support to my young niece whose parent died months ago and who is struggling to cope with the loss?”
- “Can HIV and AIDS be transmitted through breast feeding?”
- “How do you know which immune boosters to use when you are HIV positive?”
- “Does the hospital ‘have’ the right to refuse admission or continued stay to a terminally ill patient?”
- “Are herbal remedies recommended for the treatment of HIV and AIDS related illnesses?”

By the end of the programme the respondents mentioned the following about the pandemic and REs:

- “When sharing information about the pandemic, the message has to be clear and direct.”
- “Now I know what to do.”
- “I feel confident to talk about HIV and AIDS.”
- “I will start supporting others who are affected and infected.”
- “I am hopeful that medical research will find a cure for HIV and AIDS.”
- “I have acquired the fighting spirit and thus feel resilient.”

These results seem to indicate that at the beginning of the programme the respondents felt disempowered and frustrated, because as educators they are expected to be knowledgeable about the pandemic and they were not.

By the end of the programme their knowledge base on HIV and AIDS matters had grown and they even became aware of some of the resources in the school that they did not know existed.

For the researcher, these results show that the respondents moved from being helpless to being helpful, that is to say being a resource for themselves and others in the face of the pandemic.

PART 2: QUALITATIVE DATA GATHERED FROM THE SCHOOL MANAGEMENT TEAM

The purpose of gathering data from the school management team was to establish whether or not they have observed any change or impact of REds among the respondents.

2.1 QUALITATIVE DATA GATHERED FROM THE SEMI-STRUCTURED INTERVIEW SCHEDULE

The researcher interviewed the five members of the school management team and wrote down their responses in the form of notes. Some responses were noted verbatim. They were all aware of the educators that participated in REds. The semi-structured interview schedule consisted of four questions. The researcher will focus on question 3 and 4, as these directly relate to the impact of REds. The first two questions were merely for identification purposes (see Appendix K).

The responses are presented in Table 12.

Table 12: Responses to the semi-structured interview schedule (SMT)

QUESTION	RESPONSES
In your opinion, how has REds impacted on the participants personally and professionally?	<ul style="list-style-type: none"> - “One participant showed improved understanding of the pandemic and her/his role.” - “Participants are more caring and empathetic towards affected

	<p>learners.”</p> <ul style="list-style-type: none"> - Three respondents mentioned that they have not noticed any change in the participants.
<p>Did the learners benefit indirectly from REds?</p>	<ul style="list-style-type: none"> - One respondent said that because they are approachable, learners are opening up to them - Four respondents answered no and recommended structured follow-up of the participants to encourage them to initiate support programmes in the school.

Additional comments from the school management team were:

- “It is difficult to comment as the school has about 40 teachers and observing REds participants among these is not easy.”
- “I prefer to have been given indicators at the beginning of the programme on what to observe.”
- “The interviews were conducted shortly after completion of the programme and did not give participants time to start organizing themselves and implement what they have learnt as they have other responsibilities as educators.”
- “It is difficult to give objective input as some of the respondents’ conduct as educators has been questionable in the recent months.”

The researcher is of the opinion that these results seem to indicate that the school management team, on the overall, did not observe any impact of REds

among the programme participants probably because of the mentioned extraneous variables.

2.2 DISCUSSION AND INTERPRETATION OF RESULTS

Among members of the school management team, only one member noticed the impact of REs in the programme participants. Although the remaining four members did not observe any impact, they gave reasons for their responses. The researcher views the reasons as valid, as they are extraneous variables that are difficult to predict and control.

The researcher therefore finds these results as different from what the educators (respondents) reported about how they themselves experienced REs. A possible explanation for this is that the respondents are encouraged to see themselves primarily as educators, and HIV and AIDS work as secondary. This is supported by findings by Simbayi *et al.* (2005:121) that a slight majority of educators reported that they received proportionally more support for their role in HIV and AIDS work from their trade union than the Department of Education.

The researcher's view is that even though the school management team was aware that some educators were participating in REs, they did not monitor to ensure that the participants implement what they have learnt probably because the programme was run after school hours and therefore not seen as part of the educators' core tasks.

Kelly (2000:36) adds that HIV and AIDS programmes in the education sector could work better if the relevant activities are better targeted, more flexible, consistent, intensive, intersectoral, multi-strategy and coordinated.

The researcher understands this to mean that coordination and strategic team work between the school management team and REs participants could have

led to obtaining more meaningful data from the school management team about the impact of REds.

4.4 CONCLUSION

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

The quantitative research results suggest that the REds Support Programme, the independent variable, seems not to have had a significant effect on the respondents. In other words, there is no significant difference between the pre- and post-test research findings.

Qualitative research results, on the other hand, clearly indicate that the respondents have benefited from the programme and there is a positive difference prior to and after exposure to REds, even though this was not validated by the school management team. This implies that the respondents, experienced the programme (REds) as supportive and empowering.

The researcher is of the opinion that the different results may be due to the fact that with the standardized questionnaire the respondents were restricted in terms of responses to the questions, whilst with the non-standardized questionnaire and interviews they had the opportunity to freely express themselves in a way that suited them as individuals.

This is supported by Schurink's (2002:297) statement that interviews help to explore the respondents' personal perceptions, experiences and feelings, as well as to understand the closed worlds of individuals, families, organizations and communities.

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

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter, the researcher presented the reader with empirical research findings from both the quantitative and qualitative approaches. The implications of these research results with regard to the goal and objectives of the research project and the future of REs were not discussed.

The focus of this chapter is therefore: to give a general summary of the research project and make conclusions and recommendations on the effectiveness of REs as a support programme for HIV and AIDS affected educators based on the research findings.

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

Goal:

- To evaluate the effectiveness of the Resilient Educators Support Programme in supporting and empowering HIV and AIDS affected educators in Mpumalanga.

Objectives:

- To conceptualize theoretically the phenomenon of HIV and AIDS and the impact thereof on the school environment as an educational setting with specific focus on HIV and AIDS affected educators.
- To implement the improved version of REs to HIV and AIDS affected educators in Mpumalanga.

- To evaluate the effectiveness of the improved version of REds in supporting and empowering HIV and AIDS affected educators in Mpumalanga.
- To make recommendations based on the research findings to improve REds, in order to implement it to a broader audience of educators.

Secondly, to give an answer to the research question, namely:

How effective is the improved version of the Resilient Educators Support Programme in supporting and empowering educators affected by HIV and AIDS in Mpumalanga?

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

- Summary
- Conclusions
- Recommendations

5.2 RESEARCH METHODOLOGY

5.2.1 SUMMARY

The research methodology is briefly explained in Chapter 1 and a more detailed discussion is given in Chapter 4. Chapter 1 started with an introduction and a general overview of what the study is about. The researcher then discussed the problem formulation, giving background on circumstances that led to the investigation of the problem situation.

