CHAPTER ONE
ORIENTATION TO THE STUDY

"The man who thinks he can live without others is mistaken. The man who thinks others can’t live without him is more mistaken."
-Hasidic saying-

1.1 INTRODUCTION

The purpose of this chapter is to introduce the outlines of my study which focuses on making suggestions towards the improvement of the support programme, Resilient Educators (REds). I base my recommendations on the pre-experimental implementation of REds in the Thabo Mofutsanyana district in the Free State.

In this chapter the problem statement is discussed, research objectives are set out, the research method and research paradigm are summarised and a vision is given of the chapters that follow. Figure 1.1 below provides an overview of Chapter One.

Figure 1.1: Overview of Chapter One

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1 Quote is included because it summarises the essence of REds which encourages mutual support as a means towards resilience
1.2 PROBLEM STATEMENT AND MOTIVATION

I start the motivation for my study with a broad description of how HIV/AIDS affects educators as a lead-up to the argument that teachers need to be supported towards resilience. I then argue that support programmes can encourage resilience, but that they need to suit the context and culture of the people participating in the programme, and this then provides the rationale for my study:

People are either infected or affected by the HIV/AIDS pandemic. According to Raubenheimer (2002:41), since 1981 HIV and AIDS have spread rapidly to every part of the globe. In the 25 years since the first report, more than 65 million persons have been infected with HIV, and more than 25 million have died of AIDS. What is disturbing is that 40% of new infections among adults are young people between 15 - 24 years of age and AIDS is the leading cause of premature death among people 15 - 59 years of age (Merson & Michael, 2006).

Recent global statistics of HIV and AIDS do not illustrate a different picture (UNAIDS & WHO, 2007). Table 1.1 illustrates the global summary of the AIDS epidemic (UNAIDS & WHO, 2007).

Table 1.1: Global summary of the AIDS epidemic (UNAIDS & WHO, 2007)

<table>
<thead>
<tr>
<th>Global summary of the AIDS epidemic</th>
<th>Total</th>
<th>33.2 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people living with HIV in 2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td>30.8 million</td>
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<tr>
<td>Women</td>
<td></td>
<td>15.4 million</td>
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<tr>
<td>Children under 15 years</td>
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<td>2.5 million</td>
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<tr>
<td>People newly infected with HIV in 2007</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2.5 million</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td>2.1 million</td>
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</table>
Over 6 800 new infections a day were reported in 2007 and women accounted for 50% of an estimated 5 800 infections in adults aged 15 years and older (UNAIDS/WHO, 2007). These statistics mean that collaborative efforts need to be engaged in to combat the pandemic (Theron, 2007: 177).

The region most affected by the pandemic is Sub-Saharan Africa (UNAIDS/WHO, 2007). South Africa is not exempt from the effects of the pandemic either. According to UNAIDS/WHO (2007: 40), South Africa carries the largest number of HIV infections in the world. In 2005, an estimated 10.8% of South Africans were living with HIV/AIDS (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay, 2005b: 135). Although scientists and researchers have tried hard to find a cure, none has yet been found. This means that when people are infected, their families and communities suffer along with them. This is true for educators as well (Ebersohn & Eloff, 2002: 78; Hall, Altman, Nkomo, Peltzer & Zuma, 2005:23; Theron, 2005: 56; Visser, 2005: 204; World Bank, 2002: 12).

The HIV/AIDS pandemic is affecting the demand and supply of education, the quality of education and how education is managed (Coombe, 2004: 106; Theron, 2007: 175). The South African education sector is badly affected by the challenges of the HIV/AIDS pandemic for various reasons (Maile, 2004: 114; Ngwena, 2003: 185). These reasons include that many educators and many learners are infected and/or affected (Bhana, Morrell, Epstein, Moletsane, 2006: 7-8; Coombe, 2000). The impact of this on educators who are affected (i.e. not infected but impacted by ill or vulnerable learners, loved

<table>
<thead>
<tr>
<th>AIDS deaths in 2007</th>
<th>Children under 15 years</th>
<th>420 000</th>
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<tr>
<td></td>
<td>Total</td>
<td>2.1 million</td>
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<tr>
<td></td>
<td>Adults</td>
<td>1.7 million</td>
</tr>
<tr>
<td></td>
<td>Children under 15 years</td>
<td>330 000</td>
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</table>
ones or ill colleagues) is often negative (Shisana et al., 2005b: 91; Theron, 2005: 57-58).

