"REds empowered me. I am resilient. Maybe I will bend, but I will not break." The piloting of resilient educators (REds): an intervention programme to encourage resilience among educators affected by the HIV/AIDS pandemic

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Abstract

The challenges of the HIV pandemic are multiple and frequently inimical to educators who are affected when their loved ones, colleagues and learners become ill or when learners are orphaned. Consequently there have been numerous appeals for intervention efforts aimed at enabling affected educators to cope. One response to this appeal was the compilation of the Resilient Educators (REds) intervention programme. The following article documents the initial piloting of REds with volunteer educators (n=15) living in the Vaal Triangle area. The aim of this piloting was to test and refine REds using pre-experimental, participatory research within an intervention research paradigm. Data were collected prior to, during and following REds by means of triangulated mixed methods, including survey research, detailed observations, facilitator and participant reflections, open-ended questionnaires, semi-structured interviews and projective media (fifteen incomplete sentences). The pilot results are encouraging because they suggest that it is possible to enable affected educators to cope more resiliently with the challenges of the pandemic. The pilot results also suggest that programme content and process are essentially effective, but altered logistical arrangements, increased use of participatory methods and heightened sensitivity to cultural preference will need to receive attention in future REds interventions.

Introduction

Many educators who are affected by the HIV/AIDS pandemic, report that they are negatively impacted. Coombe (2003) argues that all educators are affected by the pandemic. Bhana, Morrell, Epstein and Moletsane (2006) argue that Life Orientation educators (especially those teaching in economically challenged communities) are even more affected as the burden of supporting learners and colleagues through loss and grief related to the pandemic

inevitably falls on Life Orientation educators. Bennell (2005) and Shisana, Peltzer, Zungu-Dirwayi and Louw (2005) do not agree that all educators are affected, but there is nevertheless an urgent call within South Africa to buffer teachers against the negative personal and professional impacts of the pandemic (Cf. Table 1) (Bennell, 2005; Coombe, 2003; Hall, Altman, Nkomo, Peltzer and Zuma, 2005; Kinghorn and Kelly, 2005; Shisana *et al*., 2005; Simbayi, Skinner, Letlape and Zuma, 2005; Theron, 2007). This call is echoed in the findings of an international study concerning the readiness of the education sector (including the South African education sector) to cope with the impacts of the pandemic – the findings suggest that although HIV/AIDS management structures are generally in place, there is (amongst others) continued need for increased support for educators confronted by the pandemic (UNAIDS Inter Agency Task Team on Education, 2006).

Table 1: Personal and professional impacts of HIV pandemic on educators

Negative personal impacts linked to pandemic's challenges	Negative professional impacts linked to pandemic's challenges
1. Grief 2. Mood disturbances 3. Emotional lability 4. Elevated stress 5. Fear 6. Poor health (e.g. disturbed sleep; poor appetite) 7. Attenuated socialization 8. Spiritual doubt	1. Professional stress, including: • escalating workloads/larger classes when colleagues are absent for pandemic-related reasons • teaching/caring for vulnerable learners • interacting with HIV + colleagues/learners 2. Decreased morale 3. Multiple roles, including: • educator • counsellor • confidante • caregiver • social worker • preventative agent

What is reflected in Table 1 above can be described as a dynamic set of environmental hazards (Leadbeater, Marshall and Banister, 2007), typically associated with the HIV crisis, that are likely to predispose HIV-impacted educators to unhealthy functioning. These personal and professional risks associated with being an educator in the age of HIV and AIDS will vary in intensity and frequency from context to context and are more likely to inflame

educator vulnerability when they are multiple and when educators have little accessible, mitigating support (Schoon, 2006; Leadbeater *et al*., 2007).

