AN EXPLORATORY STUDY OF THE TYPES OF PSYCHOSOCIAL SERVICES PROVIDED TO EDUCATORS LIVING WITH HIV AT SELECTED PRIMARY SCHOOLS IN THE LIMPOPO PROVINCE

by

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I declare that **AN EXPLORATORY STUDY OFTHE TYPES OF PSYCHOSOCIAL SERVICES PROVIDED TO EDUCATORS LIVING WITH HIV AT SELECTED PRIMARY SCHOOLS IN THE LIMPOPO PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE DATE

(MRS J N THINDISA)

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The journey to complete this dissertation has been a challenging one. Numerous people have helped me along the way and have contributed directly or indirectly to the success of this work.

The last bit of the mountain has been the hardest to climb but through faith and belief in the Almighty God, hard work, dedication, encouragement and sacrifice I managed to reach the top of the mountain.

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DEDICATION

I dedicate this dissertation to each and every one who is affected and infected by HIV and AIDS.

ABSTRACT

Educators play an essential role within the education system as role models. Many educators, in addition to being affected by learners living with HIV and AIDS, are themselves living with HIV and struggle to cope. SMTs have to play a role in the provision of psychosocial services. The purpose of this study was to explore the types of psychosocial services provided to ELWHIV by their SMTs in order to gain insight and understanding and to make suggestions on how psychosocial services can be improved. A qualitative study was undertaken in 2008. Fifteen interviews were conducted with ELWHIV and members of SMTs at four primary schools in Bela-Bela, Limpopo Province. The findings reveal that SMTs are failing to implement government policies and are not providing adequate support for ELWHIV. None of the participating schools had a functional AIDS policy. Support structures were found to be inadequate and ineffective. Disclosure was identified as one of the major obstacles to the provision of effective services.

Key terms: Educator; ELWHIV; SMTs; Psychosocial services; Qualitative research.

ACRONYMS AND ABBREVIATIONS

ACE	Advanced Certificate in Education
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
AVERT	AVERTing HIV and AIDS
CBOs	Community Based Organizations
DPSA	Department of Public Service and Administration
DoE	Department of Education
DoH	Department of Health
DSD	Department of Social Development
ELWHIV	Educators Living With HIV
EST	Educator Support Team
FBOs	Faith Based Organizations
FIND	Foundation for Innovative New Diagnostics.
HAART	Highly Active Antiretroviral Therapy
HAC	Health Advisory Committee
HIV	Human Immunodeficiency virus
HOD	Head of Department
JPTD	Junior Primary Teachers' Diploma

MDG	Millennium Development Goal
NGO	Non-Government Organization
OVC	Orphans and Vulnerable Children
PLHA	People Living With HIV/AIDS
SADTU	South African Democratic Teachers Union
SAIDE	South African Institute for Distance Education
SAPS	South African Police Services
SGB	School Governing Body
SMT	School Management Team
STIs	Sexual Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programmes on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's emergency Fund
UNISA	University of South Africa
VCT	Voluntarily Counseling and Testing

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CHAPTER 1

INTRODUCTION AND STATEMENT OF THE RESEARCH PROBLEM

1.1 INTRODUCTION

Education plays a vital role in the prevention and spread of HIV infections through its impact on individuals, families, communities and society (UNICEF 2002: 11). Educators play an essential role within the education system as role models, mentors and guardians. As with all members of the population, however, educators themselves are susceptible and vulnerable to HIV infections. This susceptibility is increasingly noticeable in countries with high HIV infection rates, and particularly in sub-Saharan African countries (UNAIDS 2005). The HIV and AIDS epidemic is expected to have a catastrophic impact on educators in sub-Saharan Africa as educators themselves are believed to be a relatively high-risk group with respect to HIV infection (Mbetse 2006). A study conducted by Rehle, Shisana, Glencross and Colvin in 2005 (2005: 8) revealed that more than a fifth (22 percent) of educators in South Africa were living with HIV. In 2009 it was estimated that 5, 6 million people, including educators, were living with HIV and AIDS in South Africa (http://www.avert.org/aidssouthafrica.htm).

HIV/AIDS not only attacks individuals, it also attacks systems (Coombe 2000: 14). The education sector in South Africa has been significantly affected by the AIDS epidemic in various ways. As HIV and AIDS reduces the number of parents 20-40 years old, numbers of orphaned children increase, and poverty intensifies, school enrolment rates are expected to decline. Dropouts due to poverty, illness, lack of motivation and trauma are set to increase, together with absenteeism among children who are heads of households, those who help to supplement family income, and those who are ill. The education service is the largest occupational group in South Africa. As educators

become ill, are absent or die, are preoccupied with family crises, school effectiveness will decline (Coombe 2000: 16-17).

Hall (2004: 3) observes that HIV has changed the nature of educators' work and that they now require an advanced repertoire of skills to deal with its impact. The task of educators is consequently expanding to include raising HIV and AIDS awareness, teaching HIV-prevention, aiding infected and affected learners and colleagues, executing increased teaching loads as infected colleagues are increasingly absent, and coping with the ordeal of AIDS-related illnesses and deaths of their significant others. Vulnerable learners are often homeless, experience hunger, discrimination, abuse and rejection and may be in need of grief counselling, and other forms of support which are executed by educators. Many schools do not have professionally trained staff to respond to the HIV-related needs of learners. It therefore becomes the responsibility of the educators, who very often do not have the necessary knowledge, skills, or support systems to fill this gap (Bhana, Morrell, Epstein & Moletsane 2006).

In general, educators in South Africa report high levels of stress and the psychosocial impact of the AIDS epidemic aggravates their situation (Theron 2009: 231). Many educators report that both their professional lives and day-to-day functioning are compromised because of epidemic-related stress factors such as grief, fear, escalating workloads and pastoral care demands (Theron 2009). Educators are being affected on a psychosocial level in that their colleagues, learners and family members may be either infected with HIV, or dying from AIDS-related illnesses, or by the fact that they have to teach orphans and vulnerable children (OVC) who have been made vulnerable by the impact of HIV and AIDS (Theron, Geyer, Strydom & Delport 2008: 78).

The impact of the HIV epidemic is not necessarily limited to the professional challenges faced by educators (Theron et al 2008: 80). Many educators are themselves living with HIV and they are struggling to cope on both an emotional and social level. It is the researcher's experience that when educators are diagnosed with HIV, their psychosocial life is severely disrupted. They are most likely to suffer from stress and become depressed and may even isolate themselves socially. This is because HIV is

regarded as a life threatening illness by most people who therefore dissociate themselves from people living with HIV and AIDS (PLWHIV)[1] (Rehle et al 2005). The implication of these multiple stressors extends to the education system where absenteeism and poor teaching performance become routine.

The support for educators who are affected and infected by the epidemic has become a matter of concern. The provision of psychosocial services i.e. care, support and treatment to educators living with HIV (ELWHIV) can be an effective strategy for reducing absenteeism and medical dismissals.

1.2 BACKGROUND AND RATIONALE

With more than five million (an estimated 11 percent) of the overall population currently living with HIV, South Africa is currently experiencing one of the most severe AIDS epidemics in the world. The total number of new HIV infections for 2009 was estimated to be 413 000. Children were expected to account for 60 000 of those newly infected (Statistics SA 2009). The impact of HIV and AIDS is felt not only by the infected person, but also by friends, family and the wider community (Bialobrzeska, Randell, Hellman & Winkler 2009: 2). The Joint United Nations Programme on HIV and AIDS (2005) declared the AIDS epidemic to be the most 'globalised' epidemic in history. The global nature of the epidemic is clearly observable in countries such as South Africa where no sector has managed to escape its effects. Families experience severe financial loss as breadwinners (who are usually from the most economically active groups) pass away because of AIDS-related deaths. Communities are left with the massive burden of caring for orphans and vulnerable children who have lost one or both parents due to AIDS-related deaths. Society is challenged to develop prevention programmes while extending care and support to those infected and their loved ones.

Coombe (2006) highlights the way in which the education sector has been affected:

[1] The general term 'people living with HIV and AIDS (PLWHIV)', where referred to in the text, includes educators living with HIV and AIDS (ELWHIV).

Learners: Fewer children enrol in school because HIV-infected mothers die young; children die of AIDS complications; many families suffer financially; and many children are orphaned or caring for younger children, or are trying to earn some sort of a living and are therefore staying out of school. These conditions generally lead to absenteeism or total withdrawal from school to lower educational performance; and premature termination of education. These factors result in fewer vocational opportunities for these children

Teachers: Teachers die through HIV and AIDS related deaths and these results in a loss of the education personnel.

School effectiveness: A decline in school effectiveness is likely to occur owing to large number of teachers, officials and children being ill, lacking in morale, and unable to concentrate.

The schooling system: HIV and AIDS makes it even more difficult to sustain the structures necessary to provide formal education of the scope and quality envisioned by the government's policies, especially as management, administration and financial control systems are already fragile.

Coombe (2006: 16) warns that under these conditions current education development goals (including the Millennium Development Goals[2] and Education for All[3]) will be unattainable within the foreseeable future and that these conditions may possibly signify a reversal of development gains achieved since 1994.

1.3 THE RESEARCH PROBLEM

[2] The Millennium Development Goals are eight international development goals that all 192 United Nations member states and at least 23 international organisations have agreed to achieve by the year 2015. Available at: http://www .undp.org/mdg/goal3.shtml

[3] Education for all is a global movement led by UNESCO, aiming to meet the learning needs of all children, youth and adults by 2015. Available at: http://www.unesco.org/education/efa/ed_for_all/background/background_documents.shtml

UNAIDS (2006: 234) stresses the role that governments can play in addressing problems encountered by ELWHIV, for example by keeping pace with extended and comprehensive psychosocial services such as prevention, treatment, care and support services. The provision of psychosocial services to ELWHIV can be an effective strategy in reducing educator absenteeism and dismissals by providing care, support and treatment. These services can be effective in dealing with the psychosocial, spiritual and socio-economic problems related to HIV and AIDS. Psychosocial services have the advantage of providing the coping skills that are required to address the reactions associated with HIV diagnosis such as feelings of anxiety, helplessness, grief, fear, denial, guilt, anger, and loss and feeling depressed (van Dyk 2005: 214). The researcher's experience as an educator herself is that there is an insufficient and inadequate provision of psychosocial services to ELWHIV.

The Department of Education's *National Policy on HIV/AIDS for Learners and Educators* provides guidance on discrimination in schools and institutions, workplace advocacy and sensitisation, and sports safety (Department of Education 1999). Bialobrzeska et al (2009: 6), however, in their investigation of good practice in supporting both learners and educators who are affected by the AIDS epidemic in South Africa, found that while there were many initiatives to support learners, there was "very little evidence of care or support initiatives aimed at teachers who were affected or infected by HIV and AIDS". Despite their extensive work roles and responsibilities, teachers are left to deal with the emotional and psychological burdens of being infected and affected by HIV and AIDS on their own.

School Management Teams (SMTs) can be described as the structural sites of participative management within schools (van der Mescht & Tyala 2008) and have an integral role to play in the provision of psychosocial services to ELWHIV. Adequate and effective provision of psychosocial services by SMTs to ELWHIV can address the challenges that are associated with the illness. Rehle et al (2005), however, found that the psychosocial services offered by some SMTs are inadequate and ineffective. Lack of effective services is, for example, impeding ELWHIV from accessing and making use

of voluntary counselling and testing (VCT) services and from accessing treatment centres available in their respective communities.

Lack of, or inadequate, prevention, treatment, care and support strategies to prevent the spread of HIV and AIDS to ELWHIV may have serious consequences in terms of replacing the knowledge and skills required to ensure on-going and quality education. It is therefore imperative to determine the underlying nature of psychosocial services required to ELWHIV, and to determine also the challenges faced by the SMTs in providing these services to educators. This will enable schools to develop the necessary strategies to improve its core business of education.

1.4 THE PURPOSE OF THE STUDY

The purpose of this study was:

1. To explore the types of psychosocial services provided to educators living with HIV at four selected primary schools in Bela Bela, Limpopo Province;
2. To identify the challenges impeding the effective provision of such services in order to gain insight into and an understanding of these services,
3. To make suggestions as to how psychosocial services can be improved by SMTs at primary schools.

1.5 RESEARCH QUESTIONS

The study was based on the following questions:

1.5.1 What types of psychosocial services are provided to educators living with HIV by their SMTs in Limpopo Province?

1.5.2 What challenges do the SMTs face in providing psychosocial services to educators living with HIV?

1.5.3 How can the psychosocial services for ELWHIV be improved to assist educators living with HIV in the Limpopo Province?

1.6 THE RESEARCH SITE

This study was limited to four primary schools in the Waterberg district of the Bela-Bela area in Limpopo Province. The schools were selected because they were easily accessible to the researcher. Participants were selected according to their first-hand experience of and knowledge about the issues being investigated.

A qualitative approach was chosen for this exploratory study. Primary data was collected by means of an interview schedule used in face-to-face interviews with a sample of 15 purposefully selected participants, i.e. eight ELWHIV and seven members of SMTs. All of these individuals were willing to participate in the study. Appointments were scheduled with the selected participants. The purpose of the study and the research process was explained to them and all the participants gave informed consent to participate in the study.

1.7 DEFINITIONS OF KEY TERMS

According to Fisher and Foreit (2002: 40) contextual definitions of terms are imperative as it enables the reader to understand the terms as used in such specific context. Key terms used in this study were educator, educator living with HIV (ELWHIV), school management teams (SMTs), psychosocial services. These terms are defined as follows:

1.7.1 Educator

An educator is a professional who is employed by the Department of Education and who imparts knowledge, skills and values to the learners and or students. The Employment of Educators Act states that “educator means any person who teaches, educates or trains other persons at an education institution or assists in rendering education services or education auxiliary or support services provided by or in an education department, but does not include any officer or employee as defined in section 1 of the Public Service Act, 1994” (Government Gazette 19320 1998: 2).

