CHAPTER TWO

THE RISKS OF HIV/AIDS FOR TEACHERS IN SOUTH AFRICA

2.1 INTRODUCTION

In this chapter the following topics will be discussed:

• the impact of the pandemic worldwide;
• the impact of the pandemic on South Africa;
• the impact of the pandemic on education, with an emphasis on how the pandemic impacts on affected educators.

The purpose of this chapter is to describe the context of the educator who is affected by the pandemic so that it becomes clear that in most cases this context puts teachers at risk for non-resilient outcomes. This context emphasises the need for interventions, like REds, that support teachers to cope resiliently with the many risks that are part and parcel of the pandemic.

2.2 HIV/AIDS STATISTICS

2.2.1 Global Statistics

The HIV/AIDS pandemic is a world-wide problem and is one of the most pressing threats known to mankind (Lyman & Fox, 2004). Many people have become infected with and affected by HIV/AIDS. In 2007 it was estimated that 33.2 million [30.6-36.1 million] people were living with HIV worldwide (UNAIDS, 2008a: 32). It has been estimated that world-wide more than 3 million new infections occur per year. In 2007 the figure was about 2.5 million [1.8-4.1 million], of which more than two thirds (68%) occurred in Sub-Saharan Africa (UNAIDS/WHO, 2007: 6). According to Raubenheimer (2002:41), since 1981 HIV/AIDS has spread rapidly to every part of the globe, infecting 70 million people and killing 28 million by the end of 2002. Table 2.1 below summarises the global statistics.
It is estimated that by 2010 roughly 100 million people will have been infected and there will be 25 million AIDS orphans world-wide (Lyman & Fox, 2004; Raubenheimer 2002: 41). Raubenheimer (2002: 41) reports that orphans are the most unfortunate and long-term victims of the HIV/AIDS epidemic. In 2005 it was estimated that there were more than 13.2 million AIDS orphans and more than 90% of these orphans lived in Sub-Saharan Africa (Lyman & Fox, 2004). The pandemic is also a threat to global economic and geopolitical stability (Cohen, 2002: 13; Lyman & Fox, 2004). What is important is that the disease hits the most productive part of a population, thus corrupting human resources necessary for economic development and geopolitical stability (Cohen, 2002: 13).

Thorough intervention is needed in order to minimise the spread of HIV and AIDS. The World Health Organisation (WHO) has estimated that providing
basic health services to developing countries will require financial assistance of 27 billion rand per year by 2007, and up to 38 billion rand annually during the next eight years. While those figures are high, WHO estimates that such initiatives would save 8 million lives per year by 2010 and generate 186 billion rand in economic output per year by 2015 (Lyman & Fox, 2004).

The most recent statistics on the global incidence of HIV suggest that the pandemic has been stabilised in many African countries (possibly because of basic health services), but that the pandemic is on the increase in many non-African countries (UNAIDS, 2008b: 5).

2.2.2 Sub-Saharan Statistics

Even though the pandemic is stabilising in most African countries (UNAIDS, 2008b: 5), these levels are high and Sub-Saharan Africa continues to be the region most affected by the HIV/AIDS pandemic (UNAIDS, 2008b: 5). In 2007 more than two out of three (68%) adults and 90% of children infected by HIV lived in Sub-Saharan Africa. In other words, in 2007 there were about 22 million people living with HIV in Sub-Saharan Africa (UNAIDS, 2008b: 5) with notably more women than men infected (UNAIDS, 2008b: 7). 90% of children younger than 15 and living with HIV reside in Sub-Saharan Africa (UNAIDS, 2008b: 9). This region also experienced the highest AIDS-related death rate: 72% of all AIDS-related deaths occurred here (UNAIDS, 2008b: 5). About 12 million AIDS orphans live in this area of Africa (UNAIDS, 2008b: 5). The major route of HIV transmission in sub-Saharan African is heterosexual intercourse, but in East and Southern Africa, another contributing factor is drug use with contaminated equipment (Erasmus, 2008).