These negative effects include unpleasant personal consequences (including unhealthy emotion, grief, poor sleeping and eating, declining spirituality and negative social behaviours) (Theron, 2008a: 33) and harmful professional experiences (including work stress, feeling responsible for orphans and declining morale) (Theron, 2008a: 33-34). These effects put educators at risk and so they need to be supported to function resiliently in the face of the challenges of the HIV/AIDS pandemic (Bennell, 2005: 460; Hall et al., 2005: 30; Shisana, Peltzer, Zungu-Dirwayi & Louw, 2005a: xxi; Simbayi, Skinner, Letlape & Zuma, 2005: 134-139, 2005: 139).

Although many educators do not cope well (Theron, 2008a: 34), some manage to be resilient and cope with the pandemic and its challenges (Theron, 2007: 183; Theron, 2008b: 92). Resilience theory suggests that resilience is more common than many researchers and social scientists believe (Masten, 2001: 227). Resilience, or the ability to bounce back, is encouraged by protective resources within the person (e.g. tenacity, a sense of humour) and protective resources within the environment of the individual (supportive families; employee support programmes; community support groups) (Cameron, Ungar & Liebenberg, 2007: 286; Theron, 2008b: 96). To continue being resilient, individuals need to become aware of protective or promoting resources that would support them towards greater well-being and they need to navigate towards and negotiate for these resources (Cameron et al., 2007: 286-287; Malindi, 2009: 28 & 43; Schoon, 2006; Theron, 2009: 233; Ungar, 2008). At the same time, the communities in which these individuals can be found need to make resources available that encourage resilience (Cameron et al., 2007: 297).

When an educator who is challenged by the pandemic copes resiliently, usually he or she does not develop negative patterns of behaviour or negative emotional functioning (Theron, 2007; Theron, 2008a: 34; Theron, Mabitsela & Esterhuizen, 2009: 130-132; Theron, 2008b: 92), despite facing multiple
personal and professional challenges. By reviewing the findings from previous REeds studies (Mabitsela, 2009; Ngemntu, 2009; Serero, 2008; Theron, 2008a: 39) and studies that have reported resilience among teachers (Theron, 2007), it is possible to suggest what the profile of a resilient teacher might be. This profile is summarised in Table 1.2 below.

Table 1.2: Resilient Educators

<table>
<thead>
<tr>
<th>Resilience-promoting factors</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Strong Faith / Religious Practices</strong></td>
<td>Faith and worship have helped affected educators cope with the challenges of the pandemic (Theron, 2007: 181; Theron et al., 2009: 131; Theron, Geyer, Strydom &amp; Delport, forthcoming). Mostly, their faith and practices like prayer and going to church have given them hope and helped them feel supported.</td>
</tr>
<tr>
<td><strong>Access to information</strong></td>
<td>When teachers have access to information (like where they can get counselling; knowing where their learners can receive assistance), they cope more resiliently with the pandemic (Theron, 2007: 181; Theron et al., 2009: 142). Expanded information encourages teachers to feel informed and more in control and this contributes to them being professionally competent in the face of the pandemic (Theron et al., 2009: 142).</td>
</tr>
<tr>
<td>Resilience-promoting factors</td>
<td>Description</td>
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<tr>
<td>Empathy</td>
<td>Empathy relates to the ability to enter and understand the world of someone else (Van Dyk, 2005: 188). Empathy relates to resilience in that it encourages positive social relationships that have strengthened affected teachers (Theron, 2007: 181; Theron et al., forthcoming) and other groups of people who are at risk (Schoon, 2006: 1). Teachers who were resilient in the face of the HIV and AIDS pandemic reported compassion and empathy for others who were infected and/or affected (Theron, 2008a: 34; Theron et al., forthcoming).</td>
</tr>
<tr>
<td>Hope</td>
<td>A sense of hopefulness is associated with resilient teachers (Theron, 2007: 37; Theron et al., 2009: 132; Theron et al., forthcoming). Hope has been used to indicate resilience among other groups at risk (Cyrulnik, 2009: 6-7).</td>
</tr>
<tr>
<td>Seeing oneself as strong</td>
<td>Some educators who reported resilience saw themselves as strong enough to cope with the pandemic's challenges. (Theron, 2008a: 34; Theron et al., forthcoming).</td>
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</table>
### Resilience-promoting factors