1.7.2 Educator living with HIV (ELWHIV)

For the purpose of this study, ELWHIV refers to individuals who are infected and/or affected by HIV.

1.7.3 School Management Teams (SMTs)

SMTs are defined as a group of people mandated to oversee the smooth running of the school system. This group is made up of the school principal, the deputy principal and the heads of departments (HODs) who are either appointed or acting and who have the responsibility to assist the principals with their management tasks more widely in the school (Department of Education 2000: 2). SMTs are mandated to make sure that the management of schools is conducted in a more democratic, inclusive and participatory fashion. The teams are also expected to mitigate problems that are experienced by both the educators and learners. SMTs have specific duties involving organization and decision-making, and leadership and policy formulation that will ensure effective teaching-learning process.

1.7.4 Psychosocial services

UNAIDS (2006: 175) defines psychosocial services as the psychosocial interventions which denote an "integration of psychosocial services in treatment programmes and increased access to psychotropic medication." For the purpose of this study, the term psychosocial services refers to all the activities and interventions which are conducted in order to provide people living with or affected by HIV and AIDS with treatment, care and support.

1.8 CHAPTER OVERVIEW

The rest of the dissertation is organised as follows:

Chapter two details the conceptualization of the psychosocial services for ELWHIV. In this chapter, the researcher provides an in-depth discussion of the psychosocial services that are available to ELWHIV. An emphasis is placed on the nature of the

psychosocial theoretical approach, and on the types of and challenges facing the psychosocial services that are provided to ELWHIV at selected primary schools.

In **Chapter three** the researcher outlines the research design and the methodology adopted for the study. Data collection methods are discussed and attention is focused on qualitative interviews. A discussion is provided regarding the ethical considerations of the research and this discussion indicates how the researcher strove to observe ethical principles and guidelines during the study.

In **Chapter four** the researcher presents the research findings.

Chapter five consists of conclusions and recommendations drawn from the study. In this chapter the attention is focused on a summary of the findings, the limitations of the study, and suggestions for further research. The chapter concludes with some recommendations for policy and practice.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The spread of HIV infection within South African society has become a widespread social problem as it affects virtually every sector of society. HIV is associated with numerous conditions that affect large numbers of people. The challenges faced by those infected with, and by those affected by HIV, range from experiencing the death of a loved one to having to deal with the psychosocial impact of living with HIV themselves (Sullivan & Thomson 1994). This chapter provides a discussion of literature around an exploration of the types and challenges of psycho social services provided to educators living with HIV at selected primary schools in the Limpopo Province.

2.2 THE IMPACT OF HIV AND AIDS ON ELWHIV.

The impact of HIV and AIDS on educators occurs at a number of levels. The most direct impact is on the educator as an individual, in terms of his or her HIV status. Educators may be reluctant to undergo an HIV test due to fear of discrimination if they are found to have HIV. Those educators who know they are HIV- positive may be unlikely to disclose their status in schools where HIV-related stigma is found and may be unaddressed, where they feel they would not be treated fairly, or where they might lose their jobs. They may also isolate themselves from their colleagues and communities in an attempt to conceal their HIV-positive status. This can be both psychologically, emotionally and socially damaging (UNESCO 2007).

2.3 THE ROLE OF SMTs.

At the school level, ELWHIV are expected to be provided with adequate psychosocial services by their respective SMTs. These teams are composed of elected educators and other non-teaching staff who have the responsibility to assist the principal with the administrative functions of the school.

SMTs can play a critical role in addressing and alleviating some of the challenges faced by ELWHIV. They can address some of the challenges faced by ELWHIV in their workplace by exercising leadership to build trust and dialogue among educators, facilitating collaboration, encouraging and developing the capacity of educators to deliver messages on HIV and AIDS, and creating methods of work adjustments and sick leave (UNESCO 2007). SMTs also have a key role to play in supporting HIV-positive educators through interactions with policies provided by the Ministry of Education. This may include providing or applying the mechanisms needed to operationalize the HIV and AIDS workplace policy (accountability and disciplinary procedures that respect confidentiality) (UNESCO 2007).

2.4 POLICIES AND PROGRAMMES FOR THE PROVISION OF PSYCHOSOCIAL SERVICES TO ELWHIV.

The South African Department of Education (DoE) acknowledges the challenges that educators are confronted with and has developed policies and programmes aimed at assisting educators living with HIV and those affected by HIV and AIDS (Mbetse 2006). The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions were some of the interventions formulated to address the problem of HIV and AIDS in the education sector (National Education Act 27 of 1996). The DoE acknowledges the increasing prevalence of HIV and AIDS within schools and the need for each school to have a planned strategy to cope with learners and educators living with HIV and AIDS. The DoE is committed to minimize the social, economic and developmental challenges associated with HIV on the education system and to provide leadership in this regard.

In line with the National Education Act, various programmes have been developed by the DoE to mitigate HIV and AIDS and its impacts within the education sector. Some of the programmes developed in order to address HIV and AIDS- related challenges are:

(a) *Life skills education programmes:* The life skills programmes were developed and introduced in schools with the aim of improving the manner in which SMTs and school communities deal with the everyday challenges associated with HIV. HIV and AIDS talks, HIV and AIDS education are activities that can be developed to address problems associate with HIV and AIDS.

(b) *Prevention programmes:* Prevention programmes were developed and introduced in schools in order to equip educators and communities with the knowledge of prevention strategies. SMTs are responsible for collecting HIV and AIDS prevention material (usually from health care institutions and/or from the district/local office) which they distribute amongst educators, learners, parents, and the school governing body. Other activities involve both educators and learners taking part in social action campaigns that are aimed at increasing HIV and AIDS awareness within communities.

(c) *Community-based nutritional programmes:* Basic nutritional needs must be met since adequate food intake is effective in addressing the health conditions related to the HIV and AIDS illness. SMTs must encourage educators and learner representation to identify learners who are from poor families and they can assist by providing them with these basic necessities.

(d*) Voluntary counselling and testing (VCT) programmes:* Most schools within the South African context do not have a VCT facility. SMTs must encourage educators, learners, parents and school governing body members to make use of VCT at local community clinics.

(e) *Antiretroviral therapy (ART) programmes:* These programmes are intended for individuals who have reached the AIDS stage of the illness. As with VCT programmes, ART programmes are available only at hospitals and clinics. In a school environment, SMTs should encourage educators, learners, parents and school governing body members to make use of the programmes available at local community clinics and hospitals.

(f) *Home-based and community-based care programmes.* These programmes include care, treatment and support provided to ELWHIV by SMTs, members of the community and other specialized volunteers (AIDS Guide 2007: 124). The SMTs should encourage educators, learners, parents and school governing body members to make use of the programmes.

HIV and AIDS workplace policies for the education sector are powerful tools to support and protect educators, learners and non-teaching education staff (UNESCO 2007). However, while the provision of psychosocial services to ELWHIV is well articulated in legislature, policies and programmes such as those mentioned above, it would appear that these services are not reaching the people for whom they are intended.

2.5 THE PSYCHOSOCIAL THEORETICAL APPROACH

The psychosocial theoretical approach is a multidimensional theory of intervention that has been built up from practical experience (Fan, Conner & Villarreal 2004). Fan et al (2004) assert that the practicality of this theory stems from therapeutic settings which include a variety of role players, namely, individuals, groups, families, multiple therapists and the entire community. Dush, Cassileth and Turk (1986: 43) define the psychosocial approach as "a composite of intrapersonal, interpersonal, occupational and physical characteristics" of an individual. Fundamental to the psychosocial theoretical approach is the belief that people are social beings and that their physical, psychological, emotional and spiritual well-being is improved through their interaction with others. According to Fan et al (2004: 158), this theoretical perspective explains the behavioural patterns of people within groups because "people's attitudes and beliefs are also shaped and reshaped through interaction with other people."

Dobson and Kendall (1993: 302-303) maintain that one-dimensional theories are no longer regarded as tenable. The psychosocial approach is multidimensional in nature in that it seeks to include the different social and psychological challenges that face people living with HIV, and its interventions include addressing their needs, helping with coping mechanisms and providing support services. It is an integrated approach which combines both psychological and social interventions that differ from that of other

interventions. Berke, Fagan, Mak-Pearce and Pierides-Muller (2002: 19) refer to this integrated approach as being 'psychosocial' and argue that psychosocial interventions "have been relatively successful primarily because they address this issue by providing whole environments". Lipkin and Kupka (1982: 2) are of the opinion that psychological and social factors are critical in predisposing individuals to disease. Psychological, physical and social being is interrelated. In other words, one cannot feel happy if one is not physically healthy and consequently this might affect one's relationship with significant others. The psychosocial approach is aimed at attaining a quality of life which is comprised of the intrapersonal, interpersonal, occupational and physical characteristics of an individual (Dush et al 1986: 43). When quality of life is of a high standard, people tend to live well. Taking an integrated, multidimensional psychosocial approach to ELWHIV means that their social, physical, psychological, emotional and spiritual welfare can improve.

2.6 THEORETICAL PERSPECTIVES OF THE PSYCHOSOCIAL NEEDS OF PEOPLE LIVING WITH HIV.

There are a number of theoretical perspectives applicable to the psychosocial needs of people living with HIV. Gerrity, Keane and Tuma (2001: 65) identify learning theory, information processing theory, the social-cognitive model, social support theory, developmental models and learned helplessness theory. Only learning theory and learned helplessness theory will be elucidated for the purposes of this study.

2.6.1 Learning Theory

Learning of one's HIV-positive status is a traumatic event because the illness is regarded by most people as a life-threatening one. Learning theory models seek to explain the relationship between stimuli (which in this analysis is an HIV-positive status) and responses which refer to the personal behaviour of an individual infected and affected by their status. This theoretical model explains that individuals who learn that they are HIV-positive tend to change their behaviour due to stress resulting from their status (Gerrity et al 2001).

Learning theory asserts that that fear and other aversive emotions are learned and can be expressed through other defence mechanisms of classical conditioning. This entails that most persons acquire a variety of aversive emotions immediately after they experience fear (Gerrity et al 2001:65). “The second factor involves principles of instrumental conditioning in that some persons will learn to escape from or avoid cures that stimulate aversive emotions (Gerrity et al 2001: 66). The stimuli-response relationship which is purported by this theory was elaborated by Steptoe and Ayers (2004: 174) who maintain that any life change is capable of taxing resources and is therefore likely to be detrimental to the health and wellbeing of individuals affected. This model therefore maintains that the news that one is HIV-positive is the necessary factor that predisposes maladaptive behavioural patterns.

2.6.2 Learned Helplessness Theory

People who undergo distressing experiences may feel apathy, dysphoria and passivity. They may have highly generalized beliefs about personal lack of control over future events (Gerrity et al 2001: 69). The knowledge that there is no cure available for HIV makes people believe that the only option available for them is to wait for death (van Dyk 2005: 217). These challenges predispose them towards the psychological state of helplessness. A person who has learned helplessness has a reduced capability and willingness to do something to improve his or her own circumstances. They simply tend to wait for death to take its toll.

When experiencing a life-threatening condition like HIV/AIDS, there are psychosocial needs without which an individual can find it difficult to adjust to his or her respective environments. These needs refer to a variety of cognitive, emotional and interpersonal factors which enable individuals to cope with stressful events in their lives (Young, Van Niekerk & Mogotlane 2003: 100). Pendlebury, Grouard and Meston (1999: 153) argue that the delivery of extended and comprehensive provision of psychosocial services to people living with HIV can be measured by the consideration of how far their psychosocial needs were met in the process.

2.7 PSYCHOSOCIAL SERVICES

UNAIDS (2006: 175) defines psychosocial services as the psychosocial interventions which denote an "integration of psychosocial services in treatment programmes and increased access to psychotropic medication."

Social support, as defined by Dageid and Duckert (2008: 185) is the interaction between people which includes the sharing of advice, information and food, and is crucial for successful coping with HIV. Social support can be provided by means of treatment and care. (Four types of psychosocial support, namely emotional, informational, material and financial and instrumental support are discussed later in this chapter.)

2.8 STIGMATIZATION AND DISCRIMINATION OF HIV/AIDS EDUCATORS

Van Dyk (2005) points out that educators are particularly afraid of being isolated, stigmatized, discriminated against and rejected by their significant others. Stigmatization and discrimination have long been identified as being two critical impediments that badly undermine the effectiveness of the prevention, care and treatment efforts of HIV and AIDS (Weinreich & Benn 2004). Various forms of stigmatization and discriminatory practices are observed within the education sector.

2.8.1 Stigma and discrimination

Discrimination is an infringement of human rights that often leads to ELWHIV being subjected to various forms of abuse (UNAIDS 2004: 126). Stigmatization can be perpetuated by the general community. Certain individuals are able to influence the community and assist in the stigmatization of individuals living with the pandemic. This ultimately leads to ELWHIV being further discriminated against and to their being excluded, isolated, and rejected. They can also be denied certain benefits such as care, support and treatment (Weinreich & Benn 2004).

ELWHIV endure the burdens of possible prejudice and intolerance because of the terrible stigma attached to their illness (Zappulla 1997: 214). Discrimination in the school environment is apparent when the ELWHIV are isolated by other staff members,

the learners, parents and members of the SMT. This practice can make the school a dysfunctional unit due to absenteeism on the part of the infected and/or affected ELWHIV who may be trying to dissociate themselves from those who are stigmatizing them.

2.8.2 Forms of stigma

A number of forms of stigma – physical, social, verbal and institutional – have been identified by Ogden and Nyblade (2005):

- **Physical stigma**

Physical stigma includes isolation and violence. Physical isolation happens when ELWHIV are isolated from their workplaces, homes, communities and other public places.