The goal and objectives of the research project are stated, including the research question. The researcher further briefly explained the research approach and type of research, followed by research design, methods of data collection from the quantitative and qualitative approaches, the pilot study and the sampling method used to select the respondents for the project.

The researcher also addressed the ethical issues that are relevant to the study. The chapter concludes 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 from the research methodology:

- The dominant-less-dominant model of combining the quantitative and qualitative approaches enabled the researcher to gather valuable data on the topic under investigation and managed to neutralize any possible bias from the research results obtained from the quantitative approach.
- 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 adequately evaluate the effectiveness of REs as a support programme for HIV and AIDS affected educators.
- Data collected, pre- and post-test exposure to REs, and using quantitative and qualitative data collection methods provided the researcher with rich data from a variety of sources that facilitated the effective evaluation of REs.

5.2.3 RECOMMENDATIONS

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

5.3 LITERATURE REVIEW

5.3.1 SUMMARY

The literature review in Chapter 2 focused on an in-depth discussion of HIV and AIDS in the education sector.

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

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

- Conceptualization of HIV and AIDS
- Different stages of HIV and AIDS
- Difference between being HIV and AIDS infected and affected
- The extent of the HIV and AIDS pandemic

- HIV and AIDS pandemic in the education sector
- HIV and AIDS affected educators
- Available support structures for HIV and AIDS affected educators

5.3.2 CONCLUSIONS

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

- The HIV and AIDS pandemic is a global problem, with Sub-Saharan Africa, particularly South Africa, being more affected according to statistics obtained from the UNAIDS.
- The education sector in South Africa is one of the essential public service sectors that are seriously affected by the pandemic, because it is staffed by young females of an average age of 32 years; an age group that is regarded as high risk for HIV and AIDS.
- The response of the National Department of Education to the pandemic was a formulation of comprehensive HIV and AIDS policies. The respective Provincial Education Departments were delegated the responsibility to implement these policies. HIV and AIDS affected educators found these interventions inadequate in meeting their support needs.
- The University of North West took the initiative of 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

- To ensure that the HIV and AIDS policies benefit HIV and AIDS affected and/or infected educators, the National Education Department needs to

- put systems in place for regular monitoring and evaluation of HIV and AIDS programme implementation in the respective provinces.
- It is further suggested that the National Education Department establish a properly structured, accessible, user-friendly and confidential HIV and AIDS Employee Assistance Programme for educators, in order to assist and empower them to cope better with the effects of the HIV and AIDS pandemic.

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

5.4.1 SUMMARY

REds is an interactive support programme which aims to equip educators with skills and knowledge to cope with being HIV and AIDS affected and support others who are HIV and AIDS affected and/or infected. The programme consists of seven modules which are facilitated over eight sessions. Each session lasts about two hours.

5.4.2 CONCLUSIONS

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

- The REds manual had the relevant information that respondents needed in order to cope with the pandemic and to support others.
- The respondents took advantage of the interactive nature of the programme and discussed HIV and AIDS related matters that bothered them in a spontaneous manner.
- Running the programme after school hours limited time available to adequately discuss all pertinent matters.

5.4.3 RECOMMENDATIONS

- The researcher recommends that REds be made available to all educators, that is to say it should be incorporated as part of in-service training for all educators on a national basis.
- After completion of the programme, participants should form a committee that will oversee the establishment of proper support structures for HIV and AIDS affected and/or infected educators, learners and support staff in the school.

5.5 EMPIRICAL RESEARCH FINDINGS

5.5.1 QUANTITATIVE RESEARCH FINDINGS

5.5.1.1 Summary

In order to obtain quantitative research data, the Professional Quality of Life Scale (ProQOL) standardized questionnaire was administered to the 10 respondents, pre- and post-exposure to REds, to determine whether REds addressed the support needs of the respondents.

5.5.1.2 Conclusions

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

- The findings indicated that no statistical significant results were found.
- The researcher then concludes that, according to the quantitative results based on the ProQOL, REds did not adequately address the support needs of the respondents.

- The researcher is of the opinion that there is a possibility that the ProQOL standardized questionnaire is perhaps not applicable enough in the context of REs.

5.5.1.3 Recommendations

- The researcher recommends that the reason for non-significant test results from the ProQOL be investigated.
- The researcher further recommends that other possible standardized questionnaires be explored or a self-structured questionnaire be compiled in order to identify a more applicable measuring instrument.

5.5.2 QUALITATIVE RESEARCH FINDINGS

5.5.2.1 Summary

The non-standardized questionnaire which included drawings, semi-structured interview schedules, as well as observation and field notes were methods used to gather qualitative data pre- and post-exposure to REs, in order to obtain results on the effectiveness of REs.

Qualitative research data was obtained from two groups of respondents; the primary research respondents, namely the 10 educators, and the secondary source, namely five members of the school management team. The school management team was interviewed only after the primary respondents were exposed to REs, as explained in Chapter 4.

5.5.2.2 Conclusions

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

- A comparison of pre- and post-test results from the non-standardized questionnaire revealed that prior to exposure to REds, the respondents were challenged by the pandemic and thus were more inclined towards pessimism in their perception about the future, adversity, giving up and what they can do. After exposure to REds a positive change was observed from the comments that they made when completing the sentences. Input from the drawings also displayed a similar pattern.
- The pre-test results from the semi-structured interview schedule indicated that the respondents experienced the pandemic as negatively impacting their lives as educators and as individuals. From the post-test results, the respondents reported that they felt empowered to deal with the challenges presented by HIV and AIDS.
- Results from observation and field notes also revealed that prior to REds, the respondents felt frustrated and disempowered, but after REds their knowledge base grew and they started to regard themselves as resourceful to themselves and others.
- There is consistency in the results from all the qualitative data collection instruments used with the primary respondents, that is to say the respondents experienced REds as empowering.
- The results from the school management team did not confirm the effectiveness of REds and reasons were given for this.

5.5.2.3 Recommendations

- The researcher recommends that factors that impacted negatively on the input of the school management team need to be controlled in the next phase of REds, specifically giving indicators to the school management team on what to look out for in the respondents and to interview the team at least three months after completion of REds.
- The drawings which form part of the non-standardized questionnaire was challenging to respondents and some ended up drawing what they could,

and not something that was demonstrative of how the pandemic actually affected them. This was evident in the quality of the drawings. Some respondents even approached the researcher to assist them with the drawing. The researcher therefore recommends that this section of the questionnaire be omitted in future to limit bias.