The above statistics paint a picture of a region which has been placed at risk by the many challenges of the HIV/AIDS pandemic. Its people are dying, there are worrying numbers of orphans, and its economy is understandably threatened (UNAIDS, 2008a: 23). This is also true for South Africa, as discussed in more detail below.
2.2.3 South African Statistics

South Africa has the highest numbers of HIV-positive citizens as compared to other countries (Page, Ebersohn & Rogan, 2006: 103; UNAIDS, 2008a: 40). The HIV/AIDS pandemic is weakening the future development of our nation and it is more than a health issue; it is a development and social issue (UNAIDS: 2008a: 16). It is acknowledged that the spread of HIV and AIDS is associated with poverty, micro- and macro-economic issues, a breakdown in traditional social structures and cultural issues. It can be called a natural disaster (Department of Health, 2006).

In South Africa new infections are still increasing with no sign of reaching a natural limit (UNAIDS, 2008a: 40). According to Van Dyk (2005: 7) in five of the South Africa’s nine provinces, including those with the biggest population, at least 25% of pregnant women are now HIV-positive. The epidemic varies within South Africa: In KwaZulu-Natal HIV prevalence among those who attend antenatal clinics is almost 37%, higher than in the Western Cape, the province with the lowest prevalence.

The tables below provide more detail regarding HIV prevalence in South Africa. In the first of these, Table 2.2 below, HIV prevalence is overviewed according to sex and race.

**Table 2.2: The estimated HIV prevalence among South Africans by sex and race** (Shisana et al., 2005a: 34, 36)

<table>
<thead>
<tr>
<th>Sex and Race</th>
<th>Number surveyed</th>
<th>Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6,342</td>
<td>8.2</td>
</tr>
<tr>
<td>Female</td>
<td>9,509</td>
<td>13.3</td>
</tr>
<tr>
<td>African</td>
<td>9,950</td>
<td>13.3</td>
</tr>
<tr>
<td>White</td>
<td>1,173</td>
<td>0.6</td>
</tr>
<tr>
<td>Coloured</td>
<td>3,382</td>
<td>1.9</td>
</tr>
<tr>
<td>Indian</td>
<td>1,319</td>
<td>1.6</td>
</tr>
<tr>
<td>National</td>
<td>15,851</td>
<td>10.8</td>
</tr>
</tbody>
</table>

According to this table, Africans are more infected than other races and females are more infected than males (Castle & Kiggundu, 2007: 46). More
Africans may be infected because they are the largest South African population group and many Africans are illiterate, which makes it harder for them to access preventive information. It must also be noted that the HIV pandemic is partly due to socio-economic stresses and social inequalities (Welch, Clocherty, Donald, Moll & Winkler, 2008: 36) and that, given the Apartheid history of South Africa, Africans would be more at risk. The females are vulnerable due to various factors, including early marriage, lack of knowledge of prevention strategies, especially in rural areas or farms (Van Heerden, 2005: 90), and because many females have fewer rights than men (Van Dyk, 2005: 23-27; Welch et al., 2008: 36). Some people living in rural areas still believe in witchcraft and so may not accept modern or medical prevention advice. Females do not have enough skills to be assertive and often have to accept what their husbands or male partners want, including unprotected sex that may be unsafe for women whose partners have multiple sexual partners (Welch et al., 2008: 36).

In Table 2.3 below HIV prevalence is overviewed according to provincial distribution.

**Table 2.3: The estimated prevalence among South Africans by Province (Shisana et al., 2005b: 35)**

<table>
<thead>
<tr>
<th>Province</th>
<th>Numbered surveyed</th>
<th>Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>KwaZulu-Natal</td>
<td>2,729</td>
<td>16.5</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1,224</td>
<td>15.2</td>
</tr>
<tr>
<td>Free State</td>
<td>1,066</td>
<td>12.6</td>
</tr>
<tr>
<td>North-West</td>
<td>1,056</td>
<td>10.9</td>
</tr>
<tr>
<td>Gauteng</td>
<td>2,430</td>
<td>10.8</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>2,428</td>
<td>8.9</td>
</tr>
<tr>
<td>Limpopo</td>
<td>1,570</td>
<td>8.0</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>1,144</td>
<td>5.4</td>
</tr>
<tr>
<td>Western Cape</td>
<td>2,204</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,851</strong></td>
<td><strong>10.8</strong></td>
</tr>
</tbody>
</table>
The table shows that Kwazulu-Natal and Mpumalanga have the highest prevalence, followed by the Free State, then North-West and Gauteng. A possible reason for the high prevalence in Gauteng might be that many people go there to find jobs and subsequently start additional relationships with other migrants.

