

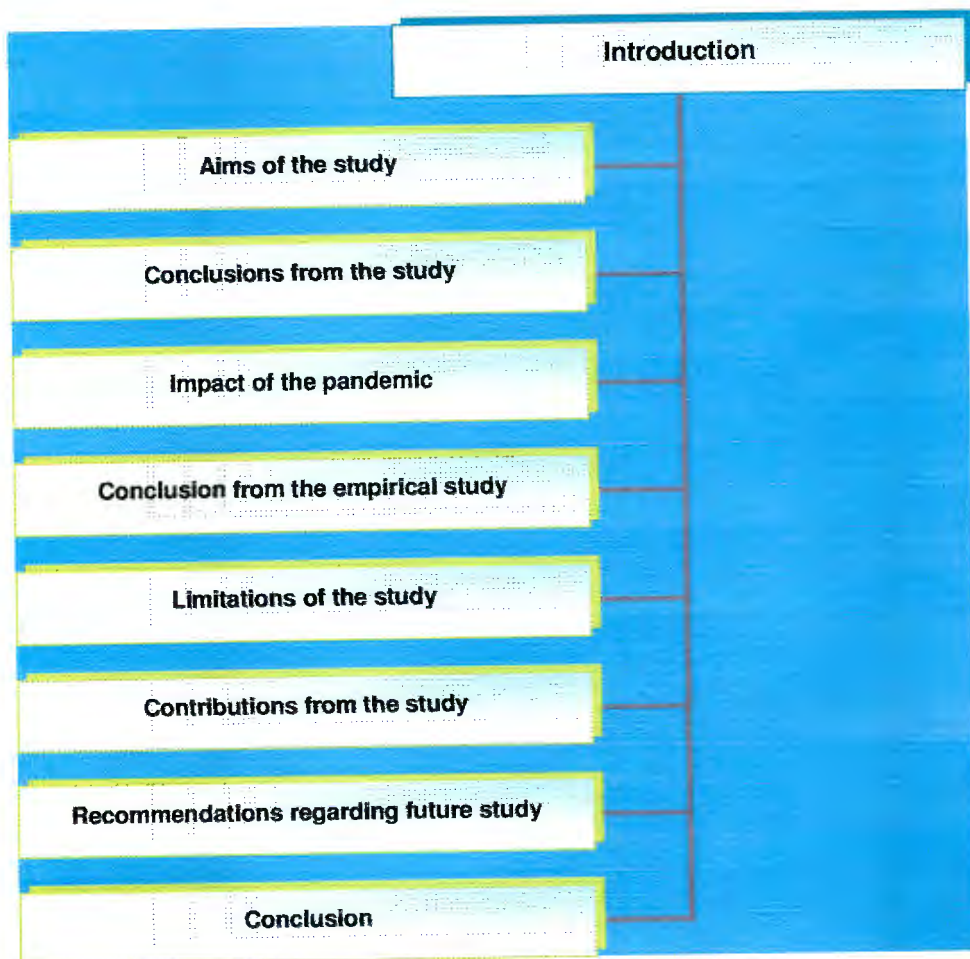
CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter Five will provide a general summary of the findings of this study, including a summary of the literature study and the results of the empirical study. This chapter will also present a brief discussion on limitations and contributions, and in conclusion make recommendations for future research. An overview of this study is summarised in Figure 5.1 below.

Figure 5.1: Overview of Chapter 5



5.2 AIMS OF THE STUDY

The general aim of the study was to examine how effectively educators in primary schools in the Thabo Mofutsanyana district (QwaQwa in the Free State Province) affected by the HIV/AIDS pandemic, can be supported to cope more resiliently with the challenges of the pandemic, using REds. The general aims of my study were actualised by using the specific aims as summarised in Table 5.1 below

