PSYCHOSOCIAL PROBLEMS AND NEEDS OF EDUCATORS INFECTED WITH HIV AND/OR AFFECTED BY HIV AND AIDS IN SELECTED JOHANNESBURG INNER CITY SCHOOLS

by

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DECLARATION

I declare that *"Psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools"* is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

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Signature Date

DEDICATION

This piece of work is dedicated to the remembrance and in loving memory of my late father, *Boy Solomon Mampane*.

The manuscript is also dedicated to
Educators who died of HIV and AIDS,
Educators living with HIV and AIDS, and
Educators involved in the struggle against HIV and AIDS.

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ABSTRACT

The impact of HIV and AIDS has threatened to destroy the education sector in South Africa. This qualitative study set out to investigate the psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. The study explores and describes the need to develop and implement a comprehensive and holistic treatment, care and support programme for educators infected with HIV and/or affected by HIV and AIDS. This study also reviews HIV/AIDS policies and programmes implemented by the Department of Education to indicate that these interventions are not effective in addressing the problems and needs of these educators. Therefore, the study contends that the Department of Education should revise and reformulate these HIV/AIDS policies and programmes to cater for the needs of educators infected with HIV and/or affected by HIV and AIDS. Ten educators infected with HIV and/or affected by HIV and AIDS from two selected Johannesburg Inner City schools participated in this study. Phenomenological strategies and in-depth interviews were used to capture day-to-day personal life experiences of these educators. The findings of the study reveal that there is a need for an urgent response by the Department of Education to develop and implement treatment, care and support programmes for educators infected with HIV and/or affected by HIV and AIDS.

KEY WORDS

Psychosocial; Educators; HIV and AIDS; Johannesburg Inner City; Schools; Treatment, Care and Support; Anti-Retroviral Therapy; Policies and Programmes; Education Sector; Department of Education.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CBO	Community-Based Organisation
CD4	Cluster of Differentiation 4
CoJ	City of Johannesburg
DHHS	Department of Health and Human Services
DoE	Department of Education
DoH	Department of Health
ELRC	Education Labour Relations Council
FBO	Faith-Based Organisation
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
MRC	Medical Research Council
MTT	Mobile Task Team
NGO	Non-Governmental Organisation
R	Rand, the South African currency
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
USA	United States of America
WHO	World Health Organisation

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"We risk a failure of words, of concepts, of sympathetic insight in the face of AIDS. We need to fight this failure. We need to respond with imagination and compassion to what is happening around us."

Edwin Cameron, Justice of the Constitutional Court of South Africa and a prominent AIDS Activist (Cameron 1993:29).

CHAPTER 1: SITUATING THE RESEARCH PROBLEM

Nobody ever said AIDS *by Eddie Vulani Maluleke*

Skinny as a broomstick
With black spots
My sisters' children
Coughed and died
My brother coughed and died
I was coughing and dying
The enemy was in our bodies
Making us cough and die
Eating us like worms
But some of us
Still made love
And made each other cough and die

We all died
Coughed and died
That was us
Whispering it at funerals
Because nobody ever said AIDS

(Excerpted from Rasebotsa, Samuelson & Thomas 2004:17-20)

1.1 INTRODUCTION

For approximately the past three decades, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have posed a threat to the health and wellbeing of people worldwide. Until now, attempts to find a cure for this dreadful and gruesome disease have not been successful. According to van Dyk (2005:3), AIDS is a pandemic that threatens to destroy the development of humankind in the history of the world. In South Africa, for example, the Department of Health (DoH) Antenatal HIV Survey of the year 2009 estimated that there are 1800 new HIV infections and 980 AIDS-related deaths per day, especially among young adults who are actively involved in the socio-economic development of the country. These horrifying and shocking statistics are predicted to increase in the future because South Africa has the fastest growth of HIV and AIDS prevalence and incidence rates in the world (Whiteside and Sunter 2002:58).

The threats of HIV and AIDS to human development are emphasised by Stine (2005:323) who quotes the Joint United Nations Programme on HIV/AIDS (UNAIDS) Report of the year 2000 which stated that:

"HIV will kill at least a third of the young men and women of countries where it has its firmest hold, and in some places up to two-thirds. Despite millennia of epidemics, war and famine, never before in history have death rates of this magnitude been seen among young adults of both sexes and from all walks of life. If death rates continue, even for a few more years, AIDS will kill more humans on the African continent than the 50 million who died on every front and in death camps in World War II."

Regan (2002:185) also emphasises these threats to human development by quoting the UNAIDS Report of the year 2000 which stated that:

"When AIDS emerged from the shadows two decades ago, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. Now, at the start of the new millennium we are past the stage of conjecture. We know from experience that AIDS can devastate whole regions, knock decades off national development, widen the gulf between rich and poor nations and push already stigmatized groups closer to the margins of society. Just as clearly, experience shows that the right approaches, applied quickly enough with courage and resolve, can and do result in lower HIV infection rates and less suffering for those affected by the epidemic. An ever growing AIDS epidemic is not inevitable; yet, unless action against the epidemic is scaled up drastically, the damage already done will seem minor compared with what lies ahead."

According to the United Nations Children's Fund Report of the year 2000 on the progress of nations, HIV and AIDS affect all socio-economic development sectors, but the major effects are concentrated in the education sector. Baxen and Breidlid (2004:9) assert that, until recently, research into the impact of HIV and AIDS has focused mainly on the health and economic sectors, often excluding the education sector. Patel, Buss and Watson (2003:4) mention that the impact of the AIDS epidemic has undermined the development and success of educational systems in Africa. Coombe (2000:15) points out

that research into the health of South African educators, coordinated by the Human Sciences Research Council (HSRC) and commissioned by the Education Labour Relations Council (ELRC) in the year 2003, reported that "education is an essential ingredient of the socio-economic development of any country, and educators are a vital part of any nation's educational system. If educators are sick, or absent from school, or leave the profession, the nation stands to lose." This statement shows that educators are important in the provision of manpower to the nation, and if they die or leave the education sector, the situation will have a negative impact on the socio-economic development of the country.

According to Bennell (2009:1), educators are regarded as a group with a high-risk of HIV infection. Coombe (2000:15) agrees by stating that the 443 000 South African teachers constitute the largest occupational group in the country, and 12 per cent of them are reported to be infected with HIV according to the HSRC/ELRC study. She further mentions that the HIV infection rates of 20 per cent to 30 per cent among educators means that 88 000 to 133 000 educators will die due to AIDS-related diseases by the year 2010. Shisana, Peltzer, Zungu-Dirwayi and Louw (2005:53) report that teacher HIV prevalence rates are the highest within the age cohort of 25 to 34 years. These researchers further mention that the HIV prevalence rates between male and female teachers are almost the same and there are no differences in prevalence rates between primary and secondary school teachers. The Shisana et al (2005:53) Report findings reveal that the number of HIV-infected educators in South Africa is between 42 809 and 47 804. This Report further reveals that South African teachers have a higher HIV prevalence rate (12 per cent) when compared to other teachers in Senegal (0,5 per cent), Nigeria (5,8 per cent) and Ghana (9,2 per cent) and have a similar HIV prevalence rate to that in Cameroon (11,8 per cent). Moreover, the Report indicates that black South African educators have a higher HIV prevalence rate of 16,3 per cent than other racial groups which have HIV prevalence rates of less than 1 per cent. These shocking statistics clearly indicate that young and black South African teachers (both male and female in primary and secondary schools) are more vulnerable and susceptible to HIV infection than teachers of other racial groups.

Bennell (2005:1) points out that research conducted by a health and population consultancy company, AbT Associates, reveals that the HIV prevalence rate among educators is projected to increase from 12,5 per cent in the year 2000 to 30 per cent in the year 2015. Furthermore, the AbT Associates' research reveals that annual AIDS-related mortality rates among educators are projected to increase from 0,5 per cent in the year 2000 to 4,0 per cent in the year 2015. In addition, the AbT Associates' research further proclaims that cumulative teacher deaths between the years 2000 and 2015 are estimated to be around 120 000, which is one-third of the total number of teachers employed in the year 2000. These worrying statistics show that there are escalating numbers of AIDS-related morbidity and mortality rates among educators in South Africa.

In another study conducted by Rehle, Shisana, Glencross and Colvin (2005:8) it is reported that 22 per cent of educators infected with HIV have a Cluster of Differentiation 4 (CD4) cell count of less than 200 cells per cubic millimetre and are in need of Anti-Retroviral Therapy (ART). Due to the well-known fact that there is lack of access to ART in South Africa, it is inevitable that many HIV-infected educators will die due to AIDS-related diseases before they could be started on ART. This situation clearly indicates that the South African government should take immediate action in the provision of ART to educators with AIDS-related diseases.

1.2 THE SITUATION OF HIV AND AIDS IN THE CITY OF JOHANNESBURG

The City of Johannesburg (CoJ) is regarded as the economic hub of South Africa due to the concentration of major industries and businesses in and around the city. This has resulted in high migration of people into the city in search of better employment opportunities. Therefore, educators are part of the workforce that migrates into the city to look for better teaching positions in the CoJ schools. Regan (2002:196-7) argues that due to poor working conditions and lack of resources in rural schools, most educators choose to relocate to urban areas to look for better teaching positions.

Johannesburg has a population of 2,8 million people with an unemployment rate of about 29 per cent, and almost one-fifth (18,12 per cent) of residents survive on less than five hundred Rands (R500) per month (iGoli 2010 HIV/AIDS Impact and Intervention Analysis Report). Hence there are many poverty-stricken households in the city, and commercial sex work and transactional sex, which are catalysts for HIV-infection, are often common ways to earn a living. According to the iGoli 2010 HIV/AIDS Impact and Intervention Analysis Report, there are social norms which encourage promiscuity and infidelity among people in the city because of the fact that most people who migrated into the city are away from their partners. The World Bank (2002:11) concurs by stating that educator postings away from home can lead to extra-marital affairs which may result in a higher risk of HIV-infection. Therefore, all these factors increase the spread of HIV and AIDS in the city, with educators teaching in the CoJ schools also vulnerable and susceptible to HIV infection.

The iGoli 2010 HIV/AIDS Impact and Intervention Analysis Report further mentions that 1 out of 5 teenagers and young people under the age of 30, and 1 out of 10 adults, are already infected with HIV and will become ill and die due to AIDS-related diseases in the next ten years. These statistics clearly indicate that there are increasing AIDS-related morbidity and mortality rates in the CoJ. Hence educators teaching in the CoJ schools are also prone to HIV infection and may die due to AIDS-related diseases in the near future. Therefore, it is crucial and imperative for the researcher to conduct this study in this city which has increasing HIV and AIDS prevalence and incidence rates.

1.3 PROBLEM STATEMENT

The impact of HIV and AIDS has posed major challenges to the socio-economic development of South Africa, including the education sector (Regan 2002:192). The International Labour Organisation Report of the year 2004 on HIV and AIDS proclaims that "HIV/AIDS poses one of the major challenges to the aims of the Education for All initiative in sub-Saharan Africa." Stine (2005:324) indicates that many South African teachers are dying due to AIDS-related diseases and there are few teachers who are

graduating to replace them. He further states that some South African schools are facing closure due to the shortage of teachers who are not replaced after they have died due to AIDS-related diseases, especially in rural communities. Stine (2005:324) goes on to state that there has been an 85 per cent decrease in the intake of student teachers in higher education institutions which further exacerbates and aggravates the situation of the shortage of educators in South Africa. Furthermore, he states that about 1 in 8 teachers in South Africa is HIV-positive. Moreover, he mentions that at the University of Durban-Westville about 25 per cent of student teachers are HIV-positive. This situation will inevitably lead to severe consequences and repercussions that will jeopardise the quality of teaching and learning in the education system (Coombe 2000:15; Kelly 2000:10).

AIDS-related attrition is also one of the problems facing the South African education system (Bennell 2005:4; Hall, Altman, Nkomo, Peltzer and Zuma 2005:4). Regan (2002:196) points out that many educators die in the early years of their careers due to AIDS-related diseases, long before retirement. He further mentions that other educators resign due to their own deteriorating health or they resign to take care of their loved ones who have AIDS-related diseases. Bennell, Hyde and Swainson (2002:86) and Kelly (2000:29-31) concur that other educators are compelled to relinquish teaching due to social ostracism, stigmatisation and discrimination related on grounds of their HIV status. By doing so, they find themselves unemployed and unable to take care of themselves or loved ones because of the high costs of a healthy HIV lifestyle in terms of nutritional needs and medical costs. This situation is further confirmed by Hall et al (2005:13) who argue that educators infected with HIV and/or affected by HIV and AIDS experience financial problems because they have to take care of themselves or loved ones on tight salary budgets. Van Dyk (2005:218) also concurs that many people living with HIV experience financial difficulties.

Baxen and Breidlid (2004:17) state that HIV and AIDS affect educators in a number of ways, whether they are infected with HIV themselves, or have a significant other who is infected with HIV. Professor Michael Kelly (2000:67) , an expert on the impact of HIV and AIDS on the education sector, points out that educators infected with HIV and/or

affected by HIV and AIDS may be ineffective in the classroom due to lack of morale or deteriorating health. These educators are frequently absent from school due to deteriorating health or caring for loved ones infected with HIV (Kelly 2000:67; World Bank 2002:13). HIV and AIDS may affect educators whose colleagues are infected with HIV because they may have to work overtime to substitute for colleagues who are ill or take the place of colleagues who have died due to AIDS-related diseases, which in turn demotivates them and elevates their lack of morale due to the large class sizes they have to teach (Hall et al 2005:14; Regan 2002:196). These educators may experience burnout due to the increasing workload they have to perform. Educators who have significant others who are infected with HIV may also experience problems such as stress and depression because of witnessing the traumatic ordeal these people go through (Coombe 2000:17).

Furthermore, HIV and AIDS may affect educators who have family members or relatives who are infected with HIV in a way that they have to take care of them and inevitably plan for their funerals (World Bank 2002:13). According to the World Bank Report of the year 2002 on Education and HIV/AIDS, these educators may experience problems such as grief and bereavement associated with mourning for family members and relatives who have died due to AIDS-related diseases. Some educators may turn to alcohol and substance abuse with the aim of avoiding their problems. In addition, Bennell et al (2002:48) mention that educators who have learners who are infected with HIV in their classrooms may experience emotional and psychological problems because of witnessing the traumatic ordeal these learners go through.

1.4 RATIONALE FOR THE STUDY

The core of this study will focus on the psychosocial (psychological and social) problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools. This study will also look at the need to develop a comprehensive and holistic treatment, care and support programme to address the problems and needs of these educators. The choice of this topic was influenced by the

fact that there is a paucity of research that focuses on psychosocial aspects of HIV and AIDS in South Africa. This situation is corroborated by the HIV & AIDS and STI National Strategic Plan for South Africa 2007–2011 which states that interventions to address HIV and AIDS have focused more on biomedical aspects of the disease and placed less emphasis on the psychosocial impacts of the disease (DoH 2006:40). Ross and Deverell (2010:vii) also concur that there is lack of academic texts focusing on psychosocial approaches to health and illness in South Africa. They argue that there is a need to integrate both biomedical and psychosocial approaches when dealing with issues of health and illness in order to be able to overcome the challenges posed by diseases such as HIV and AIDS (Ross and Deverell 2010:13-22).

The reason for the researcher to select educators as his study subjects is because there is a dearth of HIV/AIDS interventions aimed at mitigating the effects of the epidemic on educators in South Africa. The latter is substantiated by Badcock-Walters (2009:8) who concurs that responses to HIV and AIDS have been focusing mainly on learners, with educators being overlooked in the development and implementation of HIV/AIDS policies and programmes. Therefore, this situation denotes the relevancy and urgency of conducting this study that has been long overdue in South Africa.

1.5 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this study is to investigate the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools. This study will also investigate the need to develop a comprehensive and holistic treatment, care and support programme aimed at addressing the problems and needs of these educators. The study aims to provide an understanding of and insight into the day-to-day personal life experiences of educators infected with HIV and/or affected by HIV and AIDS in order to be able to identify their problems and needs so that appropriate measures are put in place to address these problems and needs. Therefore, the objectives to accomplish the purpose of the study are as follows:

1. To investigate the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools.

2. To investigate the needs of educators infected with HIV and/or affected by HIV and AIDS in terms of treatment, care and support programmes aimed at addressing the problems and needs of these educators.

3. To investigate which specific treatment, care and support programmes could be developed to address the problems and needs of educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools.

1.6 RESEARCH QUESTIONS

From the objectives above, the corresponding research questions for the study are as follows:

1. What are the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools?

2. What are the needs of educators infected with HIV and/or affected with HIV and AIDS in terms of developing treatment, care and support programmes aimed at addressing the problems and needs of these educators?

3. Which specific treatment, care and support programmes could be developed to address the problems and needs of educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools?

1.7 CLARIFICATION OF CONCEPTS

1.7.1 Psychosocial

Psychosocial is derived from the two words 'psycho' and 'social'. Coulsen (2009:10) defines the term 'psycho' as things that exist within us, such as thoughts (mental and spiritual), feelings, emotions, beliefs, attitudes and values. She defines the term 'social' as the context of the environment in which we live in and the relationships we have within our families and community. Therefore, Coulsen (2009:10) defines psychosocial as the relationship between the psychological and the social world around us.

1.7.2 Psychosocial problems

In the context of this study, psychosocial problems refer to the psychological and social challenges and difficulties experienced by educators infected with HIV and/or affected by HIV and AIDS.

1.7.3 Psychosocial needs

In the context of this study, psychosocial needs refer to coping strategies aimed at ameliorating the psychological and social wellbeing of educators infected with HIV and/or affected by HIV and AIDS. According to Giese (2009:8) psychosocial needs should encompass the physical, mental, emotional, spiritual, social and economic wellbeing of a person.

1.7.4 Educators

In the context of this study, educators refer to primary and secondary school teachers.

1.7.5 Educators infected with HIV

This refers to primary and secondary school teachers who have tested positive for HIV infection.

1.7.6 Educators affected by HIV and AIDS

This refers to primary and secondary school teachers who have significant others such as family members, relatives, colleagues and/or learners who are infected with HIV.