- **Social stigma**

The manifestation of social stigma can be social isolation, loss of identity and role. Isolation can be expressed through the taking away or diminishing of the roles, responsibilities, and social standing of those living with HIV within the family and the community. As a result, HIV positive people lose power, respect, and identity. This expression of stigma is a result of both the perception of how people living with HIV (PLHIV) are assumed to have contracted HIV, as well as the belief that HIV means immediate disability and death (Ogden & Nyblade 2005).

- **Verbal stigma**

Verbal stigma can be indirect (gossip and rumours) or direct (pointing fingers, insulting, taunting or blaming). Expressions of disapproval take the form of blame and shame, scolding or judgemental statements accusing people with HIV of having “got what they deserved.” People living with HIV are blamed for becoming infected through their “irresponsible” and “selfish” behaviour, and for bringing shame upon themselves, their families and the community, as well as for becoming a burden to the family. Gossip and rumours focus on speculation as to whether a person actually has HIV, usually because of visible signs, such as illness, kinds of behaviour, or association with groups seen as

“high risk”. Gossip is reported to be one of the most significant forms of stigma. Once a person is assumed to be positive, people often speculate as to how he/she contracted HIV. Direct forms of verbal stigma are likely to be expressed by means of insulting, mocking, taunting, cursing, and threatening those living with HIV and AIDS (Ogden & Nyblade 2005).

- **Institutional stigma**

Institutional stigma refers to differential treatment within any broadly defined institutional setting that leads to a negative outcome for persons living with HIV (Ogden & Nyblade 2005). It can be loss of or inability to secure livelihoods, housing, health care, and education. It can also include losing access to new or future opportunities because an HIV test is required to qualify for a job, loan, scholarship or visa for travel; differential treatment within institutions that leads to less than satisfactory outcomes (for example having to wait longer for health services). The isolation of individuals within the educational institution is common. Individuals isolate themselves due to fear of HIV and AIDS related stigma and discrimination.

2.9 PSYCHOSOCIAL ATTRIBUTES THAT ARE EXPERIENCED BY ELWHIV

Psychosocial services must, inter alia, take cognizance of psychosocial attributes that have been identified in ELWHIV. A number of psychological attributes manifested by PLHIV have been identified by van Dyk (2005). These attributes have a dysfunctional impact on the teaching-learning process in the school environment.

2.9.1 Fear and anxiety

The terms fear and anxiety are often used interchangeably by psychosocial specialists and practitioners. In most instances educators become fearful and anxious before they test for HIV, and also before they disclose their status to their significant others. Educators who are anxious tend to mistrust the safety within the school environment in which they work. They develop panic disorders or phobias. According to van Dyk (2005: 217), PLHIV are anxious because they fear the risk of infecting others, the risk of losing loved ones, and the risk of rejection.

Overcoming fear and anxiety responses requires a new definition of HIV that does not define the illness as a death sentence. ELWHIV should be encouraged to form their own support groups through which they can encourage each other to address the effects of the illness and its aftermath. Within these groups, they can learn from others as to how to run their lives in a healthier manner. ELWHIV can be empowered by these groups to accept their status and to live openly with it.

2.9.2 Loss and grief

Loss is often associated with HIV. HIV-positive educators often feel that they have lost everything that is important to them: the opportunity to teach and develop their respective learners, and the opportunity for self-development. They experience loss of ambition, physical attractiveness, sexual relationships, status and respect in the community, financial stability and independence. The psychosocial problems faced by all individuals living with the illness are encapsulated by Uys and Cameron (2003: 122) as having to cope with “multiple losses and fear of losses, such as the loss of friends, health, independence, job and income”.

Whenever individuals have lost something they appreciated and/or loved, they enter into a state of grieving. In the case of ELWHIV, loss and grief are experienced when their future is threatened. Grief refers to the subjective experience of the psychological, behavioural, social and physical reactions to a specific loss (Bonde 2001: 85). When ELWHIV experience loss and grief, they feel irritable, have sleep and somatic disorders, hallucinate, feel guilty, and sometimes even resort to suicide. In the context of this condition, ELWHIV should be accurately and appropriately assisted by their respective SMTs to lessen their feelings of loss and grief.

2.9.3 Guilt

Van Dyk (2005: 216) points out that guilt and self-reproach for having contracted HIV and for having also possibly infected others are frequently expressed by HIV-positive individuals including educators. They consequently tend to withdraw from colleagues and interact poorly with their learners. Treating these educators will require SMTs

and/or counsellors to work with them throughout their historical lifestyles. Guilt can be reduced if individual educators review their previous interactions with those close to them. Once they are able to resist destructive interaction, they should be able to come to terms with their current situation of being HIV-positive and as a result be able to cope more adequately with feelings of guilt. SMTs are an effective social support group available within the school environment that can assist ELWHIV to work through their feelings of guilt.

2.9.4 Denial

According to Weinreich and Benn (2004: 47), denial occurs when people repress the subject of HIV in order to avoid dealing with it: “On the individual level, denial means not wanting to admit to infection, or the possibility of infection.” Many ELWHIV regard an HIV-positive status as a death sentence. The threat of impending death is usually dealt with by this type of defence mechanism. Educators who are in a state of denial tend to avoid those who actively confront the HIV and AIDS issue such as their respective SMTs and any person of significance to them. According to van Dyk (2005: 216), most HIV-positive educators go through a phase of denial as it is an important and protective defence mechanism in that it temporarily reduces emotional stress. In the short term it actually becomes a very useful tool in helping those who are living with HIV. Van Dyk (2005: 216) maintains that ELWHIV should be allowed to cling to their denial if they are not yet ready to accept their diagnosis, because it often gives them a breathing space in which to rest and gather additional strength. It is only when denial is overused by ELWHIV that the SMTs and or counsellors need to start intervening. Denial can be dealt with through psychosocial intervention. When ELWHIV are supported they are able to come to terms with their positive status and will in turn behave in an adaptive manner.

2.9.5 Anger

HIV-positive educators are often very angry; they experience anger towards God, themselves and others, towards the person who infected them, and towards others who are healthy (Uys & Cameron 2003). This anger is sometimes directed at those closest to them (van Dyk 2005: 216). Emotional outbursts towards colleagues, learners,

members of SMTs, parents, school staff, parents and others within the school environment are common occurrences. This anger is exacerbated by the fact that there is no cure for AIDS and that there is no certainty about the future.

Anger has been found to be a highly dysfunctional attribute in the teaching-learning process within the school environment. It can also be classified as a maladaptive behaviour that is termed 'emotional personality' (van Dyk 2005) This anger is often exhibited by educators who have received news about their futures, such as those who have lost limbs, eye sight, or are HIV- positive. Contrada and Goyal (2004: 148) view emotional personality as a condition which predisposes infected and affected individuals towards psychological stress and emotion.

Hostility often accompanies anger. Hostility refers to "a broad personality attributes involving negative attitudes, easily aroused anger and aggressive behaviour" (Contrada & Goyal 2004: 149). ELWHIV tend to develop hostility toward themselves and/or those they believe have infected them with the illness. The ELWHIV find it very difficult to interact with their significant others. They therefore resort to isolating themselves from others. This behaviour could lead to other manifestations of withdrawal and depression. According to Contrada and Goyal (2004), a maladaptive emotional personality tends to contribute to the deterioration of the physical attributes of PLHIV.

2.9.6 Low self-esteem

Most ELWHIV tend to be confused, withdrawn and to perform at their minimum level (van Dyk 2005). This condition of withdrawal and confusion can be identified and defined as a loss of self-esteem. Low self-esteem among most ELWHIV individuals is caused by a loss of confidence and social identity which in turn leads to feelings of reduced self-worth. This condition has the ability to inhibit their being open to any measures necessary to assist them. Educators experiencing feelings of low self-esteem tend to be like learners in that they cannot have positive feelings about their own development because they do not trust those around them. Self-esteem is achieved by the feeling of control over our own actions, by acknowledging our self-worth and by the ability to gain recognition from those around us. Van Dyk (2005: 217) observes that

PLHIV cannot devise their own initiatives unless they are encouraged by their respective SMTs and colleagues to do so. Thus, if they are not encouraged, they do little to improve the teaching-learning process.

2.9.7 Depression

Depression is the most serious maladaptive psychological defence mechanism. Bogart, Catz, Kelly, Gray-Bernhardt, Hartman, Otto-Salaj, Hackl, & Bloom, (2005: 515) view depression and feelings of hopelessness as serious psychological and emotional states which people can enter into when they fail to cope with day-to-day stressors. The most debilitating psychological and emotional attribute that is experienced by PLHIV is depression. Depression has the following symptoms: depressed mood, diminished interest or pleasure in most activities, significant loss or gain of weight, difficulty in sleeping, feelings of restlessness or of being slowed down, loss of energy, feelings of worthlessness or inappropriate guilt, lost concentration and recurrent thoughts of death (Dowrick 2004: 17).

SMTs are the most effective and strategic intervention modes to improve the lives of ELWHIV, and to challenge their depressive states. When depressive states are not addressed adequately, they may lead to suicidal attitudes.

2.9.8 Suicidal attitudes

Van Dyk (2005: 217) describes a suicidal attitude as anger that is inwardly directed at self-blame, self-destructive behaviour or (in its most intensive form) suicidal impulses or intentions. Suicidal inclinations may be explained as a way of avoiding pain and discomfort, or of lessening the shame and grief of loved ones and of trying to obtain a measure of control over one's illness. Such individuals end their lives without the knowledge that being HIV-positive does not automatically result in death.

Suicidal tendencies are difficult to detect and even to prevent. ELWHIV who are suicidal can be helped by an enhancement of their social interaction with others such as family members, colleagues, members of the SMTs, parents of the learners and members of the school governing bodies.

2.10 PSYCHOSOCIAL NEEDS OF PEOPLE LIVING WITH HIV

Provision of the psychosocial services is organised to meet the needs of people living with HIV. ELWHIV often have physical and medical needs. An educator infected with HIV lives with a body that constantly struggles to fight disease and illness. Ways in which to boost the body's immune system include among other things: working in a healthy and supportive environment (Department of Education 2003: 66).

The most important psychosocial needs are listed by Young et al (2003: 100-101) as being cognitive needs, adaptation needs, self-esteem needs, autonomy needs, relatedness needs. Young et al (2003: 100) are of the opinion that unless these needs are addressed accordingly, infected individuals may find it difficult to adapt to their working and personal environments. ELWHIV experience stress because the disease is associated with huge negative changes in their lives.

2.10.1 Cognitive needs

Cognitive needs are concerned with knowing. In other words, in order for an individual to function adequately in relation to others and the environment within which they exist, he/she must have effective thought processes (van Dyk 2005: 92). Knowledge of their environment is determined by their interaction with their significant others. Given the reality that those living with HIV remain dissociated, their cognitive needs remain largely unmet.

2.10.2 Adaptation needs

People must learn to adapt to their environments and situational conditions. Young et al (2003: 100) highlight the fact that in order to be able to deal with stress and life events effectively, individuals must develop a variety of coping skills. Coping skills are defined as the ability to use problem- solving techniques and relaxation as well as the avoidance of stressful situations (Young et al 2003). The less healthy coping mechanisms include aggression, withdrawal, substance abuse and others. Young et al (2003: 100) also include unconscious coping behaviour in the form of defence mechanisms such as denial, projection, depression and regression.

People affected and infected with HIV and AIDS are unable to adapt to stress. Henderson and Baum (2004: 74) define adaptation as the process of “preparing and enabling the body to respond to challenges or threats in ways that will increase the likelihood of surviving this threat.” When people cannot adapt adequately to extremely stressful circumstances, they develop maladaptive behavioural patterns.

2.10.3 Self-esteem needs

Self-esteem is the individual’s ability to regard his/her self in a positive way. The importance of a positive self-image is explained by Young et al (2003: 100) as the basis of sound interpersonal relationships and mental health. Empowerment is an effective approach towards the enhancement of self-esteem.

2.10.4 Autonomy needs

Young et al (2003: 101), describe autonomy needs as those of independence, control and competent management of the cognitive, perceptual and behavioural processes of an individual within societal definitions of ‘normality’ or ‘mental health’ and conforming to the accepted social needs. ELWHIV needs independence and also to be accepted as part of the society.

2.10.5 Relatedness needs

According to Young et al (2003) relatedness needs posit human beings as social animals who tend to rely on the cooperation of and close associations with others. Human relationships are reciprocal in nature, meaning that people give and receive from such relationships.

2.11 COPING STRATEGIES

According to Dageid and Duckert (2008), the phrase 'coping with HIV' means the manner in which individuals develop their different manifestations aimed at dealing with the illness. It is the behaviour adopted and the psychological effort made to manage, master, minimize or tolerate the stress and demands related to HIV and AIDS (Dageid & Duckert 2008: 182). When people cope with the experiences and conditions that are

associated with HIV, they avoid the realities and exclude themselves from interacting with others. In other circumstances some people may choose to express their disappointment to others. Dageid and Duckert (2008: 182-183) classified the reactions to coping with being HIV positive into two categories, namely, the problem-focused coping strategy and the emotional coping strategy.

2.11.1 The problem- focused coping strategy

This is a positive means of coping in that it is active and confrontational in nature. In this view, according to Dageid and Duckert (2008), ELWHIV take charge of their circumstances, from communicating with health care workers to collecting information related to their condition, to interacting with others rather than withdrawing all the time, to helping others who are also living with the illness. The strategies which are developed according to this approach are more beneficial and adaptive in nature for they are associated with better self-rated general health, psychological resilience, and self-esteem, fewer mood disturbances, confusion, fatigue or anxiety (Dageid & Duckert 2008: 183).