Table 5.1: Aims and Achievements of my study

AIMS	ACHIEVEMENTS
Implementation of REds, using one group.	I implemented the REds programme with eight educators from one local school in rural QwaQwa (Thabo Mofutsanyana district). My REds formed part of the early pilot-testing which initially took place in Gauteng and which proved to be successful. This is why mine took place in the Free State Province to pilot it further. I implemented REds twice a week from July to November 2007.
Assessment of how resiliently (<i>Cf. Table 1.2</i>) participants cope with the challenges of the HIV/AIDS pandemic before and after the implementation of REds.	I conducted a one group pre- and post-test design using mixed methods of data collection: <ul style="list-style-type: none"> • I interpreted the data to answer the research question. I used the literature research to interpret the data collected in the pre-experimental study. In other words, the literature study provided a framework for me to understand how the pandemic was challenging

teachers (*Cf.* Chapter Two) and what the indicators of resilience were when teachers coped with these challenges resiliently (*Cf.* Table 1.2). I compared my pre- and post-test results with these to comment on how effectively REds had enabled participants.

The study I conducted was documented in Chapter Three and Chapter Four.

From the above it is clear that all the aims which I set out to achieve were achieved.

5.3 CONCLUSIONS FROM THE LITERATURE STUDY

The following conclusions were drawn from the literature in Chapter 2:

5.3.1 HIV/AIDS Statistics

HIV remains a global health problem that affects all countries (UNAIDS, 2008b: 3). HIV has caused an estimated 25 million deaths worldwide and has produced great demographic changes in the most seriously affected countries (UNAIDS, 2008a: 31). Although HIV is still rife in most countries, recent findings show that HIV infection has declined in several countries, in part as a result of the maximised access to antiretroviral drugs, therefore the situation is levelling (UNAIDS, 2008a: 31). It has been also reported that the estimated death rate is declining (UNAIDS, 2008a: 31).

5.3.2 Sub-Saharan Statistics

According to UNAIDS (2008a: 39), an estimated 1.9 million [1.6 million– 2.1 million] people were newly infected with HIV in sub-Saharan Africa in 2007, bringing the number of people living with HIV to 22 million [20.5 million–23.6 million]. Most epidemics in sub-Saharan Africa appear to have stabilised,

although often at very high levels, particularly in Southern Africa. Additionally, in a growing number of countries, adult HIV prevalence appears to be falling. According to UNAIDS (2008a: 31), the level of HIV/AIDS global prevalence might have decreased slightly due to ARV treatment provided, especially in sub-Saharan countries. Even though the numbers seem to be falling, women are still regarded to be more affected as compared to men, meaning that much has to be done to protect women against this vulnerability (UNAIDS, 2008a: 39).

5.3.3 HIV/Aids South African Statistics

South Africa is the country with the largest number of HIV infections in the world (Shisana *et al.*, 2009: 74; UNAIDS, 2008a: 47). The epidemic varies considerably between provinces, from 15% in the Western Cape to more than double that (39%) in KwaZulu-Natal (Department of Health South Africa, 2007; Shisana *et al.*, 2005: 35). KwaZulu-Natal, Mpumalanga, Free State and Gauteng are the provinces experiencing the highest HIV prevalence and the other provinces, Western Cape, Northern Cape and Limpopo show lower HIV/AIDS statistics (Shisana *et al.*, 2009: 74).

5.3.4 The impact of the HIV/Aids pandemic on education

Education is being put at risk by the higher death rate among teachers and students due to HIV/AIDS (Bennell, 2003: 493; Hoadley, 2007: 256) and by the ways in which the pandemic is affecting healthy teachers and learners (Theron, 2005: 56). It has also been noted that teachers who are infected and/or affected are struggling to teach, students who are infected and/or affected are more inclined towards failing, and school managers are battling to run the organisations as they are challenged by the impact of HIV/AIDS (Cohen, 2002: 17; Hoadley, 2007: 256).

5.3.4.1 Supply for Education


The HIV pandemic affects the supply of educators, because many educators who are HIV-negative experience so much HIV-linked professional stress, that they are considering quitting the teaching profession (Hall *et al.*, 2005: 23).