<table>
<thead>
<tr>
<th>Description</th>
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<tr>
<td><strong>Acceptance and Tolerance</strong></td>
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<tr>
<td>When teachers have a positive attitude towards HIV/AIDS, accept AIDS-affected learners and colleagues and that their professional reality is changed by HIV/AIDS (Theron, 2007: 39; Theron <em>et al.</em>, 2009: 144; Theron <em>et al.</em>, forthcoming), they cope better. This could be because acceptance of difficult realities helps people to work towards meaningful solutions, rather than wasting energy on being angry or fearful (Carr, 2004: 213-218). Teachers who were resilient in the face of the HIV/AIDS pandemic also reported that they had accepted the reality of the pandemic (Theron, 2008a: 34). In some cases this encouraged teachers to preach health promotion to their learners and to take care to protect their own health (Theron <em>et al.</em>, 2009: 143). In other cases this encouraged educators to be tolerant of learners and colleagues who were HIV-infected or -affected (Theron <em>et al.</em>, forthcoming).</td>
</tr>
<tr>
<td><strong>Willingness to be a health promoter</strong></td>
</tr>
<tr>
<td>Resilient educators were not afraid to teach prevention (Theron, 2007: 181). This seemed to help them to be resilient because it gave them a sense of purpose and encouraged them towards positive actions (Theron <em>et al.</em>, 2009: 141).</td>
</tr>
<tr>
<td><strong>Talking openly about the pandemic</strong></td>
</tr>
<tr>
<td>Teachers who were resilient in the face of the HIV/AIDS pandemic reported that they wanted to teach health promotion and help prevent the spread of the pandemic. They were not afraid to speak about the pandemic openly, nor were they afraid of disclosure (Theron, 2007: 181).</td>
</tr>
<tr>
<td>Resilience-promoting factors</td>
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<tr>
<td>-------------------------------</td>
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<tr>
<td>Assertiveness</td>
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<tr>
<td>Positive attitude</td>
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<td>Supportive resources</td>
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One way in which educators (and other people who are threatened by adverse circumstances) can be encouraged to develop resilience, is by means of intervention or support programmes (Masten & Reed, 2005: 85). Interventions promote resilience by encouraging processes that lessen risks, and/or by providing more (or easier access to) protective resources (Masten &
Reed, 2005: 85). More recently, researchers who focus on resilience have begun to argue that these processes probably need to relate to the culture and the context of the people that they are designed for, if they are going to be effective in encouraging resilience (Cameron et al., 2007: 298-299; Ungar, Brown, Liebenberg, Othman, Kwong, Armstrong & Gilgun, 2007: 288). This means that intervention programmes need to suit the culture and the context of participants, and the same applies to REds (Theron et al., 2009: 149).

REds was created in response to the call for support for educators affected by the pandemic (Theron, Geyer, Strydom & Delport, 2008: 84). REds aims at further capacitating the affected educator to cope well with the challenges presented by the pandemic so that teachers will have a profile similar to the one set out in Table 1.2 after participating in REds. To do this effectively it needs to take the culture and context of participants into account (Theron et al., 2009: 149).

