

CRITIQUE OF AN INTERVENTION PROGRAMME FOR EDUCATORS AFFECTED BY THE HIV/AIDS PANDEMIC

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HED, FDE, B.Ed. HONS

**A dissertation submitted in fulfilment of the
requirements for the degree**

MAGISTER EDUCATIONIS

in

Educational Psychology

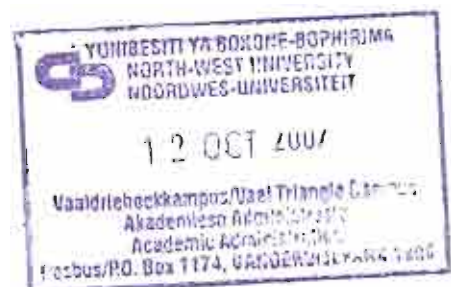
NORTH-WEST UNIVERSITY

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Why?

**On the street I saw a small girl,
Cold and shivering in a thin dress,
with little hope of a decent meal.
I became angry and said to God:
Why did you permit this?
Why don't you do something about it?**



**For a while God said nothing.
That night he replied, quite suddenly:
"I certainly did something about it.
I made you..."**

Author unknown

(Taken from PhD (in progress) by M J Malindi)

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God, who gave me the strength to persevere

Johan Esterhuizen, my supportive husband

Sumari, Elani and Johanli Esterhuizen, my precious children

Harry and Elize Vorster, my parents

Annatjie Vorster, my late mother

Family, friends and colleagues



***Your continuous encouragement and support will
never be forgotten!***

DECLARATION

I, Stefanie-Mariè Esterhuizen, declare this dissertation, "Critique of an intervention programme for educators affected by the HIV/Aids pandemic", to be my original work and that all consulted sources are completely referred to in the bibliography.

.....*Esterhuizen*.....

Stefanie-Mariè Esterhuizen



OPSOMMING

Beoordeling van 'n intervensie-program vir opvoeders wat deur die MIV/Vigs-pandemie geaffekteer word

Deur

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Aangesien Suid-Afrika een van die lande is met die hoogste MIV/Vigs-voorkoms in die wêreld, word baie Suid-Afrikaners deur die pandemie geaffekteer. Een van die strukture wat daardeur bedreig word, is die opvoedingsstelsel. Opvoeders word veral deur die pandemie getref weens die feit dat hulle nie net hul kollegas wat aan MIV/Vigs ly, moet hanteer nie, maar ook die groot hoeveelheid kinders in skole wat, as gevolg van die pandemie, wees en kwesbaar gelaat word. Soms moet hierdie opvoeders selfs vir hul eie geliefdes sorg wat aan die siekte ly of daaraan sterf. Die impak van die pandemie is persoonlike spanning, soos depressie en selfmoordgedagtes, asook professionele benadeling, soos deur verhoogde werkslas en personeelnegatiewe. Betrokke opvoeders is kwesbaar, sukkel om die mas op te kom en het ondersteuning dringend nodig weens die druk wat hulle ten opsigte van die pandemie ervaar.

Huidige literatuur meld min ondersteuning vir opvoeders wat deur MIV/Vigs geaffekteer word, rakende die persoonlike en professionele impak van die pandemie. Hierdie studie fokus daarop om te bepaal hoe doelmatig REs (Resilient Educators) is. REs is 'n ondersteuningsprogram wat opvoeders, wat deur MIV/Vigs geaffekteer word, bemagtig. Die implementasie hiervan is ook deur hierdie studie van stapel gestuur.

'n Kwalitatiewe navorsingsontwerp, wat eksperimentele- en aksie-navorsing insluit en op laasgenoemde (aksie-navorsing) fokus, is gebruik. 'n Doelgerigte gerieflikheidsteekproef bestaande uit agt vrywilligers van plaaslike laerskole het deelgeneem. Die navorser het gebruik gemaak van 'n gemengde-metode ontwerp vir die voorafgaande- en die na-toets wat kwalitatiewe- en kwantitatiewe-meetinstrumente ingesluit het.

REds is in groepsverband oor 'n tydperk van nege opeenvolgende weke geïmplementeer en voortdurend deur die deelnemers geëvalueer sodat verandering voorgestel kon word met die oog op die verbetering van die program.

Ten spyte daarvan dat hulle realisties is oor die struikelblokke wat hulle sal teëkom ten opsigte van die MIV/Vigs-pandemie, het die deelnemers gerapporteer dat hulle verlig, bemagtig en gemotiveerd was om die uitwerking van die pandemie te beveg. Die kwantitatiewe uitslae bewys 'n geringe verbetering in die deelnemers se ervaring van sekondêre trauma wat uit die impak van die pandemie voortspruit. Die uitslae dui daarop dat REds doelmatig was, maar dat opvoeders voortgesette ondersteuning nodig het. Sekere wysigings aan REds word ook voorgestel.

aksie-navorsing	geaffekteer	impak
MIV/Vigs	ondersteuning	intervensie-program
opvoeders	pandemie	weeskinders



SUMMARY

Critique of an intervention programme for educators affected by the HIV/Aids pandemic

by

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Degree: M.Ed. (Educational Psychology)

As South Africa is one of the countries with the highest HIV/Aids prevalence in the world, many South Africans are affected by the pandemic. One of the structures being endangered by the HIV/Aids pandemic is the education system. Educators are especially affected by the impact of the pandemic due to the fact that they not only have to cope with infected colleagues who are often absent, but are also burdened with numerous orphans and vulnerable children at their schools because of the pandemic. Sometimes these affected educators even have to care for their own loved ones who suffer from or die of the disease. The impact of the pandemic is personal stress, such as depression and suicidal ideation, plus professional impairment such as through increased workload and staff negativity. Affected educators are vulnerable, struggle to cope and are desperately in need of support, due to the pressure they experience regarding the pandemic.

Current literature reports little support for educators affected by HIV/Aids with regard to the personal and professional impact of the pandemic. This study focuses on determining the efficacy of REds (Resilient Educators), a support programme compiled to empower educators who are affected by HIV/Aids, the implementation of which was also piloted by this study.

A qualitative research design which included experimental and action research which focused on the latter (action research) was used. A purposive

convenience sample consisting of eight volunteers from local primary schools participated. The researcher made use of a mixed-methods design for the pre- and post-tests which included both qualitative and quantitative measuring instruments.

REds was implemented over a period of nine consecutive weeks in a group setting and was continuously evaluated by the participants who proposed changes in order to improve the programme.

In spite of being realistic about the obstacles they will face with regard to the HIV/Aids pandemic, participants reported to be relieved, empowered and motivated to fight the effects of the pandemic. The quantitative results show some improvement in participants' experience of secondary trauma resulting from the impact of the pandemic. The results suggest that REds was efficacious, but that educators need continued support. Some modification of REds is also suggested.

action research	affected	impact
HIV/Aids	support	intervention programme
educators	pandemic	orphans



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GLOSSARY

Aids	Aquired Immune Deficiency Syndrome
ART	Anti-retroviral treatment
ATIC	Aids Training and Information Centre
CBS	Community-based Support
EAP	Employee Assistance Programme
EST	Educator Suport Team
FBO	Faith-based Organization
HAC	Health Advisory Committee
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
NAPTOSA	National Professional Teachers' Organization of South Africa
NGO	Non-Governmental Organisation
OVC	Orphans and vulnerable children
PLWHA	People living with HIV/Aids
ProQOL	Professional Quality of Life
SADTU	South African Democratic Teachers' Union
SBST	School-based Support Team
SGB	School Governing Body
SMT	School Management Team

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CHAPTER ONE

ORIENTATION TO THE STUDY



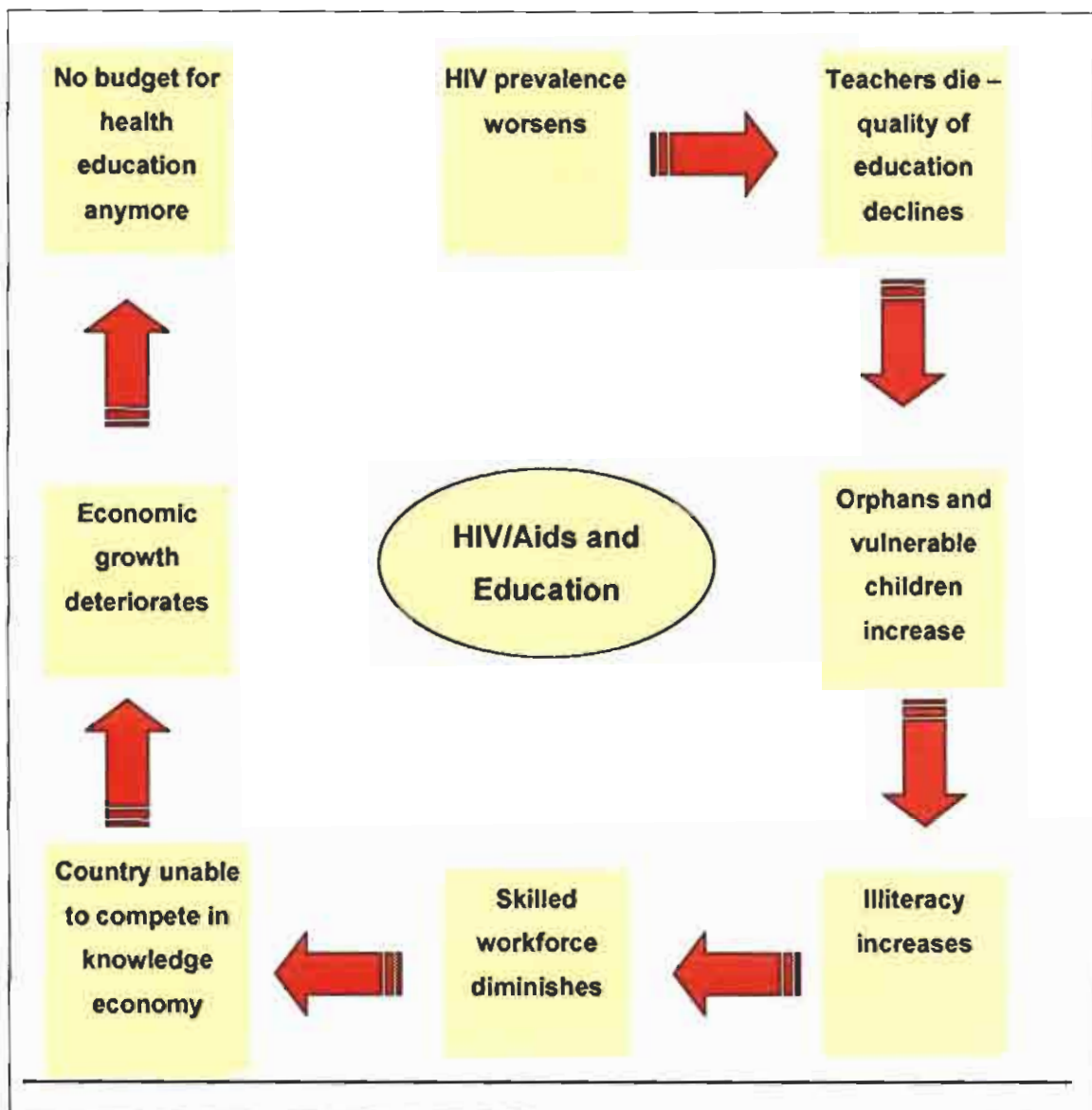
"We have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now.

The time to act is now!" – Nelson Mandela (2002) –

1.1 INTRODUCTION

The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (Aids) have struck the world with vulnerability (UNESCO & UNAIDS, 2006:18). When a person becomes infected with HIV/Aids, the virus attacks and destroys a subset of immune system cells, which organize the body's overall immune response. Something similar happens in society. HIV/Aids weakens and destroys vital "cells" – the individuals, organizations, structures and projects - that sustain the functioning and development of society. If necessary measures are not taken, the structures of society in a seriously HIV/Aids-infected country become weakened and disrupted; this leads to uncertainty and disarray, which, in turn, leads to a number of reactive changes and adaptations (Cohen, 2002; Kelly, 2002). One such structure, which is being endangered by the HIV/Aids pandemic, is education, as illustrated in Figure 1.1 (Bennell, 2005a:441; Hall, Altman, Nkomo, Peltzer & Zuma, 2005; Shisana, Peltzer, Zungu-Dirwayi & Louw, 2005a:xiv; UNESCO & UNAIDS, 2006:18).

Figure 1.1: HIV/Aids and education (Anon, 2006)



According to Hall *et al.* (2005), South African educators fall in a high risk group regarding HIV/Aids due to the fact that education is generally occupied by Africans, females and youth and that the average person living with HIV/Aids is a female African between the ages of 15 – 35 years (Vass, 2003:195). HIV/Aids affects the education system just as it affects the body. For years the effects of the sickness remained unnoticed, people were ignorant and governments unsympathetic. The various reasons for the fact that slightly more teachers were absent, more and more teachers left the educational system or died went unnoticed. When statistics showed skilled and highly educated manpower to be infected - much higher than for the rest of the

population - people were struck by reality (Kelly, 2002). The number of teachers infected and dying, and the decline in the number of pupils and students could no longer be ignored.

1.2 PROBLEM STATEMENT AND MOTIVATION

Educators are completely overwhelmed by the toll that HIV/Aids is taking on their communities. The United Nations (U.N.) estimates that 18 million African children will be orphaned due to Aids by 2010 (Wilson, 2006). At the moment, 12 million children from Africa are orphaned as a result of this devastating disease (Hamlett, 2006). In most of the cases, educators are the last resort for hungry, orphaned children. Educators become these children's mothers and fathers, a responsibility that is thrown upon them, rather than chosen by them (Anon, 2006). Educators are concerned about children affected by the pandemic, especially girls, who may leave school at an early age in order to care for sick relatives or take over household responsibilities (UNESCO & UNAIDS, 2006:26). HIV/Aids-affected children may also become inattentive and apprehensive and therefore less able to learn. Between teaching and "social work", educators affected by HIV/Aids also have to deal with the agony of illness and death in their own families (Anon, 2006). If affected educators are not supported and cared for, who will care for the children of our country who are infected and affected by the HIV/Aids pandemic?

According to the UNAIDS 2006 Report on Global AIDS Epidemic (Hanson, 2006), 30 million out of the 38,6 million Persons Living With HIV/Aids (PLWHAs) live in Africa and one in 12 African adults is PLWHA. According to UNESCO and UNAIDS (2006:13), 70% of people infected with HIV/Aids worldwide are from Sub-Saharan Africa. Life expectancy has declined from 62 to 47 years. More than 4 000 South African teachers died of HIV/Aids-related complications in 2004 (Hall *et al.*, 2005). In KwaZulu-Natal eleven teachers die daily due to HIV-related illness and by 2010 one in every four teachers may be infected with HIV (Mchunu, 2006). According to Crouch and Perry in Hall *et al.* (2005) from 2006 an estimated 20 000 educators will need to be replaced annually. The reality of teachers, school administrators and support staff, as

well as family, colleagues and friends who die or fall ill further weakens and traumatizes affected educators (UNESCO & UNAIDS, 2006:27).

All these factors mentioned above accumulate stress, anxiety, depression, insecurity, and even suicidal ideation and staff negativity among educators affected by the HIV/Aids pandemic (Hall *et al.*, 2005; Simbayi, Skinner, Letlape & Zuma, 2005; Theron, 2005:59).

It is clear that educators affected by HIV/Aids are vulnerable and struggle to cope in the face of the pandemic. Urgent support for affected educators who become involved and go beyond the call of duty in the fight against HIV/Aids, is of the utmost importance (Coombe, 2003; Hall *et al.*, 2005; Simbayi *et al.*, 2005, Theron, 2005:59). These educators need to be taught skills in order to cope with HIV/Aids. Affected educators necessitate being psychosocially and emotionally strong while facing this ravaging pandemic. In other words, educators need to become resilient.

Resilience is the ability to persevere and adapt successfully when things go amiss (Jenson & Fraser, 2006:8; Reivich & Shatté, 2002:1). In other words, when an individual is able to cope with life's unexpected and inescapable challenges and setbacks, such a person can be seen as resilient. Schoon (2006:6) defines resilience as a dynamic process where individuals positively adapt despite difficult circumstances. Leading researchers summarize the prevailing understanding of resilience by saying that resilience is the "ability to overcome, steer through, and bounce back when adversity strikes" (McAdam-Crisp, Aptekar & Kironyo, 2005:72; Reivich & Shatté, 2002:3; Schoon, 2006:1; Sternberg, 2004:325-338; Ungar, 2005:xvi-xviii).

Resilience is all about the way an individual responds in an adverse or difficult situation. Responsive emotions such as anger, guilt, defeat, vulnerability and worry or responsive emotions such as persistence, perseverance, diligence and determination can be perceived as the thinking style of an individual (Reivich & Shatté, 2002:3). According to Reivich and Shatté (2002:3), your thinking style causes your emotional reaction to incidents and experiences and therefore determines your level of resilience.

But resilience is not only a facet of the individual. Resilience depends upon constitutional factors and life circumstances and presents dynamic interactions between the individuals, their psychosocial resources and their environment (Schoon, 2006:1, 15; Sternberg, 2004:325-338; Ungar, 2007: xxvi) as indicated in Figure 1.2 below.

Figure 1.2: Facets of Resilience (Schoon, 2006:1; Sternberg, 2004:325-338; Ungar, 2005: xvi-xviii)

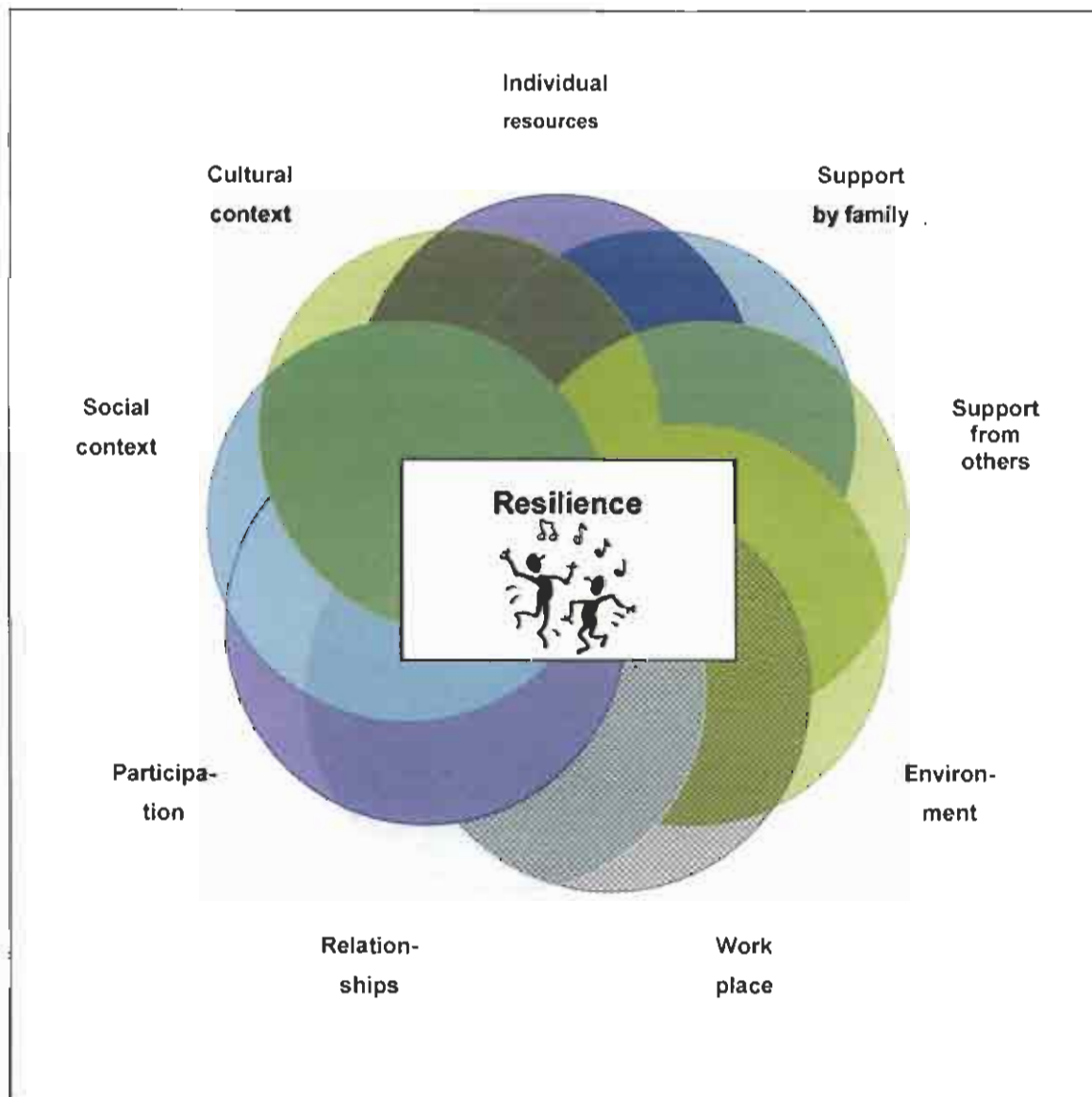


Figure 1.2 clearly illustrates that resilience is a dynamic person-environment interaction (Schoon, 2006:17; Sternberg, 2004:325-338; Ungar, 2005:xvi-xviii), as explained below.

Although resilient people possess a sense of hope and gratitude (McAdam-Crisp *et al.*, 2005:72), Sternberg (2004:325-338) found that social and cultural context also play a role in becoming resilient. According to Fraser and Terzian (quoted by Jenson & Fraser, 2006:8), protective factors are individual or environmental resources that diminish the impact of risk. Studies completed by Ungar and Liebenberg (2005:218) and Schoon (2006:16) found that not only individual capacities, behaviours and protective factors, despite adverse circumstances, promote resilience (Elder, 1974 and 1999 as quoted by Schoon, 2006:1, 3, 6; Ungar, 2005:xvi-xviii; Ungar, 2007:xxvi), but also external protective factors, such as the influence of processes and interactions between the individual, her¹ family and her environment as illustrated in Table 1.1. (all aspects which contribute to being resilient). In their study, Ungar and Liebenberg (2005:218-219) categorize the most important protective processes indicated by their participants as follows:



Culture: such as cultural or spiritual identification.



Community: such as safety, security, social equity, access to school and education.



Relationships: such as meaningful relationships with friends and family.



Individual attributes, such as assertiveness, self-awareness, sense of duty, aspirations, balance, and social support.

According to the above-mentioned information, risk factors (heightening adversity) and protective factors (reinforcing resilience) play an important role in the well-being of every individual. For the purpose of this study, the researcher distinguishes between risk factors and protective factors which influence the well-being of the educator affected by HIV/Aids, as illustrated in Table 1.1.

¹ Although the study is about both genders, reference will be made only to the female gender: she, her, hers.

Table 1.1: Risk and protective factors which influence educators affected by HIV/Aids (Bennell, 2005a:441; Boler & Jellema, 2005:16; Coombe, 2000; Kelly, 2002; Sachs & Sachs, 2004; Schierhout, 2004; Schoon, 2006:12-15; Shisana & Simbayi, 2005; Shisana *et al.*, 2005a; Shisana, Rhele, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay *et al.*, 2005b:19; Theron, 2005:37, 57, 58; Ungar & Liebenberg, 2005:218-219)

 Risk factors	 Protective factors
 Characteristics of the individual • Self-inefficiency. • Negative self-esteem. • Hopelessness. • Weakness.	 Characteristics of the individual (Psychosocial resources) • Self-efficacy. • Positive self esteem. • Problem-solving ability. • Future orientation. • Good communication.
 Family environment • Unsupportive family. • Family conflict. • Dysfunctional families. • Unsatisfactory relationships. • Disrupted family life (divorce).  Work environment • Unsupportive work environment, such as: - crowded classes; - increased workload, due to infected educators who are often absent; and - insufficient teaching and learning resources due to poverty. • Affected educators have to deal with infected learners, colleagues and loved ones. • Learners who are orphaned due to Aids. • Insufficient information and training	 Family environment • Support by family. • Family harmony. • Positive relationships. • Living in harmony with family members.  Work environment • Supportive work environment. • Information and training regarding the pandemic. • The presentation of self-empowering courses to teach affected educators skills concerning how to deal with unpleasant situations and circumstances. • Assistance from the government and school districts regarding teaching and learning resources. • Workshops regarding HIV/Aids.

regarding the HIV/Aids pandemic.	
 Wider social context • Non-supportive community. • Socio-economic adversity. • Disadvantaged circumstances, such as poor housing. • Trauma, caused by violence and abuse among others. • Exposure to the HIV/Aids pandemic. • Poor health. • Deprivation.	 Wider social context • Support by other important stakeholders such as, among others, the government, the education department, universities, businesses, colleagues and principals. • Meaningful participation in the community. • A sense of belonging to the community. • Positive communication between neighbours and colleagues. • Support programmes to empower educators affected by Aids.

Depending on the interaction with other factors, such as family, environment and individual characteristics, the same stressor can weaken or strengthen an individual's reaction to adversity (Schoon, 2006:17; Ungar, 2007:xxv). With regard to the above-mentioned, the researcher can conclude that resilience is not only derived internally, but also from the dynamic interaction between an individual's external and internal world (Schoon, 2006:17; Ungar, 2005: 15; Ungar and Liebenberg, 2005:217-218; Ungar, 2007:xxvi; Ungar, Brown, Liebenberg, Othman, Kwong, Armstrong & Gilgun, 2007:3,4).

Because communities are labouring under the deleterious impact of the HIV pandemic, there are fewer community and contextual protective factors operating in favour of educators affected by HIV/Aids. For this reason it is necessary to provide educators with a programme such as the REds support programme, which purposefully aims to buffer educators against the impact of HIV/Aids.

In order to support and teach educators to become resilient in the face of the pandemic, the following questions arise:

-  Will the implementation of a support programme compiled for educators affected by HIV/Aids effectively contribute to their empowerment in the face of the pandemic?

1.3 AIMS

The main purpose of this study was to gauge how effectively educators affected by the HIV/Aids pandemic can be supported, using the REds support programme. In other words, the aim of this study was programme evaluation.

In order to achieve this objective, the following sub-aims are proposed:



The implementation of an intervention programme (REds) for educators affected by the HIV/Aids pandemic, designed by Theron (2006b), for the Thutuka Project 2005-2007 using one group of volunteers.



Assessment of the effectiveness of the intervention programme: using action research and an experimental pre-test, post-test design.



Recommendations regarding increased effectiveness of the intervention programme.

1.4 METHOD OF RESEARCH

The method of research consisted of a literature study and an empirical study as detailed below:

1.4.1 Literature study

A summary of literature being used for this study is indicated in Table 1.2 below:

Table 1.2: Summary of literature

Themes	Sources
The HIV/Aids pandemic worldwide  (Soul City, 2005)	Among others: ▪ Blandy, 2006 ▪ Mulder, 2005:4 ▪ Mulder, 2007:2 ▪ O'Connor, 2006:6 ▪ Pienaar, 2006a:13 ▪ Sachs & Sachs, 2004 ▪ UNAIDS/WHO, 2005 ▪ UNESCO AND UNAIDS, 2006

The HIV/Aids pandemic in South Africa

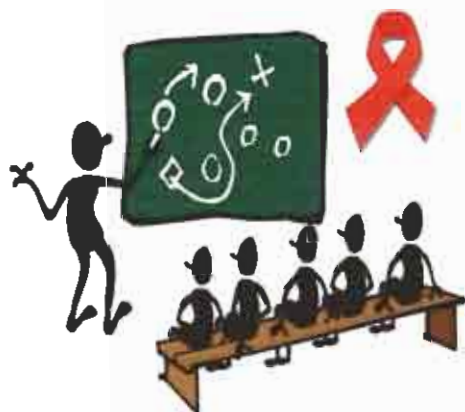


(Soul City, 2005)

Among others:

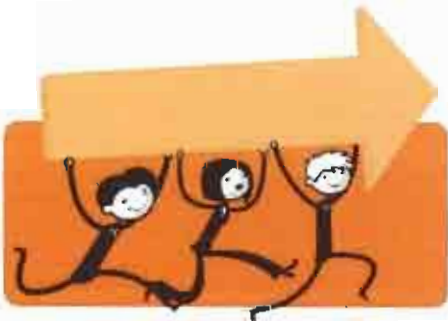
- AfrolNEWS, 2006
- Davidek, 2006
- Department of Health South Africa, 2005
- Lewis, 2006
- Meldrum, 2006
- Mulder, 2005:4
- Noble, Berry and Fredriksson, 2005:1
- O'Connor, 2006:6
- Pienaar, 2006a:13
- Pienaar, 2006b:2
- Rolls, 2006:15
- Shisana, Rhele, Simbayi, Parker, Zuma Bhana, Connolly, Jooste, Pillay *et al.*, 2005b:41
- Sjabalala, 2006
- UNAIDS, 2005
- UNAIDS/WHO, 2005:21
- USAID, 2003

Impact on education



Among others:

- Bennell, 2005a:440,441
- Blaine, 2006
- Boler and Jellema, 2005:6,16
- Burnard, 1993:1782
- Cohen, 2002
- Coombe, 2000:11
- Coombe, 2003:3
- Department of Health, 2001:1
- Geldenhuys, 2005
- Hall, Altman, Nkomo, Peltzer and Zuma, 2005
- HIV/Aids NEWS, 2006
- Isaacs, 2005:4
- Kelly, 2002:157
- Kinghorn and Kelly, 2005:491
- Lewis, 2006
- Naudé and Pretorius, 2003
- Nillson, 2003

	▪ Rademeyer, 2005:12 ▪ Ramrathan, 2003 ▪ Sachs and Sachs, 2004 ▪ Schierhout, 2004 ▪ Shisana and Simbayi, 2005:xv ▪ Shisana, Peltzer, Zungu-Dirwayi & Louw, 2005a ▪ Shisana, Rhele, Simbayi, Parker, Zuma, Bhana, Connoly, Jooste, Pillay <i>et al.</i>, 2005b ▪ Simbayi, Skinner, Letlape, and Zuma, 2006 ▪ Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo, Tlou and Chitiyo, 2004 ▪ Theron, 2005:56, 57 ▪ Theron, 2006a ▪ Wehmeier, 2000:852
Types of support 	Among others: ▪ AfroAIDSinfo, 2006-12-09 ▪ Allegrante, 1998:224 ▪ Allemanno, 2003:25 ▪ Badcock-Walters, 2002:109 ▪ Bana Pele, 2006:12 ▪ Blummer, Burt, Gans, Goldberg, Guild, Kim, Lee, Vaughn, Warner, 2002 ▪ Car-Hill, 2003 ▪ Charleson, 2006 ▪ Coombe, 2003:13-14 ▪ Department of Health, 2005:8 ▪ Department of Social Development, 2002:17 ▪ De Villiers, 2005:6 ▪ Fourie, 2006 ▪ Gauteng Provincial Government, 2004:5 ▪ Gauteng Provincial Government, 2005a:3 ▪ Hall <i>et al.</i>, 2005:30 ▪ HARC, 2005 ▪ Hatane, 2005 ▪ Hornby, 2001:226 ▪ Howe, 2000

- International HIV/Aids Alliance, 2006
- Kelly, 2002
- Lewis, 2006
- McElligott, 2005
- Mkosi, 2005
- Mulder, 2005:4
- Mzolo, 2006
- Reber and Reber, 2001:162
- Ross and Deverell, 2004:6
- Rolls, 2006:14
- Russel & Schneider, 2001:1
- Schierhout, 2004
- Scriven and Stiddard, 2002
- Seckinelgin, 2004:288
- Shisana and Simbayi, 2005
- Shisana *et al.*, 2005a
- Simelela, 2002
- Simbayi Skinner, Letlape, and Zuma, 2005
- Soul City 2004:1,47
- Soul City, 2005:6, 21, 22,26
- Theron, 2005:56-60
- Theron, 2006a
- USAID, 2002:9
- World Health Organisation, 2005
- Xaba, 2006:52

1.4.2 Empirical Study

The empirical research was conducted to evaluate the efficacy of the REDs intervention programme. Typically intervention research follows six phases (De Vos, 2001:385):

1. Problem analysis and project planning
2. Information gathering and synthesis
3. Design
4. Early development and pilot testing
5. Evaluation and advanced development
6. Dissemination

This study focused on phase 4: it pilot-tested REds using experimental and action research.

The effectiveness of REds was measured by conducting a pre-test to measure the impact of HIV/Aids on a group of affected educators. The group willingly participated in the REds intervention programme. A post-test was conducted to measure the efficacy of the intervention programme (Leedy & Ormrod, 2005:217). Simultaneously action research was conducted to gather participant recommendations for the improvement of REds for phases 5 and 6 (not part of this master's study).

1.4.2.1 Research Design

The research design is a detailed plan of how the research will be conducted (Fouché & de Vos, 2001: 123). Because the aims of this study are varied, more than one research design was needed. In order to assess the effectiveness of the REds programme, a quasi-experimental design (one-group pre-test post-test design) (Fouché & de Vos, 2001: 129) was followed. In order to make recommendations for future implementations of REds, an action research design was followed (Welman, Kruger & Mitchell, 2005: 205) primarily because action research allows for the modification of an existing programme and requests participant feedback (Welman *et al.*, 2005: 205). The design is discussed in detail in Chapter Four (*cf.* 4.3).

1.4.2.2 Population and sample

The population included all educators who were directly affected by the HIV/Aids virus. However, this study was localized due to logistics. Therefore the population for this particular study consisted of all educators in the Vaal Triangle. The specific study population consisted of all educators in the

Sedibeng East District who were directly affected by the virus. From this population, a purposive sample was drawn ($n=10-15$). Due to the fact that the researcher worked continuously with the group over a period of 9 weeks, the desirable size of the group should not exceed fifteen participants. According to Corey and Corey (2002:107), a group of this size is adequate to give sufficient time for interaction and small enough for every participant to be actively involved, to feel accepted and part of the group. The final sample consisted of 8 participants.

A purposive, convenience sample was used in that volunteers from local schools were requested to participate, provided they conformed to the following:



- participants had to be educators;



- these educators had to be affected by the HIV/Aids pandemic. Educators are affected when they have HIV-positive loved ones, colleagues or learners. They are affected when their loved ones, colleagues or learners die of HIV/Aids. They are also affected when they have orphans and vulnerable children in their classes; and



- due to logistics, participants had to come from the Vaal Triangle.

1.4.2.3 Measuring instruments

Assessment of the effectiveness of the intervention programme was conducted, using a mixed methods approach. A mixed methods design refers to the inclusion of both qualitative and quantitative research work, where qualitative methods are vital in order to contextualize results obtained from quantitative instruments (Ungar & Liebenberg, 2005:219; Ungar, 2007:213).

The quantitative instruments (*cf.* 4.3.4.1.1) included:



- The ProQOL questionnaire (*cf.* Addendum E). The Professional Quality of Life (ProQOL) is an instrument which measures the professional quality of life among staff at organizations such as a state's social workers, police force or educators (Stamm, 2005:25).

The qualitative instruments included:

-  symbolic drawings;
-  observation and field notes;
-  open-ended questions; and
-  semi structured interviews.

1.4.2.4 Data collection procedure

The REds programme was implemented over 9 consecutive weeks, which fitted easily into the school term. The duration of each session (module) was 2 hours. The programme was implemented in a group setting. Continuous assessment of the programme was done by participants in order to improve its efficacy. A one group pre-test, post-test design that consisted of quantitative and qualitative media was used to determine how effectively educators were empowered by REds (*cf.* 4.3.4).

1.4.2.5 Statistical techniques

An independent statistician from the North-West University, Vaal Triangle Campus, was consulted regarding the results of the ProQOL. The qualitative data were obtained by means of deductive analysis in consultation with a registered Educational Psychologist.

1.4.2.6 Ethical considerations

The researcher strictly adhered to prevailing ethical guidelines (De Vos, 2001:62; Leedy & Ormrod, 2005: 101) as described in Chapter 4 (*cf.* 4.4). Participants voluntarily took part in the programme; they gave permission for photos to be taken, sessions to be recorded and drawings to be printed. All the qualitative measuring instruments were completed anonymously. No activities in which participants had to take part exposed them to physical, emotional or psychological harm.

1.5 CONCEPT CLARIFICATION

1.5.1 HIV

The Human Immunodeficiency Virus (UNESCO & UNAIDS, 2006:8) reproduces in the white blood cells of humans. White blood cells are very important to the immune system of human beings. When an individual is infected with HIV, the virus multiplies until there are millions of viruses present. Although the white blood cells make antibodies to HIV, these antibodies cannot eradicate the virus completely and gradually damage the white blood cells (Watson, 2006:70).

1.5.2 Aids

When the white blood cells inside the body of an individual infected by HIV become so damaged that they can no longer protect the body from infections which healthy people can normally fight, it is said that such a person has the Acquired Immune Deficiency Syndrome (Aids) (Watson, 2006:70).

1.5.3 Affected

For the purpose of this study all educators who have loved ones, colleagues and learners who are HIV-positive, who have loved ones, colleagues or learners who have died of Aids-related diseases or have Aids orphans and vulnerable children in their classes (Hall *et al.*, 2005; Theron, 2006b:4) are considered affected.

1.5.4 Infected

According to Hornby (2001:614), a person is infected when a disease or illness consisting of harmful bacteria is spread to her. In other words, people who fall ill due to a virus (in this study, the Human Immunodeficiency Virus) are infected.

1.5.5 Resilience

Resilience is the ability to overcome, steer through and bounce back when adversity strikes (Jenson & Fraser, 2006:8; McAdam-Crisp *et al.*, 2005:72;

Reivich & Shatté, 2002:3; Schoon (2006:1,6); Sternberg, 2004:325-338; Ungar, 2005:xvi-xviii).

1.5.6 OVCs

OVCs are orphans and vulnerable children because of the HIV/Aids pandemic (Sachs & Sachs, 2004; Shisana & Simbayi, 2005).

1.5.7 PLWHA

PLWHAs are people living with HIV/Aids (Hall *et al.*, 2005). In other words, people who have infected loved ones, colleagues and learners are referred to as PLWHA.

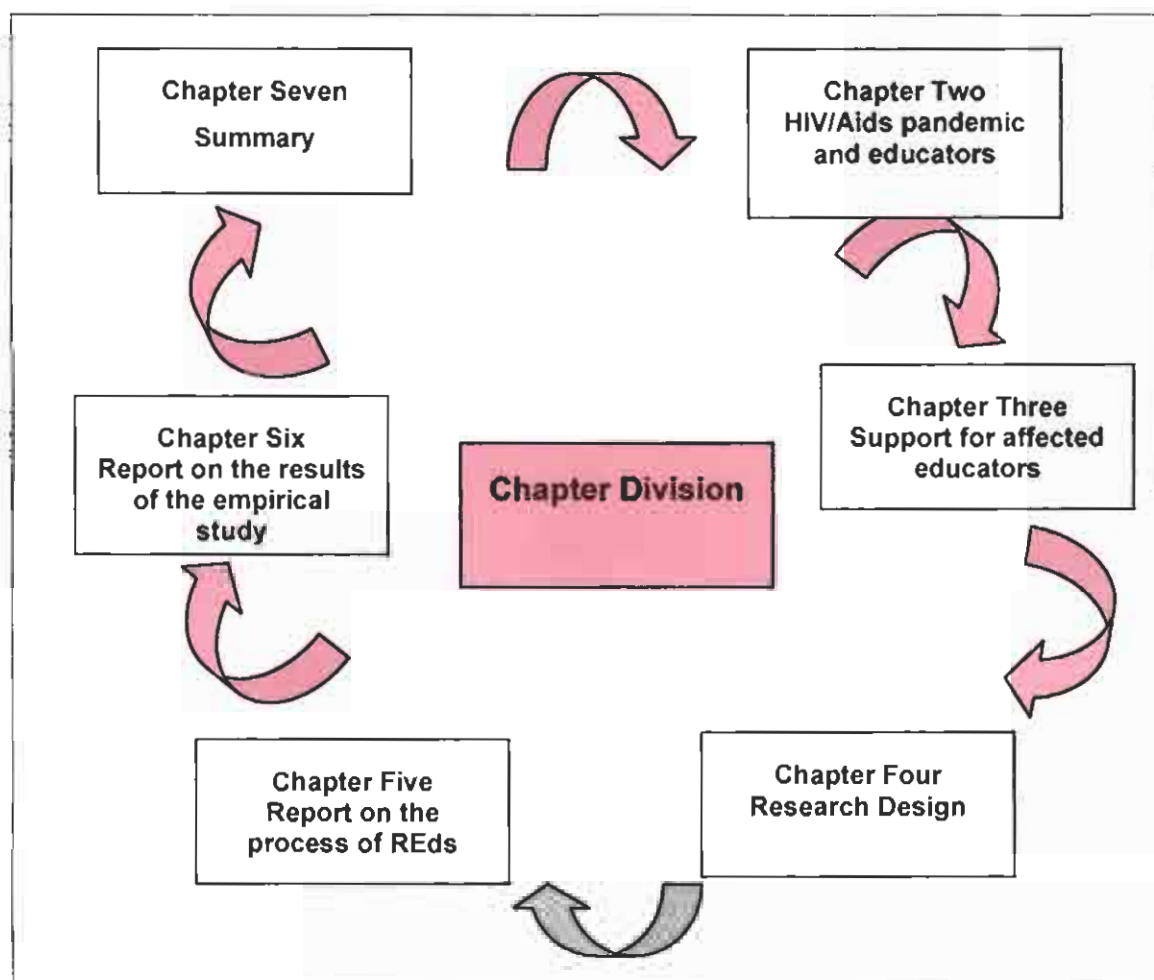
1.5.8 Stigma

When someone is seen as inferior due to an attribute they have, they are stigmatized or labelled (Change Project, 2005:12). The reason why HIV-infected individuals fear to disclose their status is because HIV/Aids is stigmatized as an illness that is contracted through sexual interaction.

1.6 CHAPTER DIVISION

For this study, information has been carefully analysed and selected. The information is divided into different aspects of the study. These aspects are discussed fully in six separate chapters as illustrated in Figure 1.3. Chapter Seven is a summary of the study.

Figure 1.3: Chapter Division



In Table 1.3 a description of each chapter is given.

Table 1.3: Description of chapters

Chapter	Description
Chapter Two	Although the shattering effect of HIV/Aids worldwide and especially in South Africa is discussed in Chapter Two, and background is given on the effect of HIV/Aids on education in general, the main aim is to determine the impact of HIV/Aids on the affected educator.
Chapter Three	Chapter Three mainly entails the support needs of affected educators, designates various stakeholders and determines the efficacy of intervention programmes, if any.

Chapter Four	The research methodology is described in Chapter Four. This includes the aim and motivation of the empirical study, measuring instruments being used, the intervention programme, methods of assessment and ethical aspects.
Chapter Five	Chapter Five contains an overview of the process of the implementation of the REds (Resilient Educators) programme.
Chapter Six	Chapter Six discusses the results of the REds intervention programme for educators affected by HIV/Aids. Chapter Six also serves as a conclusion of the study, as well as recommendations made by participants.
Chapter Seven	Chapter Seven is a summary of the study.

A bibliography and addendum, containing results of the pre-test and post-test, will follow after Chapter Seven.

1.7 CONCLUSION

While working intimately with educators affected by HIV/Aids, the researcher experienced the destructiveness of the pandemic for the first time. She experienced the fear, depression and anxiety which accompany HIV/Aids. The researcher realized how desperately these educators affected by HIV/Aids are in need of any kind of support, because they just could not cope in the face of the pandemic. The researcher was also struck by the fear that, if affected educators quit, who will teach the future of this country – our children?

Chapter Two entails the catastrophic impact of HIV/Aids worldwide, but more specifically in South Africa and education in general. The emphasis, however, will be on the impact of HIV/Aids on the affected educator.



CHAPTER TWO

THE HIV/AIDS PANDEMIC AND EDUCATORS



Let no one ever come to you without leaving better and happier. Be the living expression of God's kindness: Kindness in your face, kindness in your eyes, kindness in your smile.

- Mother Theresa -

2.1 INTRODUCTION

HIV/Aids has a devastating and highly adverse effect on the world, our country, provinces, cities, townships, communities and families. Institutions which hold societies together, such as health organizations, the education system and industries are threatened by Aids (Boler & Jellema, 2005:14). As mentioned in Chapter One, education is particularly vulnerable to the HIV/Aids pandemic (Hall *et al.*, 2005; Kelly 2002). According to Kelly (2002) and Hall *et al.* (2005) experienced and highly educated manpower is infected with HIV, which could cause low morale, low motivation and overall poor performance of all teachers and support staff, if necessary measures are not taken (Bennell, 2005a:442). The aim of this chapter is to determine the:



existence of HIV/Aids worldwide;



existence of HIV/Aids in South Africa;



impact of HIV/Aids on education in South Africa; and



impact of HIV/Aids on affected educators in South Africa.

2.2 HIV/AIDS PANDEMIC WORLDWIDE

The statistical proportions of the reality of HIV/Aids are grim:



More than 40, 3 million adults and children worldwide have been infected with HIV/Aids since the beginning of the epidemic (Mulder, 2005:4).



Seventeen comma five million of these infected people are women (Mulder, 2005:4).



Two comma three million of infected people are children younger than 15 years (Mulder, 2005:4).



At least 25 million people have died worldwide due to HIV/Aids (O'Connor, 2006:6).



In 2005 alone, 5 million new infections worldwide were noted (Pienaar, 2006a:13), which brings the total to 14 000 infections worldwide per day (Mulder, 2005:4) and 8000 worldwide die every day of Aids (Blandy, 2006).



According to Mulder (2005:4), 3, 1 million people worldwide died of HIV/Aids during 2005 from which 570 000 were children, mostly from Africa.



Worldwide, 15, 2 million children lost one or both their parents due to Aids (Mulder, 2007:12).



Eighty percent of these orphans, that are 12 million, live in Sub-Saharan Africa (Mulder, 2007:12).



Five hundred and thirty thousand children younger than 15 years of age were infected with HIV during 2006. Without treatment, half of them will die before the age of 2 (Mulder, 2007:12).

UNAIDS and UNICEF predict that the number of AIDS-orphans will increase to 25 million by 2010 and increase to 40 million by 2020 (Sachs & Sachs, 2004). The statistical proportions of the reality of HIV/Aids worldwide are devastating as portrayed in Table 2.1.

**Table 2.1: Worldwide approximation for adults and children, 2005
(UNAIDS/WHO: 2005)**

Worldwide approximation for adults and children, 2005			
Continent	Adults and children living with HIV in 2005	Newly infected adults and children during 2005	Adult and child deaths from HIV and AIDS during 2005
North America	1.2 million	43 000	18 000
Caribbean	300 000	30 000	24 000
Latin America	1.8 million	200 000	66 000
Western and Central Europe	720 000	22 000	12 000
North Africa and Middle East	510 000	67 000	58 000
Sub-Saharan Africa	25.8 million	3.2 million	2.4 million
Eastern Europe and Central Asia	1.6 million	270 000	62 000
East Asia	870 000	140 000	41 000
South and South-East Asia	7.4 million	990 000	480 000
Oceania	74 000	8 200	3 600
TOTAL	40.3 million	4.9 million	3.1 million

In other words, the pandemic is wreaking havoc worldwide. South Africa is not exempt from this devastation.

