

CHAPTER TWO

THE REALITY OF HIV/AIDS IN SOUTH AFRICA

2.1 INTRODUCTION

This chapter aims at unearthing information about the HIV/AIDS pandemic in South Africa. It discusses various issues related to the research topic, including:

- Statistics of the HIV / AIDS pandemic in South Africa;
- the impact of HIV / AIDS on education; and
- the impact of HIV / AIDS on affected educators.

This information provides the broad context in which affected educators must teach and it also shows how the pandemic puts teachers at risk for negative outcomes like stress, job dissatisfaction and a lot of negative emotion (Shisana *et al.*, 2005: viii). In other words, living and working in the context of the pandemic requires resilience.

Support for educators is advocated in education and union policy, but it is nevertheless noted that there is an inadequate recognition of the impact of HIV/AIDS on the context of educators (Simbayi *et al.*, 2005:134) mainly due to various factors around HIV including stigma, which may cause educators not to come forward with their status or their loved ones' status, or even not to go for testing or treatment (Louw *et al.*, 2009: 206). These circumstances make it hard for the educators to get the proper support they deserve to become resilient. For the above reasons and more, there is an urgent call for South African educators affected by the HIV/AIDS to get support to enable them to cope at work and in the community (Bennel, 2005: 460-462; Bhana, Morrel, Epstein & Moletsane, 2006: 18-19; Hall *et al.*, 2005: 30; Louw *et al.*, 2009: 205; Theron, 2005: 56; Theron, 2007: 184; Theron *et al.*, 2008: 78).

2.2 HIV/AIDS STATISTICS

HIV remains a global health problem that affects all countries (UNAIDS, 2008b: 3). HIV has already caused an estimated 25 million deaths worldwide, and has caused a lot of demographic changes in the most heavily affected countries (UNAIDS, 2008b: 3). Many people have become infected and affected by HIV/AIDS. In 2007 it was estimated that 33.2 million [30.6-36.1 million] people were living with HIV worldwide (UNAIDS, 2008a: 32). Researchers reported that more than 3 million new infections occur per year globally. In 2007 about 2.5 million [1.8-4.1 million] occurred during 2007, of which over two thirds (68%) occurred in Sub-Saharan Africa (UNAIDS, 2008a: 32). Overall, 2.0 million [1.8 million–2.3 million] people died due to AIDS in 2007, compared with an estimated 1.7 million [1.5 million–2.3 million] in 2001 (UNAIDS, 2008a: 32). Table 2.1: below summarises the global statistics.

Table 2.1: Global statistics of the HIV/AIDS epidemic (UNAIDS, 2008a)

Global summary of the AIDS epidemic		
Number of people living with HIV in 2007	Total	33.2 million
	Adults	30.8 million
	Women	15.4 million
	Children under 15 years	2.5 million
People newly infected with HIV in 2007	Total	2.5 million
	Adults	2.1 million
	Children under 15 years	420 000
AIDS deaths in 2007	Total	2.1 million
	Adults	1.7 million
	Children under 15 years	330 000

Although HIV/AIDS is still regarded as a serious health problem, recent findings show that HIV infection has fallen in several countries, and the situation is levelling (UNAIDS, 2008a: 31). It is also reported that the estimated death rate is also declining (UNAIDS, 2008a: 31).

Globally, the percentage of women among people living with HIV has remained stable (at 50%) for several years, although women's share of infections is increasing in several countries (UNAIDS, 2008a: 30). These statistics mean that we are in one way or the other all affected by the pandemic and ways and means have to be devised of dealing with this dangerous reality (Coombe, 2004: 103).

2.2.1 Sub-Saharan Statistics

Sub-Saharan countries have been greatly affected by the HIV/AIDS pandemic (Louw *et al.*, 2009: 205; UNAIDS 2008a: 30). This region is home to 67% of all people living with HIV. A total number of 1.9 million [1.6 million – 2.1 million] people in sub-Saharan Africa became infected with HIV in 2007 (UNAIDS 2008a: 39).

Sub-Saharan Africa's epidemics differ from country to country. Adult national HIV prevalence is below 2% in several countries, but in 2007 it exceeded 15% in seven Southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe), while it was above 5% in seven other countries in Central and East Africa (UNAIDS, 2008a: 39). Although most epidemics in sub-Saharan Africa appeared to have stabilised, in a growing number of countries in Southern Africa adult HIV prevalence appears to be falling. For the region as a whole, women are most excessively affected in comparison with men (UNAIDS, 2008a: 39), with especially more differences between the sexes in HIV prevalence among young people (UNAIDS, 2008a: 39).