Kwazulu-Natal is a popular holiday and tourist destination, visited by many people from other provinces and countries – this may encourage risky sexual behaviours and prostitution. In rural areas people do not have enough information about the disease. The Free State is a central province and may be exposed to sex workers because of long-distance trucks passing through (Noble, 2005).

In Table 2.4 below HIV prevalence is overviewed according to age.

Table 2.4: The estimated HIV prevalence among South Africans, by age and sex (Dorrington, Johnson, Bradshaw, & Daniel, 2006: 10; Shisana et al., 2005b: 34)

<table>
<thead>
<tr>
<th>Age [years]</th>
<th>Male prevalence %</th>
<th>Female prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 - 4</td>
<td>3.7</td>
<td>3.7</td>
</tr>
<tr>
<td>5 - 9</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>10 - 14</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>15 - 19</td>
<td>0.3</td>
<td>7.5</td>
</tr>
<tr>
<td>20 - 24</td>
<td>7.2</td>
<td>26.5</td>
</tr>
<tr>
<td>25 - 29</td>
<td>21.8</td>
<td>32.5</td>
</tr>
<tr>
<td>30 - 34</td>
<td>26.5</td>
<td>28.2</td>
</tr>
<tr>
<td>35 - 39</td>
<td>23.9</td>
<td>22.9</td>
</tr>
<tr>
<td>40 - 44</td>
<td>21.0</td>
<td>17.7</td>
</tr>
<tr>
<td>45 - 49</td>
<td>17.7</td>
<td>11.1</td>
</tr>
</tbody>
</table>

This table indicates that young females between the ages of 20 - 34 are more infected than males. It also shows that males between the ages of 35 - 49 are more infected than females in this age range (Noble, 2005; Raubenheimer,
What is most concerning is that the above table indicates high prevalence among males and females (Shisana et al., 2005b: 34).

From the tables above it is clear that in South Africa the HIV/AIDS epidemic is severe and affects all South Africans, but especially women. As a nation we are at risk, because the effects of the HIV/AIDS pandemic impact negatively on the South African economy and society.

One key social structure that is very negatively affected is education, as discussed below.

2.3 THE IMPACT OF HIV/AIDS ON EDUCATION

It is well recognised that the HIV/AIDS pandemic is impacting negatively on education, learners and educators and disempowering the schooling system (Coombe, 2000; Elhoweris, 2004: 330). HIV/AIDS compromises the supply of education due to factors like ill and absent educators or educators who decide to quit the teaching profession. It also compromises the demand for education due to factors like ill and absent learners and/or learners who forego education for financial reasons when they have to care for ill parents or head households (Coombe, 2004: 115; Elhoweris, 2004: 330; Hoadley, 2007: 257; Theron, 2005: 56). Along with this compromised supply of and demand for education, the quality of education suffers (Coombe, 2004: 106) as discussed below. The personal and professional problems of learners and educators which are related to the HIV pandemic (e.g. when educators are sick or absent for a long time; replacement educators who do not have enough knowledge/training; vulnerable or orphaned children who cannot cope with their school work; unmotivated and tired educators and learners) impact negatively on education and so the quality of education suffers (Coombe, 2004: 115; Louw, Shisana, Peltzer & Zungu, 2009: 207; Theron, 2007: 177).