One potential way to support educators confronted by the risks of the HIV pandemic is by engaging in some form of intervention. Intervention is understood to mean any course of action that buffers and/or modifies processes and circumstances that are potentially threatening for individuals and communities (Donald, Lazarus and Lolwana, 2006; Lazarus, 2007). In the context of HIV/AIDS, the greater emphasis has been on preventive interventions, also with regard to educators, both in Africa (Norr, Norr, Kaponda, Kachingwe and Mbweza, 2007) and South Africa (McElligott, 2005). There are limited documented accounts of supportive interventions (interventions that seek to empower within an existing risk-laden context rather than to prevent risk) with South African educators who are affected by the pandemic. One such account relates to a collaborative research project conducted in Vulindlela, a rural area of KwaZulu-Natal, with teachers and community health care workers (Mitchell, De Lange, Moletsane, Stuart and Buthelezi, 2005). As a consequence of this project, local multi-disciplinary interaction was encouraged, community projects were planned, HIV-related stigma was explored and community education promoted, all of which contributed to teacher support. Another example is the participatory reflection and action research project conducted with primary school educators in an informal-settlement in the Eastern Cape (Ebersöhn, Eloff and Ferreira, 2007; Ferreira 2007). One outcome of this research was the facilitation of asset-based coping among teachers who participated. Participants were also empowered in the form of education with regard to basic HIV knowledge and training in additional coping skills. In both of the aforementioned, participant empowerment was partly attributed to the participatory methods that the researchers favoured (Ebersöhn *et al*., 2007; Mitchell *et al*., 2005).

To the best of our knowledge, there are no other examples of supportive interventions with South African teachers *affected* by the pandemic. This article reports on another recent attempt to do so in the form of a group intervention programme, Resilient Educators (REds), designed to support South African educators affected by the pandemic by encouraging resilience as a coping skill.

The purpose of this article is to comment on the efficacy of REds to empower affected educators as demonstrated in its pilot implementation and reflect on what fine-tuning (as recommended by participants and inferred from the

analysis of data) is needed to improve REds. The implementation of REds is framed by an intervention research approach which suggests that there is a period during which the programme is trialed and tweaked (De Vos, 2006), akin to that of formative evaluation (Babbie and Mouton, 2007). As such, the article reports work in progress. The initial findings suggest that educators who participated in the pilot intervention evidenced some positive change and could be assisted towards resilient functioning.

The results of the pilot intervention may be useful to service providers working with educators who are affected by the pandemic in that the nascent results suggest that educators can be enabled despite the adversities incumbent to teaching in the face of the pandemic this knowledge may in turn encourage service providers and educators that positive change among educators affected by the HIV pandemic is possible. These emerging positive results may further encourage service providers to implement REds with other groups of teachers. Finally, the understanding of how teachers changed following participation in REds might be used in professional development activities with both pre- and in-service teachers directed at fostering resilience and so reducing the risk of staff attrition (Edward, 2005).

Resilient functioning

In essence, resilience refers to the process of functioning relatively well despite adverse circumstances (Almedom, 2005; Edward, 2005; Haeffel and Grigorenko, 2007; Masten and Reed, 2005; Rutter, 2000; Ungar, 2005). Typically, such adverse circumstances are beyond an individual's control (e.g. war, pandemic, entrenched poverty; continued crises) (Edward, 2005; Wong, Reker and Peacock, 2006). When the individual copes well (proactively or creatively) with such adversity, resilience is evidenced (Edward, 2005; McCreary, Cunningham, Ingram and Fife, 2006; Wong, Wong and Scott, 2006).

A study that sought to explore resilience among mental health practitioners involved in perpetual crisis counselling, suggested that resilient practitioners had adequate expertise, creativity and experience to cope with work demands; had faith and hope; had insight into their role and engaged in self-care, that included healthy habits and social networking (Edward, 2005). Resilience among these health practitioners, and others, might then be described as the ability to cope with stress, to network, to hope, to solve problems, to accept

the status quo, to persist and so forth (Hjemdal, Friborg, Stiles, Rosenvinge and Martinussen, 2006; Leadbeater *et al*., 2007; Masten and Reed, 2005). Rather than enumerate a list of descriptors, resilience might be summarized as a coping strategy that has the potential to encourage people to develop confidence in dealing with challenges and to reframe a negative status quo as a more positive, manageable one (Almedom, 2005; Edward, 2005; Rutter, 1985).