As noted above, HIV prevalence in Southern Africa is surprisingly going down in places. In Zimbabwe HIV prevalence in pregnant women attending antenatal clinics fell from 26% in 2002 to 18% in 2006 (UNAIDS, 2008a: 39). In Botswana, a drop in HIV prevalence among pregnant women between the ages of 15–19-years (from 25% in 2001 to 18% in 2006) suggests that the rate of new infections could be slowing (UNAIDS, 2008a: 39). Sadly, this more positive trend is not true for all countries. HIV prevalence among pregnant women in Lesotho and in some parts of Mozambique is increasing (UNAIDS,

2008a: 40). In some of the provinces in the central and southern zones of the country, adult HIV prevalence has reached or exceeded 20%, while infections continue to increase among young people (ages 15–24) (UNAIDS, 2008a: 40).

In sub-Saharan Africa, recent studies suggest that unprotected anal sex between men is probably a more important factor in the epidemic than it has been thought to be. In Zambia, one in three (33%) surveyed men who have sex with men, tested HIV-positive (UNAIDS, 2008a: 43).

Life expectancy at birth has fallen significantly in countries with high HIV prevalence. In Southern Africa, average life expectancy at birth is believed to have dropped to levels last noted in the 1950s, thus it is now below 50 years for the sub-region as a whole (UNAIDS, 2008a: 46). This is a very worrying projection, in part because it suggests younger Africans will be robbed of mature role-models and the wisdom of elders.

In Southern Africa, premature death and poorer fertility among HIV-positive women have together lowered population growth rates and so dramatically reshaped the population structure. In a country such as Lesotho where HIV infection rates are high, the groups most heavily affected by HIV are infants and young children, and the 30–50 age groups (UNAIDS, 2008a: 47). This pattern is common in countries that are economically active and have child-raising populations (UNAIDS, 2008a: 47). As noted previously, this has worrying implications for Africa, more especially Sub-Saharan Africa.

In 2007, an estimated 270 000 [250 000–290 000] HIV-infected children younger than 15 years died because of AIDS — more than 90% of them in sub-Saharan Africa (UNAIDS, 2008a: 37). South Africa has very similar trends, as discussed below.

2.2.2 South African Statistics

South Africa is the country with the largest number of HIV infections in the world (Shisana, Rehle, Simbayi *et al.*, 2009: 74; UNAIDS, 2008a: 47). HIV prevalence data collected from a recent round of antenatal clinic surveillance

suggest that HIV infection levels might be levelling off (UNAIDS, 2008a: 40). Although, according to UNAIDS (2008a: 40), there is no evidence yet of major changes in HIV-related behaviour. The estimates show that 5.7 million [4.9 million–6.6 million] South Africans were living with HIV in 2007, making this the region with the largest HIV epidemic in the world (UNAIDS, 2008a: 40) with prevalence among pregnant women at 30% in 2005 and 29% in 2006 (UNAIDS, 2008a: 40).

However, the decrease in HIV prevalence among young pregnant women (15–24 years) suggests a possible decline in the annual number of new infections (UNAIDS, 2008a: 40). This is encouraging, but does not mean that South Africans can relax about the HIV incidence in our country. According to *The Demographic Impact of HIV/AIDS in South Africa*, prepared by Dorrington, Johnson, Bradshaw and Daniel (2006:i) about 5.4 million people out of a total of nearly 48 million South Africans were HIV positive in the middle of 2006, giving a total population prevalence rate of a little over 11%. Around 600 000 are sick with AIDS (11% of the HIV-infected), (UNAIDS, 2008a: 47). Related HIV death rates among men and women were estimated to be 40%, with women still higher than men (UNAIDS, 2008a: 47).

According to Shisana *et al.* (2009: 74) although South African HIV prevalence has stabilised, this has happened at a very high level, which in turn means that too many South Africans are infected and affected. HIV infects and affects male and female South Africans in all provinces, from all races, across all age groups (as shown in Tables 2.2 – 2.4 below).

The epidemic varies considerably among provinces, from 15% in the Western Cape to more than double that (39%) in the province of KwaZulu-Natal (Department of Health South Africa, 2007; Shisana *et al.*, 2005: 33-35) as shown in Table 2.2. below.