Educators who are able to deal positively with stress have a higher probability of psychologically and physically recovering from the experience of being HIV. According to Dageid and Duckert (2008: 183), the main task of coping could be survival which is broadly defined as a physical, psychological and social coping strategy. The problem-solving strategy of coping is a psychological mechanism which is expressed in seeking to provide ELWHIV with adequate psychosocial support services.

2.11.2 The emotional coping strategy

An emotional coping strategy is characterized by passiveness and avoidance. Educators become withdrawn; they solve problems on their own and experience a vast number of emotions which are associated with the illness such as anxiety, denial, avoidance, self-blame, fatalism, mental disengagement and helplessness (Dageid & Duckert 2008: 183). This type of coping is maladaptive and can lead to serious depression. Davis, Frankis and Flower (2006: 325) report that most PLHIV develop

lowered self-esteem and are “seen to lack skills needed to cope with their life with treatment.” Individuals with lowered self-esteem tend to do little to improve their condition. Emotional coping strategies are adaptive in areas only when they are used temporarily or in extreme situations. Davis et al (2006: 340) describe an ELWHIV who is in an extreme emotional situation as one who is classified under ‘post-illness’ and ‘loss of confidence’, and it is during this state that such people feel emotionally distressed. Psychosocial support services which are provided to ELWHIV are intended to address emotional coping mechanisms.

Bogart et al (2005) argue that there is a need for “understanding the psychosocial impact of HIV disease and for identifying the coping issues that confront persons living with HIV”. Kalichman, Rompa and Cage (2005: 258) see coping skills interventions as those including relaxation training, cognitive restructuring exercises and the gaining of rational problem-solving skills. These skills can be imparted through education and skill-building techniques.

2.12 TYPES OF PSYCHOSOCIAL SUPPORT SERVICES FOR ELWHIV

Psychosocial support measures are meant to produce different kinds of life changes for ELWHIV. Bogart et al (2005) are of the opinion that once adequate psychosocial services are provided to ELWHIV, they will attain the mature psychosocial adjustment which will enhance their living standards. Colenso (2000: 18) distinguishes between services that are things (concrete) and information (abstract). Several types of psychosocial support services are essential for the daily functioning of ELWHIV and these include emotional, informational, material and financial, and instrumental services.

2.12.1 Emotional support

Emotional support is identified by Dageid and Duckert (2008: 189) as being the primary type of psychosocial service. This type of support may be provided by a variety of individuals such as significant others (spouses, family members). In the school environment (workplace), SMTs, the community and colleagues are expected to be important sources of emotional support for ELWHIV.

In terms of Maslow's needs theory, emotional support services are categorized as belonging needs (Hjelle & Zeigler 1981: 371). Belonging needs entail that individuals develop and maintain relationships with their significant others who can provide them with care, love and support. According to Maslow, an individual is motivated by the need to be loved and longs for affectionate relationships with others (Hjelle & Zeigler 1981: 371). However with ELWHIV this is not always the case. Their lives are characterized by stigmatization, rejection and fear of association. This isolation and stigmatization of ELWHIV prevents their emotional needs from being addressed.

The most effective strategy for providing psychosocial support to ELWHIV is to empower them so that they are able to take charge of their lives. Individuals who reach this state tend to experience very little emotional turmoil. ELWHIV want to be actively involved in their HIV care (Davis et al 2006: 339). Indeed educators who are highly involved in programmes or interventions intended to improve their lives have a greater probability of achieving improvement with regard to their health, psychological and emotional states and interaction with others.

2.12.2 Informational support

Psychosocial services that include information on HIV and AIDS management, risk reduction and counselling are imperative. Informational support is also motivational in nature. ELWHIV should be provided with adequate information to abate their fear and to prepare them for living a healthy lifestyle (Zuyderduin 2004: 52).

Counselling is one form of information support that is aimed at reducing high risk behaviour which can expose individuals to further infection. Counselling is effective in the reduction of the spread of the illness and in the prevention of new sexually transmitted infections (STIs) and can also lead to improvement in terms of engaging in healthy sexual behaviour (Mathiti, Simbayi, Jooste, Kekana, Nibe, Shasha, Bidla, Magubane, Cain, Cherry & Kalichman, 2005: 268). HIV risk reduction counselling intervention may be provided in conjunction with voluntary counselling and testing (VCT) services. Mathiti et al (2005: 269) maintain that information-motivational

enhancement counselling sessions demonstrate outcomes of lower rates of unprotected intercourse and greater use of risk reduction strategies.

2.12.3 Material and financial support

Material support refers to essential needs such as food, shelter and treatment. ELWHIV require material needs for survival because without these needs being met their health could be adversely compromised. As their conditions deteriorate, some of them may not be able to continue with their daily duties because their physical strength is also likely to decline. The implication of this is that eventually they will die and leave their families with inadequate or no material and financial support (Zuyderduin 2004).

2.12.4 Instrumental support

Instrumental support as a type of psychosocial service to ELWHIV can be described as 'practical assistance with daily living' and can include the therapies which are provided to ELWHIV in terms of the psychosocial support services paradigm.

Highly Active Antiretroviral Therapy (HAART) has been identified as one of the most relevant therapies available to psychosocial support services. HAART is the name given to aggressive treatment regimens used to suppress HIV viral replication and the progression of the disease. The usual HAART regimen combines three or more different drugs. These HAART regimens have been proven to reduce the amount of active virus in the body and in some cases can even lower the number of active virus until the disease is undetectable in current blood testing techniques (http://aids.about.com). HAART said to have greatly improved health and reduced the need for continuous care and support among people living with HIV (Dageid & Duckert 2008: 189). Davis et al (2006: 323) are also of the view that HAART has significantly reduced death rates among people living with HIV and that the therapy leads towards improved life expectation because it combines the anti-HIV drugs; reduces the viral activity and protects or restores the immune systems of people living with HIV. Kalichman, Picciano and Roffman (2008: 317) also ascribe to the belief that combinations of antiretroviral (ARV) medications reduce viral burden, improve health

and quality of life of people living with HIV, and contribute directly to the decline in HIV-related mortality".

Numerous reports have been obtained from subjects who took part in the HAART programme conducted by Bogart et al (2005) which indicate that once ELWHIV were introduced to the programme their lives changed dramatically in a positive direction, that is, they started planning for the future and having a positive perception of themselves. Even though this does not include everyone, some of the participants reported that the results of their tests indicated an 'undetectable viral load.' This is defined simply as "the HIV viral load had not been detectable in their blood for some time" (Bogart et al 2005: 505). In South Africa, the standard of care with regard to HAART is described in the South African HIV Clinicians Society's ARV treatment guidelines. ARVs have also been shown to reduce the risk of women transmitting the virus to their infants (www.aidstruth.org/science/arvs).

2.13 PSYCHOSOCIAL SUPPORT SYSTEMS FOR ELWHIV.

According to the DoE National Policy (Act 27 of 1996) on HIV and AIDS for Learners and Educators in Public schools, as well as Students and Educators in Further Education and Training Institutions, SMTs are expected to design and develop effective strategic interventions to assist ELWHIV.

The following are the support systems that ELWHIV require in their daily lives:

2.13.1 Psychosocial support

Psychosocial support is meant to reduce the impact of a disease on affected individuals (Dowrick 2004: 193). Psychosocial support includes relieving educators of the stress associated with depression, anxiety, spiritual pain, support for families and care-givers including practical assistance with nursing, respite, care and counselling to help them work through their emotions and grief (UNAIDS 2004: 120). Psychosocial support is not only meant for prevention and/or to safeguard individuals and/or groups at high risk of the HIV- infection but also for adjacent chronic illnesses such as tuberculosis (TB).

2.13.2 Social support by the family

The family has always been a primary source of social support for its members (Sutton, Baum & Johnston 2004: 246). The authors are of the view that living within a supportive family with positive interactions and clear communication has been shown to be associated with low levels of stress, high levels of stress-coping behaviour and active adaptation to illness (Sutton et al 2004: 248). Rather than SMTs claiming ownership of the lives of ELWHIV, they should encourage these educators to develop and maintain close relationships with the significant members of families such as spouses, children, parents and other close members of the extended family.

2.13.3 Social support by the community

AIDS-affected households rely heavily on relatives and community support systems to weather the epidemic's economic impact (UNAIDS 2004: 48). The advantages associated with social support were identified by Sutton et al (2004: 179) as being a positive sense of self-worth, well-being and the gaining of information and material support. Schools do not operate in isolation but are invariably part of the community. One of the key obstacles to supporting HIV- positive educators has been stigma and discrimination from communities. Therefore supporting HIV- positive educators will be impossible unless negative attitudes in the community are tackled (UNESCO 2007). School governing bodies, parent- and educator associations can play a central role in supporting infected and affected educators and in reducing stigma in communities. The SMT, together with the school governing body, parents, learners and other members of the school community thus become the associate members of the educator's community.

2.13.4 Home-based care

Uys and Cameron (2003) argue that the home visit is central to the concept of home-based care. It enables health care workers to make a realistic assessment of a patient such as in the case of an educator's holistic care, and to provide care and support that is suited to the individual circumstances of each individual. When ELWHIV become

bedridden they are no longer able to show up at their place of employment. At this stage these educators need more care than their families alone can provide. SMTs must encourage ELWHIV to make use of the home-based care facilities available to them. The members of the SMTs should also provide educators who have reached the AIDS stage with home visits, that is, they are expected to visit the bedridden educators in their own homes in order to encourage them to take all the prescribed medication and to exercise all behavioural modification strategies that are associated with coping with the illness.

2.13.5 Educator-based care

Since there are many people living with HIV who have experienced fear or rejection by their families of origin, they often 'create' new families from friends and community groups (Jue & Lewis 2001: 68). Educator-based care is a 'family' that can be developed by the SMTs and the school community. This care system maintains that ELWHIV should receive special treatment, care and support from their colleagues when this is not being provided by family members.

2.14 CONCLUSION

This chapter has provided the reader with an overview of the provision of psychosocial services to ELWHIV. The provision of psychosocial services is designed according to the psychosocial theoretical approach. This approach is effective in the development of policies and programmes needed to assist ELWHIV. ELWHIV experience a variety of challenges that need to be identified and dealt with by their SMTs. In the context of this study, the challenges that are experienced by ELWHIV centre around their maladaptive behavioural patterns aimed at coping with the stresses related to being HIV-positive. The SMTs are expected to design and develop effective strategic interventions necessary for the assistance of ELWHIV.

The research methodology is discussed in the following chapter.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

In this chapter, the methodology used in the study is discussed. Research design involves a set of decisions regarding what topic is going to be studied; among what population; with what research methods; and for what purpose (Babbie 2010: 117). The chapter begins with a discussion of the qualitative approach which is the methodological orientation of this exploratory and descriptive study. The ensuing discussion of the research design includes a general orientation to the study; a description of the research method; the selection of the research sites, and the sampling design and procedure; a description of the data analysis and interpretation; and the ethical considerations underlying the study.

3.2 METHODOLOGICAL ORIENTATION

Exploratory research is conducted when little is known or has been written about a topic. De Vos (1998: 126) explains that exploratory studies are relevant only in circumstances where the research problem has not been thoroughly researched before. Marshall and Rossman (1999: 33) also point to the use of exploratory research to investigate little-understood phenomena and to identify or discover important categories of meaning for further research. Exploratory studies are used to gain new insights into a topic (Babbie 2010: 93). The study was exploratory and descriptive in nature because it was the first investigation into the nature and type of the challenges facing psychosocial services provided to ELHIV at selected primary schools in the Limpopo Province.

Most exploratory research studies are of a qualitative nature. Qualitative research entails the gathering of data in their subjective form, and that data is soft in nature

(Neuman 2000: 122). Soft data is usually expressed in words, sentences, impressions and phrases. The basic position of a qualitative orientation as employed in this study is that in order to understand social phenomena the researcher needs to uncover the individual's perception and interpretation of reality, and how these relate to his/her behaviour. The use of a qualitative approach enabled the researcher to capture the perceptions and feelings of both the members of SMTs and the potential users of the services with a view to determining the challenges involved in both the provision and use of these services.

3.3 TRUSTWORTHINESS OF DATA

Social science research studies are expected to collect trustworthy or valid data. Different commentators suggest different validity criteria for qualitative research. Neuman (2007: 120), for example, suggests that qualitative researchers are more interested in authenticity than validity. He describes authenticity as providing "a fair, honest and balanced account of social life from the viewpoint of someone who lives it every day". It was therefore important to capture the experiences of the participants from their own point of view. The credibility of the data was enhanced by the fact that participants were allowed to provide their own accounts of the psychosocial services offered by SMTs.

3.4 THE RESEARCH DESIGN

In this section the selection of the research sites is discussed, followed by a discussion of the sampling method; the interviews which were used as the main research method; the data analysis of the interview transcripts; the validity and credibility of the research process; and the ethical considerations underlying the study.

3.4.1 Selection of the research sites

The four primary schools selected for the study are located within the Bela-Bela area in the Waterberg District of the Limpopo Province. These schools, which provide educational services to the Bela-Bela community, are located within a kilometre of one another. These research sites were selected for the following reasons:

- **The time factor and financial resources**: The researcher could spend minimal time travelling between these sites within the Bela-Bela community. Travelling costs were also reduced because of the geographical location of the sites.

- **Community membership**: As the researcher was working as an educator within the Bela-Bela community during the period of this study she was known to the potential participants of the study.
-

For reasons of confidentiality the selected schools were given the following names:

1) Lepelle, 2) Sediba, 3) Tshwane, 4) Sehlare

3.5 SAMPLING DESIGN AND PROCEDURES

In keeping with the exploratory and qualitative nature of the study, purposive sampling was used to select participants who had first-hand information about the issue being investigated. Purposive sampling is also called judgement sampling because it selects cases with a specific purpose in mind or uses the judgement of an expert to select cases, and is typically employed in exploratory or field research (Robson 1993: 140).