5.6 ACCOMPLISHMENT OF THE GOAL AND OBJECTIVES OF THE STUDY

The researcher will first discuss accomplishment of the objectives of the study, followed by the goal of the study. The discussion is presented in tabular form as reflected in Table 13.

Table 13: Accomplishment of the objectives of the study

Number	Objective	Achievement
1.	To conceptualize theoretically the phenomenon of HIV and AIDS and the impact thereof on the school environment as an educational setting, with specific focus on HIV and AIDS affected educators	This objective was achieved through an elaborate discussion of HIV and AIDS in the education sector in Chapter 2, starting from the global picture and narrowing it down to Mpumalanga.
2.	To implement the improved version of the REds Support Programme to HIV and AIDS affected educators in Mpumalanga	This objective was achieved through a discussion in Chapter 3 of the contents of the programme and how it was facilitated.
3.	To evaluate the effectiveness of the improved version of REds in supporting and	The objective was successfully achieved as explained in Chapter 4 from both the quantitative and

	empowering HIV and AIDS affected educators in Mpumalanga	qualitative approaches.
4.	To make recommendations based on the research findings, to improve REds in order to implement it on a national level	This objective was accomplished through conclusions and recommendations on the future of REds as deliberated in this chapter, Chapter 5.

The goal of the study:

- To evaluate the effectiveness of the Resilient Educators Support Programme among HIV and AIDS affected educators in Mpumalanga.

The effectiveness of REds as a support programme for HIV and AIDS affected educators in Mpumalanga has been successfully evaluated as demonstrated through accomplishment of the objectives. The empirical findings confirmed, primarily from the qualitative approach, that the REds Support Programme has empowered the respondents with valuable information and skills to cope with being HIV and AIDS affected and enabled them to support others who are affected and/or infected with HIV and AIDS. However, the same conclusion cannot be reached from the quantitative research findings.

5.7 CONCLUDING REMARKS

The HIV and AIDS pandemic continues to affect the education sector to date and therefore educators need working support structures to cope with the pandemic. Through REds, the participating educators (respondents) addressed their fears, anxieties, worries and misconceptions about the pandemic and acquired valuable

knowledge and skills about HIV and AIDS that assisted them to be resilient in the face of the pandemic.

The researcher expects the respondents to be ambassadors of REds by reaching out to others who are HIV and AIDS affected and/or infected and providing support, sharing the correct HIV and AIDS information and referring them to relevant resources.

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APPENDIX A

**Permission letter for research: Mpumalanga Education
Department, Nkangala District Office**



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

MPUMALANGA PROVINCIAL GOVERNMENT

Government Complex
Department of Education
Building No. 5
Kwamhlanga

Private Bag X4021
Kwamhlanga
1022
South Africa



DEPARTMENT OF EDUCATION NKANGALA REGIONAL OFFICE

Our Ref: 17/713
Inquiries: J.J MABENA
REGIONAL DIRECTOR
013 947 3892 / 1710

Tel. No. (013) 9472060
Fax No. (013) 947 2755
(013) 947 2026
(013) 947 2591

Mrs Viola Kupa
University of Pretoria
Faculty of Humanities
PRETORIA
0002
RSA

Dear Mrs Kupa

RE: REQUEST TO CONDUCT A RESEARCH PROJECT: YOURSELF

1. Your application in respect of the above project dated 05 July 2007 has reference.
2. Kindly be informed that your application is approved for you to conduct your research in Nkangala District in offices and schools.
3. You are requested to contact Mr. C.R Mhlabane at 013 947 2011 to give you details of the division dealing with HIV/ AIDS.
4. You are requested to make prior arrangements with every structure / individual you would like you to interview so that there is no disturbance of service delivery.

Yours faithfully


REGIONAL DIRECTOR

2007.07.16
DATE

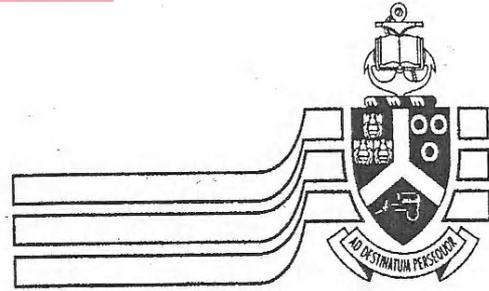
*"Age of hope, developing an education system for
faster and shared growth"*


AIDS HELPLINE
0800-0123-22
Unite against HIV/AIDS
Our action counts



APPENDIX B

Letter of ethical clearance



University of Pretoria

Research Proposal and Ethics Committee
Faculty of Humanities

Members:

Research Proposal and Ethics Committee

Prof P Chiroro; Dr M-H Coetzee; Prof C Delpport;
Dr JEH Grobler; Prof KL Harris; Ms H Klopper;
Prof E Krüger; Prof B Louw (Chair); Prof A Mlambo;
Prof G Prinsloo; Mr C Puttergill; Prof H Stander;
Prof E Taljard; Prof C Walton; Prof A Wessels; Mr FG
Wolmarans

27 July 2007

Dear Prof. Delpport

Project: *An evaluation of the effectiveness of Resilient Educators Support Programme among HIV and AIDS affected educators in Mpumalanga*

Researcher: PM Kupa
Supervisor: Prof. CSL Delpport
Department: Social Work and Criminology
Reference number: 2640418

Thank you for the application you submitted to the Research Proposal and Ethics Committee, Faculty of Humanities.

I have pleasure in informing you that the Research Proposal and Ethics Committee formally **approved** the above study on 26 July 2007. The approval is subject to the candidate abiding by the principles and parameters set out in her application and research proposal in the actual execution of the research.

The Committee requests you to convey this approval to Ms Kupa.

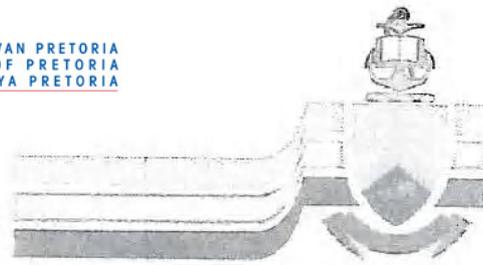
We wish you success with the project.

Sincerely

Prof Brenda Louw
Chair: Research Proposal and Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA

APPENDIX C

Informed consent letter for respondents (educators)



University of Pretoria

Pretoria 0002 Republic of South Africa <http://www.up.ac.za>

Department of Social Work and Criminology
Faculty of Humanities

Tel. +27 12 420-2325

Fax. +27 12 420-2093/420-5256

Researcher: Penelope Viola Kupa

Tel. numbers: Work: (011) 380 6800

Cell: 073 1720 604

Home: (011) 882 4445

Sozama High school

Middelburg

Participant's name:.....