The antecedents of resilience are attributed to the dynamic interplay of inter- and intra-personal protective resources and processes that empower individuals and communities to live adaptively notwithstanding adversity (Cameron, Ungar, and Liebenberg, 2007; Carrey and Ungar, 2007a; Carrey and Ungar, 2007b; Hjemdal, 2007; Kirby and Fraser, 1997; Leadbeater *et al*., 2007; Powers, 2002; Phan, 2006; Schoon, 2006). Intra-personal protective resources might include attributes such as a sense of humour, internal locus of control, social competence, intelligence and so forth, whilst interpersonal resources relate to supportive family, social and cultural structures, such as mental health care; supportive interventions; mentors and so on (Hjemdal *et al*., 2006; Leadbeater *et al*., 2007; Masten and Reed, 2005). Typically, resilient individuals negotiate or have access to buffering resources and capitalize on these resources. In other words, resilience is not exclusive to either the individual or the environment, but is an interactive process of protective give-and-take. In this way individual and collective strengths protect individuals interchangeably.

Theron (2007) noted such reciprocity among some South African educators who continued to function resiliently regardless of the pandemic negative impacts. These educators described both interpersonal (e.g. availability of counselling, collegial support) and intrapersonal (e.g. assertiveness skills, religious beliefs) protective resources that contributed to their wellness. Their ability to function resiliently did not mean that these educators were not challenged, disturbed or disheartened at times, but rather that they used inter- and intrapersonal resources to function adaptively most of the time.

Interventions can encourage resilience, either by reducing exposure to adverse circumstances, or by increasing the number of/access to protective resources that encourage competence, or by encouraging or influencing processes that facilitate resilience. Comprehensive interventions include all three these strategies (Masten and Reed, 2005) and encourage a sense of personal control over life trajectories and some sense of influence over the forces that impact

on daily life (Lazarus, 2007). This sense of control or influence is allied to a sense of empowerment (Donald *et al*., 2006), a phenomenon believed to be integral to resilience and one encouraged by effective resilience-focused intervention programmes (Yates, Egeland and Sroufe, 2003).

An overview of REds

REds aimed to encourage resilience as a coping skill among affected educators by amplifying protective resources and processes. Because of its alignment with the tenets of positive psychology, REds was based on the assumption that educators who are affected by the pandemic have individual and collective strengths (Ryff and Singer, 2005; Seligman, 2005) which might be amplified to encourage resilience.

To encourage resilient coping, REds aimed to buffer the personal and professional impacts of the pandemic as outlined by current research (Bhana *et al*. 2006; Coombe, 2003; Hall *et al.,* 2005; Kinghorn and Kelly, 2005; Theron, 2005; Theron, 2007) by using group-process and programme content that encouraged the awareness and development of personal and collective protective resources and skills and concomitant participant resilience.

The pilot version of REds consisted of eight interactive, practical modules. The modules focused on the facts of the pandemic; how teachers can give and gain support; how teachers can remain psychosocially well and cope with stigma; how teachers can cope with stress and fatigue; teacher rights with regard to the pandemic; how teachers can prevent HIV at school; guidelines for teachers and pupils on nursing ill loved ones and how teachers can function resiliently in the face of the pandemic. These modules were compiled by means of multi-disciplinary collaboration in line with reported educator support needs (Coombe, 2003; Simbayi *et al*., 2005; Theron, 2005). As noted previously, the collective aim of these modules was to build "buffering strengths" (Seligman, 2005, p.6) by making teachers aware of available protective resources and encouraging skills, knowledge, and processes that might support resilient functioning.