2.3.1 Supply of Education

According to Coombe (2004: 114), HIV/AIDS is affecting the supply of education services due to the increased mortality rate among educators as well as the attrition of educators. The volume and the quality of education services depend on the number of teachers, on teaching facilities and system
managers. HIV and AIDS have long been threatening the supply of educators (Cohen, 2002: 17). The majority of teachers are women and they are more strongly affected and infected by HIV/AIDS than men (Coombe, 2004: 108; Welch et al., 2008: 66)

In 2004, a national survey estimated that 12,7% of educators were HIV-positive (Shisana et al., 2005a: xvi; Van Wyk & Lemmer, 2007: 303). The survey was conducted with educators of various ages, both genders and different racial groups from all provinces and did not include sick or hospitalised educators (Rehle & Shisana, 2005:305). The study showed a high HIV prevalence among educators between the ages of 25 – 34, followed by those between the ages of 35 - 44. There was a low HIV prevalence in more mature educators of 55 years and older (Shisana et al., 2005b: 53). In this survey, female educators were more affected than men (Shisana et al., 2005a: xvi). It was thought that women become infected at an early age because they are vulnerable to HIV infection due to their biological make-up and their low socio-economic status (Peltzer & Promtussananon, 2003: 350; Rehle et al., 2005: 305-306; Shisana et al., 2005a: xvi).

Ill educators may not supply the same quality education as healthier educators (Van Wyk & Lemmer, 2007: 303). Ill educators are frequently absent: infected educators lose approximately 6 months of professional time before developing full-blown AIDS and 12 months thereafter (World Bank, 2002:13, United Nations, 2003). One result is that other educators who are not absent have to share the workload of the infected educators who are absent and this typically means that educators become more stressed and morale declines (Coombe, 2004: 113 & 116; Louw et al., 2009: 212-213; Theron, 2007: 177; Van Wyk & Lemmer, 2007: 303). The HIV-negative educators cannot afford to teach more learners and so in general this leads to poorer quality education (Coombe, 2004: 113; Elhoweris, 2004: 330). In many instances, educators living with HIV and AIDS are seriously discriminated against by their managers, colleagues and/or learners (Theron, 2007: 180; Theron, 2009: 232). Due to the stigma attached to HIV, many educators are not willing to reveal their status (Bennell, 2005: 449-451; Bennell &
Akyeampong, 2007: ix, 12 & 20; Hall et al., 2005: 25; Louw et al., 2009: 212; Theron, 2005: 56; Theron, 2007: 182) and so are absent without clear reasons. Often, ill educators leave the schools where they were teaching once their HIV status becomes more obvious (Hall et al., 2005: 25). Some move to be closer to treatment centres while some just leave without explanation, leaving learners without an educator (Bennell, 2005: 460-462; Hall et al., 2005: 25; Shisana et al., 2005a: xix; Van Wyk & Lemmer, 2007: 303).

The learning process in schools will be negatively affected through increased absenteeism (Theron, 2007: 180). At times learners are left without consistent teaching and colleagues have to take extra classes. The educators who carry double loads experience high stress levels and can feel demotivated (Louw et al., 2009: 212-213; Theron, 2007: 177). Many HIV-infected teachers become increasingly unproductive because of opportunistic infections (Cohen, 2002: 14; Van Wyk & Lemmer, 2007: 303). Ill educators who remain can not always provide the same quality of teaching. Unfortunately their learners notice that they are ill and they are affected by their educators’ worsening health and associated difficulties (Theron, 2005: 56). Often the ARVs have negative side-effects, initially making educators feel and look even more ill (Bennell, 2005: 490; Hall et al., 2005: 25; Shisana et al., 2005a: xix; Van Wyk & Lemmer, 2007: 303). This further compromises the supply of education.

Getting replacements for specialist staff and ill teachers causes great problems (Coombe, 2004: 114 - 115). As noted above, the HIV/AIDS pandemic causes a high level of absenteeism and it results in a loss of skills and a limited supply of education (Theron, 2007: 177).

Because of the pandemic, it is believed that there will be a shortage of educators in important fields like science, mathematics and technical skills (Coombe, 2004: 115). This in turn means that economic growth and the public budget for health and education declines (Coombe, 2004: 115). Typically, educators die between the ages of 30 - 39 when they have accumulated important experiences and the system will have to rely on less qualified
teachers (Coombe, 2004: 115). When this happens the quality of education deteriorates.