INFORMED CONSENT

1. **Title of the study:** An evaluation of the effectiveness of Resilient Educators (REds) Support Programme among HIV and AIDS affected educators in Mpumalanga.
2. **Purpose of the study:** The purpose of this study is to evaluate the effectiveness of the REds Support Programme among HIV and AIDS affected educators in Mpumalanga.
3. **Procedures:**
 - I am expected to, together with other nine participants; attend all the nine modules of the REds Support Programme for HIV and AIDS affected educators with each module taking approximately two hours.

- I understand that the dates, time, duration of sessions, including break time, will be agreed upon by the group, that is, it will be based on group consensus.
- I understand that participating in REds Support Programme does not mean that I can present REds to other HIV and AIDS affected educators without being trained as a REds facilitator.
- I expect to complete a standardized group administered questionnaire, the Professional Quality of Life Screening, before the commencement of the first training session and after completion of the last session of the REds Support Programme. This will take approximately one hour each time.
- I also expect to complete two additional non-standardized questionnaires and make a drawing, before commencement of the first training session and after completion of the last session of the REds Support Programme. This will take approximately one hour each time.
- The researcher will also interview me individually, before the commencement of the first training session and after completion of the last session of the REds Support Programme. The first interview will focus on how the HIV and AIDS pandemic has affected me and the coping mechanisms I use, whilst the second interview will be on how the REds Support Programme has impacted on me personally and professionally. Each interview will take approximately 30 minutes.
- I am aware that there will be an observer during the sessions whose role will only be to record, in writing, the group member's interaction. He/she will thus not partake in any activities during sessions.
- I understand that information gathered through the questionnaires, drawings, interviews and observation will be used to evaluate the

effectiveness of the REds Support Programme in supporting HIV and AIDS affected educators in Mpumalanga.

4. **Risks and discomforts:** There are no known risks and discomforts associated with this study. In the event that I may experience discomfort due to re-living the pain of losing loved ones, colleagues and/or learners to HIV and AIDS, I will inform the researcher. I expect the researcher to then arrange a debriefing session for me with a suitably qualified counselor.
5. **Benefits:** I understand that the only direct benefit of participating in the study is acquisition of knowledge to cope with the challenges of being an HIV and AIDS affected educator. The results of the study will assist the researcher to gain better understanding of the effectiveness of REds in supporting HIV and AIDS affected educators.
6. **Participant's rights:** I may withdraw from participating in the study at any time.
7. **Financial compensation:** I will receive no financial compensation from the researcher for my participation in this study.
8. **Confidentiality:** In order to record accurately what I say in the interview and my input during training sessions, a tape recorder will be used. The tape will be listened to only by the above-named researcher and authorized members of the research team. I understand that the data obtained will be kept confidential unless I ask that they be released. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.
9. If I have any questions or concerns, I can call Viola Kupa at 073 1720 604 at any time during the day.

I understand my rights as a research respondent and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for five years.



I will receive a signed copy of this consent form.

Signature of respondent

Date

Signature of researcher

Signature of the supervisor

APPENDIX D

Pre-test questionnaire: ProQOL



We would like you to please complete the following questionnaires (ProQol & Incomplete sentences) and then participate in an interview because we want to improve REds (which is a program to empower you to cope with how the HIV & AIDS pandemic is affecting you as an educator). To improve REds we need to see whether it has helped you to cope better. The questionnaires and interviews will help us to determine this. We will give you the same questionnaires at the end of REds and then again a couple of months later. To complete the questionnaires will not take longer than one hour.

I understand that all information which is collected from me will be kept confidential. I give permission that any information which is collected from me may be used for research and publication purposes, both in South Africa and other countries.

Signature: _____



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



12. I like my work.

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

13. I feel depressed as a result of my work as a helper.

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

14. I feel as if I am experiencing the trauma of those I help.

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

15. I have beliefs that support me.

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

16. I know how to use different helping techniques.

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

17. I am the person I always wanted to be.

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

Questionnaire 2

Please complete / finish the following sentences honestly:

1. When I think of the future
2. Giving up
3. I hope that
4. When things go wrong
5. I can

APPENDIX E

Pre-test non-standardized questionnaire with drawings



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

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

Questionnaire 2

Please complete / finish the following sentences honestly:

1. When I think of the future
2. Giving up
3. I hope that
4. When things go wrong
5. I can

3. When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below:



3. When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below:

APPENDIX F

Pre-test semi-structured interview schedule

INTERVIEW SCHEDULE FOR EDUCATOR-

RESPONDENTS, BEFORE ATTENDING REDS SUPPORT

PROGRAMME

Purpose: To gain deeper understanding of how the HIV and AIDS pandemic affects the respondents and how they cope, if at all they are coping.

The questions are as follows:

1. How has the HIV and AIDS pandemic affected you emotionally?
2. How has the HIV and AIDS pandemic affected you spiritually?
3. How has the HIV and AIDS pandemic affected you physically (for example, do you sleep well, has your appetite decreased; etc)?
4. How has the HIV and AIDS pandemic affected you socially, how has it changed the way you interact with others?



APPENDIX G

Post-test questionnaire: ProQOL



Post-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*.

31. I am happy.

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

32. 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

33. I get satisfaction from being able to help.

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

34. I feel connected (joined) to others.

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

35. 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



36. 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

37. 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

38. 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

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

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

40. 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

41. 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



42. I like my work.

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

43. I feel depressed as a result of my work as a helper.

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

44. I feel as if I am experiencing the trauma of those I help.

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

45. I have beliefs that support me.

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

46. I know how to use different helping techniques.

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

47. I am the person I always wanted to be.

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



48. My work makes me feel satisfied.

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

49. Because of my work, I feel exhausted.

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

50. 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

51. 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

52. 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

53. 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



54. 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

55. 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

56. I feel frustrated by the system.

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

57. 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

58. 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

59. I am a very sensitive person.

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



60. 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

Questionnaire 2

Please complete / finish the following sentences honestly:

- 6. When I think of the future
- 7. Giving up
- 8. I hope that
- 9. When things go wrong
- 10. I can

APPENDIX H

Post-test non-standardized questionnaire with drawings



60. 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

Questionnaire 2

Please complete / finish the following sentences honestly:

6. When I think of the future

7. Giving up

8. I hope that

9. When things go wrong

10. I can



1. When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below:

APPENDIX I

Post-test semi-structured interview schedule

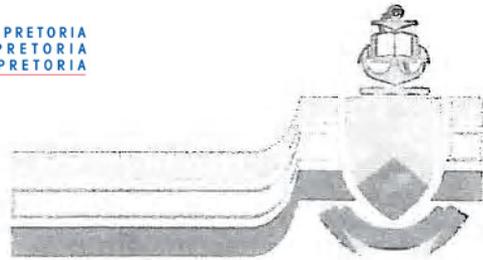


3. In your own words, write down a story, describing what REds Support Programme means to you, the role it has played in your life.
(Please do not exceed three paragraphs)



APPENDIX J

Informed consent letter for the school management team



University of Pretoria

Pretoria 0002 Republic of South Africa <http://www.up.ac.za>

**Department of Social Work and Criminology
Faculty of Humanities
Tel. +27 12 420-2325
Fax. +27 12 420-2093/420-5256**

Researcher: Penelope Viola Kupa

Tel. numbers: Work: (011) 380 6800

Cell: 073 1720 604

Home: (011) 882 4445

Sozama high school

Middelburg

Participant's name:.....