As an intervention programme REds depended on small group process. The therapeutic worth of group interaction, especially groups limited to a maximum of fifteen members (Corey and Corey, 2002) is well documented (Ross and Deverell, 2004; Smit, 2004). In practice, each of the eight REds

modules was presented to a group of volunteer participants that met weekly. A ninth meeting was included as a finale. Each session lasted between 150 and 180 minutes and depended, in part, on group activities and group process. The venue (local school classroom) was chosen by the participants as this was convenient for them.

REds included participatory methods. Each session invited participant interaction and input and depended in part on participant activity for success. Participant activities included amongst others reflection, listing of community resources, art therapy, music therapy, gestalt work, role-play, debate and discussion. Within this participatory framework, participants and researchers shared knowledge and experiences, and changes were envisaged 'with' participants, rather than 'to' participants (Mullen and Kealy, 2005).

Methodology

REds is based on intervention research. Intervention research focuses on ascertaining whether an intervention has merit for participants and/or their communities and typically has six phases (De Vos, 2006):

1. Problem analysis and project planning (completed 2003–2004)
2. Information gathering and synthesis (completed 2004–2005)
3. Design (completed 2005)
4. Early development and pilot testing (completed 2006)
5. Evaluation and advanced development (ongoing: 2007–2009)
6. Dissemination

This article focuses on the pilot-testing of Phase Four. This phase is allied to formative evaluation which is done with the express purpose of gaining feedback that might improve the intervention programme (Babbie and Mouton, 2007). To gain this feedback, we followed a pre-experimental pretest-posttest design, with no control group (Leedy and Ormrod, 2005). Mixed methods were used to gather data: quantitative and qualitative data were gathered concurrently in the pre- and post-tests to comment on participant empowerment (Babbie and Mouton, 2007; Ivankova, Creswell and Plano Clark, 2007). In order to ascertain how REds might be further developed, written participant and facilitator reflections (Ivankova *et al.*, 2007) were gathered at the close of each REds session.

The hypothesis underlying the methodology used in Phase Four was that if REds was efficacious as an intervention, educators would be empowered towards resilient functioning that might be reflected in post-test data that suggested a sense of participant mastery over the pandemic impacts (Lazarus, 2007). Specifically we hypothesized that participant job satisfaction would improve, participant stress would decline, and participants would develop confidence to deal with the pandemic challenges (Almedom, 2005; Edward, 2005; Rutter, 1985).

Sample and recruitment

Two fieldworkers approached schools within the Vaal Triangle that were geographically accessible to them and where they knew gatekeepers that could facilitate their entrance into these school communities. Once introduced by the gatekeepers, the fieldworkers promoted participation in the piloting of REds by talking to school principals and to school staff during staff meetings. Educators who considered themselves affected by the pandemic were invited to participate. Affected educators encompassed educators who had HIV-positive loved ones, colleagues or learners; or educators with loved ones, colleagues or learners who had died from HIV/AIDS-related illnesses; or educators who were teaching learners who were orphaned or vulnerable as a consequence of the pandemic.

For the initial piloting, fifteen educators volunteered to participate. All fifteen were black primary school teachers teaching at township schools. Twelve were female and three were male. Their ages ranged from 32 to 54. The participants did not speak English as first language and so a translator was present to facilitate communication.

Consent procedures

Informed participant consent as well as the permission of the provincial and local educational authorities was obtained prior to commencement. Ethical clearance from the university funding this research was also obtained. We observed basic ethical principles (e.g. voluntary participation, confidentiality, respect for participant rights to withdraw at any stage or choose not to disclose or discuss anything that they would prefer not to) (Roos, Visser, Pistorius and Nefale, 2007; Strydom, 2005; Wassenaar, 2008). Participants provided

permission for data generated in this study to be documented. We referred participants to local counselors if the need arose and debriefed them at the close of the intervention. We also followed up on participants three months after completion of piloting.