To arrive at a point where REds becomes an effective intervention that enables resilience, the larger REds project follows an ongoing intervention research design (De Vos, 2005b: 392-407) (see Addendum D) so that REds can be refined to be even more effective (Theron et al., 2008: 85). Traditionally, intervention research involves repeated trial runs of an intervention programme so that it can be refined (De Vos, 2005b: 404). This refinement relates to the contents, language and presentation of the programme (De Vos, 2005b: 404). As part of this ‘iterative intervention research’ (Theron et al., 2008: 85) on the effectiveness of REds to support affected educators, the following research question was asked:

How should REds be refined to make it even more effective in supporting affected educators to cope resiliently with the challenges of the pandemic?

This is the rationale for my study. I was invited to implement REds in order to provide the larger REds project with information on how REds could be fine-tuned. The above question framed my study.
I am aware that the answer to the above question will be based on my interpretation of how I think REds can be improved: While I was implementing REds, I interpreted my observations and other qualitative data that I collected to arrive at guidelines for the improvement of REds. This means I followed an interpretative paradigm (Nieuwenhuis, 2007a: 58-60) partly as a result of the research question, but also because of my way of looking at things (see 1.4).

1.3 AIMS

The overall aim of my research was to make recommendations for the refinement of REds that should increase its effectiveness in supporting educators affected by the HIV and AIDS pandemic towards coping resiliently with the challenges of the pandemic.

The aim was supported by the following sub-aims:

- Implementation of REds, using one group, as an opportunity for observation of its contents, its language and its methods.
- Recommendations for the refinement of REds.

1.4 RESEARCH PARADIGM

A paradigm determines how a problem is formulated and methodologically approached (Maree & Van der Westhuizen, 2007: 32; Nieuwenhuis, 2007a: 47). The general purpose of a research paradigm is to guide what sense the researcher will make out of collected data (Nieuwenhuis, 2007a: 47). As noted at the end of the motivation for my study (1.2), in order to make recommendations to improve REds, I would need to reflect on and interpret the data I collected and what I observed during my implementation of REds. When data are interpreted, the paradigm is a qualitative, interpretive one which is not absolute or completely objective (Nieuwenhuis, 2007a: 58-60). This paradigm provides an understanding of the research context and the participants' reality (Henning, Van Rensburg & Smit, 2005: 3). In other words, my interpretations of what I observed and collected were not hard facts, meaning that the conclusions I would come to could not be seen as facts but should rather be taken as my subjective interpretation (Nieuwenhuis, 2007a: 59-60).
Because an interpretive approach is influenced by the experience and beliefs of the researcher, it is important for the researcher to be aware of assumptions that could shape the interpretation of data (Gilgun, 2005a: 6). One way of lessening how these assumptions could affect the final interpretation, is to list them up front. I approached the study with the following assumptions:

- The participants would benefit from participating, as had previous participants.
- Because REds is in English and my participants were Sesotho-speaking, I anticipated that there would be language difficulties.
- I wondered how comfortable male participants would be because in my Sesotho culture men lead and women follow. In the context of my research, I would be leading.
- I also expected that the participants might not find it easy to talk about HIV and AIDS because often this is a taboo topic.

These assumptions meant that I started out with the belief that REds would encourage positive change, but I also expected to find parts of REds that needed changing and so I had to be careful that this did not influence how I interpreted the data. To guard against this, my supervisor and I and the observer and I purposefully looked for themes in the data that suggested the opposite of the themes that were emerging (Gilgun, 2005b: 44).