INFORMED CONSENT

- 1. Title of the study:** An evaluation of the effectiveness of Resilient Educators (REds) Support Programme among HIV and AIDS affected educators in Mpumalanga.
- 2. Purpose of the study:** The purpose of this study is to evaluate the effectiveness of the REds Support Programme among HIV and AIDS affected educators in Mpumalanga.
- 3. Procedures:** I expect to be interviewed individually by the researcher. The interview will be on my observation and perception about educators who participated in the REds Support Programme, on whether:
 - They are able to cope better with the challenges of being HIV and AIDS affected, and/or

- They have been able to support others in the school environment, colleagues and/or learners who are HIV and AIDS affected.

The interview will take approximately thirty minutes and it will be scheduled at my convenience.

- 4. Risks and discomforts:** There are no known risks and discomforts associated with this study, although I may experience emotional distress when being interviewed. If I experience distress, I will inform the researcher. I expect the researcher to then arrange a debriefing session for me with a suitably qualified counselor.
- 5. Benefits:** I understand that there are no known direct benefits for me for participating in this study. The results of the study will, however, assist the researcher to gain better understanding of the effectiveness of REs in supporting HIV and AIDS affected educators.
- 6. Participant's rights:** I may withdraw from participating in the study at any time.
- 7. Financial compensation:** I will receive no financial compensation from the researcher for my participation in this study.
- 8. Confidentiality:** In order to record accurately what I say in the interview, a tape recorder will be used. The tape will be listened to only by the above-named researcher and authorized members of the research team. I understand that the data obtained will be kept confidential unless I ask that they it be released. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.
- 9.** If I have any questions or concerns, I can call Viola Kupa at 073 1720 604 at any time during the day.

I understand my rights as a research respondent and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for five years.



I will receive a signed copy of this consent form.

Signature of respondent

Date

Signature of researcher

Signature of the supervisor

APPENDIX K

Semi-structured interview schedule for the school management team



4. Did the learners benefit indirectly from participation of educators (respondents only) in the REds support programme?

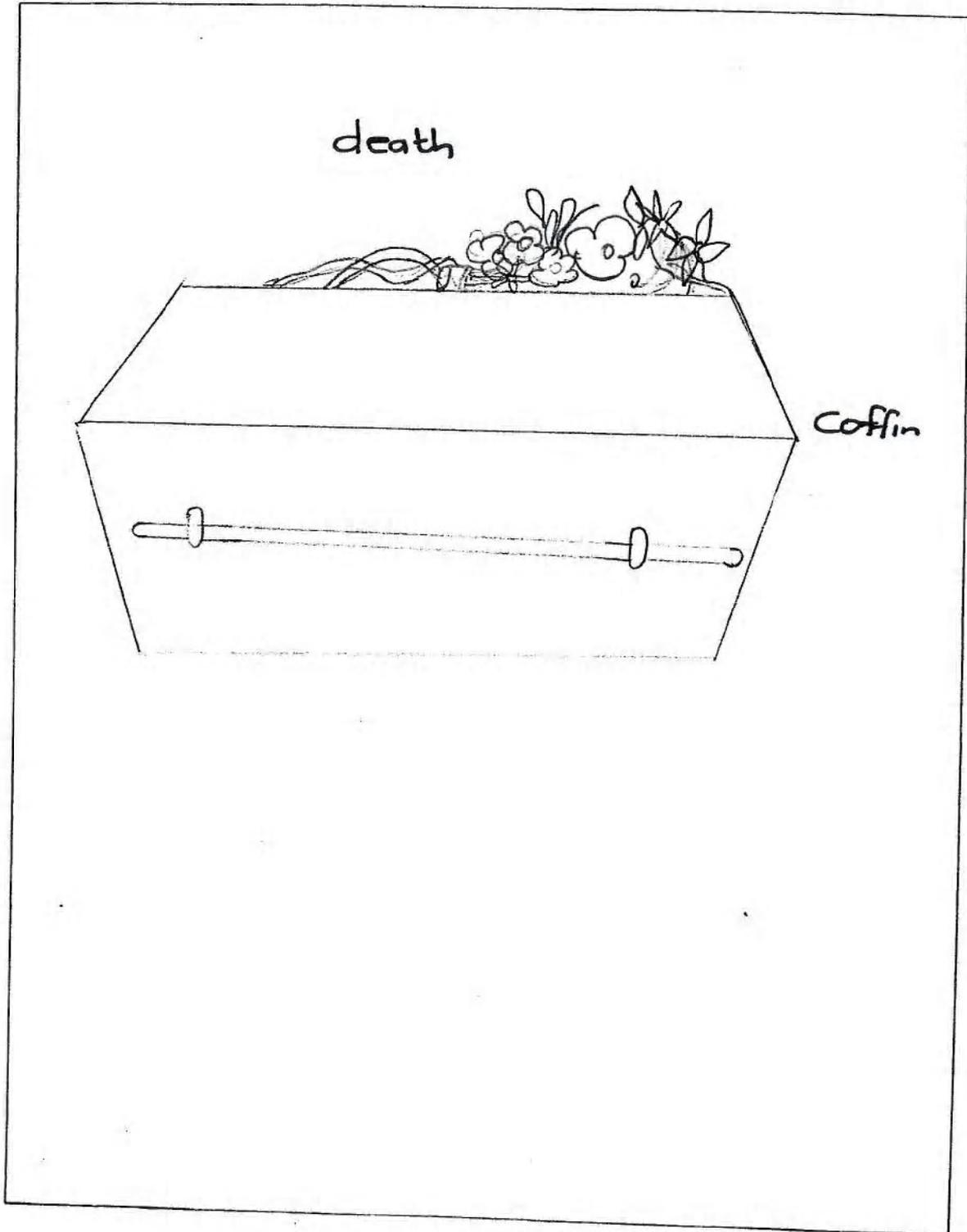
If yes, explain how.