Affected educators report lower levels of professional morale and higher stress levels, related to increased workloads and overcrowded classes when colleagues are absent due to the pandemic (Bennell, 2005: 449; Hall *et al.*, 2005: 23), and sometimes having to assist learners in their classes who are either infected or affected by the pandemic.

5.3.4.2 Demand for education

How the demand for education is decreasing was discussed with special focus on the roles of orphanhood and vulnerability in this decline. Table 5.2 below summarises this.

Table 5.2: Decreasing demand for education due to orphanhood and vulnerability

<p>(Orphanage)</p>  <p>Orphanhood</p>	<p>When parents die, children are left with extended families or grandparents or have to live by themselves. The eldest children then have to assume responsibilities for which they are mostly not prepared, like taking care of younger siblings (Ebersöhn & Eloff, 2002: 78; Bennell, 2003: 493). Learners who are affected by HIV/AIDS experience hardship, find it difficult to concentrate and to do well at school, meaning that educational performance of learners from disrupted families suffers (Coombe, 2003, Elhoweris, 2004: 330: 53; Hoadley, 2007: 256; Van Wyk & Lemmer, 2007:303). Orphans can often not afford schooling (Bennell, 2003: 493; Coombe, 2003; Ebersöhn & Eloff, 2002: 78; Elhoweris, 2004: 330: 53).</p>
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Vulnerability



The HIV pandemic makes it difficult for vulnerable children to receive a good education (Ebersöhn & Eloff, 2002: 78). Learners in poor communities are especially at risk since there are higher infection rates in poor communities and fewer resources to cope with the problems caused by the disease (Coombe, 2003; Ebersöhn & Eloff, 2002: 82; Maile, 2003: 186; Van Wyk & Lemmer, 2007: 304). Vulnerable learners are learners who are forced into adult roles because of HIV-related circumstances (Coombe, 2003; Ebersöhn & Eloff, 2002: 78; Elhoweris, 2004: 330: 53). These adult roles often rob them of the chance to go to or complete schooling (Bennell, 2003: 493; Coombe, 2003; Ebersöhn & Eloff, 2002: 78; Elhoweris, 2004: 330: 53).

5.3.4.3 Quality of Education

Educators report being tired, stressed and not able to teach well, and ill or grieving learners not being able to learn well. Both of these compromise the quality of education (Ngemntu, 2009: 40; Serero, 2008: 40; Shisana *et al.*, 2005: 112; Theron, 2007: 178-179). In addition, the current shortage of educators offering scarce subjects like mathematics, science and technical skills will be even more compromised as many are also leaving education due to low motivation and being overloaded with the work of other colleagues who are ill and absent from school due to HIV/AIDS-related illnesses (Coombe, 2004: 115; Hall *et al.*, 2005: 23; Shisana *et al.*, 2005: 3).

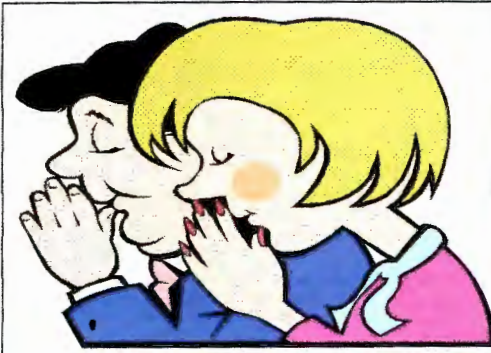
5.3.4.4 The impact of the pandemic on affected educators

Educators can be negatively affected by the pandemic even when they are HIV-negative. When educators have loved ones, learners or colleagues who are HIV-positive or who have died from AIDS-related complications, many report personal and professional suffering (Coombe, 2003; Hall *et al.*, 2005:

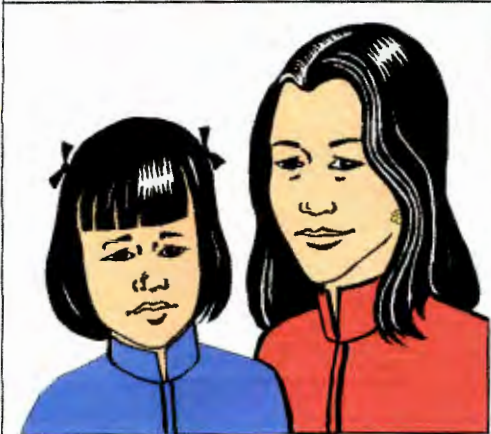
23; Mabitsela, 2009: 50; Theron, 2007: 175; Theron, 2008a: 33-34). Table 5.3 below summarises personal impact.