Table 2.2: Estimated HIV prevalence among antenatal clinic attendees, by province (Shisana *et al.*, 2005: 33- 35)

Province	2001 prevalence %	2002 prevalence %	2003 prevalence %	2004 prevalence %	2005 prevalence %	2006 prevalence %
KwaZulu-Natal	33.5	36.5	37.5	40.7	39.1	39.1
Mpumalanga	29.2	28.6	32.6	30.8	34.8	32.1
Free State	30.1	28.8	30.1	29.5	30.3	31.1
Gauteng	29.8	31.6	29.6	33.1	32.4	30.8
North-West	25.2	26.2	29.9	26.7	31.8	29.0
Eastern Cape	21.7	23.6	27.1	28.0	29.5	29.0
Limpopo	14.5	15.6	17.5	19.3	21.5	20.7
Northern Cape	15.9	15.1	16.7	17.6	18.5	15.6
Western Cape	8.6	12.4	13.1	15.4	15.7	15.2
National	24.8	26.5	27.9	29.5	30.2	29.1

The above statistics show that KwaZulu-Natal, Mpumalanga, Free State and Gauteng were the provinces experiencing the highest HIV prevalence among people who attended antenatal clinics from 2000 to 2004. The results may imply that KwaZulu-Natal (and other provinces with higher rates of incidence) needs to pay more attention to prevention strategies (Noble, 2005; Shisana *et al.*, 2005: 33-35). The recent South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (Shisana, Rehle, Simbayi *et al.*, 2009) shows that this pattern of prevalence has continued. There has been some decrease in prevalence in the Western Cape, Gauteng, Northern Cape and Free State (Shisana *et al.*, 2009: 74) but generally the provincial

incidence noted in this 2009 report remains the same. The results also suggest that teachers in these provinces may be more affected.

Table 2.3 below shows the infection rate of South Africans per age group.

Table 2.3: Estimated HIV prevalence among antenatal clinic attendees, by age (Shisana *et al.*, 2005: 35)

Age group (years)	2001 prevalence %	2002 prevalence %	2003 prevalence %	2004 prevalence %	2005 prevalence %	2006 prevalence %
<20	15.4	14.8	15.8	16.1	15.9	13.7
20-24	28.4	29.1	30.3	30.8	30.6	28.0
25-29	31.4	34.5	35.4	38.5	39.5	38.7
30-34	25.6	29.5	30.9	34.4	36.4	37.0
35-39	19.3	19.8	23.4	24.5	28.0	29.6
40+	9.8	17.2	15.8	17.5	19.8	21.3

According to the above table, people in the age group 25 – 34 were most infected. This may be because they fall in the age group of people who are most typically sexually active. The high incidence of HIV in this age group may further be related to poverty, fewer or no jobs, ignorance and desperation for survival. Researchers called for immediate attention to this age group and the other groups since it is known that HIV affects everybody (Noble, 2005; Shisana *et al.*, 2005: 33-35). In the most recent survey by Shisana *et al.*, (2009) it became clear that South Africans in the age group of 25+ were still showing the highest rates of HIV prevalence (Shisana *et al.*, 2009: 79). The incidence in this group is now thought to be 16, 8% (Shisana *et al.*, 2009: 79).

Because infection rates vary between different groups of people, the findings from antenatal clinics cannot be applied directly to men, newborn babies and children. This is one of the reasons why there was a more general South African national survey by various researchers (Shisana *et al.*, 2005: 33 - 34), that is repeated regularly (Shisana *et al.*, 2009). Table 2.4 below shows the

estimated prevalence of HIV among South Africans when looked at according to race and gender.

Table 2.4: Estimated HIV prevalence infections in South Africa by sex and race (Shisana *et al.*, 2005: 33)

Sex and Race	Number surveyed	Prevalence %
Male	6,342	8.2
Female	9,509	13.3
African	9,950	13.3
White	1,173	0.6
Coloured	3,382	1.9
Indian	1,319	1.6
National	15,851	10.8

Based on the prevalence percentage of the 2005 survey (Shisana *et al.*, 2005: 33), researchers estimate that 10.8% of all South Africans were living with HIV in 2005. Among those, females and Africans appear to have the highest HIV prevalence, in other words, women and African people appear to be more vulnerable to HIV infection. As with my other tables, the most recent survey (Shisana *et al.*, 2009) shows a repeat of this trend: Africans have the highest HIV – incidence (13, 6%) and females are still more infected than males (13, 6% compared to males with 7, 9%) (Shisana *et al.*, 2009: 79). This implies that more attention still needs to be paid to prevention programmes and HIV/AIDS education aimed at females and Africans, while not ignoring other races, as HIV is still a national crisis (Noble, 2005; Shisana *et al.*, 2005: 33-35).

A number of factors seem to be responsible for the above findings, including poverty and social instability; low status of women (many women have no or limited rights within their communities and relationships); sexual violence; high mobility of African people related to their attempts to find work; and the lack of leadership in fighting HIV (Shisana *et al.*, 2005: 33-35; Van Heerden, 2005:

90). These various factors tell us that HIV infection is a complex issue. The 2009 Prevalence Survey by (Shisana *et al.*, 2009) tells us that although South Africa is progressing in its fight against HIV (Shisana *et al.*, 2009: 74), HIV/AIDS remains a problem that affects us as South Africans and that impacts negatively on social structures, including education.