In order to secure participants for the study, invitation letters were distributed to the four selected primary schools inviting educators to participate in the study (See Appendix A). An informed consent form (See Appendix B) was attached to the letter. The final sample for the study comprised fifteen participants who were infected and/or affected by HIV and who volunteered to take part in the study. The final sample was made up as follows:

1) Lepelle Primary School: 2 educators; 3 members of the SMT

2) Sediba Primary School: 3 educators; 1 member of the SMT

3) Tshwane Primary School: 1 educator; 2 members of the SMT

4) Sehlare Primary School: 2 educators; 1 member of the SMT

Individual interviews were conducted with each participant at their particular schools. All interviews were conducted in English since participants were from different cultural and language groups (Northern Sotho, Setswana and Tsonga) but were all able to communicate adequately in English.

3.6 DATA COLLECTION METHOD

Following the nature of the data sought in this study, a semi-structured interview, called the interview guide (see Appendix C) was selected for its flexibility in eliciting data of a predominantly qualitative nature. The use of semi-structured interviews allowed the researcher to collect rich information that was derived from the opinions, beliefs, experiences and views relating to psychosocial services provided by SMTs from both educators and members of SMTs.

Qualitative research is interactive in nature, meaning that its data collection methodologies are in the form of interaction between the researcher and those involved in the research. Struwig and Stead (2001: 18) point out that the interplay between the researcher and the participants allows subjects the opportunity to use their own words, statements and explanations in order to inform the researcher about their opinions, beliefs, feelings and views about a problem being investigated.

Semi-structured interviews have the advantage that the researcher is able to encourage the participants to refine their responses as much as possible to make their responses relevant to the study. Semi-structured interviews usually require the participants to respond to questions which are posed to them in an open-ended fashion. Robson (1993: 237) explains that semi-structured interviews have the objective of providing participants with the freedom to define and describe in detail how they experience, view and feel about the problem under review. The semi-structured interview takes the form of an interaction between the researcher and the interviewees, where the latter are given follow-up questions in order to clarify their answers. There is a probing element involved that allows the researcher to draw out information by means of repeating

the questions in a slightly different form and/or repeating the respondent's answer and then asking if the information was correct (Fisher & Foreit 2002: 81).

All interviews were conducted by the researcher herself and were tape recorded.

3.7 METHOD OF DATA ANALYSIS

For De Vos, Strydom, Fouche and Delport (2002: 286), qualitative data analysis means the reduction of the data, its presentation and interpretation. Qualitative data analysis methodology requires that the data should first be transcribed, then summarised and coded. After transcribing the recorded interviews the researcher then read through each response and made notes of similar phrases and/or words in order to identify themes. When similar responses were removed from the transcriptions (i.e. reduction), only those which diverged from the others remained. The researcher repeated the process by acknowledging the remaining and divergent responses in the report. In this fashion, data could be counted by saying, for example, that four respondents reported that those educators living with HIV were receiving adequate psychosocial services from the SMTs.

After the recorded interviews had been transcribed, the data was analysed by means of reading through the context and selecting similar themes and/or phrases and grouping them together. The researcher continued to highlight differing themes and/or phrases that emerged, and highlighted their occurrence in the report.

3.8 VALIDITY AND CREDIBILITY

The researcher addressed the concepts of validity and credibility in this study.

Validity refers to data that is not only reliable but also true and accurate (Fisher & Foreit 2002). The research instruments and/or questions used to generate data in this study were valid in that they were capable of obtaining information which was both truthful and accurate in measuring their responses with regard to their opinions, views and feelings about the nature and types of psychosocial services provided to ELWHIV and the challenges facing that provision.

According to Neuman (2007: 120), “Qualitative researchers are more interested in authenticity than validity. Authenticity means giving a fair, honest and balanced account of social life from the viewpoint of someone who lives it every day”. The researcher found it important to understand the experiences of the participants from their own point of view, as suggested by Neuman (2007) above.

The researcher covered the credibility of the data gathered by allowing participants to tell her about their experiences regarding the provision of psychosocial services and challenges encountered. In this regard, Neuman (2007:249) explains that “field researchers depend on what members tell them. This makes the credibility of members and their statements part of reliability… field researchers takes subjectivity and context into account as they evaluate credibility”.

3.9 ETHICAL CONSIDERATIONS

Ethical considerations concern the principles and guidelines which researchers must follow in order to ascertain that they do not violate the physical, psychological and emotional states of the subjects of the study during the data collection process (Shisana et al 2005: xv). The following elements of ethical were taken into consideration during the data collection phase of the study:

3.9.1 Harm to subjects

Harm to subjects refers to the discomfort that may be experienced by participants, for example, during interviews. Participants should not be potentially exposed to harm such as to questions and topics that evoke their psychological and emotional states (De Vaus 2001: 86). The researcher ensured that the questions asked during interviews did not contain elements which compromised the participants’ psychological and emotional well-being. Participants were given an option to withdraw from the study at any time.

3.9.2 Informed consent

Informed consent is synonymous with voluntary participation (De Vaus 2001: 85). All participants in this study were informed by the researcher about the aims of the

research and were then able to decide whether or not to participate. (Neuman 2000: 96). Those who were willing to participate then signed the consent form. (The consent form is included as Appendix B).

3.9.3 Anonymity

According to anonymity requirements, the identities of participants cannot be revealed. Anonymity may be guaranteed by assigning numbers, codes and/or pseudonyms to participants (Neuman 2000: 98). In this study the participants (and schools) were assigned pseudonyms, and no information or other biographical characteristics which could have exposed the participants were revealed. All interviewees were assured of anonymity prior to and during the interview.

3.9.4 Confidentiality

Confidentiality exists when only the researchers are aware of the participants' identities and have promised not to reveal their identities nor the information shared by the participants to others (Neuman 2000: 99). Names of selected primary schools and names of educators infected and/or affected by HIV were not disclosed for reasons of confidentiality. Interviewees were assured of confidentiality prior to and during the interviews**.**

3.9.5 Deception

A well-established principle of social research is that people should not be required or led to believe that they are expected to participate in a study (De Vaus 2001: 183) and that deception be avoided (Marshall & Rossman 1999: 97). All participants were fully informed as to the purpose of the study and all signed informed consent forms prior to their participation.

The Department of Education, Provincial Government of Limpopo gave permission for the study to be conducted. (Appendix D).

3.10 SUMMARY

The methodological orientation and exploratory qualitative research design were discussed in this chapter. Brief information on the research setting was provided. The findings of the study and the interpretation thereof are presented in the next chapter.

CHAPTER 4

FINDINGS AND INTERPRETATION

4.1 INTRODUCTION

The findings and interpretation of data are presented in this chapter. The chapter commences with the profiles of the schools in which the study was conducted and the profiles of the educators who participated in the study. This is followed by the presentation of research findings and the interpretation of the findings in terms of the types of psychosocial services provided to ELWHIV. The challenges to the effective provision and utilisation of psychosocial services are also presented. The research findings are presented in the form of themes that are guided by the goals and objectives of this study.

The data was generated through fifteen face-to-face interviews conducted with fifteen key participants selected from four primary schools. The key participants were seven male and eight female educators from four primary schools (Lepelle, Sediba, Tshwane and Sehlare) from the Bela-Bela area. Participants were all over the age of 30, seven of the participants were members of the SMT and eight were not involved with their respective SMT in any way. Amongst the participants, only one disclosed that she was infected. From the responses, however, the researcher believes that some were not prepared to disclose their status.

4.2 PROFILES OF SCHOOLS AND PARTICIPANTS

The profiles of the four primary schools and their respective educators who participated in this study are presented below.

4.2.1 Lepelle Primary School

Lepelle Primary School was built and officially opened in the early fifties. It was mainly built to cater for learners from the black population groups in the Bela-Bela area. Like many other schools in the country, it has been affected by HIV and AIDS. Educators and learners alike face the challenge of HIV and AIDS as they and their significant others are infected. At the time of this study, Lepelle Primary comprised of 575 learners and 19 educators. Five staff members (Maggie, Matome, Merriam, John and Thomas) were interviewed from this school. Their profiles are provided below.

4.2.1.1 Maggie

Maggie was a single 45 year old Tsonga speaking educator, who had obtained her Honours Degree in Education. Maggie lived with her three children and her mother who was a pensioner and. She was the sole breadwinner of the family. She was the head of department (HoD) at the time of this study. She started working as an educator in 1993 and has been involved in the SMT since then. At the time of the study; she was a grade four and five Mathematics, Technology and Natural Science educator.

4.2.1.2 Matome

Matome was a 53 year old father of two who lived with his wife, children and two grandchildren. Matome's wife was employed by the DoE. He was a Northern Sotho speaker with 33 years' experience as an educator and he possessed a Higher Diploma in Education at the time of the study. He was a grade six and seven Mathematics educator and at the time of the study he was the deputy principal and was actively involved also as an assistant manager of the SMT.

4.2.1.3 Merriam

Merriam was a 44 year old single grade R educator who lived with her mother who was a pensioner. She was the sole breadwinner and had no children. At the time of this study, Merriam possessed a Diploma in Higher Education and had 24 years' experience as an educator. She was not involved in the SMT in any way.

4.2.1.4 John

John was a 57 year old father of two who spoke Northern Sotho and lived with his wife, two children, and daughter-in-law and grandchild. At the time of the study the wife was employed by the DoE. John as an educator was involved in teaching Social Science to grades five and six. He was also serving as the principal of the school. John possessed a Diploma in Higher Education. He had 34 years' experience of teaching and 17 years of experience as a principal. As principal of the school, John was also the manager of the SMT.

4.2.1.5 Thomas

Thomas was a 43 year old father of three who spoke Northern Sotho. His wife was employed by the DoE. He possessed a Senior Primary Teacher's Diploma. He was a grade four, five and six Northern Sotho educator. At the time of this study, Thomas was not involved in the SMT in any way.

4.2.2 Sediba Primary School

Sediba Primary School was officially opened in 1995. The school comprised of an estimated 900 learners who were mostly from the surrounding areas of Bela-Bela. The staff of this school comprised 27 educators. Four educators (Mokgadi, Anna, Sophy and Tinyiko) participated in this study. Their profiles are provided below.

4.2.2.1 Mokgadi

Mokgadi was a 43 year old single Tswana speaking Grade R educator who possessed a Diploma in Higher Education. She lived with her mother who was a pensioner at the time of this study. Mokgadi was the breadwinner in the family. She had one year's experience as Head of Department (HoD) and 15 years' experience as an educator. The fact that she was a HoD automatically made her a member of the SMT.

4.2.2.2 Anna

Anna was a 44 year old Tswana speaking foundation phase (grade R) educator. She lived with her husband and had no children at the time of the study. The husband was employed by the DoE. She had 15 years' experience in the teaching profession. She possessed an advanced Certificate in Education (ACE). Anna was involved in teaching three main foundation phase learning areas, i.e. Numeracy, Literacy and Life skills. She was not a member of the SMT.

4.2.2.3 Sophy

Sophy was a 38 year old Tsonga speaking foundation phase (grade R) educator. She lived with her pensioner mother and her two children. She was the sole breadwinner of the family. Like Anna, Sophy was also involved in teaching Numeracy, Literacy and Life skills. She had been an educator for 15 years and was in possession of a Junior Primary Teachers' Diploma (JPTD). She was not a member of the SMT.

4.2.2.4 Tinyiko

Tinyiko was a 43 year old Tsonga speaker who lived with his wife and two children. He was the sole breadwinner of the family. He was a grade four and five Tsonga educator. He had been in the education field for 20 years. During the time of this study, he was in possession of a JPTD qualification. Tinyiko was not involved in the SMT.

4.2.3 Tshwane Primary School

Tshwane Primary School was officially opened in 1994, at the dawn of the South African democratic era. The school comprised of 1036 learners and 35 staff members. Lindi, Phinias and Thabo were participants from this school. Their profiles are presented briefly below.

4.2.3.1 Lindi

Lindi was a 40 year old Northern Sotho speaker. She was single, lived with her three children and was the sole breadwinner. She was a grade one educator and also worked as the deputy principal. Her position as deputy principal automatically made her assistant manager of the SMT. She started working as an educator in 1996 and had

eight years' experience as deputy principal. At the time of this study, she possessed an Honours Degree in Education.

4.2.3.2 Phinias

Phinias was a 44 year old Northern Sotho speaker and a father of three children who lived with his wife. His wife was employed by the DoE. He was the head of department (HoD). During the time of this study, Phinias was in possession of an Honours Degree in Education. He was a grade six English educator who had 17 years' experience in the education field. He was a member of the SMT.

4.2.3.3 Thabo

Thabo was a 33 year old single Northern Sotho speaker. At the time of the study he was living with his fiancé and child, and was the family breadwinner. He was a grade five Natural Science educator who had nine years' experience in education. At the time of this study, Thabo held an advanced Certificate in Education (ACE) and was not a member of the SMT.

4.2.4 Sehlare Primary School

Sehlare Primary School was officially opened in 1999 and, like most schools in rural areas, it lacked resources and was mainly comprised of learners who were from poor socio-economic backgrounds. Three staff members, Naledi, Thapelo and Joyce, participated in this study. Their profiles are provided briefly below.

4.2.4.1 Naledi

Naledi was a 31 year old Northern Sotho speaking grade one educator. She lived with her husband and two children. Her husband was employed by the South African Police Services. She had five years' experience in the teaching profession. At the time of this study, she was in possession of a Junior Primary Teachers Diploma (JPTD). She was not involved with the SMT in any way.