Finally, I have personal experience of how the pandemic can disrupt a family’s life: my own sister passed away from AIDS-related complications. My personal experience helped me to bond with the participants, but it also meant that I assumed the participants would know similar pain and that they would be capable of bouncing back, as I did. This meant once again that my interpretations would be influenced by my experience and expectations and so I worked hard with my supervisor and observer to make sure that my interpretations were supported by my data (Gilgun, 2005b: 44).
1.5 RESEARCH METHODOLOGY SUMMARISED

As already mentioned, the greater REds project follows an intervention research design (Theron et al., 2008: 84-5). Part of intervention research design focuses on refinement of the intervention, by recording observations about (among others) the intervention’s contents, language and methods (De Vos, 2005b: 404). To be able to record observations, I implemented REds with one group, which meant I followed a pre-experimental research design (Leedy & Ormrod, 2005: 217). Experimental designs are used in research to identify cause-and-effect relationships, using control and experimental groups.

Pre-experimental research is limited because there is no control group and so the conclusion cannot be drawn that it was the intervention only which led to change in the participants (Leedy & Ormrod, 2005: 217). Nevertheless, it allowed me an opportunity to observe REds in process and to comment meaningfully on its contents and methods and on how it had influenced the resilience of my participants (to comment on the latter, I used qualitative pre- and post-tests). During this time I facilitated REds and made detailed process notes and reflected on what I was observing (Welman, Kruger & Mitchell, 2005: 204). I also included a co-student as an observer ['observer as participant' (Nieuwenhuis, 2007b: 85)], to make observation notes in each REds session (Henning et al., 2004: 87) and I asked the participants to complete reflection worksheets that gave them an opportunity to give feedback on each session (Theron et al., 2008: 84). The qualitative data (Nieuwenhuis, 2007b: 83) that came from all of these helped me to comment on how REds could still be improved. In other words, within the pre-experimental design, I used qualitative techniques (observation, reflection, open-ended questionnaires and symbolic drawings) to collect rich data (Mertens, 2009: 81, 264, 279; Nieuwenhuis, 2007b: 84-86).

1.5.1 Participants

Eleven participants (all primary school teachers affected by the pandemic) took part in the implementation of Reds voluntarily. I verbally recruited geographically accessible participants who were affected by the pandemic, meaning I used purposive convenience sampling (Babble & Mouton, 2007: 277; Leedy & Ormrod, 2005: 144-145; Strydom & Delport, 2005: 328-329).
The participants, four males and seven females, were easily available and willing to participate, as they were affected by the pandemic and had been offered very little other support. Full details will be discussed in Chapter 3 (Cf. 3.3.2)

1.5.2 Soundness of the research process

The aim of establishing the credibility of data is to determine whether the data provides information that is true and can be trusted (Du Plooy, 1996: 100). Validity and reliability are very important aspects in quantitative research and qualitative research refers to credibility and trustworthiness (Nieuwenhuis, 2007b: 80 & 113; Strydom & Delport; 2005: 346). I adhered to practices which increased credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). These will be discussed in detail in Chapter 3 (Cf. 3.6).

1.6 ETHICAL ASPECTS

Research ethics should be observed in all research undertakings and in this study I adhered to basic prevailing guidelines (Strydom, 2005:62; Leedy & Ormrod, 2005:101-104; Strydom, 2005: 58-68). Permission was obtained from the director of the Department of Education in the Free State at the Thabo Mofutsanyana district and informed consent was also obtained from the participants. Participants took part in the programme voluntarily. They also gave permission for tape-recording and taking of photographs during the sessions. Participants did not take part in activities that exposed them to emotional, physical and psychological harm. The data were recorded anonymously to maintain self-respect and human dignity.

The Ethics Committee of the North-West University also provided ethical clearance for this study (Number: NWU-00013-07-A3).
1.7 CLARIFICATION OF KEY CONCEPTS

Throughout my study, I conceptualised the following core concepts as defined here:

1.7.1 HIV and AIDS

AIDS (Acquired Immune Deficiency Syndrome) is caused by infection with HIV (Human Immunodeficiency Virus), which kills or harms cells of the body’s immune system (T-cells), gradually destroying the body’s ability to fight infections and certain cancers (Hillman, Wood & Webb, 2008:3; Van Dyk, 2005: 3). AIDS is called ‘acquired’ to distinguish it from the inherited (genetic) form of immunodeficiency. It is called a ‘syndrome’ because it is a set of symptoms which occur together rather than a clear-cut disease (Cohen: 2002). It is the final stage of HIV, typically ending in death.