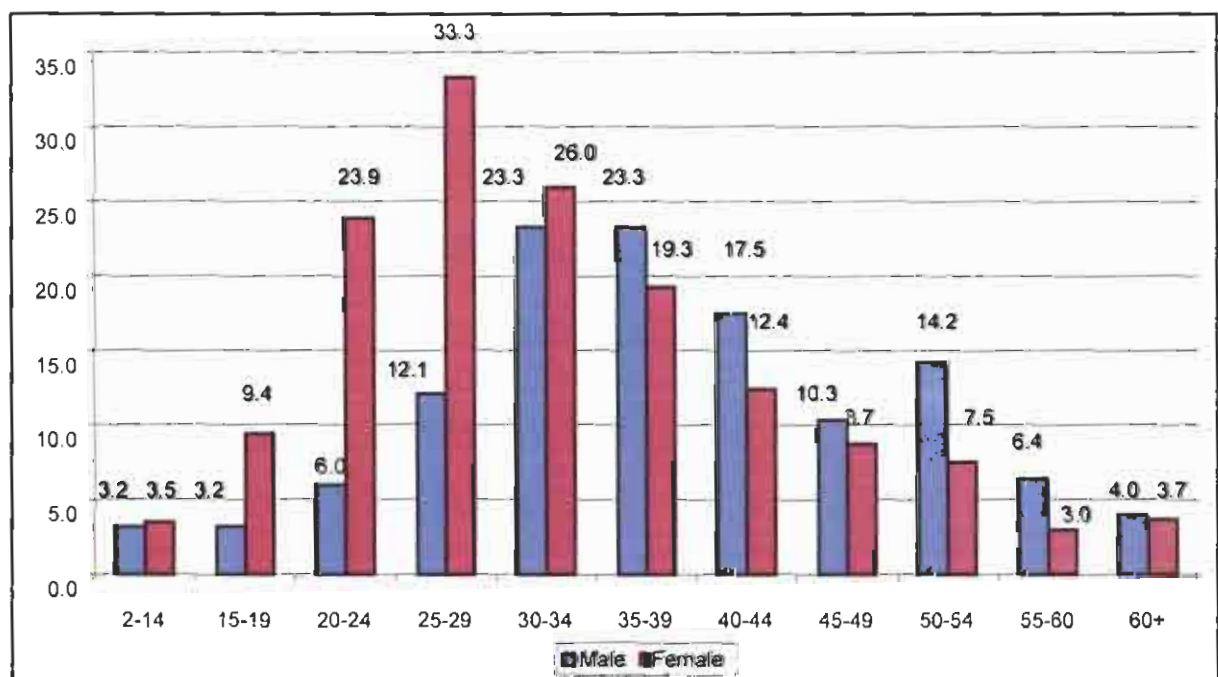
2.3 HIV/AIDS PANDEMIC IN SOUTH AFRICA

According to Mulder (2005:4), 3, 2 million of the 5 million new HIV/Aids infections worldwide occur in Africa south of the Sahara. More than 630 000 children in Africa were infected in 2005. Approximately 26 million people (adults and children younger than 15) are HIV-positive in Africa south of the Sahara (*cf.* Table 2.1).

An analysis of South African death certificates between 1997 and 2002 by the government and Statistics South Africa in February 2005 indicates a 116% increase in registered deaths among 25-49-year-olds. An in-depth analysis led researchers to believe that at least 61% of these deaths were probably as a result of Aids (Noble, Berry & Fredriksson, 2005:5). According to the ASSA2002 model, 70% of all deaths among adults aged 15-49 years were due to Aids.

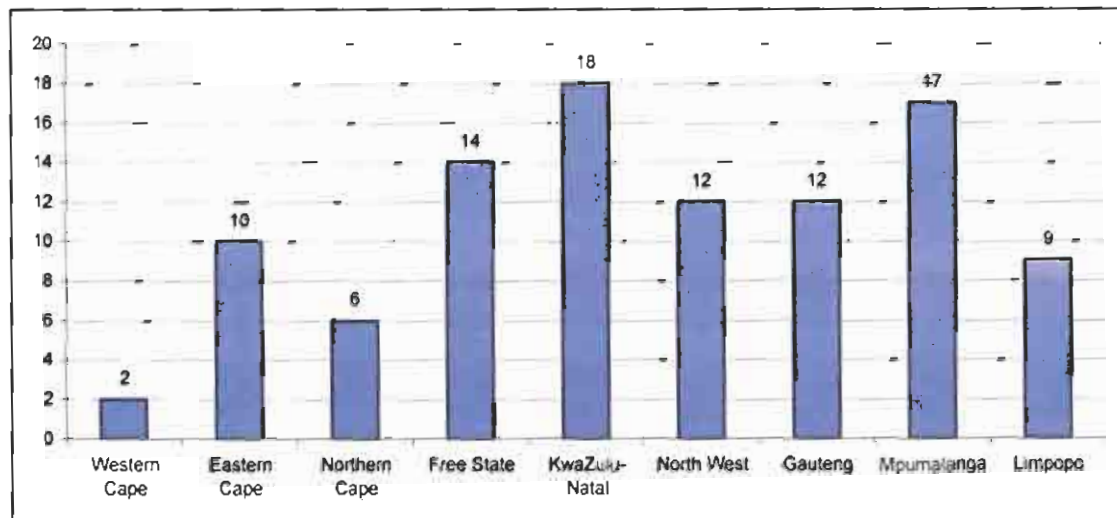
In Figures 2.1, 2.2 and 2.3, the prevalence of HIV among South Africans is illustrated:

Figure 2.1: HIV-prevalence according to sex and age group, South Africa 2005 (Shisana *et al.*, 2005b)



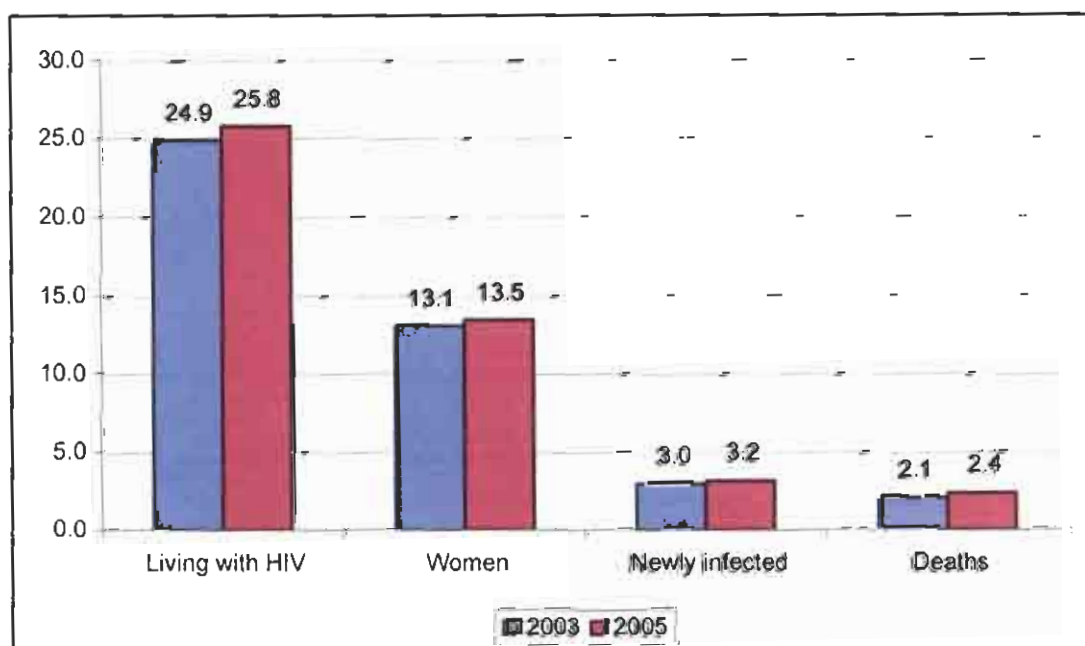
Prevalence is highest among females aged 25 - 29 and among males aged 30 - 34.

Figure 2.2: HIV-prevalence among respondents aged 2 years and older per province, South Africa 2005 (Shisana *et al.*, 2005b)



Prevalence is highest in KwaZulu-Natal, closely followed by Mpumalanga and lowest in the Western Cape.

Figure 2.3: HIV/Aids statistics and features, in 2003 and 2005 (Shisana *et al.*, 2005b)



According to the above-mentioned figures, it can clearly be seen that there is still an alarming increase in the prevalence of HIV/Aids among South Africans and that there is a need for a cure and a change of attitude towards this devastating disease.

Recent data, according to the Department of Health in South Africa (2005), show:

-  The typical South African person living with HIV/Aids is a female African between the age of 25-35 years (UNAIDS, 2005:21).
-  Twenty nine comma five percent of women attending clinics were HIV-positive in 2004 (Shisana *et al.*, 2005b).
-  More than one in three women aged 25 – 34 years are infected with HIV/Aids, while almost one in three women aged 20 – 24 years is infected with the disease (Shisana *et al.*, 2005b).
-  Prevalence in KwaZulu-Natal has reached its highest at 40%, while the incidence rate in Eastern Cape, Free State, Gauteng, Mpumalanga and North West provinces remained high at between 27% and 31% (Shisana *et al.*, 2005b).
-  People living in informal localities in towns or cities present a much higher prevalence of HIV/Aids than those in either urban formal or rural formal localities (Shisana *et al.*, 2005b).

Distressing data show the speed at which the epidemic grows:

-  In 1990 the HIV prevalence among adults nationally was less than 1% (UNAIDS, 2005).
-  Within 10 years it evolved to almost 25% (UNAIDS, 2005).
-  A recent study of death registration data has shown that deaths among people of 15 years of age and older increased by 62% in 1997-2002 with deaths among people aged 25-44 years more than doubling (Mulder, 2005:4).

-  Based on information from nearly 2,9 million death notification certificates, the study showed that more than one third of all deaths were among people in the age group 25 – 44 years (UNAIDS, 2005).
-  Statistics indicate an infection rate of 5, 3 million in 2003. It increased to 5, 5 million in 2005 (Meldrum, 2006; Rolls, 2006:15).
-  Three comma one million are women (Rolls, 2006:15).
-  Between 500 000 and 800 000 people is living with Aids, but less than 200 000 of these receive ART (AfrolNews: 2006).
-  Some 354 000 people died of Aids in South Africa between July 2005 and July 2006 (Davidek, 2006).
-  Seven hundred and eighty thousand children were orphaned due to Aids during 2003 (Rolls, 2006:15). The 2005 estimate of orphans in South Africa was 2, 5 million (Shisana *et al.*, 2005a).
-  Two comma three million children under 15 years are HIV-positive. A third of them will die before their first birthday, half of them will die before their second birthday (Pienaar, 2006a:2) and 60% of the children in Africa die of HIV/Aids before their fifth birthday (O'Connor, 2006:6).
-  Seventy four out of 1000 children in South Africa die because of the pandemic (O'Connor, 2006:6).

According to the above-mentioned statistics, Aids in South Africa has reached pandemic proportions (UNAIDS, 2005). Educators are not excluded from the pandemic, as discussed below.

2.4 IMPACT ON EDUCATION

Although Bennell (2005a:440) qualifies the impact of the pandemic, he concludes that because education is "person-intensive" it is extremely vulnerable to the pandemic (Bennell, 2005a:441) and could be negatively affected, especially in countries where the prevalence is high. Nevertheless Bennell (2005a:440) does indicate that Aids-related teacher mortalities are

lower than those for the adult population as a whole. Kinghorn and Kelly (2005:491) emphasize the need for caution regarding educator mortality, especially if data comes from small surveys, because of the fact that the accuracy of small surveys has limitations.

According to Boler and Jellema (2005:6), ministries of education are not prepared to deal with the potential impact of HIV/Aids on educators, because there are no laws, policies or procedures in place to prevent discrimination against HIV-positive educators. Governments are unable to monitor absenteeism and mortality among educators. Most governments do not have a plan to tackle Aids-related educator attrition. Only a few governments have sufficient workplace policies on HIV/Aids (Boler & Jellema, 2005:6).

Social isolation due to the stigma of Aids only heightens trauma and decreases effective teaching (Theron, 2005:57). As one person with HIV-infection stated:

"It is not the HIV-virus which is killing me or making my life not worth living, but the bad attitudes of people towards me and their rejection of me"

(Department of Health, 2001:1).

The pandemic has negative impacts on the education system, including the following (Geldenhuys, 2005):

-  Enrolments are declining as Aids orphans can no longer afford to attend school.
-  Healthy educators are affected.
-  Education finance is impacted.
-  Learners are affected.
-  Education management structures are impacted.

For the purpose of this study, the above-mentioned factors are grouped together and will briefly be discussed under the following headings:

-  Quality of education.

-  Supply of and demand for education.
-  HIV/Aids pandemic and the educator.

2.4.1 Quality of education

HIV/Aids affects education at all levels (Cohen, 2002) by:

-  Slowing down the educational process.
-  Negatively affecting the quality of education.
-  Heightening the risk of illiteracy.
-  Disrupting school activities.
-  Negatively influencing the morale of colleagues.
-  Negatively impacting on education management - with the risk that the whole system may become disorganized and weakened by fear (Cohen, 2002).

The quality of education is also at risk because of the following pandemic-related factors:

-  Ill educators who remain in their posts negatively influence the quality of teaching (Bennell, 2005a:450; Hall *et al.*, 2005).
-  Lack of guidance on what is to be done also reduces resources available for education (Kelly, 2002).
-  Rural districts report shortages in specialist teaching areas such as Science and Mathematics (Coombe, 2003:3).
-  It would seem that rural districts have a higher proportion of HIV-positive educators. Rural school efficacy is expected to decline as new employees cannot make up for the loss of experienced senior educators, managers, educators, professors and science and mathematics specialists (Coombe, 2003:3).

-  As experienced educators are lost, poorer quality can be expected with regard to creating, presenting and explaining learning material (especially of highly important subjects such as mathematics and science) to learners. This, in turn, is likely to result in less capable future students and subject specialists in relevant subjects, which suggests a long-term decline in the quality of education (Coombe, 2003:3).
-  Hundred thousand South African learners have lost educators to Aids. Learners lose out on quality education because of the fact that infected educators are frequently absent and can lose up to 6 months of professional time before developing full-blown Aids (Theron, 2005:57).
-  Ill educators cannot model good health and cannot devote themselves to their profession; therefore they cannot provide the same quality of teaching as before (Theron, 2005:57).
-  Due to the fact that educators must often take ill educators' learners into their classes when they are absent, an undesirable learner-educator ratio of one educator to fifty or more learners is reached which impacts negatively on the quality of education (Theron, 2005:57).
-  Learners find it difficult to observe HIV-positive educators' health decline, their absenteeism and eventual death. The value of educators as positive role models to learners is lessened and this also impacts negatively on the quality of education (Theron, 2005:57).

2.4.2 Demand for and supply of education

The demand for education relates to having sufficient learners who require teaching and the supply of education relates to having sufficient educators to teach learners.

2.4.2.1 Demand for education

Children who are HIV/Aids-positive, children in households with sick family members and children whose parents or guardians have died of Aids are especially affected by the pandemic which put their education possibilities in

jeopardy (Bennell, 2005b:468). Shisana and Simbayi (2005) have stated that children are affected by HIV/Aids long before they become orphans, because they are in contact with ill parents daily over a long period of time. The Chief Executive of the British charity "Save the Children", Jasmine Whitbread (2006) said in a statement made on 20 March 2006 that 9 million children in Africa have lost a mother to Aids, depriving them of their childhood and mothers, missing school and having to work and care for their mothers because they are too sick to look after themselves. In this way, the pandemic affects the demand for education. Learner numbers are affected, because of the following three situations:

2.4.2.1.1 Orphans and vulnerable children (OVCs) cannot afford schooling

Stephen Lewis, the United Nations' face in Africa regarding HIV/Aids, reported that 15 million children in Sub-Saharan Africa have been orphaned due to Aids (Lewis, 2006).

Shisana *et al.* (2005b:21) define orphans as children who lost their parents through death and vulnerable children are those who belong to high-risk groups who require access to basic social services or facilities. These children often do not have access to education.

Enrolments are declining, because learners are orphaned or in the process of being orphaned and cannot afford school fees (Bennell, 2005a:441; Boler & Jellema, 2005:16; Sachs & Sachs, 2004). The long illness of the parents results in an impoverished household and the social stigma often prevents adequate family and community support (Boler & Jellema, 2005:16; Sachs & Sachs, 2004). Therefore learners may not enrol or may drop out of school as a result of HIV/Aids among their family members (Bennell, 2005b:473, Kelly, 2002). This will negatively affect income for school fees, stationery, textbooks and school uniforms, because of the increased demand for healthcare costs to care for ill family members (Bennell, 2005b:467-468, 472; Shisana *et al.*, 2005b:19). According to Kelly (2002), students in the majority of countries are faced with direct (tuition) fees, as well as indirect costs like educational

material, school-related activities and uniforms. Where HIV/Aids is prevalent, cash may not be available for education.

Many orphaned or affected learners will have to move long distances to find new homes. This leads to migration-related education interference (Shisana *et al.*, 2005b:21). For others, there are no homes at all (Coombe, 2003:4). This can effectively terminate schooling.

According to Boler and Jellema (2005:6), governments and departments of education have little understanding of the educational challenges OVCs have to face. To mention just a few:

-  Only some OVCs have access to bursaries and free meals due to sponsorships made by NGOs (Non-Governmental Organisations). Unfortunately these sponsorships only reach a few OVCs, because they are localized.
-  Existing bursary schemes seem to be under-resourced.
-  Countries do not have sufficient laws, policies or procedures to prevent discrimination against HIV-positive learners.
-  OVCs are not only desperately in need of financial assistance, but counselling is also necessary to address their psycho-social needs. Counselling is not easily available.

2.4.2.1.2 OVCs are occupied with caring for their ill

Children or young people in Aids-stricken homes may need to care for or stay with the sick and even accompany sick persons to health-care centres so that other adults in the household can go to work to generate an income. Others must liberate an adult from domestic or economic activities so that the adult can care for the sick. A number of OVCs stay at home to care for younger siblings, while some of these affected learners take over an adult's income-generating activities. Some children have to head households because of the death of or terminal sickness of parents (Kelly, 2002). Learners in the Aids-stricken home are consequently traumatised (Coombe, 2000). Children live in

over-extended families and are sometimes under pressure to contribute to family income as poverty deepens (Coombe, 2000).

According to Kelly (2002), these factors lead to coming late, distraction and repeated absence from school, which affect the learning achievement of the child and which may ultimately lead to termination of school participation. Orphans, OVCs and foster children are less eager to attend school than children whose parents are still alive. Low educational expectations of orphans are also experienced (Boler & Jellema, 2005:16).

2.4.2.1.3 OVCs are ill themselves

HIV/Aids-infected learners experience various emotional, social and educational difficulties, not only due to areas of the brain being affected as discussed completely in 2.4.5.4 (Naudé & Pretorius, 2003), but also because of exhaustion, aching body parts, weakness and the negative stigma surrounding the pandemic. According to Lewis (2006) only 3 to 5 % of orphans receive some intervention from the government; most OVCs experience high levels of trauma and personal needs.

Fear of the stigma and the trauma they experience in seeing a loved one suffer and die, has a devastating impact on the health of the affected child (Kelly, 2002). Affected learners may become so preoccupied that schooling is no longer feasible.

Some of these learners are ill themselves and thus do not come to school (Shisana and Simbayi, 2005), which also impacts negatively on enrolment figures. According to Shisana *et al.* (2005b:112), children in the age group two to fourteen years have a HIV prevalence of 13.3%, while children in the age group fifteen to eighteen have a HIV prevalence of 21.0% which will further jeopardize the demand for education and affect the learner-educator ratio (Shisana *et al.*, 2005b:12). Ratio can be described as the average of full-time study learners per full-time working educator (Nilsson, 2003).

It is clear that OVCs experience numerous disadvantages in their lives, which are mirrored in their educational needs (Boler & Jellema, 2005:16).

2.4.2.2 Supply of education

The supply of education (as well as the quality of the educational process) is also affected through:

-  mortality of trained educators and support staff; and
-  lower productivity of sick educators (Bennell, 2005a:441, 449; Schierhout, 2004).

Educator health and educator mortality is negatively impacted by the pandemic:

-  From a sample surveyed (45 000 educators), it emerged that 12,7% of the teacher workforce in South Africa is HIV-positive (Simbayi, Skinner, Letlape & Zuma, 2006). According to Blaine (2006), in 22% of these educators, the disease is so advanced that they need immediate antiretroviral treatment (ART).
-  One out of eight educators (1:8) in South Africa is HIV-positive. Mortality in the teaching profession increased in the past seven years from 7% to 17, 7% (Isaacs, 2005:4).
-  HIV-prevalence among educators in South Africa, although somewhat uncertain regarding Aids and demographic data, is anticipated to increase from 13 % in 2000 to almost 30% by 2010, although the accessibility of ART could reduce Aids-related teacher mortality in Africa by half (Bennell, 2005a:452, 453).
-  Infected educators lose approximately 6 months of professional time before developing full-blown Aids (Hall *et al.*, 2005).
-  Many educators choose to relocate once they are visibly ill or simply disappear, leaving learners without educators (Hall *et al.*, 2005).
-  More than 4 000 South African educators died of HIV/Aids-related complications in 2004 (Shisana *et al.*, 2005a). In other words: every

second hour, one educator dies of HIV/Aids in South Africa (Isaacs, 2005:4).



According to a survey executed by Simbayi *et al.* (2006) approximately eighty percent of the educators who died of HIV/Aids-related complications were younger than 45 and about 33, 6% were between the ages of 25 and 34.



Researchers found that 19% of the men and 24,2% of the women in the teaching profession in South Africa between the ages of 30 and 34 years are HIV-positive (Rademeyer, 2005:12). With an educator infection rate of 20 – 30%, it is estimated that some 88 000 to 133 000 educators will have died by 2010 (Kelly, 2002), while 10, 3 per 1 000 educators (1:10) are currently dying because of HIV/Aids (Shisana *et al.*, 2005b).

According to Shisana and Simbayi (2005: xv), at least 12, 7% of South African education administrative staff and educators and 8.2% of student educators are infected. In Figures 2.4 and 2.5 below, the prevalence of HIV among South African educators is illustrated:

Figure 2.4: HIV/Aids prevalence among South African Educators according to age group for 2005 (Shisana & Simbayi, 2005:xv)

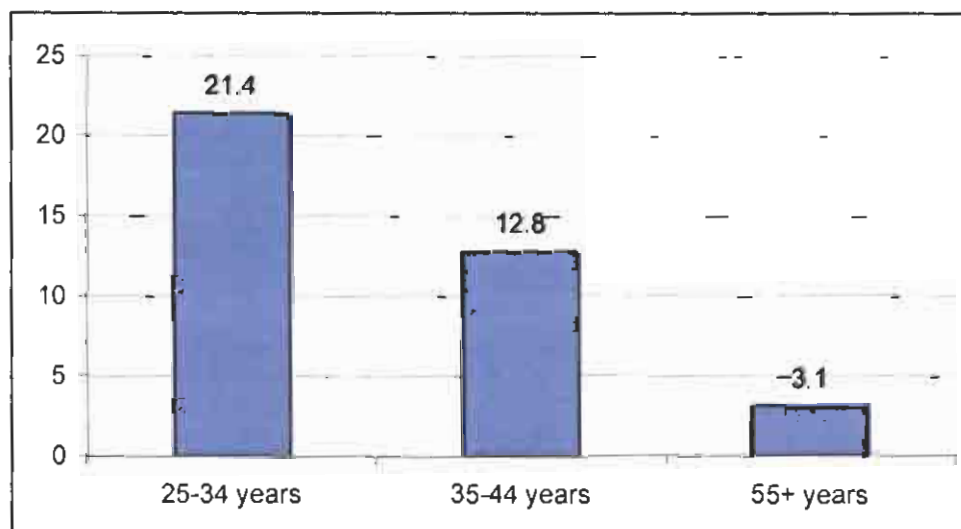
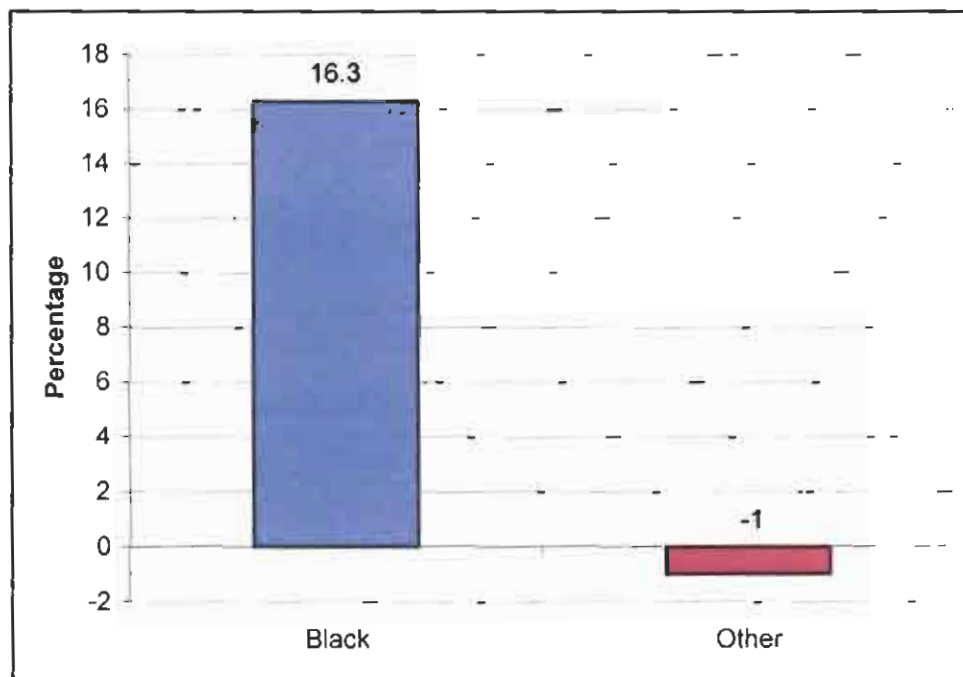


Figure 2.5: HIV/Aids prevalence among Black and Other (White, Coloured, Indian/Asian) South African Educators (Shisana & Simbayi, 2005:x)



The above Figures 2.4 and 2.5 (relating to educator mortality and educator ill health) contribute to HIV/Aids having a mammoth effect on the whole education system, which is the primary mechanism for the development of future human resources.

Absenteeism is increasing due to sickness of self, looking after sick loved ones and funerals (Bennell, 2005a:450). School principals report that Fridays are generally not productive teaching days, because affected educators are attending more and more funerals (Coombe, 2000:11). On such days educators are simply not available to supply education.

Managerial staff also notes that educators are traumatized whether they are infected or affected (Coombe, 2000:11). Traumatized educators may be too preoccupied to educate learners effectively.

In KwaZulu-Natal, South Africa's largest and mostly rural province on the country's east coast where one in five people carries the virus, 70 000 new teachers will be needed by 2010 to replace sick and dying educators (Shisana

& Simbayi, 2005), and the prevalence of HIV among young students will result in fewer new educators available in the system.

Because of the fact that prospective student educators are scared of being infected and affected by the HIV/Aids pandemic, a smaller enrolment of students can cause a shortage of educators in future (Bennell, 2005a:441; Ramrathan, 2003). Moreover, the disturbing prevalence of HIV/Aids among 8% of student educators is very high for people who are being trained to enter the teaching profession (Shisana *et al.*, 2005b:112). This means that the future supply of educators is jeopardized by the pandemic.

In Table 2.2, the impact of the pandemic on the supply and demand for education is summarized (Boler & Jellema, 2005:12-14; Schierhout, 2004; Shisana & Simbayi, 2005).

Table 2.2: Summary of the impact of the pandemic on the supply and demand for education

Aids affecting the supply of education	Aids affecting the demand for education
• Loss through mortality of trained educators.	• Fewer children to educate.
• Reduced productivity of sick educators.	• Fewer children wanting to be educated.
• Loss of support staff.	• Fewer children able to afford education.
• Stress-related illnesses among affected educators.	• Fewer children able to complete their schooling (orphans or affected learners).
	• Migration-related educational interference (orphans move to grandparents or family members).

2.4.3 Pandemic and the educator

Although educators are not usually regarded as mobile or migratory workers, they share some of the infection risks of a migratory labour force. Aspects such as the following leave educators increasingly vulnerable to HIV/Aids:

-  distance away from their homes and families due to the lack of suitable housing;
-  family members who are reluctant to move to rural locations could cause educators to have more sexual partners (Coombe, 2003:4);
-  access to income due to higher socio-economic status could urge young village women to compete for male educators' attention;
-  fairly wealthy circumstances enable educators to engage in "commercial and other forms of transactional sex" (Bennell, 2005a:443);
-  male educators' could take advantage of their learners due to their status, authority and power which may lead to sexual abuse of female students, increasing their vulnerability too (Bennell, 2005a:443).

The above behaviours may lead to greater chances of educators being infected, although not all researchers believe this to be a foregone conclusion (Bennell, 2005a:443). The effect in terms of educators being infected will not be discussed further, as this has been discussed in 2.4. Rather, the focus will be on how educators are affected by the pandemic. Educators can be affected when they have:

-  loved ones, colleagues or learners who are HIV positive; or
-  when their loved ones, colleagues or learners have died of AIDS- related diseases; or
-  when they have Aids-orphans and vulnerable children in their classes.

The above can leave the educator personally and professionally affected.

2.4.3.1 When educators are personally affected

The pandemic does not only impact depressingly on the quality of teaching, but also plays a negative role in the health status of uninfected but affected educators, due to anxiety, trauma and constant worry that they experience (Theron, 2005:57).

Educators who are personally affected report being psychologically affected because of the death of loved ones and friends as well as being depressed by the stigma of Aids (Theron, 2005:57). Affected educators cannot cope emotionally and financially with sickness and death among friends, colleagues and learners, and are concerned about the uncertainty of their own future and that of their dependents. According to Shisana *et al.* (2005a) educators are tormented emotionally when colleagues, learners and relatives are suffering from HIV/Aids. They experience feelings of depression, sadness and hopelessness (Theron, 2005:57). These feelings may lead to low educator morale, which can lead to more educators leaving the profession (Hall *et al.*, 2005).

Due to the immorality associated with Aids, educators are less likely to disclose their status or their loved ones' status (Boler & Jellema, 2005:6). Although discrimination is prohibited, infected as well as affected people (educators included) are stigmatized, due to the following unfair perceptions as illustrated in Table 2.3 (Kelly, 2002; Nyblade, Pande, Mathur, MacQuarrie, Kidd, Banteyerga, Kidanu, Kilonzo, Mbwambo & Bond, 2003; Theron, 2005:4):

Table 2.3: Unfair perceptions regarding HIV/Aids (stigma)

Stigma	
 Understanding and Challenging HIV Stigma: Toolkit for Action	 Sexual taboos
	 Immoral behaviour
	 God punishes sexual sin
	 Sorcery
	 Witchcraft
	 Easy transmission
	 Painful death

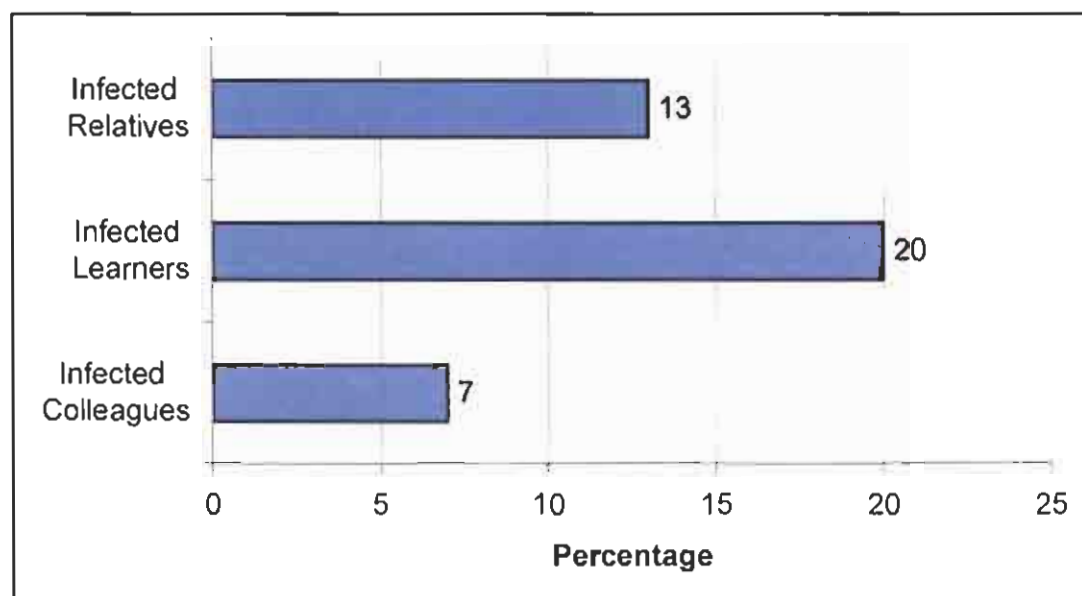
The above mentioned perceptions (*cf.* Table 2.3) can lead to the deterioration of educators' personal and professional wellness (Theron, 2005:5).

Educators also experience a lack of confidential voluntary counselling and testing services, as well as free or affordable access to anti-retrovirals (ARVs) (Boler & Jellema, 2005:6).

2.4.3.2 When educators are professionally affected

The implications for many remaining teachers are bleak. They may not be infected, but they are affected when colleagues, learners or loved ones are HIV-positive or when they die of HIV-related illnesses. Figure 2.6 shows proportionally how affected educators are influenced in practising their profession when HIV/Aids is present among educators, learners and family members (Hall *et al.*, 2005).

Figure 2.6: Impact of HIV/Aids on affected educators (Hall *et al.*, 2005)



From Figure 2.6 it is clear that educators in this sample reported are most affected when learners are infected. Often educators are required to become involved in cases where children are exposed and abandoned or neglected by parents who are infected by the pandemic. These educators have to report the affected child to social workers or police and nearly all of them want to make sure that the child is taken care of or in a place of safety. Educators feel

responsible for the learners' school attendance (Shisana *et al.*, 2005a). Learners who are forced to sell their bodies in order to provide for themselves and siblings in cases where these learners are orphaned or abandoned often trouble educators (Shisana *et al.*, 2005a). In other words, their association with affected and infected learners burdens educators.

Infected colleagues, infected learners and infected relatives lead to increasing workloads and heightened responsibilities as affected educators have to witness HIV-positive colleagues, learners and relatives dying (Hall *et al.*, 2005). All of these impact negatively on the psychological wellness of educators.

When psychological wellness declines, physical health is often affected. According to Shisana *et al.* (2005a) HIV/Aids plays a major role in the health status of uninfected educators. Illnesses diagnosed in the past five years among educators have been stress-related, which indicate that educators may be working under extremely high levels of stress. The following illnesses (in descending order) were most frequently diagnosed among affected educators in the past five years (Shisana *et al.*, 2005a):



Depression;



high blood pressure;



ulcers; and



diabetes.

Many educators go far beyond their call of duty. They are not responsible only as educators; they must also function as parents, social workers, policemen, confidants and psychologists for affected and infected learners. Many educators feel that they cannot effectively guide these learners. Affected educators are constantly in need of support and training to make it possible for them to cope with this aspect of their work (Shisana *et al.*, 2005a).

2.4.3.3 When educators have infected colleagues

According to Burnard (1993:1782) and Shishana *et al.* (2005a) emotions such as: shock, unacceptableness, self blame, denial, fear, relief, anger, guilt,

decreased self-esteem, loss of identity, loss of personal control, sadness, depression and hopelessness, are often experienced by infected, as well as affected people. Sometimes these people have multiple behaviour changes, like alcoholism, misuse of drugs and social withdrawal, which in their turn lead to isolation and deprivation. Affected educators are often concerned about the well-being of their infected colleagues, trying to help them to cope with their health status. This can be emotionally draining, leaving the affected educator with feelings of despair.

Teachers who are ill, are increasingly absent from class and it is often difficult to find relief cover for them. Ill educators who remain in their posts cannot provide the same quality of teaching; therefore there is reduced productivity of sick teachers. Teachers who are not ill have to cover for those who are (Theron, 2005:58). In other words, when healthy educators have infected colleagues, they face extra teaching loads. Most educators will have to take on additional teaching and other work-related duties in order to cover for sick colleagues (Coombe, 2000). This will affect their psychological wellness.

2.4.3.4 When educators have infected learners

The prevalence of HIV/Aids among school-going children, as stated earlier in 2.4.2.1.3, is between 13.3% (2-14 years of age) and 21.0% (15-18 years of age) (Shisana *et al.*, 2005b:112). According to these statistics, it is clear that numerous infected learners are being taught by educators, which will burden already stressed educators additionally.

Naudè and Pretorius (2003) state that one of the areas of the body that is being affected by HIV/Aids, is the central nervous system. Scholastic performance is linked closely to the adequate functioning of the brain. In relation to areas of the brain being affected, infected learners may experience educational difficulties that include:



confusion;



memory loss;



seizures;

-  impairment of motor, cognitive and emotional activities;
-  disturbances in speech, vision and thought;
-  inattentiveness; and
-  apathy.

All of the above make optimal learning difficult. In other words, when educators teach infected learners, teaching may be more complicated, thereby further burdening educators. It is difficult to teach a sick learner, because ill learners will find it difficult to concentrate, co-operate, and develop. Ill learners are also often absent from school and may be faced with learning disabilities (Naude & Pretorius, 2003). Educators would benefit from additional training to provide for the needs of infected learners.

For an educator to witness the declining health and suffering of learners may be devastating. These educators may become extremely involved in assisting these learners, whether financially, emotionally or physically. This involvement affects their performance as professional educators, because they cannot find enough time or energy to perform as expected (Theron, 2006a).

2.4.3.5 When educators have Aids-orphans in their classes

An orphan can be described as a child whose parents (father and mother) passed away (Wehmeier, 2002:825). Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo, Tlou and Chitiyo, (2004) define an orphan as a child under 18 years who has lost both parents through death. UNAIDS and UNICEF predict that the number of Aids orphans could reach 25 million by 2010 and 40 million by 2020 (Sachs & Sachs, 2004). According to Shisana *et al.* (2005a) 14,4% (that is 2 531 800) of the child population in South Africa between the ages of 2 and 18 years are orphans. Being orphaned, impacts very negatively on schooling (*cf.* 2.4.2.1.1). The negative impact extends to educators teaching orphans too.

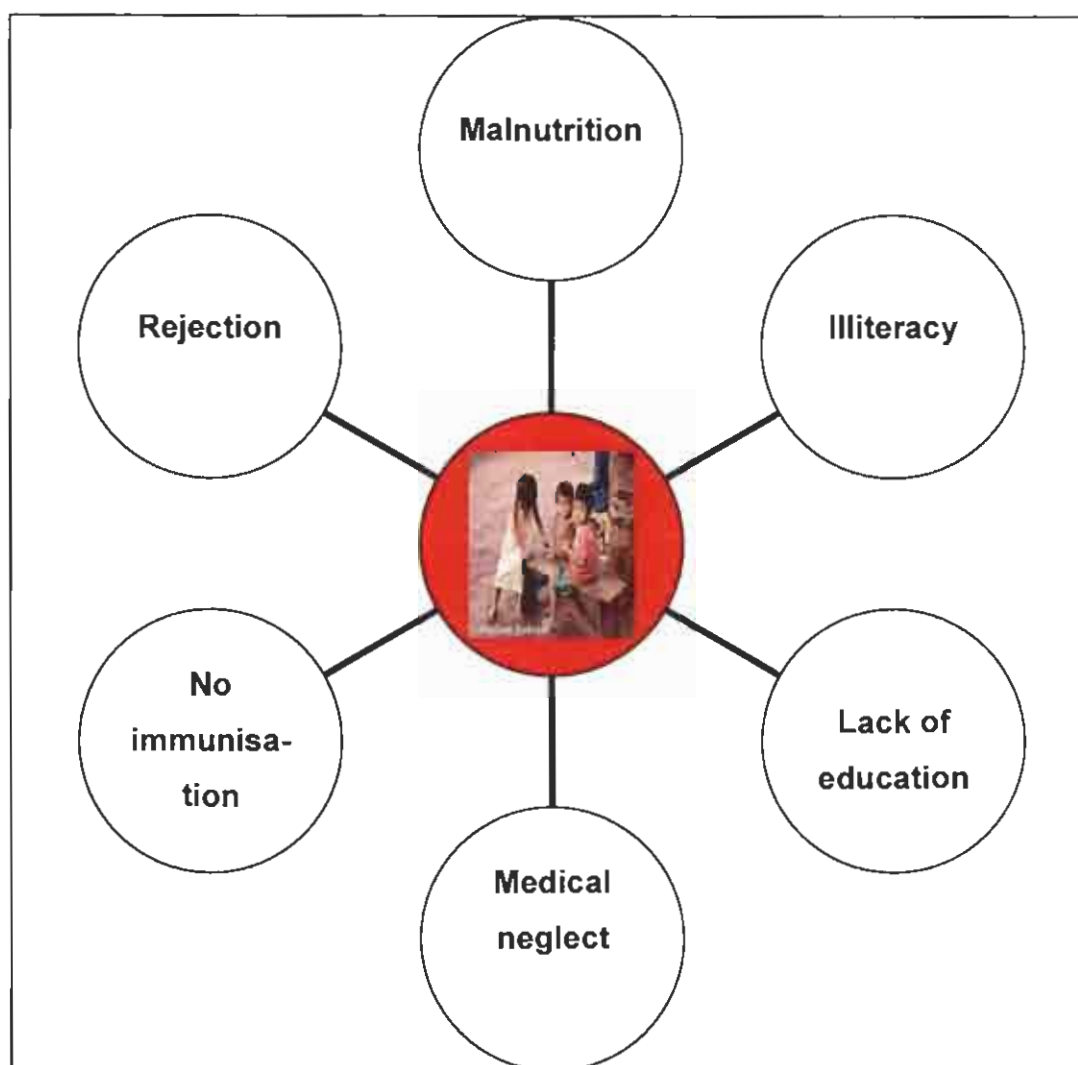
The negative impact begins even before the learner is orphaned: ill parents may not be able to have a constant monthly income and their children may be

burdened with extra responsibilities and household tasks. These learners may become troubled and depressed, which may affect their learning negatively. Educators, in turn, will be affected by witnessing the circumstances in which these learners are growing up, some of whom are heading households, or whose parents are mobile workers and only return once a month or during holidays. These children's needs vary from a meal per day and clothes to wear, up to the psychological and emotional need for love, support and acceptance (Shisana *et al.*, 2005a). In many places, teachers take care of orphans in their own homes, and provide for needy relatives (Shisana *et al.*, 2005b:23). A female primary school teacher from Mpumalanga says:

"We are parents ourselves, we can see that there is a need; we can see that this child has nothing; we become ex-official and go to the neighbours. We have a nine year old who stays with siblings there is no mother and father in that family but the neighbour is keeping an eye...There are so many cases if I can relate them the sun would go down, the sun would go down really." (Shisana *et al.*, 2005b:23).

HIV/Aids orphans have to face many difficulties, like trauma, neglect, and social implications, as seen in Figure 2.7 (Kelly, 2002):

Figure 2.7: Implications for HIV/Aids-orphans



All of the above-mentioned are devastating factors that may contribute to the already excessive workload of educators and impact on their emotional, physical, social and psychological well-being, because many of the educators become personally involved in caring for these orphans.

2.5 CONCLUSION

Figure 2.8 illustrates the impact of HIV/Aids on the role of the affected educator, professionally and personally.

Figure 2.8: The impact of HIV/Aids on the affected educator

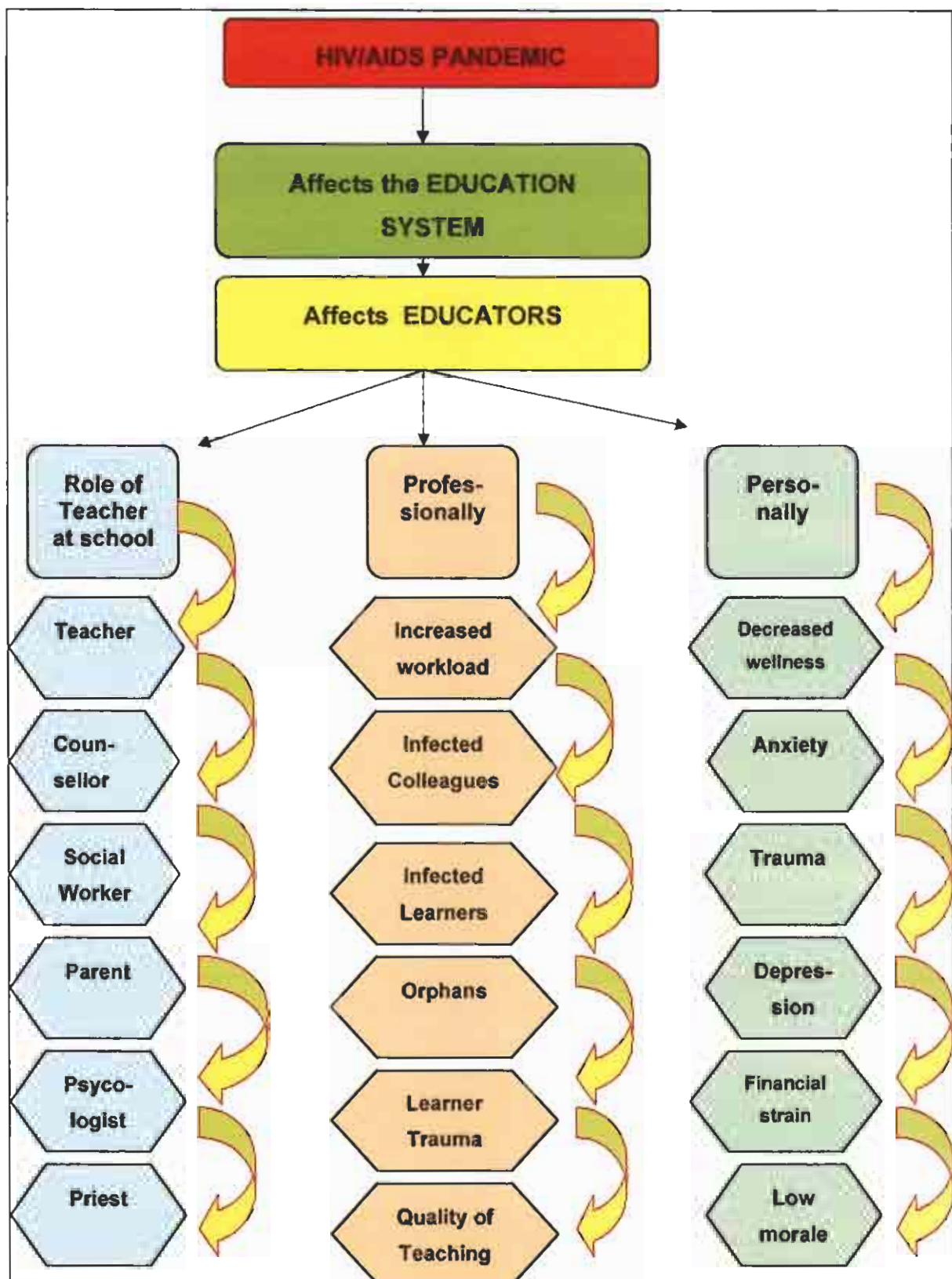


Figure 2.8 clearly indicates the potential effect the pandemic may have on educators affected by the pandemic. Educators perform not only the role of

teacher, but also the role of counsellor, social worker, parent, psychologist and priest.

These different roles usually distract their attention from teaching (Shisana *et al.*, 2005a), adding to educator stress.

HIV/Aids infected learners, colleagues and loved ones, may not only affect educators professionally but emotionally and psychosocially as well. Educators feel they cannot cope anymore with stress-related situations that obstruct teaching and learning. They do not only deal with infected family members, but also with orphans who are heading households, traumatized children who are nursing sick and dying parents, learners whose parents are mobile workers who come home only once a month, as well as infected colleagues (Shisana, *et al.*, 2005a).

The potentially devastating effect HIV/Aids may have on learners, educational staff, communities and countries can no longer be denied. It is clear that affected educators are in need of some kind of support programme or system to provide them with the necessary skills to support infected colleagues, learners and loved ones, as well as staying healthy themselves.

Chapter Three gives an overview of current support structures available to educators.



CHAPTER THREE

SUPPORT FOR AFFECTED EDUCATORS



"We are not victims, we are not patients, we are not sufferers. These names are both derogatory and disempowering. We are people living with HIV. We laugh, we cry, we dance, we sing, we play, we argue, we pay tax, we are parents and children. We belong to families. We are all in communities. Above all these things we are part of human nature."