1.7.7 ART

ART is the acronym for Anti-Retroviral Therapy. ART is a combination of drugs used to inhibit and suppress HIV replication and decelerate the progression and onset to AIDS (Evian 2000:79; Stine 2007:58; van Dyk 2005:73). ART prolongs the life of an AIDS patient and promotes ongoing wellness and health (Evian 2000:79; Stine 2007:58; van Dyk 2005:73). According to van Dyk (2005:73), ART has the following four primary goals:

1. Virological goal to reduce the viral load of HIV up to undetectable levels
2. Immunological goal to improve the immune system of AIDS patients and to reduce opportunistic infections and delay the progression to full-blown AIDS
3. Therapeutic goal to improve the quality of life of a person living with HIV and AIDS
4. Epidemiological goal to reduce HIV-related diseases and AIDS-related deaths as well as the impact of HIV and AIDS in communities.

In the context of this study, ART refers to these drugs as they are taken by educators infected with HIV.

1.7.8 Treatment, Care and Support

Green, Dhaliwal, Lee, Nguyen, Curtis and Stock (2003:19) state that treatment is an important element of care and support for people living with HIV and AIDS. According to Green et al (2003:19), treatment refers to the provision of medicines to treat AIDS-related diseases. They mention the following three types of treatment:

1. Curative medicines for curing AIDS-related diseases
2. Preventive medicines for preventing AIDS-related diseases
3. Palliative medicines for alleviating AIDS-related diseases

Green et al (2003:17) assert that care and support is concerned with the wellbeing of people living with HIV and AIDS, and also involves the families of people living with HIV and AIDS as well as the communities they live in. The main aim of care and support is to improve the quality of life for people living with HIV and AIDS, their families and communities. According to Green et al (2003:17), the provision of a comprehensive and holistic treatment, care and support programme entails the following elements:

- Diagnosis of AIDS-related diseases
- Treatment of AIDS-related diseases
- Referral to AIDS-related services and follow-up on each case
- Nursing care of patients with AIDS-related diseases
- Counselling of people infected with HIV and/or affected by HIV and AIDS
- Support to meet psychological, spiritual, economic, social and legal needs of people infected with HIV and/or affected by HIV and AIDS

The provision of a comprehensive and holistic treatment, care and support programme to people living with HIV and AIDS requires the working together of different people such as health-care professionals, family members, community members, and faith and spiritual leaders. In the context of this study, a comprehensive and holistic treatment, care

and support programme refers to the provision of such a programme to improve the quality of life for educators infected with HIV and/or affected by HIV and AIDS.

1.8 RESEARCH DESIGN AND METHODOLOGY

A qualitative research approach was adopted for this study. This is an explorative and descriptive research study aimed at the investigation of psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools. The study explores and describes the need to develop a comprehensive and holistic treatment, care and support programme for these educators. The research strategy of phenomenology was used to capture day-to-day personal life experiences of these educators by conducting in-depth interviews with ten educators selected from two Johannesburg Inner City schools. The research design and methodology for this study will be dealt with in detail in Chapter 3.

1.9 OUTLINE OF THE STUDY

Chapter 1: This chapter presents an overview of the study. The problem statement, purpose and objectives of the study as well as the research questions are discussed within this chapter. In addition, concepts used in this study are clarified. The chapter also briefly explains the research design and methodology employed in conducting this study.

Chapter 2: This chapter presents a review of the literature pertaining to the study. The chapter provides an analysis and examination of both national and international information sources related to the study.

Chapter 3: In this chapter the research design and methodology employed in the study are discussed. Qualitative research methods adopted for this study are described. The chapter encompass the steps and actions that the researcher took in conducting the study and analysing the data. Research ethics that were adhered to in conducting this study are also discussed.

Chapter 4: This chapter presents a discussion on the research findings. The chapter discusses the findings for the three research questions posed by this study in Chapter 1 (Refer to Section 1.6). The description of the research sites and the biographical information of the research participants are also provided.

Chapter 5: This final chapter concludes the study. Conclusions and recommendations emanating from the study are made. Limitations of the study and suggestions for future research are also discussed.

1.10 CONCLUSION

This chapter provided the overview of the study in terms of the impact of HIV and AIDS on the education sector with particular focus on educators infected with HIV and/or affected by HIV and AIDS. The problem statement, rationale, purpose and objectives as well as the research questions for the study were discussed. Clarification of concepts used in this study and the outline of the study were explained. The research design and methodology used in this study was briefly introduced. The next chapter reviews the literature pertaining to the study.

CHAPTER 2: LITERATURE REVIEW

Not at All! *by Nasabanji E. Phiri*

It is like the mamba,
Whose deathly strike
Paralyses the heart instantly
Yes – old one, it is called AIDS,
Look at your grandchildren,
Where are their mothers?
The mamba struck once
Without sympathy,
Leaving great sorrow behind it.

Tell the world, wise grandmother
That it is not at all like yesteryear
When the medicine man could rush to the rescue.
It is AIDS, grandmother.
Not like any other sicknesses,
Not at all.

(Excerpted from Rasebotsa, Samuelson & Thomas 2004:109-110)

2.1 INTRODUCTION

This chapter reviews the literature covering the impact of HIV and AIDS on the education sector, and the psychosocial effects that the epidemic poses for educators. The chapter will also review policies and programmes aimed at mitigating the effects of HIV and AIDS in the education sector. In addition, the chapter will also be integrating a discussion on theoretical frameworks related to the study.

2.2 THE IMPACT OF HIV AND AIDS ON THE EDUCATION SECTOR IN SOUTH AFRICA

According to Coombe (2000:5), South Africa has approximately 12 million learners and 375 000 educators in primary and secondary schools. Bennell (2005:1) points out that in the year 2000 the South African Department of Education (DoE) commissioned the health and population consultancy firm called AbT Associates to undertake an

assessment of the impact of HIV and AIDS on the ability to deliver education. The DoE has never released the main report, but the main findings of the study were presented and recorded. Bennell (2005:1) mentions that the DoE's decision to conceal the report is that the estimates of projected levels of teacher HIV infection and mortality were very high. Therefore, there was a need to do another study to verify and confirm the projected statistics.

Bennell (2005:2) points out that the Human Sciences Research Council (HSRC), the Medical Research Council (MRC) and the Mobile Task Team (MTT) were commissioned in the year 2004 to conduct a study on the demand and supply of educators in South Africa. The study researched the impact of the AIDS epidemic on South African teachers. In this study a relatively large and representative group of teachers were tested for HIV. The results revealed that the Abt Associates report overestimated the levels of HIV infection and AIDS-related mortality among educators. The HSRC, MRC and MTT Report of the year 2004 revealed that the HIV prevalence rate among educators was 12,7 per cent in that year (Bennell 2005:2). The results of this research study are indicated by the table below:

Table 2.1: HIV Prevalence rates as percentages among teachers by gender and age cohort in South Africa (2004)

AGES	FEMALE	MALES
25-29	21,5	12,3
30-34	24,2	19
35-39	14,1	16,6
40-44	10,1	10,5
45-49	6,3	7,6
50-54	3,8	5,8
55+	3,7	1,6

(Source: Bennell 2005:2)

The table above indicates that female educators in the age cohort of 25 to 34 and above the age of 50 have a higher HIV prevalence rate than male educators of the same age. This could be attributed to the fact that females are more vulnerable and susceptible to HIV infection because of the reason that they often have limited choice when it comes to using prophylactic protection during sex due to patriarchy and gender inequality. In addition, this could also be attributed to the fact that the biology of the vagina elevates the chances of HIV infection (Whiteside and Sunter 2000).

According to Baxen and Breidlid (2004:13), HIV and AIDS will affect the education sector in the following ways:

- There will be less demand for education as AIDS orphans leave school.
- Educators will also leave the education system due to their own ill-health or the need to look after significant others.
- The quality of education will be compromised.

Sections 2.2.1, 2.2.2 and 2.2.3 discuss these issues in detail.

2.2.1 THE IMPACT OF HIV AND AIDS ON THE DEMAND FOR EDUCATION

Strickland (2000) proclaims that the impact of HIV and AIDS decreases the demand for education by increasing infant mortality, increasing number of orphans and decreasing family budgets for school fees. Kelly (2000:48) concurs that HIV and AIDS affect the demand for education in a manner that there will be fewer children to educate because many of them will be AIDS orphans who cannot afford education because of losing their parents to AIDS-related diseases. Some of these learners will have to leave school to look for work in order to survive. Bennell et al (2000:2) agree that due to high levels of poverty attributed to the macro-economic impact of HIV and AIDS, parents and guardians will not be able to afford to send their children to school. This is also substantiated by Gachuhi (1999:3) who states that such an effect on the affordability of

education includes a number of issues: the direct loss of income due to AIDS-related deaths of breadwinners in the household as well as the loss of income due to AIDS-related medical and funeral costs.

Kelly (2000:51) points out that learners infected with HIV and/or affected by HIV and AIDS may find the school environment stressful due to the stigmatisation, discrimination and social ostracism they may encounter. He further mentions that many HIV-infected children will leave school due to AIDS-related diseases. Those who have family members who are sick and dying of AIDS-related diseases may leave school to take care of their loved ones, or they may leave school due to low morale caused by witnessing their loved ones die of AIDS-related diseases.

The above factors inevitably impact on the psychosocial health and wellbeing of educators who teach these children. In some cases, educators end up becoming involved by fostering or adopting some of these AIDS orphans. In addition, educators will find it difficult to teach children who are not motivated to study. Consequently they may have to deal with the problems of academically underachieving and failing children. This situation will also decrease the desire of educators to teach. Moreover, in some cases, educators have to care for HIV-infected children who are sick. This care has the potential to affect them psychosocially because they are close witnesses of the trauma and pain these children go through.

2.2.2 THE IMPACT OF HIV AND AIDS ON THE SUPPLY OF EDUCATION

The World Bank (2002:11) states that "the death of one teacher deprives a whole class of children of education." Strickland (2000) proclaims that the impact of HIV and AIDS decreases the supply of education by increasing the morbidity and mortality of educators. Kelly (2000:63) points out that educators infected with HIV and/or affected by HIV and AIDS are often absent from school due to AIDS-related diseases or taking care of their loved ones who are infected with HIV. He further

mentions that some schools are facing closure due to lack of teachers who are sick and dying because of AIDS-related diseases. Coombe (2000:15), Gachuhi (1999:5) and the World Bank (2002:11) agree that in southern Africa teachers are believed to have a higher HIV prevalence than the general population due to their higher socio-economic status and greater mobility which exacerbates and aggravates their susceptibility and vulnerability to HIV-infection. According to the World Bank (2002:11), educator postings away from home can lead to infidelity and more sexual partners which may result in a higher risk of HIV-infection. Coombe (2000:15) points out that over 53 000 educators will die due to AIDS-related diseases by the year 2010. Therefore, this situation will inevitably cause psychosocial problems among educators who witness their colleagues who are sick and dying due to AIDS-related diseases.

Educators who are sick and dying due to AIDS-related diseases have to be replaced, which often compels the education sector to recruit unqualified teachers as substitutes (Barnett and Whiteside 2003:202). If a replacement is not available or not budgeted for, the situation will pose a strain on other educators who will have to assume the duties of sick or deceased educators (Coombe 2000:15; Kelly 2000:65). Therefore, this will result in large class sizes to be taken up by other educators thereby decreasing the teacher to learner ratio to 1:50 (Coombe 2000:15). This situation may cause burnout among educators who have to take up the workload left behind by colleagues inflicted with AIDS-related diseases.

Gachuhi (1999:4) and Kelly (2000:65) agree that higher education institutions produce low rates of newly qualified educators to replace deceased educators. This may be attributed to the fact that student educators also die due to AIDS-related diseases before they can graduate and join the teaching workforce. Kelly (2000:65-66) asserts that there will be shortages of educators in scarce skills subjects such as Mathematics, Science and Technology, and the education sector will find it difficult to replace labour in these scarce skills fields (Kelly 2000:65-66). This will affect educators in a way that they have to teach subjects that they are not qualified to teach.

Therefore, this situation will decrease the morale and motivation of educators who have to teach subjects that they lack knowledge of or interest in.

Kelly (2000:67) and the World Bank (2002:13) concur that recurring absenteeism of HIV-infected educators is apparent in many schools. This is directly attributed to opportunistic diseases to which immune-compromised individuals are susceptible. Buchel and Hoberg (2006:2) assert that this erratic school attendance decreases the productivity and supply of education. Educators who have family members or relatives who are HIV-infected have a greater likelihood of being absent from school due to attendance of funerals or taking care of sick loved ones (Kelly 2000:68; World Bank 2002:13). Finally, there is a socio-geographical impact. In this regard, HIV-infected educators tend to relocate to areas where they can easily access health care services, especially in urban areas, which leave rural schools without educators (Gachuhi 1999:4; Kelly 2000:68; World Bank 2002:13). Cumulatively, the increasing workloads in conditions of educator shortages decrease the desire, morale and the motivation to teach.

2.2.3 THE IMPACT OF HIV AND AIDS ON THE QUALITY OF EDUCATION

Strickland (2000) proclaims that the impact of HIV and AIDS affects the process and quality of education by decimating the ranks of educators responsible for the provision of education. AIDS-related morbidity undermines the quality of teaching in schools because sick educators are often absent from school or are unable to teach effectively due to deteriorating health (Bennell et al 2002:84). This is corroborated by Barnett and Whiteside (2003:202) when they suggest that sick teachers are often absent from school which leaves other educators with increasing workloads. This is further substantiated by Kelly (2000:97-98) when he mentions that the loss of educators through AIDS-related morbidity and mortality has negative implications for the provision of quality education. Buchel and Hoberg (2006:1) assert that education managers are faced with a challenge of providing quality education due to escalating

statistics of sick, absent and demoralised educators and learners in schools because of the impacts of HIV and AIDS. Kelly (2000:77-78) agrees that the erratic school attendance of educators and learners due to AIDS-related diseases will pose a disruption in the process of teaching and learning. Buchel and Hoberg (2006:2) also argue that AIDS orphans lack parental care and guidance which results in disruptive behaviour and rebelliousness that affects the process of teaching and learning in schools. Therefore, in a deteriorating educational environment, the incentive to continue teaching is negatively affected.

Bennell (2005) states that the HSRC, MRC and MTT Report of the year 2004 revealed that 10 000 South African teachers (22 per cent of HIV-infected teachers) are in need of ART. However, the criterion of starting ART at a CD4-cell count of 200 or less probably renders them unable to teach effectively in classrooms due to illness and associated physical and psychological symptoms of HIV and AIDS. This results in poor quality in the provision of education. Buchel and Hoberg (2006:2) assert that 8 per cent of school principals and heads of departments are HIV-infected, which will inevitably increase the potential for maladministration and mismanagement of schools due to AIDS-related morbidity and mortality.

2.3 PSYCHOSOCIAL PROBLEMS OF EDUCATORS INFECTED WITH HIV AND/OR AFFECTED BY HIV AND AIDS

HIV and AIDS pose psychological and social (or psychosocial) problems among people infected with the disease and/or affected by the disease. These psychosocial problems include ethical, moral and legal challenges that people face in their day-to-day life experiences. Hence this section will discuss these psychosocial challenges as they are experienced by educators infected with HIV and/or affected by HIV and AIDS.

2.3.1 AIDS-RELATED STRESS AND DEPRESSION

Ross and Deverell (2010:400) describe stress as a psychological condition that is caused by a demanding and frustrating situation that exceeds a person's means, and can result in mental, emotional, physical and behavioural problems. According to van Dyk (2005:223-225), difficult situations such as lack of access to treatment, care and support can cause stress among people living with HIV and AIDS. Depression is defined as a psychological condition characterised by feelings of sadness, hopelessness, anxiety, emptiness and worthlessness (van Dyk 2005:225-226). People infected with HIV and/or affected by HIV and AIDS frequently experience depression because of day-to-day difficult situations such as social ostracism by significant others (van Dyk 2005:225). Hence educators infected with HIV and/or affected by HIV and AIDS are also prone to stress and depression. For example, an educator who is in denial and angry about contracting HIV may have feelings of stress and depression and may resort to alcohol and substance abuse in order to avoid thinking about being HIV-positive. This situation will further exacerbate and aggravate stress and depression because their problems will not just fade away.

2.3.2 AIDS-RELATED GRIEF AND BEREAVEMENT

Newman and Newman (2006:548) define grief as an emotional reaction that follows after a person has lost a loved one because of death. They mention that grief is associated with mourning, longing and thinking about the deceased loved one. Bereavement refers to a long-term process of adjusting to the death of a loved one (Newman and Newman 2006:549). It is said that bereavement is accompanied by anger, anxiety, stress and depression (Newman and Newman 2006:549). Therefore, educators who have significant others or loved ones such as family members, relatives, colleagues or learners who are dying due to AIDS-related diseases also experience grief and bereavement.

2.3.3 AIDS-RELATED BURNOUT

According to Kirton (2003:159), burnout refers to the burden and strain experienced by caregivers of people living with HIV and AIDS. This can include financial aid, caring responsibilities and duties such as feeding and bathing people living with HIV and AIDS. Ross and Deverell (2010:403) and van Dyk (2005:326) agree that burnout is a type of stress involving physical and emotional exhaustion among caregivers of people living with HIV and AIDS. Educators are often compelled to take care of colleagues and learners infected with HIV, and in most cases they are forced to assume the duties of other educators who are dying due to AIDS-related diseases. This situation inevitably creates a problem of burnout among these educators.

2.3.4 AIDS-RELATED SUICIDE IDEATION

According to van Dyk (2005:227) suicide ideation refers to contemplating and fantasising about ending one's own life. Van Dyk (2005:227) states that people living with HIV and AIDS are 36 times more likely to commit suicide than people who do not have the disease. She mentions that suicide ideation or contemplation is influenced by difficult situations such as lack of treatment, and care and support experienced by people living with HIV and AIDS. Therefore, educators infected with HIV and/or affected by HIV and AIDS are also susceptible and vulnerable to suicide ideation. For example, an educator who has feelings of guilt and shame for contracting HIV may not cope with life and may resort to ending his or her life.