2.3 THE IMPACT OF HIV/AIDS ON EDUCATION

Education, as an important tool especially in developing countries, is being put at risk by the higher death rate among educators and learners due to HIV/AIDS (Bennell, 2003: 493; Hoadley, 2007: 256) and by the ways in which the pandemic is affecting healthy educators and learners (Theron, 2005: 56). HIV/AIDS is associated with many negative impacts on education, with regard to educators, learners, schools as a system and for school communities. In sub-Saharan Africa many people important to the education process are dying (Bennell, 2003: 493-494; Theron, 2005: 56). In addition, educators who are infected and/or affected are struggling to teach, learners who are infected and/or affected are 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). These impacts of HIV/AIDS on Education will be discussed further in the sub-topics below that address the supply and demand for education.

2.3.1 Supply of Education

Following a 2005 study of HIV incidence among educators, Hall *et al.* (2005: 23) report that 12,7% of sampled educators were HIV positive, with the highest prevalence among 23-34 year old educators, (21,4%), and 35-44 year old educators (12, 8%). In these two groups, female educators had a higher HIV prevalence than men. A higher prevalence of HIV infection was noted among African educators (16.3%) compared to other educator groups whose prevalence was counted at less than 1% (Coombe, 2003; Hall *et al.*, 2005: 23; Shisana *et al.*, xvii). In other words, the HIV pandemic is threatening the supply of educators because it is well-known that HIV limits life expectancy and it seems to be threatening the supply of black educators and female

educators the most. Not all researchers are convinced that educators are at extreme risk for HIV infection (Bennell, 2005: 441), but the truth is that in South Africa many educators are HIV-positive and even more are HIV-affected. Furthermore, the projected incidence of AIDS-related deaths means that not only will there be fewer educators but also that the death of an educator may have psychological impacts on those educators (and even learners) who are not infected (Elhoweris, 2004: 330; Hoadley, 2007: 256).

Sadly, it seems that most educators infected by HIV/AIDS are working in the poorer provinces and in rural areas which typically have schools with larger classes, longer formal contact hours and low matric results (Theron *et al.*, 2008: 79). This has serious education implications, meaning many South Africans who suffer due to poverty and related social issues are the same people who will bear the impact of the HIV/AIDS (Elhoweris, 2004: 330; Hoadley, 2007: 256).

The HIV pandemic also affects the supply of educators as many educators are absent because of the impacts of the pandemic (Bennell 2005: 449; Coombe, 2003; Hall *et al.*, 2005: 23). Absenteeism among educators is increasing rapidly because of the following reasons:

- sickness of self;
- attendance at funerals almost every week; and
- taking care of orphans in their own homes (Coombe, 2003; Louw *et al.*, 2009: 207).

Coombe (2003) reports that Fridays are typically lost days to teaching due to funeral arrangements, which means that educators (and often learners) are absent.

In Malawi, attendance at funerals accounted for roughly the same level of teacher absences as personal sickness, which is approximately 35–40% but only 10–20% of absences in Botswana and Uganda (Bennell, 2005: 449; Coombe, 2003; Hall *et al.*, 2005: 23; Van Dyk, 2005: 4). Ill educators absent

themselves from school more often, due to the treatment required and some even transfer to other centres to be able to access medication (Coombe, 2003; Machawira, 2008: 180-181). Personal illness in countries like Botswana and Malawi accounts for 35–45% of absences in at least one day and 20–30% of absences in Uganda in both primary and secondary schools (Bennell, 2005: 449). One way of coping with ill and absent educators is for education departments to look for substitutes and temporary educators to close the gap created by ill educators (Cohen, 2002: 17; Hoadley, 2007: 256; Theron, 2005: 56).

The HIV pandemic can also affect 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; Louw *et al.*, 2009:207), and sometimes having to assist learners in their classes who are either infected or affected by the pandemic.

In summary, national HIV prevalence rates are still worryingly high and new infections continue to be reported, also among educators. Educators, especially those under 40 years of age, are infected and affected and even universities and colleges are feeling the loss of students, as well as teaching and administrative staff (Coombe, 2003; Elhoweris, 2004: 330; Hoadley, 2007: 256; Van Wyk & Lemmer, 2007: 303). Illnesses associated with HIV, absenteeism to recuperate or to care for ill loved ones, and the death of educators from AIDS-related illnesses are all linked to poorer supply of education. Furthermore, healthy educators consider quitting because they don't cope well with the many stresses that working with ill colleagues brings (Hall *et al.*, 2005: 1; Theron, 2007: 176).