Table 5.3: The personal impact of the pandemic on affected educators

	<p>Educators experience a lot of stress as they have to cope with colleagues, learners or family members who are ill or dying because of HIV/AIDS (Bennell, 2005: 449; Coombe, 2003; Hall <i>et al.</i>, 2005: 23; Theron, 2005: 57).</p>
	<p>The physical well-being of educators is affected when they report having poor appetite, interrupted sleep, nightmares, having to teach learners who are malnourished and working with colleagues who are very sick (Hall <i>et al.</i>, 2005: 30; Ngemntu 2009: 40; Serero, 2008: 37; Theron, 2007: 182).</p>
	<p>Educators report having emotional distress. They experience feelings of sadness, anger, hopelessness, loneliness, despair, fear and confusion because of the many challenges brought about by teaching and living in the age of HIV/AIDS (Coombe, 2003; Ngemntu, 2009: 152; Serero, 2008: 123; Theron, 2007: 178-179).</p>



Educators affected by HIV/AIDS need to be strengthened spiritually as they experience trauma and anxiety because of the situation in which they find themselves. Many reports that they are spiritually disillusioned, (Theron, 2007: 182).



Educators' social well-being is also affected due to the trauma and grief they experience when they have to bury their loved ones, colleagues and learners (Coombe, 2003: 11; Kinghorn and Kelly, 2005: 493; Theron, 2007: 175). A number of educators report experiences of stigma related to HIV/AIDS (Serero, 2008: 124-125; Theron, 2007: 182).

5.3.4.5 Professional impact on affected educators

Educators affected by HIV/AIDS are severely challenged by having to become caregivers to a huge number of learners who are orphans or who are made vulnerable by HIV/AIDS (Bhana *et al.*, 2006: 5; Boler, 2003). Orphans mostly turn to educators for assistance as sometimes they have no one to support them regarding social and health services (Bhana *et al.*, 2006: 4-5; Coombe, 2003; Serero, 2008: 39). Some educators take responsibility for these orphans, even taking them into their homes for care and support (Bhana *et al.*, 2006: 4-5; Coombe, 2003; Serero, 2008: 39).

It is clear from the literature study above that the effect of the pandemic on educators is a negative one.

5.3.4.6. Overall Conclusion

My review of literature focused on the HIV/AIDS pandemic, its influence on education, and more especially on educators, led me to conclude that educators are mostly negatively affected by the HIV/AIDS pandemic. Even if the pandemic is levelling off in some countries (UNAIDS, 2008a: 40) it continues to threaten South Africans (Shisana *et al.*, 2009: 74). When educators are affected, their personal lives (physical, social, emotional and spiritual functioning) and their professional lives take a beating. Some educators cope better with the challenges of the pandemic (Esterhuizen, 2007: 165; Mabitsela, 2009: 184; Theron, 2007: 183). When educators are resilient, they have personal strengths (e.g. confidence to talk openly, good social skills) and community support (e.g. supportive colleagues, access to resources) and cultural values (e.g. strong faith) (see Table 1.2 for a complete list of indicators of resilient affected educators). This profile of resilient, affected educators gave me a framework to evaluate how well REs supported my participants towards resilience.