2.3.5 AIDS-RELATED MORBIDITY AND MORTALITY

According to Whiteside and Sunter (2000:28) morbidity refers to "the disease condition seen within a population" whereas mortality refers to "deaths within a stated population." Rehle and Shisana (2005:1) assert that research on AIDS mortality among educators is based on mathematical and statistical modelling because many deaths go unreported and unrecorded. Bennell (2005:1) further stipulates that until recently there has not been any

good quality data available on HIV infection levels as well as morbidity and mortality rates among educators. The South African Democratic Teacher's Union conducted a study to investigate mortality among its members from August 1999 to May 2000, which revealed that out of 701 deaths approximately half of them were AIDS-related (Rehle and Shisana 2005:1).

Rehle and Shisana (2005:9) projected that 8,3 per cent of educators were infected with HIV in the year 2004 (which is 1,1 per cent of the total educator population) and they may have died due to AIDS-related diseases in that same year. They further stipulate that almost half (48,7 per cent) of the estimated 3974 AIDS-related deaths among educators were in the age cohort of 35 to 44. This scenario is indicated by the table below:

Table 2.2: Distribution of AIDS deaths among educators by age in South Africa (2004)

Age group	**Number of AIDS deaths**	**% Proportion of AIDS deaths**
<24	12	0,3
25-34	1337	33,6
35-44	1935	48,7
45-54	587	14,8
55>	105	2,6
Total	3976	100

(Source: Rehle and Shisana 2005:9)

The table above indicates that there have been high death rates due to AIDS-related diseases among educators aged 25 to 44. Comparatively, there have been lower death rates for educators with the age less than 24 and the age more than 55. This situation denotes that there is increasing AIDS-related morbidity and mortality among young, active and productive educators.

Buchel and Hoberg (2006:1) stipulate that in the year 2004 more than 4 000 educators died due to AIDS-related diseases and a further 45 000 (12,5 per cent of the teacher workforce) is reported to be infected with HIV. They assert that a quarter of the deceased educators were in the age cohort of 30 and 40, which indicates that many potential principals and experienced educators were lost to AIDS-related deaths. Furthermore, Buchel and Hoberg (2006:7) argue that by the year 2010 more than 53 000 educators will die due to AIDS-related diseases, leaving behind increasing workloads for other educators who have to manage large class sizes. On the other hand, Kelly (2000:64) argues that with a teacher infection rate of 20 to 30 per cent, 88 000 to 133 000 South African teachers will die due to AIDS-related diseases by the year 2010. However, there is a huge difference in Kelly (2000) prediction of AIDS-related deaths by the year 2010. Hence I argue that Buchel and Hoberg (2006) prediction of AIDS-related deaths by the year 2010 is more acceptable and recent. However, both arguments of AIDS-related mortality by Buchel & Hoberg (2006) and Kelly (2000) clearly indicate that South Africa will lose many teachers due to AIDS-related diseases.

Bialobrzeska (2007:4) reports that there has been a significant increase in teacher mortality from 7,9 per cent in 1997/98 to 17,7 per cent in 2003/04. Furthermore, she mentions that gross mortality which is calculated as the total number of in-service deaths and number of post-service educators who died within one year of resignation amounts to 14 192 in the same period. The ELRC/HSRC Educator Supply and Demand Report of the year 2005 predicted a shortfall of approximately 15 000 teachers by the year 2008, which is also attributed to AIDS-related mortality (Bialobrzeska 2007:4). Bennell (2005:4) argues that mortality rates (from all causes) among male teachers are higher than those of female teachers. He asserts that the reason for this could be that male teachers die from non-AIDS related diseases as well as from accidents or lower uptake of ART if living with AIDS. In addition, the MTT (2005:4) Report reveals that black African educators have higher death rates than other races.

Bennell (2002:84) states that the total number of teachers permanently leaving the public service due to AIDS-related morbidity has increased from 1057 in 1998 to 1200 in 2003.

Bialobrzeska (2007:4) asserts that the proportion of termination of service due to AIDS-related morbidity has increased from 4,6 per cent in the year 1997 to 8,7 per cent in the year 2004.This situation of increasing AIDS-related morbidity and mortality rates will inevitably cause psychosocial problems for educators who witness the death of their colleagues. They may suffer from burnout due to the increasing workload they have to perform because of the shortage of educators who are absent or have died due to AIDS-related diseases. In addition, they may suffer from grief and bereavement because of mourning for their colleagues who died due to AIDS-related diseases.

2.3.6 AIDS-RELATED ATTRITION

A research study conducted by Hall et al (2005:1) on educator attrition lists job satisfaction, morale, workload and HIV and AIDS as factors that influence the movement of educators away from the teaching profession. The study reveals that since 2006 approximately 20 000 of educators who have left the teaching profession have had to be replaced annually. These researchers mention that there are low levels of job satisfaction and morale among educators because of low remuneration, lack of recognition of experience, lack of training and resources, as well as increased bureaucracy in the DoE. In addition, Hall et al (2005:1) proclaim that there is lack of interest in the teaching profession among young people, and that young teachers are already leaving the profession in large numbers which raises some concerns about the quality of education in the future. It is reported that the impact of HIV and AIDS on educators and learners increase the chances of educator attrition (Hall et al 2005:1).

Educators infected with HIV and/or affected by HIV and AIDS are not satisfied about the teaching profession because of low remuneration. These educators cannot afford to take care of themselves and loved ones on low salaries when taking into account the high costs of living with HIV in terms of nutritional needs and medical costs. Furthermore, these educators often leave the teaching profession because their workload has increased due to AIDS-related morbidity and mortality. This situation inevitably causes

psychosocial problems such as stress and depression among these educators and they are compelled to leave the education sector to look for better paying jobs in other sectors.

2.3.7 AIDS-RELATED ABSENTEEISM

Educators infected with HIV and/or affected by HIV and AIDS are frequently absent from school due to personal illness or caring for loved ones who are infected with HIV. This creates a problem for other educators who have to work overtime and manage large class sizes because of educators who are absent. According to Maile (2004:122), school managers often misunderstand the issue of dealing with educators who are often absent from school due to AIDS-related reasons. He states that educators are charged with incapacity to perform duties or misconduct due to absconding from work. Maile (2004:122) points out that if an educator is allegedly incapacitated and unfit to perform his or her duties, medical reports are needed in support of sick leave and an official inquiry may be launched by the district education department to investigate the case of such an educator. This situation might pressurise an educator to unwillingly disclose his or her HIV status which in the end makes that educator prone to HIV-related stigmatisation and discrimination by colleagues.

The HIV-infected educator might also be dismissed on charges of incapacity or misconduct due to recurring AIDS-related absenteeism. Bennell et al (2002:90-91) assert that most HIV-infected educators continue to work even if they are not able to do so in order to avoid these repercussions. Consequently, these educators are likely to be ineffective in their classrooms and to further jeopardise their deteriorating health by continuing to teach. Apart from the physical risk of further compromising their immune system, this situation inevitably causes psychosocial problems such as stress and depression among educators who are infected with HIV. Even educators who are not infected may experience psychosocial problems as they are directly or indirectly affected by HIV and AIDS.

2.3.8 JOB INSECURITY AND THE RIGHTS OF EDUCATORS INFECTED WITH HIV

Regan (2002:185) quoted Peter Piot, Executive Director of the UNAIDS, when he mentions that "Today, it is clear that AIDS is a development crisis, and in some parts of the world is rapidly becoming a security crisis too." Whiteside and Sunter (2000:158) assert that the Constitution of South Africa Act No. 108 of 1996, as enshrined in the Bill of Rights, clearly states that every person has the right to equality and non-discrimination, privacy and fair labour practices. The right to privacy particularly implies that an employee has the right to confidentiality pertaining to his or her medical information, including information about HIV status. Van Dyk (2005:334) concurs that the constitution of South Africa is the supreme law of the country and all the laws must comply with it and it includes the Bill of Rights which stipulates basic human rights including the rights of people living with HIV and AIDS. According to van Dyk (2005:334-335), the Constitution lists the following rights which apply also to people living with HIV and AIDS:

- The right not to be unfairly discriminated against, either by the state or by another person
- The right to bodily and psychological integrity, which includes the right to security and control over the body
- The right not to be subjected to medical or scientific experiments without the person's own informed consent
- The right of access to health care services, including reproductive health care
- The right not to be refused emergency medical treatment
- The right to information and a basic education
- The right to privacy
- The right not to have the privacy of one's communications infringed.

Van Dyk (2005:335-336) adds that people living with HIV and AIDS have the following rights:

1. Liberty, autonomy, security of the person and freedom of movement

People living with HIV and AIDS should not be restricted access to any public place they wish to enter on grounds of their HIV status. They should not be segregated, isolated or quarantined, and they are entitled to make their own decisions pertaining to personal matters such as marriage and child-bearing.

2. Confidentiality and Privacy

People living with HIV and AIDS have the right to conceal or not to disclose their HIV status. Health care professionals are ethically and legally obliged to keep all information about HIV-positive patients private and confidential. Information about a person's HIV status may not be disclosed to anyone without that person's fully informed consent.

3. HIV testing

No person may be tested for HIV infection without their informed consent, unless required by law. Pre- and post-testing counselling sessions should be undertaken and those who test HIV-positive should be offered treatment, care and support.

4. Education on HIV and AIDS

All people have the right to proper education and information about HIV and AIDS, as well as the right to prevention.

5. Employment

No person should be forced to be tested for HIV infection in employment applications. Moreover, no person should be refused or terminated from employment because of their HIV status.

6. Health and support services

People living with HIV and AIDS have the same right of access to health care services, housing, food, social security, medical assistance and welfare as other members of society. Medical schemes may not discriminate against people on grounds of their HIV status.

7. Insurance

Insurance companies may not unfairly discriminate against or refuse people insurance based on their HIV status.

8. The responsibilities of the media

People living with HIV and AIDS have the right to fair treatment by the media, especially concerning privacy and confidentiality. People have the right to be offered information and education pertaining to HIV and AIDS through the media.

9. The right to safer sex

People have the right to protect themselves against HIV transmission by taking precautionary measures when engaged in risky sexual behaviours and activities.

10. Equal protection under the law, and public benefits.

People living with HIV and AIDS have the same right of access to public benefits and services offered by the state as any other citizen would. The justice system should protect HIV-positive people against discrimination and unfair treatment.

Whiteside and Sunter (2000:158) argue that these rights are not absolute and have some limitations, provided such a limitation is reasonable and justifiable. This is corroborated and echoed by Maile (2004:113) who states that if a person chooses to disclose their HIV-positive status to an official, the official is bound by principles of confidentiality not to divulge this information to third parties, unless legally compelled to under procedures prescribed by law and policy.

Whiteside and Sunter (2000:159) stipulate that the Employment Equity Act No. 55 of 1998 prohibits medical testing of an employee by employers to determine the HIV status of an employee. However, this can be allowed in circumscribed circumstances when such testing is determined to be justifiable and authorised by the Labour Court. In this view, most educators living with HIV choose to conceal their illness from officials to avoid the legal implications of these statutes and to keep and protect their jobs. Bennell et al (2002:86) mention that most educators conceal their HIV-positive status because of fear of stigmatisation and discrimination by superiors, colleagues, learners and parents. Maile (2004:114) makes an example by referring to a case that made headlines in media reports when an educator who disclosed her HIV-positive status to her school principal was dismissed by the principal. Therefore, educators living with HIV are reluctant to disclose their HIV status in fear of losing their jobs. Moreover, Kelly (2000:30) states that there are cases where educators are denied employment and promotion opportunities because of their HIV-positive status.

For example, there was a prominent case against South African Airways that exacerbated and aggravated the decision of individuals to conceal their HIV-positive status from their employers. Whiteside and Sunter (2000:165) quote a case where an individual applied for

a flight attendant position with South African Airways and during medical examinations was found to be HIV-positive, and was offered alternative employment as a member of the ground staff instead. The individual took the matter to the courts, alleging that South African Airways violated his constitutional rights to dignity, equality, fair labour practices and privacy by denying him the position on grounds of his HIV-positive status. South African Airways argued that cabin crew must be fit to work worldwide, including countries with yellow-fever endemic which South African Airways claimed is potentially dangerous to HIV-positive people. Moreover, South African Airways argued that cabin crew are not supposed to endanger or compromise the health of passengers, emphasising that HIV-positive cabin crew might pose a threat to the health of passengers. The court ruled in the favour of South African Airways that their policies were justified and substantiated. Based on this case, it is conspicuous and inevitable that most HIV-positive educators will choose to conceal their HIV status to avoid legal implications and protect their jobs, and this also creates psychosocial problems of keeping a secret about their disease.

2.3.9 AIDS-RELATED STIGMATISATION AND DISCRIMINATION

The Blackwell Online Dictionary of Sociology (2000) defines stigma as "a negative social label that identifies people as deviant not because their behaviour violates norms but because they have personal or social characteristics that lead people to exclude them". The Collins Online Dictionary of Sociology (2005) defines discrimination as "the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group". Educators infected with HIV and/or affected by HIV and AIDS are often prone to stigmatisation, discrimination and social ostracism by their principals, colleagues, learners, parents and community members where they teach (Bennell et al 2002:86). This is due to the belief that they deserve to be punished for their promiscuous sexual behaviour (Kelly 2000:29). Hence educators infected with HIV experience psychosocial problems attributed to the way in which their communities perceive and mistreat them.

Kelly (2000:30) points out that HIV and AIDS are often associated with fear due to lack of knowledge about the disease. He further proclaims that the stigma related to HIV and AIDS is an obstacle to accessing prevention, treatment, care and support services due to the rejection, discrimination and shame attached to HIV and AIDS. For the mere reason that many educators infected with HIV and/or affected by HIV and AIDS choose not to disclose their HIV status, they are not able to access prevention, treatment, care and support services available in public health care facilities. On the other hand, educators who choose to disclose their HIV status are prone to discrimination and stigmatisation by their colleagues, learners and communities they live in. This statement is substantiated by Kelly (2000:30) when he mentions that there are authenticated cases of people being denied medical care, employment or job promotion because of their HIV-positive status. He further emphasises that this situation breeds fear and silence about the disease, which develops into a vicious circle because the concealment, denial and secrecy about the disease is also a breeding ground for the further spread of HIV.

Therefore, educators infected with HIV and/or affected by HIV and AIDS are also subjected to these unfair practices in their day-to-day life experiences. For example, Maile (2004:114) refers to the court case of Hoffman *versus* South African Airways in 2000, where Mr. Hoffman was dismissed from employment after South African Airways established that he was HIV-positive. After the Constitutional court proceedings, South African Airways lost the case and Mr. Hoffman was reinstated in his position. Whiteside and Sunter (2000:166) also refer to another Labour court case against South African Airways in May 2000, when an individual was refused employment because of his HIV-positive status. In this case South African Airways decided to settle out of court and paid out a lump sum of R100 000 for compensation and all legal costs incurred by the complainant. South African Airways admitted that refusal of employment to people living with HIV is unjustified and that it should have obtained informed consent, and conducted pre- and post-counselling sessions before testing the individual for HIV. Whiteside and Sunter (2000:167) mention that South African Airways also promised to update and reformulate its policies on HIV and AIDS. Based on these cases, it is reasonable to infer that educators infected with HIV and/or affected by HIV and AIDS

may be similarly stigmatised and discriminated against on grounds of their HIV-positive status by their employers.

2.3.10 ETHICAL AND MORAL PROBLEMS EXPERIENCED BY EDUCATORS INFECTED WITH HIV

Prior-Jonson (1988:14) states that "ethics is about right and wrong." Cameron (1993:1) further argues that people living with HIV experience particularly difficult ethical problems because AIDS is a life-threatening, communicable, chronic and stigmatising disease. Furthermore, she points out that how people living with HIV resolve their ethical problems can profoundly affect themselves, their significant others, health care professionals and the society they live in. Due in part to the stigma and discrimination attached to HIV and AIDS, society blames people living with HIV for becoming infected. These people are also perceived to have done wrong and therefore deserve punishment for their actions. There have been cases of unfair discrimination against educators infected with HIV in South African educational institutions. Educators infected with HIV have been denied employment, promotion and dismissed on grounds of their HIV-positive status. Therefore, this situation shows that educators infected with HIV are prone to unfair practices and judgement by their communities in their day-to-day life experiences.

According to Maile (2004:114) we often hear people passing the following comments despite HIV/AIDS education interventions:

"Our priest said that this disease is punishment for sinners. AIDS is God's way of punishing sinners. Nobody should have sex with anyone else outside marriage."

"It's those moffies who have unnatural sex that get it. AIDS will clean them out."

"There are too many people on this planet. AIDS is nature's way of controlling the population."

"The government wants us to wear condoms to control the size of our families."

These remarks show that people living with HIV, including educators, experience ethical challenges in their day-to-day life experiences. Because educators are role models and highly respected in many communities, society often portrays educators as perfectionists with desired principles and morals which makes them prone to mischief. Therefore, if educators are found to be HIV-positive, society regards them as deceivers and liars. They view these HIV-positive educators as sexual predators who could molest, rape, or sexually abuse their children. Because educators are believed to be at the forefront of HIV/AIDS education, if they are HIV-infected themselves, the society views them as wrong role models and terrible examples to their children. These educators are often socially ostracised by their communities on grounds of their HIV-positive status. Therefore, some educators are in denial of their HIV-positive status or they choose to keep their status a secret in fear of being stigmatised and discriminated against by their communities.

Maile (2004:116) argues that if HIV-positive educators choose to disclose their status to officials and colleagues, they are prone to gossip and rejection. He states that other colleagues may use this opportunity to disempower HIV-positive educators by using this situation as a stepping stone to gain privileges from managers. Some HIV-positive educators are regarded as useless in the school because they are perceived to be there just to pass time awaiting death. These educators are seen as unfit to perform responsible duties in the schools. For example, an HIV-positive educator might not be given a chance to coach a sporting activity in the school, even if he or she is capable, fit and healthy enough to do so. These unfavourable day-to-day experiences and scenarios inevitably create psychosocial problems among HIV-positive educators.

2.3.11 TREATMENT PROBLEMS OF EDUCATORS INFECTED WITH HIV

The South African government was reluctant to provide Anti-Retroviral Therapy (ART) to patients with AIDS-related diseases. This was reinforced by the controversy surrounding the former President Thabo Mbeki when he denied and disputed the links between HIV and AIDS, and attributed the cause of AIDS to poverty. Furthermore, the resistance to providing ART to patients living with AIDS was worsened by the former Minister of Health Dr. Manto Tshabala-Msimang when she publicly announced that ART is toxic and that AIDS can be cured by a diet of garlic and beetroot (Treatment Action Campaign 2009). The Treatment Action Campaign (TAC) took the DoH to the Constitutional Court in 2001 in order to force the government to provide ART to patients with AIDS-related diseases (TAC 2009). In 2002 the TAC won the Constitutional Court case and the government was ordered to provide ART to patients living with AIDS (TAC 2009). On 19 November 2003 the DoH implemented ART in public health care facilities through the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (TAC 2009).