- Doro Thanduxolo (2002) -

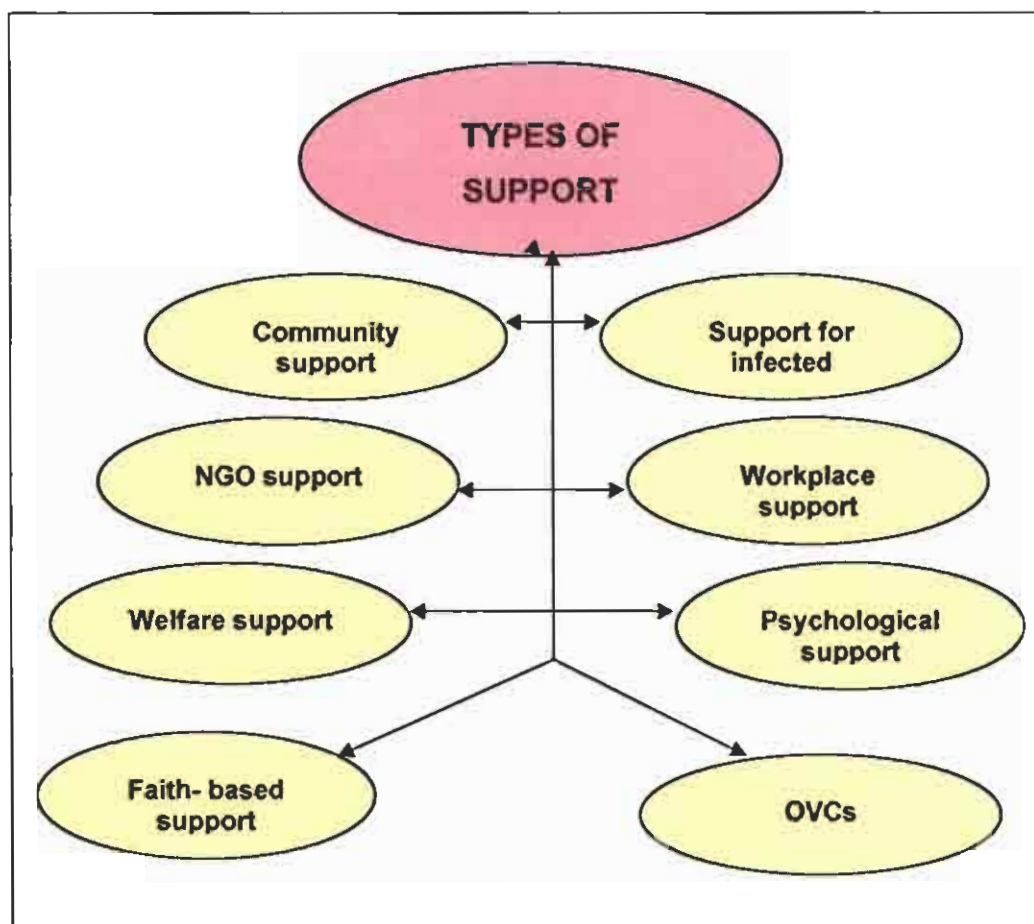
3.1 INTRODUCTION

Support can be defined as providing another person with comfort, recognition, approval and encouragement. There are multiple forms of support, but they share a general aim, namely to ensure a better wellbeing and a general feeling of wellness (Reber & Reber, 2001:726). When people maintain wellness and continue to function adaptively, despite a risk-laden context, they are thought of as being resilient. Donald, Lazarus and Lolwana (2002:222) define resilience as the ability to deal with and recover from difficulties. To empower educators to be resilient in the face of HIV/Aids, they need to be supported. The various types of support (*cf.* Figure 3.1) will briefly be discussed first, whereafter the various stakeholders (*cf.* Figure 3.2) and, finally, educators' support needs (*cf.* Table 3.2) will be specifically discussed in more detail.

3.2 TYPES OF SUPPORT

The purpose of this section is to outline the basic types of support that could be used to empower educators affected by the HIV/Aids pandemic. There are multiple types of support as summarized in Figure 3.1:

Figure 3.1: Types of support



Each of the above mentioned support will be discussed in more detail as it relates to affected educators.

3.2.1 Community-based support (CBS)

Individuals are worst affected by HIV/Aids when they don't have access to information, services and protection for their rights or if they are excluded from acting freely in their community (International HIV/Aids Alliance, 2006). Civil society's role is to provide assistance for the "marginalized" and the vulnerable where public or private services cannot. CBS consists of small and large groups of people who strive to change structures and societies and support the vulnerable by drawing attention to injustices. In this way civil society influences HIV/Aids policies and programmes. They also play a role in providing basic services and programmes (International HIV/Aids Alliance, 2006), as well as ensuring inclusion. Civil society has become an important partner of

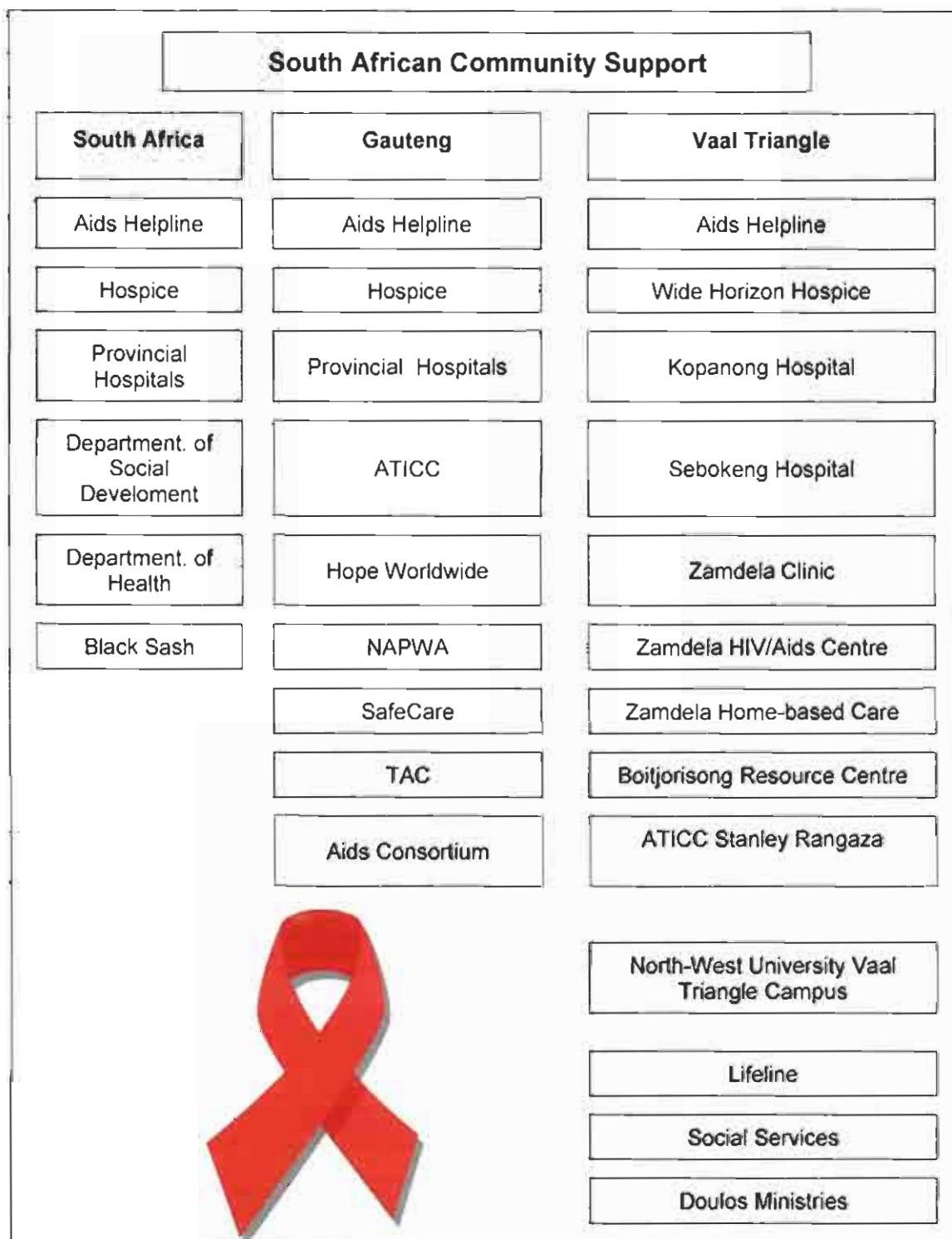
government in the fight against HIV/Aids, in welfare support organizations such as BANA PELE and Khomanani which were initiated by the Gauteng Provincial Government.

CBS can be defined as volunteers helping people in the local community (a particular area where people live) who suffer from poverty, sickness, grief or old age (Hornby, 2001:226). CBS consists of community-based organizations and non-governmental organizations. Community-based Organizations (CBOs) are less formally comprised than Non-Governmental Organizations (NGOs) and mainly focus on activities in a particular community (AfroAIDSinfo, 2006). In terms of HIV/Aids, CBOs should assist in educating learners and educators about HIV/Aids (Soul City, 2005:26), as well as in teaching people the necessary skills to cope with the reality of the pandemic.

3.2.1.1 Examples of South African (SA) community support structures

In addition to organizations such as churches and religious groups (which will be individually discussed in 3.2.5), there are a number of South African community support structures for HIV/Aids-infected and affected people as noted in Figure 3.2. The Vaal Triangle-based organizations are specifically included as this study was located in the Vaal Triangle and made use of the Vaal Triangle community support structures.

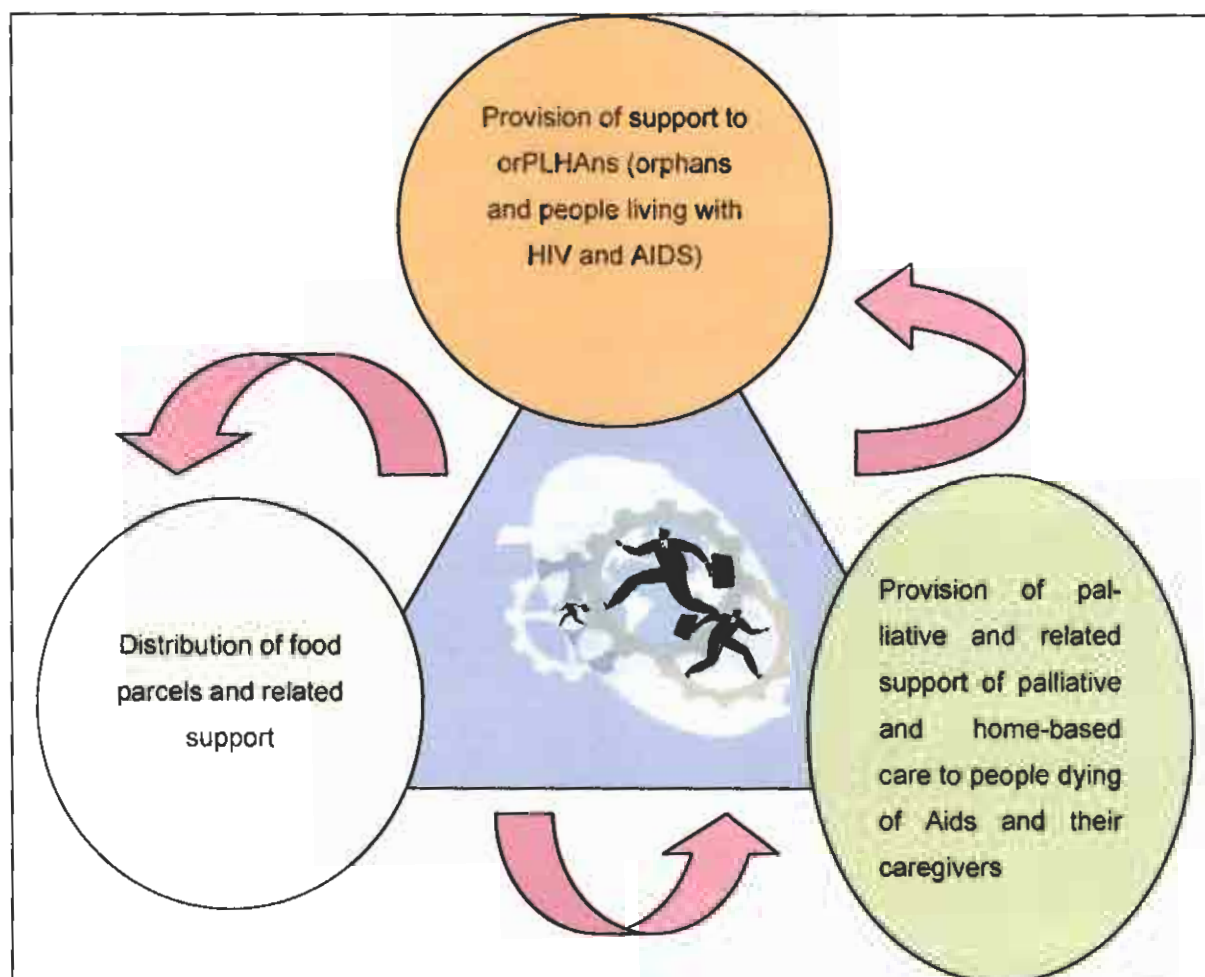
Figure 3.2: South African Community Support



3.2.1.2 How will the affected educator benefit from this form of support?

CBOs provide vital support, as indicated in Figure 3.3, to groups and sectors which are not directly or sufficiently supported by government and other programmes, and address areas such as the following (AfroAIDSinfo, 2006):

Figure 3.3: Support areas addressed by CBOs



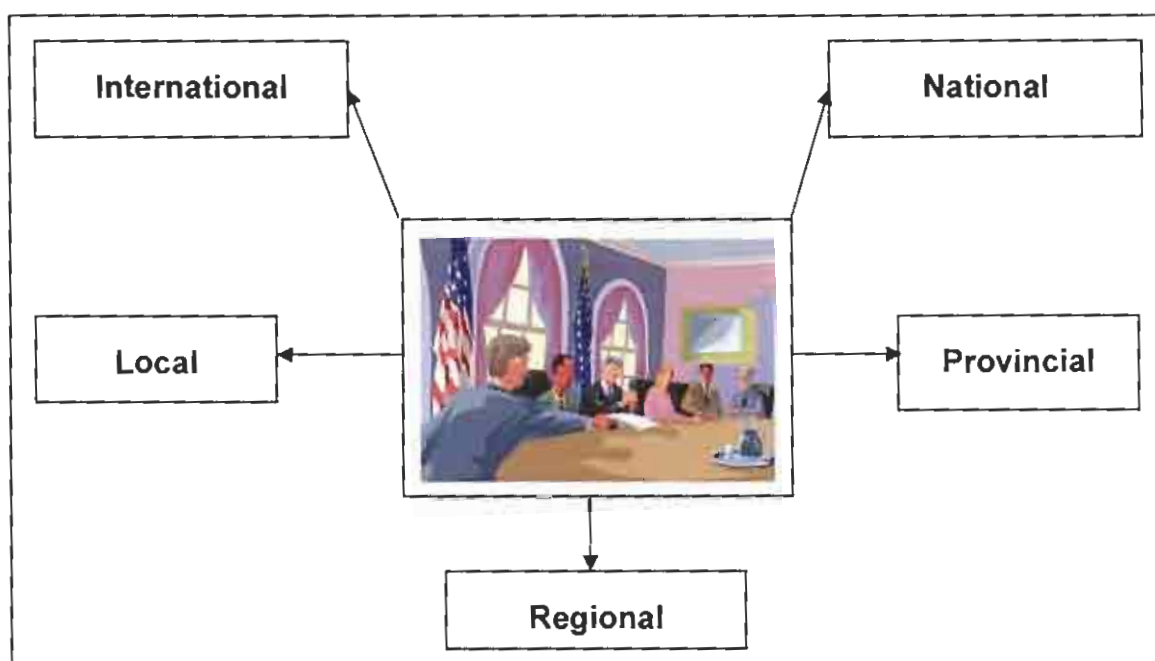
Communities can organize groups to help educators when and where it is needed. Educators have a need for practical support (*cf.* Table 3.2 in Chapter Three). Local skilled people or professionals can share their medical or counselling skills, which will lessen the burden on educators who are affected (Soul City, 2004:27). These groups can also help OVCs to apply for the Child Support Grant from the Department of Social Development (Gauteng Provincial Government, 2004:5) or bursary schemes (Allemano, 2003:25), which will also take this responsibility away from the educators, so that they can spend more quality time on teaching and learning.

Educators will therefore be empowered through obtaining skills, knowledge, confidence and interpersonal ability (Scriven & Stiddard, 2002), which will strengthen them to become resilient in the face of the HIV/Aids pandemic.

3.2.2 Non-governmental support

Non Governmental Organizations (NGOs) focus on a range of activities, operate in a number of communities and are formally constituted (AfroAIDSinfo, 2006). NGOs function at a wide range of levels, as illustrated in Figure 3.4 below:

Figure 3.4: Levels at which NGOs function



NGOs include activities such as research, political lobbying, policy-related activities and networking on international, regional, national, provincial and local level (AfroAIDSinfo, 2006). These are organizations not involved with the government of a country, but provide funds through diverse policy actors for certain issues like HIV/Aids (Seckinelgin, 2004:288).

3.2.2.1 Examples of South African NGO support structures

There are numerous NGOs in South Africa. Only a few related to HIV/Aids support will be highlighted.

3.2.2.1.1 International non-governmental organizations

The following are examples of international NGOs functioning in South Africa (Soul City, 2005:1):

-  The World Health Organization (WHO).
-  The Organization of African Union.
-  The European Union.
-  USAIDS (US) (United States).
-  UNAIDS (United Nations).
-  DFID (UK) Department of International Development: British development co-operation.
-  Save the Children.
-  Action AIDS.
-  Clearinghouse.
-  AVERT.ORG.
-  Nurturing orphans of AIDS for Humanity.

3.2.2.1.2 Multinational Companies:

Multinational companies worldwide provide funding for advertising, workshops, medical necessities, food and clothing to NGOs to be distributed among countries and communities in need.

The following are examples of multinational companies which fund NGOs (Seckinelgin, 2004:300):

-  BP.
-  Mercedes Benz.
-  Coca Cola.
-  Ford.
-  World Bank.
-  International Monetary Fund.

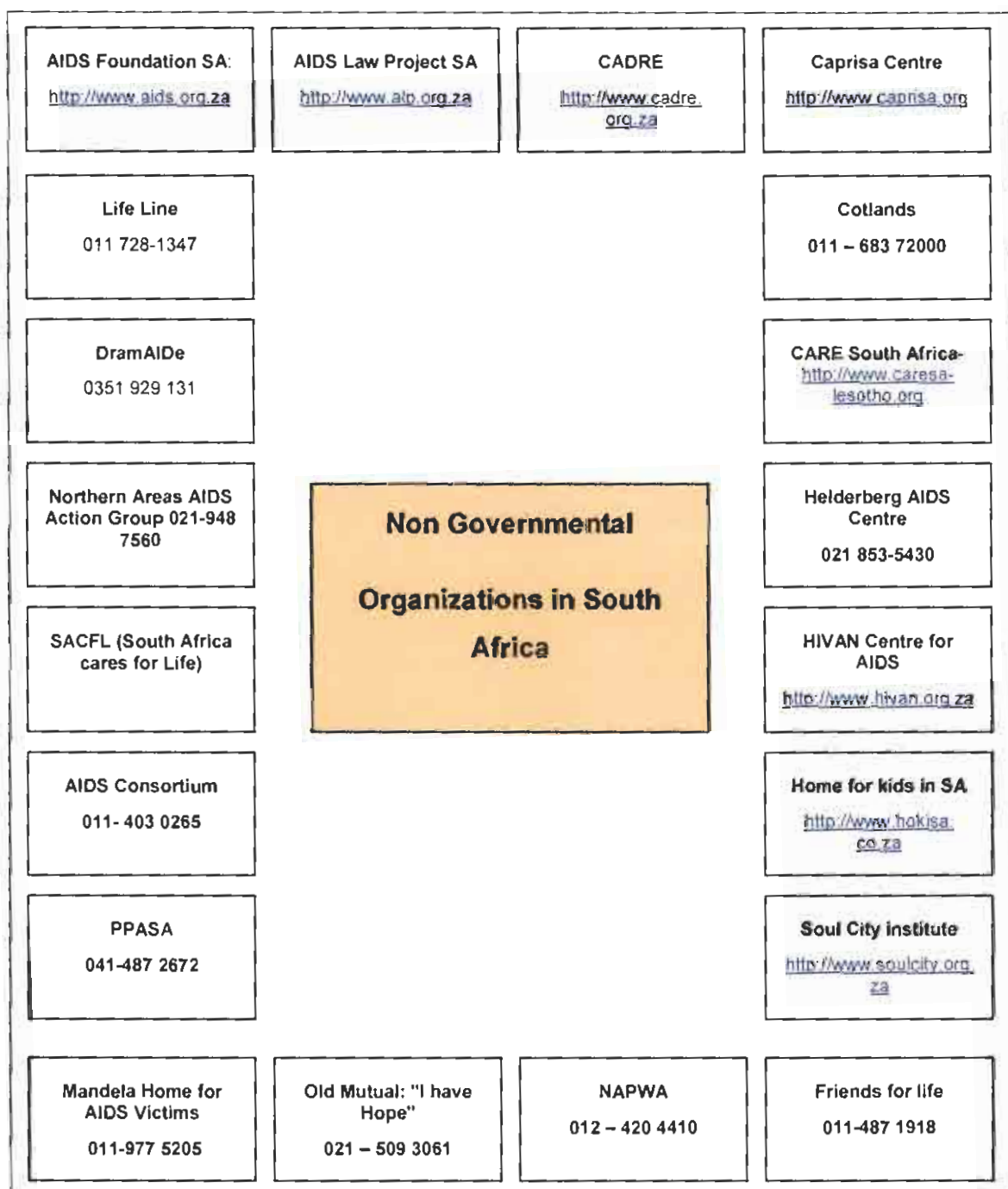


Bill and Melinda Gates Foundation.

3.2.2.1.3 Non-Governmental Organizations in South Africa

The following NGOs, as indicated in Figure 3.5, originated in South Africa and specifically serve the South African communities in need with regard to the HIV/Aids pandemic.

Figure 3.5: Non-Governmental Organizations in South Africa



3.2.2.1.4 How will the affected educator benefit from this form of support?

Non-Governmental organizations usually provide funds which can be used for home-based care and community empowerment. In other words, the infected persons will be visited by volunteers and or professionals to provide them with medical, as well as psychological care. The rest of the family receives information which will provide them with skills to cope with the circumstances, such as (Soul City, 2004: 47; Theron, 2006b:5):

-  giving and gaining support;
-  remaining psychologically well by coping with stigma;
-  coping with stress and fatigue;
-  nursing the infected loved one;
-  where to be tested;
-  nutrition;
-  knowledge about the spreading of the virus;
-  anti-retroviral treatment;
-  treating secondary illnesses relating to HIV/Aids;
-  preparing for the future;
-  dealing with death and dying; and
-  applying for grants.

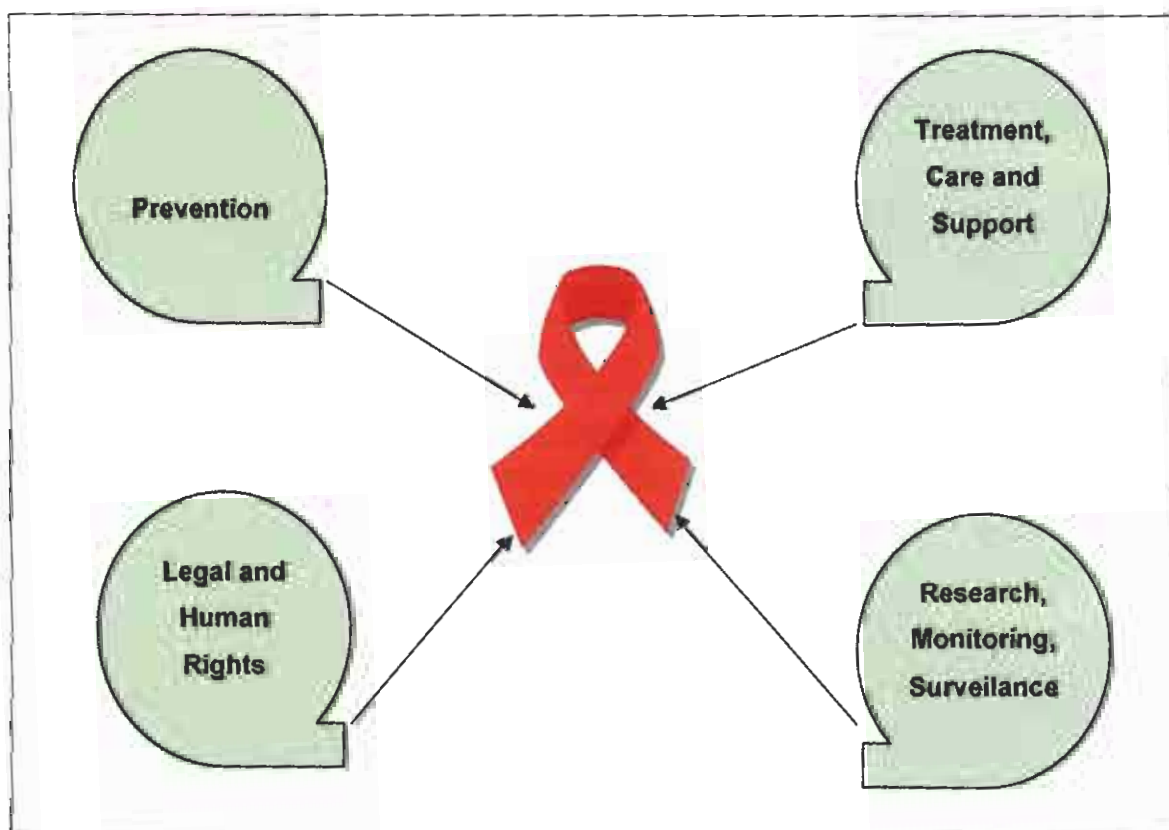
Affected educators will find assistance in the sense of other people relieving them from some of their responsibilities, for example cooking one or two meals per week for the household or caring for the infected patient if loved ones are sick. These volunteers can also take patients to the clinic or doctor. In this way they help the educator to go to work without being solely concerned about the infected at home, and also give them the opportunity to spend quality time

with their infected and affected loved ones and be able to give quality education and support to OVCs (Soul City, 2005:27).

3.2.3 Governmental support

The spread of HIV/Aids throughout the world requires a dramatic, heightened response to the pandemic. The Government of South Africa realized the seriousness and magnitude of the pandemic and created the STI Strategic Plan for South Africa, 2000 – 2005 which focuses mainly on four areas as indicated in Figure 3.6 below (Simelela, 2002).

Figure 3.6: Four main strategy areas of STI



Lewis (2006), however, believes that the South African Government is still insensitive and inattentive regarding the provision of treatment. It is, for example, unacceptable that 85% (900 000) of HIV-infected people in South Africa who are desperately in need of treatment, do not have access to ART (Mulder, 2005:4). Only 10 000 of the 50 000 children in need of ART receive ART (De Villiers, 2005:6). Seven hundred thousand South Africans could have

been saved between 2003 and 2006, if they had received ART (Rolls, 2006:14).

3.2.3.1 Examples of Governmental support organizations

The BANA PELE (children first) programme brings all the services for children together to make help more available for Gauteng children who are facing barriers to learning, including those who are affected by the HIV/Aids pandemic. Poor families are prioritized. Local NGOs are funded to help families and foster parents to look after children in their own homes. These NGOs help any responsible person caring for children in their home. Trained child care workers visit the children regularly to help with counselling, social problems and school work. These NGOs also assist poor families with food, clothing, obtaining grants, free schooling, health care and dealing with other problems. School education is free for poor children and food is provided in poor schools. Some of the poorest children also receive free school uniforms (Gauteng Provincial Government (GPG), 2005a:3).

Khomanani is also an organization from the Gauteng Provincial Government whose logo is: "Caring together for life" (Soul City, 2004:1). They play an important role in distributing knowledge, pamphlets and workshops to enable people to be fully informed about HIV/Aids.

3.2.3.2 How will the educators benefit from this support?

By addressing the problem, local governments are responding to the needs of their citizens, which include the educators (AfroAIDSinfo, 2006). In this way, they can ensure the sustainability of their communities, including educators and the school environment.

3.2.4 Welfare support

Welfare support can be defined as a system by which the government provides a range of free services to people in need, for example medical care, money for people without work and care for the elderly (Hornby, 2001:1355). According to the Department of Social Development (2002:17), liability

methods should be put into place to observe and assess welfare organizations to become more receptive to the needs of PLWA.

3.2.4.1 Examples of SA welfare support structures

South African welfare support structures are social programmes which assist people with and contribute to the well-being of community members regarding basic necessities, health, behaviour and family problems (Howe, 2000). The following are examples of welfare support structures in South Africa:

-  Department of Social Development Offices;
-  Department of Social Welfare; and
-  Verulam Child and Family Welfare Society (VCFWS).

3.2.4.2 How will the affected educator benefit from this form of support?

When welfare assists with orphans and other vulnerable children or loved ones, the educator's burden is alleviated. The affected educator has thus been supported, albeit indirectly. Involving educators in HIV/Aids prevention and Life Skills programmes such as peer counselling, will improve school effectiveness. Enhanced relationships between educators and learners can develop through team-building and working on common goals. Educators will extend their roles as educators and enhance self-esteem by acquiring new skills (Department of Social Development, 2002:17).

According to the South African Child Care Act, children have the right to protection and care (Gauteng Provincial Government, 2004:6). Some services are provided directly by Social Services, as well as organizations funded by the Social Services, to provide more services in communities, including:

-  Applications for social grants like foster care grants, disability grants for adults with full-blown Aids, child support and care dependency grants.
-  All children between the ages of 0-6 years in Gauteng receive access to free Primary Health Care (PHC) at clinics and hospitals run by the Department of Health and receive exemption form paying school fees.

They also receive free meals at school. All children who qualify for the Child Support Grant are also entitled to free screening and free psycho-social support by social workers (Bana Pele, 2006):



- Training people in their communities to provide care.



- Organizing alternative care for children, preferably in the community, such as foster care.



- Support for NGOs, CBOs and FBO's (Faith-based Organizations) which provide grants through Social Services, subsidized housing, water and electricity through municipalities, food gardens and the running of income generation projects, like sewing (Gauteng Provincial Government, 2004:6).

When educators are made aware of the above, they may experience being alone in the support of vulnerable learners.

3.2.5 Faith-based support

Faith-based support is defined as religious organizations or religious leaders, preachers and priests who support the affected in assisting with funerals, food and counselling (Soul City, 2005:21).

3.2.5.1 Examples of SA spiritual support structures



- Churches and religious groups.



- Church Aids Resource and Educational Network (Soul City, 2005:21).

3.2.5.2 How will the affected educator benefit from this form of support?

The affected educator receives the opportunity to consult a priest or a counsellor with regard to her emotions and feelings. They can take time to pray and be spiritually strengthened or allow other people from FBOs to look after the infected individual for a while in order to attend to other important issues, like paying bills or just simply relaxing (Soul City, 2005:22).

FBOs also provide volunteers and foster parents, donations of food and clothing, support for the affected and caring for families in the course of the

death of family members (Soul City, 2005:22). Churches can also "adopt" a family or families to provide them with necessary food, clothing, children's school fees and medical care. This means that the educator is not alone in supporting learners and families who are suffering because of the HIV/Aids pandemic.

3.2.6 Psychological support or counselling support groups

Counselling refers to professional processes designed to help individuals solve problems (Reber & Reber, 2001: 162). Affected educators are burdened with ill learners, affected or infected colleagues and loved ones who are constantly seeking support and advice. Affected educators are therefore in need of counselling and debriefing. Psychological support or counselling will assist and empower affected educators in order to put their circumstances into perspective and resiliently face the impact of the pandemic.

3.2.6.1 Examples of SA psychological support or counselling support groups

People infected and affected by HIV/Aids might suffer from mood changes, such as feeling low, depressed, anxious, frightened or stressed. These feelings can be hard to cope with alone. Psychological support and counselling can help the infected and affected to explore problems they experience and examine alternative ways of dealing with them to address these problems (Charleson, 2006). The following are examples of South African psychological support or counselling support groups related to HIV/Aids:



Voluntary Counselling and Testing Sites;



ATICCs (Aids Training, Information and Counselling Centres);



Aids Helpline;



social workers;



community organizations; and



3.2.6.2 How will the affected educator benefit from this form of support?

One of the main concerns regarding PLWHA (People Living with HIV/Aids) is their mental health. Feelings like depression, anxiety, sadness and fear of stigma, as well as sleeping, eating and anxiety disorders are often observed in PLWHA (Simbayi *et al.*, 2005).

If affected educators can be psychologically supported, they will be able to share their feelings and concerns openly. Counsellors and psychologists will provide them with coping strategies to deal with the burden of having a loved one, colleague, or learner suffering or dying of HIV/Aids (Kelly, 2002). Educators will also be able to refer infected and affected colleagues, learners and loved ones to professionals, which will bring great relief to affected educators. If educators are supported psychologically, it will enhance their well-being and aid them to function resiliently.

3.2.7 Workplace support

Simbayi *et al.* (2006) describe workplace support as policies which can contribute directly to reducing the repeated weakening of educators, by encouraging and providing protection against threats such as HIV/Aids, and by creating a positive and supportive working environment. A supportive working environment can be defined as an environment where teaching and learning are advanced, including the right to education, a safe environment, freedom from discrimination, recognition of the dignity of those who are infected and care for those affected; an environment which focuses primarily on the best interest of learners and educators. The school must therefore be a "centre of hope and care in the community" (Simbayi *et al.*, 2006).

According to The World Health Organization (WHO) (2005), health can be defined as a state of physical, mental and social well-being, interrelated with the environment in which an individual lives and works and not merely the absence of disease or infirmity. Workplace support in the form of policies

protecting the teaching profession is essential (Allemano, 2003:24). If educators are to be sustained, their health and well-being must be promoted.

3.2.7.1 Examples of SA workplace support structures

Cooperative workplace support structures improve communication and broaden participation in decision-making, leading to improved management relations and employee morale. Morale plays a very important role in "healthy" and resilient employees and educators. According to Blummer, Burt, Gans, Goldberg, Guild, Kim, Lee, Vaughn and Warner (2002), workplace support structures are excellent forums for communication, workplace problem-solving and psychological well-being. The following are examples of SA workplace support structures.

Simbayi *et al.* (2006) identify the following Department of Education (DoE) policies and structures for HIV/Aids:



The National Policy on HIV/Aids for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions.



Department's Workplace Policy for HIV/Aids.



Unions' HIV/Aids policies:

- Sadtu's (South Africa's Democratic Teachers' Union) HIV/Aids policy works towards member empowerment by understanding and managing the impact of the HIV/Aids pandemic. It also attempts to protect its members from discrimination (Simbayi *et al.*, 2006).
- Naptosa's (National Professional Teachers' Organization of South Africa) policy on HIV/Aids focuses on prevention by promoting awareness and support programmes (Simbayi *et al.*, 2006).
- A US-funded project, supported by four teacher unions, aims to preclude HIV transmission, proceed to counselling, testing and treatment and promote workplace policies on HIV/Aids (McElligott, 2005):

-  Health Advisory Committees (HAC).
-  School Governing Bodies (SGB).
-  Educator Support Teams (EST).
-  School Management Teams (SMT).

3.2.7.2 How will the affected educator benefit from this form of support?

A supportive work environment for educators affected by HIV/Aids can:

-  reduce stress;
-  minimize forms of discrimination;
-  inform educators about their rights;
-  motivate educators to work under difficult conditions;
-  combat depression;
-  create an open school where staff model positive relationships for learners;
-  make educators aware of human rights;
-  let people feel free to disclose;
-  make educators aware of the physical, medical, emotional and social needs of the ill educator;
-  help educators to deal with death and grief;
-  promote support and respect among staff at school;
-  build supportive and appreciative leadership; and
-  build awareness and knowledge (Xaba, 2006:52).

Educators will become more resilient if they are part of a supportive work environment, because if a person works under strenuous circumstances, he or she may become physically and emotionally weak. But if they feel they are

being understood and supported, they may become less stressed and depressed and may be able to fight the negative effect of the disease resiliently.

3.2.8 Support for the infected

Support for the infected can be defined as any form of support aimed at the individual who is HIV-positive. Support for the infected can be given by means of home-based care, free medical services, information regarding the future of their loved ones and subsidized ART. These forms of support can diminish the burden on the affected person.

3.2.8.1 Examples of South African support structures regarding the HIV/Aids infected person

Home-based care volunteers from, for example Africare, can look after the individual who is infected during the day when the affected are working. When the infected are supported, the burden on the affected may be less.

CARE is an organization whose mission is to alleviate poverty and realize human rights. They also want to increase people's access to comprehensive services that prevent transmission, provide care and support, and lessen the impact of HIV/Aids (Hatane, 2005). Because of the fact that care for the ill is reducing existing assets and leaving households unable to manage under the strain of increasing and competing demands (Hatane, 2005), the need for support in this area is increasing. CARE runs various projects, such as:



SHARP (Sexual health and rights project).



Local Links project, which demonstrates success in impacting on vulnerable households and OVCs by providing a model based on unpaid savings and loans. This project works in close partnership with local NGOs and CBOs (Hatane, 2005).



The WHELL (Water, Health & Livelihoods) Project investigates linkages between gender and access to sufficient water and sanitation services within the context of caring for HIV/Aids-infected and -affected

households and strives to support households infected and affected by HIV (Hatane, 2005).



ATICC (Aids Training and Information Counselling Centre) offers training (Aids-counselling and peer education skills) and education services that are available to all individuals and organizations. ATICC staff is uniquely equipped to give advice on a range of issues relating to HIV/Aids and are trained in counselling (Mkosi, 2005). ATICC's goals are to:



reduce the spread of HIV-infection;



reduce the personal and social impact of HIV/Aids for people living with Aids, their families and communities; and



mobilize communities and community resources.

Infected persons can obtain access to free ART through their local clinic. The use of ART will lengthen the infected person's life by many years (Soul City, 2005:6). According to Mzolo (2006:32), the number of people taking ART has risen from 47 400 in 2004 to almost 130 000 in 2005. However, more than 500 000 Aids-patients are still not on ART.

Although HIV cannot be cured, it becomes a manageable chronic disease similar to diabetes through HAART (Highly Active Antiretroviral Therapy) (Soul City, 2005:6). PLWHA can therefore take comfort in the fact that their infected loved one can still lead a life of quality while on ART.

3.2.8.2 How will the affected educators benefit from this form of support?

The affected educators may have more time for themselves, away from the person they care for when they know that the person infected with HIV is being cared for. They can take time to exercise or talk to other people in the same situation. In this way, they can strengthen their inner selves to cope with their circumstances (Soul City, 2005:21). They will, however, not be in a position to do this if there is no support from outside for the infected.

3.2.9 Support for Aids orphans and vulnerable children (learners) (OVCs)

According to the Department of Social Development (2002:19), taking care of potential orphans should focus on the family holistically in order to assist the dying parents to die peacefully, as they know that their children will be taken care of by someone who is caring and forms part of home-based care. Support for OVCs will unquestionably minimize the impact of HIV/Aids on the affected educator, because other organizations will take care of issues regarding a foster home, food, clothing, grants and care.

3.2.9.1 Examples of SA support structures regarding support for OVCs

It is of the utmost importance to support OVCs, because the social and economic impact of Aids threatens the well-being and security of millions of children, not only in South Africa, but worldwide (USAID, 2002:9). These children face decreased access to various important, but basic needs, such as housing, education, health care, food and clothes as shown in Figure 3.7:

Figure 3.7: Decreased access which OVCs experience

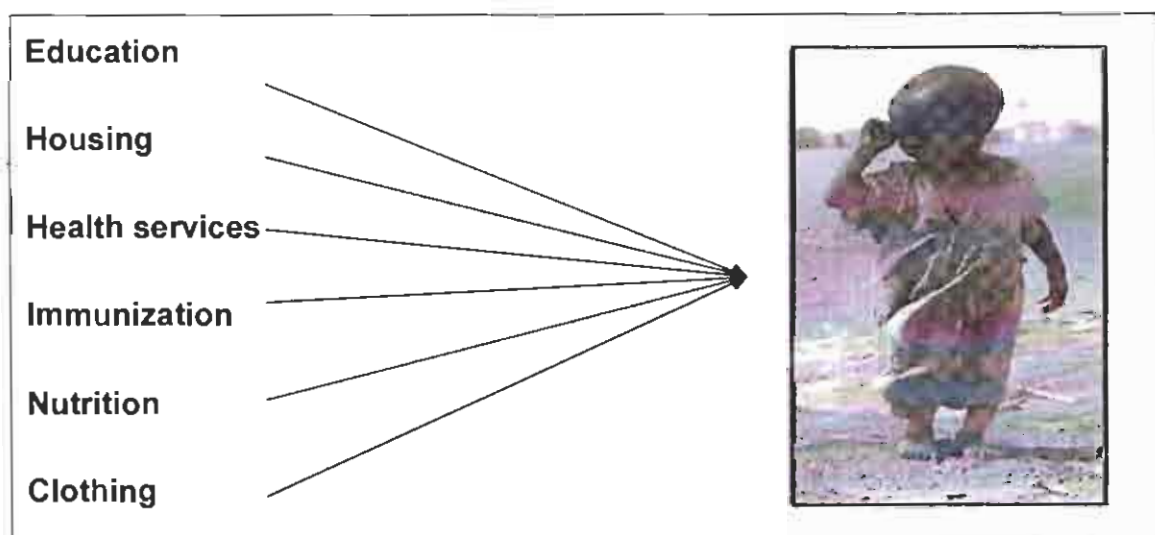
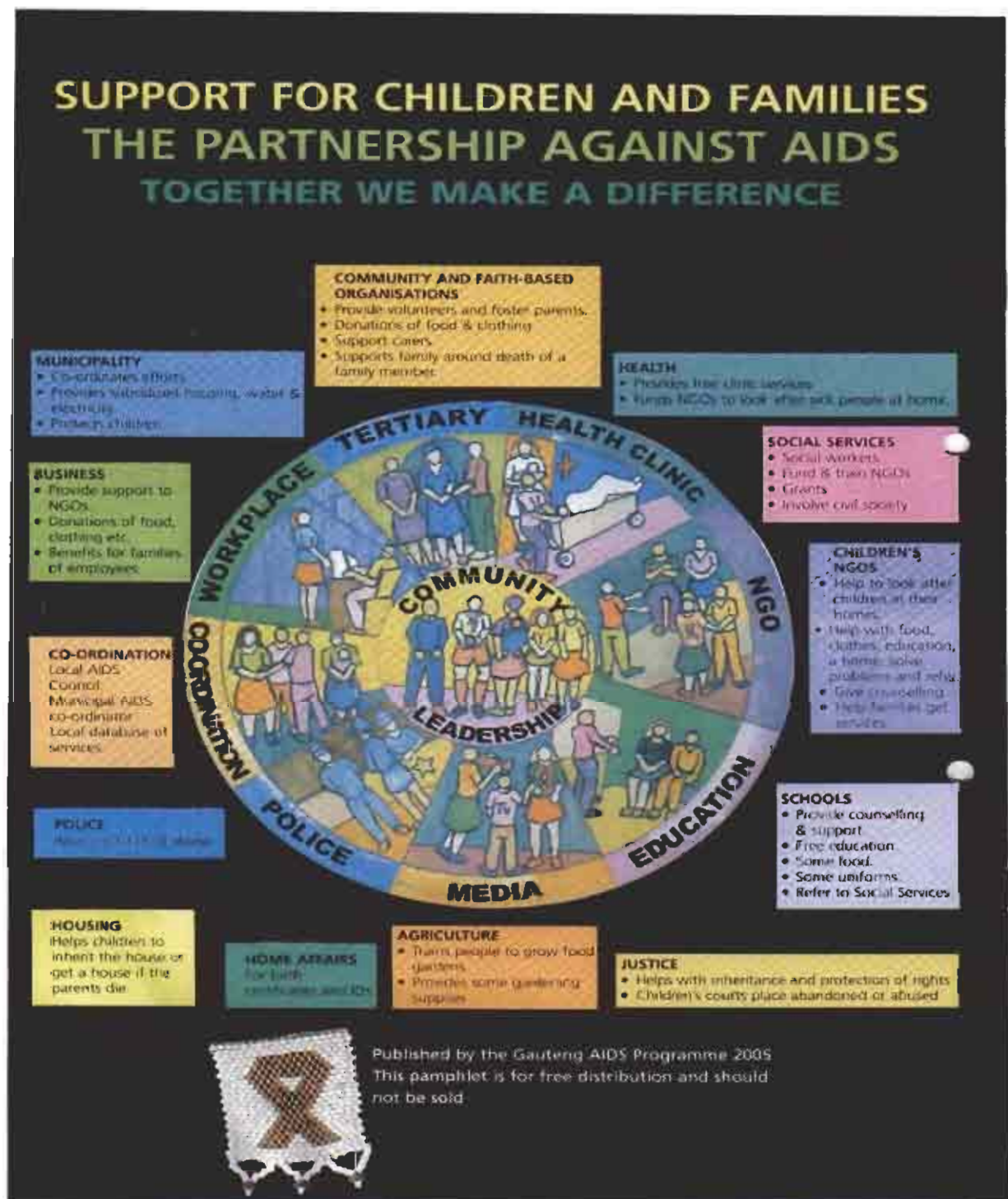


Photo taken by Roger LeMoyne for UNICEF (Beeld, 2005)

The following organizations, as indicated in Figure 3.8, offer their specialized assistance in order to ensure these children a future (Gauteng Provincial Government, 2005a:8):

Figure 3.8: Support for children and families



3.2.9.2 How will the affected educator benefit from this form of support?

A number of affected educators take OVCs into their homes and care for them (Shisana *et al.*, 2005b:23). The affected educator may benefit from support

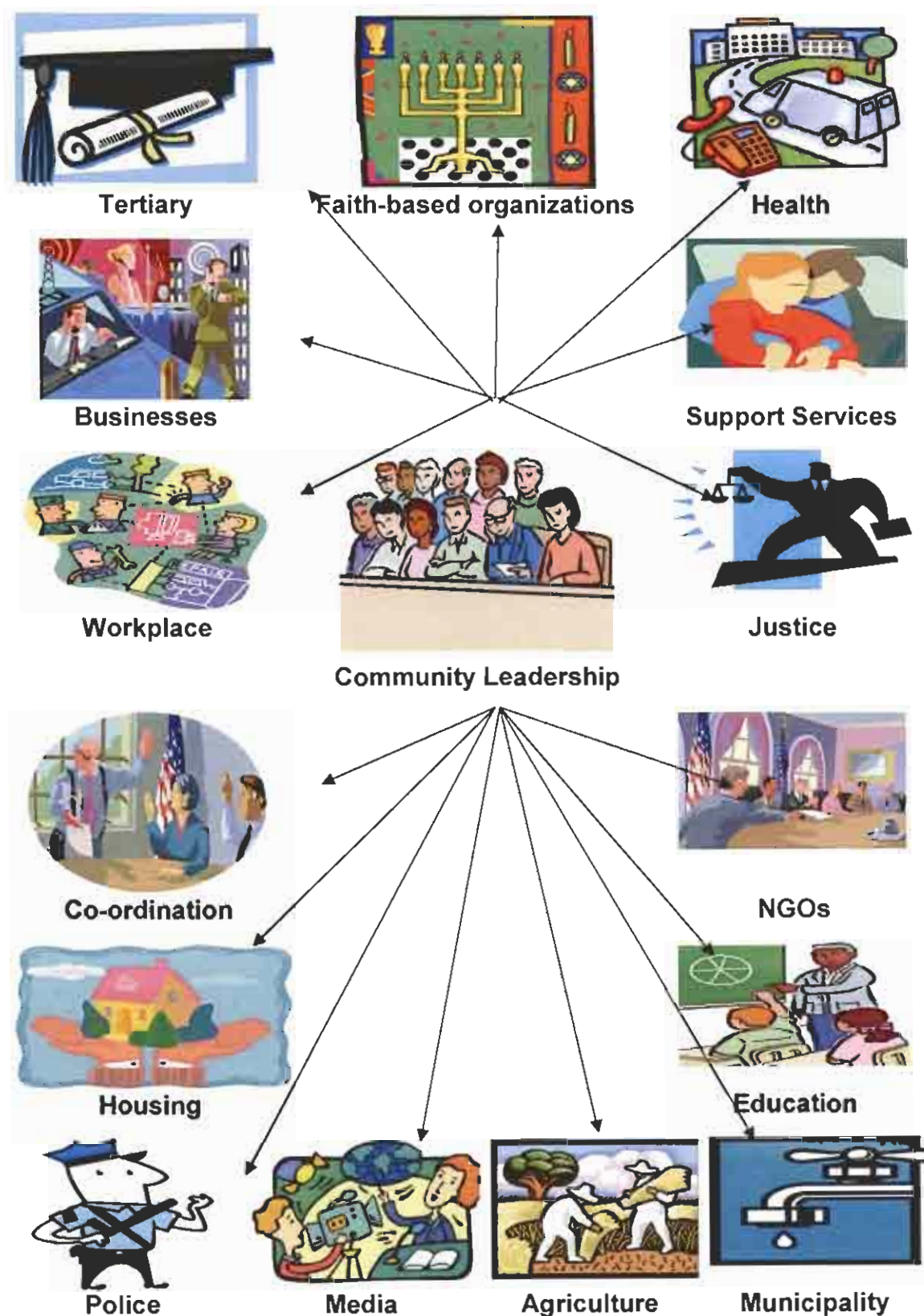
regarding OVCs because provision is being made to counsel orphans or learners affected by HIV/Aids.