5.4 CONCLUSIONS FROM THE EMPIRICAL STUDY

I started this study with the following question: How effectively can primary school educators in the Thabo Mofutsanyana district who are affected by the HIV/AIDS pandemic be supported towards coping resiliently with the hardships of the pandemic, using REs? After the implementation of REs, I observed that most of my participants showed more indicators of resilience than before their participation in REs (Cf. Table 4.9). Using the summary (Table 4.9) of how the indicators of resilience (i.e. as originally set out in Table 1.2 in Chapter One) grew, I drew the following conclusions about how effectively REs encouraged my participants to cope resiliently:

Table 5.4: Conclusions from empirical study

Effective (Growth of at least 2 points from pre- to	Quite effective (Growth of at least 1 to 1 ½ points from	Not effective enough (Growth of less than 1 point from pre- to
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post-REds)	pre- to post-REds)	post-REds)
<p>The greatest growth pre-REds to post-REds was in participants' capacity for hope. My participants also grew in terms of being well informed and having faith.</p>	<p>After participating in REds my participants showed some growth in knowing where to access help, knowing how to solve their own problems and showing empathy and accepting that HIV is a disease, rather than a death sentence.</p>	<p>After participating in REds, my participants showed very little growth in how much they enjoyed working with other people, in knowing that their colleagues were supportive and in talking about the pandemic openly.</p>

From my study it seems that REds was generally effective in encouraging participants towards resilience (all resilience indicators improved as summarised in Table 4.9). Because this was a pre-experimental study, the growth in resilience indicators (See Table 4.9) cannot be conclusively linked to REds (Leedy & Ormrod, 2005: 217), but the growth was most probably influenced by participation in REds. My conclusion is that REds was an effective intervention for my rural participants, just as it was for urban participants (Esterhuizen, 2007; Mabitsela, 2009).

The summary in Table 5.4 leads me to suggest a number of changes for future REds. In summary, I believe that REds offered my participants many benefits (as can be seen in the "Effective" and "Quite effective" sections summarised in Table 5.4), but I also believe REds can be modified to encourage more job satisfaction, more positive relationships with colleagues and others, and freedom to speak openly about HIV, as detailed in 5.5 below.

5.5 RECOMMENDATIONS FOR CHANGES TO REDS

Given my conclusions in 5.4, I recommend the following:

- The indicators that show the least growth related to being engaged in positive, supportive relationships, enjoy working with others and being able to talk openly about the pandemic. This suggests that future REds may need to adapt so that these resources are more strongly encouraged. This could include spending more time on activities and contents, or adding more contents and activities, that would encourage these indicators of resilience. It could also mean that REds possibly needs to also involve community members to enable educators to become more actively involved in their immediate society and in so doing experience supportive relationships. If educators complete REds along with other community members it might also break down barriers to talking openly about the pandemic. REds should perhaps involve the whole staff of the school rather than just a group of volunteers, because this might encourage bonding among educators as a whole group and facilitate the development of more supportive relationships with colleagues.
- It is also possible that longer facilitation periods will be more important in future REds facilitation. By this I mean that if participating educators have more time to adjust to new skills and knowledge, they might grow more resilient.
- Because there were resilience indicators that existed prior to participating in REds (see Table 4.9), future REds facilitators should make more of the strengths that participants already possess when facilitating REds. If facilitators use the strengths that the participants bring, they can build on these to encourage greater growth to resilience.

The above recommendations are based on my study with rural participants. It is possible that their rural context (e.g. being quite isolated or being conservative – see 3.3.3) contributed to them being less confident about speaking openly or not having a sense of collegial support. Still, the above recommendations might be important in non-rural contexts too.

5.6 LIMITATIONS OF THE STUDY

The following limitations were noted:

- The study was conducted in one school with eight participants in a rural area. This means I can comment only on how REds enabled these participants in particular. I cannot easily generalise my findings to educators in schools from urban areas or educators in high schools or FET colleges.
- The results of this study cannot be taken as the final conclusion as it included only Sesotho-speaking teachers; it therefore did not include coloureds, Indians & white teachers. This means that I cannot comment on whether REds would be meaningful for other population groups.
- As noted often, my study was pre – experimental (Leedy & Ormrod, 2005: 217) and so my findings are not conclusive.