Data collection

Four sets of data were collected. The first set was collected prior to the piloting of REds and included both quantitative and qualitative data that reflected educator well-being. The second set was collected at the end of each REds session in the form of written participant, facilitator and observer reflections on the efficacy of each session. The third set replicated the first and was collected on completion of the piloting of REds. The fourth was collected three months after completion of the piloting and included qualitative data on participant perception of REds and the pandemic.

The quantitative instrument used was the Professional Quality of Life scale (ProQol). The ProQol has been used internationally to determine job satisfaction, burnout and fatigue among school personnel (Stamm, 2005). Qualitative instruments were used to triangulate the data obtained by means of the quantitative instrument and gather rich information on how participants perceived the pandemic and its challenges for them as educators, how well they thought they were coping with these challenges and what, if anything, empowered coping. Qualitative data included detailed observations by an observer, facilitator reflections, open-ended questionnaires, semi-structured interviews (either in English or in mother tongue; mother tongue responses were translated by the participant observer) and projective media (fifteen incomplete sentences).

REds was implemented by two post-graduate students (one black, one white; both female) over nine consecutive weeks. One student facilitated and one fulfilled the functions of an observer. The duration of each session was two and a half hours on average. In the written reflections, participants were asked to reflect on what in the session had been beneficial, not beneficial and what they would like added to each REds session. The facilitator and observer also completed reflections.

Analysis

The ProQol protocols were scored by an independent statistician according to the guidelines in the ProQol manual (Stamm, 2005). The scores were statistically computed to provide pre- and post-test averages for the three scales of the ProQoL, namely compassion satisfaction, burnout and compassion fatigue. These averages were interpreted according to scale averages (Stamm, 2005).

The qualitative data which included transcribed interview responses, open-ended questionnaire responses, written projections (derived from the incomplete sentences test) and observations were thematically coded (Bogdan and Biklen, 2007). The codes were influenced by current literature on negative educator experiences of the pandemic (Bhana *et al*., 2006; Coombe, 2000; Coombe, 2003; Ebersöhn, 2008; Fredriksson and Kanabus, 2002; Hall *et al*., 2005; Hjemdal *et al*., 2007; Kelly, 2000; Kinghorn and Kelly, 2005; Shisana *et al*., 2005; Theron, 2005; United Nations, 2003; World Bank, 2002) and by prevailing literature documenting coping and resilience (Almedom, 2005; Carrey and Ungar, 2007b; Edward, 2005; Schoon, 2006, Solomon and Laufer, 2005, Strümpfer, 2006, Taylor, Dickerson and Klein, 2005, Theron, 2007). They were also influenced by our professional experiences of service delivery to education stakeholders affected by the pandemic.

We contrasted the broad thematic categories from the pre- and post-tests and then drew inferences regarding emerging educator resilience and the efficacy of REds. Our inferences were moderated by a diligent search for contrasting emerging themes (Gilgun, 2005). We also compared quantitative data results with those of the qualitative data and discussed these with other, experienced researchers. In this way we attempted to ensure trustworthiness.

Participant reflections were analyzed for comments relating to necessary improvements to the content and/or process of REds. We used their comments, as well as those provided by an independent reviewer of the programme content and those of the facilitator and observer, to tweak REds content and process.