4.2.4.2 Thapelo

Thapelo was a 40 year old Tswana speaker who was the principal of the school. He lived with his wife and two children. The wife was employed by the Department of Health. Thapelo's position as the principal automatically made him the SMT manager. At the time of this study, he was in possession of an Honours Degree in Education. Thapelo was also a grade six and seven English educator.

4.2.4.3 Joyce

Joyce was a 42 year old Northern Sotho speaker. She lived with her child and was the sole breadwinner. She was a grade one educator teaching Numeracy, Literacy and Life skills. At the time of this study, Joyce was in possession of a Bachelor of Education degree. She had ten years' experience in the education field and was not involved in any way with the SMT.

4.3 THE TYPES OF PSYCHOSOCIAL SERVICES PROVIDED TO ELWHIV

Psychosocial services which should be provided to ELWHIV and learners have been identified by Uys and Cameron (2008) as: counselling, nutrition, medical care, home visits, interpersonal and social support, practical and basic needs (transport and food distribution). As there were some differences between the services offered by the participating schools, the findings from each school are presented separately.

4.3.1 Lepelle Primary School

4.3.1.1 The current situation regarding the provision of psychosocial services to ELWHIV at schools

The findings of the study revealed that only a limited number of psychosocial services were available to ELWHIV at some of these schools. These comprised of care and support and were largely limited to home visits and emotional and spiritual counselling.

When asked about the current situation regarding the provision of psychosocial services to ELWHIV at their school, the following replies were forthcoming:

The involvement of the SMT was explained by Maggie:

Umm, in my school in the past, the SMT was not so involved when coming to the treatment, but recently as one of our colleagues has disclosed, as from October, the SMT volunteered to help him with taking the medication from our local clinic. And when coming to care, we used to go to the home visit, if somebody is not attending regularly so that we give him support to his physical but at least they don't accept the health that one has the condition. When coming to prevention, there is nothing about the workshops or even the talks about the pandemic as the staff or the SMT does not have full knowledge of the epidemic.

4.3.1.2 Treatment, care, support and prevention

Merriam explained that insofar as care was concerned:

Educators living with HIV are supplied with three vegetables since we have greenery project in our school.

She also explained that in terms of prevention -

Educators are advised to abstain from unprotected sex or stick to one partner.

The supportive atmosphere at Lepelle Primary School was also mentioned by Matome (assistant manager of the SMT).

In as far as we are concerned, we the SMT of Lepelle Primary School have agreed to assist in administering treatment for educators living with HIV at school level. And then, in terms of care, we normally share ideas. We show love and we also pray together with those affected educators. Eh- we also show support by organising home visits as a staff.

Maggie, a SMT member, explained the type of treatment and support provided by the SMT:

The treatment that we have at my school is the one that are provided by the local clinic as we ask them to administer such medication so that the teachers must not go to the

clinic in the morning, they just have to have medicine at school as we know that HIV goes hand in hand with TB so these teachers which are taking TB treatment, they take it from the school and the support is that every time we support them so that them must not feel a lonely and we care them by giving them the vegetables from our school garden.

John's views were:

Eh, well, in my view in terms of treatment the SMT we can only encourage the infected to follow the medical advice and take medication regularly without failure and to eat healthy and exercise in regular basis. Regarding care, as the SMT, we should ensure that educators, learners and employees embrace a caring attitude towards the infected. And then on support- supporting systems said we defend the infected against all forms of prejudice stigma and discrimination should be established. Campaigns for provision of affordable treatment should be held. And on prevention we should encourage members to undertake voluntary confidential testing and counselling. [We need] c*ampaigns for changing lifestyle through advocacy.*

He also emphasised that emotional and spiritual support are give to those who are infected.

Thomas explained that:

At our school, support and care are the only psychosocial services that we are providing. Treatment and prevention - those are still a challenge to us.

4.3.1.3 Challenges

Various challenges were identified by participants when asked about the challenges faced by the SMT in providing services.

The lack of knowledge and educational materials was highlighted by Maggie:

According to my understanding is that we lack knowledge about this [psychosocial services] *because we don't have such a contact with the Health Services and we don't*

even have materials like pamphlets, charts or even the address from the Department of Health.

Matome explained that currently medication was available on request by infected ELWHIV, but the biggest challenge was:

… *to convince the service providers to accept dispensing medication to the institution.*

Absenteeism was regarded as one of the biggest challenges by Merriam:

Ok, the challenges are that of absenteeism by educators. Learners lack behind, workload becomes a problem to other educators.

The stigmatisation of the infected by health care workers was a concern for John:

Well, the challenges are numerous and various such as bad treatment by health care officers stigmatising infected people and that's leading to non-disclosure the fear of being rejected and leading to depression. Those are challenges that we face as the SMTs.

The lack of knowledge around HIV and AIDS, particularly regarding SMTs, was identified by Thomas:

Ja, the SMT is faced with the challenge … because presently what I have realised is that they lack knowledge about this disease.

4.3.1.4 The effectiveness of services provided by SMTs

There were mixed feelings as to whether the psychosocial services provided at their school were effective, and participants had different recommendations for ways in which the provision of services could be improved.

The sensitivity of the issue was Maggie's concern:

Not really, because the SMT does not have skills on how to support them psychologically as we don't know how to address them so that they cannot be hurt by our speeches or what we say.

Maggie pointed out the connection between HIV and TB felt that services could be improved by:

… being in contact with the infected more often and to monitor their progress if they disclose and again to provide the DOT service as we know that TB goes hand in hand with the HIV, most of them they are also affected by TB.

Matome, however felt that the services were successful:

Yes, they are effective because it boost self esteem of colleagues especially if support comes from within.

Matome felt that services could be improved by collaborative partnerships with other stakeholders:

It [services] *be improved by engaging other stakeholders, for an example, support from the Department of Education and the NGOs.*

Merriam commented:

No hey, are not effective. They [the SMT] *take a long time to respond on that issue.*

She had a number of recommendations for improving psychosocial services to ELWHIV:

This must be internal arrangement, medication must be sent to the schools at all times, workshops can be held, road shows in the form of fund raising and the healing sectors can be invited for the healing process to take place.

John referred to the positive indirect role taken by their SMT:

Eh - so far I can't say as we have very few or none of the infected people in our school but the thing that we have as the SMT we speak to the health care givers to treat those who are infected with sympathy and empathy so that they should be able to take their medication on a regular basis.

John felt that psychosocial services to ELWHIV could only be improved

…*by having educators living with HIV disclose and being embraced by law*.

The lack of knowledge of the SMTs was also expressed by Thomas, who expressed the view that psychosocial services to ELWHIV could be improved by workshops to help both the infected and affected.

4.3.1.5 Policies and programmes

All respondents were aware of AIDS policies, but lamented the lack of programmes. When asked about the policies and programmes in place for ELWHIV in Limpopo Province, and their effectiveness, typical responses were:

Maggie: *I cannot say yes, but I can just say partially, because what I know is about the policies but coming to programmes, I have never even come across that one in the Limpopo Province.*

Matome: *Yes, there is policy because the Department of Education has trained educators in various workshops to develop policies which to assist educators living with HIV in different sites. But in as far as programmes are concerned up to now we don't have such programmes.*

John: *Well eh—such policies are there but they are not effective since they are just written policy and no advocacy was undertaken to make them more practical and realistic as far as the Limpopo Department of Education is concerned.*

Thomas: *Ja policies are there, policies are there because eh, we, once attended some workshops in order to deal with this disease of HIV and AIDS but eh, the programmes are the problems because in that workshop we were only workshopped on how to draw up policies but eh, since then we never came together to discuss the programmes so that to see whether these policies are functional or not. No, they are not effective. They are not effective.*

4.3.2 Sediba Primary School

4.3.2.1 The current situation regarding the provision of psychosocial services to ELWHIV at schools

Responses from participants at this school revealed that there were virtually no services of any type being offered, and an SMT totally lacking in knowledge and initiative. When asked about the current situation regarding the provision of psychosocial services in terms of treatment, care, support and prevention to ELWHIV at Sediba Primary School, typical responses were:

Mokgadi, who was a member of the SMT answered:

No, treatment - we don't have treatment. We don't even have care, no support and no prevention.

This was confirmed by the other participants. Tinyiko volunteered the following regarding the lack of knowledge of the SMT:

Yeah, in my view when coming to the item of psychosocial services, eh, from the SMT. Seemingly eh, our SMT has no full information concerning the HIV pandemic, wherein eh, if you have people living with HIV then they won't be in a position to maybe give you that full information concerning HIV or anything concerning HIV, especially when coming to care, support and maybe a little bit of prevention information, maybe I can say, a little is there but when coming to the whole information, we are lacking.

4.3.2.2 Treatment, care, support and prevention

No care, support or prevention services were being offered by the SMT at this school. Tinyiko expressed the need for comprehensive information:

Yeah, obviously when coming to this psychosocial services, one needs to have that full information, the knowledge on how to go about when given to, given that type of a service and if one is not having that whole knowledge, then it is going to be difficult for one to [be able to] *acknowledge a person needing support or needing care.*

4.3.2.3 Challenges

The lack of knowledge of, and information on, the types of services that should be provided to ELWHIV was the biggest challenge identified by all participants.

4.3.2.4 The effectiveness of services provided by SMTs

Tinyiko expanded on the need for knowledge in order to render effective services:

I cannot say they are effective because, seemingly there is no enough knowledge and if there is no enough knowledge obviously the information could not be rendered easily to eh, maybe people that need support.

He also touched on the need to actively seek information:

And also we need to look into the situation where presently when you need support then you have to go out of the institution to go look for information but [if] *we are having information within our disposal then it is going to be easy for SMT to can provide services to those people living with HIV.*

There were some suggestions as to how the position could be improved:

Mokgadi: *Committees can be formed and they must have knowledge about HIV.*

Anna: *I think that the SMT can get support from the NGOs and the Health Department. Maybe there will be something better.*

4.3.2.5 Policies and programmes

As with the previous school, all participants were aware of the existence of polices, but did not perceive them as effective. They also pointed to the lack of programmes.

Mokgadi: *Policies are there but they are not effective. There are no programmes.*

Sophy: *Eh, policies are there but are not effective. Programmes, they don't know how to use them.*

The fractured and indirect nature of the knowledge they did receive was expressed by Tinyiko:

In my knowledge, according to the media there are programmes and policies but they are not reaching people eh, [in] *a way, the way it should be because in my opinion, the information that we get, we get maybe through in-passing, maybe you've been in a meeting or workshop and it is given to people or to individuals just to know something about HIV and AIDS and that way, it makes policies and programmes not to be effective.*

4.3.3 Tshwane Primary School

4.3.3.1 The current situation regarding the provision of psychosocial services to ELWHIV at schools

At Tshwane Primary School, the focus of services in respect of HIV and AIDS was on the learners rather the educators. The educators' right to privacy was seen as paramount, and if educators did not disclose their status, the assistance or support was forthcoming.

Lindi, a member of the SMT, explained how educators' rights to privacy prevented the SMT from becoming involved:

Ok, there is no one on treatment. Eh, there is no treatment we are offering at our school since educators do not disclose so we do not provide treatment to a person who did not disclose. We are respecting the view of the right to privacy. Care also is not offered we just assume that somebody might be suffering this sickness so we don't have the guards of confronting the person as to discuss about his or her illness.

While prevention efforts were focused on learners, this was rudimentary:

Support like the first two - we are not doing any support we only talk to learners as to warn them against playing around or getting involved into unprotected sex.

And then in terms in terms of educators we just do individual visit if an educator happened to stay away for a long time then we visit as to find out what might be

preventing him from coming to work. Prevention like we are afraid to discuss issue with educators. We respected that privacy. We only talk to learners.

Lindi referred to the lack of training in her school:

… we don't have the expertise as to the sickness is concerned… because we do not have proper training as to the sickness [HIV and AIDS].

Phineas, who was also a member of the SMT, also explained how they were restricted by the lack of disclosure and the fear of violating educators' rights to privacy:

On treatment, ah, we don't offer any treatment at our institution because people don't come open, people don't disclose. Number 2, that is care, I will combine care with support – usually we visit these educators who may be absent for about three to four weeks - then we intervene to find out what is the problem. On prevention there is nothing we are doing nothing on prevention.

Thabo referred to the stigma attached to HIV, and the need for SMTs becoming sensitive to this, and also the role of the SMT in raising awareness among educators:

I think, when coming to this psycho-social services provided by SMTs, it must be provided by the SMT, while the SMT knows about the problem and then the only way that SMT can know about the problem is when a person has disclosed, and then the other thing is when this SMT also is user friendly when coming to disease. Stigma is another problem when coming to this disease. This person, for them not to disclose is because they are afraid of stigma. If they can remove this stigma as SMT and then steer this SMT and the other educators to understand that this epidemic has come so we have to deal with it and then accept whatever we see, then we can be able to help these people to disclose so to can start talking about treatment, care, support and prevention because we cannot talk about them now when people are not disclosing.

4.3.3.2 Treatment, care, support and prevention

While nothing was done in terms of treatment or prevention, Phineas explained that they talked about care and support when they visited educators (suspected of being infected because of long periods of absenteeism).

Thabo also revealed the lack of services:

Uh, usually now we don't have any treatment that we are offering to educators or to learners concerning the epidemic. And prevention also, we don't talk, give talks to eh, learners about the epidemic.

A disturbing revelation he made was:

… and we do not accept people who are coming from the department who say they want to workshop teachers on HIV/AIDS and then on the question of what disease he is suffering from. Eh, we cannot assume that somebody is suffering from HIV but when he is suffering, we pay a visit to him, to the person.