2.3.2 Demand for education

In this study, the demand for education refers to how many learners will be in need of education or able to access education, given the negative impacts of

the pandemic on learners, their families and communities. Demand relates to the decreasing numbers of learners who are entering school due to HIV/AIDS pandemic (Coombe, 2003; Ebersöhn & Eloff, 2002: 78-79; Theron, 2005: 56). HIV/AIDS impacts on learners and children negatively in that it deprives many of them of an opportunity to learn - which is a fundamental human right - because affected children often have to stay at home to look after their orphaned brothers and sisters, or ill parents (Ebersöhn & Eloff, 2002: 78-79; Van Dyk, 2005:153; Van Wyk & Lemmer, 2007: 304).

Children and young people need knowledge and life skills to protect themselves against HIV/AIDS, and to enable them so that they do not become victims of the HIV pandemic themselves, and they can mostly acquire such life skills and knowledge if they are at school. Because of the impact of the pandemic, this is not always the case, as they sometimes don't have the opportunity of being at school (Ebersöhn & Eloff, 2002: 78-79; Van Dyk, 2005:153; Van Wyk & Lemmer, 2007: 304) and so the demand for schooling is affected.

Demand for education is related to the following issues:

2.3.2.1 Orphanhood

When children have lost parents due to death, they are called orphans (Maile, 2003: 186; Van Wyk & Lemmer, 2007: 304). An AIDS orphan is said to be a child younger than 15 years of age who has lost either a mother or father or both parents due to HIV/AIDS-related illnesses and lives with overburdened caregivers or in child-headed households (Kendall & O'Gara, 2007: 5; Van Wyk & Lemmer, 2007: 304; Townsend & Dawes, 2004: 69). In South Africa recent statistics suggest that 13% of children aged between 2-14 years have lost a mother, a father or both parents due to HIV/AIDS (Van Wyk & Lemmer, 2007: 304; Townsend & Dawes, 2004: 69). These statistics prove that a large number of children will grow up without the love and guidance of parents probably due to the impact of HIV/AIDS. These children will probably be deprived of many resources, including education, due to associated issues like poverty and stigma (Coombe, 2003).

When parents die, children are left with extended families, grandparents or have to live by themselves and the eldest children have to take on responsibilities that they are mostly not ready for, like taking care of smaller ones (Ebersöhn & Eloff, 2002: 78). Often this gets in the way of these learners completing their schooling. Learners affected by HIV/AIDS experience many hardships. They find it difficult to concentrate and do well at school, meaning that the educational performance of learners from disrupted families suffers.

Furthermore, orphans are at high risk of HIV infection because they are more vulnerable to abuse (Elhoweris, 2004: 330; Hoadley, 2007: 256; Van Wyk & Lemmer, 2007:303) – in instances of HIV infection, demand for schooling drops.

Death of the parents affects children negatively, often impacting their self-esteem negatively. Depression, anxiety, behavioural problems, academic problems, psychosomatic difficulties and suicidal acts often increase (Griessel-Roux, Ebersöhn, Smit & Eloff, 2005: 253). Children, who are emotionally impacted in this manner struggle to learn and so often drop out of school.

Many schools have accepted learners whose parents cannot pay school fees. This often also applies to orphans so that they may have access to free education, but there are certain documents that must be handed in before orphans can be exempted from paying school fees, such as death certificates of parents or birth certificates, which sometimes can be hard to find because parents did not apply for or receive them (Coombe, 2004: 111; Van Wyk, 2007: 309). Orphans or children heading households may not know that such exemption is possible and so the demand for schooling is affected. Delays in enrolment can also cause children to leave school because they are too old for required grades, or they cannot afford to pay, and some schools do not accept children who cannot pay school fees or buy the right uniforms and books (Coombe, 2004: 111; Van Wyk, 2007: 309). This also adds to the decreasing demand for education.

2.3.2.2 Vulnerable learners

Vulnerable learners refer to children (under the age of 18 years) who are orphaned or who are living with a terminally ill caregiver. These children are vulnerable to poverty, neglect, malnutrition, disease, abuse, physical and psychological trauma, exploitation and interrupted schooling (Bhana *et al*, 2006: 6; Coombe, 2004: 107; Maile, 2003: 186). Because orphaned learners were discussed in the preceding section, this section will focus on learners who are vulnerable because they are affected by HIV/AIDS (for example, when they are living with ill parents).