In 2005 there was a concern that many educators would leave the teaching profession (Hall et al., 2005:25). Many factors were associated with this, including teachers feeling overloaded by work demands, low levels of job satisfaction and low morale (Coombe, 2004: 116; Hoadley, 2007: 256; Louw et al., 2009: 212). One of the reasons educators said was contributing to their desire to leave the education profession, was the impact of HIV/AIDS (Hall et al., 2005:25; Van Wyk & Lemmer, 2007: 303). So, in addition to the supply of education being threatened by ill educators, educator attrition that is linked in part to the pandemic also has a role to play.

When educators are not ill themselves, their productivity may be low and absenteeism high when they care for HIV-positive family members and when they attend funerals (Coombe, 2004: 114; Fredriksson & Kanabus, 2002: 56; Theron, 2005: 56; Van Wyk & Lemmer, 2007: 303).

In summary, the supply of education is compromised by ill educators who may either be absent or quit the profession or provide poorer quality education; or by healthy educators who are absent to care for ill loved ones, or who have to shoulder ill educators' responsibilities and so consider quitting the profession. Either way, education is at risk.

### 2.3.2 Demand for education

In countries with a high prevalence of HIV/AIDS, the pandemic is affecting the demand for education (Coombe, 2004: 106-112). When the potential recipients of education services (i.e. learners) are affected by HIV/AIDS, this leads to large cohorts of orphans and other vulnerable learners whose schooling is disrupted (Coombe, 2004: 112; Theron, 2005: 56). When orphans have lost both parents, they are 12% less likely to attend school (UNAIDS, 2008a: 22). In needy households that are worse off because of HIV affecting household income, there is a lack of money to send each child to school. These situations become worse as HIV-positive people fall ill and lose their
jobs (Coombe, 2004: 108). Learners will be withdrawn from school as orphaning and poverty rise, or will not enrol because of their inability to pay school fees and limited access to schools, and the need to provide care and support for those who are ill (Bhana et al., 2006: 5-6; Coombe, 2004: 108 - 112; Ebersöhn & Eloff, 2002: 79).

Many orphaned and other vulnerable learners do not enrol in schools, delay enrolment or leave schools because some schools cannot accept children who cannot pay the school fees or buy the right uniforms and books (Coombe, 2004: 111-112). Although in many cases, parents who cannot pay school fees are exempted from doing so, this will happen only when parents or caregivers applied for exemption (Coombe, 2004: 113; Van Wyk & Lemmer, 2007: 309). When orphans are heading up their households they may not know that such exemption is possible and so the demand for schooling is affected.

The demand for schooling is also affected when learners are HIV-positive and drop out because they are sick and cannot attend classes consistently (Coombe, 2004: 108 & 113; Maile, 2003: 186).

How these factors mentioned above impact on the demand for schooling will be discussed in more detail below.

2.3.2.1 Orphanhood

According to Van Dyk (2005:270), an orphan is a child under the age of 18 who has lost at least one parent to death or who has no surviving parent caring for him or her. UNAIDS defines an orphan as a child less than 15 years of age who has lost his/her mother or both parents (Skinner, Tseko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo, Tlou & Chitiyo, 2005: 2). Often AIDS is the cause of such children being orphaned. Presently the estimated data in South Africa show that 13% of children between the ages of 2-14 years have lost a mother, a father or both parents to HIV/AIDS (Van Wyk & Lemmer, 2007: 304). In forthcoming years huge
numbers of South African children will grow up without the support of an unbroken family life (Van Wyk & Lemmer, 2007: 304).

When families are torn apart by HIV/AIDS (e.g. by the death of parents and relatives) such children are negatively affected because they are grieving the loss of their parents and they must live with the stress of being without the familiar care of a mother or father (Ebersohn & Eloff, 2002: 78 & 83; Levin, 2006: 287; Maile, 2003: 186). This affects schooling in practical ways. For example, many orphaned learners come to school on an empty stomach and so it is difficult for them to cope well in the classroom or to learn according to their level of development (Coombe, 2004: 112). Often they suffer from malnutrition, which affects their own health, and then they cannot concentrate properly in school (Ebersohn & Eloff, 2002: 78). In the end, their progress at school (if they still go to school) suffers.