APPENDIX L

Examples of respondents' drawings (pre- and post-test)

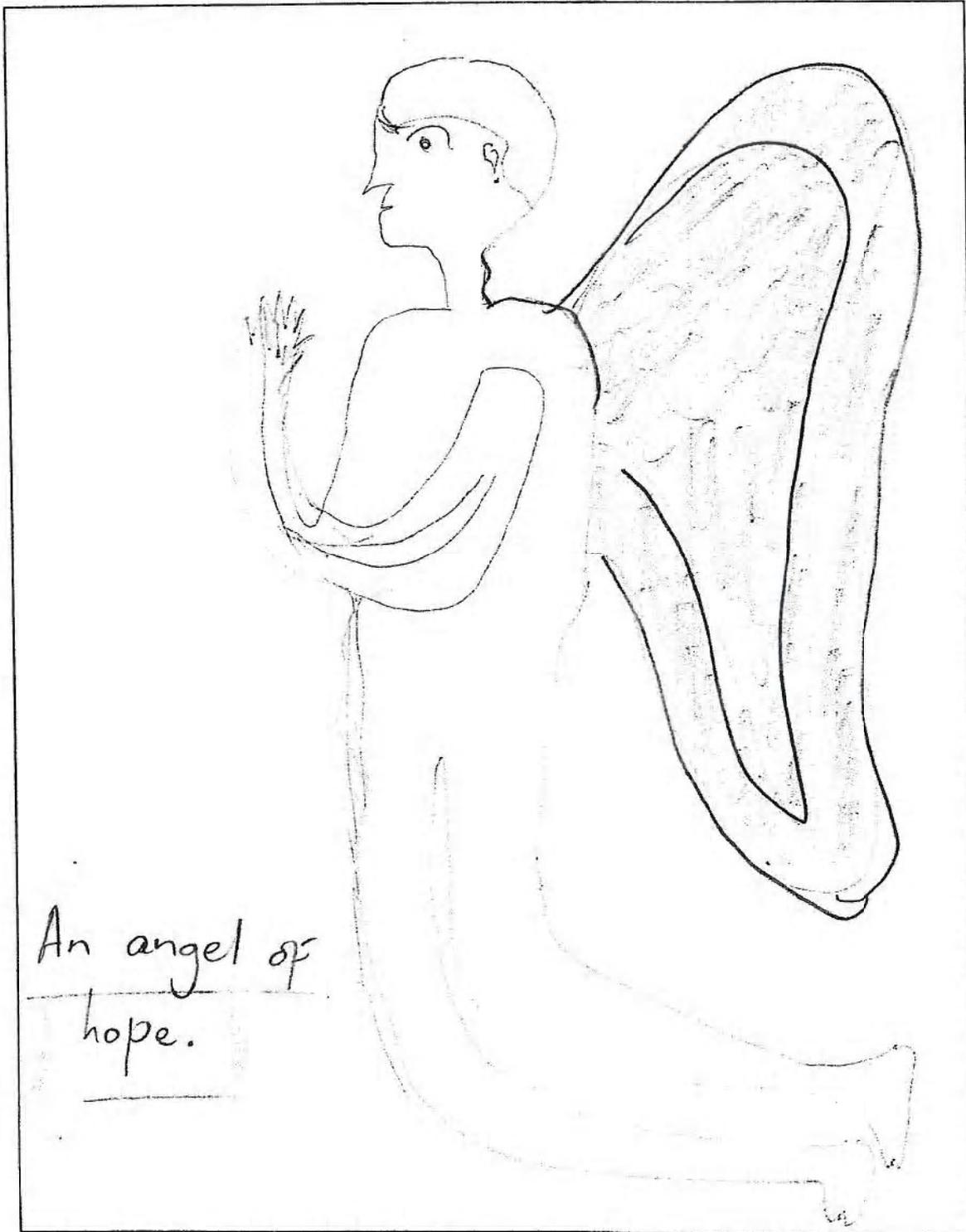


3. When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below:





3. When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below:



An angel of
hope.



APPENDIX M

Copy of ProQOL manual

The ProQOL Manual



*THE PROFESSIONAL QUALITY OF LIFE SCALE:
Compassion Satisfaction, Burnout & Compassion
Fatigue/Secondary Trauma Scales*

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THE PROFESSIONAL QUALITY OF LIFE SCALE: Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Trauma Scales

I. INTRODUCTION

The Professional Quality of Life Scale (ProQOL) is the current version of the old Compassion Fatigue Self Test (Figley, 1995). This version and the name change emerged for two reasons. First, the original scale has known psychometric problems. Second, we chose to change the name because we realized after market testing, that focusing the overall effort toward a positive thing, professional quality of life, made it easier to support positive system change to prevent or ameliorate the negative effects of caregiving and buttress the positive effects of providing care.

Multiple versions of the Compassion Fatigue test (CFST or CSF, Figley, 1995; Figley & Stamm, 1996) have been widely used in assessing compassion fatigue or secondary/vicarious trauma. Subscale psychometric difficulties have been noted (Figley & Stamm, 1996; Jenkins & Baird, 2002; Larsen, Stamm, & Davis, 2002). The ProQOL is a third revision of the CSF. This revision addresses difficulties separating burnout and secondary/vicarious trauma and reduces participant burden by shortening the test from 66 to 30 items. The revision, based on over 1000 participants from multiple studies, was developed by retaining the strongest, most theoretically salient items. Specifically, items were retained if they met both high item-to-scale criteria and were theoretically good representatives of the subscale construct. Quantitative decisions were made using Chronbach's alpha, factor analysis, and multigroup factorial invariance. Each new subscale has 10 items: 7 items from the previous CSF version and 3 new items designed to strengthen the overall theory of the subscale. New items were developed from the most recent literature on burnout and theory relating to compassion satisfaction. The ProQOL now consists of three subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue. Initial data suggest that these subscales have excellent internal consistency.

II. SCALE DEFINITIONS

The ProQOL is composed of three discrete scales that do not yield a composite score. Each scale is psychometrically unique and cannot be combined with the other scores. Considerable work has been undertaken to create a composite indicator score but to date, no satisfactory arrangement has been discovered. The key reason for this is the complex relationship between



the scales. It is possible for people to report high scores on CS combined with high scores on CF; this is not atypical among those who retain their altruistic desire to help when working in distressing situations such as in war or refugee camps. Typically, we do not see high scores on burnout with high satisfaction, but there is a particularly distressing combination of burnout with trauma. These latter cases seem to be at the greatest risk for negative outcomes, including, but not limited to, depression or PTSD and bad professional judgment which may contribute to patient care error or poor administration.