As noted in the previous section, the HIV pandemic makes it difficult for children to receive a good education (Ebersöhn & Eloff, 2002: 78). This also applies to vulnerable learners. Learners in poor communities are especially at risk due to the higher infection rate 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). This means that often their parents are ill and there is little or no support to cope with all the difficulties that come with this.

Often learners affected by the pandemic are more vulnerable than adults because they cannot look after themselves financially and socially, and they have not yet been taught how to protect themselves from infections and life threats (Coombe, 2000; Coombe, 2004; 107; Griessel- Roux *et al.*, 2005: 254).

The presence of HIV/AIDS in the family often means that children have to drop out of school for a while or for good because of having to work full-time to help or care for their sick parents (Coombe, 2003). In other words, vulnerable learners take on adult roles which get in the way of their schooling (Griessel- Roux *et al.*, 2005: 254).

Coombe (2003) reports that young people also cannot go to school because their vulnerable situations mean they cannot afford schooling. Although at some schools they don't have to pay fees, they require other items such as uniforms or even everyday necessities like soap to keep clean. Children

without emotional and practical support may withdraw, give up or keep to themselves because they do not have a sense of security and stability and so their schooling is disrupted (Bennell, 2005: 449; Coombe, 2003; Ebersöhn & Eloff, 2002: 78; Van Wyk & Lemmer, 2007: 304).

The fact that many vulnerable learners need to take on adult responsibilities like looking after parents and siblings, and working to help their families survive means that the number of school-going children is likely to decrease and this affects the demand for education. It also means that the number of illiterate South Africans may increase, which can also impact on future demands for education (Coombe, 2000; Coombe, 2003; Ebersöhn & Eloff, 2002: 78; Griessel-Roux *et al.*, 2005: 254).

The situation of children acting as caregivers and small adults often becomes permanent when their parents die and they become the primary caretakers of their orphaned siblings (Bhana *et al.*, 2006: 6-7; Coombe, 2003; Ebersöhn & Eloff, 2002: 78; Van Wyk & Lemmer, 2007: 304).

Children can also be vulnerable when they do not have enough information. This is especially true during the pandemic. For example, girls may be exposed to sexual harassment by boys if there is too little or incorrect information about HIV/AIDS or when there is a lack of communication with family members and educators about sex and HIV/AIDS (de Lange, Mitchell, Moletsane, Stuart & Buthelezi, 2006: 54; Kendall & O'Gara, 2007: 10; Van Wyk & Lemmer, 2007: 308). Their vulnerability may become a barrier to their coming to school and becoming educated.

One of the biggest challenges for school learners is the threat of living with the HIV virus in that it is surrounded by stigma (Maile, 2003: 186), which makes it difficult for a learner who is positive (or whose parents are positive) to receive undivided support from educators all the time and acceptance from peers. This could encourage dropping out of school to avoid other children who call them names that make them feel bad and drive them from school (Coombe, 2003; Maile, 2003: 186; Van Wyk & Lemmer, 2007: 304).

The HIV/AIDS pandemic may lead to a decline in levels of formal education and less demand for education because there may be fewer adults to encourage children to get an education. Children without good examples or good role-models are vulnerable and may engage in criminal activities for survival and not attend school (Van Dyk, 2005:153).

Although many children may seem to be so negatively affected by the pandemic, there are children who have managed to develop well in the context of adversity and risks (Masten, 2001: 227). Nevertheless, most learners who are affected or infected by HIV are vulnerable and this lessens their demand for schooling.

2.3.3 Quality of Education

What I overviewed under the previous two sections on supply and demand indicates that HIV/AIDS also affects the quality of education negatively. With regard to educators, when they are infected or affected they struggle to deliver quality teaching and are often ineffective and unproductive due to illness or worries about those who are infected (Coombe, 2004: 115; Theron, 2009: 238). Educators are being lost to the profession due to illness or because they are leaving education to take up other jobs (Hall *et al.*, 2005: 3; Theron, 2007: 176). Often, experienced educators are replaced with less experienced or temporary educators and this can affect the quality of education (Coombe, 2003; Coombe, 2004: 115).

HIV/AIDS makes it difficult for educators as well as learners to concentrate as they are often faced with illness, death and mourning (Coombe, 2004: 116; Theron, 2009: 238). The impact of AIDS on the African educational system is alarming in that the death an educator may have psychological impacts on those who are not infected (other colleagues and learners) (Coombe, 2004: 116; Theron, 2005: 56; Theron, 2009: 238). Furthermore, the high rate of absenteeism of infected educators disrupts time scheduled for teaching while those at work will have to take care of their own classes as well as the classes of absent educators (Elhoweris, 2004: 330; Hall *et al.*, 2005: 3; Van Wyk & Lemmer, 2007: 303). This means that often learners either have no educator

or are having an overworked educator, which leads to poorer quality of education.