1.7.2 Resilience

Resilience is defined as both a characteristic of the individual and quality of that individual’s environment which provides the resources necessary for positive development, irrespective of adverse situations (Malindi, 2009: 30; Masten, 2001:228; Theron, 2008b: 92). Resilience is only present in contexts of risk. In this study the educators were confronted by the risk and adversity of being burdened by the impact of the HIV/AIDS pandemic (Bhana et al., 2006:5-8; Hall et al., 2005: 27; Theron, 2007:175; Theron, 2008b: 92-93). Resilient people are like green twigs: they bend as they experience pressure, but they do not break. When teachers are resilient, they may suffer because of the pressures of the pandemic, but they will not break, when they have access to and use the resources summarised in Table 1.2.

1.7.3 Affected

When educators have loved ones, colleagues and learners who are HIV-positive or who died of Aids-related diseases, or have Aids orphans and vulnerable children in their classes (Car-Hill, 2003; Coombe, 2003: 10-11; Hall et al., 2005: 23; Theron, 2006: 4; Theron, 2009: 231), they are considered affected.
1.7.4 Support

Support is providing another person with comfort, recognition, approval and/or encouragement. The aim of support is greater well-being (Reber & Reber, 2001: 726). Resilience can be encouraged by interventions that support educators to cope better with the challenges of the pandemic (Theron et al., 2009: forthcoming).

1.8 CHAPTER DIVISION

A preview of the chapters in this study is as follows:

The description of each chapter is given below.

Chapter Two: The impact of the HIV/AIDS pandemic on educators

Chapter Two contains the background information on the effect of the HIV/AIDS pandemic worldwide, but especially in South Africa. The main aim is to determine the impact of HIV/AIDS on the affected educators. I conduct this literature research so that I will have a better understanding of how the pandemic affects teachers. Although I have personal experience of this, the literature research is important to help me make sense of my observations and the data collected in a more objective way: I will be able to compare what I have observed and interpreted with those of other studies.
Chapter Three: Empirical Research Design

Chapter Three contains the qualitative research methodology to be used in the empirical study. In this chapter I show how my qualitative study fits into the overall intervention design of REds (Theron et al., 2008: 84)

Chapter Four: Process of REds (observational data)

Chapter Four overviews the process of REds using observational data on how REds encouraged participants towards greater resilience (or not).

Chapter Five: Data Analysis and Findings

Chapter Five contains the pre- and post-test data and provides interpretations of this data in an attempt to determine how successful REds was in enabling participants to be resilient.

Chapter Six: Conclusion and Recommendations

Chapter Six serves as a conclusion to this study, incorporating findings of the literature study, the observations recorded in Chapter Four and the interpretations of data in Chapter Five. Using these I compiled guidelines on how REds can be refined.

I also note the limitations and contributions of this study, as well as recommendations for further studies.

Chapter Six is followed by a bibliography and addenda.

1.9 CONCLUSION

As the pandemic continues, educators are challenged and many struggle to be resilient. My study will focus on how well REds encouraged a group of affected teachers in the rural Free State to survive and cope with the pandemic and comment on how REds can be improved. If REds can encourage coping skills and resilience, educators in the Free State might bounce back from the stress associated with the HIV/AIDS pandemic and
resume their lives as those in the Vaal Triangle did (Esterhuizen, 2007; Mabitsela, 2009).

The next chapter will deal with the effects of the HIV/AIDS pandemic worldwide, but more especially in South Africa. The main aim of this chapter is to provide the context of risk in which teachers in the age of HIV/AIDS function.