Compassion Satisfaction: Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

Burnout: Most people have an intuitive idea of what burnout is. From the research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

Compassion Fatigue/Secondary Trauma: Compassion fatigue (CF), also called secondary trauma (STS) and related to Vicarious Trauma (VT), is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly in the path of danger, such as being a soldier or humanitarian aide worker, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, such as in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.



Languages Available: The ProQOL and its predecessors have been used in projects in more than 30 countries around the world. It is available in English, French, Spanish, German, and Hebrew. Other translations are invited.

The ProQOL is used across many different types of professions. Sometimes it is appropriate to change the word helper to one that is more specific for the group being tested. For example, if you are working with teachers, you might choose to replace *helper* with the word *teacher*. This change can be made without specific permission from the test developer.



III. SCALE CREATION METHODS

The revision was based on a database of 365 cases from the original measure known as the CFST (Figley, 1995; Stamm & Figley, 1996), 940 cases from the “middle revision” known as the CSF (Stamm, 2002) and 463 cases using the current revision, the ProQOL. The data are amalgamated from separate studies. Data are aggregated by type of participant group (e.g., therapists, teachers, nurses, humanitarian aide workers, etc.). Because it is difficult to obtain information about the sex of the participants, data are not analyzed for male/female differences, although multiple previous studies have not yielded sex differences on any of the subscales. The psychometric data reported here are from an entirely new sample of 463 people taking the ProQOL.

The revised version was developed by retaining the strongest, most theoretically salient items and bolstering the subscales with new items to best represent their respective constructs. Specifically, items that met both high item-to-scale criteria and were theoretically good representatives of the subscale construct were retained. Quantitative decisions were made using Chronbach’s alpha, item-to-scale analyses, common factor analysis, and multigroup factorial invariance. Each new subscale has 10 items: 7 items from the previous CSF version and 3 new items designed to strengthen the overall theory of the subscale. New items were developed from the most recent literature on burnout and theory relating to compassion satisfaction.

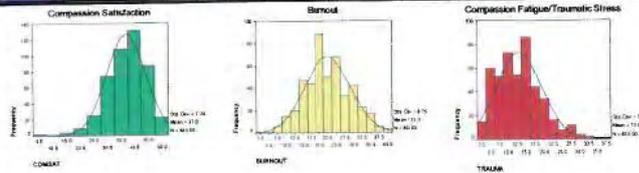
The overall length of the measure dropped from 66 to 30 items. The three subscale structure was retained—Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Traumatic Stress. In order to reflect the changing nature of the construct, which includes positive as well as negative items, the measure was given a new name, the Professional Quality of Life Scale, or the ProQOL. The measure, psychometric information, and scoring key is located at www.isu.edu/~bhstamm.

IV. PSYCHOMETRIC INFORMATION

Scale Distributional Properties: The scales generate distributions that are generally unimodal and symmetric (figure 1). The Compassion Satisfaction Scale typically is skewed toward the positive side and the compassion fatigue/trauma is skewed toward the absent side (e.g., most people report little disruption).

Figure 1: Subscale Distributional Properties

	Mean	Median	Mode	SD	S Error	Skew	Kurtosis	Min	Max
CS	37	38	39	7.3	.34	-.88	1.77	3	50
BO	22	22	21	6.8	.31	.07	-.35	3	40
CF/STS	13	12	15	6.3	.29	.66	.43	2	37



Reliability: The alpha reliabilities for the scales are as follows (see figure 2): Compassion Satisfaction alpha = .87, Burnout alpha = .72 and Compassion Fatigue alpha = .80. While these are in absolute value somewhat lower than the original test (Compassion Satisfaction alpha = .87, Burnout alpha = .90, Compassion Fatigue alpha = .87), given that the scales are shortened by half in length, these scores are actually more reliable than the longer form (see Spearman Brown formula, for example, if original reliability was .82, a comparable reliability on the shortened scale would be .69). The measure has considerable improvement on the item-to-scale statistics due to increased specificity and reduced colinearity. In addition, the standard errors of the measure are quite small so that the test typically has less error interference improving the potential measurable effect size. This latter point is particularly important with the sample sizes common among small clinical studies. Early returns on test-retest data suggest good reliability across time with a small standard error of the estimate.

Comment: Does not match value in Figure 2 (.71 vs .72). Text uses .72 in all documents.



Figure 2: Alpha Reliabilities

	Compassion Satisfaction	Burnout	Compassion Fatigue/ Sec Traumatic Stress
Compassion Satisfaction	alpha = .89 n = 457		
Burnout		alpha = .71 n = 379	
Compassion Fatigue/ Sec Traumatic Stress			alpha = .80 n = 369

See also:

Larsen, D., Stamm, B.H., & Davis, K. (2002). Telehealth for Prevention and Intervention of the Negative Effects of Caregiving. *Traumatic StressPoints*, 16(4). <http://www.istss.org/publications/TS/Fall02/telehealth.htm>

Figley, C.R., & Stamm, B.H. (1996). Psychometric Review of Compassion Fatigue Self Test <http://www.isu.edu/~bhstamm/pdf/figleystamm.pdf>. In B.H. Stamm (Ed), *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran Press. <http://www.sidran.org/catalog/stms.html>

Stamm, B.H. (2002). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C.R. Figley (Ed.). 107-119, *Treating Compassion Fatigue*. New York: Brunner Mazel.

Validity: The construct validity upon which the test is based is well established with over 200 articles noted in the peer-review literature (see Stamm, 1999 or www.isu.edu/~bhstamm for bibliographies). Using the multi-trait multi-method mode for convergent and discriminant validity (Campbell & Fiske, 1959), the scales on the ProQOL do, in fact, measure different constructs. In addition, the ProQOL revision of the CFST reduced the known colinearity between Compassion Fatigue and Burnout. The inter-scale correlations are as small. Compassion Satisfaction has 5% shared



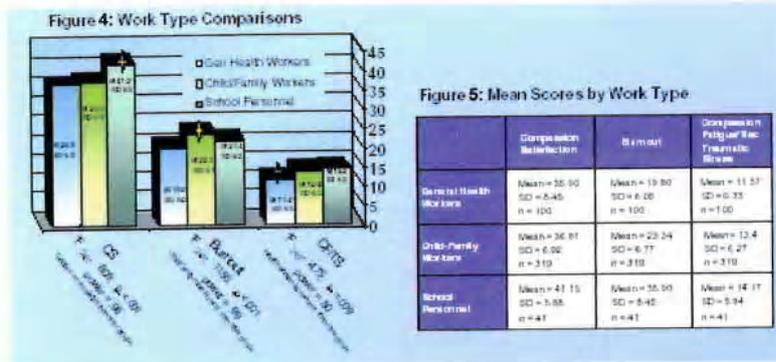
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variance with Burnout and 2% shared variance with Compassion Fatigue/Trauma. The shared variance between Burnout and Compassion Fatigue/Trauma is somewhat higher, likely reflecting the distress that is common to both conditions (21%), but the two scales are clearly different (see figure 3). Studies of discriminant and convergent validity are underway by several doctoral students at multiple universities.