The impact of HIV/AIDS adds more stress to individuals in senior management positions like education planners, principals and school management developers (SMGDs) (Coombe, 2004: 115; Hall *et al.*, 2005: 3). Many educators are leaving the education system due to lack of recognition, unsatisfactory salaries and the low morale in education, and the effects of the HIV/AIDS pandemic (Coombe, 2004: 115; Hall *et al.*, 2005: 3). The lower numbers of educators offering important subjects like mathematics, science and technical skills will become even more problematic as they 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: 27). This means that the quality of education is in danger.

Educators are often overworked, given the number of HIV-related challenges besides their core duty, which is to teach (Coombe, 2003; Hall *et al.*, 2005: 23). They also have to act as counsellors and social workers as they are faced with learners who are orphans and vulnerable due to HIV/AIDS (Bennell, 2005: 460; Hall *et al.*, 2005: 30; Shisana *et al.*, 2005: xxi; Simbayi *et al.*, 2005: 134 – 139). Educators experience further distress because they need to cope with AIDS orphans in their classes (Hall *et al.*, 2005: 23; Kendall & O’Gara, 2007: 16). This often means that their time is taken up with non-teaching activities and this can impact poorly on the quality of education.

2.3.4 Conclusion

All of the above describe a context that has many risks for educators, learners and for our country as a whole. Because my study focuses on how REds might enable educators affected by the pandemic to cope more resiliently with its many challenges, it is necessary to look at how educators are affected in more detail.

2.4 THE IMPACT OF THE PANDEMIC ON AFFECTED EDUCATORS

As noted previously, 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 educators report personal and professional suffering (Coombe, 2003; Mabitsele, 2009: 50; Theron, 2007: 175; Theron, 2008a: 33-34).

2.4.1 Personal impact on affected educators

Personal impact refers to the effects which the pandemic has on the educator as an individual. The educator's individual life impacts on her role as a professional and may therefore not be ignored. When educators experience personal wellness, their professional functioning is enhanced (Allegrante, 1998: 224; Theron, 2005: 57).

HIV/AIDS affects educators' emotional status negatively. Educator morale is low where the HIV/AIDS impact is high. 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 (Shisana *et al.*, 2005: xxi; Theron, 2005: 57).

HIV/AIDS is affecting educators physically, emotionally, spiritually and socially (Ngemntu, 2009: 40; Serero, 2008: 37; Theron, 2007: 178 – 180).

2.4.1.1 Physical Impacts

The physical well-being of educators is affected when their sleeping patterns and eating habits are disturbed. Poor appetite, interrupted sleeping and nightmares are reported by educators who are teaching malnourished learners and working with colleagues who are very sick, or who are nursing loved ones or worried about HIV-positive loved ones (Hall *et al.*, 2005: 30; Ngemntu, 2009: 40; Serero, 2008: 37; Theron, 2007: 182).

2.4.1.2 Emotional Impacts

Educators affected by the pandemic often report difficulty in adjusting because their experiences of the pandemic affect their emotional well-being. Many have reported that they experience feelings of sadness, anger, hopelessness, loneliness, despair, fear and confusion (Coombe, 2003: 11; Ngemntu, 2009: 152; Serero, 2008: 123; Theron, 2007: 178-179). Furthermore educators report high stress levels (Hoadley, 2007: 256; Theron, 2007: 182; Theron *et al.*, 2009: 3).

Educators who are affected report grief (Ngemntu, 2009: 152; Serero, 2008: 123; Theron, 2007: 182; Theron *et al.*, 2009: 128) and some even report depression (Theron, 2007: 182; Theron *et al.*, 2009: 128). Other educators talk about experiences of anger and despair when they are affected (Ngemntu, 2009: 40; Serero, 2008: 40). There is also mention of hopelessness, loneliness and anxiety (Serero, 2008: 40; Theron, 2007: 182; Theron, 2008a: 35).

2.4.1.3 Spiritual Impacts

Some affected educators report feeling that God has deserted them or that the pandemic is a punishment. This leads to them going to church less and to spiritual doubt (Ngemntu, 2009: 153; Serero, 2008: 124; Theron, 2007: 179). Other educators report that the pandemic has helped them grow spiritually by strengthening their trust in God; therefore they have a positive attitude towards the situation which brings them spiritual relief (Theron, 2007: 182). 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 (Theron, 2007: 182). Some affected educators show signs of comfort when they have positive religious support (Theron, 2007: 182).