According to Badcock-Walters (2002:49), the needs of OVCs go beyond formal schooling and include psycho-social and material needs. Educators cannot really provide for these needs, because of their commitment to their own family. Therefore the NGOs can play an important role in satisfying these needs simultaneously freeing affected educators from the obligation to care for the OVCs in their class or school. NGOs like Africare assist orphans through home-based caretakers to ensure healthy and supportive environments, emphasising education, nutrition and health care (HARC, 2005).

3.3 ROLE PLAYERS AND STAKEHOLDERS IN SUPPORT

The types of support discussed in 3.2 need committed role-players and stakeholders in order to be realized effectively. Generally, effective support requires multiple roleplayers who function in a multidisciplinary context (Ross & Deverell, 2004:6). A number of these roleplayers were explicitly identified in the preceding discussion (*cf.* 3.2). A summary of all the potential roleplayers, as suggested by the Department of Health (2005:8), is presented in Figure 3.9 which follows.

Figure 3.9: Roleplayers in support of HIV/Aids-affected individuals
(Department of Health, 2005:8)



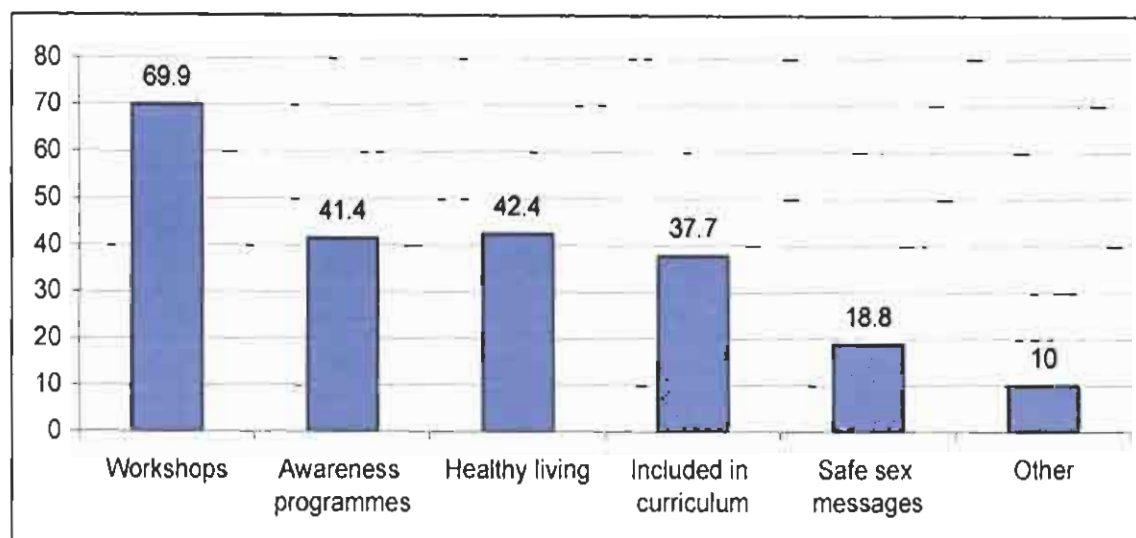
In Figure 3.9 it can clearly be seen that the HIV/Aids pandemic is everyone's business, including community leadership, health clinics, NGOs, tertiary institutions, the media, local co-ordination committees, the workplace and schools. In order to provide adequate care and support in the context of HIV/Aids, greater community participation is necessary. However, meaningful community involvement in health services is not easy to develop and sustain (Russel & Schneider, 2000:1).

3.4 EDUCATOR SUPPORT NEEDS IN THE FACE OF THE HIV/AIDS PANDEMIC

The HIV/Aids pandemic has the potential to undermine the ability of the education sector to deliver quality education and to support economic growth and human development (Schierhout, 2004). Although some researchers (Shisana *et al.*, 2005a) believe that not all educators are affected by the pandemic, Coombe (2003:13-14) believes that all educators are affected, whether directly or indirectly. Current research argues that affected educators are in need of support if they are to cope with the impact of the pandemic (Hall *et al.*, 2005:30; Shisana *et al.*, 2005b:xxi; Simbayi *et al.*, 2005:134 -139, Theron, 2005:56-60).

According to Simbayi *et al.* (2005:122), educators indicated that their support needs regarding the prevention of new HIV-infections among educators and learners can be summarized as represented in Figure 3.10:

Figure 3.10 Educators' support needs regarding prevention of new HIV-infections (Simbayi *et al.*, 2005:122)



From Figure 3.10 it is clear that educators are in need of information in order to prevent new HIV-infections among educators and learners structured in the form of:

-  workshops and manuals;
-  awareness programmes;
-  information about healthy living;
-  curriculum outcomes, which include curriculum development and ready-made lessons; and
-  safe sex messages (Simbayi *et al.*, 2005:122).

Furthermore, educators indicate that the DoE should provide the following additional forms of support when it comes to the care of ill educators and learners, as represented in Figure 3.11.

Figure 3.11 Additional forms of support regarding the care of ill educators and learners (Simbayi *et al.*, 2005:123)

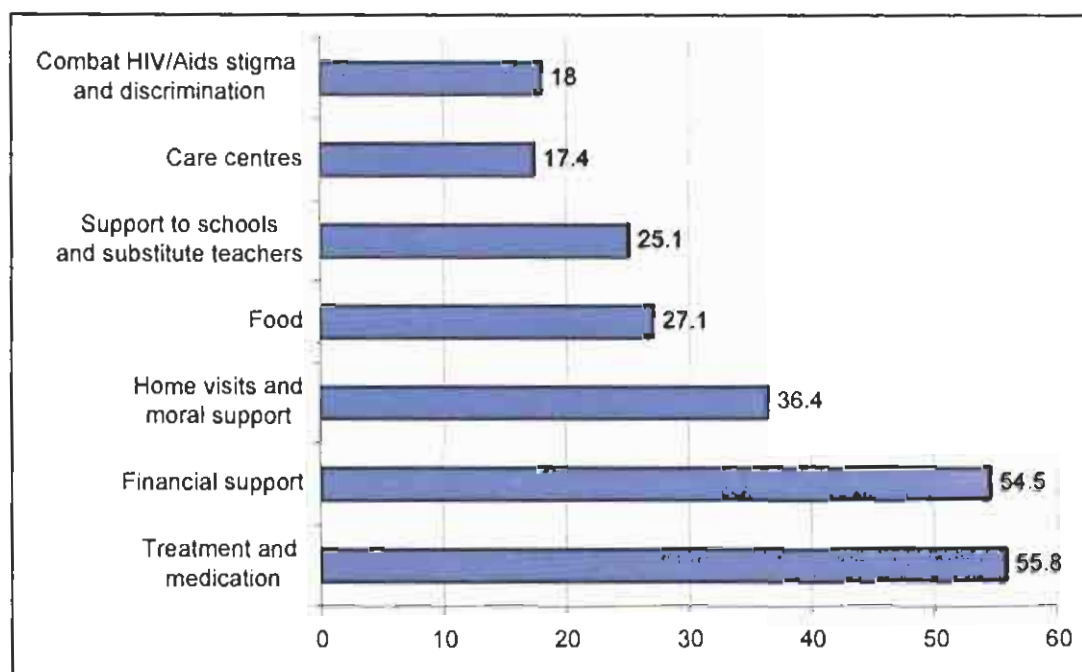


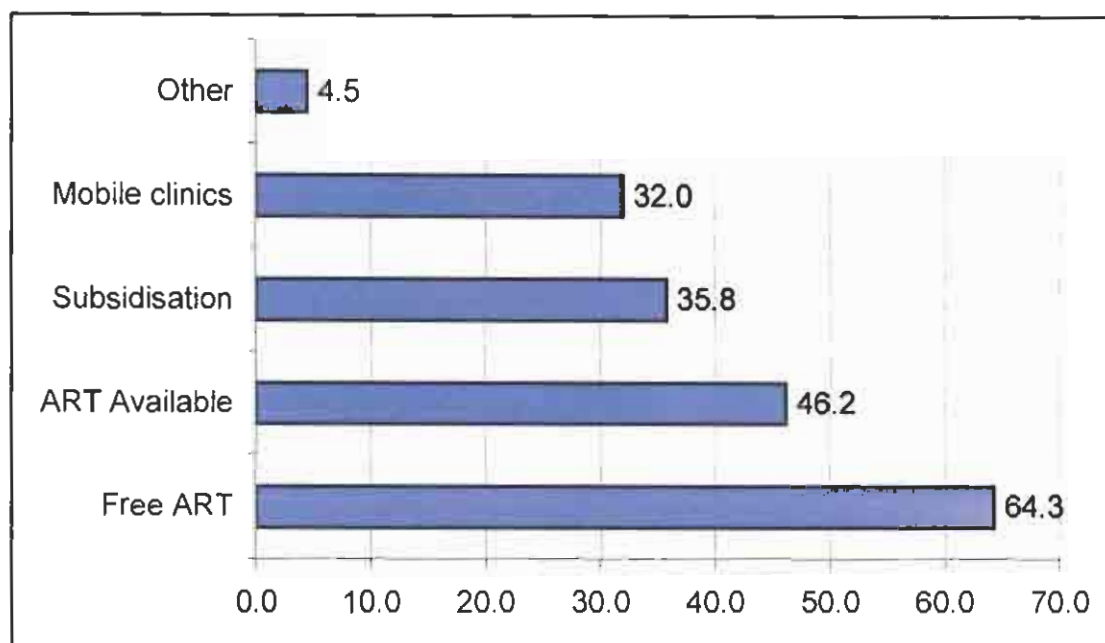
Figure 3.11 indicates the following (Simbayi *et al.*, 2005:123):

-  The majority of educators prioritise the need for treatment of HIV/Aids, as well as the provision of medication.
-  Financial assistance (grants or assistance towards medical costs) for the care of ill educators, learners and loved ones.
-  Emotional support is needed in the form of regular home visits and moral support.
-  Material support in the form of food parcels will also be welcomed.
-  Assistance and support to schools regarding substitute teachers and workshops to empower the affected educators are indicated as important.
-  Fewer educators mentioned combating stigma and discrimination, as well as home schooling or care centres, as a form of support.

In addition, educators require support from the DoE regarding Anti-Retroviral Drugs (Simbayi *et al.*, 2005:123). In Figure 3.12, educators indicate the kind of

support they believe the DoE should offer educators regarding ART (Anti-Retroviral Therapy) (Simbayi *et al.*, 2005:123).

Figure 3.12: Support that the DoE should provide South African educators regarding ART (Simbayi *et al.*, 2005:123).



It is clear from Figure 3.12 that almost two-thirds of the educators indicate that the DoE should provide ART free of charge, while one-third of the educators indicate that the DoE should support subsidization of the medication and also provide this to nurses and mobile clinics (Simbayi *et al.*, 2005:123).

3.4.1 Supportive interventions to empower affected educators to cope in the face of HIV/Aids

Currently the DoE provides support to affected educators, which entails programmes and policies regarding prevention of the pandemic and support to the infected (Theron, 2006a:7).

Educator unions also have policies regarding empowerment, discrimination, prevention and support programmes (*cf.* 3.2.7.1) (Simbayi *et al.*, 2005:34).

South Africa's Democratic Teachers' Union (Sadtu) policy tries to empower their members against the impact of the pandemic and protects their members from discrimination and stigma, while the objective of the National Professional

Teachers' Organisation of South Africa (Naptosa) policy is to advocate prevention, awareness and support programmes (Simbayi *et al.*, 2005:35). All these policies reason for a compassionate and civilized response to the HIV/Aids pandemic, but focus primarily on prevention and support for those who are ill (Simbayi *et al.*, 2005:31), in other words, for the infected.

The Department of Education Workplace Policy for HIV/Aids provides guidelines on how to deal with HIV/Aids in a supportive work environment (Simbayi *et al.*, 2005:34).

However, the main critique of the DoE's Workplace Policy for HIV/Aids remains the difficulty of implementing the new policies regarding the impact of HIV/Aids on educators (Simbayi *et al.*, 2005:31). Although there are policies in place, the following concerns are mentioned (Simbayi *et al.*, 2005:31):



- the lack of theory on behaviour change (people's understanding to change their sexual behaviour with regard to various sexual partners and to practise safe sex by means of using condoms) in the National HIV/Aids Policy;



- inadequate information on treatment issues; and



- a lack of clarity on how educators affected by HIV/Aids will be assisted by the DoE.

It is also believed that a policy on the supply of relief teaching at schools with a high incidence of HIV/Aids-related illnesses and deaths among educators should be implemented (Simbayi *et al.*, 2005:31). Treatment and the role of ART in the treatment of Aids also require attention.

Educators affected by HIV/Aids, whether directly (HIV-infected loved ones, colleagues or learners) or indirectly (aware of the pandemic, but do not have HIV-positive loved ones, colleagues or learners), indicated that they do not experience sufficient support regarding the pandemic and that they are in need of a wide range of support (Theron, 2006a:13). In other words, educators feel that current support is inadequate.

Five categories of "supportive intervention" were tested in a 2004-2005 Gauteng study (Theron, 2006a:5). The majority of participants reported high need for and low experience of support in all 5 of the following categories as shown in Figure 3.13:

Figure 3.13: Categories of supportive intervention (Theron, 2006a:5)



White educators reported less need of support in all 5 of the above-mentioned areas, in comparison with African, Coloured and Indian educators. African educators reported to be in a greater need of support in all five of the above-mentioned areas, in comparison with White, Coloured and Indian educators. The reason for this can be the fact that the incidence rate of HIV/Aids is higher among African educators than in any other race group (Shisana *et al.*, 2005b: xvii; Theron, 2006a:4).

All of the above were rated as support needs of 80% and above, suggesting that no single area can be prioritized in favour of another. In order for affected educators to manage classroom education successfully, an extensive and comprehensive support programme should be put into practice for these educators to cope with the pandemic (Car-Hill, 2003).

A summary of educator support needs to date as argued by Coombe (2003:13-14); Simbayi *et al.* (121-123); and Theron (2006a:8, 24-27) is shown in Table 3.1.

Table 3.1: Educator support needs to date

Coombe (2003:13,14)	Simbayi <i>et al.</i> (2005:121-123)	Theron (2006a:8, 24-27)
 Information on caring for the infected and affected.  Universal measures on precautions at schools.  Learner information on how to care for those who are ill.  Referral procedures.  Professional support.  Teaching and learning materials.  Social sector support.  Service conditions relating to HIV/Aids.  Participation in the development of policies to address the impact of HIV on education.	 Prevention of new HIV-infections among educators and learners.  Caring for ill educators and learners.  Accessing ART.	 Psychological support.  Encouragement.  Support for learning and teaching about HIV/Aids (including ready-made teaching and learning materials on HIV/Aids or more ready access to such materials).  Support for learning and teaching in the face of the HIV/Aids pandemic (including empowering schools towards a more flexible curriculum and substitute educators for schooling disrupted by the pandemic).  Education environment support (including HIV/Aids workplace- and leave-related policies or more ready access to such policies and individual contextually-based school plans in response to the pandemic).  Support for educator wellness (including open discussion of HIV/Aids at schools; addressing the stigma of HIV/Aids; in-service training regarding HIV/Aids; stress workshops and employee assistance).

		programmes).  Health education as a source of support (including training for educators and learners regarding care for those infected and affected by HIV/Aids; school health workers and overt school precautions against HIV/Aids).  Social sector support (including school-based support groups; accessible and clear referral procedures; social workers and Aids counsellors to be active at schools).
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Table 3.1 emphasizes that educators affected by the pandemic want specific forms of support. Currently there is no single support programme for these educators that holistically address the support needs reflected in Table 3.1. For this reason Theron (2006b) compiled REds (*cf.* 4.3.4) in accordance with the needs reflected in Table 3.1. However, REds cannot be accepted as an answer to educator support needs without first being implemented and evaluated. This gave rise to the aim of this study, namely to determine the efficacy of REds as a supportive intervention for educators affected by the HIV/Aids pandemic.

3.5 CONCLUSION

HIV/Aids not only robs the health and livelihood of those infected, but also the health and livelihood of their families and communities: the affected.

When the Department of Social Development did a countrywide survey of HIV/Aids projects during 1999/2000, their major aim was to provide evidence on organizations involved in local and national intervention programmes regarding the HIV/Aids pandemic. From questionnaires distributed among 115 NGOs and other organizations which were actively involved in HIV/Aids prevention and care in all nine provinces in South Africa, only 36 of the 41 respondents dealing with HIV/Aids projects completed and submitted their questionnaires. In Table 3.2, the list of respondents is indicated (Department of Social Development, 2002:13).

Table 3.2: List of respondents (Department of Social Development, 2002:14)

Organization	Project
Zululand Chamber of Business Foundation	Ethembeni Care Centre
Kagiso Youth Centre	Youth Help-Line
The Centre for Development and Population Activities	Better Life Options Programme
Township Aids Project	Prevention Aids Resource Centre
St. Francis Care Centre	Home-based Care
Millennium Aids Awareness	HIV/Aids Awareness programme
Kempton Park / Tembisa Aids Forum	Thandanani (for) P.W.A. Khulani (for) Orphans
Arepp Educational Trust	Educational Theatre and Puppetry Project
Youth For Christ, South Africa	Youth For Christ, HIV/Aids Prevention
The Futures Group International	The Policy Project
Friends for Life	Community Home-based Care for PWAs
Tumelong Anglican Diocese of Pretoria	Tumelong Hospice and Home-based Care
Soul City – Institute for Health and Development Communication	Soul City
Hillcrest Aids Centre	Molweni Aids Centre
Soul City – Institute for Health and Development Communication	Soul Buddyz
Society for Family Health	Condom Social Marketing in South Africa
Oasis of Life Support Network and Home-based Care Services	Oasis of Life Home-based Care
Mothusimpilo Outreach Project	Mothusimpilo Outreach Project
Ekuseni Youth Development Centre	Aids Project: Ekuseni
Bela Bela Welfare Society	Aids/Aids Prevention Group
Tshwaranang Aids Centre	Training not as a project but as a function
Health Training and Information Centre	Voluntary Testing and Counselling Centre
Motivation Educational Trust	Keruz-Adult Aids/Aids Care, Prevention and Development
The Western Cape ATTIC	Training for Health Care Workers
Aids Action Committee Worcester	Aids Action

Gauteng Health Department	Aids Directorate, Media Unit, Awareness Programme
Training Institute for Primary Health	Witbank Aids Education Counselling
Ubunu Youth Organization (U.Y.O)	Aids/Aids Peer Education, Counselling
Lasedi Project	Lasedi Project
Rutanang Community Theatre Project	Aids/Aids Project (Love Them)
Bushbuckridge Health and Social Services Consortium	Aids/Aids Project
Metropolitan	Metropolitan Life Aids Action Road Show
Old Mutual	Old Mutual's I Have Hope
Vaal Aids	Aids Home-based Care
Aids Sexuality Health Youth Organization	STDs/HIV/Aids Prevention Project
DC of C	Aids Programme
Takalani HIV/Aids Resource Centre (RHRU)	Takalani HIV/Aids Resource Centre
Reproductive Health Research Unit (RHRU)	National STI Initiative
Reproductive Health Research Unit	Women At Risk
Reproductive Health Research Unit (RHRU)	National Adolescent Friendly Clinic Initiative
Reproductive Health Research Unit (RHRU)	Love life

From Table 3.2 it is obvious that no provision is made to implement intervention programmes for educators affected by HIV/Aids. Although there are some forms of support, educators affected by the pandemic indicated that these forms of support are inadequate and that there is not yet a comprehensive programme in place to support affected educators, as can clearly be seen in Table 3.2. Therefore the need for this study.

The health of a nation is everyone's business, therefore it is important for all role players and stakeholders to take hands and tackle the devastating disease.



CHAPTER FOUR

RESEARCH DESIGN



"In virtually every subject area, our knowledge is incomplete and problems are waiting to be solved. We can address the holes in our knowledge and those unresolved problems by asking relevant questions and then seeking answers through systematic research"

Leedy and Ormrod (2005:1)

4.1 INTRODUCTION

This chapter outlines the empirical study. The research conducted in this M.Ed. will form part of the supervisor's Thutuka research to determine the most effective and affordable form of a support programme for educators affected by the HIV/Aids pandemic, in order to secure educator excellence and sustainability. The chapter also summarizes the aims and motivation of the empirical study and the research design.

The focus will be on:

-  information regarding the research group;
-  measuring instruments to be used;
-  the intervention programme;
-  methods of assessment; and
-  ethical aspects.

4.2 AIMS OF THE STUDY

The main purpose of this study was to gauge how effectively educators affected by the HIV/Aids pandemic can be supported, using the REds support programme. In other words, the aim of this study was programme evaluation.

In order to achieve this objective, the following sub-aims are proposed:



The implementation of an intervention programme (REds) for educators affected by the HIV/Aids pandemic; designed by Theron (2006b) for the Thutuka Project 2005-2007, using one group of volunteers.



Assessment of the effectiveness of the intervention programme: using action research and an experimental pre-test, post-test design.



Recommendations regarding increased effectiveness of the intervention programme.

4.3 METHOD OF RESEARCH

The method (*cf.* 1.4.2.1) was varied (depending on the aim) and consisted of experimental research as well as action research, as summarized in Table 4.1:

Table 4.1: Summary of research method

Aim	Method chosen
 The implementation of REds for educators affected by the HIV/Aids pandemic, designed by Theron (2006b).	➤ Quasi-experimental design: ○ One Group Pre-test – Post-test Design.
 Assessment of the effectiveness of REds.	➤ Quasi-experimental design: ○ One Group Pre-test – Post-test Design: ▪ Qualitative pre- and post-tests. ▪ Quantitative pre-and post-tests. ➤ Action Research: ○ Participant reflection.
 Recommendations regarding increased effectiveness of REds.	➤ Action Research: ○ Participant reflection.

4.3.1 Experimental Designs

The rationale of an experimental study is to study the possible impact of one factor or condition on another factor or condition; in other words, it examines cause-and-effect relationships (Leedy & Ormrod, 2005: 217). In this study, the researcher will use a quasi-experimental design to determine whether REds succeeds in empowering educators affected by the HIV/Aids pandemic.

4.3.1.1 Quasi experimental designs

Sometimes it is not possible to randomly select and assign participants to research experiments. In such instances non-randomized participants form the research sample and this has implications for the interpretation of results, because if the sample is not randomized the researcher cannot control all confounding or nuisance variables and this must be acknowledged when data is interpreted (Leedy & Ormrod, 2005: 227; Welman *et al.*, 2005: 87). A quasi-experimental design was chosen: for logistical reasons, the researcher needed to work with educators in her geographical area.

An example of such a quasi-experimental design is a one group pre-test – post-test design (Leedy & Ormrod, 2005:236). The group participates in an intervention programme and the post-test indicates whether there is any change in their functioning, but because there is no control group, the researcher cannot conclusively say that the intervention caused the change or effect. It can be depicted as follows:

Table 4.2: One Group Pre-test – Post-test Design (Leedy & Ormrod, 2005:236)

Group	Time →		
	Observation (i.e. pre-test)	Intervention	Observation (i.e. post-test)
Group 1			

4.3.1.2 Action research design

Action research, a qualitative method, was chosen for this study, because the researcher regarded this study as an opportunity for participants to benefit from the REds programme. The researcher also considered this study as a learning experience to develop as researcher and facilitator. Furthermore, action research was conducive to gathering participant recommendations for the improvement of REds.

An action research study focuses on the incorporation of knowledge, empowerment, increasing awareness (Fouché, 2002:112), developing reflective practice, effecting positive changes in the school environment, improving the lives of those involved (Mills, 2003:5), creating a support network and alternating action with critical reflection (Dick, 2002; McNiff & Whitehead, 2006:37) and finding solutions to a specific problem in a community (Creswell, 2000: 602, 603, 635; Leedy & Ormrod, 2005:108; Mertler, 2006:12; Welman *et al.*, 2005:25). According to Lewin, quoted by Reber and Reber (2001:8), the aim of action research is to understand incidents which lead to the application and solution of real-life problems. Mertler (2006:23), Murcia (2005:5), Zuber-Skerritt (1996:3; 1997:111), Altrichter, Kemmis, McTaggart and Zuber-Skerritt (2002:130) and Zuber-Skerritt and Perry (2002:176) define action research as an adaptable and contributive course of action that is recurring and exchanges phases of the following:



Planning

During the planning phase, the research problem is defined and the literature is surveyed (Zuber-Skerritt & Perry &, 2002:176).



Action

The action phase includes field work and identifying themes (in this research, themes empowering educators affected by HIV/Aids) (Zuber-Skerritt & Perry, 2002:176).



Description, observing or development

During the observation phase, the research process and procedure are described. The results of action (qualitative and quantitative measuring instruments) are analysed and evaluated (Zuber-Skerrit & Perry, 2002:176).

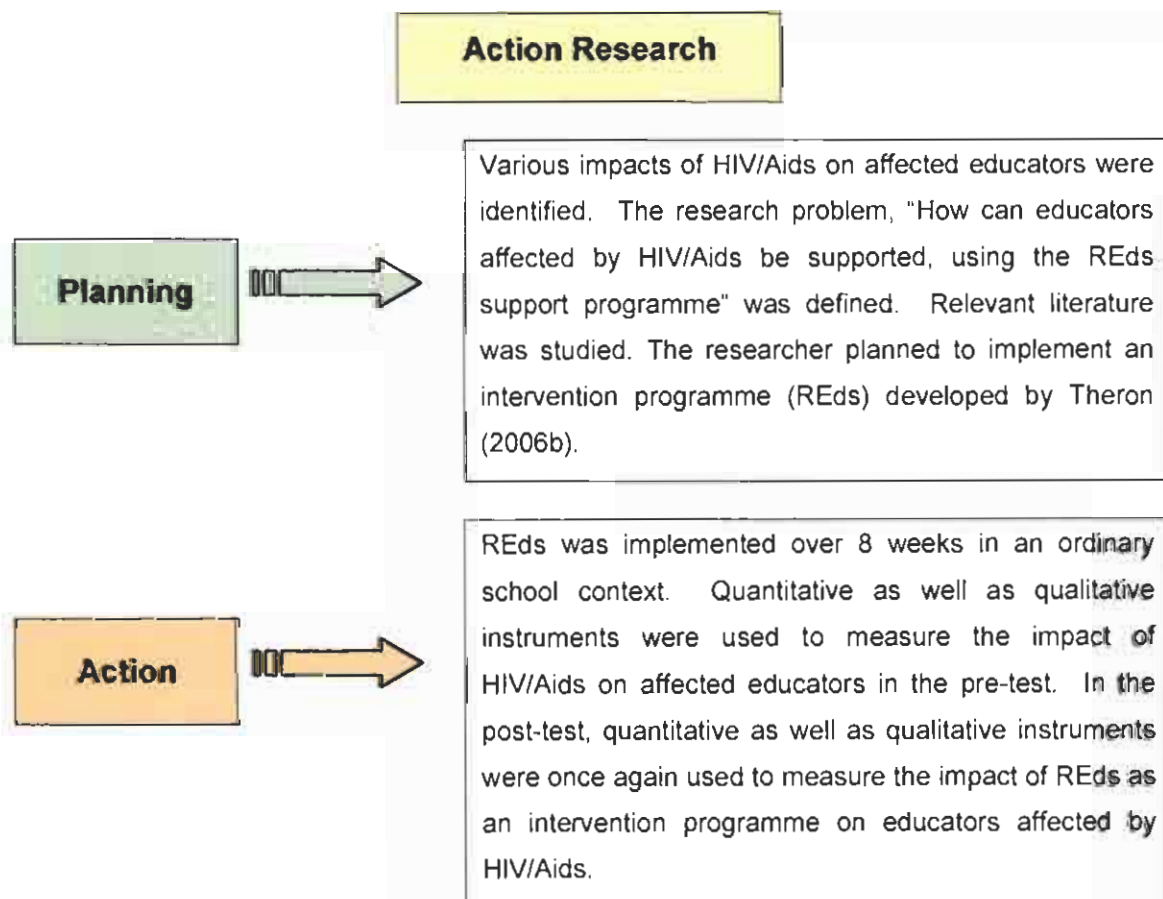


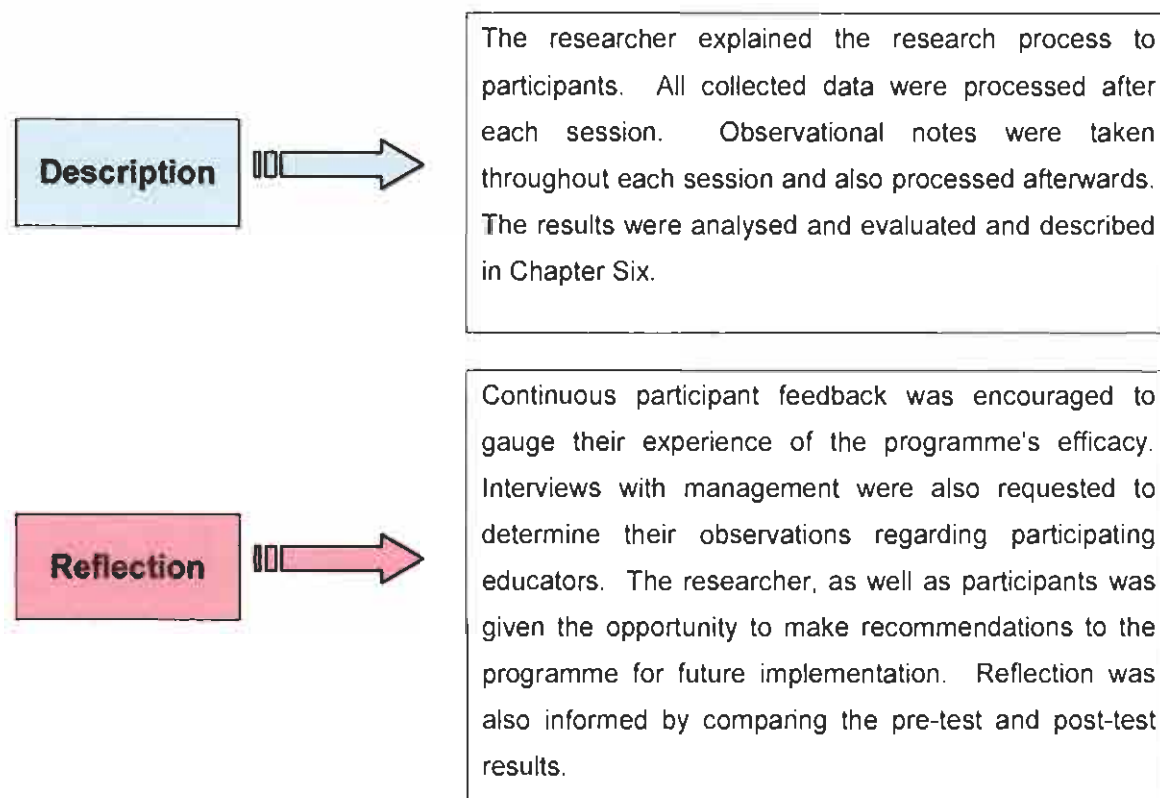
Critical reflection

During the critical reflection phase, reflection by the researcher and the participants is analysed. Conclusions are drawn from the research and suggestions for further research are made (Zuber-Skerrit & Perry, 2002:176).

This particular study involves the investigation and improvement of the impact of an intervention programme, REds, on educators affected by Aids as illustrated in Figure 4.1 (Mertler, 2006:23).

Figure 4.1: Action Research to determine the impact of REds on educators affected by HIV/Aids





4.3.2 Population and sample

The population included all educators who were directly affected by the HIV/Aids pandemic. However, this study was localized due to logistics. Therefore the population for this particular study consisted of all educators in the Vaal Triangle.

In preliminary research conducted by Theron (2005), it became clear that affected educators in the Vaal Triangle are in need of supportive intervention if they are to cope with the HIV/Aids pandemic. The specific study population consisted of all educators in the Sedibeng East District who were directly affected by the virus.

From this population, a purposive sample with a maximum of 15 participants and a minimum of 8 participants was recruited. A sample of 8 participants was considered ideal because REds was implemented in a group setting. According to Corey and Corey (2002:107); Garvin (1997:67); Toseland and Rivas (2001:77), a group of this size is adequate to give sufficient time for interaction and small enough for every participant to be actively involved, to feel accepted and part of the group. Kleber's experience (1995:6) is that rarely

more than eight people usually engage in intimate conversation about normal life and that it is important that participants should rather interact with one another, than only answer the facilitator's questions.

A purposive sample was used because it restricts the sample population to a very specific population (educators affected by HIV/Aids) and it validates a test or instrument with a known population (Leedy & Ormrod, 2005:206). Mack, Woodsong, MaQueen, Guest and Namey (2005) define purposive sampling as the grouping of participants according to pre-selected criteria relevant to a particular research question.

In this study, the participants had to share all the following pre-selected criteria to be included:

-  Participants had to be educators in the Vaal Triangle.
-  Participants had to be affected by the HIV/Aids pandemic (i.e. loved ones, colleagues or learners who are HIV-positive; or loved ones, colleagues or learners who have died of Aids-related diseases; or Aids orphans and vulnerable children in their classes).
-  Participants had to be willing to volunteer as REds participants after school hours.

In this study, eight educators affected by HIV/Aids participated in all the sessions, except for one session where only seven educators could participate due to the hospitalization of one participant. The researcher however, arranged a time slot convenient for this participant to make up for the session he had missed.

A gate-keeper identified two schools whose educators were interested in taking part in REds. The researcher, together with her supervisor introduced the programme to the principals. The principals advertised the opportunity to participate in REds during staff meetings and requested volunteer participants. The educators from both schools who voluntarily took part in REds formed the research sample.

4.3.3 Programme Implementation

REds is an 8-module interactive programme, designed to fit easily into a school term. The ninth session took the form of a certificate ceremony. Each module took approximately 2 hours and was presented weekly. The programme was implemented in a group setting and evaluated continuously by the participants with a view to the improvement of REds: any parts or methods that were ineffective would be reformulated.

4.3.3.1 An overview of REds themes

The REds programme consisted of eight themes. An overview of REds themes can be seen in Table 4.3:

Tabel 4.3: REds Programme

SESSION	THEME
1	Introduction: Meeting with participants. REds and core concepts introduced. Completion of ProQol rating scale. 
2	Giving and gaining support (including where to access ART-support, welfare-support for orphans; legal support for those infected and affected). 
3	How to remain psychosocially well – coping with stigma. 
4	How to cope with stress and fatigue (personal and professional impact of the pandemic). 
5	Educators' rights with regard to the pandemic. 
6	Health Education – stopping HIV at school. 
7	Health Education – nursing ill loved ones. 
8	Resilient in the face of the pandemic (educator empowerment). 
9	Finale – attendance certificates handed out. Educators complete ProQol rating scale. 

4.3.3.2 Group process

The programme was presented in the form of group sessions. According to Odendaal, Schoonees, Swanepoel, Du Toit and Booysen (1994:323);

Marckwardt, Cassidy, and McMillan (1992:559); and Hornby (2001:524), a group can be defined as a number of people or things that are together in the same place or that are commonly connected in some ways to one another. The participants were all connected to one another, because they were all affected by HIV/Aids and had all volunteered to participate in the implementation of REds. Some of them had infected loved ones, while others had infected colleagues or learners.

The focus of group work must be on the participants, their ideas and experiences (Marais, 1993:13). The facilitator only offers opportunities to the group, while individual participants offer something new for other participants in the group (Corey & Corey, 2002:14). Although group work has the potential to motivate people in creative and more life-giving directions, it also has the potential to have a devastating effect if not managed properly (Corey & Corey, 2002:5). Group work has advantages, as well as disadvantages.

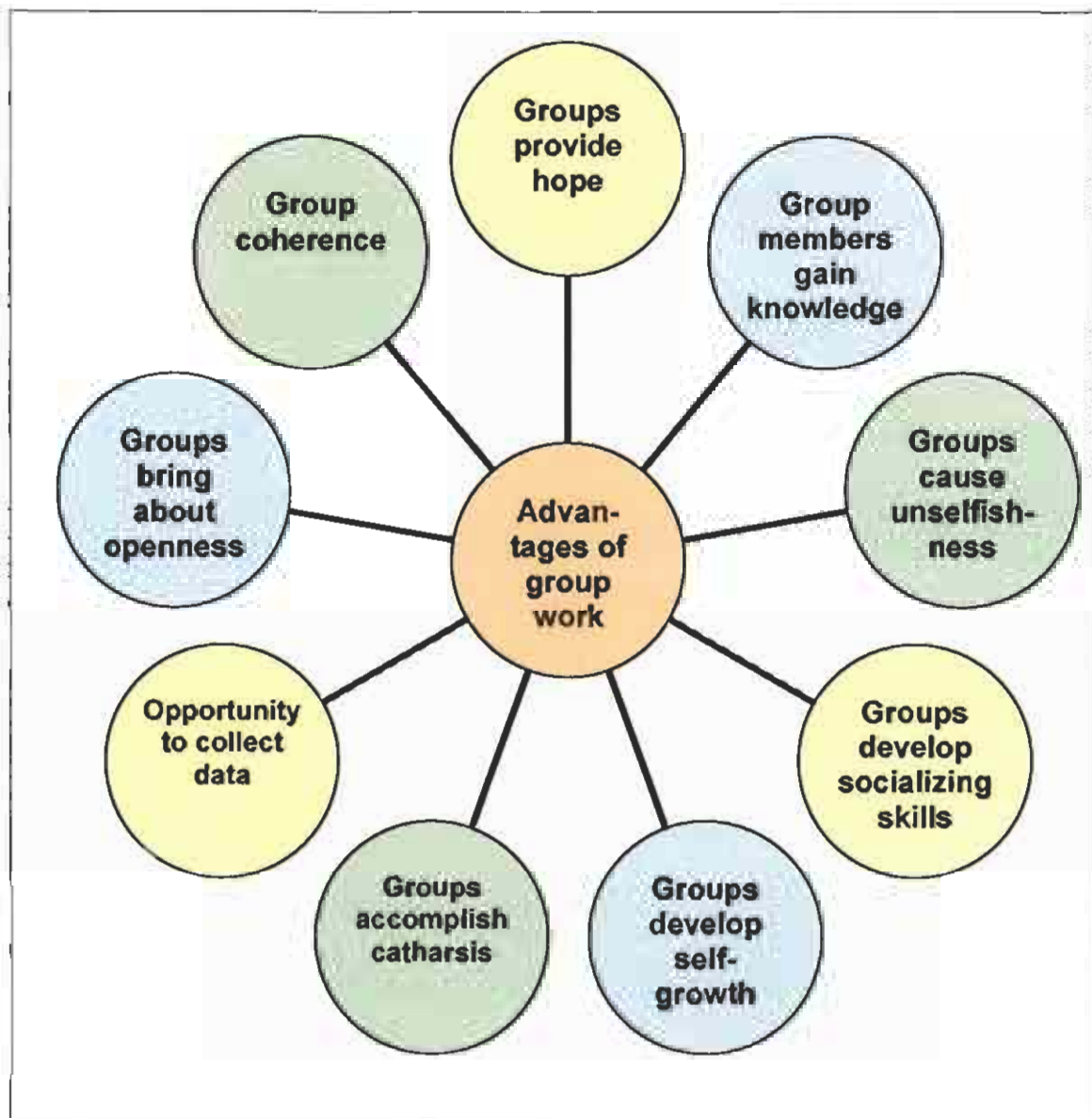
4.3.3.2.1 Advantages of group work

For the purpose of this study, a group support programme was used, because group discussions offer the following advantages (Corey & Corey, 2002:113; Marais, 1993:3):

-  Groups enhance self-esteem because group members realize that other people experience the same emotions as they do.
-  Group members learn to know, accept, support and understand one another better, therefore social skills are improved.
-  For the researcher, group work is easily understood and the results seem credible.
-  Results do not have to be presented on complicated statistical charts, but can be shared, using everyday language with quotes from group members, which could be an advantage to the researcher.
-  Group discussions have the potential to explore topics and generate hypotheses (Corey & Corey, 2002:113; Marais, 1993:3).

According to Yalom as quoted by Joubert (1995:108); Corey and Corey (2002:113) and Marais (1993:3), advantages of group work also entail the following, as illustrated in Figure 4.2:

Figure 4.2: Advantages of group work



In this study, the above advantages materialized as follows:



Groups provide hope

The facilitator, as well as the group members, entertained a feeling of hope and faith that an individual, affected by or infected with HIV/Aids would still be able to lead a life of quality.



Group members gain knowledge

All participants needed to gain knowledge with regard to themselves, their relationships, as well as the phenomenon in question, which in this study would be the impact of the REds support programme on them as educators affected by HIV/Aids. Group members had the opportunity to realize the magnitude of the influence the pandemic had on their lives. They also understood that there were other people who experienced the same fears and emotions as they did.



Groups bring about unselfishness

During group sessions participants had the opportunity to help and support one another unselfishly. In this way, group members connected and true friendships were formed. Group members also experienced feelings of significance and worth when supporting others.



Groups develop socializing skills

This is a socially oriented research procedure and people are social creatures who like to talk to one another. Group members had the opportunity to practise and develop social skills.



Groups develop self-growth

Group members learned from and empowered one another.



Groups accomplish catharsis

Group members could release their feelings of fear, sadness and aggression in a safe environment, due to the opportunity to contemplate certain issues and situations with regard to the HIV/Aids pandemic objectively.



Opportunity to collect data

The groups provided a structured opportunity for the researcher to collect data from group interaction.



Groups bring about openness

The environment and atmosphere of trust brought about openness between group members, which enhanced group sessions.



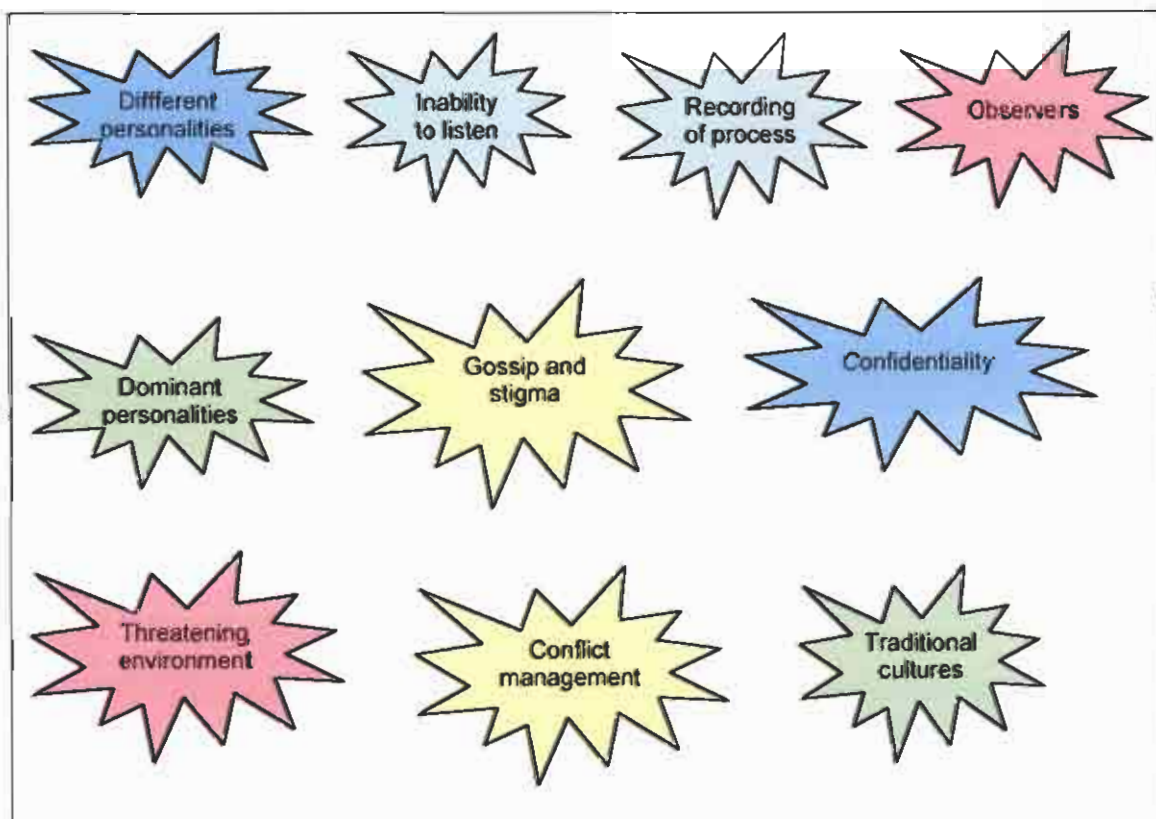
Group coherence

Due to the fact that group members realized they had a common interest and concern, they became emotionally closer to one another and supported one another which caused a feeling of belonging.

4.3.3.2.2 Disadvantages of group work

Group work cannot always be seen as a unique miracle solution to problematic situations. There are also disadvantages involved, as illustrated in Figure 4.3 (Kleber, 1995:7; Rooth, 1999:112-113). Each is explained below.

Figure 4.3: Disadvantages of group work





Different personalities

There are different personalities in a group, some being individualistic, preferring not to share personal information with strangers. Not all individuals are suited for group work, so some prefer not to take part in discussions, but rather digest information on their own.



Inability to listen

In a group of different personalities, some of the individuals would not listen to what other participants have to say.



Dominant personalities

Dominant personalities would not always give other individuals the opportunity to give their opinion regarding a certain aspect. Bias can also be caused by dominant individuals.



Traditional cultures

Participants from traditional cultures prefer to share their feelings with family members, rather than with people of other race groups and cultures. In this study, only one participant was reluctant to share her feelings.



Observers

An observer is a person involved in introspection rather than active verbal interaction (Reber & Reber, 2001:479). The participant mentioned above preferred to observe, rather than to take part in discussion.



Gossip and stigma

Some participants might be afraid of gossiping which emanates from stigmatization, especially when sensitive issues like the HIV-pandemic are discussed. In this study, participants realised that they all had one thing in common: being affected by HIV/Aids. Therefore no stigmatization and gossiping took place.



Recording of the group session

Preferably two people should manage the group approach process: One person to facilitate the discussion and the other to take notes and tape-record the event. If notes are not thoroughly taken, the transcription process will be impeded or data will be incorrect. With regard to this study, the researcher facilitated the discussion and tape-recorded the event, while a participant observer took notes.



Conflict management

Conflict may arise between personalities. Such power struggles may detract from the sessions and upset the procedure. No conflict was identified in any of the group sessions.