5.7 CONTRIBUTIONS MADE BY THE STUDY

The study made the following contributions:

There is an urgent call for South African educators affected by HIV/AIDS to get support to enable them to cope at work and in the community (Bennell, 2005: 460-462; Bhana *et al.*, 2006: 18-19; Hall *et al.*, 2005: 30; Louw *et al.*, 2009: 205; Theron, 2005: 56; Theron, 2007: 184; Theron *et al.*, 2008: 78). This is why REds was developed. Previous studies used the REds programme in urban areas, whilst my study was piloted with rural teachers in the Free State. This means my study contributed to the evaluation of REds and showed that REds can potentially encourage affected educators in rural areas to cope more resiliently. Other researchers can consider using REds with more confidence with rural teachers (similar to my participants), given the findings of my study.

I interpreted the findings of my study critically (see Table 5.4) and so my study contributes to the refinement of REds in the following manner: I make specific recommendations on how REds can be refined, I pinpoint in which areas REds was not very effective in encouraging resilience in my rural participants and suggest how future REds could address this.

Although I am aware that participants sometimes like to please researchers and so provide complimentary responses (Mouton, 2008), I do believe that my study made a meaningful contribution to the participants. They were positive about their experience of participating in REds and I think they gained skills and insights that (further) encouraged their resilience (see Table 4.9).

5.8 RECOMMENDATIONS FOR FURTHER STUDY

This study had limitations that can hopefully be corrected in the near future putting the following recommendations into practice:

- REds needs to be implemented with many more educators from schools in rural areas. These future rounds of implementation need to include educators from all race groups, diverse cultures, and from high schools as well. Future rounds of implementation should also include rural areas in other provinces.
- REds needs to be adjusted to include the recommendations made in this study and then be evaluated to see whether the recommendations do in fact improve REds and enable other rural educators to cope effectively with the challenges of the pandemic.

5.9 CONCLUSION

The HIV/AIDS pandemic is one of many stressors attacking educators, both personally and professionally (Theron, 2008a: 33). The pandemic arouses disillusionment, helplessness and hopelessness in the affected educators (Theron, 2008a: 33). When educators are affected by the pandemic, they may be forced into double roles of teachers and carers - teaching in the day time and caring for infected loved ones or others in the night time; or teaching whilst also trying to take care of the basic emotional and physical needs of orphans and vulnerable children in their classes (Theron, 2008a: 33). For the above reasons and more, educators need support to be able to cope with the adversity of the pandemic.

REds was developed with the intention of providing support to educators affected by the pandemic. In my study REds has proven to be meaningful, as educators who participated were happy about it and recommended that it be implemented to all educators as a means of support. This does not mean that there isn't any support for people living with HIV/AIDS; it simply means that support for educators is not enough, and the existing support needs to be emphasised so that educators can be enabled to cope resiliently and work happily under the existing circumstances. My hope is that REds will continue to be refined and implemented with many, many more educators who are 'alone and frightened', as suggested in the song below, so that across South Africa affected teachers can sing, "We won't bow down in defeat, we'll fight on", with which I conclude my study.

AIDS SONG: ALONE AND FRIGHTENED

Out there somewhere, alone and frightened
Of the darkness, the days are long oh.
Life is hiding, no more making new contact,
No more loving arms around my neck.

Take my hand now, I'm tired and lonely.
Give me love, give me hope.
Don't desert me, don't reject me.
All I need is love and understanding.

Today it's me, tomorrow someone else.
It's me and you, we've got to stand out and fight.
We'll shed a light in the fight against AIDS.
Let's come out, let's stand together and fight AIDS.

In times of joy, in times of sorrow
Let's take a stand and fight on to the end.
With open hearts let's stand out
And speak out to the world – we'll save lives.
Save the children of the world.

Let's be open, advise the young ones,
A new generation to protect love.
Hear them singing, playing, laughing -
Let's give them everything in truth and love.

Take the message, cross the frontiers.
Break the barriers, we'll fight together.
The doors are open, we'll lead the struggle.
We won't bow down in defeat, we'll fight on.

By: Philly Bongoley Lutaaya
(Ugandan singer)