4.3.3.3 Challenges

The fact that educators do not disclose their status and that the SMT did not have the expertise to offer services was seen as a challenge by Lindi:

Our problem is that people don't disclose so how do you support or provide treatment to a person who did not disclose. We respect the right to privacy and then the other challenge is that we don't have expertise as to sickness are concerned we don't had proper treatment. [I am] s*orry we did not have proper training as to sickness are concerned.*

Phineas viewed stigmatisation as the biggest challenge:

Ja, I think the most problem or the most challenge is that people don't disclose and if people don't disclose we cannot help them through the treatment, care, support and prevention that you asked about - and I think maybe people don't disclose because

people are stigmatised, people gossip about these people - they lower their self esteem and they become isolated and discriminated against.

Thabo also viewed stigmatisation and disclosure as the biggest challenges:

As I said the first challenge is stigma. Stigmatisation is very eh, is the biggest problem, that's the biggest challenge and another challenge it can be eh, disclosure by members of the staff and then also disclosure by the members of the SMT.

He expanded on the need for the SMT to take the lead and play an exemplary role:

The SMT must see to it that they start by themselves because if you are a leader you must be an exemplary. The SMT, they must check amongst themselves if there is somebody else who is sick and who will voluntarily say that 'I am sick' so to say to other staff members that I am sick, disclosing so to encourage those others to say that I am sick. It starts right there.

4.3.3.4 The effectiveness of services provided by SMTs

The lack of training, and the exclusive focus on learners, was viewed as underlying causes preventing the effective provision of treatment, care, support and prevention.

The lack of training and sole focus on learners was highlighted by Lindi:

No, I don't think they are effective since teachers are not trained [and that efforts are] only based on helping learners.

He expressed the need for training from other government departments:

I think if the Department of Education can intervene and train SMTs as to particular illnesses are concerned or if not training SMTs let them arrange with Social Services people, the health people, so that they continually visit the school with the aim of training educators as to services.

Phineas also expressed the lack of effectiveness of the few existing interventions and also put across the need for the information and training from the Department of Education:

Yes, I think if we can get information from our Department, if they can organise some workshops for affected and infected educators but mostly start with us as the SMT and

following number 1 - awareness, number 2 - prevention, number 3 - counselling. So if we can be workshopped about those three things I think maybe it can help to encourage those teachers or the people who are living with HIV and AIDS.

Thabo expanded on the home visits as types of support and care they conducted:

Eh, I will explain only on support and care because that is what is happening and on others because they are not happening, we cannot say anything about them. Eh, support as I mentioned that we go to their homes, and talk to them and sometimes when we are able, we pray with them, we sing with them so that we show them that support.

He believed that:

The SMT can make or form committees then that committees must be equipped with the knowledge of how to care and treat and support teachers leaving with HIV.

4.3.3.5 Policies and programmes

As with the other participating schools, knowledge of policies and programmes was elementary.

The lack of any programmes for educators is expressed by Lindi:

We don't have any policy for educators. Well, in our school in particular, we have a HIV policy for learners. Unfortunately we have nothing for educators. And then I don't think the programme is effective since it is only concerned with learners. Educators are in not any way covered.

The bureaucratic nature of policies is expounded by Phineas:

Ehmm, on policies, yes we do have policies from the Departmental policies but I think in the institution specifically our own institution we just draw policies. These policies are silent there is nothing, they are just there for the people or officials from the department to come and monitor those policies and concerning the programmes we didn't receive any programmes so far.

Thabo also commented on the lack of implementation of existing policies:

Policies are there but they are not effective and programmes, I know nothing about them.

4.3.4 Sehlare Primary School

4.3.4.1 The current situation regarding the provision of psychosocial services to ELWHIV at schools

Responses revealed that there were no services being offered at this school in terms of treatment, care, support and prevention. This was partly due to the failure of ELWHIV to disclose their status to the SMT.

Sehlare was the only primary school where an educator, Naledi, disclosed her positive status to the researcher and her reasons for not disclosing to the SMT:

For now as an educator living with HIV, I am not receiving any treatment at school for the mere reason that I did not disclose to my SMT. They are not aware of my status but the main reason causes me not to disclose to them is that I don't trust them. In case of care and support, I think if I should have disclosed to them, they will be supporting and giving me the necessary care that I need at the moment but I need their support but I don't have the know how or the initiative to approach them so that they can be open and I be honest with them to tell them about my status.

She expressed her concern for her learners:

Presently I am endangering the lives of the learners that I am teaching as I did not disclose because in the process of teaching and learning there can be blood transfusion where the lives of the learners can be put into danger, but I think over the long run, I shall have to come to my senses and inform the SMT about my status and they will give me the precautionary measures to solve my problem.

Thapelo, school principal and therefore a member of the SMT, mentioned the problem of secrecy and denialism that surrounds HIV and AIDS which prevented any interventions from the SMT:

As a principal of the school and representing the Department of Education, the unfortunate part of it, the situation is that in our school you still have the challenge of secrecy and denialism where as SMT you are unable to identify or you are unable to reach out teachers who might be having a problem in terms of the illness.

4.3.4.2 Treatment, care, support and prevention

Naledi stated that there were no types of treatment or support at the school and that this was why ELWHIV did not disclose, but that:

…if the SMT was aware of my status I think they would have established a support group for me.

Thapelo explained some of the interventions the school has:

As a school, unfortunately we don't have measures for teachers in particular for treatment. We are only exposed to sister Departments like Social Development but as a school we don't have… but as Life Orientation is part of the school we always talk about it. We also have a policy around HIV and AIDS and there we are talking to learners for prevention measures and also with regard to the learners.

He also highlighted the difficulties of offering services to learners due to the problem of non-disclosure:

…we also have problem as parent do not disclose - to us the problem that children might be having ... So as a school we do not have the ways of how to pre-treat that and how to support and how to care for the personnel and the learners of the school.

The lack of trust of SMTS was expressed by Joyce:

If I am infected it is not going to be easy to disclose hence I don't trust them my SMTs.

4.3.4.3 Challenges

Naledi, who herself is HIV positive, acknowledges that the problem of non-disclosure is an obstacle to the delivery of effective services:

The major challenge that the SMT is facing is the problem of disclosure and denial. As long as we did not disclose and we are in denial the SMT has got nothing to do.

Thapelo also touched on the problem of educators not disclosing their status:

Secrecy is one of the serious a matter. You only realise as a principal and as a SMT that a teacher no longer comes to school - the teacher is very, very weak. The teacher does not disclose or tell the manager or the management his or her problem so that becomes a serious challenge according to us.

Joyce also felt that as long as educators did not disclose their status there would not be any services available.

4.3.4.4 The effectiveness of services provided by SMTs

As there were no services being offered, ostensibly because ELWHIV were not disclosing their status, their effectiveness could not be commented on. Naledi, however, made the observation that:

It can only be improved if there can be a trust and disclosure.

Thapelo conceded that nothing was being done for educators:

I wish I could say yes but unfortunately we don't provide these services for teachers.

The solution to improving services would be:

… making sure that people are free, people are knowledgeable, people are aware that, eh, if they are having this challenge we may be open to be assisting teachers. If we don't have teachers who are disclosing, teachers who are willing to say this is what the problem is, it is going to be very difficult to come up with psychological services to educators living with HIV. So unfortunately, the major part which can improve these services is when teachers come forward and say this is what my problems is or what my problems are.

Joyce expressed the view that SMTs needed to be trained and needed to observe confidentiality.

4.3.4.5 Policies and programmes

While participants were aware of the existence of policies, the lack of implementation was a problem.

Naledi blamed the Department of Education:

According to my knowledge there are policies and programmes in Limpopo province but they have not yet reached the educators who are living with HIV and AIDS because the department is not executing its duties in connection with HIV and AIDS.

Thapelo was even less aware of the existence of policies and programmes:

Unfortunately I am not aware of any policy directly at teachers especially those who are living with HIV in our province. I wish we could have one but as a community we are aware of the groups that are moving around from door to door that are assisting maybe we think maybe the teachers are also in incorporated in this groups but with regards to the Department of Education particularly in Limpopo I am not aware of that policy.

Joyce responded:

My answer is no, there are policies in Limpopo Province but programmes are not there.

4.4 SUMMARY

In terms of the range of psychosocial services which should be offered by SMTs to ELWHIV, none of the participating schools were providing effective services. The limited services offered at the four schools varied from those schools who offered no services to ELWHIV whatsoever, to those which focussed only on learners, to those which offered some form of service in the form of care and support to ELWHIV.

Home visits were one type of care and support offered by the SMTS of two of the schools. The SMTs of Lepelle Primary School and Tshwane Primary School reported that their schools normally paid visits to affected and infected educators. The SMTs from Sediba and Sehlare schools did not conduct home visits at all.

Emotional support is an essential component of psychosocial services (Dageid & Duckert (2008: 189). While emotional support can be provided by a spouse, family members or colleagues, in the case of ELWHIV, SMTs should play a major role in caring for and supporting them.

Home visits are an important source of emotional support for ELWHIV. Home visits also address the need for belonging through the development and maintenance of relationships that are intended to provide ELWHIV with care, love and support during their experience of the illness (Hjelle & Zeigler 1981: 371).

HIV counselling provides a supportive environment and helps clients [ELWHIV] manage problems and issues (Uys & Cameron 2003: 64). Another form of support offered by the Lepelle SMT was spiritual counselling in the form of prayer. The SMT felt that praying with ELWEHIV showed love and also strengthened their spiritual being.

While SMTs are charged with the responsibility of providing psychosocial services to ELWHIV, it is clear that they face significant challenges in their provision of adequate and holistic services to ELWHIV. Their lack of skills and relevant knowledge appear to be major challenges.

The study revealed that the lack of knowledge and skills of SMTs at the participating schools was the major impediment preventing them from providing psychosocial services to ELWHIV. The issue of training and capacity building is crucial in responding to the needs of HIV-positive teachers (UNESCO 2007: 21). Given their lack of knowledge and skills, the need for training was widely expressed by the SMTs:

Another theme emerging from the data was lack of educational material and resources. Despite the large amount of material (books, pamphlets, education tools) on prevention, care and treatment that has been developed by NGOs and government departments interviews revealed that very little of this material was available to these schools.

Collaboration with other departments such as the Department of Health and the Department of Social Development is essential in order to help schools with various

materials which would provide SMTs with the necessary skills and knowledge to provide quality services to ELWHIV.

SMTs are responsible for distributing HIV and AIDS programmes to educators living with HIV. The National Policy on HIV and AIDS for Learners and Educators in Public schools, as well as Students and Educators in Further Education and Training Institutions was formulated as one of the interventions to address the problems of HIV/AIDS *(*National Education Act 27 of 1996). SMTs, however, are still unfamiliar with these policies and their provisions.

The fear of disclosure due to fear of discrimination and stigmatization and the lack of trust in SMTs came through strongly during the course of the interviews. The fear of disclosure has implications for both individuals and SMTs. Educators who have just learnt of their 'HIV-positive' status tend to feel guilty. This often results in their withdrawing from colleagues and school interaction with their learners. ELWHIV also suffer from anxiety because they fear the risk of infecting others. The risk of losing loved ones and the fear of rejection should their status become known also provokes anxiety (van Dyk 2005: 217).

It has been highlighted in UNESCO (2007) that the impact of HIV and AIDS on educators occurs at a number of levels. The most direct impact is on the educator as an individual, in terms of his or her HIV status. Educators may be reluctant to undergo an HIV test due to fear of discrimination if they are found to have HIV. Those educators who know they are HIV- positive may be unlikely to disclose their status in schools where HIV-related stigma is found and may be unaddressed, where they feel they would not be treated fairly, or where they might lose their jobs. They may also isolate themselves from their colleagues and communities in an attempt to conceal their HIV - positive status. This can be both psychologically, emotionally and socially damaging.

From the point of view of SMTs, the difficulty in reaching out to ELWHIV arises from the secrecy and denial which surround this epidemic.

Secrecy and fear of disclosure among people with HIV and AIDS make the task of providing services very difficult. If the diagnosis is kept a secret, it is difficult or impossible to get help. This is a major challenge to the effective provision of services by SMTs.

SMTs are tasked with an essential role in providing services to educators. SMTs and their members must have an understanding of what HIV and AIDS is its symptoms, preventative measures, and its treatment. This must be backed up with the knowledge of how to counsel, care and support those infected and/or affected by the disease appropriately. The findings revealed that the SMTs of all four participating schools were unequipped to offer comprehensive and effective services to ELWHIV. Members of SMTs acknowledged that they lacked the sufficient knowledge, skills and relevant educational material. SMTs and educators expressed the need for training to equip themselves with the necessary information and skills.

The conclusions of the study and recommendations are made in the following chapter.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

A discussion of the research findings was provided in the previous chapter. In this chapter, the conclusions of the study are summarised by focussing on the research questions. The chapter concludes with recommendations for policy and practice.

Educators play a key role in the education system. ELWHIV have a central role to play both in efforts to prevent new infections and in helping to address the impact of HIV and AIDS on learners and communities. It is crucial for ELWHIV to receive the support they need to live healthy lives and to become advocates for change in the response to the epidemic. Governments are central in mitigating the impact of HIV and AIDS on the education system. The National Policy on HIV and AIDS for Learners and Educators was formulated as one of the interventions to address the problem of HIV and AIDS in the South African education sector (National Education Act 1996 (Act 27 of 1996)). The purpose of the Act is to outline assistance for both educators and learners who are infected and affected by HIV and AIDS.

The education sector has the responsibility to support all educators, regardless of their HIV- status, and to show zero tolerance towards acts of HIV- related discrimination. In order for ELWHIV to continue teaching in a caring environment free of stigma and discrimination and to promote their involvement in the education sector's response to the epidemic, the Department of Education, teachers unions, SMTs and other stakeholders need to:

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- **Identify the needs of ELWHIV**

A comprehensive response supporting ELWHIV should recognise and address the various needs of educators at the different levels: The individual level, e.g. health status, psychological, social and emotional state; the occupational level, e.g. discrimination and absenteeism; and the community level, e.g. stigmatisation.