Confidentiality

Confidentiality can be a problem between participants when they are interacting in a group situation. However, in this study, participants learned to trust one another and all of the participants valued the confidentiality factor.



Threatening environment

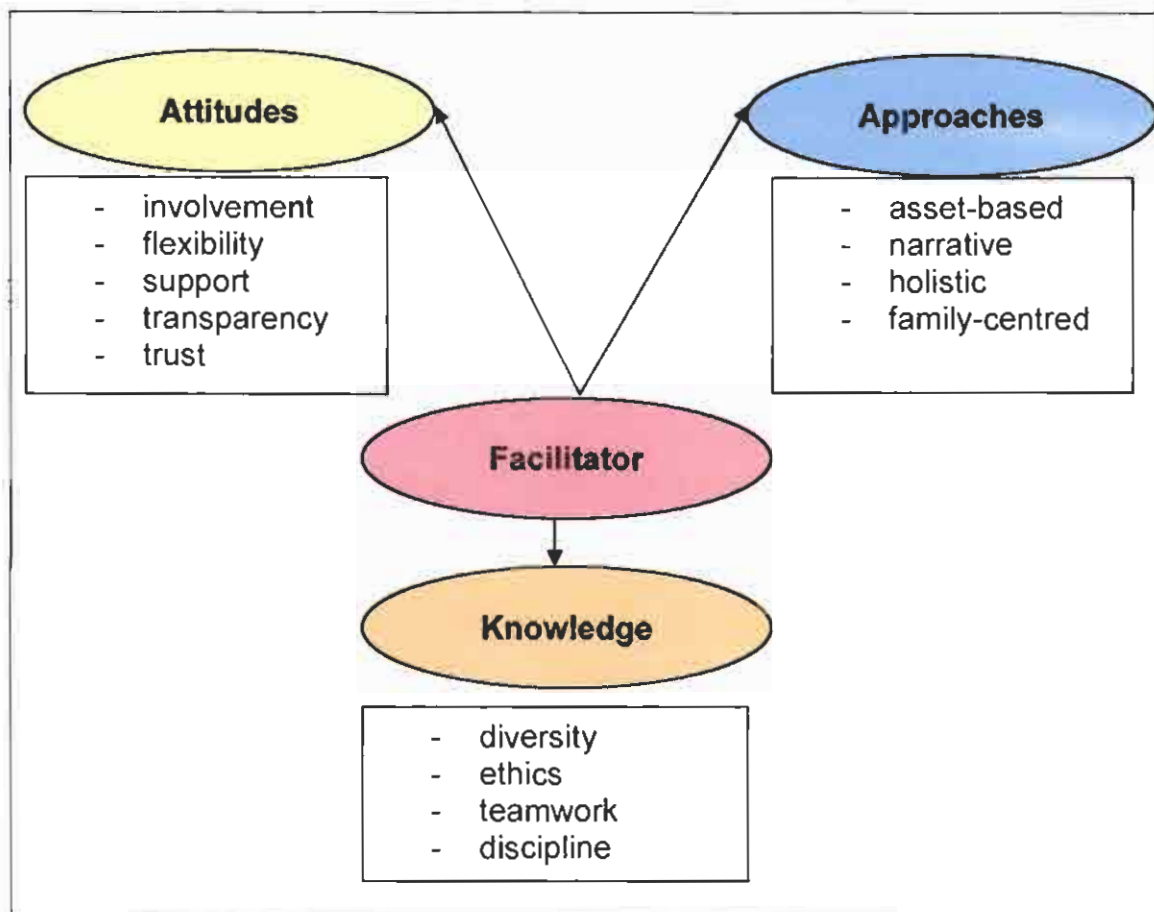
Formal focus groups can sometimes do more harm, because of a threatening atmosphere or environment. In this study, all the group sessions took place in a friendly and safe environment.

4.3.3.2.3 The role of the facilitator

According to Ferreira-Prévost, as quoted by Ebersöhn and Eloff (2006:97), facilitation can be explained as holistic and flexible teamwork where strengths are shared and members are empowered, while different personalities are used for different team roles. A facilitator can be defined as an individual who mediates a process and who supports and assists another individual or group (Ebersöhn & Eloff, 2006:28).

Ebersöhn and Eloff (2006:97) identified the following attitudes, approaches and knowledge crucial for facilitators, as illustrated in Figure 4.4:

Figure 4.4: Attitudes, approaches and knowledge crucial for facilitators
(Ebersöhn & Eloff, 2006:97)



Facilitation refers to a structured environment encompassing activities and resources in order to assist group members to grow as people, to discover themselves and to gain knowledge and skills regarding specific themes (Rooth, 1999:102). According to Rooth (2005:73), facilitation is a process of freedom and empowerment.

In this specific study, the theme was to determine the impact of REDs, a support programme, on educators affected by HIV/Aids. The facilitator strove to create an atmosphere of trust, safety and acceptance in which participants could engage in dynamic interchange (Corey & Corey, 1997:70).

The REDs support programme was presented in group facilitation format where the researcher acted as facilitator. The role of the facilitator was to support participants and to create potential opportunities to empower the group

members regarding the impact of HIV/Aids on participants as affected educators, affected colleagues and affected loved ones.

The activities of the REds support programme were created in such a way that participants were motivated to share, discover, develop and learn. According to Rooth (1999:102), facilitation must enhance growth by giving participants the opportunity to strive, experiment, discover and make mistakes in a safe environment.

The facilitator guided the development of the group and its members by helping the group as a whole, as well as each member to achieve goals set for each session. The facilitator also encouraged members to participate in the group interaction in order to empower the members and to make members feel that they have some influence, control and stake in the group situation (Corey & Corey, 1997:70). In other words, the facilitator strove to promote autonomous functioning in order that members practise skills and enhance their self-esteem (Toseland & Rivas, 2001:96).

4.3.3.2.4 The role of the observer

The role of the observer or participant observer is to understand and reveal the words and expressions used by participants in specific situations (Strydom, 2002b:279). Therefore, participant observation can be explained as a qualitative research procedure (Strydom, 2002b:280). Participant observation is usually unstructured, because the researcher can gain information from unforeseen data sources as they emerge and are recorded by the observer (Leedy & Ormrod, 2005:144).

For this study, the observer made use of field notes (Strydom, 2002b:280) while observing the reaction and comments of the participants. Process notes including the observer's field notes were written down in more detail by the researcher after the group session to assist the researcher in processing the study. The observer also used a tape recorder to record discussions and conversations in order to help the researcher make detailed interpretations after the group session and a digital camera to record activities.

The results of the observations are documented in Chapter 5.

4.3.4 Data collection

Both quantitative and qualitative data documenting participants' experience of REds were collected by pre- and post-tests and intermittent participant reflection (*cf.* 1.4.2.4 and 1.4.2.5). Multiple sources of data were collected in an attempt to triangulate data (Leedy & Ormrod, 2005:99). Data were collected in order to be able to comment critically on the efficacy of REds and to make recommendations for the improvement of REds.

4.3.4.1 Instruments used in data collection

Both quantitative and qualitative instruments were used. The same instruments were used in the pre- and post-test. The data were used to inform both the action research and to comment on the efficacy of REds (experimental research). The instruments included:

4.3.4.1.1 Quantitative instrument



ProQol Questionnaire

The Professional Quality of Life (ProQOL) is an instrument which measures the professional quality of life among staff at organizations such as a state's social workers, general health workers or educators (Stamm, 2005:9). The ProQOL consists of three subscales (Stamm, 2005:4), namely:

- ✓ compassion satisfaction;
- ✓ burnout; and
- ✓ compassion fatigue.

Compassion satisfaction entails the pleasure you obtain from being able to do your work successfully (Stamm, 2005:5). When you find delight in your work and experience positive feelings towards your colleagues, you will have a high score in this section.

Burnout is associated with feelings of hopelessness and complications when performing your work (Stamm, 2005:5). Aspects such as an ever increasing workload or non-supportive work environment can cause burnout.

Compassion fatigue or secondary trauma entails exposure to work-related stressful situations (Stamm, 2005:5). When you experience sleeplessness or fear regarding your work, you might be exposed to compassion fatigue.

The questionnaire consists of 30 questions which respondents had to answer by making use of a lickert scale according to the following categories:

- ✓ never;
- ✓ rarely;
- ✓ quite often;
- ✓ often; and
- ✓ very often.

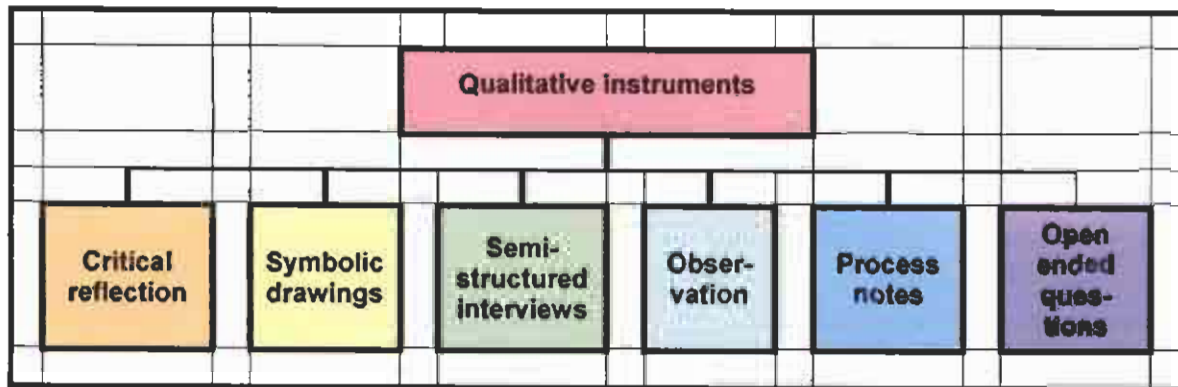
The quantitative data generated were analysed by means of descriptive data analysis, according to the specifications of the ProQOL. (Refer to 6.2.1 for a detailed description of the ProQOL scale).

4.3.4.1.2 Qualitative instruments

The analysis of all the qualitative projection techniques was guided by a registered educational psychologist.

The qualitative instruments used, are summarized in Figure 4.5:

Figure 4.5: Qualitative instruments



Critical reflection

After each session, the participants had to complete a reflection worksheet regarding elements of the session participants found particularly helpful, elements participants experienced as not helpful at all and components participants would like to change or add to the session.



Symbolic drawings

Symbolic drawings (*cf.* Addendum A) are representations (Reber & Reber, 2001:624) or expressions of the unconscious mind of a person (Furth, 2000). Metaphors can be used to explore beliefs and / or values, problems and thoughts. A symbolic drawing is much the same as a metaphor in that meaning is transferred from one concept to another, based on perceived similarity (Dunbar-Krige, 2006: 100).

Participants had to illustrate how they experienced HIV/Aids and death by drawing a symbol which they associated with HIV and with death (*cf.* Addendum B).



Semi-structured interviews

A semi-structured interview consists of a number of set questions which are flexibly administered. Although semi-structured interviews follow standard questions, the opportunity exists to ask one or more personalized questions to clarify a person's reasoning, beliefs and perception of a certain topic (Leedy & Ormrod, 2005:184; Greeff, 2002:302).

Five semi-structured questions (*cf.* Addendum D) were asked in an interview which was held in a group setting three months after the completion of REds. Questions such as “In what way did REds help you personally and professionally?” were asked. Data acquired by these interviews, were audio-taped with the permission of the participants to be transcribed by the researcher after the interviews. Content analysis was used, because it is a process that gives meaning, structure and method to an enormous amount of information (De Vos, 2002:340).



Observation

Reber and Reber (2001:479) define observation as an informal recording and interpretation of what has been observed. Reactions and emotions of participants were recorded by the facilitator and the observer in order to collect information and data (*cf.* 4.3.3.2.3 & *cf.* 4.3.3.2.4).



Process notes

In psychology, process generally refers to a series of steps or progression towards a goal. Often this process implies change (Reber & Reber, 2001: 567). Process notes record the step-by-step progression towards a goal. During the processing of notes, the researcher should consider answers, comments, specificity of comments, as well as the context which occurred during each session (Greeff, 2002:318). The researcher made use of process notes to record how REds was implemented and how participants responded to each programme module. Directly after each session, the researcher wrote the process notes. Each session was processed separately. The process notes were classified as follows:

- ✓ Aims of session: the goals of each session.
- ✓ Overview of session: a scope of the session.
- ✓ Process notes: participant reactions, emotions and information observed and gathered by the facilitator and observer are recorded and transcribed.



Open-ended questionnaire

The researcher made use of a non-standardized open-ended questionnaire consisting of 7 questions which focused on ascertaining the impact of the pandemic on educators (*cf.* Addendum C). The questions were based on a literature review. Participants completed the questionnaire in writing.

4.3.4.2 Delayed Interviews with group members

Three months after the completion of the REds programme, the researcher arranged for an informal group interview to determine how participants coped after the 8-module REds programme (*cf.* Addendum D). Participants unanimously felt that REds should continue and the information they had gained should be spread to other educators and schools. The results are discussed in detail in Chapter Five.

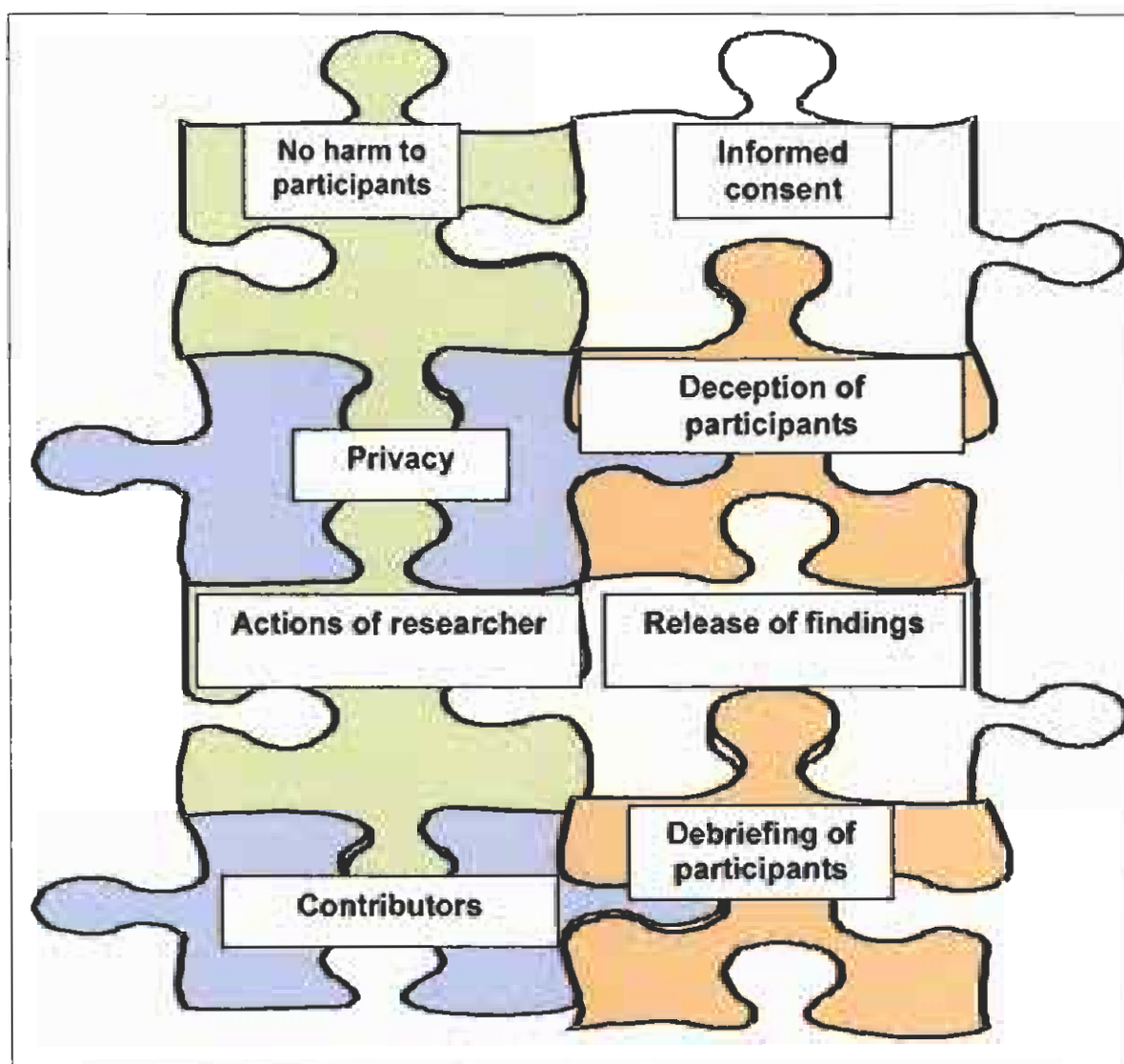
4.3.4.3 Interviews with management

The researcher arranged interviews with the principals of the different schools just after the completion of the REds programme at their school (*cf.* Addendum F). The principal of one of the schools and a member of the management team from the other school agreed to the interviews. The results are discussed in detail in Chapter Five.

4.4 ETHICAL CONSTRAINTS

Participants in a research project must clearly understand the nature of the study and must be willing to participate (Leedy & Ormrod, 2005:144). The following ethical aspects, as illustrated in Figure 4.6, should be adhered to when human beings are the objects of a research study, because data should never be acquired at the expense of participants (Strydom: 2002a:62).

Figure 4.6: Ethical aspects



 No harm to participants

No activities in which participants had to take part exposed them to physical, emotional or psychological harm. Participants were not subjected to undue stress or embarrassment. Attending the REds programme was not compulsory and the programme was thoroughly explained to participants (Leedy & Ormrod, 2005:101; Strydom, 2002a:64). At no time were participants manipulated by the researcher (Welman *et al.*, 2005:201).

 Informed consent

According to Leedy and Ormrod (2005:101) and Strydom (2002a:65), participants should clearly be informed about the aim and process of the

research, as well as possible benefits or risks participants could be exposed to. Participants should give consent to the research and must be aware that they could withdraw from the investigation at any time.

At no stage was any educator forced by the researcher to participate in the REds programme (Leedy & Ormrod, 2005:101; Strydom, 2002a:65) and participants were aware that they could withdraw from the programme if they wished to. Consent was obtained from educators who agreed to participate in the REds programme (*cf.* Addendum G), as well as from the principal of the school and the district manager (*cf.* Addendum H) (Leedy & Ormrod, 2005:101; Strydom, 2002a:65-66). All the afore-mentioned were completely informed about the aim, the process, as well as the benefits or risks of the programme. Some of the benefits of taking part in the REds programme were:

- ✓ support for the infected and affected;
- ✓ assistance in how to deal with stress and stigma;
- ✓ information with regard to educators' rights regarding HIV/Aids; and
- ✓ knowledge on how to care for people infected by HIV/Aids.

The researcher explained to participants that by participating in a programme which focused on HIV/Aids, there could be the risk of stigma or gossip. Nevertheless, all participants were eager to participate in the REds programme.

The right to privacy of participants

Every individual has the right to decide when and to whom her beliefs, circumstances, and behaviour may be revealed (Strydom, 2002a:67).

In this research, all participants' comments were kept strictly confidential (Leedy & Ormrod, 2005:102) by reporting them in an anonymous manner. Participants agreed to photos being taken, pictures and questionnaires to be copied and documented. No concealed media were used to gather information (Strydom, 2002a:69).



Deception of participants

Strydom (2002a:66) defines deception of participants as "deliberately misinterpreting facts in order to make another person believe what is not true, violating the respect to which every person is entitled".

In this research, honesty played an enormous role. Participants were fully informed about the aim and process of the REds programme, as well as the possible outcomes of this intervention programme.



Actions of researcher

According to Strydom (2002a:69), the researcher should constantly be aware of her ethical responsibility. Throughout the duration of this research, no value judgements were made on cultural aspects of the communities or participants involved.



Release of findings

When findings of a research project are released, researchers should understand the importance that findings should be documented accurately, objectively, completely and with certainty (Strydom, 2002a:71). Limitations of findings, such as making use of a purposive convenience sample in the case of this study where the researcher's findings could not be generalized to all populations, must be indicated and plagiarism and prejudice should be avoided.

In this research, findings were documented completely with accuracy, objectivity and without any bias. The researcher took great care to avoid duplication which could be seen as plagiarism.



Contributors

This research was made possible by the financial contribution of the National Research Foundation of South Africa and the North-West University.



Debriefing of participants

In order to assist participants and minimize harm, participants should receive the opportunity to express their emotions and feelings following the intervention (Strydom, 2002a:43).

In this research, participants were provided with the opportunity to record their feelings and emotions directly after each session by completing a reflection sheet. Participants were also contacted three months after the termination of the REds programme to determine their progress. They were provided with possible local contacts and resources for further debriefing if necessary.

4.5 CONCLUSION

While Chapter Four mainly focused on the research design, the empirical study will be addressed in Chapter Five and the process of the REds support programme for educators affected by the HIV/Aids pandemic will be reported in more depth.



CHAPTER FIVE

REPORT ON THE PROCESS OF REds



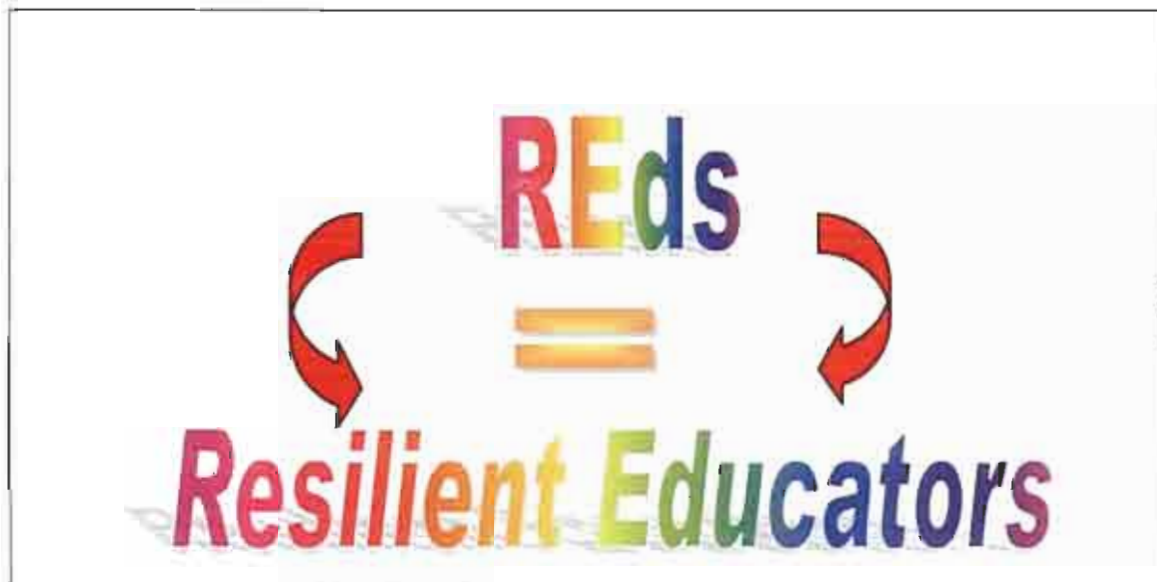
"Resilient people are like a green twig – they bend and hurt as they experience pressure, but they don't break. In fact, they will even be able to blossom again....!" – REds, 2006 -

5.1 INTRODUCTION

In this chapter, the researcher will provide an overview of the process of the Resilient Educators (REds) support programme for educators affected by the HIV/Aids pandemic. The concept REds was explained to participants as illustrated in Figure 5.1.

An overview will be provided by stating the aim of each session and documenting the process of each session as it occurred.

Figure 5.1: Explanation of the concept REds



5.2 SESSION ONE

5.2.1 Aims of Session One

Due to the fact that Session One was primarily an introductory session, the course of the programme was explained to the participants. It was not necessary to explain the aim of the research, as this had been explained to participants during prior contact sessions when the invitation to participate was issued. The aims also included:

-  Completion of the pre-test (*cf.* 6.2 and 6.3).
-  Clarification of group rules.
-  Concept clarification:
 - the concept “affected “ was explained as someone who does not have HIV/Aids, but:
 - has a learner, colleague or loved one who is infected;
 - has a learner, colleague or loved one who has died of Aids-related diseases and;
 - has Aids orphans and vulnerable children (OVCs) in her class.
 - Educators affected by the HIV/Aids pandemic need various types of support.
 - The concept “support” was explained as the comfort, appreciation, approval and encouragement one person provides another person (Reber & Reber, 2001: 726).
 - REds was explained as an acronym for Resilient Educators (*cf.* Figure 5.1) (Theron, 2006b:4).
 - The concept of resilience was explained as set out in 5.9.1.

5.2.2 Overview of Session One

The following activities were included in Session One:

-  Ice breaker.

-  Introduction of group members.
-  Symbolic drawing to explore the impact of the pandemic on each individual.
-  Symbolic self-description.
-  Clarification of concepts.
-  Clarity regarding participant expectations.
-  Completion of pre-test (*cf.* 4.3.4.1.1; & *cf.* 4.3.4.1.2).
-  Clarification of group rules.
-  In conclusion the poem, "I walk the street" was read to the group (Covey, 1998:62).

5.2.3 Process notes

At first it was difficult to determine a time suitable for all group members to commence with the REds programme. The initial date was scheduled for a Wednesday, but the participants cancelled the meeting minutes before it would have commenced. The cancellation was related to the fact that it was the beginning of a long weekend and the educators did not want to attend, due to the long weekend ahead – a clear sign that the educators were drained and de-motivated and rather preferred to be relieved of the school and all its activities.

Another date was scheduled, but again cancelled the day before, due to sudden compulsory workshops which had to be attended by the educators. Fortunately, the scheduled dates could be rescheduled at a time slot suitable to everybody on Friday afternoons. Nine participants (8 women, 1 man) attended the first session. When the facilitator originally met the gentleman who attended the first session (about two months previously), he was an energetic and dynamic man who was interested in furthering his studies. The facilitator was shocked to observe that he had no motivation at all and that he was not interested to further his studies anymore. He seemed depressed and very sad. Four of the nine participants participated actively, while one lady did

not want to participate at all. She said she was under the impression that our meeting was about school matters and that she was not interested in HIV/Aids, because she was not affected and did not know anybody who was infected or affected. Her attitude influenced the whole session and she did not complete any of the handouts. She did not attend again. In the end only eight participants participated regularly.

The facilitator explained to the participants that REds is a support programme for educators who are affected by the HIV/Aids pandemic and that it forms part of ongoing research. Ethical issues governing the study were carefully explained to and agreed on by the participants (*cf.* 4.4).

The participants were asked to complete a symbolic work sheet from Saretsky as used for REds (Theron, 2006b) (*cf.* Figure 5.2) by choosing the symbol that would describe them best. This was used as a means for participants to introduce themselves.

Figure 5.2: Symbol which describes participant best (Saretsky, 1994:115)

	Wheelbarrow	Will only go when pushed.
	Canoe	Has to be paddled.
	Kite	Will fly away unless someone holds tightly to the string.
	Cat	Content only when petted.
	Football	Never know which way it will bounce.
	Balloon	Full of hot air.
	Trailer	Will go wherever pulled.

	Lights (1)	Always goes on and off.
	Gold watch (7)	Open-faced, pure as gold, dependable, self-motivated.

Seven participants indicated that they were like a “gold watch”: open-faced, pure as gold, dependable and self-motivated, while one participant experienced himself as a “light”, because sometimes he felt extremely motivated and energetic and sometimes he felt “rock bottom” and in need of encouragement. This participant explained that he worked very hard at school and suffered because of orphans and infected learners in his class and school; he also carried loads of responsibilities.

The participants were asked to make a symbolic drawing: any symbol that came to mind when they thought about how the pandemic had affected them. The symbolic drawings are discussed in 6.3.1 (*cf.* Table 6.1) and 6.4.1 (*cf.* Table 6.3 and are included as Addendum A.

At first all the participants, except for the gentleman, appeared to be reluctant to share their thoughts and emotions with the rest of the group. Gradually the group opened up to one another, which resulted in initial stages of trust. They were tearful when sharing their feelings with the rest of the group, because they were concerned about both their own children and the learners. One participant related that she had lost her brother and as her husband was a migrant worker, she was fretful that she might be infected.

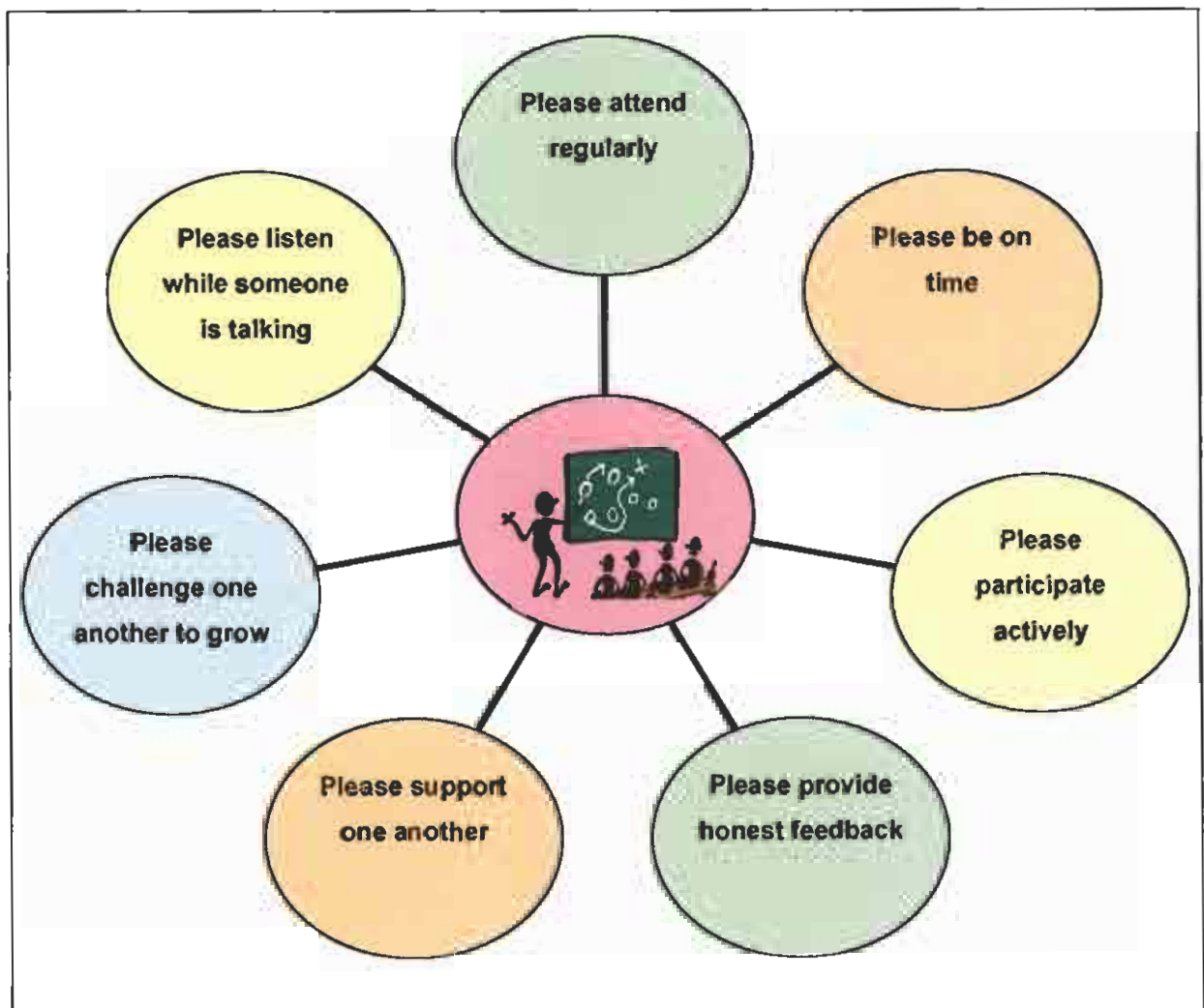
The participants did not know the meaning of resilience and the facilitator explained the concept concretely by using a brown and green twig: when pressure is applied to an old dry twig, it will break and crumble, but if one puts pressure on a green twig, it will bend and get hurt, but it will curve back to its original form and will even be able to blossom again. The last twig is a resilient twig: although it is bending and hurting, it will recover and carry on living (Vaillant, 1993:284). The participants immediately understood the concept and indicated that they would never forget this explanation. It gave them hope,

because despite the fact that they were hurting and bending under the pressure, they realised they would spring back and even blossom again.

The facilitator observed that some of the participants still did not understand the difference between infected and affected. This might be due to the language problem, so the group was invited to communicate in their mother tongue and two of the participants would translate. The participants reacted positively regarding the digital camera and tape recorder, although initially no-one wanted their faces to be photographed.

Due to the fact that the meetings would take place in group form, group rules as recommended by Corey and Corey (2002:13) were discussed and agreed upon. The identified group rules are summarized in Figure 5.3.

Figure 5.3: Group rules (Corey & Corey, 2002:13)



The participants reflected positively on the information they received and by the end of the first session, they seemed more confident and open-minded to talk about the disease. They indicated that they were looking forward to the following week's session.

In conclusion of Session One, the poem "There's a hole in my sidewalk" by Portia Nelson (Covey, 1998: 62) was read to the participants.

They were very quiet afterwards. One participant commented that after the poem was read to them, only then did she finally understand what this programme would entail.

They experienced relief and hope for the next session.

5.3 SESSION TWO

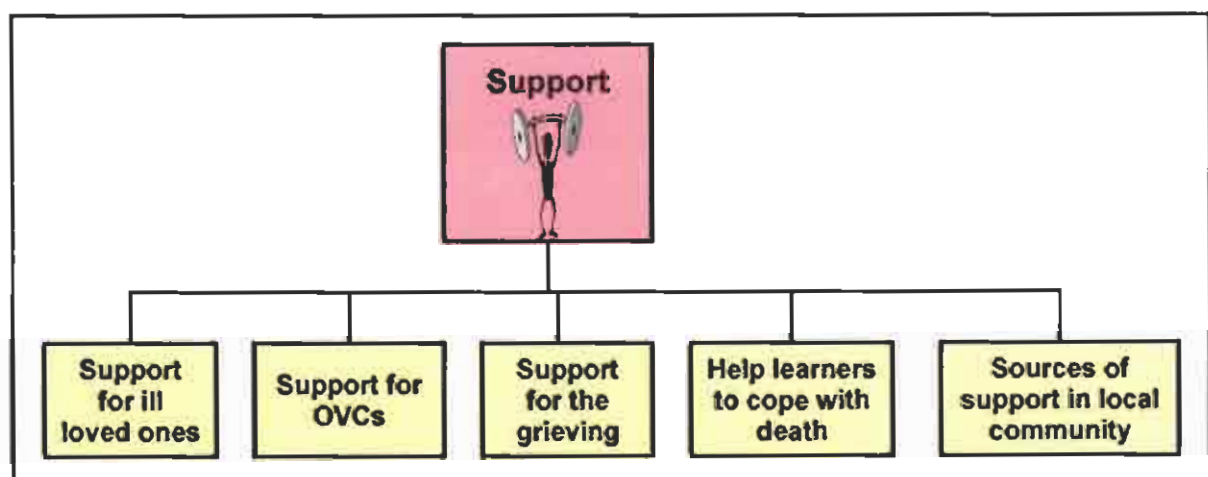
5.3.1 Aims of Session Two

Session Two was aimed at illustrating the importance of support to cope with the HIV pandemic as shown in Figure 5.4.

5.3.2 Overview of Session Two

The facets of Session Two are indicated in Figure 5.4.

Figure 5.4: Support needs of educators affected by HIV/Aids



The following activities were included in Session Two:

-  Icebreaker – group activity
-  Compilation of local support network
-  Facilitator provided participants with booklets from the Children's institute
-  Drawing on how participants experience death
-  Participants shared coping skills for empowering themselves, learners, colleagues and loved ones regarding grieving and death
-  Conclusion: Poem: Why? (Anonymous)

5.3.3 Process Notes

An icebreaker was used to open Session Two. The group members had to stand in a circle while the facilitator stood in the middle, blindfolded. The group members were asked to push the blindfolded facilitator backwards and forwards gently, being responsible for not letting the facilitator fall. The blindfolded facilitator had to learn to trust the group members - that they would not let her fall. At first, the participants hesitantly pushed the facilitator, not certain how to react. After they realized that the facilitator was "comfortable" with being pushed, they relaxed. All the participants had a turn to stand in the middle. They understood the concept "trust" better after the facilitator explained to them the importance of trust among the group members.

The lady who had appeared to be negative the previous week did not attend the second session. The group members interacted much better and shared their feelings and concerns more easily. All the participants verbalized that they were affected by the virus and in need of support. Information and contact numbers of organizations and people in their communities, as well as in their province, who could assist them regarding child support grants, health clinics and social services, were given to the participants. The participants shared their knowledge of support venues in their community and compiled a group list of local support, as shown in Table 5.1.

Table 5.1: Sources of support in local community

	
COMMUNITY SUPPORT SOURCES	TELEPHONE NUMBER ADDRESS
AIDS Helpline	0800012322
Lifeline	0861322322
Childline	0800055555
Social Services	016 930 2000
Wide Horizon Hospice	016 44281410
Kopanong Hospital	016 428 7000
Sebokeng Hospital	016 930 3000
Zamdela Clinic	016 974 1023
ATICC	016 950 5337
Bana Pele	016 988 1082
North-West University (Dr Linda Theron)	016 910 3076
Tswelo Pele Youth Group (Mr Morake)	073 362 7853
Phela o phedise (Me Seipati)	016 974 2160
Circle of Care (Me Maloka)	073 402 8459

The participants seemed more confident to share their feelings and opinions with one another openly. The facilitator observed that most of the participants seemed to be aware of support organizations in their communities, but were scared to find help, because of the stigmatization. All of them were very sensitive about the stigma surrounding HIV/Aids and they were relieved to hear that people infected by HIV should be treated the same as people with, for example, cancer or diabetes.

Some of them were not aware of the fact that they, as educators, could give support. They were excited to give support to learners and were eager to gain

knowledge on how to support the learners, for there are many affected and infected learners at their schools. They also realized that they, as educators, would be empowered if OVCs and loved ones could be supported by, for example, home-based care organizations. It would relieve them from some of the responsibilities of caring for an infected learner, loved one or colleague. One participant strongly believed in the need to teach infected and affected persons the necessary skills to be able to do things for themselves and not be too dependent on others.

Following the discussion of local support networks that participants could access, the participants were asked to visualize the appearance of death. Then they had to draw what they had visualized, including shape, colour and emotions. Illustrations of how participants visualized death are included as Addendum B. Figure 5.5, is an example of one of the participant's drawings in process:

Figure 5.5: Example of participant's visualization of death



The results were as follows:

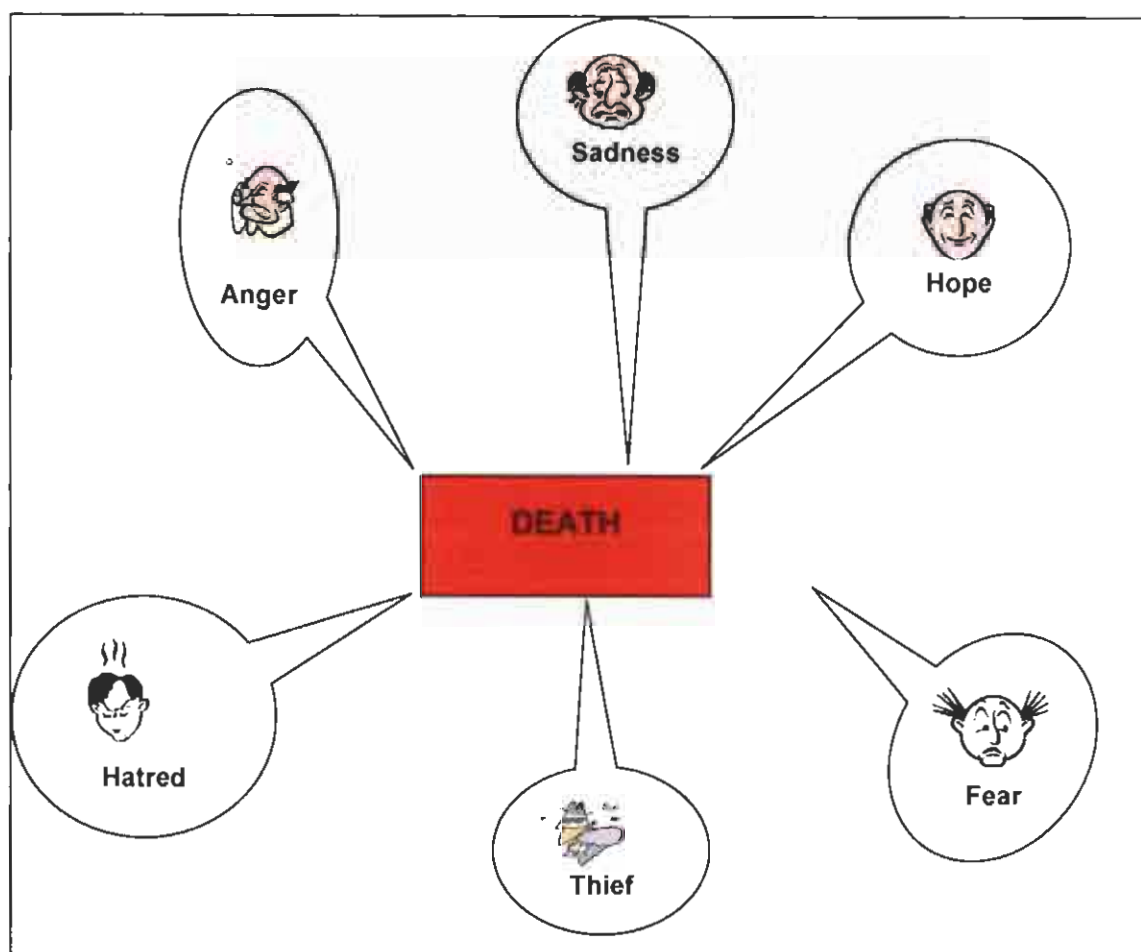
Table 5.2 Results of participants' visualization of death

Participants' pictures	Description of drawings
	One participant visualized death as a green face with no expression, because green symbolizes new life without pain and sorrow, and gives hope and relief to people left behind. The participant said she experienced only numbness when drawing the picture, because death doesn't bring happiness or sadness to her, only relief. She thought death could become a distant friend.
	One participant visualized death as an ugly black face, with protruding red eyes and red flames coming out of the mouth. Her total experience of death was one of fear and hatred. Death is a foe; it can never be a friend.
	One participant's picture consisted of triangles (ears, eyes, teeth), circles (face, nose and a rectangular mouth). Death reminded this participant of the devil, therefore the red eyes and sharp teeth. He experienced anger and frustration when drawing the picture. He also saw death as a foe.
	One participant drew a shapeless black figure. She perceived loss as sadness and despair, because for her it was difficult to face death. She indicated that death would change her way of living and definitely could not become a friend, because death scared her.

	One participant drew a circle with black scribbling all over the picture. She experienced death as a thief in the night: it doesn't respect age; it is too big to handle. She experienced a huge amount of anger, because death destroys everything you have hoped for, dreamed for, worked for. Death is nobody's friend.
	One participant visualized death as a black, mean face with big protruding eyes and a sad mouth. She fears death, she is so scared of death - she would like to run away, but she knows death will eventually catch up with her. Death will never be a friend of hers.
	One participant imagined death to be a very ugly black face with big eyes, a big mouth and big sharp teeth. Death scared her; it could never be her friend.
	One participant drew a horrible black face with a wide open nose and mouth. She described her emotions as mournful; because she lost the one she had admired most. She indicated that death is "unusual" – a horrible thing.

Referring to their pictures, it was made clear to participants that no two people experience death and grief in exactly the same way, because it is a unique process. It was important for them to grasp this concept, because they deal with grieving learners and colleagues on a regular basis. Figure 5.6 summarizes the participants' experiences of death and grief:

Figure 5.6: Participants' experiences of death and grief



All participants experienced death negatively, as they saw it from their point of view, except for one participant who saw death from the deceased's point of view, which would mean new life, without pain and sorrow, and hope for those who stay behind. The participants' discussion revealed that the grieving process is necessary and important, because it has a healing effect on a person.

The participants felt excited about the fact that they, as educators could support affected and infected people. They also felt empowered by knowing the places and people they could ask for help and by having a better understanding of the grieving process. In conclusion, a poem by an unknown author (*cf.* p.ii) was read to them so that they could understand that they could make a difference in other people's lives. They felt honoured and excited that God wanted to use them to make a difference.

The participants felt empowered by the knowledge that they had gained and were looking forward to the following session.

5.4 SESSION THREE

5.4.1 Aims of Session Three

The aim of session three was empowerment of participants with knowledge and skills to combat and cope with stigma surrounding the pandemic. They had to reflect how they experienced stigma and needed to know the steps involved in combating stigma. Facets addressed in Session Three were as follows:

- Combating stigma.
- Stigma-free community.
- Strategies to cope with stigma.

The following activities were included in Session Three:

-  Icebreaker: Discuss pictures regarding stigma and choose two which mostly represent stigma.
-  Activity: What stigma have you experienced or witnessed in your own community?
-  Activity: examples of stigmatizing behaviour at school.
-  Questions on fears people have regarding ways in which one can acquire HIV/Aids through non-sexual contact with PLWHAs at home or at school.
-  Activity: Find common language for stigma.
-  Read an excerpt of Doro (2002) who was a speaker at the First National Summit for People Living with HIV/Aids at the Eskom Conference Centre in Midrand, South Africa during October 2002 (Theron, 2006b:25).
-  Participants make a drawing of a school / community without stigma.



Ideas for combating stigma



Strategies for coping with stigma

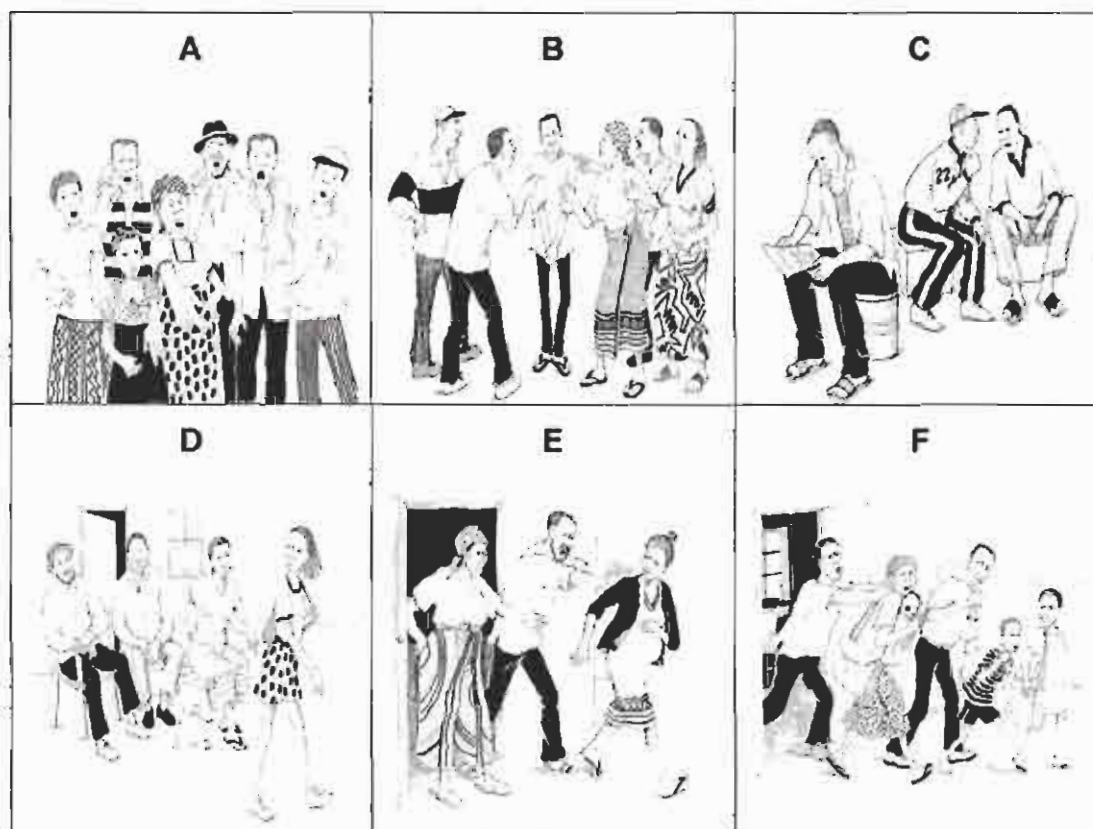


Conclusion: Inspiring thoughts.