According to Rehle and Shisana (2005:1), the government delayed the roll-out of ART programmes in the public sector and only started issuing ART when many avoidable AIDS-related deaths were occurring. However, it was already too late because the AIDS epidemic had already spread among the population. Dorrington, Bradshaw, Daniel and Johnson (2006) and the Treatment Action Campaign (2009) mention that there are over 400 public health care facilities offering ART in South Africa, but only 300 000 people are able to access it and a further 500 000 people who are in need of ART are not able to receive it.

The situation also concerned the AIDS Law Project which stated that:

"A largely untreated AIDS epidemic has profound implications not only for the people who are needlessly suffering and their loved ones, but also for the country as a whole...Rising levels of sickness and death place severe strain on the state, which is under

growing pressure and constitutional obligation to provide adequate forms of support to families affected by HIV/AIDS. There is also an increasing burden on the public health system, as people living with HIV/AIDS require repeated treatment of opportunistic infections."

Therefore, educators infected with HIV also experience problems of accessing ART and the situation will inevitably result in increasing AIDS-related morbidity and mortality rates amongst them. Due to this, they may come to experience psychosocial problems. Witnessing their significant others die due to AIDS-related diseases because of the obstacles and barriers of accessing ART could perpetuate psychosocial concerns amongst educators.

Rehle et al (2005:1) maintain that HIV Counselling and Testing (HCT) is a significant entry point to access ART, and once a person has tested HIV-positive, a measurement of their CD4 cell count will determine whether they can start taking ART. However, due to the silence, fear and denial surrounding HIV and AIDS, educators do not go for HCT in order to be able to access ART when necessary. The panel on Clinical Practices for Treatment of HIV Infection convened by the United States of America (USA) Department of Health and Human Services (DHHS) recommended that ART should be started when an HIV-infected person has a CD4 cell count of 200 – 350 cells per cubic millimetre (Rehle et al 2005:1). However, in South Africa, using the World Health Organisation (WHO) recommendation, patients with AIDS-related diseases are only started on ART when their CD4 cell count is 200 cells per cubic millimetre or less.

Rehle et al (2005:7) argue that if the WHO criteria is followed, only 22 per cent of HIV-infected South African educators will be eligible for ART. Comparatively, if South Africa follows the USA DHHS criteria, this would increase the proportion of HIV-infected educators eligible for ART to 52 per cent. Moreover, if the South African WHO criteria is followed, HIV-infected educators with a CD4 cell count of 200 – 350 cells per cubic millimetre who are very sick would have to use expensive private health care facilities to access ART because they would not be eligible to access ART in public

health care facilities. In addition, because most HIV-infected educators are not able to afford private health care facilities, this will result in increasing AIDS-related morbidity and mortality. Bureaucratic policies, based on contested counts, in accessing ART inevitably creates psychosocial problems for educators infected with HIV because they cannot access ART when they need it.

2.3.12 TEACHING LEARNERS INFECTED WITH HIV AND/OR AFFECTED BY HIV AND AIDS

Bennell et al (2002:48) state that educators can be affected by HIV and AIDS by teaching learners who are living with HIV and AIDS, or learners who have a significant other living with HIV, and learners whose parent/s or guardian/s have died due to AIDS-related diseases. The silence, secrecy and denial surrounding HIV and AIDS makes it difficult to obtain information about learners infected with HIV and/or affected by HIV and AIDS in schools (Bennell et al 2002:48). This prevents learners from receiving treatment, care and support services when the need arises. Ainsa (2000:11) argues that learners living with HIV and AIDS have posed concerns, fears and ethical issues for educators in schools. However, some education departments have introduced school HIV/AIDS policies and programmes to address the rights of learners infected with HIV and/or affected by HIV and AIDS in some schools (Ainsa 2000:11-13). In addition, other schools have implemented precautionary measures to deal with blood-borne infectious situations such as injury during sport activities (Ainsa 2000:11-13). Moreover, other education authorities have integrated HIV/AIDS education programmes in their schools' curriculum to educate learners about the disease. However, many educators are not trained to teach HIV and AIDS educational programmes or lack the knowledge and skills to teach such programmes.

Learners infected with HIV and/or affected by HIV and AIDS are also prone to stigmatisation, discrimination and social ostracism by fellow learners, educators and their communities. This was evident in South Africa when the late famous young AIDS activist Nkosi Johnson was refused admission to school due to his HIV-positive status. In

another prominent case that caused headlines in June 2002, a pre-school learner, Tholakele Pereira, was also refused admission by three pre-schools because she was HIV-positive (*Daily News* 14 June 2002:2). This case ended up in court and one of the pre-school's lawyer argued that Tholakele's mother should wait until she was 3 years old, past the stage of scratching and biting to avoid blood-borne infectious situations. These two cases are just two incidents of stigmatisation and discrimination surrounding HIV and AIDS in schools. In some cases, learners who have a significant other who is living with HIV or has died due to AIDS-related diseases face rejection and social ostracism in their communities because they are thought to be HIV-positive too. These learners often academically underperform due to low morale and poor motivation. This situation in turn creates problems for the teachers in charge of such learners.

For complex reasons, conventional moral strictures and norms have been undermined in South African communities and schools. There have regularly been reports of cases of the sexual abuse and rape of learners in schools by educators and other learners (Human Rights Commission Report 2006; Human Rights Watch 2001). Often these involve young girls being coerced into having sex with male educators. In other instances, schoolboys are the perpetrators. This situation has inevitably exacerbated and aggravated the spread of HIV in schools. Moreover, it creates an unhealthy climate of vulnerability amongst victims and perpetrators. Further, whatever the motive, the press attention and public indignation following such deplorable incidents tarnish the reputation of educators and the education system generally, and those living with HIV and AIDS specifically.

Educators who witness learners die because of AIDS-related diseases experience psychosocial problems. Educators are also not able to plan their lessons accordingly due to increased absenteeism and erratic school attendance of learners infected with HIV and/or affected by HIV and AIDS, which interrupts the whole school programme. Moreover, educators who are not trained in HIV and AIDS are not able to provide care and support to HIV-positive learners who require special educational needs and individualised attention. Therefore, Ainsa (2000:19) concludes by stating that school

attendance of learners infected with HIV and/or affected by HIV and AIDS has social, ethical and legal implications for educators in schools.

2.4 HIV/AIDS POLICIES AND PROGRAMMES IN THE EDUCATION SECTOR

According Simbayi, Skinner, Letlape and Zuma (2005:2) the South African Department of Labour requires that each institution develops an HIV/AIDS workplace policy and programme to address the problems and needs of employees infected with HIV and/or affected by HIV and AIDS. Simbayi et al (2005:2) quote the Code of Good Practice on Key Aspects of HIV/AIDS of the Employment Equity Act 55 of 1998 which declares that "Every workplace should develop a specific HIV/AIDS policy in order to ensure that employees affected by HIV/AIDS are not unfairly discriminated against in employment policies and practices." According to Simbayi et al (2005:2-3), this policy is expected to include:

- The organisation's position on HIV and AIDS
- An outline of the HIV/AIDS programme
- Details of employment policies (for example, HIV testing, employee benefits and performance management)
- Express standards of behaviour expected of employers and employees
- Means of communication within the organisation on HIV and AIDS issues
- Details of employee assistance available to persons affected by HIV and AIDS
- Details of implementation responsibilities
- Monitoring and evaluation mechanisms

The International Labour Organisation (2009) has developed a Code of Practice that established the following ten fundamental key principles on HIV/AIDS workplace programmes:

1. Recognition of HIV and AIDS as a workplace issue
2. Non-discrimination of workers on the basis of their real or perceived HIV status

3. Recognition of the gender dimension of HIV and AIDS
4. Healthy and safe working environment
5. Social dialogue – the successful implementation of an HIV/AIDS policy and programme requires co-operation and trust between employers, workers and their representatives and government
6. HIV screening should not be required of job applicants or persons in employment
7. The right to confidentiality – there is no justification for asking job applicants or workers to disclose HIV-related personal information, nor should co-workers be obliged to reveal such personal information about fellow workers
8. Dismissal – HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illness should be encouraged to work for as long as medically fit in available, appropriate work
9. Prevention of HIV infections
10. Solidarity, care and support should guide the response to HIV and AIDS in the world of work.

These abovementioned policy and programme guidelines show that the DoE is also obligated and compelled to develop and implement HIV/AIDS policies and programmes to address the problems and needs of educators infected with HIV and/or affected by HIV and AIDS. Simbayi et al (2005:2) argue that although the DoE's workplace policies and programmes have been implemented over the past ten years, there are still large gaps identified in these policies. Hence the situation calls for the review of these policies and programmes. According to Coombe (2000:26-27), an effective education sector's response to HIV and AIDS should entail the following four factors:

1. Learning: The sector needs information about conditions that encourage the spread of HIV and AIDS, and how best to educate those at risk. Much has been learned from the history of the epidemic in the Southern African Development Community region, but much more needs to be learned about sexual practices and risk behaviours. New, more robust evidence must inform HIV and AIDS teaching, learning and counselling, particularly in Life Skills education programmes.

2. Preventing: Children, parents and communities need health education aimed at mitigating infection rates in the population, especially amongst young people in and out of school. HIV and AIDS campaigns so far have emphasised such health issues but more needs to be done.

3. Understanding: Educators need much more information about the impact of AIDS on the education sector. They need to understand how AIDS is likely to influence teachers, learners, school governing bodies, sector management and systems, and the quality of education itself.

4. Responding: Strategies are needed for reducing the impact of AIDS on the education system. Creative plans to manage the effects of the epidemic on the system are vital if education and training of reasonable quality are to be provided in South Africa.

Some of these HIV/AIDS policies and programmes implemented in the education sector are discussed below:

1. Department of Education Workplace Policy for HIV/AIDS

Simbayi et al (2005:34) mention that this policy is aimed at providing guidelines for all DoE employees to manage HIV and AIDS in their place of work. The main objective of the policy is to create a supportive working environment for employees infected with HIV and/or affected by HIV and AIDS by eliminating discrimination and protecting the rights of these employees. Simbayi et al (2005:65-66) criticise the policy by pointing out that it seems to over-emphasise the elimination of discriminatory practices and attitudes, and neglects the issues of prevention, treatment, care and support for employees infected with HIV and/or affected by HIV and AIDS. Moreover, it is argued that the policy pays more attention to employees infected with HIV and less attention to the needs of employees affected by HIV and AIDS. Simbayi et al (2005:65-66) argue that employees affected by HIV and AIDS experience psychosocial problems simply due to witnessing

loved ones and colleagues die because of AIDS-related diseases. Hence it is recommended that this policy needs to be reviewed and revised.

2. The National Policy on HIV/AIDS for learners and educators in Public schools, students and educators in Further Education Training Institutions of the Department of Education

Coombe (2000:28) points out that in 1999 the DoE in partnership with the ELRC compiled and disseminated an HIV/AIDS policy and guidelines document for learners and educators at institutions of learning. This HIV/AIDS policy and guidelines document stipulates that:

- The constitutional rights of all learners and educators must be protected equally.
- There should be no compulsory disclosure of HIV status in schools.
- The HIV testing of learners as a prerequisite for attendance at an institution is prohibited.
- The HIV testing of an educator as a prerequisite for employment at an institution is prohibited
- No HIV-positive learner or educator may be discriminated against; they must be treated in a just, humane and life-affirming way.
- No learner may be denied admission to or continued attendance at an institution because of his or her actual or perceived HIV status.
- No educator may be denied appointment to a post because of his or her actual or perceived HIV status.
- Learners and educators who are HIV-positive should lead as full a life as possible.
- HIV-related infection control measures must be universally applied to ensure safe institutional environments.
- Learners must receive education about HIV and AIDS in the context of Life Skills education as part of the curriculum.

- Educational institutions should ensure that learners acquire age and context appropriate knowledge and skills to enable them to behave in ways that will protect them from HIV infection.
- Educators need more knowledge of, and skills to deal with HIV and AIDS, and should be trained to give guidance on HIV and AIDS.

It is clear that this policy and guidelines document advocates the rights of educators and learners infected with HIV in educational institutions. Moreover, this policy and guidelines document proves to be against any form of discrimination towards educators and learners infected with HIV. It is of vital significance that policies and guidelines of this nature are visibly enforced in educational institutions in order to be able to address the problems and needs of educators infected with HIV. Policies and guidelines of this nature will also help in the eradication of HIV-related stigmatisation and discrimination in educational institutions. However, Simbayi et al (2005:31) argue that this policy emphasises the needs of learners more than those of educators. They also critique the policy's focus on biomedical aspects of the disease by stating that it pays less attention to psychosocial problems experienced by educators and learners infected with HIV and/or affected by HIV and AIDS. Moreover, it is argued by Simbayi et al (2005:31) that the policy pays particular attention to educators and learners infected with HIV and neglects those affected by HIV and AIDS.

3. The Department of Education's Strategy and Programme 'Tirisano'

Coombe (2000:29-33) points out that this HIV/AIDS strategy of the DoE pays particular attention to the health and wellbeing of learners and educators infected with HIV and/or affected by HIV and AIDS. This HIV/AIDS strategy also looks at ways to deal with the impacts of the AIDS epidemic on the education sector. The programme was developed in July 1999 by the former Minister of Education Prof. Kader Asmal's Call for Action: 'Tirisano' (Setswana for working together). According to Coombe (2000:29-33) the programme addressed issues such as HIV/AIDS awareness and the integration of

HIV/AIDS in the school curriculum by implementing the following three HIV/AIDS projects:

Project 1: HIV/AIDS awareness, information and advocacy

Strategic Objectives:

- To raise awareness and the level of knowledge of HIV and AIDS amongst all educators and learners
- To promote values, which inculcate respect for girls and women and recognise their right to free choice in sexual relations.

Anticipated Outcomes:

- Increased awareness, understanding, knowledge and sensitivity concerning the causes of HIV and AIDS, its consequences and impact on individuals, communities and the society in general
- Eradication of discriminatory practices against individuals infected with HIV and/or affected by HIV and AIDS
- Development and implementation of HIV/AIDS policies and programmes for the education system
- Change of attitude and behaviour towards sexuality.

Outputs:

- Copies of HIV and AIDS policies and programmes to be distributed to all educational institutions
- HIV/AIDS Information materials to be available at all educational institutions
- Gender sensitivity and equality to form part of all learning programmes in educational institutions.

Performance Indicators:

- Myths about HIV and AIDS are eradicated
- Increased acceptance of the need to practise safe sex
- Establishment of non-discriminatory practices in all educational institutions
- Visible change of attitude towards girls and women.

Project 2: HIV and AIDS within the curriculum

Strategic Objectives:

- To ensure that Life Skills and HIV/AIDS education are integrated into the curriculum at all school levels.

Anticipated Outcomes:

- Every learner to understand the causes and consequences of HIV and AIDS
- All learners to lead healthy lifestyles and make responsible decisions about their sexual behaviour.

Outputs:

- HIV/AIDS training materials to be developed for educators to facilitate Life Skills and sexuality education.

Performance Indicators:

- Life Skills and HIV and AIDS education are integrated across all learning areas and subjects
- Increase in knowledge of, and changed attitudes towards, sexuality and HIV and AIDS amongst educators and learners
- Reduction in the prevalence and incidence rates of HIV and AIDS amongst educators and learners.

Project 3: HIV/AIDS and the Education System

Strategic Objective:

- To develop planning models for analysing and understanding the impact of HIV and AIDS on the education system.

Anticipated Outcomes:

- Plans and strategies to respond to the impact of HIV and AIDS on the sustainability of the education system, and the human resource needs of the education system in particular
- Establishment of treatment, care and support systems for learners and educators infected with HIV and/or affected by HIV and AIDS.

Outputs:

- National plan to deal with the impact of HIV and AIDS on the education system
- Impact studies and reliable statistical databases on the impact of HIV and AIDS on the education system.

Performance Indicators:

- Improved data and planning models on the impact of HIV and AIDS on the education sector are implemented.

Project 1 of this HIV/AIDS strategic programme clearly indicates that there is a need for ongoing dissemination and inculcation of HIV and AIDS information amongst educators and learners in schools. Project 1 also advocates for gender equality by treating women and girls with dignity and respect if we need to combat the spread of HIV and AIDS in the education sector. Project 2 on the other hand advocates for the integration and inclusion of HIV and AIDS knowledge in the school curriculum. Project 2 emphasises the need to include HIV and AIDS education in all learning areas and subjects at all school levels in order to increase HIV and AIDS knowledge amongst educators and

learners. Project 3 emphasises the need to implement the surveillance and monitoring of the impact of the AIDS epidemic in the education sector in order to be able to develop strategies aimed at mitigating the effects of this disease on educators and learners.

4. The HIV/AIDS Emergency: Guidelines for Educators

According to Coombe (2000:33) these guidelines stipulate the following roles for educators:

- Exemplify responsible sexual behaviour
- Spread correct information about HIV and AIDS
- Lead HIV and AIDS related discussions among learners and parents
- Create a school environment that does not discriminate against those who are infected with HIV and/or affected by HIV and AIDS
- Support those who are ill because of AIDS-related diseases
- Make the school a centre of hope and care in the community.

These aforementioned guidelines for educators clearly indicate that educators should be at the forefront of disseminating HIV/AIDS education and information programmes in schools. The guidelines emphasise that educators should create a caring and supporting environment for other educators and learners infected with HIV in schools. By doing so, educators infected with HIV and/or affected by HIV and AIDS would feel comfortable and welcome in the school, and this will create a conducive and compelling environment for teaching and learning to take place.