- **Ensure access to prevention programmes, treatment, care and support.**

One of the most important issues which need an urgent attention is to ensure that ELWHIV who are in need of ART are able to access affordable and confidential health, treatment, care and support services.

- **Developing partnerships between SMTs, teacher unions and other sectors**

SMTs have a vital leadership role to play in supporting ELWHIV within schools and communities. This role needs to be encouraged and supported by unions and the relevant district level authorities. The Department of Education is responsible for the welfare of all educators, but a comprehensive response should also involve other Departments such as Health and Social Development and which will engage with treatment and support. The Department of Labour will engage with workplace policies.

5.2 SUMMARY OF FINDINGS

From the experiences shared by the participants it was evident that schools were not doing enough to support ELWHIV, particularly in terms of psychosocial support. This was largely due to the lack of basic information on HIV and AIDS. It was also clear that while there were HIV and AIDS workplace policies in place, they had not been work shopped and stakeholder had not been trained on how to use them.

The major finding of the study is that School Management Teams are failing to implement HIV and AIDS policies and programmes that would provide support for infected and affected educators. SMTs have a critical role to play in addressing and alleviating some of the challenges faced by ELWHIV by exercising leadership and building trust and dialogue among educators.

Schools are expected to develop their own policies on HIV and AIDS consistent with the Constitution and the law, national policy and HIV and AIDS guidelines for schools. None of the participating schools had a functional school policy on HIV and AIDS. Support structures for dealing with the psychosocial aspects of HIV and AIDS were found to be inadequate and ineffective. The issue of disclosure was also identified as a major obstacle in the provision of effective services. ELWHIV were not willing to approach the SMTs due to lack of trust.

5.2.1 The provision of psychosocial services

Despite the range of psychosocial services to assist EWLWH which have been identified (these include emotional and social support; and information and material support), the study found that the services provided by the four participating schools were extremely limited.

- **Emotional and social support**

As defined in chapter two, emotional support is the primary type of psychosocial service (Dageid et al 2008: 189). SMTs, the school community and colleagues are an important source of emotional and social support for ELWHIV. Only two school SMTs were providing emotional and social support by means of home visits and also praying together.

- **Informational support**

None of the SMTs from the participating schools were involved in any awareness raising activities, or in disseminating any HIV and AIDS information despite the large amount of material available from government departments and NGOs.

- **Material support**

Material support, in the form of food, shelter and treatment was delivered at a limited level in the participating schools. Only one SMT was supplying support in the form of vegetables from the school garden to ELWHIV. One SMT administered treatment in the form of tablets (in conjunction with health professionals from the local clinic) after disclosure and in response to a request from, and in agreement with, the educator concerned.

- **Instrumental support**

No instrumental support was evident in any of the participating schools. One possible type of such support is voluntary HIV counselling and testing (VCT). VCT can reduce high risk sexual practices and can decrease rates of sexually transmitted diseases. VCT is also necessary for directing HIV infected people towards obtaining highly active antiretroviral therapy (HAART). As discussed in chapter two, HAART has reduced death and morbidity among ELWHIV. The therapy leads towards improved life expectation because it combines the anti-HIV drugs, reduces the viral activity and protects or restores the immune system (Davis et al 2006: 323).

5.2.2 The position of SMTs

The findings of the study revealed that SMTs were faced by a number of obstacles which impeded the effective delivery of psychosocial services to ELWHIV.

- **Implementation of HIV and AIDS policy**

None of the participating schools had functional HIV and AIDS policy. Despite the existence of a National Policy, the implementation thereof had not been applied at the school level. There was an awareness of a national policy, but the perception was that it had to be applied “in a practical and realistic way’’, and that the roles of SMTs in respect of providing psychosocial services to ELWHIV had to be clearly circumscribed. It has been clearly emphasised in UNESCO (2007) that Ministries of Education have the ultimate responsibility for guiding the response and supporting HIV-positive educators.

Within the framework of moving towards universal access to prevention programmes, treatment, care and support, the Ministry of Education (in its role as employer of educators) should ensure that educators are accessing related services. This includes supporting the development of workplace policies, the professional development of educators and monitoring and evaluation.

- **Lack of knowledge about psychosocial services and the need for training**

Discussions with both members of SMTs and other educators reveal a lack of the knowledge which would enable the provision of effective psychosocial services to ELWHIV.

- **Lack of HIV and AIDS educational material and information**

The lack of educational material and information appeared to be a big problem and the participants were not aware of where such material could be accessed.

- **Fear of disclosure**

The findings of the study reveal that ELWHIV are reluctant to disclose their status to SMTS due to a lack of trust. The HIV and AIDS epidemic is still viewed as an epidemic of ignorance, fear and denial which results in the stigmatization of people living with HIV and AIDS and their family members. The reluctance to disclose positive status due to fear of stigmatization and discrimination is a major obstacle in preventing SMTs from providing such support to ELWHIVs or referring them to necessary services.

5.3 LIMITATIONS OF THE STUDY

This qualitative study was limited to four primary schools in the Waterberg district of Bela-Bela area in Limpopo Province. Key informants were selected as a small, non-probability sample consisting of seven black male and eight black female educators. The findings of the study are, therefore, limited to these schools and cannot be generalized to the other schools in the district, the province or even the country. The recommendations arising from the findings, however, have relevance for all SMTs.

5.4 RECOMMENDATIONS FOR POLICY AND PRACTICE

The following programmatic components of comprehensive responses for supporting ELWHIV are recommended, based on the findings of the study.

- **HIV and AIDS workplace policies and programmes for the education sector**

Treatment must be made available for ELWHIV. In the absence of treatment, the health of ELWHIV will deteriorate and the provision of education will be undermined.

Although workplace policies have been developed in the educational sector, the specific issue of supporting ELWHIV (and learners living with HIV) is not sufficiently prioritised and action at the school level remains the greatest challenge. Policies are available but they must be revised to include provisions on the rights of ELWHIV and students as well as referral mechanisms to ensure zero tolerance of HIV- related stigma and discrimination.

Schools (SMTs) should develop functional HIV and AIDS policies and programmes that address educators' rights to access HIV prevention, treatment, care and support services as well as their right to work without discrimination.

Prevention programmes should include: creating awareness about HIV and AIDS and eradicating the stigma attached to the epidemic, developing an understanding of the economic, psychosocial, political and cultural factors facilitating the spread of HIV and AIDS and understanding all relevant HIV and AIDS policies and the resources available to deal with the epidemic.

Peer education programmes should include issues that ensure peer educators receive relevant and informative training and are able to carry out school-based interventions for educators. ELWHIV should also be encouraged to become peer educators.

With regard to treatment, care and support, wellness programmes should be introduced in schools for nutritional support and immune boosters, assistance with primary health

care and referrals for treatment of opportunistic diseases including sexual transmitted infections (STI's) and tuberculosis (TB).

- **Training and skills-building**

Training and skills-building are urgently needed to reduce stigma towards ELWHIV and to equip SMTs and all educators with the necessary knowledge and skills they need to reduce their own risk to HIV infection, to educate about HIV and to support students and colleagues who are infected and /or affected by the virus. Members of School Governing Bodies (SGB) need also to be trained as they can potentially play an important role within the school and the community in awareness and prevention initiatives.

SMTs need, inter alia, to be trained in issues of confidentiality and on how to communicate with educators infected and/or affected by HIV in order to gain their trust. This goes hand in hand with the eradication of stigmatization. SMTs must undergo training to enable them to identify the first signs and symptoms of HIV and AIDS in order that they may institute relevant interventions.

- **Community-based activities**

Community-based activities can be an effective vehicle for reducing stigma towards ELWHIV by educating and raising awareness amongst educators; by educating parents to understand the rights of ELWHIV; and raising awareness that an HIV- positive educator should be treated with the same level of respect as an HIV-negative educator.

- **Collaboration with other stakeholders**

Collaboration with other stakeholders such as Non-Governmental Organizations (NGO's), Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) can strengthen the response and assist SMTs in the fight against HIV and AIDS. CBOs can, for example, assist in helping schools to develop school garden projects. Working with community leaders such as ministers, pastors, and lay preachers can play an important role in conveying information, reducing stigma and discrimination

and providing counselling services. Social Workers should be involved in counselling exercises in order to enable those infected with the illness to live openly with their HIV and AIDS status. ELWHIV should also be involved in support groups such as an Educator Support Team (EST). Such support groups may include spiritual leaders and health workers. Support groups create a safe environment and will build healthy relationships among colleagues and allow members to share ideas and solve problems as a team.

Each school should establish and strengthen Health Advisory Committees (HACs) as recommended in the National Education Act 27 of 1996. HACs should include SMT members, Life skills and HIV and AIDS educators, community health professionals, psychologists, and HIV and AIDS counsellors. Links between teachers' unions and networks of ELWHIV have great potential for promoting the needs of their members, for raising awareness and for advocating for change.

Support and training from government departments such as the Department of Education, Department of Health and Department of Social Services are also required to build capacity in SMTs, schools and the community.

- **Monitoring and evaluation**

In order for the education system to operate effectively and efficiently, monitoring and evaluation should be carried out to assess the impact of interventions. This will provide accurate data for the Department of Education and educational planners.

5.5 SUGGESTIONS FOR FURTHER RESEARCH

Addressing and mitigating the effects of HIV and AIDS on educators in particular and in the education system in general will require extensive research. Suggestions for further research are:

- Studies of the types of psychosocial services being provided to ELWHIV should be expanded to all schools in South Africa
- The effectiveness of these services must be assessed

5.6 CONCLUSION

The major finding of this study is that SMTs in the four schools in Bela-Bela are falling short in the provision of psychosocial support to ELWHIV. These findings echo those of similar studies that have been conducted (see for example Rehle et al 2005). More sustained efforts are required on all levels - national, provincial and local – to protect and assist educators as the key custodians in the education system, and to prevent a weakened education system.

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APPENDIX A

INVITATION LETTER FOR PARTICIPANTS

P O Box 116

GA-RANKUWA

0221

24 October 2008

Dear Sir/Madam

INVITATION TO TAKE PART IN A RESEARCH STUDY AS PARTICIPANT

You were selected through an invitation sampling method as a prospective respondent in this study which reads as: **An exploratory study of the types of psychosocial services provided to educators living with HIV at selected Primary School in the Limpopo Province.**

This is a formal invitation for you to participate in the study.

You will be provided with a consent form which after reading and being satisfied of its contents, you will be expected to give a consent to voluntarily participate in this research process by signing the form. The purpose of the consent form will be to protect you from being psychologically and emotionally harmed by the questions which are posed to you during interviews, to protect your rights from being violated by the possibility of breach of confidentiality, to protect your right to voluntarily participate in the research study and to protect you from being deceived into participating in the study.

In response to this invitation, please call the researcher at 072 476 3029

Yours faithfully

The Researcher: Thindisa J.N

APPENDIX B

INFORMED CONSENT FORM FOR EDUCATORS

Please provide an informed consent by completing the under-listed items of the form.

I (full names)…… do hereby give consent to participate in a research study as a respondent after I have satisfied myself with the following: (Please tick whichever is applicable):

[ ] The title of the study is **An exploratory study of the types of psychosocial services provided to educators living with HIV at selected Primary School in the Limpopo Province.**

[ ] I fully understand the purpose of the study, namely, to investigate the importance of the provision of psychosocial services to educators living with HIV.

[ ] I will be asked to respond to questions regarding the provision of psychosocial services to educators living with HIV.

[ ] This study will not expose me to any psychological and emotional harm.

[ ] There are no physical and mental benefits I will receive after participating in the study.

[ ] No any other person except the researcher shall have access to the contents of the interview.

[ ] No any other person including the researcher, shall identify myself by my personal identification except by means of the codes attached to me.

[ ] I have the freedom to withdraw from participating in the study at any time I feel necessary.

[ ] A tape recorder will be used to record my responses and that this material will in no way be utilized to cause harm to myself and all the information will be treated in a confidential way.

[ ] Should I have questions and concerns regarding this research project, I can contact the Department of Sociology, UNISA at this number 012 429 6507 and or call the researcher (Mrs Thindisa J.N) at 072 476 3029

I understand my rights as a research subject and I voluntarily consent to participate in this study.

……..…….

Subject's Signature Date

APPENDIX C:

INTERVIEW GUIDE

1. What is the current situation regarding the provision of psychosocial services to ELWHIV in your school in terms of the following?

1.1 Treatment

1.2 Care

1.3 Support

1.4 Prevention

2. What types of treatment, prevention, support and care are available at your school?

3. What challenges does the SMT face in terms of providing the above mentioned services?

4. In your views do you think psychosocial services above provided in your school are effective? If no explain how and if yes explain how.

5. How do you think the psychosocial services to ELWHIV can be improved by SMTs?

6. Are there any policies and programmes in place to reach out ELWHIV in Limpopo Province? If yes how effective are they in reaching out ELWHIV?

APPENDIX D

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

WATERBERG DISTRICT
WARMBATHS CIRCUIT
P/BAG X 1625
BELABELA
0480
TEL:014 736 2235

Enq : Mphulo, MD
Contacts: 071 674 6816
072 477 1924

2009.09.11

Sir

Re : Request to conduct Research in your School by Ms Thindisa, J , Student Number 775 5805 enrolled with the University of South Africa.

1. The above matter bears reference :
2. Ms Thindisa, J has been granted permission to conduct Research in your school.
3. She is bound to Policies of Ethical Research Conduct as set by UNISA.
4. Attached herewith are letters from the University and the Circuit office.

.....
Circuit Manager [Mphulo, MD]

No 08 Joyceline Building
BELABELA, 0480
FAX , 014 736 5036