5.4.2 Process Notes

Participants had to divide into pairs to choose two pictures which strongly represent stigma, as illustrated in Figure 5.8 (Change Project, 2005). Then they had to explain their thoughts to the group.

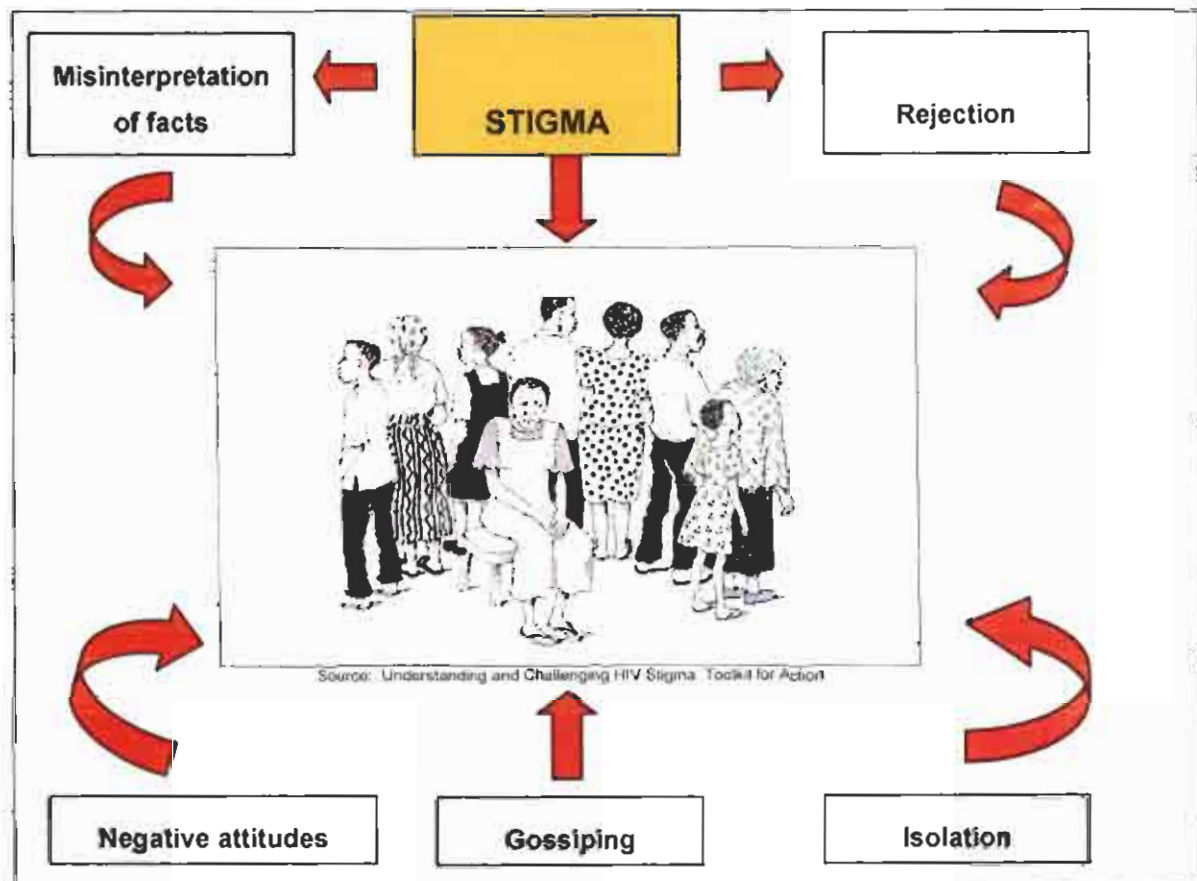
Figure 5.8: Pictures which represent stigma (Change Project, 2005)



The pictures, as illustrated in Figure 5.9, used during the icebreaker evoked a dynamic discussion on the physical and psychological effect of stigma on an individual and her family members. Participants fully agreed that HIV/Aids and the stigma surrounding the pandemic mostly affect women and children. Five participants indicated that pictures A, B, E and F strongly represented stigma, while three participants chose pictures A, C and D. All the participants experienced picture A as "finger pointing", condemning and denouncing.

Participants' interpretation and experience of stigma surrounding HIV/Aids are summarized in Figure 5.9 (Change Project, 2005).

Figure 5.9: Participants' interpretation and experience of stigma



It was clear from the discussion that, at some stage in their lives, all the participants experienced one of the behaviours mentioned in Figure 5.9. The group members did not know how to combat stigma. One participant believed it was not good to disclose one's status, because people in South Africa have not yet reached the necessary maturity to deal with HIV/Aids. One participant indicated that she feared to be isolated and gossiped about. One participant knew about discrimination in the workplace when his colleague had to resign in 1997 due to HIV/Aids because of the negative attitudes of his colleagues, parents and principal.

The facilitator observed that some of the participants were still ignorant regarding the transmission of HIV/Aids. One participant said she was afraid to help injured people, she was afraid to kiss anybody or to make physical

contact. Subconsciously she feared to be infected. This session made her realize that she could still help injured people, kiss and touch her loved ones. Her response provided a good example to the group of how ignorance can lead to stigmatizing behaviour.

To assist participants in combating stigmatization, they need knowledge of the steps needed to minimize stigmatization and therefore had to share their ideas on how to tackle the stigma surrounding HIV/Aids. All the participants agreed that it would be a good idea to involve HIV/Aids-infected people in speaking to learners and the community about their illness. In this way, they could start to combat the ignorance, as well as the negativity surrounding Aids. Participants were astonished to learn that HIV does not mean immediate death and that infected people can live for a long time if they receive medical treatment and follow a healthy diet and life style. This amazed the facilitator as most educators have been attending workshops on HIV/Aids. Their ignorance suggested the need for repeated Aids education.

The participants had to draw a symbol for their school which would tackle stigma. Three "slogans" caught the facilitator's eye, as illustrated in Figure 5.10.

Figure 5.10: How to tackle stigma



The participants had to identify ideas which might work in their community to ensure that new values towards PLWHAs were established. They also had to indicate which of these ideas were being implemented at their schools. These included:

 They felt that there were no school and community meetings to discuss what to do about Aids in their community and that the SBST should initiate these meetings.

 They suggested that it would also be a good idea to form associations of school families, neighbours and church groups to deal with HIV, organize regular visits to HIV-affected households and take care of repairs for vulnerable households.

 All the participants' schools had already identified vulnerable households, gave support where needed and where possible, and attempted to give exemption of school fees to these vulnerable households, where possible.

The participants had to comment on what they would do personally if confronted with stigma and how they would cope with stigma:

 Five participants indicated that they would avoid situations which could evoke stigma, while three would not.

 Two participants reacted that they would comment when confronted with stigmatizing behaviour, while six would not.

 One participant pointed out that she would fight back to stigmatizing behaviour, while seven would not.

 Five participants would joke about stigmatizing actions, while three would not.

 Six participants would try to explain their situation as a PLWHA, while two would not.

 Four participants would talk to friends about their status and their situation as a person living with HIV/Aids, while four would not.

 All eight participants indicated that they would join a support group.

 Six of the eight participants would try to persuade people with stigmatizing behaviour to change their attitude towards the disease.

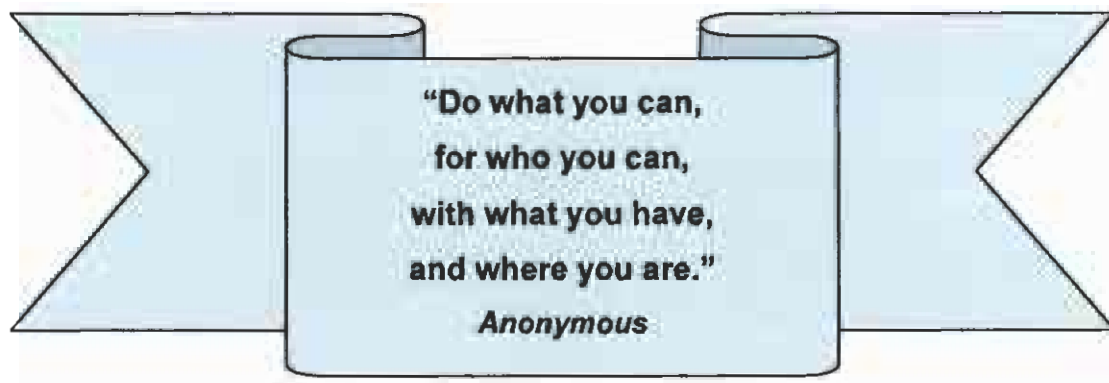
-  Five participants would go public about their status and their situation as PLWHA, while three would not.
-  Three of the eight participants would deny that they are living with people who are infected or affected themselves, while five would not.
-  Three participants would ignore people with stigmatizing behaviour, while five would not.
-  Three participants would withdraw from their friends, family and community if they were to be infected or affected by HIV, while five would not.

The participants then had to recommend a strategy to combat stigma surrounding HIV/Aids. Their recommendations were as follows:

-  One participant recommended talking about the pandemic by giving detailed information, because if you talk, there is a chance to reach those with limited knowledge.
-  Two participants recommended support groups, because a support group can empower individuals.
-  One participant recommended ignoring people with stigmatizing behaviour in order to prevent one from getting hurt and feeling ashamed and, in the process loses self-confidence and self-esteem.
-  One participant recommended avoiding vulnerable situations where one must "defend" oneself regarding the pandemic, as in this way one will make no enemies.
-  Two participants recommended disclosure, since disclosure will relieve stress.
-  One participant recommended withdrawal, for then one can avoid vulnerable situations where one can be forced to disclose.
-  One participant recommended giving information in the form of videos and pamphlets.

The group felt that the disclosure of professional people nationwide will definitely combat stigma. The participants said it helped them to share their feelings with the group, because they were without hope but realized that there is hope after all.

In conclusion, some inspiring thoughts were read to them, which the participants cherished. The example included below is the one that participants liked best.



All of the participants were looking forward to the next session.

5.5 SESSION FOUR

5.5.1 Aims of Session Four

The aim of Session Four was to provide participants with skills to be able to cope with stress and fatigue in their personal lives, as well as in their work environment. In order to combat stress, it is important to understand and recognize the stressors. Facets addressed in Session Four were as follows:

- Stress identification.
- Stress management.
- Work stress.

The following activities were included in Session Four:



Icebreaker. The participants each received a ball of clay with which they had to model any figure which symbolizes stress.

-  Group activity. To manage stress, the participants had to list their stressors and try to modify their response to the particular stressors. They also had to make a list of irrational beliefs and suggested a more realistic belief.
-  Completion of "joy-list". The participants had to list as many things as they could think of which caused them to feel happy and full of joy.
-  Stress at work. Participants had to identify ways to reduce stress at work.
-  Participants had to identify time-wasters and poor time management which can also contribute to stress at work.
-  Time management. Participants had to create a "to do-list" where they had to divide their responsibilities in a "must", "should" and "want to" column.
-  Conclusion. Relaxation exercises were done by means of relaxing music which was played to the participants on a tape recorder. They had to focus on relaxing their muscles and deep breathing.

5.5.2 Process Notes

An icebreaker was used to open Session Four. Each participant received a ball of play dough. They had to make something out of the clay which symbolizes stress and then had to explain what they had made. Examples of two of the participants' symbols can be seen in Figure 5.13.

Figure 5.13: Stress examples made from play dough



Two examples of participants' symbols which represented stress

Table 5.3 illustrates the symbols that participants created to represent stress.

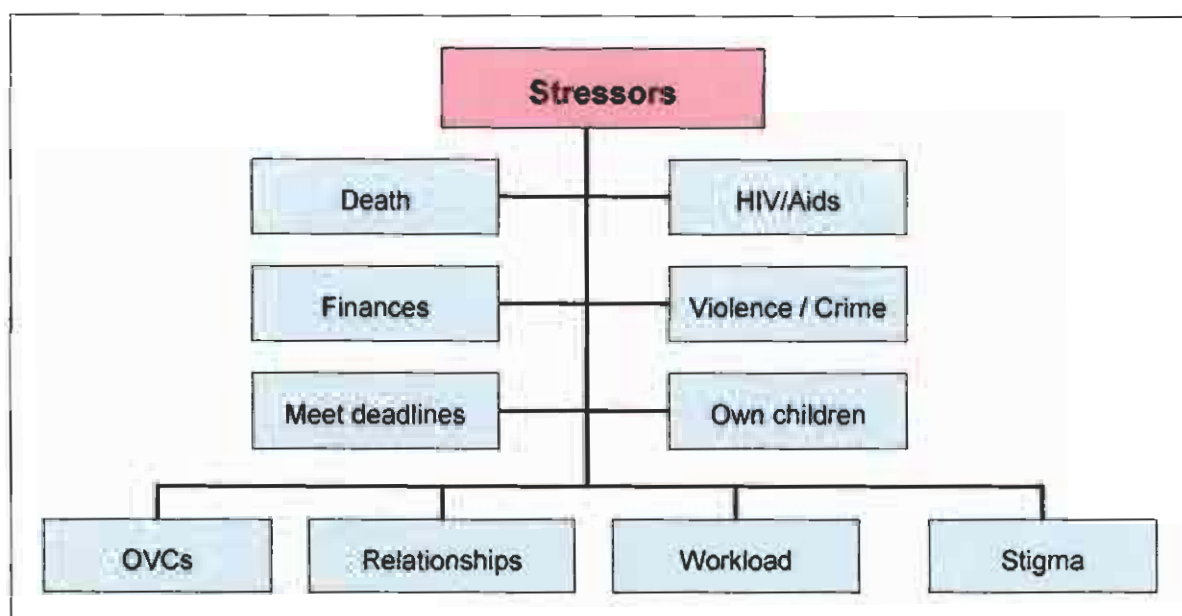
Table 5.3: Examples of participants' symbols

Examples of participants' symbols	Description of symbols
	One participant made an unhappy face, because she can't smile when she is stressed.
	One participant made a crying face, because she is always worried and unhappy.
	One participant made an ugly face, because she doesn't feel good. Everything is an effort for her, e.g. getting dressed in the morning, combing her hair, cooking food.
	One participant made a sad face, because there is no solution to her problems.
	One participant made a fat face, because she is overweight, has a low self-esteem and is depressed. Her weight problem causes stress.
	One participant made a ball, because when you are stressed, you just go round and round – like running away from your problems.
	Two participants made the AIDS ribbon, because the pandemic causes stress.

This activity had a secondary goal as well, because a good way of reducing stress is to play with clay. The participants enjoyed the activity and throughout the session, the facilitator observed that some of them were playing and squeezing the play dough.

The participants had to identify stressors in their lives. The results are summarised in Figure 5.12.

Figure 5.12: Stressors in participants' lives



The participants had to list their stressors and then try to find a solution for their three main stressors. They also had to identify which of their stressors were irrational beliefs and which were rational beliefs. This activity assisted the participants in obtaining perspective regarding their own unique situation and stress triggers.

One participant felt his family was pushing him, because he had lots of chores to do in and around the house, despite the fact that he had loads of responsibilities at his school as educator. He indicated that he felt useless, because he could not attend to all his responsibilities. The group asked him if he realised what an important role he played in the lives of his learners, colleagues and family members. All of them are looking up to him for help and assistance. This made him feel much better.

The facilitator suggested that he, as well as the rest of the participants could make a "to-do-list" which would reduce stress, because poor time management can also cause stress. They had to divide their list into "must, should and want to do". They were asked to report back in the next session. The participants were invited to make a "joy list" to remind them of all their privileges.

The participants felt that after they had seen their stressors on paper and had written a possible solution, they realized that there was no need to feel

hopeless, because there is a solution to every problem. It is a matter of positive thinking. This made them feel calmer about their different situations and stressors, because they could address them.

They enjoyed the "to-do-list" and all of them were positive that they had learned in this session to manage their time better. They had not realized that procrastination was one of the major stressors in their work environment.

Participants felt empowered being able to identify their stressors, to address their stressors and to give themselves "permission" to put the burden down. (This concept was shared with participants by reading an inspirational e-mail which concretely illustrated the stress of burdens.)

In conclusion, the participants put down their pencils; they made themselves comfortable and closed their eyes while listening to relaxing music. The participants really enjoyed this session, especially the relaxation exercises. The relaxation tape at the end of this session did not only relax the group, but in a way the whole group felt "connected" to one another. All group members were looking forward to the next session.

5.6 SESSION FIVE

5.6.1 Aim of Session Five

The main aim of Session Five was to make educators aware of their rights regarding discrimination, absenteeism, leave and protection against HIV at school. They were also introduced to the concept of a supportive school environment. Facets addressed in Session Five were as follows:

- Discrimination.
- Educator Rights.
- Protection against HIV at school.
- A supportive school environment.

The following activities were included in Session 5:

-  An icebreaker where participants had to hold a cup in the air filled half with water.
-  Participants received a quiz on discrimination in which they had to debate if certain concepts regarding discrimination were true or false.
-  A quiz on educators' rights was given to participants on which they had to encircle the correct answer regarding their rights as educators, for example sick leave.
-  A check list was given to participants according to which they had to determine if their school was following certain protective actions against HIV at school.
-  Participants then had to rate their schools in terms of providing a supportive school environment for educators.
-  Concepts like Health Advisory Committee (HAC) and Educator Support Team (EST) were discussed with participants.
-  Participants had to determine if they had HAC and EST at their schools and if not, what could be done to establish them at their schools.
-  In conclusion, the passage "Put the glass down" was read to participants to let them realize how important it is to "de-stress" from time to time.

5.6.2 Process notes

As an icebreaker and means of introducing the notion of rights to the participants, they had to hold a cup of water in the air for an indefinite time. They were puzzled while they waited for further instructions. No-one questioned the activity or asked whether they could put the glass down. The group's reaction illustrated that they didn't think enough about their rights. If they had asked whether they could put it down, their action would have illustrated their right to question. If someone just put it down, her action would have illustrated her right to decide for herself. Some participants said they actually felt silly not to think of these options.

To introduce educators to their need to be aware of their rights with regard to discrimination about the HIV/Aids pandemic and their rights as humans and employees, the participants had to split up into two groups to debate their answer before giving a final verdict. One group felt that discrimination still existed at their schools and in their communities, while the other group felt that they had experienced no observable discrimination at their school. One group indicated that they would address discrimination by changing their attitude, while the other group felt that those with less knowledge should be educated.

On the question if an educator can be dismissed from school because of HIV/Aids, the participants said that it had not happened at their schools yet, but that they were aware that discrimination against people affected and infected by HIV/Aids existed at some schools. The participants felt that everybody should take an HIV test, provided that the individual agreed to the test. One participant believed that people needed to know their own status in order to defeat the AIDS pandemic. One participant who happened to be pregnant was afraid to take an HIV test because her husband is a migrant worker.

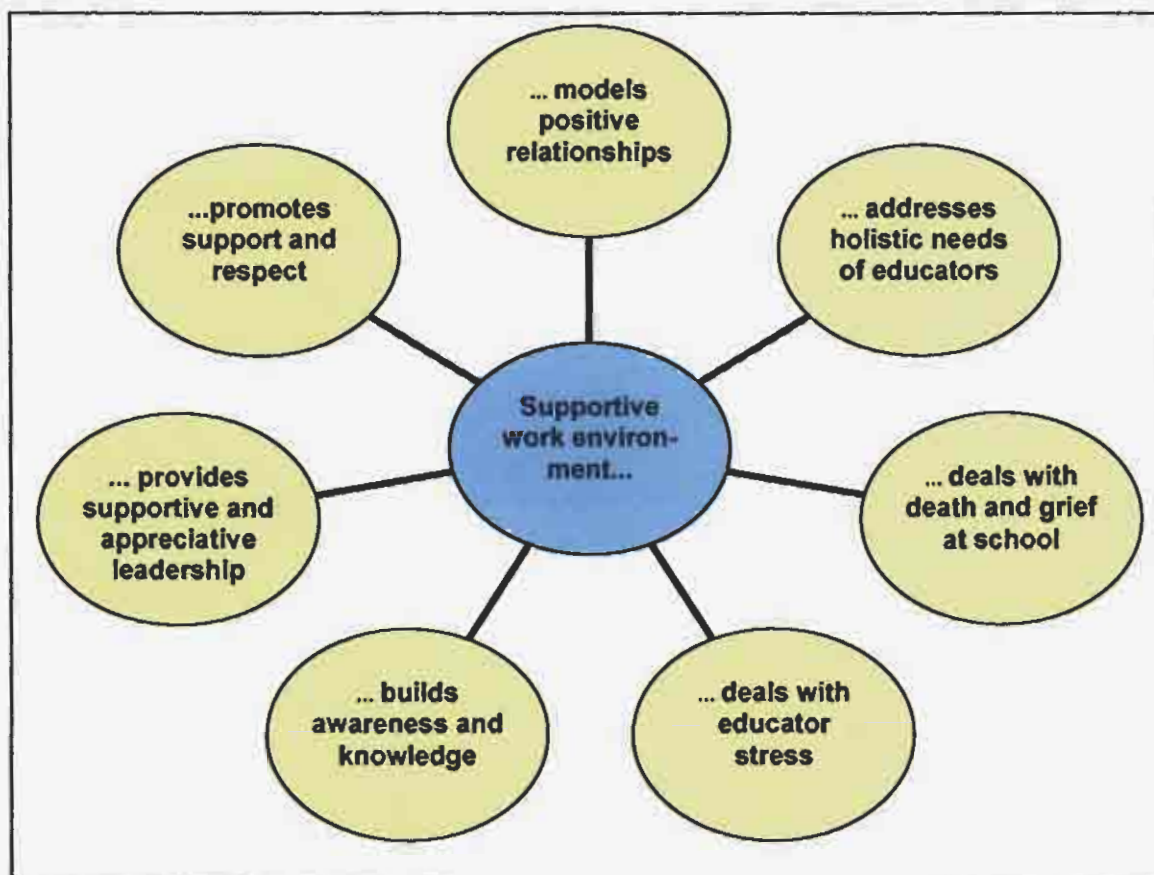
The participants were aware of their human rights regarding discrimination because of HIV/Aids, but were not sure about their rights as employees. Almost everyone thought that learners do not have rights, except for one educator who felt that if the educator disclosed her status, the learner had the right to refuse to be taught by that educator. The rest of the group felt that it would be discriminatory. The participants were not very well informed regarding their own sick leave or special leave when a spouse, partner or child was ill or passed away.

To ensure that educators understood the concept of a supportive school environment, they had to explain what they understood under a supportive environment and that it was important to work in a supportive environment, since it could motivate educators who were working under difficult circumstances and that it could reduce depression among educators.

Then they had to identify aspects they thought to be important regarding a supportive school environment and what support they would like to experience

at their school. Figure 5.13 indicates important aspects participants reported regarding a supportive work environment.

Figure 5.13: Important aspects to ensure a supportive work environment



Participants welcomed the idea of an HAC which consists of members of the community (like health workers, religious leaders, business people, educators and learner representatives) whose aim is to advise the SGB on health matters and develop and implement a plan on how to assist educators and learners infected and affected by HIV/Aids (Xaba, 2006:53). Participants also enthusiastically welcomed the idea of EST whose aim is to support educators and create a safe school environment (Xaba, 2006:54). Participants did not experience committees such as the above-mentioned at their schools.

The participants indicated that this session was very educative and informative. They enjoyed the icebreaker and realized that none of them thought enough about their rights, because everyone was waiting for the facilitator (or

someone) to supply further instruction. Afterwards they understood their right to question and their right to decide for themselves.

They agreed that a supportive environment motivates individuals to work under difficult circumstances and that support can also fight depression. The participants argued about their rights as individuals, which could cause discrimination (the learner has a right not to be taught by an HIV-infected educator and vice versa).

Due to the fact that participants were not as sure about their rights as educators regarding leave, they found this part extremely informative, especially when an educator is permanently unwell, but can still give service. One participant told the group about an educator at a certain school who had been denied early retirement and was declared medically unfit by doctors several times. However, the department declined to approve early retirement on the basis that the educator was too young. He was only 37 years old. Two participants knew a HIV-positive colleague who moved to another town where nobody would know her status, in order to carry on teaching. However, her colleagues from the new school became suspicious because of her absenteeism and made life difficult for her, complaining about looking after her learners when she was not able to attend school. In the end, their colleague moved back to her home town where she could experience the support of her family. Unfortunately she ended her teaching career because of her status.

5.7 SESSION SIX

5.7.1 Aims of Session Six

The aim of this session was to enable the participants to be knowledgeable about the correct facts one needs to know about HIV/Aids and to be less afraid of HIV/Aids regarding different facets of the infection. The participants should also be able to understand and explain to other people:



the disease AIDS;



what a virus is;

-  HIV, the human immunodeficiency virus;
-  the effect of HIV on the immune system; and
-  the phases of HIV-infection.

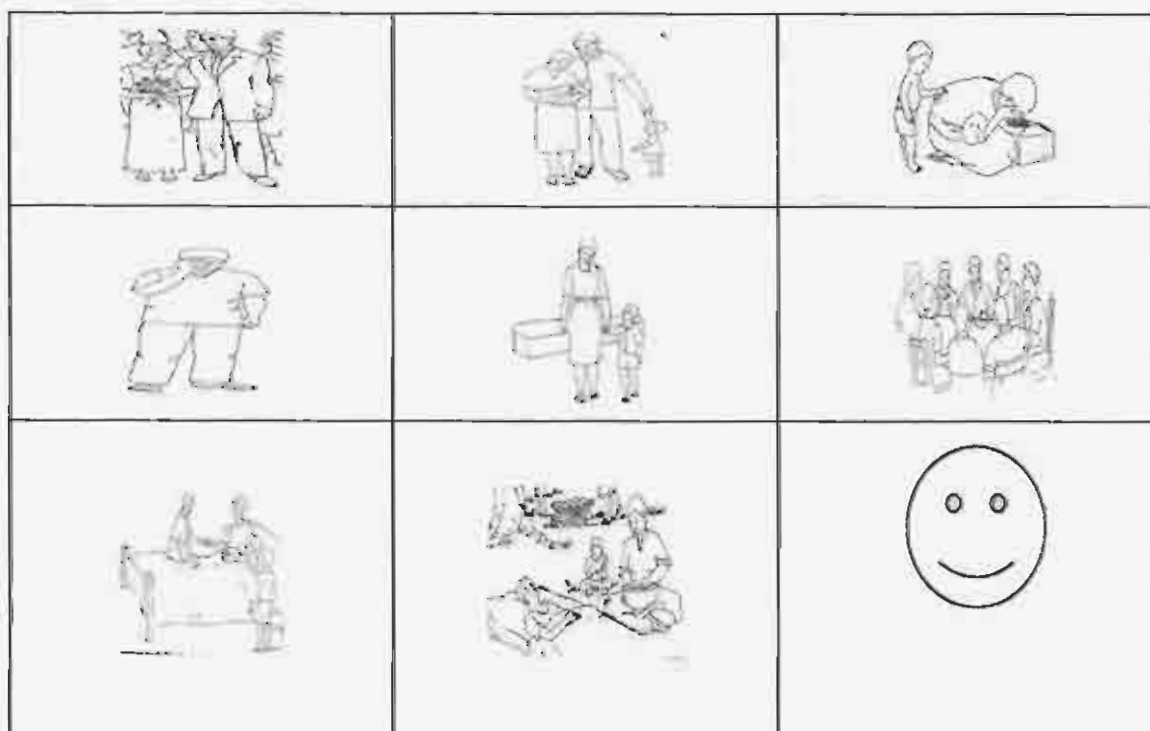
Facets addressed in Session Six were as follows:

- Facts about HIV/Aids.
- Myths about HIV/Aids.
- Preventing transmission at home.
- Avoiding other infections.
- Phases of HIV/Aids

The following activities were included in Session Six:

-  The story of Mukasa and Yulia (AIDS Support Organisation, 1993) was read to the participants. Illustrations from the story, as indicated in Figure 5.14, were showed to participants to make the story more real.

Figure 5.14: Pictures from the story of Mukasa and Yulia



By means of the last picture, the facilitator told the group members that Yulia taught her community to stand together, although she was heartbroken about the death of her husband and first-born child. Because of Yulia's pioneer work, their community "became a friendlier place in which to live and die" (Aids Support Organisation, 1993). Together we could also change our community to have more empathy with one another, so that our community could also become a "friendlier place in which to live and die".



Discussion regarding:

- the myths about the transmissions of HIV;
- how to stay healthy;
- recognition of danger signs;
- how and where to seek help; and
- feeling more confident and comfortable, because they are more able to help themselves and their family members.

5.7.2 Process Notes

The participants attentively and quietly listened to Yulia and Mukasa's story. The story was about Mukasa who contracted HIV in 1984 when he had to do business in the city. He was unaware of his status when he married Yulia in 1985. Without either of them knowing, Mukasa had passed the HI-virus to Yulia. They were blessed with two children of whom the youngest was born HIV-positive. The doctor suggested that Yulia should take an HIV/Aids blood test to determine her status, but because of the fact that Yulia didn't know how to break the news to Mukasa, she never went back for the result of her test. Late in 1989 the baby died. Mukasa became ill and late in 1991 he also died of Aids. Yulia decided to go for another blood test and was diagnosed with Aids. In 1992, Yulia took a training course to provide help to people who are sick, especially those with AIDS. She visited people in their homes and talked in the community about AIDS and health. Yulia died in 1994, but the good work she had done in her community about coping with HIV/Aids will continue through her friends and family.

One could tell from their faces that the participants were digesting facts about HIV/Aids and were perhaps thinking about their own status. Maybe participants were also reflecting about their own experiences.

The participants were overwhelmed by the story of Yulia and Mukasa. The participants' reaction was filled with emotion. Participants also indicated afterwards that the story motivated them to take an HIV blood test to determine their status.

All the participants felt that they were supposed to know all the facts about HIV and AIDS, but after this session, they found the new information very educative and understood the facts more clearly. The use of posters and flash cards explaining the myths with regard to HIV/Aids, ways in which transmission can take place, rules to follow regarding caring for the sick at home, the different phases of HIV/AIDS and a cartoon describing the process which takes place inside the body when a person is infected with HIV were very helpful in this regard.

The participants were astounded to learn that HIV is not the same as AIDS and that these terms actually have different meanings. Some of them believed that HIV/Aids was one and the same illness. The facilitator had to explain that Aids (Acquired Immunodeficiency Syndrome) is a disease caused by HIV (Human Immunodeficiency Virus). In other words, HIV is the virus which infects the body and a person is able to spread the virus (that could last between 3 and 7 years). When a person is in the last or fifth phase of HIV, it can be said that the person has now developed full-blown Aids.

Participants were also clearly relieved about the ways in which HIV/Aids cannot be transmitted. They were not aware of the phases of HIV infection and they all felt that this information would definitely help them to know what to expect of the infected person and how to support others.

5.8 GROUP SESSION SEVEN

5.8.1 Aims of Session Seven

The aim of this session was to enable the participants to understand and explain the following information to other people regarding:

-  HIV/Aids and the role that nutrition can play in feeling healthy;
-  general hygiene (personal and environmental);
-  infection control at home; and
-  general guidance on the use of medicine.

The following activities were included in Session Seven:

-  A discussion, together with a display of posters regarding the following topics as illustrated in Table 5.4, was held:

Table 5.4: Discussion of topics regarding caring for the sick

Good nutrition boosts the immune system to ensure a healthier and longer life	
The reasons for severe weight loss, even in people who follow a healthy diet (Picture adapted from Soul City, 2002:8)	
Body-building foods	

Energy-giving foods	
Body protector foods	
General hygiene	
Infection control at home	
How to use medicine (picture adapted from Soul City, 2004:32)	
Care of the dying (picture adapted from Soul City, 2004:32).	
Making a memory box when the infected person is still strong. "A memory box is something your family, children and friends will remember you by. In the memory box you can put a special scarf, hat or tie you've particularly favoured, photos of the family together, photos of yourself, children's drawings, voice tapes, letters or poems with a special message for your loved ones" (Viljoen, 2004:53).	

The facilitator also handed out booklets from Soul City which she received from a local clinic regarding:

-  caring for a person with Aids;
-  HIV/Aids affects all children;
-  George's story; and
-  HIV/Aids and treatment.

5.8.2 Process Notes

One of our participants was admitted to hospital. He had not been well for a long time and all the participants and the facilitator were concerned about his health. The participants requested permission to sing two religious songs and the facilitator prayed for the group afterwards and for the speedy recovery of the ill participant.

Information regarding the reasons for weight loss was discussed, e.g.

-  not enough nutritious foods available;
-  painful or difficult swallowing because of oral or oesophageal thrush, mouth sores, lesions on gums, inflammation of gums and teeth;
-  nausea and vomiting;
-  chronic diarrhoea;
-  tuberculosis;
-  depression or anxiety; and
-  fever.

Posters with pictures of body-building foods, energy-giving foods and foods that protect the body from infection (vitamin-rich foods) were shown to the participants and the benefits were discussed.

The importance of general hygiene (personal, as well as environmental) was discussed. The participants clearly understood the significance of a clean and hygienic environment, because your environment provides you with water and food.

One participant made an interesting comment that in Germany they only use tap water for general cleaning and not for drinking and cooking. Clean water is also delivered at the door 3 times a day. They felt that we in South Africa could also do with an arrangement like that.

The section on infection control at home was enthusiastically greeted, because nearly none of the participants were sure of the ways in which one can be infected. The facilitator divided this section into two sub-sections:



Body fluids which DO require universal precautions, like:

- blood, semen, vaginal secretion, menstrual discharge, wound secretion, amniotic fluid, fluids from the brain, backbone, abdomen, heart, chest, joint and any body fluids containing visible blood, semen and vaginal fluid; and



body fluids which DO NOT require universal precautions, unless visible blood is present, e.g. faeces, urine, vomit, nasal secretion, saliva, sputum, sweat and tears.

They should, however, always be handled with care for other disease contamination, such as TB, diarrhoea and jaundice.

The participants found the information regarding safe use of medicines, as well as the type of medicine being used to treat symptoms that occur in people with Aids, very informative. The participants understood the importance of being able to read and understand the instructions, and if not, to go back to the doctor, pharmacy, or clinic who gave them the medicine.

The section on "Care for the dying" was very interesting and comforting to the participants. One participant asked if one could ask a very sick person about the arrangements she must make after her death. The facilitator asked the rest of the group what their opinion about this question was. Some said yes, some said no. The facilitator suggested that you should allow the patient to be as independent as possible. The patient might be worried about finances, loved ones or be afraid to die. It would be good to discuss these topics with the patient. It is important that the patient must be comfortable and free from pain. Give her comfort and encourage communication. Allow the patient independence and prepare her for death. It is important to know what the patient's wishes are. At first, some of the participants completely disagreed that the patient must be burdened with sensitive issues, but after the facilitator explained that it was important to the patient to have peace of mind and heart,

and to have the reassurance that her family would be taken care of after her death, they understood and fully agreed that it was necessary to execute her wishes in order to ensure peace of mind.

One participant told the group that when her brother was sick and was to be taken to hospital, he refused to be taken on a stretcher. He walked by himself even though he was very weak. The family respected his wish and let him walk.

The group participated enthusiastically when we discussed the management of common AIDS-related health problems in the home, like anxiety, coughing, constipation, depression, fever, fatigue, night sweats and weight loss. They found the information very educative. It was clear that some of the participants had a sick loved one at home and they indicated that this information would be very helpful to them in order to care for and assist the patient.

Throughout this session, the facilitator could sense how relieved some of the participants became on realizing that there are people and organizations who really want to help HIV/Aids-infected and affected people. One participant commented afterwards, that this was the first time she really felt that there was hope and that she was excited about supporting infected and affected persons, because she herself is affected by the pandemic.

The participants felt that the information regarding how to care for the infected person was very edifying and that it prepared a person for what to do when there is a patient at home. One affected participant said that she would definitely use the guidelines on how to care for the sick at home.

All the participants were excited to share their knowledge with others.

5.9 GROUP SESSION EIGHT

5.9.1 Aims of Session Eight

The aim of Session Eight was mainly to help educators affected by HIV/Aids to be resilient and strong under the difficult circumstances they face, whether it is stress and fatigue regarding an excessive workload, or the nursing and caring

of HIV-infected loved ones, or having orphans and vulnerable children in their classes. The aim was also to assist participants to get closure on participating in the REds programme.

The example of a green twig was used to symbolize resilience:



"Resilient people are like a green twig – they bend and hurt as they experience pressure, but they don't break. In fact, they will even be able to blossom again...!" (REds, 2006).

In other words, this session was to empower affected educators to cope, adapt and continue to lead a life filled with hope. Facets addressed in Session Eight were the following:

- Stay hopeful
- Self care.
- Accept the situation.
- See the situation as manageable.
- Connect with others.
- Use the pandemic for self-growth.

The following activities were included in Session Eight



Video clip about Allie, a HIV-positive student (Walter, Rossen, & Buddy, 1989), which illustrated resilience.



Acceptance: One way of dealing with traumatic experiences is to accept the situation.



In order for educators affected by HIV/Aids to be resilient, participants need to find ways to cope with the pandemic. Participants were asked to recognise the situation as manageable by indicating what they could do to manage the impact of the pandemic.

-  Participants then had to make a list of people and organizations that they, the affected educators, could connect to in order to assist and support them, and in order to receive support.
-  The facilitator told participants they could use the pandemic or any other crisis situation for self-growth. Participants had to answer reflective questions in order to assist them to gain self-knowledge. This activity also empowered participants to visualize hope with regard to stressful situations.
-  Self care: The A-Z of resilience; steps to monitor resilience.
-  Completion of post test.
-  Debriefing of participants with regard to "life after REs".
-  Exchanging of telephone numbers.

5.9.2 Process Notes

A video clip, named "Allie" (Walter, Rossen, & Buddy, 1989), was shown to the participants to let them realize that, although people sometimes go through rough times, they can still have hope and faith. Allie is the story of a first year HIV-positive student. Allie came from a wealthy and well known family who look down upon HIV-positive people. At first her parents were shocked and disappointed, but changed their attitude later on and became positive towards HIV/Aids. Allie and her family even established a fund for HIV-positive people and gave support to such people in various ways. The participants found the video clip on how Allie and her family became positive towards the pandemic and infected people, encouraging and informative. They indicated that this story gave them ideas on how to support the infected and affected.

One of the steps towards becoming resilient in the face of HIV/Aids is to accept that the pandemic is a reality and to find ways of coping with it. The facilitator showed participants statistics on HIV/Aids in Sub-Saharan Africa in 2005 comparable to 2003 (*cf.* Figure 2.3) regarding:

-  people infected with HIV/Aids;

-  women infected by HIV/Aids;
-  newly infected people; and
-  deaths due to HIV/Aids.

The facilitator also gave participants an idea about the HIV/Aids prevalence in South Africa in 2005 (*cf.* Figure 2.1 - 2.5) (Shisana *et al.*, 2005b).

Although participants were shocked when they noticed the devastating incidence of HIV/Aids, especially in Sub-Saharan Africa, they realised for the first time the importance of combating HIV/Aids.

The impact of the reality of HIV/Aids seemed to discourage participants, but they agreed that although we cannot change the reality of the pandemic, we can, however, change the way we respond to it. Participants had to indicate what they could do to manage the impact of the pandemic. Participants indicated that they should organize a multi-disciplinary team to assist orphans and vulnerable children in their classes. They would also organize home-based care or Hospice if they had a loved one infected by HIV/Aids. Participants strongly felt that accurate information about HIV/Aids should be presented to the community and especially at their schools to combat stigma and prevent further spreading of the disease. Some participants were extremely concerned about the number of teenage pregnancies and indicated that teenagers should be thoroughly informed about the dangers of becoming sexually active at an early age.

In order to enhance resilience, participants should accept support and assistance from people who care about them (*cf.* Figure 3.2). Participants were asked to make a list of people or organizations that could help them to be strong, as indicated in Table 5.5:

Table 5.5: List of people and organizations that could assist participants to be resilient

At school	At home	In the community
		
✓ School Governing Body ✓ School Management Team ✓ EST ✓ HAC ✓ The local District Office ✓ SADTU ✓ NAPTOSA ✓ Counselling Services	✓ Family ✓ Friends ✓ Home-based care ✓ Faith-based organizations such as the church for home visits	✓ Faith-based Organizations ✓ Wide Horizon Hospice ✓ Kopanong Hospital ✓ Sebokeng Hospital ✓ Sasolburg Hospital ✓ Zamdela Home-based Care ✓ ATICC ✓ Lifeline ✓ As busy as a Bee ✓ North-West University ✓ Welfare services

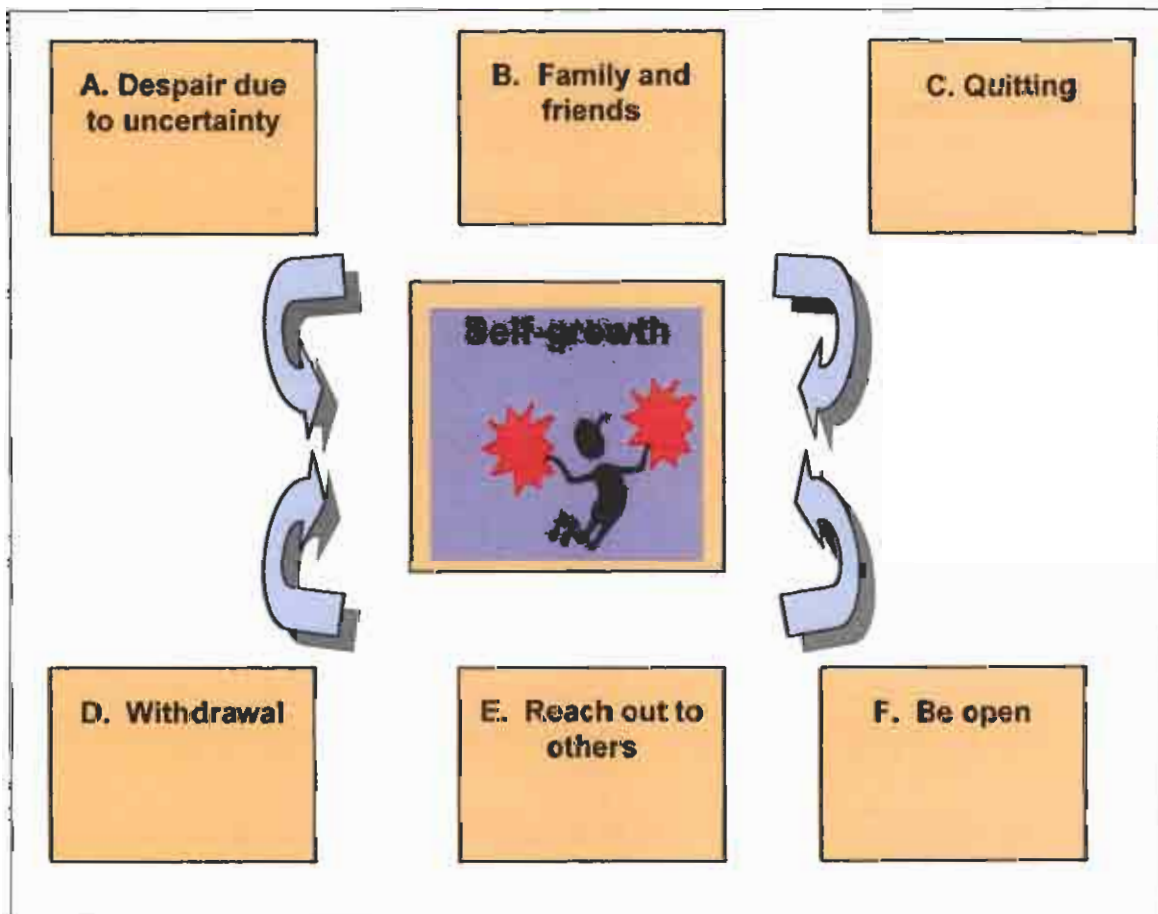
Participants realized that, although they could receive support and assistance, they would also be able to give support and assistance. In helping others, we could become stronger and more resilient, although participants understood the importance of maintaining a good balance between caring for others and caring for themselves.

In order to become resilient, participants discovered the significance of using a crisis for self-growth. They understood that self-growth also entails self-knowledge. Participants were asked to answer the following questions with regard to what they had learned about themselves in a crisis such as the HIV-pandemic. Figure 5.15 illustrates participants' responses to the following questions:

- A) What about the pandemic was most stressful to me and how did this stress affect me?
- B) Who supported me through the stressful times?

- C) What did I learn about myself in these stressful times?
- D) What did I learn about how I interact with others during stressful times?
- E) Which obstacles did I overcome and how did I do this?
- F) What would I do differently next time?

Figure 5.15: Participants' response to self-growth and self-knowledge



Participants reported that the uncertainty regarding their own status, as well as that of their partner, caused them to be uncertain. They also experienced the absence of colleagues, the extra workload and observing the emotional and physical pain of the infected and affected as contributing to their depression and anxiety.

When asked who supported them during stressful times, participants indicated that family members and friends usually support them during difficult situations.

Participants reacted differently as to what they had learned about themselves when experiencing stress. Two participants reported overeating, while the

other participants indicated that they were emotional and experienced insomnia.

On the question what they had learned about themselves with regard to interaction during stressful times, most of the participants reported that they tended to withdraw from other people. One participant, however, indicated that he preferred to go out with his friends when experiencing stress, because it helped him to relax. After such an outing, he was able to put the stressful situation into perspective.

Participants realized that when they reached out to others who also experienced stress or heartache, their problems suddenly seemed not so stressful anymore.

Participants indicated that they would seek information and support regarding stressful situations, such as death and sickness, in future. They also reported that they would never carry their burden alone anymore, because in gaining support, they would also be able to give support.

In order for participants to become resilient, they should learn to become hopeful and try to find solutions to their problems. Participants had to visualize hope by identifying current stressors in their lives. Then they had to try and face the stressors and come up with an alternative or a solution. The following stressors were identified as illustrated in Table 5.6.

Table 5.6: Identified stressors

HIV/Aids		
Current stressors	Solution to current stressors	Interpretation
 Infected colleagues, learners and loved ones.  Affected colleagues, learners and loved ones.  Participants fear their own HIV-status	 To talk openly about the disease.  Be able to support and care for the infected.  There are various organizations such as social workers	 Participants found relief from talking openly about the disease.  Educators realized they could make a difference in the lives of HIV-infected people.

	that can support people affected by HIV/Aids in order to lighten the burden on educators.  Participants should take an HIV-blood test in order to determine their HIV-status.  A solution to the uncertainty regarding your HIV-status is to live a healthy lifestyle.	 Participants realized that people affected by HIV/Aids did not have to suffer alone.  Participants realised that they themselves were affected and should therefore regularly accept support and seek empowerment.  There are organizations and people who can give support, and they themselves can support those in need.  Participants were empowered to realize the importance of knowing one's status.  Participants recognized the importance of being faithful to their partners.
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School environment

 An unapproachable principal with regard to sensitive issues such as HIV/Aids.	 Contact the School Governing Body to assist educators in approaching the principal regarding HIV/Aids.	 Participants realized that the School Governing Body could be approached to assist educators in the fight against the HIV/Aids pandemic.
 Not enough is being done at their schools to support educators and learners infected and affected by HIV/Aids.	 Educators should contact organizations (<i>cf.</i> Figure 3.2 & Table 5.6), such as ATICC and Lifeline for support.	 Participants recognized the important role they had to play at their schools by organizing support groups or workshops which would empower them to face the pandemic.
 Additional workload and responsibilities due to regular absence of HIV-infected or -affected colleagues.	 Educators should attend support programmes such as REs to learn how to give and gain support.	 Participants learned to find alternatives and look for solutions when in stressful situations.
	 Consult the headmaster or a member of the SMT to divide responsibilities evenly among staff members.	
	 Ask parents who are currently not working to assist staff members in supervising learners or assist educators in classes.	