2.4.1.4 Social Impacts

Some educators affected by the impact of HIV/AIDS report social isolation, fear of stigmatisation, withdrawal and being afraid to mix socially with others (Ngemntu, 2009: 154; Serero, 2008: 124-125). Theron (2007:182) explains

that social withdrawal may be the result of stigma and the myths behind HIV/AIDS. Educators who are infected or affected by HIV/AIDS are further traumatised and demoralised when they experience stigma. Learners, colleagues, friends, loved ones and those who die from AIDS-related causes can be sources of stigmatized experience (Serero, 2008: 124-125). Educators' social well-being is also affected by trauma and grief they experience when they have to bury loved ones, colleagues, and learners (Coombe, 2003; Kinghorn & Kelly, 2005: 493; Theron, 2007: 175).

2.4.2 Professional impact on affected educators

Educators affected by HIV/AIDS are often severely challenged by having to become caregivers to a huge number of learners who are orphans or vulnerable due to HIV/AIDS (Bhana *et al.*, 2006: 5; Boler, 2003). Orphans mostly turn to educators as they sometimes have no-one to support them regarding social and health services. 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). Providing support to these learners often causes stress for educators as it consumes their time, even after school (Bhana *et al.*, 2006: 7; Coombe, 2003; Serero, 2008: 38; Theron, 2007: 181; Theron *et al.*, 2008: 79).

In many schools educators are also expected to teach learners how to prevent the spread of HIV and to cope with the impacts with the pandemic (Serero, 2008: 38; Theron, 2007: 177), and without much skill or knowledge have to fill the gaps of staff who should have been professionally trained to deal with HIV-related issues (Bhana *et al.*, 2006: 8; Hoadley, 2007: 254-256; Theron, 2007: 181; Theron *et al.*, 2008: 79).

HIV/AIDS affect educators negatively, causing them to want to leave the profession due to unsatisfactory working conditions in which they find themselves (Hall *et al.*, 2005:25-26, 30). Educators affected by the pandemic experience higher levels of professional stress. This stress relates to overloading of daily routines and additional duties because of absent colleagues due to illness and other matters related to HIV (Coombe, 2003;

Serero, 2008: 38; Theron, 2007: 180). This means teachers are faced with overcrowded classes and there is often tension with those colleagues who are affected and ill most of the time (Coombe, 2003; Serero, 2008: 38; Theron, 2007: 180; Theron, 2008a: 34).

Educators working in the rural areas and poor communities where there is poor economical status and fewer resources, are reported to be the most challenged, as they are expected to support learners and colleagues suffering from the loss and grief caused by the HIV/AIDS pandemic (Theron *et al.*, 2008: 79; Theron *et al.*, 2009: 128), which eventually leaves them with no option but to become all-rounders by assuming many different roles at the same time (Bhana *et al.*, 2006: 14-16; Hoadley, 2007: 257; Theron, 2007: 177). This is said to be time and energy consuming and creates stressful time management problems for educators (Theron, 2007: 180; Theron *et al.*, 2008: 79).

The Department of Education assumes that educators and lecturers have adequate knowledge about HIV/AIDS and its transmission (Coombe, 2003; Hall *et al.*, 2005: 30; Shisana *et al.*, 2005: xxi), and also believes that educators can act as councillors (Coombe, 2003), but educators feel that they need training and support since they don't have enough knowledge and skills in this regard, (Coombe, 2003; Theron, 2009: 236). For some teachers the observation of cultural practices, cultural norms and religious values makes them feel uncomfortable talking about and teaching sex education (Coombe, 2003; Shisana *et al.*, 2005: xxi; Simbayi *et al.*, 2005: 134 – 139). This adds to the distress that they experience.

2.4.3 Conclusion

The effects of the pandemic on teachers' personal and professional lives described above, suggest that teachers affected by the pandemic are at risk. Despite all these adversities and negative challenges for educators created by the pandemic, there are educators who are reported to be coping resiliently with these challenges (Esterhuizen, 2007: 165; Mabitsela, 2009: 184; Theron, 2007: 183; Theron *et al.*, 2009: 140; Watson, 2005: 113-114). Their resilience

was summarised in Table 1.2, and gives hope, because it is possible for teachers to face all of the above risks and not crumble.

2.5 SUMMARY

This chapter described how HIV/AIDS is spreading and how it affects educators and learners and places them at risk. In conclusion, it is clear that HIV/AIDS affects most educators negatively. Still, some educators cope resiliently with these challenges (as summarised in chapter one in Table 1.2). Knowing that some educators are resilient in the face of the pandemic is a source of encouragement to support more educators to be resilient. This was part of the rationale for REds.

In the next chapter I give details about the research methodology I followed in my evaluation of REds.