Figure 3: Convergent and Discriminant Validity Among Scales

	Compassion Satisfaction	Burnout	Compassion Fatigue/ Sec Traumatic Stress
Compassion Satisfaction			
Burnout	R = -.23 co-σ = 5%		
Compassion Fatigue/ Sec Traumatic Stress	R = -.15 co-σ = 2%	R = -.46 co-σ = 21%	

Work Type Comparisons (Figure 4 & 5): To date, three broad classes of workers have been tested: general health workers (including clinicians through administrators); child/family workers, including residential and child protective care workers; and school personnel, which includes teachers, counselors, and administrators. Teachers were significantly more satisfied with their work, child-family workers were more burned out, and general health workers reported significantly fewer CF/STS symptoms.



V. SCORING

In this revision, missing data are managed by taking a summed score across each of the three scales on the ProQOL rather than an average score. While this does not address completely the potential problem of people refusing items due to avoidance, it does reduce the potential of misinterpretation of scores. For example, if an average score is used, there is the potential of having an abnormally low average if items are skipped and no adjustment is made in the denominator. In this case, a person who scored a 5 on each of 2 items, rejecting the other 8, would have an average score of 1. If you weight the average, then you have an average score of 5, but since data are missing on the other 8 items, you would not know if the person was reporting severe difficulty (e.g., mean 5) or if they had two areas that were troublesome and 8 that were not. With a summed score, this same case would score as 10 out of 50. While this still does not speak directly to the rejected items, because the interpretation of the score is based on distributions from the databank that includes over 2000 people across the various versions, we do have an ability to interpret that score in perspective.

To score the ProQOL, reverse items 1, 4, 15, 17, and 29 then score the three scales (Compassion Satisfaction Scale, Burnout Scale, and Trauma/Compassion Fatigue Scale) of the ProQOL. It is important to note that 0 remains 0 when scores are reversed as it always denotes the absence of the construct.

```
RECODE pq1 pq4 prq15 pq17 pq29 (1=5) (2=4) (3=3) (4=2) (5=1)
INTO pq1R pq4R pq15R pq17R pq29r.
```

```
COMPUTE CS = SUM(pq3,pq6,pq12,pq16,pq18,p20,pq22,pq24,pq27,pq30).
```

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COMPUTE BO = SUM(pq1r,pq4r,pq8,pq10,pq15r,pq17r, pq19, pq21, pq26, pq29r).

COMPUTE Trauma = SUM(pq2,pq5,pq7,pq9,pq11,pq13,pq14,pq23, pq25,pq28).

Below are the scale definitions and the average scores. This is reported on the scoring handout provided to individuals when they are given their scores.

Compassion Satisfaction: Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% of people score below 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 33, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout: Most people have an intuitive idea of what burnout is. From the research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 22 (SD 6.0; alpha scale reliability .72). About 25% of people score above 27 and about 25% of people score below 18. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 22, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Compassion Fatigue/Secondary Trauma: CF/STS and related to VT is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly



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in the path of danger, such as being a soldier or humanitarian aide worker, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, such as in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 13 (SD 6; alpha scale reliability .80). About 25% of people score below 8 and about 25% of people score above 17. If your score is above 17, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

Cut Scores (figure 6): The measure is best used in its continuous form. However, many people prefer to have cut scores to indicate relative risks or protective factors. Accordingly, a conservative quartile method is used with high (top 25%), middle 50%, and the low (bottom 25%), generally useful for screening, except close to the borders of the cut points. At the borders, extreme caution should be exercised with any decision making. Please note that while we provide cut scores based on the 75th percentile, we do not recommend that the measure be used for anything other than screening, and we prefer from a statistical perspective to use the continuous numbers. New data are being collected and if there are ways to improve the scoring, this information will be posted as soon as it is available. Currently, there are several studies using the ProQOL format. If you are willing to donate your raw data to the databank, we will run your sample against the existing database for you.

Figure 6: General Quartile Cut-Points

	Compassion Satisfaction	Burnout	Compassion Fatigue/ Sec Traumatic
Bottom Quartile	33	18	8
Mid-point	37	22	13
Top Quartile	42	27	17

VI. MISSING DATA

A decision must be made about how missing data are coded. For example, if a person chooses to score 5 items across the 30, did they mean that the blank cells were intended to be 0 (no problem) or were they rejecting the items because of avoidance typically associated with traumatic stress reactions? It is nearly impossible to discern the cause of missing data. The electronic version of the testing solves this by providing a pre-fill of 0 and asking participants to select a non-0 number if they do not agree with the 0. Based on comparisons between the pre-fill method and the paper method, it appears that a reasonably reliable decision rule is to assume 0 for missing data *if there are items responded to across the range of the scale (Decision Rule 1)*. For example, if a person responded to items 1, 3, 6, 15, 19, and 30, it is reasonable to assume that they just assumed 0 (no problem) for the non-marked item. Alternately, if a person begins the scale, filling in data for every item and then discontinues, the decision rule is to exclude that case as incomplete (*Decision Rule 2*). Occasional missing data (the current decision rule is <10% or 3 items) may be coded as “missing” and due to the sum method of scoring is not likely to affect the overall averages (*Decision Rule 3*). Cases with more than 10% missing data that do not qualify for Decision Rule 1 or Decision Rule 2 should be excluded (*Decision Rule 4*). In rare cases, interpolation methods may be used for filling in the missing data. In this case, the sample with interpolated

data should be compared statistically to the sample with the cases excluded and a thoughtful decision should be made as to which sample to use based on the distribution shape and violations of the assumptions of the planned statistical tests. We recommend that if using interpolated data changes the shape of the distribution by any of the first four moments (e.g., mean, standard deviation, skew and kurtosis), the interpolated data should not be used.

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APPENDIX N

Letter of the editor



IEDIT4

I hereby declare that I have edited Chapter 1 to 5 of this document by Penelope Monini Kupa, (student number 26404185). The edit entailed correcting spelling and grammar where necessary, and rephrasing sentences where the meaning was obscured. I have not checked the references. I have not helped to write this document or altered the student's work in any significant way.

It was not my responsibility to check for any instances of plagiarism and I will not be held accountable should the student commit plagiarism. I did not check the validity of the student's statements/research/arguments. Editing does not improve the content of the document, only the spelling and grammar.

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