Personal lives

Participants indicated that they were stressed about their partners' infidelity. One participant who was seven months pregnant feared that she, as well as her unborn baby, might be HIV-positive. Participants also indicated that ordinary life stressors such as insufficient funds make it difficult to cope with the impact of HIV/Aids. One participant complained about being obese. Whenever she experienced stress with regard to the HIV/Aids pandemic, she found consolation in food.	It is important to be tested for HIV/Aids. One of the participants would give permission for her and her baby to be tested immediately after the birth of her unborn child. Participants indicated that they would budget in future in order to manage their finances in a better way. The above mentioned participant realized the advantages of a healthy life style and diet.	Participants were not scared to know their status anymore. One of the participants was empowered to face the result of the HIV-blood test. She realised it would be in her own and her baby's best interest to know their status. Participants learned not to wait for others to come up with solutions, but to find solutions to their problems themselves. Participants also learned to make use of organizations providing support to HIV/Aids-infected and -affected people. One of the participants learned that she could defuse stressful situations by doing some exercise such as walking. Participants also realised that they should take care of themselves in order to be emotionally and physically strong.
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Participants were made aware of the importance of self-care in order to manage stress and become resilient. Participants also realized that it is not a crime or a shame sometimes to feel psychologically low due to stressful situations. It would, however, be a shame not to seek help, support and assistance.

In order to be resilient, one must be psychologically "healthy". Participants received an "alphabet", The A-Z of resilience (Theron, 2006b:127-128), to monitor themselves with regard to resilience. Participants were also reminded of various institutions, organizations and people who could be of assistance, such as psychologists, social workers and counsellors from Lifeline and Aids Line.

Participants completed the post-test, which included the following:

-  ProQOL;
-  open-ended questions; and
-  redrawing of symbols.

The results of the post-test will be discussed in detail in Chapter Six (*cf.* 6.2, 6.3, 6.4).

In order to adhere to ethical guidelines (Strydom, 2002a:43), participants were debriefed. The facilitator explained to the participants that, as known from the programme outline, no weekly sessions would be taking place anymore, because they had reached the end of the REds programme. The facilitator warned participants that they could possibly experience emotions such as emptiness, loneliness or sadness. The facilitator reassured participants that these emotions usually occurred after intimate sessions such as the sessions entailed in the REds programme. The participants expressed feeling sad, but also happy, because of the new friends they had made, as well as relieved because of all the skills and information regarding resilience they had received. The facilitator comforted participants by informing them about a follow-up session in three months' time to determine how they would cope with "life after REds". The facilitator invited participants to contact her if necessary.

A telephone list was circulated, because participants felt that they would like to stay in contact with one another. Participants felt that they made new friends and that they cherished these new friendships.

5.10 SESSION NINE

5.10.1 Aim of the session

The aim of Session Nine was mainly to hand out REds Certificates (*cf.* Addendum J), sponsored by North-West University, to confirm participants' involvement in the programme. This session was also about celebrating resilience.

5.10.2 Overview of Session Nine

The following activities were included in session nine:



A Certificate Ceremony where all participants received REds Certificates as proof of their participation.



Participants received a bookmark (*cf.* Addendum I) with telephone numbers of organizations and individuals who could give support.



Lunch was served.

5.10.3 Process Notes

Participants were excited and thrilled about the Certificate Ceremony. These certificates were awarded to the participants to confirm their participation in the programme. Participants were proud and motivated to go out to their families, schools and communities and make a difference, as illustrated in Figure 5.16 below. The painting of Nkosi Johnson is painted on one of the walls of the school where the REds programme was presented. Nkosi, also called The Face of Aids in Africa, was born with Aids and became an Aids activist until his death at the age of twelve in 2001. Together with his foster mother, he founded a refuge home for HIV-positive mothers and their children, Nkosi's Haven, in Johannesburg. In 2005 he was posthumously awarded the International Children's Peace Prize (Wikipedia, 2006).

Figure 5.16: Painting of Nkosi Johnson at Seliba Primary School



Participants indicated that they would like to be remembered one day as someone who made a difference in other people's lives. They believed this would not have been possible had it not been for the REds programme.

Participants gave permission to be photographed during the Certificate Ceremony. Figure 5.17 illustrates one of the proud participants photographed with his certificate.

Figure 5.17: Participant with his REds Certificate



The facilitator presented each participant with a laminated bookmark (*cf.* Addendum I) that contained contact numbers of various individuals and organizations who could be of support.

During lunch, the participants indicated that they felt empowered and experienced a new zest for life. They could not wait to apply the skills and knowledge they had gained through the REds programme. Participants also indicated that they would like the group to come together in three months' time.

5.11 REVIEW SESSION AFTER THREE MONTHS

5.11.1 Aim of the Review Session

The aim of this session was merely to determine if the participants still felt empowered, resilient and motivated to cope with and tackle the impact of the HIV/Aids pandemic.

The following activities were included in the Review Session:

-  An informal conversation on participants' well-being. One of the participants gave birth to a lovely baby girl. Everybody congratulated her. Those who celebrated their birthdays during the past three months were also congratulated. One participant who was in hospital was welcomed back.
-  Questions were asked regarding their experiences of the REds programme, the positive and negative aspects and what shortcomings they experienced.
-  Participants were asked to draw a picture about life after REds, to determine if they were still empowered to face the pandemic.

5.11.2 Process Notes

Participants were genuinely happy to see one another. Participants indicated that the REds programme raised their interest to read and learn more about HIV/Aids. They felt that the REds programme should be extended to other departments, like the Police Department and Correctional Services. One

participant had the idea of training educators as REds facilitators and establishing REds Centres throughout the country, where people could consult REds facilitators. The participants pointed out that their colleagues also wanted to attend the REds programme.

The participants reported that they had experienced life before REds as gloomy and filled with dark clouds, but after REds, the dark clouds were replaced by bright sunrays. The REds programme made them realize that they could not face Aids alone, that everybody infected and affected by the virus, should receive support and assistance from experts. The participants indicated that the REds programme had motivated them to disseminate the "gospel" of HIV/Aids-caring. In this regard, they again mentioned the story of Yulia and Mukasa which had made a huge impression on them and empowered their minds with regard to the pandemic. The participants realised that combating stigma would be their biggest challenge, because of people who do not want to disclose their status.

Some of the participants indicated that they had loved ones at home or family members who were infected and that they used the REds manual regularly to refer to information included in the manual, especially the parts on healthy food and caring for the ill. Another participant was working under difficult circumstances at her school and mentioned that the parts on educators' legal rights and resilience helped her a lot in her situation at school.

All the participants reported that the REds programme encouraged them to move emotionally closer to people. They were not afraid anymore to share their feelings and their status with other people. All of them, including the mother and her newborn baby girl, went for a blood test after the REds programme to determine their status. Participants indicated that they felt strong, motivated, empowered, and resilient (*cf.* Table 6.6).

Participants reported making the question Martin Luther King Jr asked, their own motto in life:



5.12 CONCLUSION

This chapter provided an overview of the process of the implementation of the REds programme. As such it contained the action and description phases of the action research process.

The following chapter, Chapter Six, will entail data analysis of the pre-test and post-test quantitative and qualitative data. Recommendations for the adaptation of the REds programme made by participants will also be discussed in Chapter Six. Chapter Six is therefore focused on the reflection phase of action research.



CHAPTER SIX

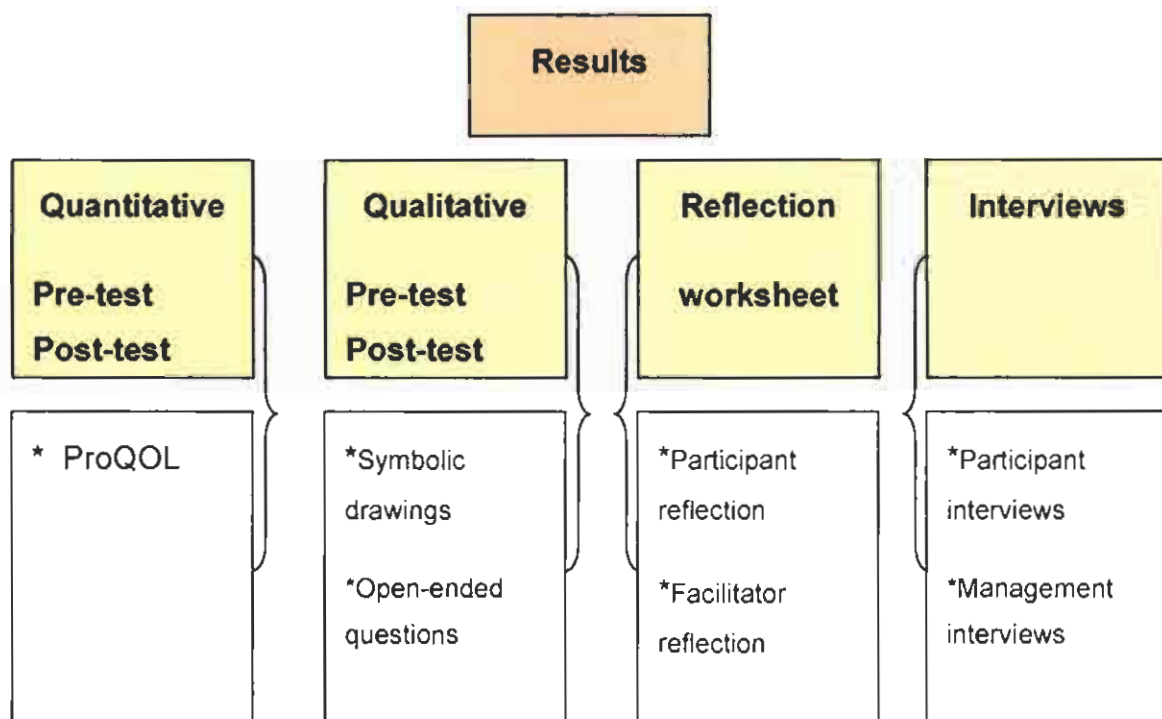
REPORT ON THE RESULTS OF THE EMPIRICAL STUDY



"I feel like a strong train that can carry any kind of load, even the heavy ones. I can go places any time to give support out of love; no matter the distance....!"

- REd's participant, 2006 -

Figure 6.1: Summary of Chapter Six



6.1 INTRODUCTION

Chapter Six overviews the impact of the REds support programme on participants (educators affected by HIV/Aids) in order to finally comment on the efficacy of REds. The results will be discussed according to the pre-test data analysis, as well as the post-test data analysis, consisting of qualitative, as well as quantitative data.

6.2 QUANTITATIVE PRE-TEST AND POST-TEST DATA ANALYSIS

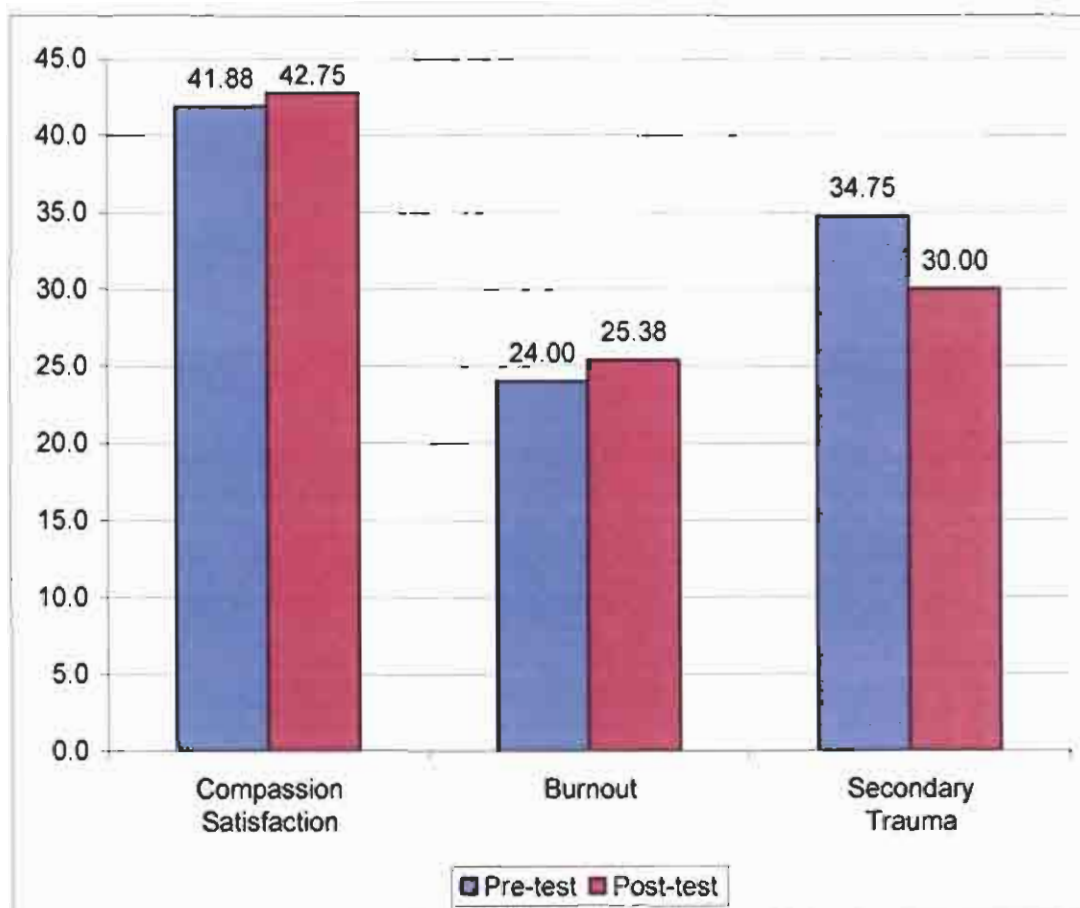
6.2.1 ProQOL results

The quantitative measuring instrument used for the pre-test as well as the post-test for this study was the ProQOL Questionnaire, (*cf.* 4.3.4.1.1). The ProQOL consists of thirty questions (*cf.* Addendum E) and is composed of three scales which determine the following (*cf.* 4.3.4.1.1):

- ✓ compassion satisfaction (C S);
- ✓ burnout (B O); and
- ✓ compassion fatigue, also referred to as secondary trauma (T).

The results of the ProQOL Questionnaire are summarized in Figure 6.2.

Figure 6.2: Results of the ProQOL questionnaire: pre-test and post-test



6.2.1.1 Compassion satisfaction

Figure 6.2 illustrates the slight, but non-significant difference between the pre-test and the post-test with regard to job satisfaction. According to the ProQOL (Stamm, 2005:11), the average score for compassion satisfaction is 37. Approximately 25% of the people score higher than 41 and approximately 25% of the people score below 32. The pre-test score was at 41.88 (above average), which means that participants experienced job satisfaction, despite adverse circumstances. The post-test score of 42.75 designated a slight, but non-significant higher level of satisfaction regarding participants' teaching career. Current literature suggests educator dissatisfaction (Cohen, 2002; Coombe, 2003:11; Hall *et al.*, 2005; Kelly, 2002; Schierhout, 2004; Shisana *et al.*, 2005a; Theron 2005:56,57), therefore it would seem that the participants in this study were more positively disposed to their profession than the average educator. The REds programme did not succeed in elevating compassion satisfaction beyond the original above average levels measured in this sample.

6.2.1.2 Burnout

When participants experience feelings of despair regarding their work environment, they will show a high score in this section. According to Figure 6.2, participants experienced burnout with regard to the teaching profession. The average score on the burnout scale according to the ProQOL (Stamm, 2005:11) is 23. Approximately 25% of the people score above 28 and about 25% of the people score below 19. Scoring below 19 reflects positive feelings about one's effectiveness in the work environment, while scoring above 28 indicates burnout. The pre-test score was 24, which means that participants experienced an average degree of burnout. The post-test score illustrated a mean group score of 25.38, which means that the REds programme did not lower the degree of burnout in this sample. The pre- and post-test scores both suggest average levels of burnout.

6.2.1.3 Compassion fatigue or secondary trauma

The exposure to stressful situations which are work-related, such as exposure to other people's trauma (being affected by HIV/Aids or witnessing learners being orphaned and left vulnerable due to HIV/Aids) could cause secondary trauma or compassion fatigue. The average score on compassion fatigue or secondary trauma is 13. According to Stamm (2005:11), 25% of the people score below 8 and about 25% of the people score above 17. Higher scores indicate clear compassion fatigue or secondary trauma. According to Figure 6.2, participants experienced an above average level of secondary trauma in the pre-test (34.74), before commencing with the REds programme. Although the post-test showed a lower score of 30, which indicates that the REds programme positively impacted on the participants, the score is still far above the average of 8 - 13. This score is a clear indication of the trauma which affected educators experience with regard to the HIV/Aids pandemic. The REds programme (implemented over nine weeks) was not enough to reduce secondary trauma scores to average level.

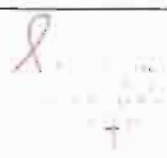
6.3 QUALITATIVE PRE-TEST DATA ANALYSIS

6.3.1 Symbolic drawings

The participants had to draw any symbol that came to mind when thinking about how the pandemic had affected them (*cf.* 4.3.4.1.2). The symbolic drawings are included as Addendum A. The symbols chosen are summarized in Table 6.1.

Table 6.1: Symbolic drawings: Pre- test

PRE-TEST	
Symbolic drawing	Explanation of symbolic drawing
	One participant drew a crying face, because that is how the pandemic is affecting its "prey": loads of tears and broken dreams.
	Another participant also drew a crying face, because whenever she thought about the pandemic, she felt like crying.

	Two participants drew dark clouds, because of the ominous and unpredictable nature of the pandemic.
	One participant drew the aids ribbon, because it symbolized to her the fight against Aids.
	One participant drew the aids ribbon with red raindrops which she called the bloody rain, as well as a grave with two crying orphans next to it. To her the pandemic is deadly.
	One participant drew a red snake, because of his fear of snakes. This can also be seen as a phallic symbol. He explained that he was petrified of contracting HIV.
	One participant drew a tree with falling leaves. The tree symbolized life and the falling and dead leaves symbolized aids victims.

The use of colour in art and drawings reflects the emotion and inner feelings of the artist (Heath, 1997; Hemphill, 1996; Kaya & Epps, 2004,). The use of dark colours, such as black, brown and grey in drawings can mirror negative emotions such as sadness, anger, depression and fear. These colours are associated with death, mourning, tragic events, darkness, night time and winter (Kaya & Epps, 2004). Red is a dynamic colour which evokes positive, as well as negative emotions. On the positive side, red reflects emotions like love and romance, while on the negative side, red evokes intense images of heat, danger, fear, blood, rage and evil (Kaya & Epps, 2004).

The use of black, brown and grey in participants' symbolic drawings may mirror participants' feelings of sadness, anger, depression and fear, while the use of red may mirror participants' feelings of danger, rage and evil.

All the participants agreed that the impact of the pandemic influenced them negatively. This was clear from their symbolic drawings. When the participants individually told the group about their drawings, all of them could relate to the various symbols they had drawn.

6.3.2 Open-ended questions

Table 6.2: Open-ended questions: Pre-test

PRE- TEST		
Question	Participants' responses	Possible interpretation of responses
1. How has the HIV/Aids pandemic affected you emotionally?	 Thinking about the new generation, participants are feeling hopeless to see their loved ones die without being able to do anything to help. They experience stress and depression, are disturbed and often feel like crying. They also experience sleepless nights.	 Participants' responses suggest feelings of despair and very low levels of resilience. This reflects current literature findings (cf. 2.4; 2.4.3.1; 2.4.3.3; 2.4.3.4) regarding the emotional impact of the pandemic.
2. How has the HIV/Aids pandemic affected you spiritually?	 Participants indicated that they often feel stressed, unhappy and down. One participant said she lost hope when thinking about Aids – not believing in the church or reading the Bible anymore.	 Feelings of unhappiness and hopelessness impact negatively on the well-being of participants as mentioned in current literature (cf. 2.4.2.1.2; 2.4.2.2; 2.4.3.1).
3. How has the HIV/Aids pandemic affected you physically (e.g. do you sleep badly / has your appetite decreased; etc.)?	 Participants indicated they have sleepless nights, lose their appetite, are often tired and experience bad dreams about the pandemic.	 From these responses, participants indicate that the pandemic influences their general functioning negatively, which is suggested by current literature (cf. 2.4.3.1).
4. How has the HIV/Aids pandemic affected you socially / how has it changed your social interaction?	 The social interaction has not changed, but now they do not trust anybody, because they are afraid to be infected. In general, the participants indicated that they want to be with someone, unlike being alone, as it "eats one up".	 Although participants reported that they were still socialising, they also reported mistrust and fear. This is possibly a by-product of stigma.
5. How has the HIV/Aids pandemic affected you professionally / impacted on you as an educator?	 All the participants indicated that they are worried, disturbed and concerned about learners who are infected or orphaned due to Aids, and feel hopeless, because of so many colleagues who passed away due to Aids-related causes. This made them realize how important	 Participants experienced a heightened feeling of responsibility towards infected or affected learners. Not all educators have adequate knowledge regarding the pandemic to support learners and

	their career as caregiver is.	colleagues infected or affected by HIV/Aids effectively (Coombe, 2003:10). In order to assist these learners and colleagues, educators need to be empowered, as pointed out in 2.4.3.1; 2.4.3.2; 2.4.3.5.
6. How has the HIV/Aids pandemic changed your daily routine as an educator?	 The pandemic made the participants realize how much the learners need support. It made them feel sad and drained, because they do not only have to attend to the learners on academic level, but also on emotional, social and psychological level.	 Educators have not been adequately trained to be sensitive counsellors, guides and mentors, and they experience a lack of knowledge and coping and supporting skills with regard to HIV/Aids (Coombe, 2003:10). Participant responses reflect this.
7. What has helped you with teaching while the HIV/Aids pandemic rages on?	 Participants indicated that their religion sometimes helped them to cope. One participant reported that she constantly prayed that God may one day end this sickness, while other participants indicated that they were trying to accept HIV/Aids even if it was hard to.	 Participants' responses indicated that they felt helpless, despite their faith. Although they realized they should accept HIV/Aids, it was difficult.

6.4 QUALITATIVE POST-TEST DATA ANALYSIS

The collective pre-test qualitative data mirrors the pre-test quantitative data: these participants appear to be stressed and vulnerable as a result of the impact of the pandemic.

6.4.1 Symbolic drawings

The pre-test instruction was repeated during the post-test as illustrated in Table 6.3.

Table 6.3: Symbolic drawings: Post-Test

POST-TEST	
Symbolic drawings	Explanation of symbolic drawings
	• The participant drew a butterfly and explained it as follows: "I was a caterpillar – my movements were limited, I felt throttled by my depressed situation, but no more, I have undergone some metamorphosis. I have done something about it – I can fly now – I'm a butterfly and I can fly VERY HIGH. I FEEL FREE". • The use of different shades of green evokes positive emotions such as relaxation and comfort, because it reminded the participant of nature, new life and growth. Yellow is a cheerful, lively, energetic and happy colour which can be associated with the sun, summer and blooming flowers (Kaya & Epps, 2004). It seems that this participant was empowered by the REds programme.
	• The participant drew a strong train and explained it as follows: "I feel like a strong train that can carry any kind of load even the heavy ones. I can go places any time to give support out of love no matter the distance." • The colour blue of the train mirrors feelings of relaxation, calmness, happiness, comfort, peace and hope. Together with the cheerful yellow smoke (Kaya & Epps, 2004), the participant indicated that she had been empowered by the REds programme.
	• The participant drew a green leaf and explained it as follows: "I feel like green leaves. Hopeful. At the end there is hope that those who are infected or orphaned will live better lives and get comfort. Food parcels can be given, social grants can be provided, and good medication can be given by the clinics and health workers. Information can be spread all over the world. At the end we shall be like green leaves." • Green represents growth, relaxation, calmness, peace and hope and is associated with nature. Green is also described as a soothing colour (Kaya & Epps, 2004). This participant projects hope in the choice of symbol, its colour and her explanation of the symbol.
	• The participant drew a happy face and explained it as follows: "I'm happy because I was in the dark, but now I am awake and I have knowledge and understanding." • The blue eyes (happiness and hope) and wide, smiling red (energetic) mouth (Kaya & Epps, 2004) illustrates the empowerment this participant experienced from the REds programme.

	• The participant drew a sad figure and explained it as follows: "Coming across difficult situations such as death, orphans struggling to overcome the problem and victims of the deceased make me sad." This participant was generally withdrawn and sad throughout the duration of REds. • The use of black indicates that this participant is possibly still sad and depressed (Kaya & Epps, 2004). For her, REds was not enough.
	• The participant drew a figure with a wide open mouth and explained it as follows: "This picture stands for acceptance. Now I know how to live positively, deal with what I know. I want to know my status. I'll have tolerance." • This participant indicated that she was empowered, because of the information she received at REds. She is determined to know her status, live positively, be open-minded and cope with the pandemic.
	• This participant drew praying hands and the aids ribbon and explained it as follows: "After all the good or bad things happening in life there is hope. Through praying, God is there for us. We can accept the HIV/Aids pandemic." • This participant made use of yellow, because she associated the colour with excitement, happiness and life (Kaya & Epps, 2004). According to Ungar and Liebenberg (2005:218-219), faith is considered to be a protective factor (<i>cf.</i> 1.2). She projects empowerment.
	• This participant drew a smiling face and explained it as follows: "I can go and test, I have hope, I can cope with my stress." • This participant indicated that she was at peace with her situation and that she would be able to face whatever came her way. The use of green possibly illustrates that the participant experienced a feeling of calmness, peace and hope (Kaya & Epps, 2004).

All the participants, except for one who still experienced feelings of sadness and depression, agreed that they experienced feelings of relief, hope and excitement after completing the REds programme. According to their colourful drawings, it is clear that most of the participants were empowered by the REds programme and were feeling more resilient to deal with the pandemic.

6.4.2 Open-ended questions

Table 6.4: Open-ended questions – Post-test

POST-TEST		
Question	Participants' responses	Possible interpretation of responses
1. How has the HIV/Aids pandemic affected you emotionally?	 Participants reported that the pandemic influenced them very badly. They had experienced feelings of depression, sadness and frustration and felt heartbroken at certain stages. However after gaining information, they felt stronger.	 Participant's responses clearly indicate that the knowledge they gained empowered them. REds purposefully aimed at increasing participants' knowledge of the pandemic and possible coping skills.
2. How has the HIV/Aids pandemic affected you spiritually?	 Participants indicated that they have lost faith because they thought that God had forsaken His people. Now, however, they have realized that we are not in this world forever.	 According to participants, the REds programme provided them with information (also about supportive churches which empowered them and accordingly contributed to their level of resilience. Ungar and Liebenberg (2005:218,219) regard faith as one of the protective factors (cf. 1.2).
3. How has the HIV/Aids pandemic affected you physically (e.g. do you sleep badly / has your appetite decreased; etc.)?	 Participants reported that they have lost weight and struggled with sleeplessness, but learned to accept the situation and feel better now.	 Participants reported heightened awareness of self-care and acceptance of the pandemic. This may have mediated the impact of the pandemic on them physically.
4. How has the HIV/Aids pandemic affected you socially / how has it changed your social interaction?	 Participants indicated that they have interacted with people more than ever before and they experienced it as part of a healing therapy.	 Participants reported that REds helped them not to be ashamed to talk openly about their feelings – thus they have been empowered.
5. How has the HIV/Aids pandemic affected you professionally / impacted on you as an educator?	 Professionally the pandemic also impacted negatively on educators with regard to Aids orphans, infected learners and colleagues, as well as procrastination, but REds made them aware of how to deal with these problems.	 Participants indicated that REds equipped them with knowledge of how to comfort the children, to make an end to procrastination, and how to make a difference in their community. In other words, participants seemed to have been empowered by REds which resulted in higher levels of resilience.
6. How has the HIV/Aids pandemic changed your daily routine as an educator?	 REds made them aware of: - transmission; - how to handle infected and affected learners and	 Participants suggest that the knowledge and information they had gained from REds, provided them with skills to face

	colleagues; - how to cope with their heavy work-load due to colleagues' absenteeism.	the impact of the HIV/Aids pandemic in their daily routine.
7. What has helped you to cope with teaching while the HIV/Aids pandemic rages on?	 Participants indicated that REds made them aware of how to care for infected people and how to cope with the pandemic.	 Participants reported that REds was very informative and equipped them to be strong and resilient. They therefore felt empowered and this helped them to cope.

6.5 CONCLUSION REGARDING THE EFFICACY OF REDS, BASED ON PRE-TEST AND POST-TEST DATA

During the pre-test, participants reported throughout that they experienced fear and uncertainty, depression, disturbance, fatigue and concern with regard to their future, as well as that of their loved ones and learners. Overall, participants felt doomed, ignorant, hopeless and desperate. Participants also made use of dark colours, such as brown, grey and black combined with red in their drawings to express fear (Kaya & Epps, 2004).

Although participants generally reported in the post-test to experience feelings of enthusiasm, hope, perseverance, motivation, strength, comfort, faith and freedom, they were realistic about the remaining challenges regarding the pandemic. Because participants were empowered by all the information they gained, they felt capable to face the challenges realistically. The ability to be realistic about your circumstances is a protective factor which contributes towards resilience in individuals.

From the above-mentioned the REds support programme apparently made a difference in the lives of the participants. In the following section their direct views on the REds programme are reported.

6.6 REFLECTIONS ON REDS

6.6.1 Participants' reflection after each session

Participants were asked to reflect critically on each session at its close in order to improve the REds programme could be improved. Table 6.5 summarized participants' reflections regarding the REds support programme.

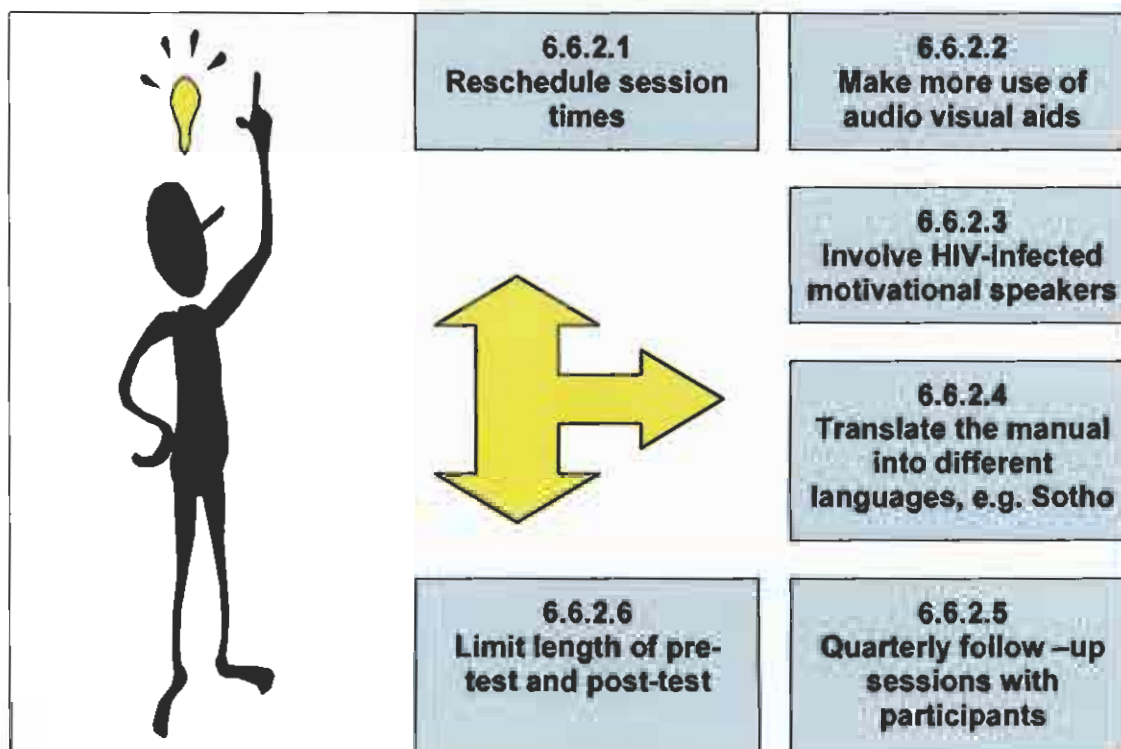
Table 6.5: Participants' reflections on each session

Session One Introduction	Session Two How to give and gain support
The participants reflected positively on the information that they received and they felt more confident and open-minded to talk about the disease. They indicated that they looked forward to the following week's session. However, they did not approve of the questionnaires, because they felt they were too long and time-consuming.	The participants felt excited about the fact that they as educators could support affected and infected people. They also felt empowered about knowing where and to whom they could turn for help. They reflected that the contents of Session Two should remain unchanged in future.
Session Three How to cope with stigma	Session Four How to cope with stress
The participants felt it helped them to share their feelings with the group, because they were without hope and then they realized that there was hope after all. One participant did not approve of the drawing activity, because she experienced it as time-consuming and felt that she was not good at drawing pictures. The other participants felt that this session was very helpful and rewarding.	Participants felt empowered to be able to identify their stressors, to address their stressors and could give themselves the "permission" to put the burden down. The measures on how to relieve stress, as well as time management were identified as most helpful in the day's session. One participant felt the relaxation music tape should have been longer, although it was played fully. Some of the participants complained about the type of music used in the relaxation exercise (cf. 6.8.3)
Session 5 Workplace policies on HIV/Aids	Session 6 How to combat Aids at school
The participants found the information regarding their rights very informative and educative. One participant felt that we could have spent more time on the rights of educators, because of the extensiveness of the subject.	The participants found the facts, myths and phases about HIV/Aids and how the virus works inside the body, as well as the posters and flash cards, most helpful. Also the different meanings of HIV/Aids were educative. One participant felt that audio-visual aids should have been used.
Session 7 How to care for the sick at home	Session 8 Resilience
The participants felt that the information regarding how to care for the infected person and to make a memory box was very informative and that it prepared them for what to do in case there was a sick person at home. Another affected participant said that she was going to use these guidelines. One participant felt that this module was an eye-opener for the infected, the affected, as well as the care-giver and educator.	Participants realised that a resilient person conquers all, no matter how difficult the situation is. Another participant said that she gained a lot, because, it felt good to talk, and laugh and discuss everything. She felt strong and brave.

6.6.2 Facilitator's reflection

The changes recommended by the researcher are illustrated in Figure 6.3.

Figure 6.3: Recommended changes



6.6.2.1 Reschedule session times

Due to the fact that participants attended sessions on a Friday afternoon after school, the researcher found that participants were tired and easily lost concentration. The researcher recommends that the sessions start early on a Saturday morning or during the holidays. Since a number of questionnaires must be completed, the researcher believes it would be better if participants complete questionnaires on a specific day before the commencement of the REds programme, or in the morning while they are still fresh. Participants complained about all the questionnaires, therefore the researcher recommend that they be reduced or shortened. Participants tended to write down or mark anything, just to finish.

6.6.2.2 Make more use of audio-visual aids

The researcher made use of a number of large, colourful visual aids, such as pictures and a video clip, since the school where implementation occurred was not equipped to use other visual aids. The researcher would, however, recommend the use of audio-visual aids, such as a computer and proxima

where photos and pictures could be presented more easily. Participants indicated that they enjoyed the visual presentations more.

6.6.2.3 Involve HIV-positive speakers

The researcher believes that participants would have been more at ease if somebody who was infected with HIV would talk to them from her experience as an infected person. Participants indicated that they would like to learn more from the infected concerning how they experience HIV/Aids and what support they require, in order being able to support learners, loved ones and colleagues.

6.6.2.4 Translate the manual into different languages

The REds programme was presented in English. The researcher believes it is necessary to translate the manual into other languages as well, such as Sotho, Afrikaans and Zulu, because people express themselves better in their mother tongue. This will be of special value in the pre-test, post-test and questionnaires.

6.6.2.5 Quarterly follow-up sessions

In order to monitor participants' well-being, the researcher recommends quarterly follow-up sessions with participants. Participants also indicated that they would value quarterly follow-up sessions.

6.6.2.6 Limit length of pre-test and post-test

When completing the ProQOL in the pre-test, the researcher believes that participants' need to impress should be borne in mind when positive results are interpreted. Due to the fact that participants complained about the length of the pre-test and post-test, the length should be limited.

6.7 INTERVIEWS

6.7.1 Participant interviews (cf. Addendum D)

6.7.1.1 Post-test semi-structured interviews with participants

During individual interviews, all the educators felt that the REds programme gave them hope and perspective. They said the REds sessions had changed their attitude towards the pandemic and infected and affected adults, colleagues, learners, loved ones and orphans. *"I only realised after REds that Aids is an illness just as diabetes and cancer."* They were no longer afraid to touch or hug infected people and they were not afraid to use the same utensils, such as pencils, anymore. Now they know how to care for and deal with the infected and affected, especially with the learners in their classes. *"I have an infected learner in my class and could never answer his questions. Now I know how to support him."* REds empowered them to treat the infected and affected as normal people. REds also informed participants on how to care for the sick. Personally and professionally they felt strong and positive, and this attitude would help the learners in their classes to experience hope and faith in the face of the pandemic. *"I always thought that Aids was like a death sentence. Infected people can live up to 15 years if they receive treatment."* Participants reported that the REds programme equipped them with the necessary skills to fight the disease. *"I've learned so much from REds. I'm not afraid anymore, I can cope."*

6.7.1.2 Post-test semi-structured interviews with management (cf. Addendum F)

A week after the last session, the researcher interviewed the principal of the one school and a Member of the Management Team (MMT) whose staff members attended the REds programme at their offices at a time convenient for them. The first interview was scheduled from 14:30 until 15:00 and the second interview was scheduled from 15:15 until 15:45. Both the principal and the MMT were very positive towards the REds programme. They experienced that the educators who attended the REds programme influenced the staff and the learners positively with their sudden zest for life, as well as their change of

attitude towards the pandemic. At one stage, the educators of one of the schools had to attend the funeral of a colleague who died of Aids. All the educators of his school paid their condolences to the deceased's next of kin by means of a hug – something they would never have done in the past. All of a sudden these educators emanate hope and faith and the MMT said the rest of her staff could not wait for a Monday morning, because they all wanted to know from the REds participants what had happened the previous Friday at the REds course. The learners could also sense the new atmosphere of enthusiasm and energy at their school. For the first time, participants had informative answers to questions asked by community members as well as by learners.

6.7.2 Conclusion to post-test semi-structured interviews with participants and management

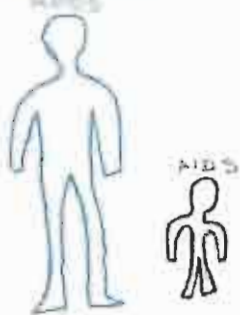
Participants and management suggested the following for future REds interventions:

-  All the participants and principals felt that the REds programme should continue and the information they had gained should be shared with other educators and schools.
-  In retrospect they felt that it would make a big difference if the REds manual could be translated into different languages.
-  They also felt that review sessions should take place at least once a term.
-  Participants also indicated that the purpose of review sessions should be for reflection and should be informal.
-  The participants felt that some of the sessions should involve HIV-positive people to speak about the illness from their own experiences.
-  One participant mentioned the idea of REds receiving a certain time slot on the radio where REds facilitators can discuss issues such as caring for the ill.

6.7.3 Participants' responses after three months

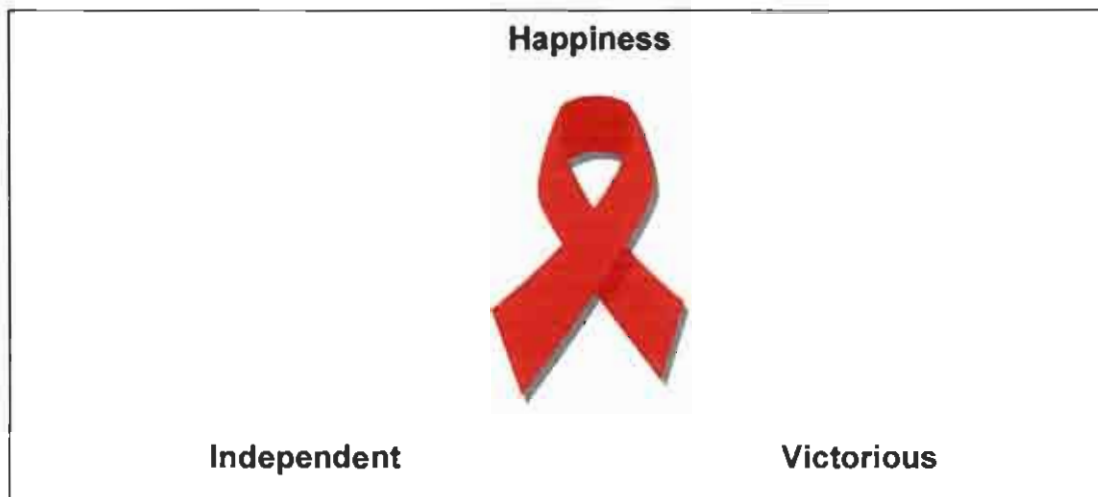
Three months after the last session took place, the researcher scheduled another session with the participants to reflect on REds (*cf.* 4.3.4.1.2). Participants were asked to draw a picture in which they illustrated what the REds programme meant to them, as indicated in Table 6.6.

Table 6.6: Participants' drawings of how they experience "Life after REds"

Participant's drawing	Interpretation of drawing
	This participant drew himself as a very big man in comparison with HIV/Aids which was represented as a very small, insignificant figure. This participant illustrated power and empowerment. The use of blue in the big figure suggests peace, hope and calmness, while the smaller black figure may illustrate that the participant still experiences Aids as a killer disease (Kaya & Epps, 2004). Nevertheless, with REds he is larger than the Aids figure.
	This participant drew herself as a lovely, healthy smiling green twig. Her picture expresses hope and resilience. The use of green suggests growth, the blue eyes suggest happiness and peace, and the wide red smiling mouth mirrors energy (Kaya & Epps, 2004).
	This participant drew Aids as a red monster and children and young people should be taught about this "monster". Although this participant still experiences Aids as a monster, her picture also expresses empowerment to speak more freely about HIV/Aids and to teach her learners the dangers of an unhealthy lifestyle. The use of red in this drawing possibly mirrors evil, while the green figures in the background illustrate hope and growth (Kaya & Epps, 2004).

	This is a picture of a lady and a girl with broad smiles on their faces and with the words "HIV/AIDS Positive" written in the picture. This can be interpreted as a teacher (participant) who has changed her attitude towards the disease and her positive attitude will positively influence her learners.
	This participant drew a man from whose mouth appeared words like: "Do not despair" and "Live cautiously", "Life after disclosure is better, because you know your status". The picture also expresses hope and empowerment, because of the information and knowledge they have gained regarding HIV/AIDS.
	This participant drew a red REds house and a crying lady with the inscription: "We can come to this place". This participant clearly received comfort and reassurance from the programme, which can also be interpreted as a sense of empowerment, hope and resilience, although she still experiences a level of sadness.

Only six participants could attend this last session, because two of the ladies had to attend a compulsory course initiated by GDE. From the pictures illustrated in Table 6.6 it is clear that the REds programme definitely served its purpose – to provide educators affected by HIV/AIDS with skills which would empower them to be resilient in the face of the pandemic, as in the case of one participant who changed the acronym HIV to:



6.7.3.1 Conclusion on participants' responses after three months

There was an obvious difference in the appearance and attitude of participants during the researcher's visit after three months. Participants were more relaxed and positive. Their symbolic drawings were colourful and suggested hope. The REds support programme apparently empowered these affected educators and enabled them to go out and make a difference.

6.8 IMPLICATION FOR FUTURE REDS

The aim of this study was to determine the efficacy of the REds programme. The research clearly indicated which facets of the REds programme could be omitted, which facets should be changed and which facets could be used for further re-implementation as summarised in Figure 6.4.

The researcher based the overall conclusions and recommendations for the efficacy and adaptation of REds on all data collected from participants, such as reflection worksheets, drawings of participants and interviews with participants and management.

Figure 6.4: Implication for future REds – final stage of action research

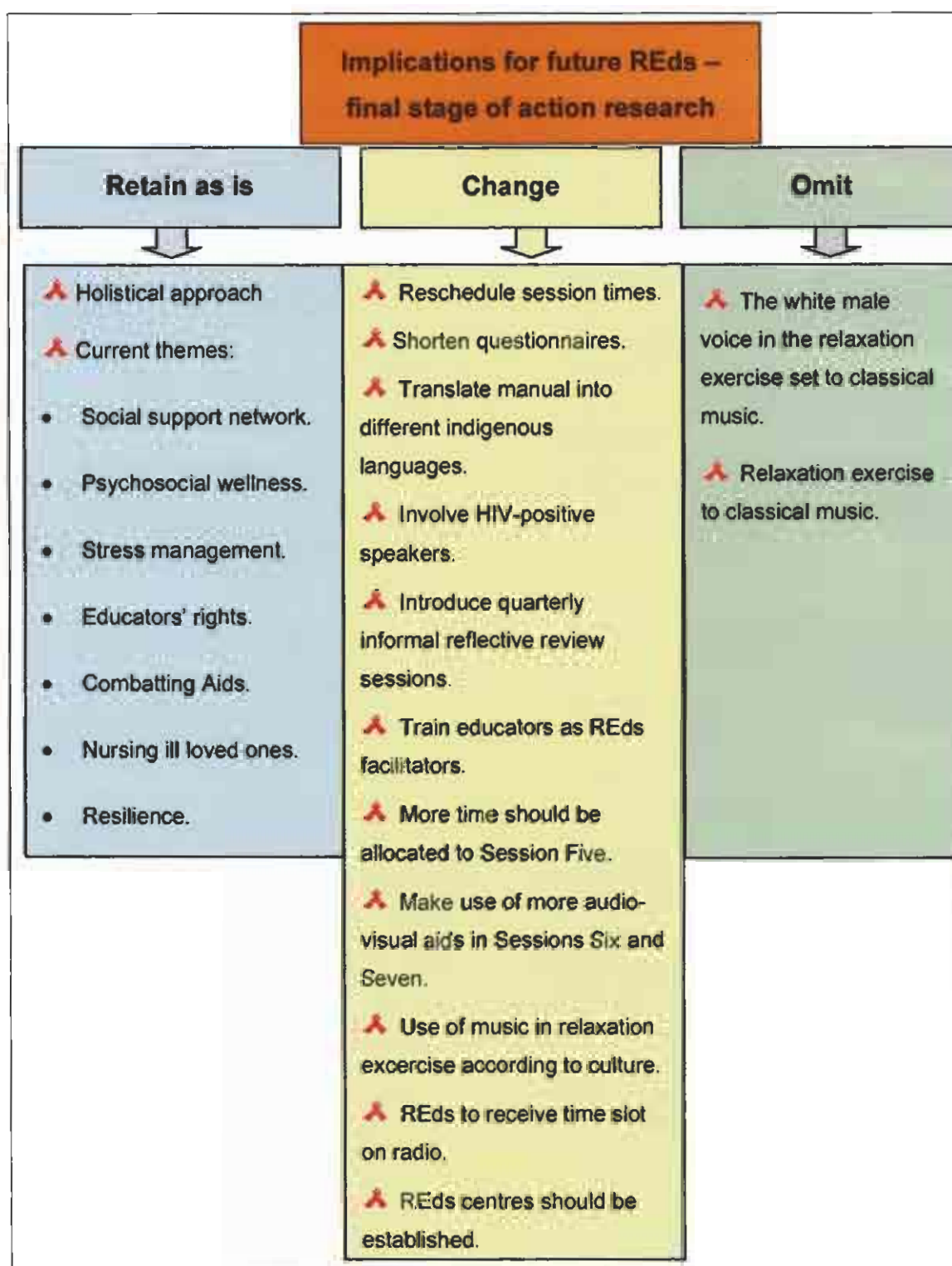


Figure 6.4 summarized the implication for future REds programmes and will be discussed below:

6.8.1 Facets to be retained

As can be deduced from Figure 6.4, participants did not find fault with the contents of REds.