These policies and programmes discussed above have been in existence for a while, but many educators at school level argue that they know nothing about and never heard of such policies and programmes. Educators at school level further argue that these policies and programmes are formulated and drafted by the DoE at national level without consulting with educators at school level. Therefore, educators infected with HIV and/or affected by HIV and AIDS argue that these policies and programmes are not effective in addressing their problems and needs. These

educators argue that the DoE should have involved them in the formulation of these policies and programmes because they possess greater knowledge of the day-to-day challenges faced by learners and educators infected with HIV and/or affected by HIV and AIDS at school level.

2.5 THEORETICAL FRAMEWORKS RELATED TO THE STUDY

According to Gandelman and Freedman (2002), theories can provide guidance in the development and implementation of HIV and AIDS interventions aimed at mitigating the effects of the epidemic in diverse settings. They mention that these theories are drawn from different disciplines such as Sociology, Medicine, Psychology or Anthropology. In addition, they mention that these theories focus on societal and environmental factors that influence health and behaviour, and how these theories can provide direction in the modification of risky behaviours. Gandelman and Freedman (2002) further advise that HIV and AIDS programme developers need to integrate relevant theories in the implementation of HIV and AIDS policies and programmes. Therefore, this section will be looking at theories that could be utilised in the development and implementation of a comprehensive and holistic treatment, care and support programme for educators infected with HIV and/or affected by HIV and AIDS.

2.5.1 AIDS Risk Reduction Model

According to Catania, Kegeles and Coates (1990:54), this theoretical model contends that psychological and social (or psychosocial) factors influence and affect risky behaviour changes. The theory mentions the following three stages of behaviour change:

- The labelling of risky behaviour change
- Making a commitment to change risky behaviours
- Seeking and enacting behavioural change to reduce HIV risk

This theory is related to this study because educators need to identify psychosocial factors that could influence them to partake in risky behaviours leading to HIV infection. After identifying these psychosocial factors, educators should be able to eliminate factors that could involve them in risky behaviours which might lead to HIV infection. Educators who are already HIV infected could change risky behaviours to avoid infecting others and re-infecting themselves which can speed up the rate of the disease. The Health Belief Model endorses the AIDS Risk Reduction Model by stating that in order for people to change their behaviours, they must first believe that they are vulnerable and susceptible to HIV infection (Gandelman and Freedman 2002).

2.5.2 Social Cognitive Theory

Gandelman and Freedman (2002) state that Social Cognitive Theory views the adoption of behaviours as a social process influenced by relationships and interactions that people have with their significant others. The two components of this theory are:

- The modelling of behaviours we see others performing
- Self-efficacy, a person's belief that he or she is capable of performing that behaviour

Educators are widely accepted as role models in many societies. This theory is related to the study because educators can act as role models for others by portraying behaviours that would discourage the risk of HIV infection. HIV-positive educators could also show other educators that one can live a healthy and productive lifestyle by modifying risky behaviours that encourage HIV infection. The Diffusion of Innovation Theory endorses Social Cognitive Theory because it helps to understand how new ideas or healthy behaviours are introduced, disseminated and accepted in communities (Gandelman and Freedman 2002).

2.5.3 Epstein's Theory of Overlapping Spheres of Life

Epstein (1990) identifies the school, family and community as the three spheres of life that influence each other. The theory emphasises that if these three spheres of life work together, it will have a positive impact on the lives of educators and learners. This theory is related to this study because if communities and families work together to support educators infected with HIV and/or affected by HIV and AIDS, it will have a positive impact on the lives of these educators. In contrast to Epstein's theory, the Social Disorganisation Theory states that where societal structures are no longer functioning, high rates of disease will occur (Gandelman and Freedman 2002). Hence it is clear that societal structures such as schools, communities and families can work together to bring about the health and wellbeing of people living with HIV and AIDS. Furthermore, schools are widely regarded as institutions that impart knowledge in society, hence they could easily disseminate HIV/AIDS education to communities and families. In this regard, educators infected with HIV and/or affected by HIV and AIDS will be able to live healthy lifestyles in communities that are more knowledgeable and supportive.

2.5.4 Social Network Theory

According to the Wikipedia Online Encyclopaedia, a Social Network refers to a web of social relationships between groups of people like friends, families or relatives. The theory states that Social Networks operate on many levels, from families up to the level of communities, and they determine ways in which problems of people are solved and needs of people are met. The Empowerment Education Theory endorses the Social Network Theory by stating that groups of people can meet to identify and discuss problems in order to understand these problems and be able to devise solutions (Gandelman and Freedman 2002). Gandelman and Freedman (2002) assert that Empowerment Education Theory seeks to promote health by increasing people's knowledge, power and control over their lives. The Social Network Theory is related to this study because educators infected with HIV and/or affected with HIV and

AIDS can form networks such as support groups for moral support or join community-based organisations such as churches for spiritual wellbeing. These networks form a backbone of support and care in times of need.

2.5.5 Attachment Theory

According to the Wikipedia Online Encyclopaedia, Attachment Theory is a psychological theory concerning close relationships between people. This theory was formulated by a psychiatrist and psychoanalyst named John Bowlby. According to the theory, 'attachment' refers to an affection bond between an individual and another person. The theory deals with the interactions between people and their loved ones or significant others. This theory is related to this study because educators are also attached to their families, relatives, friends, learners and colleagues. If they witness their loved ones or significant others die due to AIDS-related diseases, this creates psychosocial problems such as grief and bereavement. When their loved ones and significant others die due to AIDS-related diseases, the attachment is broken. Hence there is a need to strengthen this attachment between educators and their significant others in other to gain support in times of need.

2.6 CONCLUSION

This chapter reviewed the literature pertaining to the impact of HIV and AIDS on the education sector, with particular attention paid to psychosocial problems of educators infected with HIV and/or affected by HIV and AIDS. The chapter reviewed HIV/AIDS policies and programmes implemented in the education sector to address the problems and needs of these educators. This chapter also integrated a discussion on theoretical frameworks related to the study. The next chapter will be looking at the research design and methodology employed in this study.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

Our Diseased World *by Felix Mnthali*

Our world
Is not all that rosy, grandpa:
We are dying like flies
From diseases you never heard of or saw
In your time
Diseases that float in the firmament
In acts of affection and acts of begetting

You must see the pain, grandfather,
The pain of looking at skeletons
that were once your friends and your kinsmen
decomposing and falling apart
before your very eyes!

(Excerpted from Rasebotsa, Samuelson & Thomas 2004:121)

3.1 INTRODUCTION

The purpose and objective of this study is to investigate the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools. This study will also be investigating the need to develop a comprehensive and holistic treatment, care and support programme aimed at addressing the problems and needs of these educators. The study aims to provide an understanding and insight into the day-to-day personal life experiences of educators infected with HIV and/or affected by HIV and AIDS in order to be able to identify their problems and needs so that appropriate measures are put in place to address these problems and needs.

In this chapter I will be discussing the research design and methodology I employed in conducting this study as well as the reason why I chose that particular method. The chapter will also deal with the actions and steps that I have taken in the collection and

analysis of data as well as ethical considerations that needed to be adhered to during the conduction of the study.

3.2 RESEARCH METHODOLOGY

Mouton (2002:35) defines a research methodology as a plan to apply a variety of standardised methods and techniques in the systematic pursuit of knowledge. A qualitative research approach was adopted for this study. Casley and Kumar (1988:3-4) define qualitative research as information which can best be described in words, such as descriptions of situations, interactions between people and direct quotations from people. Flick (2007:x) states that qualitative research is intended to understand, describe and explain social phenomena and can be achieved by analysing everyday personal life experiences of individuals or groups. According to Tesch (1990), qualitative research tries to study and understand the participant's experiences by exploring their social contexts such as the environment they work or live in, as well as the relationships they have with others. Taylor and Bogdan (1984:2) state that qualitative research looks at settings and people holistically, so that such settings and people are not reduced to variables but are viewed as a whole. Hence the researcher will provide a description of the research site as well as biographical information of the research participants (Refer to Sections 4.2 and 4.3 respectively).

The reason for choosing a qualitative research approach was motivated by the nature of the purpose and objectives of the study. The study aims to obtain perspectives into the psychosocial problems of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools, and the need to develop a holistic and comprehensive treatment, care and support programme for these educators. White (2004:17) asserts that "when we study people qualitatively, we get to know them personally and experience what they experience in their daily lives." Therefore, the use of qualitative methods, particularly phenomenology through conducting in-depth interviews, will help to permit a better understanding of the day-to-day personal life experiences of the group in question.

As an educator in one of the two schools selected for this study, I was able to observe and witness the day-to-day personal life experiences of these educators at first hand.

3.3 RESEARCH DESIGN

Mouton (2002:107) defines a research design as a set of guidelines to be followed in addressing the research problem. De Vos, Strydom, Fouche, and Delport (2005:132) assert that a research design is a systematic plan on how a researcher intends to conduct a study. The following research design methods were adopted in this study:

3.3.1 Phenomenology

Denscombe (2003:97) and Trochim (2001:159-160) describe phenomenology as a qualitative approach that focuses on how life is experienced. The aim of choosing this qualitative research strategy is to understand the day-to-day personal life experiences of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. This was accomplished by conducting personal in-depth interviews with these educators. Biographies and day-to-day personal life experiences of these educators were captured and recorded. The educators narrated to the researcher their day-to-day personal life experiences of being infected with HIV and/or affected by HIV and AIDS. Flick (2007:x) confirms that phenomenology can be conducted by analysing everyday personal life experiences and biographies of subjects under investigation.

3.3.2 Explorative

Mouton (2002:102) points out that explorative research refers to situations where very little previous research has been conducted on a certain topic. The researcher will attempt to collect new data and discover new ideas pertaining to the topic. Hence the researcher will aim to understand psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS by exploring day-to-day personal life experiences of

these educators. This will be done through conducting in-depth interviews with these educators.

3.3.3 Descriptive

Mouton (2002:102) states that descriptive research describes the situation under investigation and provides a description of the phenomenon being studied. Descriptive research describes the data and characteristics pertaining to the population or phenomenon under investigation. Hence the researcher will provide a description of the state of affairs about educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. The researcher will provide a description of the research site (schools) and biographical information of the research participants (educators) to better understand the phenomenon under investigation. The researcher will interview educators so that they can describe their day-to-day personal life experiences of being infected with HIV and/or affected by HIV and AIDS with the aim of understanding the situation being studied.

3.4 POPULATION AND SAMPLING

According to Goddard and Melville (2001:34), a population "is any group that is the subject of the research interest." In the case of this study, the population is educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. However, the researcher cannot study each and every educator infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. Hence the researcher selected a sample of ten educators infected with HIV and/or affected by HIV and AIDS in two Johannesburg Inner City schools. Five educators were selected from each of the two schools. According to Goddard and Melville (2001:34) a sample must be representative of a population under investigation, otherwise no findings can be made.

The researcher used purposive and snowball sampling techniques in the selection of the research participants. Denscombe (2003:15) describe purposive sampling as situations

where the researcher already knows something about the specific group under investigation and purposively select participants who could produce rich and relevant data and information. Brink (1991) contends that the researcher has to choose participants who are able to provide rich and valuable data and information pertaining to the study. Because the researcher is an educator in one of the two schools selected for this study, it was easy to purposively select participants that the researcher knew would produce rich and relevant data and information. However, some researchers may argue that biases may prevail due to the fact that I am an educator in one of the schools selected for the research. Therefore, I argue that as an insider it was easy for me to purposively select participants who I knew would provide rich and relevant data and information pertaining to the study. In addition to purposive sampling, the researcher also used snowball sampling where participants referred the researcher to other possible participants who could provide rich and relevant data and information. I personally went to the two schools and negotiated access with the school principals. I produced my University of South Africa (UNISA) student card bearing my name, photograph and student number to indicate that I am a registered UNISA student and an access letter (Refer to Appendix A) addressed to the principals of the two schools asking permission to interview the educators.

After permission was granted by the principals of the two schools (Refer to Appendices D and E), I purposively approached educators whom I knew would provide rich and relevant information. I explained my research study and asked them if they could take part in my study. I did not force or influence any educator to participate, but I gave them a consent form (Refer to Appendix B) explaining the purpose and objectives of my study as well as ethical considerations that will be adhered to in the process of their participation. If anyone was willing to participate in this study, they had to sign the consent form and give it back to me for safe keeping. Not all the participants that I approached agreed to participate in my study. I also approached members of an HIV/AIDS educator support group based at the school where I teach. This is an informal interest group of HIV-infected educators who meet socially to talk about their experiences of living with HIV. The group was initiated by an openly HIV-infected

educator who recruited other educators to meet and provide moral support to one another. I managed to recruit all of my HIV-infected participants through this interest group. All of the interviews took place at the schools where the participants taught, mainly after school hours and during school holidays because the environment allowed my participants to talk more freely without any disturbances and disruptions from learners and other educators.

3.5 DATA COLLECTION

The following data collection techniques were utilised:

3.5.1 In-depth interviews

Denzin and Lincoln (2000:1-28) assert that in-depth interviews provide a rich source of information because they enable the researcher to examine each case extensively. The researcher conducted one-to-one in-depth interviews which involved a confidential meeting between the researcher and the participant (Goddard and Melville 2001:49). The researcher used the interview schedule (Refer to Appendix C) as a fundamental instrument to gather data and information. I had the discretion of asking additional questions in order to pursue relevant information. In this regard, I used probing questions to gather other relevant data and information.

A narrative approach was utilised for the participants to tell their own personal stories and experiences in their own words. The researcher recorded the in-depth interviews through field notes, where relevant and crucial statements made by participants were documented verbatim. The researcher showed the participants their verbatim statements to ascertain that they were recorded with accuracy and precision. Field notes were enhanced by making additional notes immediately after each interview. In addition, field notes recorded were compared to the literature review in order to determine similarities, to validate the information and for triangulation.

Writing of field notes during the in-depth interviews was kept to a minimum in order not to interrupt or distract the participants. Follow-up interviews were scheduled with each participant in order to verify the information previously supplied and to obtain new information. Hence the researcher conducted the follow-up interviews by probing and questioning the participant on information previously supplied for verification and validation purposes. All interview sessions lasted for approximately 60 minutes.

3.5.2 Interview schedule

Patton (1990:283) points out that an interview schedule is a guide that contains a list of key questions that the researcher will be asking the participants. Denscombe (2003:167) agrees that the interviewer must have a clear list of a set of questions relevant to the study, hence the researcher designed an interview schedule (Refer to Appendix C) containing a set of questions to be asked to participants. I used the research questions of my study to formulate a list of questions that I planned to ask all the participants. The questions I chose to ask were in accordance with the purpose and objectives of my study. I decided to use an interview schedule in order for me to be able to systematically ask all questions to all the participants without missing any questions during the interview sessions. The interview schedule also helped me to conduct the interview uniformly with all the participants and to use my time effectively without detracting from the purpose and objectives of the study. However, the participants were not compelled to answer any questions that they were uncomfortable with, and they were given the freedom to terminate the interview session if they felt that they did not want to continue.

3.5.3 Literature review

Trochim (2001:159) points out that researchers should analyse primary and secondary sources, and electronic media related to the research study. Flick (2007:x) contends that the analysis of such documents will help the researcher to understand, capture and record day-to-day personal life experiences of the research participants. In this regard, the researcher examined both national and international literature relevant to the research

study to ascertain issues raised by the participants. The researcher used the field notes obtained from in-depth interviews in conjunction with the literature to determine similarities, to validate the information and for triangulation.

3.6 RELIABILITY AND VALIDITY

According to Keats (2000:76), reliability refers to the degree of consistency regarding interviews and could be achieved by repeating interviews. However, some researchers argue that one cannot achieve the same results by repeating qualitative interviews. I did follow-up interviews with the participants and I received virtually the same responses that I got during the first interview session. Even though they were not verbatim, but they still meant the same thing and were geared towards the point the participants were trying to establish.

Keats (2000:77) defines validity as the ability of the research instrument, in this case the interview schedule, to measure what it intends to measure. According to McMillan and Schumacher (2001:407) "validity refers to the degree to which the explanations of phenomena match the realities of the world." In this case, the researcher compared and matched the responses obtained from the interviews with information from the literature review to see if there were similarities in order to be able to ascertain the validity of the information provided. I also compared the responses of the participants to see if there were instances where participants corroborated each other. I did find that statements made by some of my participants were echoed by others, although they used different words in making the same point.

3.7 TRIANGULATION

According to McMillan and Schumacher (1993:498), triangulation is the use of two or more methods of data collection in order to cross-validate information. In this case, the researcher used the responses from the in-depth interviews and the literature to cross-validate information by comparing and matching the participant's responses with what

the literature states. I also compared the participant's responses to see if there are recurring patterns of information that corroborated each other.

3.8 TRUSTWORTHINESS

Lincoln and Guba (1985:301) argue that in order to maintain the trustworthiness of data in a research study, the following four criteria need to be taken into consideration:

- Credibility: This refers to the correctness and truthfulness of the data supplied by the participants. The researcher established the credibility of the data by reading the transcripts of the interviews to the participants to confirm and verify whether the transcripts were a true account and a true reflection of what the participants have said or meant.

- Transferability: This refers to the degree to which the results and findings of a study can be applied to other contexts or settings. The researcher established the transferability of this study by using purposive sampling where he deliberately selected participants who he knew would provide rich and relevant data and information pertaining to this study. In addition to purposive sampling, the researcher also used snowball sampling where participants referred the researcher to other possible participants who could provide rich and relevant data and information. Because all the educators selected were either infected with HIV and/or affected by HIV and AIDS, there was a chance and possibility that they would produce similar responses. Hence the replication or duplication of the findings and results of this study in other contexts or settings was enhanced.

- Dependability: This refers to the consistency and stability of the data supplied by the participants. The researcher established the dependability of the study by documenting real life experiences and real personal stories of the participants. Due to the fact that the researcher is a professional educator himself, the

participants were able to identify with the researcher and were comfortable to discuss their everyday personal life experiences with someone who understands their context and perspective. Hence my study participants trusted me with the information they provided and felt at ease to communicate their personal life experiences with someone who is an insider rather than an outsider. Moreover, the insider role of the researcher increased the consistency and stability of the data because he could identify with the issues the participants were talking about.

- Confirmability: This refers to the degree to which the results and findings of the study could be confirmed or corroborated by others. The researcher used the concept of triangulation by comparing the responses of the participants to see if their responses meant the same thing. I also substantiated these responses by reviewing the literature to see if the participant's responses match with what the literature says. This procedure was crucial in confirming and validating the results and findings of the study.