Orphans of school-going age and children with infected parents are often teased by other children and called names (Ebersohn & Eloff, 2002: 78). Sometimes the teasing leads to physical bullying and so many learners decide to stay at home rather than go to school. They have to cope with being stigmatised by society, with economic crisis and lack of security, without support systems or services within a poor community (Hernes, 2002: 116-117; UNICEF, 2003: 25). Sometimes they may be forced to move from their homes, some are placed in institutions or live in child-headed households with older siblings (Ebersohn & Eloff, 2002: 78-79, Van Dijk, 2008: 4-5). Others are taken care of by communities and others lose all contact and identity with carers. They are all affected by emotional stress and poverty, which can disrupt their education (Van Wyk & Lemmer, 2007: 304). Mostly, they cannot pay school fees or afford school uniforms and they drop out of school early and many become street children because of the financial burden (Coombe, 2003: 7-8; Ebersohn & Eloff, 2002: 78-79 & 83; Edwards, Louw, & Orr, 2005; Maile, 2003: 186).

Grandparents sometimes shoulder the responsibility of caring for young children, but in some cases the eldest orphaned siblings have to assume
these duties (Ebersohn & Eloff, 2002:78-79; Shisana et al., 2005a: 124; Van Dijk, 2008: 4-5; Van Wyk & Lemmer, 2007: 304). Many orphans have no other choice than to live in child-headed households that struggle to survive (Van Dijk, 2008: 26). In such cases, it is often very difficult for elder siblings to continue their schooling. Often, HIV/AIDS impact more severely on adolescent girl orphans who have to take on most of the responsibilities in a child-headed household (Chabilall & Hartell, 2008: 148).

Understandably, when learners have to spend time heading households or when they relocate following the death of their parents, or even when their grief gets in the way of learning, the quality of their education is at risk (Ebersohn & Eloff, 2002:78).

2.3.2.2 Vulnerable learners

A vulnerable learner is a child who lives within homes and communities without family love or in an environment where there is no or limited support, nurturing and guidance to help them with the challenges of life and nothing (or almost nothing) to fulfill their basic needs (Van Dyk, 2005: 272). Mostly vulnerable children face circumstances that are beyond their control, including poverty, neglect, malnutrition, physical and psychological trauma, violence, limited education, travelling long distances to and from school and so on (Shisana et al., 2005a: 126). Learners living with HIV/AIDS are part of this vulnerable group who need protection from discrimination and stigma (Coombe, 2000; Coombe, 2004: 107; Ebersohn & Eloff, 2006: 104; Kendall & O’Gara, 2007: 5; Louw et al., 2009: 212; Maile, 2003:196; Welch et al., 2008:61). Often, when learners have parents or caregivers who are HIV-positive, they have to care for them and so may head their households even before their parents die (Bennell, 2003: 493; Coombe, 2003: 7). When their parents do die, these children often become the primary caretakers of their orphaned siblings (Bhana et al., 2006: 6-7; Coombe, 2003:7; Ebersohn & Eloff, 2002: 78; van Wyk & Lemmer, 2007: 304). Many learners turn to prostitution to earn money and child labour is not uncommon (Ebersohn & Eloff, 2002: 98; Maile, 2003: 186; Mallmann, 2002). These vulnerable learners need emotional and practical support (like assisting them to gain social
grants) (Welch et al., 2008: 80-81). Their emotional and practical needs often get in the way of regular school attendance and successful schooling (Welch et al., 2008:90). This in turn compromises quality education.

Children are also vulnerable when they are infected. Infected learners miss a lot of school and eventually fall behind their classmates. Even when they are at school, they have less strength and energy than their friends and may not be able to take part in games and activities (Coombe, 2002: 125). Even though their friends may not know that they have HIV, they may be teased because they get tired quickly. Infected learners need special support; they should not be discriminated against or rejected at school and they should go to school as long as their health and strength permit (Coombe, 2000; Maile, 2003: 186; Mallmann, 2002). When this does not happen, they may drop out and so their demand for schooling decreases.