6.8.2 Facets to be changed

Recommended changes did not relate to thematic content, but to presentation style and frequency as summarised in Figure 6.4 and as discussed in 6.6.2.

In addition, participants make the following recommendations:

-  One participant mentioned the idea of REds receiving a certain time slot on the radio where REds facilitators can discuss issues such as caring for the ill. In this way communities will be made aware of the existence of a support programme such as REds.
-  Participants also recommended that educators should be trained as REds facilitators.
-  REds centres should be established so that the programme could be accessible to everybody.
-  The REds programme should be implemented at every school and become part of the curriculum. The programme will be altered for the learners.
-  Educators should also form partnerships with other stakeholders such as social workers.

6.8.3 Facets to be omitted

The session on stress management was concluded by relaxation exercises involving classical music. The voice of a white male could be heard throughout the exercise. Although none of the participants complained about the voice, the researcher believed it would be better to omit the voice in light of perceptions among certain cultures regarding white males being oppressors.

Three of the eight participants indicated that the music should be omitted, while one participant indicated that the music exercise should have been done for a longer period.

6.9 CONCLUSION

It would seem from the results of the pre-tests and the post-tests provided in Chapter Six that educators affected by the HIV/Aids pandemic reacted positively to the REds programme and benefitted from the programme. It cannot be decisively concluded that REds alone was responsible for the empowerment. Hope and a more positive attitude were noted in the post-test because this study depended on a one group design. Nevertheless, participants did verbalise having experienced that the REds programme affected this improvement for them. It is also clear that the REds programme needs to be modified in terms of presentation in order to be even more effective.

Chapter Seven will provide a summary of the study.



CHAPTER SEVEN

SUMMARY OF THE STUDY



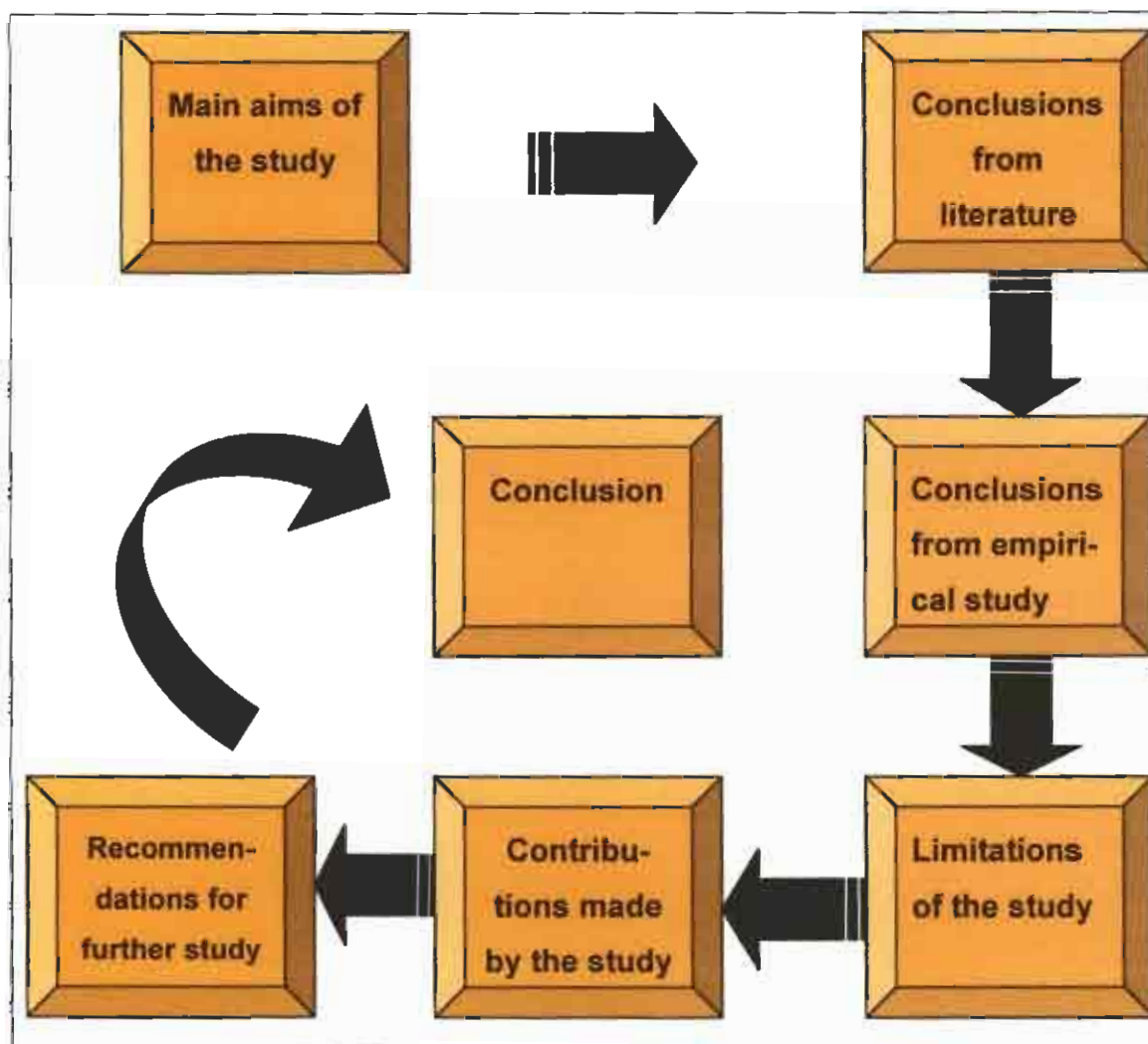
"I long to accomplish a great and noble task, but it is my chief duty to accomplish small tasks as if they were great and noble.

– Helen Keller –

7.1 INTRODUCTION

A summary of the contents of Chapter Seven is illustrated in Figure 7.1:

Figure 7.1: Summary of Chapter Seven

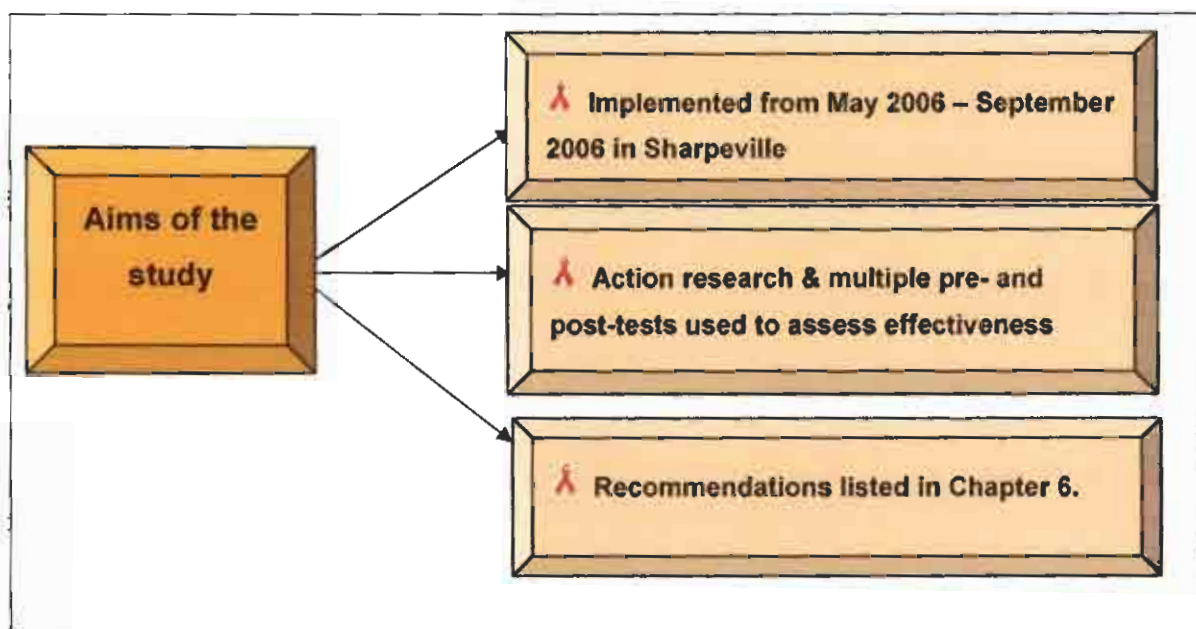


7.2 AIMS OF THIS STUDY

The main purpose of this study was to gauge how effectively educators affected by the HIV/Aids pandemic can be supported, using the REds support programme. In other words, the aim of this study was programme evaluation.

Figure 7.2 presents an overview of the aims (*cf.* 1.3 & 4.2) achieved in this study:

Figure 7.2: Aims of the study



7.2.1 Aim achievement

-  The REds programme was implemented weekly from May 2006 until September 2006 at a time suitable for all participants. The programme was presented at Seliba Primary School in Sharpeville. Eight participants voluntarily took part in the programme.
-  By means of action and experimental research, the researcher determined the effectiveness of REds by using multiple pre- and post-tests (*cf.* 7.4).
-  One of the advantages of action research is that the researcher, as well as participants, is invited to reflect on the efficacy of the action taken. The researcher and participants were invited to make recommendations

for future REDs implementations. These recommendations are listed in Chapter Six.

7.3 CONCLUSIONS MADE FROM THE LITERATURE

From an intensive literature study, the following conclusions were made by the researcher as summarized in Table 7.1

Table 7.1: Conclusions made from the literature

The HIV/Aids pandemic world-wide 	 The HIV/Aids pandemic is wreaking havoc worldwide, due to: - increasing numbers of infection; and - increasing numbers of orphans (Blandy, 2006; Lewis, 2006; Mulder, 2005:4; Mulder, 2007:12; Noble <i>et al.</i>, 2005:2; Sachs & Sachs, 2004; Sjabalala, 2006; UNAIDS, 2005; UNAIDS/WHO, 2005).
The HIV/Aids pandemic in South Africa 	 South Africa is one of the countries with the highest HIV/Aids rates in the world.  According to Lewis (2006) and Sjabalala (2006) between 600 and 1000 people die of Aids in South Africa per day.  Sjabalala (2006) reported that 1000 new infections take place in South Africa per day.  The 2005 estimate of orphans in South Africa was 2, 5 million (Shisana <i>et al.</i>, 2005a).  Two comma six percent of children between 12 and 18 years of age identified themselves as heads of households (Shisana <i>et al.</i>, 2005a).

Impact of HIV/Aids on education



According to Isaacs (2005:4), one in eight (1:8) educators in South Africa is HIV-positive.

Kelly (2002) estimates that some 88 000 to 133 000 educators will have died by 2010.

Not only educators are infected, but also student educators, learners and education administrative staff (Shisana & Simbayi, 2005:xv).

HIV/Aids impacts negatively on:

- quality of education;
- demand for education;
- supply of education; and
- the educator (Bennell, 2005a:450; Boler & Jellema, 2005:12-14; Cohen, 2002, Coombe, 2003:3; Hall *et al.*, 2005:3; Kelly, 2002; Shisana *et al.*, 2005b:112).

Types of support



From the literature study it is evident that no provision is made to implement intervention programmes for educators affected by HIV/Aids (Hall *et al.*, 2005:30; Shisana *et al.*, 2005b:xxi; Simbayi *et al.*, 2005:134-139; Theron, 2005:56-60).

The following types of support are discussed in this study (Coombe, 2003:1,143 Hall *et al.*, 2005:30; Kelly, 2002; Shisana & Simbayi, 2005; Shisana *et al.*, 2005a; Shisana *et al.*, 2005b;):

Community support.

NGO support.

Welfare support.

Faith-based support.

- ⚠ Workplace support.
- ⚠ Support for the infected.
- ⚠ Psychological support.
- ⚠ Support for orphans and vulnerable children.

Educators revealed the following support needs as reflected by current literature (*cf.* 3.4):

- workshops;
- manuals;
- awareness programmes;
- information regarding healthy living;
- curriculum development;
- safe sex messages;
- provision of treatment;
- financial assistance;
- emotional support;
- material support;
- mobile clinics; and
- assistance regarding substitute teachers (Hatane, 2005; Kelly, 2002; Simbayi, *et al.*, 2005:122-123; Theron, 2006a: 23-27).

From the literature study it is clear that the HIV/Aids pandemic impacts negatively on educators. Current literature calls for educator support to cope with the pandemic's impact (Bennell, 2005a:460; Hall *et al.*, 2005:30; Kinghorn & Kelly, 2005; Shisana *et al.*, 2005a: xxi; Simbayi *et al.*, 2005:139). Currently there is no documented support for affected educators and this prompted the compilation and implementation of REds.

7.4 CONCLUSIONS MADE FROM THE EMPIRICAL STUDY

In order to determine the efficacy of the REds programme, it was implemented over a nine-week period with eight volunteer participants in Sharpeville. The implementation followed an experimental and action research framework (participants reflected weekly on the effectiveness of each module and proposed changes). Pre- and post-tests were also used to determine the effectiveness of the REds programme.

The following is concluded from the quantitative and qualitative data as reported in Table 7.2:

Table 7.2: Conclusions made from the empirical study

Quantitative data			
ProQOL	Pre-test	Post-test	Significance
Compassion satisfaction	41.88	42.75	A non- significant increase in the level of satisfaction regarding teaching careers was reported after REds.
Burnout	24.00	25.38	Both the pre-test and post-test indicated an average level of burnout among educators. The non-significant increase might be as a result of educators being more sensitive to the plight of Aids orphans and affected and infected colleagues, and learners following REds.
Compassion fatigue (secondary trauma)	34.75	30.00	The decrease in the compassion fatigue score is non-significant and shows that participants still experienced above average levels of compassion fatigue following REds. The decrease in the score does suggest that participants experienced some relief following REds.

Qualitative data			
	Pre-test	Post-test	Significance
Symbolic drawings	Participants' drawings reflected feelings of sadness, anger, depression and fear (cf. 6.3.1).	Participants' drawings reflected signs of hope and faith (cf. 6.4.1).	The post-test drawings reflected participant empowerment regarding to the impact of the HIV/Aids pandemic.
Open-ended questions	Responses suggested that the HIV/Aids pandemic affected participants negatively. Participants experienced feelings of despair, worry, unhappiness, disturbance and concern (cf. 6.3.2).	Participants reported to feel relieved and empowered because they gained valuable information, which contributed to their level of resilience. This information also equipped them with skills to cope with the pandemic (cf. 6.4.2).	Although participants remained realistic about the challenges they had to face regarding the pandemic, they reflected a sense of empowerment and renewed motivation following REds.

The quantitative, as well as the qualitative pre-test data clearly indicated affected educators' need for empowerment. The post-test data indicated feelings of hope and empowerment, which could be an indication of the positive impact REds had on educators affected by HIV/Aids.

The main aim of this study was to determine the efficacy of REds as an intervention programme for educators affected by the HIV/Aids pandemic. From the empirical research conducted, the researcher concluded that REds was efficacious in supporting the participants of this study. The researcher bases this on the comparison of pre- and post-test data and on participant reflections and the reflections of their management staff. The quantitative pre- and post-test data showed no significant results, but did suggest some improvement and possible heightened awareness. The quantitative post-test data also suggested the possible need for continued intervention. Overall, however, the evaluation of the REds programme in this pilot implementation

was positive. To determine this conclusively, further implementation using a pre-test – post-test control group design (Leedy & Ormrod, 2005:236) is needed.

Because this study also followed an action research paradigm, participants were also asked to comment weekly on the effectiveness of REs. Their comments were used to amend REs for future implementations. The following recommendations based on the empirical study were made, as summarized in Table 7.3.

Table 7.3: Summary of recommendations based on the empirical study

Effective components	REs	Ineffective components	REs	Recommended additions to REs
 Holistic approach.  Current themes: • Social support network. • Psychosocial wellness. • Stress management. • Educators' rights. • Combatting Aids. • Nursing ill loved ones. • Resilience.		 The white male voice in the relaxation exercise set to classical music.  Relaxation exercise to classical music.		 Reschedule session times.  Use shorter questionnaires.  Translate manual into different indigenous languages.  Involve HIV-positive speakers.  Introduce quarterly informal reflective review sessions.  Train educators as REs facilitators.  More time should be allocated to Session Five.  Make more use of audio-visual aids in Sessions Six and Seven.  Use of music in relaxation exercise according to culture.  REs to receive time slot on radio.  REs centres should be established.

7.5 LIMITATIONS OF THE STUDY

The following limitations were recorded:

⚠ No generalization can be made from this study, because only eight participants took part in this study.

⚠ The researcher made use of a purposive convenience sample which means that all participants came from the same geographical region, therefore the findings cannot be generalised to all populations.

⚠ Prospective participants were recruited by announcements in school staffrooms and word-of-mouth, which created two forms of sampling bias:

- Recruiters may have approached educators whom they knew to be affected – such knowledge may have stemmed from these affected educators being more expressive or more publicly forthright about their experience.
- The participants who volunteered first may well have experienced the impact of the pandemic more keenly and were therefore eager to participate in REs and eager to be empowered.

⚠ This sampling bias could imply that participants in this study may not be truly representative of all affected educators – this must be borne in mind when conclusions are drawn from the data.

⚠ Participants who voluntarily took part in the research were all black educators from primary schools. This limits the generalization of this study to affected educators at high schools and educators from other races.

7.6 CONTRIBUTIONS MADE BY THE STUDY

⚠ Information with regard to HIV/Aids prevalence, as well as the impact of HIV/Aids on affected educators from current literature is categorized and summarized, which makes the information more accessible.

⚠ This study was implemented in Sharpeville and it had a positive community spin-off. This study made the community realize what impact

HIV/Aids has on affected educators because participants began to speak freely about REds in their community.



Participants gained important information regarding HIV/Aids, which could assist them personally and professionally.



Participants realized the importance of disclosure and are willing to spread the advantages of disclosing one's HIV-status.



The study provided participants with information regarding various types of support. They were provided with telephone numbers and internet contacts and this enlarged their network of potential resources.



This study suggests that participants valued REds and found it to be effective. In so doing, this study provides a support tool for black, primary school educators affected by the pandemic.



This study made a number of recommendations for the improvement of REds. By suggesting improvements, this study provides a potentially better support tool for future implementations with educators who are affected by the pandemic.

7.7 RECOMMENDATIONS FOR FURTHER STUDY

The following are recommended with regard to further studies:



REds should be implemented as a weekend intervention and its efficacy should be compared to that of the weekly programme.



REds should also be implemented with high school educators to determine whether it is equally efficacious in supporting them.



It is recommended that REds should be implemented with Coloured, Indian and White educators to determine its efficacy among other cultures as well.

7.8 CONCLUSION

Although much had been done to accommodate HIV-positive individuals, little had been done for the silent sufferers of the pandemic – amongst others the

affected educator. The pandemic negatively influences the morale and performance of affected educators. These affected educators experience trauma and depression and suffer due to their extended workloads. The question arises: "What will happen to our children if our educators collapse?"

Therefore it is necessary to ignore boundaries of silence, stigma and non-support and reach out to educators affected by HIV/Aids by empowering them to cope with all the challenges regarding the pandemic. The health of a nation is everyone's business, therefore it is important to reach out to one another – together we can tackle this disease, as Nelson Mandela said:

"We have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now.

The time to act is now!"

Based on this study, the REds programme is recommended as one possibility to reach out and support educators affected by the pandemic.



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ADDENDUM A
SYMBOLIC DRAWINGS:
PRE-TEST

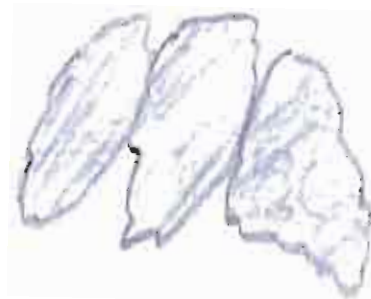
Participant 1



Participant 2



Participant 3



Participant 4



Participant 5



Participant 6

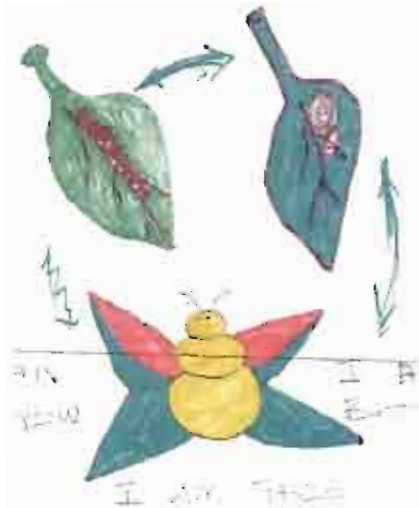


Participant 7

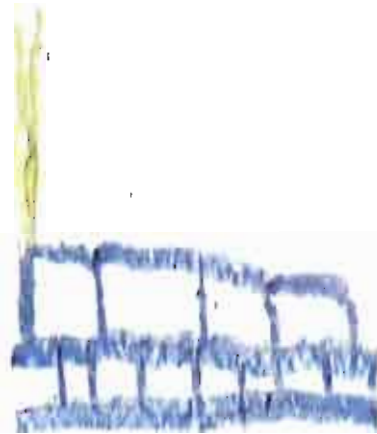


SYMBOLIC DRAWINGS POST-TEST

Participant 1



Participant 2



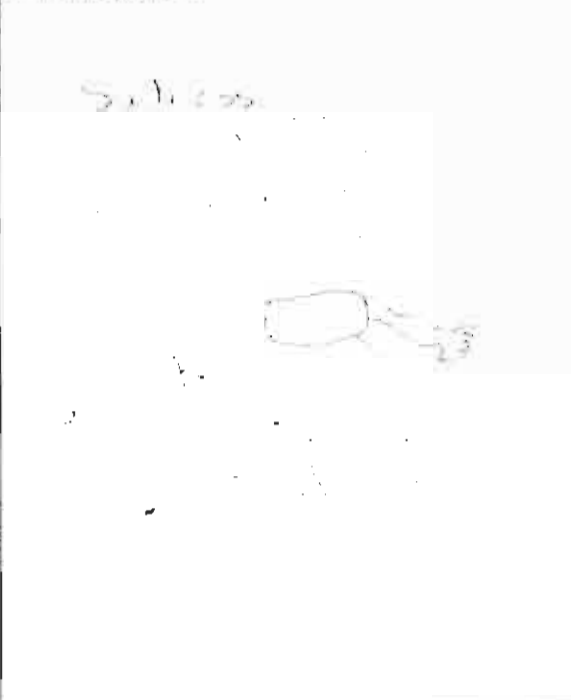
Participant 3



Participant 4



Participant 5



Participant 6



Participant 7

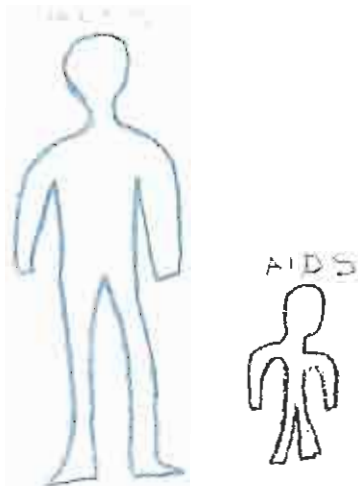


Participant 8



SYMBOLIC DRAWINGS
DELAYED POST-TEST

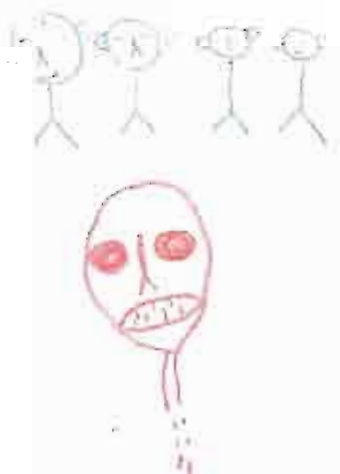
Participant 1



Participant 2



Participant 3



Participant 4



Participant 5



Participant 6



ADDENDUM B

PARTICIPANTS' VISUALIZATION OF DEATH

Participant 1



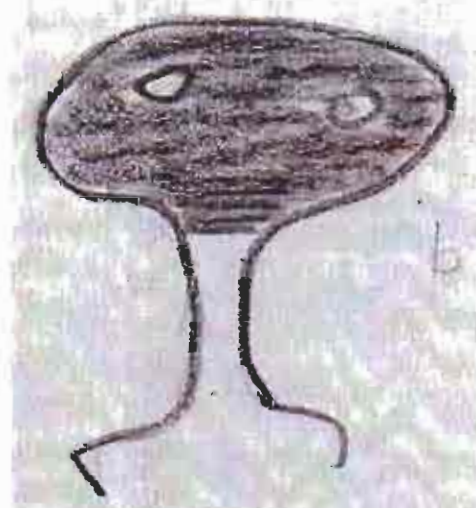
Participant 2



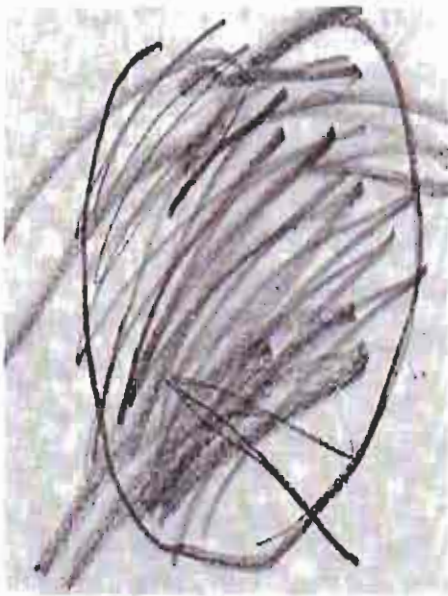
Participant 3



Participant 4



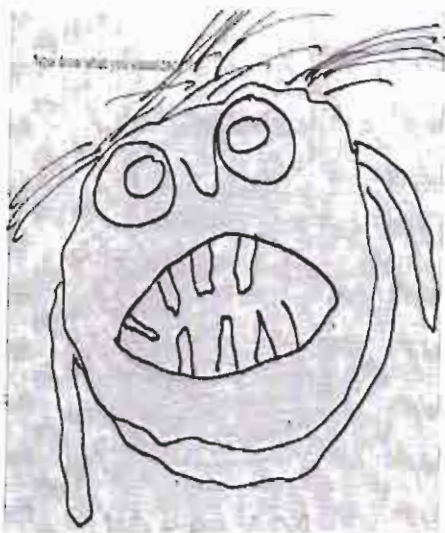
Participant 5



Participant 6



Participant 7



Participant 8



ADDENDUM C

RESPONSES TO OPEN-ENDED QUESTIONS – PRE-TEST

1. **QUESTION 1: How has the HIV/Aids pandemic affected you emotionally?**

2. **Participant 1:** By thinking of the new generation.
3. **Participant 2:** Badly! When seeing the infected people I feel like crying.
4. **Participant 3:** That feeling of despair – watching your loved ones dying
5. without doing anything to help.
6. **Participant 4:** I am full of stress.
7. **Participant 5:** I'm depressed because my younger sister passed away.
8. **Participant 6:** I always feel sorry for those who are infected. You also loose
9. people you love.
10. **Participant 7:** HIV/Aids pandemic affected me emotional (*emotionally*), because
11. we had buried many of our colleagues that affected me.
12. **Participant 8:** Sometimes I don't sleep and I will sleep late and wake up crying.

13. **QUESTION 2: How has the HIV/Aids pandemic affected you spiritually?**

14. **Participant 1:** I feel sorry for those affected.
15. **Participant 2:** I always feel stressed.
16. **Participant 3:** Better in a way.
17. **Participant 4:** Initially I was down, but now I know that the Almighty is doing
18. something I must just hold on to him.
19. **Participant 5:** I just think of dying.
20. **Participant 6:** I'm always praying so that I cannot be affected spiritually.
21. **Participant 7:** I don't feel happy.

22. **Participant 8:** Spiritually I lost hope when thinking about Aids. You end up not
23. believing in the church or reading the Bible anymore.

24. **QUESTION 3: How has the HIV/Aids pandemic affected you physically (e.g.
25. do you sleep badly / has your appetite decreased; etc.)**

26. **Participant 1:** Yes, I sleep badly, because I keep on thinking about the infected
27. and affected.

28. **Participant 2:** I have sleepless nights.

29. **Participant 3:** I go on as normal.

30. **Participant 4:** Sometimes I have sleepless nights thinking of all the orphans in
31. my school. As long as I think of what happened and what is happening, I simply
32. loose appetite, but try to eat, because I need strength to support others.

33. **Participant 5:** I have no appetite for food. No eating.

34. **Participant 6:** I sometimes get tired and then eat less.

35. **Participant 7:** You don't sleep and you always feel tired and you loose appetite.

36. **Participant 8:** I sleep badly, because even if I am not positive I think of those
37. who suffer from that and die.

38. **QUESTION 4: How has the HIV/Aids pandemic affected you socially / how
39. has it changed your social interaction?**

40. **Participant 1:** Nothing changed.

41. **Participant 2:** It has not changed. I'm stil able to socialise with affected people.

42. **Participant 3:** I am still making friendships.

43. **Participant 4:** It has made me to be with people so that we share and support
44. each other, unlike being alone, as it eats on you.

45. **Participant 5:** Badly! I am even afraid to sleep with anybody who is coughing.

46. **Participant 6:** I like socializing with people with HIV/Aids, because if you don't

47. we will all die, but I trust nobody.

48. **Participant 7:** You spend more money for medication. You go to different

49. doctors to try and save their lives. You spend more.

50. **Participant 8:** Because I don't socialize fully because I am afraid of that disease.

51. **QUESTION 5: How has the HIV/Aids pandemic affected you professionally**

52. **/ impacted on you as an educator?**

53. **Participant 1:** When looking at the affected I become sad.

54. **Participant 2:** It has affected me socially and emotionally.

55. **Participant 3:** Children who are infected.

56. **Participant 4:** Made me realise how important is my career as caregiver.

57. **Participant 5:** I was not coping with children. I was really disturbed.

58. **Participant 6:** If I see a learner suffering I just can't hold my tears.

59. **Participant 7:** You want to give help to learners, colleagues and it won't be

60. sufficient.

61. **Participant 8:** Because many educators died.

62. **QUESTION 6: How has the HIV/Aids pandemic changed your daily routine**

63. **as an educator?**

64. **Participant 1:** I feel so sorry for the affected. I keep on thinking about it and

65. wonder that when is it going to end.

66. **Participant 2:** Becoming or trying to accept situations of that kind.

67. **Participant 3:** Things are still normal.

68. **Participant 4:** Made me realise how needy are my learners as for support is

69. concerned. I have to be strong and helpful.

70. **Participant 5:** I was sad, crying tears were falling every day and night.
71. **Participant 6:** By always teaching us they make me strong and motivated.
72. Sometimes I spend the break without eating and making sure the children
73. (*learners*) are fed.
74. **Participant 7:** You meet infected learners daily, and you are willing to help, but
75. you don't know how.
76. **Participant 8:** It changed it because I must be careful before I can eat.
- 77. QUESTION 7: What has helped you to cope with teaching whilst the**
- 78. HIV/Aids pandemic rages on?**
79. **Participant 1:** I keep on praying that God may one day end this sickness.
80. **Participant 2:** Trying to accept even if it is hard to.
81. **Participant 3:** My religion.
82. **Participant 4:** Sharing ideas and talking on how to help and to be resilient.
83. **Participant 5:** Praying time and again.
84. **Participant 6:** My colleagues at work.
85. **Participant 7:** The SMT at my school and the district office.
86. **Participant 8:** The feeding scheme at our school and nutritious food every day.

RESPONSES TO OPEN-ENDED QUESTIONS – POST-TEST

1. **QUESTION 1: How has the HIV/Aids pandemic affected you emotionally?**

2. **Participant 1:** Accept that this disease is alive.
3. **Participant 2:** I was depressed, sad, frustrated, but I'm on top of the situation
4. now.
5. **Participant 3:** Not so much.
6. **Participant 4:** Because we see what is going on outside, very bad.
7. **Participant 5:** Bad, but I now have information.
8. **Participant 6:** It had affected me. Emotionally I feel sad and unhappy; I feel it is
9. not happening. It is a dream.
10. **Participant 7:** At first it broke my heart, but now I'm stronger than I thought.
11. **Participant 8:** It makes me sad. It also makes me crying.

12. **QUESTION 2: How has the HIV/Aids pandemic affected you spiritually?**

13. **Participant 1:** I always pray to God to provide.
14. **Participant 2:** That God has forsaken His people, that how can He take
15. my brother from us? But I know and understand that we are not in this world
16. forever.
17. **Participant 3:** When thinking of people with HIV.
18. **Participant 4:** Spiritual (*spiritually*) I thought that there is a mistake between us.
19. **Participant 5:** Bad.
20. **Participant 6:** I lost faith in God, but the priest gives me a support.
21. **Participant 7:** It brought me very close to my God and family.
22. **Participant 8:** I have hatred to (*towards*) man (*men*).

23. **QUESTION 3: How has the HIV/Aids pandemic affected you physically (e.g. do you sleep badly / has your appetite decreased; etc.)**

25. **Participant 1:** I don't sleep at night. Sometimes I get depressed.

26. **Participant 2:** I lost a bit of weight, and I couldn't sleep properly, but I've learnt to
 27. accept the situation and I feel better now.
28. **Participant 3:** Yes, I sleep badly, but after that I was doing okay.
29. **Participant 4:** Yes, I think for those who are suffering.
30. **Participant 5:** Yes. My appetite is incredibly high.
31. **Participant 6:** I wake up crying. I don't eat during breaks or I left my food for this
 32. child who has lost both parents.
33. **Participant 7:** Didn't sleep well before, but now I sleep and eat well.
34. **Participant 8:** I have sleepless nights when I think of it.

**35. QUESTION 4: How has the HIV/Aids pandemic affected you socially / how
 36. has it changed your social interaction?**

37. **Participant 1:** In our community by talking freely.
38. **Participant 2:** Not at all. I interact with people like never before, I think it is part
 39. of therapy – healing.
40. **Participant 3:** Love one and be honest.
41. **Participant 4:** I want to help each and everyone who is starving.
42. **Participant 5:** Improved.
43. **Participant 6:** My social interaction has changed immediately after realising I
 44. have a learner in my class.
45. **Participant 7:** In a number of different social clubs and offer my help at
 46. homespecies (*hospices*).
47. **Participant 8:** You don't enjoy socializing with other people.

**48. QUESTION 5: How has the HIV/Aids pandemic affected you professionally
 49. / impacted on you as an educator?**

50. **Participant 1:** Looking at the children left by their parents, but its hard to comfort
 51. how am I going to say to him or her.
52. **Participant 2:** Not being able to meet deadlines, but have now decided to plan

53. my work and set due dates.
54. **Participant 3:** Many lost their lives.
55. **Participant 4:** Bad.
56. **Participant 5:** All the effort are (is) in vain, knowing that his poor kid is going to
57. die.
58. **Participant 6:** It made me realise how really my community needs me.
59. **Participant 7:** You feel sorry for those who are positive.
60. **Participant 8:** The orphans trouble me.

61. QUESTION 6: How has the HIV/Aids pandemic changed your daily routine
62. as an educator?

63. **Participant 1:** I feel free to talk about it, share everything utensils, chairs and
64. food.
65. **Participant 2:** Have to always provide counselling to learners, assist them in
66. whatever way.
67. **Participant 3:** So that we must learn to abstain.
68. **Participant 4:** Heavy load of work due to absentism (*absenteeism*).
69. **Participant 5:** My routine has changed. I check the wheather (*that whether*) is
70. she absent, may she is (*be*) absent because not having food.
71. **Participant 6:** It made me care more about my learners and other children at
72. school, especially orphans.
73. **Participant 7:** Sometimes you want to help, but you don't know how.
74. **Participant 8:** I offer help to those learners and colleagues.

75. QUESTION 7: What has helped you to cope with teaching whilst the
76. HIV/Aids pandemic rages on?

77. **Participant 1:** Caring of (*for*) infected people. Giving them healthy food,
78. vitamins, fruit and vegetables.
79. **Participant 2:** By practising what I preach.

- 80. **Participant 3:** We learn a lot.
- 81. **Participant 4:** Information.
- 82. **Participant 5:** My team as resilient educators (*REds*) as well as my colleagues.
- 83. **Participant 6:** The counsellor from the district who counselled the staff
- 84. about the HIV/Aids.
- 85. **Participant 7:** REds lead me to accept the situation in my class and school.
- 86. **Participant 8:** Resilient (REds) course helped me a lot to cope.

ADDENDUM D

SEMI-STRUCTURED INTERVIEWS WITH PARTICIPANTS – DELAYED POST-TEST

1. **QUESTION 1: Can you remember how you felt on our first meeting before
2. you started with REds?**

3. **Participant 1:** Scared.

4. **Why were you scared?**

5. I was scared about what Aids was doing to us.

6. **Participant 2:** Yes. I remembered well. My mind was with all the orphans and
7. sick learners in my school.

8. **Participant 3:** I was nervous to meet new people.

9. **Participant 4:** I felt happy to socialise with other people.

10. **Participant 5:** You know, I was sad, because my brother just died of Aids.

11. **Participant 6:** Heart hatred because bad things were happening to us.

12. **Participant 7:** I was also concerned about the sick learners in our school.

13. **Participant 8:** Hopeful.

14. **Why did you feel hopeful?**

15. I had hoped to learn more about Aids.

16. **And did you learn more about Aids?**

17. Yes, I did!

18. **QUESTION 2: How did you experience REds?**

19. **Participant 1:** Being this the first time to attend something like REds I
20. experienced REds as excellent.

21. **Participant 2:** For me REds was extremely informative.

22. **Participant 3:** Although I didn't like the questionnaires, the information I had
23. gained were very helpful.

24. **Participant 4:** REds helped me to make new friends who would not gossip.

25. **Participant 5:** I looked forward to each and every session.

26. **Why?**

27. Because I had learned so much.

28. **Participant 6:** I also felt the questionnaires were a bit too long, but I realised the

29. necessity of the questionnaires.

30. **Why were the questionnaires necessary?**

31. I think for you to know us better. To see if REds helped us?

32. **Participant 7:** I had learned so much.

33. **Participant 8:** The positive way in which you presented REds, made me positive

34. and hopeful about each session and about the disease.

35. **QUESTION 3: In what way did REds help you?**

36. **Participant 1:** REds has helped me to make new friends.

37. **Participant 2:** I'm so interested. I want to read and learn more about the illness.

38. **Participant 3:** Now I can cope better with my situation.

39. **Participant 4:** I've learned how to deal with the infected, especially the learners

40. in my school.

41. **Participant 5:** REds made me realise that I cannot face Aids alone. There are

42. people who can help me.

43. **Participant 6:** REds helped me how to give support to the infected and affected.

44. **Participant 7:** I've learned a lot about my rights as educator. Especially with

45. regard to leave.

46. **Participant 8:** REds gave me hope for the future, no matter my circumstances.

47. **QUESTION 4: So, would you say REds empowered you? Made you more**

48. **resilient?**

49. **Participant 1:** Yes.

50. **Participant 2:** Yes. REds empowered me.

51. In what way?

52. In the way that I know more about the spreading of the disease.
53. **Participant 3:** Yes and also that Aids do not have to be a death sentence any
54. more.
55. **Participant 4:** I feel free to talk to other people about the disease. I'm not
56. scared or ashamed anymore. REds made me believe that Aids is an illness just
57. like cancer or diabetes.
58. **Participant 5:** Yes. I feel strong and motivated because of REds
59. **Participant 6:** Yes. I'm stronger now than ever before.
60. **Participant 7:** Yes. I'm resilient. Although I know that some days will be difficult,
61. at least I know now how to cope with that.
62. **Participant 8:** I agree. REds empowered me. I am resilient. Maybe I will bend,
63. but I will not break.

64. QUESTION 5: What would be your biggest challenge in diffusing the

65. "gospel" of HIV/Aids?

66. **Participant 1:** I think to stop the gossiping.
67. **Participant 2:** The giving of support to the affected, as well as the infected.
68. **Participant 3:** The fact that an infected person can live up to 15 years if she
69. receives ART and follow a healthy diet. In other words to disclose!
70. **Participant 4:** I would also say to stop the gossiping.
71. **Participant 5:** I think to encourage people to disclose. But first of all we must
72. stop the stigma surrounding Aids.
73. **Participant 6:** I would encourage people to go for a HIV blood test. It is better if
74. you know your status.
75. **Participant 7:** I also think to go and test and be open about your status.
76. **Participant 8:** I would also say to disclose and stop the stigma.

ADDENDUM E

EXAMPLE OF PROQOL QUESTIONNAIRE

As a teacher, you help many people. Mark the block that honestly shows how often you felt like this <i>in the last 30 days</i> .	Never	Rarely	Quite often	Often	Very often
1. I am happy.	1	2	3	4	5
2. I am worried about more than one person I help.	1	2	3	4	5
3. I get satisfaction from being able to help.	1	2	3	4	5
4. I feel connected to others.	1	2	3	4	5
5. I jump or am nervous when hearing unexpected sounds.	1	2	3	4	5
6. I feel re-energized after working with those I help.	1	2	3	4	5
7. I find it difficult to separate my personal life from my life as a helper.	1	2	3	4	5
8. I am losing sleep over experiences of people I help.	1	2	3	4	5
9. I am affected by the disturbing experiences of those I help.	1	2	3	4	5
10. I feel trapped by my work as a helper.	1	2	3	4	5
11. Because of my helping, I feel nervous about various things.	1	2	3	4	5
12. I like my work.	1	2	3	4	5
13. I feel depressed as a result of my work as a helper.	1	2	3	4	5
14. I feel as if I am experiencing the trauma of those I help.	1	2	3	4	5
15. I have beliefs that support me.	1	2	3	4	5
16. I know how to use different helping techniques.	1	2	3	4	5
17. I am the person I always wanted to be.	1	2	3	4	5
18. My work makes me feel satisfied.	1	2	3	4	5

19. Because of my work, I feel exhausted.	1	2	3	4	5
20. I have happy thoughts and feelings about those I help.	1	2	3	4	5
21. I feel overwhelmed by the amount of work I have to deal with.	1	2	3	4	5
22. I believe I can make a difference through my work.	1	2	3	4	5
23. I avoid some situations because they remind me of disturbing experiences of people I've helped.	1	2	3	4	5
24. I plan to be a helper for a long time.	1	2	3	4	5
25. As a result of my helping, I have disturbing thoughts.	1	2	3	4	5
26. I feel frustrated by the system.	1	2	3	4	5
27. I think I am a success as a helper.	1	2	3	4	5
28. I can't remember important parts of when I've helped others.	1	2	3	4	5
29. I am a very sensitive person.	1	2	3	4	5
30. I am happy that I chose to do this work.	1	2	3	4	5

ADDENDUM F

INTERVIEWS WITH MANAGEMENT

1. QUESTION 1: Do you think that educators are affected by Hiv/Aids?

2. **Principal 1:** Oh yes, of all the professional occupations, educators are certainly
3. the most affected by HIV/Aids.

4. **Member of Management Team (MMT):** Yes, I would say educators are
5. affected by HIV/Aids.

6. QUESTION 2: Do educators receive any formal training with regard to
7. Hiv/Aids?

8. **Principal 1:** Yes, they do receive training.

9. **MMT:** Yes, from time to time educators receive training regarding
10. HIV/Aids.

11. QUESTION 3: What are educators' experiences with regard
12. to the pandemic?

13. **Principal 1:** Educators are over-worked and experience the pandemic very
14. badly, because of all the infected and affected learners in our school. The
15. orphans are a very big problem. Educators feel responsible for the orphans
16. and some of them provide these orphans with food and clothing. Financially
17. educators cannot afford it.

18. **MMT:** Educators are struggling with their health because of the
19. pandemic. They have heart diseases and depression because of all the stress.

20. **QUESTION 4: Do you agree that educators affected by HIV/Aids need to**
21. **be empowered in order to withstand the impact of the pandemic?**

21. **Principal 1:** Yes. I think so. Because you know, it is not only happening in
22. our school. Some of our educators have HIV-positive family members too.
23. **MMT:** Yes. They need to be empowered.

24. **QUESTION 5: What is your opinion with regard to the REds**
25. **support programme?**

26. **Principal 1:** At first my staff thought "No. Not another workshop!" But after that
27. very first day they were so excited. I could tell from their faces and their
28. attitudes that REds made a difference in their lives personally and
29. professionally.

30. **MMT:** I am very positive about the REds programme. My staff
31. members were positive from the start, because of all the orphans in our
32. school. Some of our colleagues lost loved ones due to Aids during that time
33. you were presenting the REds programme at our school. Every Monday
34. morning my staff members wanted to know what you discussed during the
35. Friday session. For the first time my staff members could give informative
36. answers to questions asked by fellow staff members and learners. It is a very
37. good programme. I would like all my staff members to attend a programme
38. such as REds.

ADDENDUM G

INFORMED CONSENT

Informed consent

I _____ agree to voluntarily participate in REds. I understand that the purpose of REds is to empower me as an educator who is affected by the HIV/AIDS pandemic. I understand that REds consists of _____ sessions and that each session should take approximately _____ hours.

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.

I understand that if something troubles me while participating, the researcher will be prepared to provide me with information about community resources that can help me.

I understand that participating in REds does not mean that I can present REds to other affected educators without being trained as a REds facilitator.

If I have any concerns about this study or my participation in it I am free to contact the local researcher _____ at _____ or Linda Theron (email: Linda.theron@nwu.ac.za or 016 910 3076 / 016 910 3082 or P.O. Box 1174, Vanderbijlpark, 1900).

Signature: _____

ADDENDUM H

CONSENT FROM THE DISTRICT MANAGER



UMnyango WezeMfundo
Department of Education

Lefapha la Thuto
Departement van Onderwys

Date:	20 April 2008
Name of Researcher:	Theron Linda
Address of Researcher:	97 Beethoven Street
	Vanderbijlpark
	1911
Telephone Number:	(016) 9103076
Fax Number:	(016) 9103078
Research Topic:	Educator support needs in the face of HIV pandemic
Number and type of schools:	1 Primary & 1 Secondary School
District/s/HO	Sedibeng East

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

Permission has been granted to proceed with the above study subject to the conditions listed below being met, and may be withdrawn should any of these conditions be flouted:

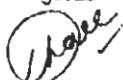
1. The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.
2. The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.
3. A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.

Office of the Senior Manager – Strategic Policy Research & Development
Room 525, 111 Commissioner Street, Johannesburg, 2001 P.O.Box 7710, Johannesburg, 2000
Tel: (011) 355-0488 Fax: (011) 355-0286

4. A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.
5. The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.
6. Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Senior Manager (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.
7. Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year.
8. Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.
9. It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.
10. The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.
11. The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.
12. On completion of the study the researcher must supply the Senior Manager: Strategic Policy Development, Management & Research Coordination with one Hard Cover bound and one Ring bound copy of the final, approved research report. The researcher would also provide the said manager with an electronic copy of the research abstract/summary and/or annotation.
13. The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.
14. Should the researcher have been involved with research at a school and/or a district/head office level, the Senior Manager concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards


ALBERT CHANEE
ACTING DIVISIONAL MANAGER: OFSTED

The contents of this letter has been read and understood by the researcher.	
Signature of Researcher:	
Date:	

ADDENDUM I

BOOK MARK



Resilient people are like a green twig
- they bend and hurt as they
experience pressure, but they don't
break. In fact, they will even be
able to blossom again....!

AIDS Helpline:	0800012322
Lifeline:	0861322322
Childline:	0800055555
Social Services:	016 930 2000
Wide Horizon Hospice:	016 44281410
Kopanong Hospital:	016 428 7000
Sebokeng Hospital:	016 930 3000
Zamdela Clinic:	016 974 1023
ATICC:	016 950 5337
Bana Pele:	016 988 1082
Dr. Linda Theron:	016 910 3076
Me Steffie Esterhuizen:	016 910 3070

ADDENDUM J
CERTIFICATE



YUNIBESITHI YA BOKONE-BOPHIRIMA
NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT

School of Educational Sciences

Honours are hereby awarded
to

for
successful completion of
REds

June 2006
DATE


.....
Mrs S Esterhuizen
PROGRAMME FACILITATOR


.....
Dr LC Theron
PROJECT LEADER

Vaal Triangle Campus