3.9 DATA ANALYSIS

Data analysis for this study comprised transcribing, collating, coding and categorising of data obtained from the field notes (Denscombe 2003:269). I compared and matched the responses I got from the participants with each other to look at the responses that meant the same thing and thereafter categorised them into themes. In addition, I compared the responses with what the literature review indicated, and integrated them into the themes that I had developed. The data was organised and grouped into common and recurring themes derived from participants' day-to-day personal life experiences, and compared them with the literature review to show corroboration. The aim of doing this was to validate data in order to justify and verify the information as well as for triangulation purposes. Irrelevant data and information were discarded and rejected. The themes that emerged from data analysis are dealt with in detail in Chapter 4 where I discuss the findings of the study. These themes were also developed in accordance with the purpose and objectives of the study in order to be able to answer the research questions.

The analysed data was categorised in accordance with the research questions into themes as follows:

Research question 1 yielded the following themes

- Psychological problems
- Stigmatisation and discrimination
- Educator morbidity and mortality

Research question 2 yielded the following themes

- Medical treatment and health care
- Social support and care

Research question 3 yielded the following themes

- Mobile clinics
- Support organisations
- Better employment benefits
- Anti-Retroviral Therapy
- Training of educators

3.10 ETHICAL CONSIDERATIONS

Due to the sensitivity of talking about HIV and AIDS, which revolves around sickness and death, it was imperative for the researcher to implement ethical measures to ensure that the participants were protected from harm and their rights were not violated. Goddard and Melville (2001:49) mention that the researcher must avoid harming the

participants psychologically, respect their privacy and confidentiality as well as not force them to get involved or continue with the research process. Taylor and Bogdan (1984:2) assert that researchers have to be sensitive to the effects that their research process may have on their participants. They state that researchers have to understand participants from their own frame of reference without judging them. In addition, they mention that researchers have to empathise and identify with the participants in order to be able to understand how they view things. Herbst (2000:88-89) contends that researchers should apply the ethical concepts of non-maleficence and veracity in their research process. Non-maleficence requires that researchers should not harm their research participants intentionally, through lack of knowledge or by negligence. In addition, non-maleficence requires that researchers should protect their research participants who are not able to protect themselves from harm during the research process. Veracity requires that researchers should be truthful and honest in the process of conducting their research (Herbst 2000:88-89).

In order to ensure ethical considerations in this study, the researcher completed an official online web-based training course entitled "Protecting Human Research Participants" offered by the National Institutes of Health in the United States of America (Refer to Appendix F). The ethical considerations that were adhered to and complied with in the study are discussed below:

3.10.1 Fundamental Ethical Principles

Smith (1999:6-7) contends that all research studies involving human subjects should be conducted in accordance with the following three fundamental ethical principles:

3.10.1.1 Respect for persons

Respect for persons incorporates two ethical principles. The first principle is respect for an individual's autonomy, which requires that those who are capable of deliberation about their personal choices should be treated with respect for their self-determination.

The second principle is the protection of persons with impaired or diminished autonomy, which requires that those who are dependant or vulnerable should be afforded security against harm or abuse. To enforce this principle, the researcher required informed consent from the participants as discussed in Section 3.10.2 below.

3.10.1.2 Beneficence

Beneficence refers to the ethical obligation to maximise benefits and minimise harms when working with participants. The principle contends that the risks of the research should be reasonable in light of the expected benefits, that the research design be sound, and that researchers should be competent with regard to both conducting the research and safeguarding the welfare of the research participants. To enforce this principle, the researcher ensured confidentiality as discussed in Section 3.10.3 below. In addition, the researcher gained competence in working with the participants by completing a training course on researching human subjects as mentioned in Section 3.10 above.

3.10.1.3 Justice

Justice refers to the ethical obligations to treat each person in accordance with what is morally right and to give each person what is due to him or her. There must be equitable distribution of burdens and benefits of research participation. To enforce this principle, the researcher offered debriefing to the research participants as discussed in Section 3.10.4 below.

3.10.2 Informed consent

Flick (2007:141) mentions that participants in research studies must be informed that they are studied and given a chance to agree or disagree to be investigated. In this regard, the researcher wrote a consent letter to the participants to inform them about the purpose and objectives of the study as well as their responsibility as the participants of the study. The participants were required to sign the consent form if they agreed to take part in the study

and they had the right to decline to be involved in the study (Refer to Appendix B). Moreover, if the participants decided to withdraw their involvement in the study during anytime of the research process, they were given a chance to do so without being questioned or disadvantaged.

3.10.3 Confidentiality

To protect the identity of the participants, their names and the names of the schools where they teach were not revealed and were treated as private and confidential. Hence the researcher used pseudonyms such as Educator A and School X. The privacy of the information they provided was treated in the strictest manner.

3.10.4 Debriefing

Due to the sensitivity of talking about HIV and AIDS with infected and affected persons, it is possible that participants may develop emotional feelings of distress. In this regard, the researcher has completed an official course in HIV/AIDS Care and Counselling offered by the Centre for Applied Psychology at the University of South Africa (Refer to Appendix G). Therefore, the researcher was able to offer care and counselling to participants who needed that after the interview sessions. I did give counselling sessions to all of my participants after the interview sessions and I also gave motivational talks to them about living positively with HIV and AIDS. I stressed the point that HIV is not a ‘death sentence’ and definitely not ‘the end of the world’, emphasising that one can live a healthy and productive lifestyle with the disease. I used examples of prominent public figures who live openly and positively with HIV and AIDS, such as the Justice of the Constitutional Court of South Africa, Edwin Cameron and the famous AIDS Activist Zackie Achmat of the Treatment Action Campaign.

3.11 CONCLUSION

This chapter discussed the qualitative research design and methodology employed in this study. Population and sampling, data collection and analysis, as well as ethical considerations were dealt with in this chapter. The chapter also outlined the steps and actions that I have taken in recruiting participants, collecting and analysing the data. Phenomenology as a qualitative research strategy was regarded as best suited to accomplish the purpose and objectives of this study as day-to-day personal life experiences of the participants were documented. Analysing the data collected during the in-depth interviews and the review of literature helped in making research findings relevant in helping me to answer the research questions of this study. These findings are dealt with in detail in the next chapter.

CHAPTER 4: FINDINGS

Flakes of the light falling *by Karen Press*

Approximately and here also
one in four vanishing
even as we speak –
lightly and without technique they are dying
good citizens of a good country, dying modestly
embrace of the infected is a national project
rejection the prerogative of the intimate circle
we are ending, we are ending
flakes of the light falling away

(Excerpted from Rasebotsa, Samuelson & Thomas 2004:48-49)

4.1 INTRODUCTION

The purpose and objective of this study is to investigate the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools. This study will also be investigating the need to develop a comprehensive and holistic treatment, care and support programme aimed at addressing the problems and needs of these educators. The study aims to provide an understanding and insight into the day-to-day personal life experiences of educators infected with HIV and/or affected by HIV and AIDS in order to be able to identify their problems and needs so that appropriate measures are put in place to address these problems and needs.

This chapter provides the description of the research sites and biographical information of the research participants. Ten educators infected with HIV and/or affected by HIV and AIDS from two Johannesburg Inner City schools took part in this study. This chapter will also be presenting the findings of the study in order to answer the research questions as posed in Chapter 1 (Refer to Section 1.6).

4.2 DESCRIPTION OF THE RESEARCH SITES

The descriptions of the two schools selected for this study are based on the field notes taken during site visits at these schools.

4.2.1 School X

This is a private Primary school from grades R to 7 with mainly black African educators and learners. There are 15 educators and 503 learners in the school. This school rents a three floor building in the Johannesburg Central Business District. The school is governed by a Board of Directors comprising private donors who provide funding to the school and the principal who manages the school. The school has a small library with a limited collection of books and a computer centre with only 8 computers. The school office has a photocopier, two telephones and a fax machine. There is running water and electricity in the school. The school has one male ground staff member who looks after the maintenance of the school premises and one female ground staff member who takes care of domestic duties in the school. There is a clerk who handles administrative duties and a security guard who controls the entrance of the school.

4.2.2 School Y

This is a private Secondary school from grades 8 to 12 with mainly black African educators and learners. There are 19 educators and 658 learners in the school. This school rents a five floor building in the Johannesburg Central Business District. The school is governed by a School Governing Body which comprises four parents, two educators, two learner representatives and the principal. The school has a library, laboratory and a computer centre with 20 computers. There is also a tuck shop where educators and learners buy their food during breaks. The school has an office block with a large staff room and the principal's office. The office is equipped with a photocopier, telephone and a fax machine. There is running water and electricity in the school. The school has an alarm system and a security guard who patrols the school premises. There are two

administration staff and four ground staff members who take care of the maintenance, gardening and cleaning duties in the school.

4.3 BIOGRAPHICAL INFORMATION OF THE RESEARCH PARTICIPANTS

Ten educators infected with HIV and/or affected by HIV and AIDS from two selected Johannesburg Inner City schools took part in this study. The biographical information of these educators is represented by the table below:

Table 4.1: Biographical information of educators

Educator	School	Age in years	Gender	Marital status	Occupation	Teaching experience in years	HIV status
A	X	32	Male	Single	Educator	6	Infected
B	Y	40	Female	Married	Educator	13	Infected
C	X	52	Female	Divorced	Head of Department	25	Affected
D	X	49	Male	Married	Principal	19	Affected
E	Y	50	Female	Divorced	Principal	22	Affected
F	Y	38	Female	Single	Educator	11	Infected
G	X	35	Male	Married	Educator	9	Infected
H	Y	26	Female	Single	Educator	2	Infected
J	X	31	Female	Divorced	Educator	6	Infected
K	Y	28	Male	Single	Educator	4	Infected

1. Educator A from School X

Educator A is a single male educator aged 32 living in a township near Johannesburg. He has a Diploma in Education and has been teaching Mathematics and Science for 6 years. Mr. A disclosed to me that he was diagnosed with HIV in 2002 when he was still a student teacher and that he is homosexual. He went to the HCT clinic when he lost weight and was feeling tired most of the time and out of curiosity after he suspected that he might have AIDS. When he got very sick he went to the doctor and it was discovered that he had Kaposi's sarcoma and his CD4 cell count was found to be 189 cells per cubic millimetre. The doctor referred him to a public ART clinic to start taking AIDS medication. He mentions that he is experiencing 'double rejection' from his colleagues and family because of his HIV status and sexual orientation.

2. Educator B from School Y

Educator B is a married female educator aged 40 living in a suburb near Johannesburg. She has a Bachelor's degree in education and has been teaching Social Sciences for almost 13 years. Mrs. B disclosed to me that she was diagnosed with HIV when she was pregnant with her last born child five years ago when she went for prenatal medical examinations. She was enrolled in a Prevention of Mother-to-Child Transmission programme and her baby was not infected with HIV. She disclosed her HIV-positive status to her husband and children as well as her school principal and some of her colleagues at work. She mentions that she has a feeling that her colleagues who know her HIV status are spreading rumours and gossiping about her in the school, and she is afraid that the news might leak to learners who might develop a negative attitude towards her. She also mentions that her relationship with her husband has 'turned sour' and she is contemplating divorce.

3. Educator C from School X

Educator C is a divorced female educator aged 52 living in a township near Johannesburg. She has an Advanced Certificate in Education and has been teaching Economic Sciences for almost 25 years. Ms C disclosed to me that she has a daughter who has AIDS. She has another three children of which two are still at school and one at tertiary level. Ms C is a single parent and struggles to make ends meet on a teacher's salary. She mentions that she cannot cope financially and emotionally to take care of her sick daughter. I selected this participant because she is affected by HIV and AIDS through the infection of her daughter, which may result in her experiencing psychosocial problems by having a loved one dying due to AIDS-related diseases.

4. Educator D from School X

Educator D is a married male principal aged 49 living in a suburb near Johannesburg. He has an Honours degree in Education and has been heading the school for 7 years. During my interview with him, Mr. D acknowledged that there are educators whom he personally knows that are HIV-positive in his school. He told me that some of them disclosed this information to him and he suspects that some of them might have AIDS because of HIV-related symptoms he perceives them to have. I chose this participant because he has colleagues who are HIV infected and he might experience psychosocial problems by witnessing others die due to AIDS-related diseases.

5. Educator E from School Y

Educator E is a divorced female principal aged 50 living in a suburb near Johannesburg. She has a Diploma in Education and has been heading the school for 5 years. During my interview with her, Ms E acknowledged that there are HIV-positive educators and learners in her school. Her main concern is the escalating statistics of educators and learners who are HIV infected. I selected this participant because she is affected by HIV

and AIDS through the infection of her colleagues and learners. Hence she might be experiencing psychosocial problems by witnessing her significant others dying due to AIDS-related diseases.

6. Educator F from School Y

Educator F is a single female teacher aged 38 renting a flat in Johannesburg Inner City. She has a Bachelor of Arts degree and has been teaching in different Johannesburg city schools for 6 years. Ms F disclosed to me that she has been living with HIV for four years and is the organiser of the HIV/AIDS educator support group mentioned in Section 3.3 above. She points out that the group is still in its infancy and holds informal meetings at least twice a month by rotating at the residences of the group members. Ms F and other group members advertise their group meetings by word of mouth and written notices in their schools and other schools in the city. However, she mentions that the meetings are usually poorly attended, perhaps because of the stigma and discrimination attached to HIV and AIDS. She states that she was once dismissed from work because of her HIV status.

7. Educator G from School X

Educator G is a married male teacher aged 35 renting a flat in Johannesburg Inner City. Mr. G has a Diploma in Education and has been teaching for 8 years. He disclosed to me that he is HIV-positive and he is a South African Democratic Teacher's Union site steward at his school. Mr. G got very sick recently and was absent from school for a long period of time and his colleagues and learners suspected he had AIDS because he showed some of the symptoms associated with HIV-infection, especially that he had lost a lot of body weight. He states that he sometimes overhears gossip and rude sarcastic remarks passed at him by his colleagues and learners about him being HIV-positive. This situation has created unbearable working conditions for him.

8. Educator H from School Y

Educator H is a single female teacher aged 26 living in a township near Johannesburg. She has a Higher Diploma in Education and has been teaching for nearly 2 years. Ms H disclosed to me that she has been recently diagnosed HIV-positive and has just joined the HIV/AIDS support group for educators. After the diagnosis Ms H contemplated suicide and was always depressed and under severe stress. She could not cope with being HIV-positive and wanted to end her life. She was hospitalised due to stress and depression and she is on anti-depressant medication and sleeping tablets because she cannot sleep at night.

9. Educator J from School X

Educator J is a divorced female educator aged 31 living in a flat in Johannesburg Inner City. Ms J has a Bachelor's degree and has been teaching for 6 years. She disclosed to me that she has AIDS and is on ART. Ms J is a single parent and has two children whom she struggles to support on a meagre teacher's salary. She mentions that most of her salary pays for exorbitant medical bills that accumulated due to her sickness. She is experiencing financial problems which put her under stress and depression most of the time.

10. Educator K from School Y

Educator K is a single male teacher aged 28 living in a township near Johannesburg. Mr. K has a Bachelor's degree and has been teaching for nearly 4 years. He disclosed to me that he is HIV-positive and has informed his principal, and most of his colleagues also know about his HIV status. He explained that some of his colleagues distanced themselves from him after he disclosed his HIV status to them. He says that he feels socially ostracised.

4.4 FINDINGS FOR RESEARCH QUESTION 1

Research question 1 deals with the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools.

Researcher: *What are the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools?*

Educator A: *There is too much stigma attached to HIV and AIDS in our schools, that is why I decided to conceal my status. Also being gay is another problem for many people who are homophobic, if you are gay they immediately think that you have AIDS too. That is why I try to keep my personal life private and secret when I am at work. I read in the newspapers about teachers who are discriminated against because they are HIV-positive by their colleagues and principals, and I decided to keep my status a secret. When I have to go for medical check-ups and to collect my ART medication at the clinic I have to make up stories and lie to my principal about being absent. I have noticed that my colleagues and principal are inquisitive about me being absent frequently, but I ignore them and tell them lies if they ask.*

Educator B: *Many teachers who are HIV-positive are in denial and they are secretive about their HIV status. They are always stressed and under depression which affects their health and work. They do not have any enthusiasm to live and work for their children and families, and they take AIDS as a death sentence. Their productivity at work deteriorates because they lack motivation. This is not good for their health, both mentally and physically. They end up dying before their time and leave behind mourning children, friends and families.*

Educator C: *I have a daughter who is bedridden because of AIDS and I cannot afford to keep her healthy to prolong her life. She constantly needs immune boosters and nutritious food which is expensive, I have to also pay a caregiver I employed to care for her during the week when I am at work because she cannot do anything for herself. She is in and out*

of hospital and I cannot afford the doctors as well because she is not on medical aid. I am not in a good relationship with my school principal because I am often absent from school to take her to doctors and to nurse her at home, sometimes I take long leave because I have to wait for her to recuperate. This is stressing me a lot financially and emotionally, I am thinking of leaving teaching and look for greener pastures elsewhere.

Educator D: *We have a lot of teachers who are sick and dying of AIDS these days, the schools are not coping anymore. Teachers are often absent from work due to sick leave and hospitalisation. I struggle every morning trying to get other teachers to substitute for absent teachers, this has created arguments because other teachers are complaining of being overworked on top of the workload of their own classes. Teachers are losing motivation about the profession and they are leaving the teaching profession for other jobs.*

Educator E: *There are growing numbers of educators and learners who are succumbing to AIDS. We are hurt to see so many poor and young children suffering through a fault that was not committed by them, and this traumatic ordeal is affecting us emotionally and is discouraging us to teach.*

Educator F: *I was once dismissed from work because of my illness. I was very sick and could not go to work and therefore I took long sick leave, that's when I discovered that I am HIV-positive. The principal told me that parents are complaining about my absenteeism because they are paying money and their children are not being taught, and that as a private school they are trying to minimise costs and can't keep me on the payroll if I am not working, they have to hire someone else instead . This is a problem for many HIV-positive educators.*

Educator G: *When I returned to work from sick leave there were rumours amongst learners and other teachers that I was dying of AIDS. Some learners started bunking and dodging my classes because they did not want to interact with me, other teachers also*

kept a distance from me and gave me a cold shoulder, I was anti-social, withdrawn and felt socially ostracised.