2.4 THE IMPACT OF THE PANDEMIC ON AFFECTED EDUCATORS

Because my study focuses on helping educators to cope more resiliently with the challenges of the HIV/AIDS pandemic, it is necessary to describe how the pandemic challenges educators, both on a personal and a professional level.

2.4.1 Personal impact on affected educators

To understand the educator as a person and how HIV/AIDS challenges educators, it is necessary to think of the educator as a social, emotional, spiritual and physical being (Theron, 2007:177). HIV/AIDS is affecting educators physically, emotionally, socially and spiritually (Theron, 2007: 175).

2.4.1.1 Physical impacts

How HIV/AIDS affects teachers physically, probably relates to how they are affected (e.g.seeing or hearing someone you love in pain compared to knowing about a colleague who is HIV-positive) (Theron, 2007: 179). When educators are affected because their loved ones are ill, the effects seem to be worse (Theron, 2009: 238). Affected educators who have described how they are affected physically have said that they have poor sleeping patterns and
that they are often woken up by nightmares (Ngemntu, 2009: 40; Serero, 2008: 37; Theron, 2007: 179).

Other educators say that they have lost their appetite and a few have reported that they gained weight because they turned to food as a source of comfort (Ngemntu, 2009: 40; Serero, 2008: 37; Theron, 2007:179). Some affected educators often talk about low energy levels because they are teaching learners who are undernourished and work with ill colleagues (Coombe, 2003: 7).

2.4.1.2 Emotional impacts

Many educators find it difficult to adjust to the reality of the pandemic and many experience feelings of intense emotional discomfort like sadness, loneliness, anxiety, anger, hopelessness and so on (Ngemntu, 2009: 40; Theron, 2007: 182). Some educators experience these feelings because they have loved ones who died due to HIV/AIDS, others because they have to identify, support, monitor and teach vulnerable and orphaned learners and work with colleagues who are affected by HIV/AIDS. This affects them personally (Coombe, 2003: 7 & 9; Hoadley, 2007: 256; Theron, 2007: 182).

Many educators grieve for their colleagues, learners, family and friends who have died from Aids-related illnesses (Coombe, 2000; Hall et al., 2005: 23; Theron, 2005: 59; Theron, 2007: 177). Stress, tension and suicidal ideation are also reported: for example, some educators are concerned about their own personal health in the future and others worry about their loved ones (Ngemntu, 2009: 40; Theron, 2005: 59). Some educators report high levels of fear, both for their personal safety and for the future of our country (Kinghorn & Kelly, 2005: 493; Page, et al., 2006: 108; Shisana et al., 2005a: xxxv; Theron, 2005: 59).

2.4.1.3 Spiritual impacts

Educators affected by the pandemic report that they are changed spiritually. Some indicate that they have become more religious and that they pray much more. Others had the opposite experience and explain that they think that
God is punishing them or has deserted them and so they are no longer very religious (Ngemntu, 2009: 40; Serero, 2008: 37; Theron, 2007:182). Spiritual dissatisfaction suggests a poor prediction for educator well-being (Coombe, 2003: 8-10).

2.4.1.4 Social impacts

The most stressful experiences educators undergo are usually those that damage or break social connections or changes in a relationship, like discrimination and social stigma (Hernes, 2002: 116-117; Ngemntu, 2009: 40). HIV/AIDS has strained the social connection of educators; therefore they need support systems and coping resources (Theron, 2007: 182). Many affected educators report that their social lives have changed as a result of the pandemic. Some say that they have isolated themselves or withdrawn from interacting with others. Many do this because they are afraid of stigmatisation (Louw et al., 2009: 212; Ngemntu, 2009: 40). Others say they have become more cautious because they do not want to become infected (Serero, 2008:36; Theron, 2007:182). In the study conducted by Serero (2008:36), some participants indicate that they socialise more because this helps them to cope and others use socialisation as a chance to teach others about HIV.


2.4.2 Professional impact on affected educators

Professionalism refers to behaviour that enhances performance and representation at work. It relates to employees being able to do their work effectively and efficiently (Van Heerden, 2005: 264). This is often hard for educators affected by the pandemic. Although educators experience high levels of general stress (e.g. changes in education and society, high learner-teacher ratio, curriculum changes, poor relationships with the Department of Education, lack of respect for the profession, poor collegial relationships, lack of support and increase in job mobility), many educators indicate that the
challenges of the pandemic add to their stress and worsen their overall health (Coombe, 2000; Hall et al., 2005: 25; Theron, 2007: 182; Theron, 2008a: 33).

Many affected educators are overwhelmed because of the challenges of the pandemic which bring about high levels of professional stress (Louw et al., 2009: 213). This stress is partly related to multiple professional roles that they are expected to fulfil as well as changed educator roles and therefore many educators report that their professional morale has deteriorated (Coombe, 2000; Hall et al., 2005: 23; Kendall & O’Gara, 2007: 17; Theron, 2007: 182; Theron, 2008a: 33; Van Wyk & Lemmer, 2007: 303).

Many affected educators are placed in poor working conditions with greater workloads, lack of resources, lack of job security and overcrowded classes (Hall et al., 2005: 3; Louw et al., 2009: 207; Ngemntu, 2009: 41; Serero, 2008: 38). HIV/AIDS has a negative impact on infected and affected educators when colleagues are either ill or absent from work and this is stressful for them. Low morale and increased absenteeism disrupt work activities and raise frustration among educators who often have to teach bigger classes and help with the responsibilities of their absent colleagues (Coombe, 2000; Coombe, 2003; Hall et al., 2005: 23; Hoadley, 2007: 256; Louw et al., 2009: 212-215; Ngemntu, 2009: 41; Theron, 2005: 58; Theron, 2008a: 33-34).

Educators are also burdened with AIDS orphans and vulnerable children in their classes (Bennell, 2003: 493; Bhana et al., 2006: 14-15; Coombe, 2003 Louw et al., 2009: 212-215). Both educators and learners who experience AIDS deaths need care and support because they experience emotions of anxiety and loss. In rural areas many learners have nobody to turn to other than their educators and so the latter have to provide support to learners who are grieving or who are infected by HIV (Bhana et al., 2006: 6-7). There is an increasing demand for pastoral or caring work in schools due to HIV/AIDS, which adds to and complicates the usual demands on educators and gives them difficult responsibilities (Bhana et al., 2006: 8).
The education system is faced with a great responsibility for delivering mass prevention campaigns with regard to HIV/AIDS (Coombe, 2004: 117). This means that educators are expected to teach their learners about responsible sexuality and how to avoid HIV infection (Ngemntu, 2009: 42). This is difficult for many educators because not all have been adequately trained to do this and others feel uncomfortable teaching about sex and HIV (Bennell, 2005:467; Bhana et al., 2006: 8; Coombe, 2003).

Some educators who are affected by the pandemic explain that the quality of their work is no longer as good, often because they do not have enough time for preparation and for extra-mural activities, as their time is taken up with coping with the challenges of the pandemic. Others say that their daily routines have become stressful and that this and the additional duties when colleagues are ill, mean that they cannot do their jobs as well as they used to (Louw et al., 2009: 212-213; Ngemntu, 2009: 41-42; Serero, 2008: 38; Theron, 2007:180).

2.4.3 Resilient educators

As summarised in Table 1.2 (see Chapter One), resilient educators have access to a number of protective resources. The idea that not all teachers are laid low by the challenges of the pandemic is encouraging and gives me hope that REds will help more teachers to develop similar resilience.

2.5 SUMMARY

In this chapter I outlined how HIV is spread and described how it has affected people across the world. The focus of this chapter was on how HIV/AIDS has affected education and mostly educators. In summary, it can be said that mostly educators seem to be affected negatively.

Even in this difficult situation educators need to be resilient in order to promote quality education and support learners and colleagues (Hall et al., 2005: 27).
In the next chapter, I will describe the research methodology I followed to be able to make recommendations to refine REds, as one possible way of enabling educators to be resilient (Esterhuizen, 2007; Mabitsela, 2009; Theron et al., 2009).