Educator H: *After my doctor told me that I am HIV-positive my world fell apart, I've just started working and trying to find my feet and create a good life for myself. I recently had a confrontation with my principal because she complained that I have exhausted my sick leave and she cannot allow me to go on further leave. I am always stressed and depressed. I'm taking anti-depressants and sleeping tablets which have side effects that affect my job performance, the principal threatened to suspend or dismiss me if I don't pull up my socks.*

Educator J: *The lifestyle of a person living with AIDS is demanding financially, I am on ART drugs and they are very expensive, I part with exorbitant amounts of money on a monthly basis to purchase my medicines and consult with doctors. I am also renting a flat here and accommodation is expensive in Johannesburg. I can't afford to take care of myself and my children on the salary I'm earning.*

Educator K: *HIV-positive teachers are discriminated against in schools. I applied for an HOD post at school and I was sure that I qualified for that position but I was turned down. I am a sportsman and wanted to coach soccer this year at school but the principal appointed someone else. I regret disclosing my status because now I am seen as a useless and sick person who is awaiting death. I am not assigned any responsible duties in the school, I am just there to teach in the classroom and take care of the children. They are not interested in me, my skills are wasted."*

After the data analysis of the above interview responses, I was able to categorise the data into the themes discussed below. I compared and matched the responses of the educators together and corroborated them with the literature review to validate the data.

4.4.1 Psychological problems

Educators C, G and H reported that they have suffered from stress and depression because of the situations that they encounter in their day-to-day life experiences of being infected with HIV or affected by HIV and AIDS. Educator C mentions that she is always stressed and depressed because she has a daughter who is dying due to AIDS-related diseases and she has no financial resources to take care of her. It is clear that this educator cannot bear the thought of losing her daughter and it hurts badly to see her daughter suffer the pain of succumbing to AIDS-related diseases and opportunistic infections. It is also clear that it affects her emotionally by not coping financially to afford the best medical care she can give her daughter. Educator J also mentions that she has financial difficulties which in turn create stress and depression because she cannot financially afford to take care of herself as an HIV-infected educator in terms of medical costs, and she has children and other familial obligations that need money. Educator C further asserts that she is contemplating leaving the teaching profession because of being underpaid to the point that she cannot cope with living in this stressful situation anymore. From this, I have realised that educator attrition is the product, inter alia, of dissatisfaction with remuneration amongst South Africa educators. It is understandable why these educators experience psychological problems of stress and depression, because they have been extremely affected by the recent period of economic recession, where expenses have skyrocketed, including medical costs and food prices. Hence being HIV infected or affected exacerbates and aggravates the situation and this in turn creates psychological implications. Hall et al (2005:13) and van Dyk (2005:218) concur that many people living with HIV and AIDS experience financial difficulties.

Educators G and H indicated that they have been rejected and maltreated by their colleagues at work because of their HIV status, and this has created psychological problems such as stress and depression for them. Bennell, Hyde and Swainson (2002:86) and Kelly (2000:29-31) concur that other educators are compelled to relinquish teaching due to social ostracism, stigmatisation and discrimination related on grounds of their HIV

status. In addition, Educators B, C, D and E concur that they have experienced grief and bereavement by witnessing their loved ones and significant others die due to AIDS-related diseases. Educator E mentions that teachers also suffer from the emotional problems of witnessing educators and learners succumbing to AIDS-related diseases. These educators experience grief and bereavement because of going through the traumatic ordeal of witnessing their colleagues, learners and family members die due to AIDS-related diseases or mourning their deaths. As the World Bank (2002:13) validates, educators infected with HIV and/or affected by HIV and AIDS experience psychological problems attributed to the trauma caused by these conditions. It is clear from the above testimonies that educators infected with HIV and/or affected by HIV and AIDS have psychosocial problems in the form of stress and depression, grief and bereavement attributed to the impact of HIV and AIDS in their day-to-day life experiences. Therefore, this situation shows that there is a need to develop psychosocial support programmes for these educators.

4.4.2 Stigmatisation and discrimination

Educators A, B, F, G and K agree that there is stigma and discrimination attached to HIV and AIDS. Educator A indicated that he experienced double discrimination because of his HIV status and being a gay man. Educators A and B assert that they have lived a life of denial and secrecy about their HIV status for fear of being stigmatised and discriminated against. Educator F concurs. She was discriminated against by her employer and was dismissed from work because of her HIV status. Educators G and K agree that they were discriminated against on grounds of their HIV status by their employer, colleagues and learners. This is in line with the findings by Bennell et al (2002:86) and Kelly (2000:30). Educators who are HIV-positive are often prone to stigmatisation and discrimination by their principals, colleagues, learners, families and communities. It is clear from the testimony that people still have the fear that they can be HIV-infected by associating with infected persons. There are people who still think that by sharing utensils, shaking hands or hugging a person who is HIV-infected they too are at risk of infection. This situation is substantiated by van Dyk (2005:35-37). Moreover, I realised that people still think that if

you are HIV-infected you were doing wrong things by either being promiscuous or being unfaithful to your partner and that you deserve the punishment. This situation is corroborated by Whiteside and Sunter (2000:5). Furthermore, there are still myths and misconceptions surrounding HIV and AIDS. For example, particularly in black African communities, if a person dies due to AIDS-related diseases, their families often attribute the death to witchcraft, or if they knew it was AIDS-related, they conceal the cause of death and come up with a lie that the deceased was sick because they did not want to follow the ancestral calling to be initiated into a 'Sangoma' or 'Inyanga' (Zulu for Witchdoctor).

HIV infected or affected educators who are stigmatised and discriminated against by their colleagues, friends and families feel rejected and socially ostracised by society, which in turn creates psychosocial problems such as loneliness for these educators and they might contemplate committing suicide. I personally know of an educator who committed suicide and left behind a note that she did that because she found out that she was HIV-infected and could not bear the thought of telling her family because she knew they would react negatively towards her. Stigmatisation and discrimination also prevents educators from going for HCT because they are afraid of knowing their HIV status, fearing that if they are HIV infected they will be subjected to stigmatisation and discrimination. This in turn results in them not accessing ART and they subsequently die due to AIDS-related diseases. This shows that the stigma and discrimination attached to HIV and AIDS directly and indirectly kills people infected with HIV. The situation shows that there is a need for HIV/AIDS education programmes and policies to be introduced to eliminate HIV-related stigma and discrimination in schools, families and communities.

Stigmatisation and discrimination also create job insecurity among educators infected with HIV. Educators F and H agree that they were insecure about their jobs because of their HIV status. This is corroborated by Bennell et al (2002:86), Kelly (2000:30) and Maile (2004:114), who point out that educators infected with HIV are discriminated against by their employers and they may face dismissal from their jobs. Educator F

revealed that most private schools lack support for HIV-infected educators because they focus on maximising profit and cannot afford to keep educators who are frequently absent from school due to AIDS-related diseases and opportunistic infections. Therefore, most HIV-infected educators continue to work even if they are sick in order to secure their jobs, which in turn jeopardises their health and well-being. I quote a case that made headlines on the ETV (Television channel) 3rd degree programme in the year 2006 when an educator sued the Gauteng provincial DoE because she was allegedly discriminated against and dismissed by her principal on grounds of her HIV status. This shows that there are many unreported cases of stigmatisation of and discrimination against educators infected with HIV in South African schools. Hence these stressful working conditions create psychosocial problems for educators infected with HIV.

4.4.3 Educator morbidity and mortality

Educators B, D and E echoed each other that there are escalating statistics of educators who are sick from HIV infection and who are already dying due to AIDS-related diseases. Educator B asserts that many educators are dying due to AIDS-related diseases because they do not want to disclose their sickness and access ART. Educator D points out that we witness AIDS-related morbidity through increased absenteeism amongst educators who are sick because of AIDS-related diseases and cannot attend work. The situation is corroborated by Buchel & Hoberg (2006:1) and Kelly (2000:64). Furthermore, in the journey of my profession as an educator, I have witnessed some of my colleagues die due to AIDS-related diseases in the schools that I have taught at. I have also seen educators who are sick due to AIDS-related diseases.

Educators B and E mention that the problem of AIDS-related morbidity and mortality among educators has decreased the morale and motivation of educators to perform their teaching duties. This is attributed to the fact that they have to substitute sick or deceased educators by managing large class sizes which places an additional burden on their existing workload. The latter is corroborated by Educators D and H when they argue that educators are being overworked to the point that the teacher to learner ratio in the

classrooms does not balance because one teacher has to teach many learners even though he or she cannot manage to do so. Educator D goes further to state that this situation has created the problem of AIDS-related educator attrition because educators cannot cope with the increased workload they have to perform. The lack of access to ART has exacerbated and aggravated AIDS-related morbidity and mortality amongst educators in South Africa. This is corroborated by Rehle et al (2005:9) when they state that the demand for ART exceeds the supply of treatment of AIDS patients. If educators could easily access ART, there will definitely be a reduction in AIDS-related morbidity and mortality within this cohort. This situation has made me realise how important it is for the government to roll-out ART programmes aimed at improving the health and saving the lives of educators infected with HIV.

4.5 FINDINGS FOR RESEARCH QUESTION 2

Research question 2 deals with the needs of educators infected with HIV and/or affected by HIV and AIDS in terms of treatment, care and support programmes that could be developed to address the problems experienced by these educators.

Researcher: *What are the needs of educators infected with HIV and/or affected by HIV and AIDS in terms of developing treatment, care and support programmes aimed at addressing the needs of these educators?*

Educator A: *The department of education must work together with the department of health to provide teachers living with AIDS with ART, otherwise we are going to lose many teachers. Many of us cannot afford to buy ART drugs privately over the counter because they are expensive and we earn less.*

Educator B: *Teachers need to form school-based support groups to support each other in times of need, principals must play an important role by supporting HIV-positive teachers. HIV-positive teachers must also surround themselves with people who are there to support them not to judge or condemn and bring them down.*

Educator C: *In my case I urge the government to really go back to their drawing boards and increase our wages, we are really earning peanuts. If I was earning much I could afford the best care for my daughter and she will stabilise and be healthy.*

Educator D: *We need treatment and support for teachers living with HIV and AIDS, otherwise we will lose experienced and skilled manpower. AIDS drugs are not easily accessible, that is the reason teachers die before they can get treatment. As a principal, I think the department of education must workshop us on managing this epidemic in schools, lot of us do not know much about it. There are HIV/AIDS policies in education but we do not know how to reinforce them at school level. Therefore, we need training from the department of education.*

Educator E: *The department of education must step in and offer HIV/AIDS prevention, treatment, care and support services to educators and learners, otherwise the schools will close down because of dying educators and learners.*

Educators F: *Particularly in private schools, the management must introduce treatment, care and support structures and policies to support HIV-positive teachers. Many private schools do not have these interventions in place.*

Educator G: *There is a need for HIV/AIDS education in schools to inform that one cannot get AIDS from interacting with an infected person. As a teacher's union representative, I have realised that the unions are not actively involved that much in HIV/AIDS issues to help infected teachers, they only focus on better salaries and strikes. I challenge and encourage other stakeholders such as teachers' unions to get involved in the struggle against HIV and AIDS in our schools.*

Educator H: *There is lack of support from the school management and the department of education to support teachers living with AIDS. We are treated the same as healthy teachers and given a lot of work we cannot manage, we need to be given reasonable*

compassionate sick leave to heal for the sake of our health. We cannot pretend to be healthy and work ourselves to death in order to keep our jobs, it is just not fair.

Educator J: *The department of education must revisit their policies on HIV/AIDS, especially personal circumstances of HIV-positive teachers, the current policies do not address the problems and needs of HIV-positive teachers and this situation has a negative impact on our health and well-being. The department must also look at ways of increasing our salaries because cost of living is too high these days.*

Educator K: *The department of education must implement and enforce ethics and policy guidelines to combat discrimination of HIV-positive teachers. All teachers must be treated equally irrespective of their HIV status.*

After the data analysis of the above interview responses, I was able to categorise the data into the themes discussed below. I compared and matched the responses of the educators together and corroborated them with the literature review to validate the data.

4.5.1 MEDICAL TREATMENT AND HEALTH CARE

Educators A, D, E, F and J mentioned that the provision of ART is imperative in improving the quality of life in terms of the health and well-being of educators infected with HIV. This is supported by Rehle et al (2006:6) who argue that if the South African government provides ART to educators with AIDS-related diseases, many will be saved and would continue to teach for many years. To access ART, it is crucial that educators are encouraged to go for HCT in order to be able to ascertain their HIV status and their CD4 cell count which will determine their eligibility for ART. If educators are given ART they would not be absent from school or die due to AIDS-related diseases. This shows that ART is significant in alleviating AIDS-related morbidity and mortality amongst educators and hence eliminating the psychosocial problems of educators infected with HIV as discussed in Section 4.4.3 above. However, Educators A, C and J concur that educators infected with HIV and/or affected by HIV and AIDS cannot

financially afford ART because they are underpaid and the cost of ART is expensive. Hence these educators mention that there is a need for adequate and sufficient medical aid benefits in order for them to be able to afford health care services such as ART and treatment of HIV and AIDS-related opportunistic infections. In this way, HIV infected educators will be able to ameliorate the psychosocial problems associated with the lack of access to ART as discussed in Section 4.4.3 above. Moreover, educators affected by HIV and AIDS will be able to use these medical aid benefits for their loved ones infected with HIV to access health care services. Hence this will also alleviate the psychosocial problems experienced by educators who have loved ones infected with HIV such as Educator C.

Rehle et al (2005:9) assert that the demand for ART exceeds the supply of treatment of HIV-infected people. This means that educators infected with HIV will find it difficult to access ART in public health care facilities. Therefore, if adequate and sufficient medical aid benefits are available for educators infected with HIV, it will be easy for them to access ART in private health care facilities. In addition, educators infected with HIV and/or affected by HIV and AIDS are often prone to psychological problems such as stress and depression, as well as grief and bereavement as discussed in Section 4.4.1 above. There is a need for mental health services such as bereavement counselling and psychotherapy. An extension of medical aid benefits will enable educators infected with HIV and/or affected by HIV and AIDS to access professional psychologists and therapists to maintain a good mental health and wellbeing. This will inevitably alleviate some of the psychosocial problems educators in the context of HIV/AIDS encounter and improve their psychosocial wellbeing.

4.5.2 SOCIAL SUPPORT AND CARE

Educators B and F proposed that school-based support programmes in terms of forming support groups to provide social support to educators infected with HIV and/or affected by HIV and AIDS could be introduced. This is supported by Buchel and Hoberg (2006:17) that the school management and the principal need to play a significant and

vital role in supporting educators infected with HIV and/or affected by HIV and AIDS. Educators D, F and K agreed that principals need to be trained in HIV/AIDS policies in order for them to be able to implement these policies at school level. These policies are said to be implemented with the aim of addressing the problems and needs of educators infected with HIV and/or affected by HIV and AIDS in the context of that particular school. Educators C and J mentioned that there is a need for the DoE to increase educator salaries in order for HIV infected and affected educators to afford HIV and AIDS-related health care services. Educators C, F and J reported that they are working under poor conditions of service because there is lack of adequate and sufficient medical aid benefits and compassionate or extended sick leave. Hence Educator G commented that there is a need for teacher unions to be actively involved in supporting their educator members who are infected with HIV. In this regard, the teacher unions will be responsible for HIV/AIDS social mobilisation and advocacy where HIV infected educators will have a platform to air their views and concerns, and to lobby for their rights to better wages, access to ART and improved conditions of service such as medical aid benefits and extended or compassionate sick leave. If the aforementioned social support structures are implemented, it is inevitable that the psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS will be addressed.

4.6 FINDINGS FOR RESEARCH QUESTION 3

Research question 3 deals with specific treatment, care and support programmes that could be developed for educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools.

Researcher: *Which specific treatment, care and support programmes could be developed for educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools?*

Educator A: *The best way is to implement mobile clinics that travel around schools to provide HIV-positive teachers with ARV's, with doctors and nurses doing medical check-*

ups. In this way, HIV-positive teachers will be healthy and we will not be absent from schools frequently because of HIV and AIDS related diseases.

Educator B: *School-based support programmes in the form of support groups to counsel and care for each other when times are tough are important. Community-based organisations, faith-based organisations and non-governmental organisations are needed to offer different services to people living with HIV and AIDS.*

Educator C: *In my case, I appeal to the department of education to support teachers by providing better medical aid benefits, the medical aid scheme we have is insufficient and cannot afford to pay for a comprehensive health care service.*

Educator D: *AIDS drugs must be easily accessible, particularly to HIV-positive educators who are important in developing the future of this country. Principals must be trained on how to manage HIV and AIDS in schools in order to support HIV infected and affected teachers.*

Educator E: *Teachers must be trained in HIV and AIDS in order to be able to cope with the disease at school level. This will help teachers to take care of themselves, their HIV-positive colleagues, learners and family members.*

Educator F: *There is a need for HIV/AIDS support groups to give hope to teachers who are suffering from stress and depression because of not coping with being HIV-positive.*

Educator G: *As a teacher's union representative I urge teacher unions to be actively involved in the fight against HIV and AIDS by introducing awareness and outreach campaigns to educate learners and teachers about HIV/AIDS in order to get rid of misconceptions and myths surrounding the disease.*

Educator H: *The department of education must employ Psychologists to deal with our mental health problems so that we are able to perform our duties with a good frame of mind.*

Educator J: *The department of education must work on providing HIV-positive teachers with AIDS drugs, we can't afford them on our own because they are very expensive.*

Educator K: *There is a need for HIV/AIDS workshops in schools, this will eliminate issues of stigma and discrimination.*

After the data analysis of the above interview responses, I was able to categorise the data into the themes discussed below. I compared and matched the responses of the educators together and corroborated them with the literature review to validate the data.

4.6.1 Mobile clinics

Educator A suggested that mobile clinics that rotate around schools with the aim of providing treatment, care and support should be introduced. Educator H indicated that the DoE must employ psychologists to rotate around schools and provide care and counselling for the good mental health of educators, especially those infected with HIV and/or affected by HIV and AIDS. In his view this will eradicate psychosocial problems of these educators and improve the health and well-being of the educators.

4.6.2 Support organisations

Educator B suggested that community-based organisations (CBO's), faith-based organisations (FBO's) as well as non-governmental organisations (NGO's) should work together with schools in order to offer HIV/AIDS-related services to educators infected with HIV and/or affected by HIV and AIDS . In addition, Educators B and F agreed that there is a need for educators to form support groups in order to provide care and support for each other in times of need.

4.6.3 Better employment benefits

Educator C suggested that the DoE should offer HIV infected educators with better medical aid benefits in order for them to be able to access HIV and AIDS-related treatment, care and support services. In addition, Educator H indicated that there is a need for improved conditions of service such as extended or compassionate sick leave for educators infected with HIV and/or affected by HIV and AIDS. This will help HIV infected educators to recuperate and HIV affected educators to take care of their loved ones.

4.6.4 Anti-Retroviral Therapy

Educators D, E, F and J suggested that ART should be provided to educators with AIDS-related diseases in order for them to be healthy and be able to teach for a longer period. They assert that this will prevent HIV and AIDS related morbidity and mortality among educators.

4.6.5 Training of educators

Educator D suggested that the DoE should offer training to principals so that they are able to manage HIV and AIDS in schools. In addition, Educator E suggested that there should be HIV/AIDS workshops to train educators in managing the impact of HIV and AIDS at school and community level. Educators G and K agreed that the DoE should introduce HIV/AIDS education programmes in schools to eradicate misconceptions and myths surrounding the disease.

4.7 CONCLUSION

This chapter dealt with the description of the research sites and biographical information of the research participants who took part in this study. The chapter also discussed the findings of the study in order to answer the research questions posed in this study. The

research participants' narrated to the researcher their day-to-day personal life experiences of being infected with HIV and/or affected by HIV and AIDS. The findings of the study were validated by corroborating the participant's responses with the literature review for triangulation purposes. However, it is conspicuous that there is a paucity of research that focuses on psychosocial issues of educators infected with HIV and/or affected by HIV and AIDS, hence I was not able to triangulate some of the findings with the literature review. Therefore, the situation shows how crucial it was to conduct this study in order to augment the available literature. In the next chapter, the summary of the research findings, recommendations and conclusions are discussed.

CHAPTER 5: CONCLUSION

Arise Afrika, Arise! *by Nape 'a Motana*

Today, under the jaws of man-eater AIDS, red
As vicious viruses colonise black blood.
Today AIDS laughs
with reddened teeth,
coffins coughing death
tears tearing Afrikan cheeks.

Arise Afrika, arise!
Out of the valley of skulls!
For AIDS viruses are no
Spots of an Afrikan leopard!
Awake Afrika, awake!
Where is the man's child-mother
to grab an AIDS knife-edge
and break the dagger to pieces?

(Excerpted from Rasebotsa, Samuelson & Thomas 2004:103-104)

5.1 INTRODUCTION

This chapter summarizes the research findings, recommendations and conclusions of the dissertation. The study set out to investigate the psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. Ten educators infected with HIV and/or affected by HIV and AIDS from two Johannesburg Inner City schools were selected to participate in the study. In-depth interviews were conducted privately with each participant to collect data and information.

The study revealed that Johannesburg Inner City schools are increasingly affected by the AIDS epidemic. The study also revealed that educators infected with HIV and/or affected by HIV and AIDS experience psychosocial (psychological and social) problems in their day-to-day personal life experiences. This study contends that there is a need for urgent response from the DoE in terms of treatment, care and support for these educators.
The following psychosocial problems were identified by the research participants:

1. Stigmatisation and discrimination

The research participants reported that they have been stigmatised and discriminated against by their seniors, colleagues and learners, which in turn created psychosocial problems attributed to feeling isolated and being socially ostracised. This study shows that there is lack of education and information about HIV and AIDS in our schools. If educators and learners were more knowledgeable about the disease, these instances of AIDS-related stigmatisation and discrimination would not occur. Moreover, it is conspicuous from the study that HIV and AIDS are still surrounded by denial and secrecy, educators and learners need to 'break the silence' and strive for HIV/AIDS awareness in schools. Schools are widely regarded as institutions that impart knowledge in communities, hence these institutions need to take the platform of disseminating positive messages about HIV/AIDS in communities in order to be able to eradicate AIDS-related stigmatisation and discrimination. Furthermore, the study makes it clear that there is lack of support from school management, which calls for school management teams to play an active and crucial role in supporting educators infected with HIV and/or affected by HIV and AIDS.

2. Stress and depression

The participants indicated that they have constantly been under stress and depression because of the difficulties they go through in their daily personal life experiences of being infected with HIV and/or affected by HIV and AIDS. They identified financial problems, lack of access to ART, maltreatment by seniors and colleagues and lack of support from the DoE as some of the issues that created stress and depression. The problems of stress and depression are detrimental to the health and wellbeing of these educators, especially those infected with HIV because stress and depression could suppress the immune system and speed up the rate of the disease. Therefore, this study shows that it is of vital significance that mental health programmes such as school counsellors and peer support groups are available in schools in order to eliminate AIDS-related stress and depression.

3. Grief and bereavement

The research participants mentioned that they have endured grief and bereavement due to witnessing their colleagues, learners, friends and family members succumb due to AIDS-related diseases. This study has shown that there are no grief and bereavement counselling programmes implemented in schools to cater for the needs of educators who have lost loved ones or significant others because of AIDS-related diseases. Educators who are mourning for loved ones or significant others who have died due to AIDS-related diseases are often not productive in their classrooms and have low morale in performing their teaching duties. The study has revealed that most educators who are infected with HIV and/or affected by HIV and AIDS are demotivated to continue teaching and hence they require some form of counselling or therapy to motivate them.

The following psychosocial needs were identified by the research participants:

1. Medical treatment and health care

The research participants highlighted that there is a need for ART to save the lives of educators infected with HIV and their significant others who are also HIV infected. In addition, the participants indicated that they need adequate and sufficient medical aid benefits to access health care facilities for ART and treatment of HIV and AIDS related opportunistic infections. Moreover, the participants reported that they need mental health care services in terms of psychological counselling and psychotherapy for their well-being. Hence the availability of adequate and sufficient medical aid benefits will be crucial in accessing mental health care services.

2. Social support and care

The research participants highlighted that there is a need for school-based support groups for educators to support each other socially and emotionally in times of need. It was also mentioned by the participants that there is a need for CBOs, FBOs and NGOs to work together with schools in rendering HIV/AIDS services to educators infected with HIV

and/or affected by HIV and AIDS. In addition, the participants mentioned that principals and educators should be trained in HIV/AIDS issues in order for them to be able to manage the disease at school level. Moreover, the research participants reported that there is a need for teacher unions to get involved to lobby for the rights of HIV infected and affected educators, in order for these educators to access comprehensive and holistic treatment, care and support services. Furthermore, the participants indicated that the DoE should provide support in terms of offering better terms and conditions of employment such as better salaries, extended and compassionate sick leave and improved medical aid benefits for educators.

5.2 LIMITATIONS OF THE STUDY

Due to the secrecy, denial as well as the stigma and discrimination attached to HIV and AIDS it was difficult to recruit more educators for this study. Hence the study recruited a small sample of educators infected with HIV and/or affected by HIV and AIDS in two selected Johannesburg Inner City schools, which impacted on the generalisation of the findings of this study (McMillan and Schumacher 1993:506). The study did not include the interviewing of other parties related to educators infected with HIV and/or affected by HIV and AIDS, namely, learners and family members. Their views and input would have been imperative but fell outside the scope of this research study. In addition, due to lack of resources and time constraints, the researcher was unable to interview other stakeholders involved in the education sector, such as union officials and DoE officials, which might have provided other relevant information. Moreover, some of the participants were preoccupied with their daily activities and busy on weekends, hence it was difficult to schedule interviews and follow-up interviews. Often school holidays and rescheduling of the appointments were alternative options to gain access to the participants.

5.3 SUGGESTIONS FOR FUTURE RESEARCH

- There is a need for research on the development and implementation of support mechanisms for educators infected with HIV and/or affected by HIV and AIDS as identified in the findings of this study.

- This study could be duplicated and replicated in other provinces and countries, particularly in sub-Saharan Africa where the AIDS epidemic is killing people, including educators, in large numbers.

5.4 RECOMMENDATIONS

1. HCT

Educators are encouraged to go for HCT services in order to ascertain their HIV status and to make informed decisions based on the outcome of an HIV test. This will help educators to access treatment, care and support if their HIV test is positive.

2. Disclosure of HIV-status

Educators are encouraged to disclose their HIV-positive status in order to be able to access treatment, care and support services. Disclosure would also encourage support by family members, colleagues and school management. This will also lead to positive living and management of the disease by educators. Although there are negative effects of disclosing one's HIV-status, such as stigmatisation and discrimination, it is important that educators join HIV/AIDS support groups that will help them to deal with these negative effects. In addition, it is imperative that teachers educate others about HIV and AIDS in order to dispel the myths and misconceptions surrounding the disease and to eliminate HIV and AIDS related stigmatisation and discrimination.

3. HIV/AIDS policies

Every school should have an HIV/AIDS policy to address issues pertaining to the disease in the school. The policy should be tailor-made to the needs and conditions of the educators and learners in that particular school. This policy should deal with challenges faced by educators and learners and to protect their rights.

4. Treatment, care and support

The DoE has to ensure that educators infected with HIV and/or affected by HIV and AIDS are able to access treatment, care and support such as ART, treatment of opportunistic infections, nutritional support, psychosocial support as well as financial support.

5. Improved remuneration

The DoE needs to increase the salaries of educators in order for HIV infected and affected educators to afford treatment, care and support services such as ART, medical expenses and proper nutrition.

6. Reduction of workload

Schools are encouraged to reduce the workload of educators infected with HIV in order to allow them to recuperate and seek medical attention which is often not within the school environment. The DoE should consider hiring teacher assistants to substitute absent educators who are ill due to AIDS-related diseases.

7. Protection against stigmatisation and discrimination

Schools are encouraged to enforce rules against stigmatisation and discrimination of HIV-positive educators within the school and the community. There should be policies and guidelines to combat HIV-related stigmatisation and discrimination in schools. Educators should also be knowledgeable and be informed about HIV and AIDS to avoid instances of stigmatisation and discrimination of HIV-infected people in schools.

8. Formation of support groups

Educators infected with HIV and/or affected by HIV and AIDS need to form school-based support groups in order to be able to care, counsel and support each other in times of need. The school management should also support the implementation of such groups.

9. Affiliation with the community and other stakeholders

Schools must network with the community in order for educators infected with HIV and/or affected by HIV and AIDS to access NGOs, FBOs, and CBOs which offer HIV/AIDS treatment, care and support services. Parents, teacher unions and the DoE should work together in the fight against HIV and AIDS through awareness and outreach campaigns.

10. Provision of HIV/AIDS information and prevention programmes

The DoE must disseminate information and provide training pertaining to HIV and AIDS to educators in order for them to be able to manage the disease in schools. Prevention programmes should also form part of the school curriculum to educate educators and learners about protecting themselves against the disease.

5.5 CONCLUSION

This study has proved that there are psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. Therefore, it was shown in this study that there is an urgent need for the DoE to develop and implement treatment, care and support programmes for educators infected with HIV and/or affected by HIV and AIDS. The study has shown that it is imperative that educators infected with HIV and/or affected by HIV and AIDS are also given a priority in accessing treatment, care and support services because they are responsible for educating the nation and they are also important in the development of the future manpower of the country. If they continue to die in large numbers due to AIDS-related diseases, the important structures of the society will be completely destroyed. The study has also showed that in order to be able to address the problems and needs of educators infected with HIV and/or affected by HIV and AIDS, a multi-disciplinary approach which integrates biomedical and psychosocial aspects of the disease is required.

When I rise *by Mthuthuzeli Isaac Skosana*

Behind I shall leave
All the symptoms
All the opportunistic infections
Shall remain
When I rise

I will conquer the infection
I will conquer the syndrome
I will conquer stigma
I will conquer discrimination
When I rise

I shall defeat HIV
I shall defeat AIDS
I shall defeat anger
When I rise
Yes when I rise I shall smile
Oh, when I rise.

(Excerpted from Rasebotsa, Samuelson & Thomas 2004:183-184)

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APPENDIX A

ACCESS LETTER

Date: 26 June 2009

Dear Principal,

I am a student doing the degree of Master of Arts (Social Behaviour Studies in HIV/AIDS) at the University of South Africa. As part of the requirements for completing the degree, I have to write a dissertation investigating the psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. The aim of conducting this study is to explore the need to develop a comprehensive and holistic treatment, care and support programme to address the problems and needs of these educators. Hence I hereby request permission to conduct interviews with educators in your school where I will interview them about their day-to-day life experiences of being HIV infected and/or affected. I will also ask them about psychosocial problems that they have experienced and the needs that they think will be able to address these problems. The following ethical considerations regarding their participation will be adhered to:

- No educator will be forced to participate in this research.
- They will not have to answer any question they do not wish to answer.
- Their identity and that of the school will be kept confidential to the extent provided by law and their identity will not be revealed in the final manuscript. Pseudonyms will be used instead.
- The interviews will be conducted privately at a place and time convenient to them, after I have received a copy of this signed consent letter from them. I will also be conducting follow-up interviews in order to make sure and confirm that the information that I have previously collected from them is correct and a true account of their day-to-day experiences of being HIV infected and/or affected. Each interview session will last not more than an hour.

There are no anticipated risks, compensation or other direct benefits to them as participants in the interviews. They are free to withdraw their consent to participate and may discontinue their participation in the interview at any time without consequence.

If you have any questions about this research protocol, please contact me at 0769117278 or ntshil@yahoo.com

Yours in Education

Mr. Johannes N. Mampane

APPENDIX B

CONSENT LETTER

Date: 26 June 2009

Dear Educator,

I am a student doing the degree of Master of Arts (Social Behaviour Studies in HIV/AIDS) at the University of South Africa. As part of the requirements for completing the degree, I have to write a dissertation investigating the psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. The aim of conducting this study is to explore the need to develop a comprehensive and holistic treatment, care and support programme to address the problems and needs of these educators.

As a participant, you will be interviewed by me where I will ask you questions about your day-to-day life experiences of being HIV infected and/or affected. I will also ask you about psychosocial problems that you have experienced and the needs that you think will be able to alleviate these problems. The following ethical considerations regarding your participation will be adhered to:

- No educator will be forced to participate in this research dissertation.
- You will not have to answer any question you do not wish to answer.
- Your identity and that of the school will be kept confidential to the extent provided by law and your identity will not be revealed in the final manuscript. Pseudonyms will be used instead.
- The interviews will be conducted privately at a place and time convenient to you, after I have received a copy of this signed consent letter from you. I will also be conducting follow-up interviews in order to make sure and confirm that the information that I have previously collected from you is correct and a true account of your day-to-day experiences of being HIV infected and/or affected. Each interview session will last not more than an hour.

There are no anticipated risks, compensation or other direct benefits to you as a participant in this interview. You are free to withdraw your consent to participate and may discontinue your participation in the interview at any time without consequence.

If you have any questions about this research protocol, please contact me at 0769117278 or ntshil@yahoo.com

Yours in Education

Mr. Johannes N Mampane

Please sign and return this copy of the letter to me if you agree to participate in the study. A second copy is provided for your records. By signing this letter, you give me permission to report your responses anonymously in the final manuscript to be submitted to the University for examination.

Name: _____

I have read the procedure described above for the proposed research study. I voluntarily agree to participate in the research and I have received a copy of this description.

_____ _____

Signature of participant Date

I would like to receive a summary copy of the final report submitted to the University for examination. YES..... / NO.....

APPENDIX C

INTERVIEW SCHEDULE

Good day,

My name is Johannes Mampane, and I would like to ask you questions about the psychosocial problems and needs of educators infected with HIV and/or affected by HIV and AIDS in Johannesburg Inner City schools. The aim of this interview is for you to tell me your day-to-day personal experiences of being infected and/or affected by HIV and AIDS.

1. **PERSONAL DETAILS**

- How old are you?
- What is your marital status?
- Where do you stay?
- What is your occupation at the school?
- Which qualifications do you have?
- How long have you been teaching?
- What is your area of specialisation?

2. **RESEARCH QUESTIONS**

2.1 What are the psychosocial problems experienced by educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools?

- How are you personally affected by HIV and AIDS?
- When did you know of your HIV status?
- How did you find out about your HIV status?
- How were you affected by the news of your HIV status?
- Did you disclose your HIV status to anybody?
- If not, why do you conceal your HIV status?
- Do your colleagues at school know about your HIV status?
- Do your family and friends know about your HIV status?
- How did the people react after learning about your HIV status?
- Did you have any regrets for disclosing your HIV status?
- Tell me of about personal problems you have encountered in your daily experiences of being HIV infected and/or affected?
- How do you overcome these problems?

5.4 What are the needs of educators infected with HIV and/or affected with HIV and AIDS in terms of developing treatment, care and support programmes aimed at addressing the problems and needs of these educators?

- What do you think could be done to help educators infected with HIV and/or affected by HIV and AIDS in terms of treatment, care and support?
- When did you join the support group for HIV infected educators?
- Why did you join this support group?
- Do you find the support group helpful?
- Are you on Anti-Retroviral Therapy?
- Where do you get your ART?
- Is the ART helping you?
- Do you have medical aid?
- If not, how do you access health care services?

5.5 Which specific treatment, care and support programmes could be developed to address the problems and needs of educators infected with HIV and/or affected by HIV and AIDS in selected Johannesburg Inner City schools?

- What particular treatment, care and support programmes do you think will be able to address the problems and needs of educators infected with HIV and/or affected by HIV and AIDS?
- Do you have HIV/AIDS policies implemented in your school?
- Does your school have any support structures for HIV infected and/or affected educators?
- Is your school involved in any HIV/AIDS programmes?
- Have you attended any HIV/AIDS training or workshops?
- Have you received any information about HIV/AIDS from the DoE?
- What do you think should be done to meet the needs of HIV infected and/or affected educators?
- What specific needs do you think will meet these needs in terms of treatment, care and support?
- Do you think the DoE is involved in supporting HIV infected and/or affected educators?
- Which other stakeholders do you think should be involved in supporting and caring for HIV infected and/or affected educators?

Thank you for your time and your invaluable input in this study. Take care and Goodbye.