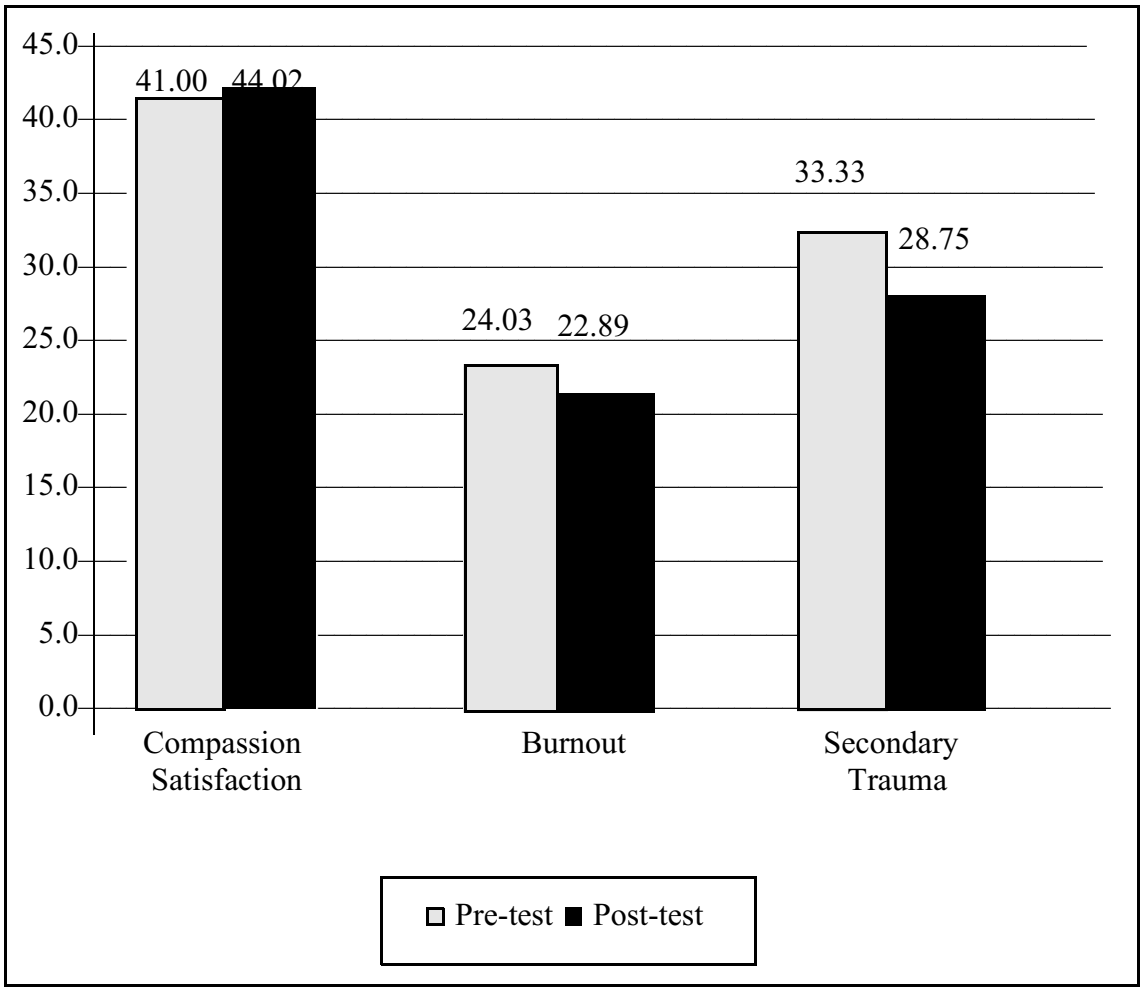
Results

The results from the initial piloting of REds suggested that REds facilitated a degree of educator resilience. To facilitate an overview of the results, the quantitative and qualitative results and reflections on REds will be discussed independently.

Quantitative results

The pre- and post test ProQol results are provided as a group average in Figure 1 below.

Figure 1: Pre- and post-test ProQol scores



The average ProQol range for compassion satisfaction (the fulfilment that participants derive from a profession which involves compassionate work) is 32–41. In the pre-test, participants recorded an average satisfaction score of 41. The post-test average fell into the above average range (44.02), suggesting increased (albeit non-significantly) professional fulfilment among participants following participation in REds.

The average ProQol range for burnout ranges from 19–28. In the pre-test, participants recorded an average burnout score of 24.3. The post-test average was marginally lower (22.89), suggesting decreased (albeit non-significantly) levels of burnout. These levels are in line with current literature that suggests that South African educators are generally a stressed corps (Hay, Smit and Paulsen, 2001; Jackson and Rothmann, 2006; Lessing and De Witt, 2007; Schulze and Steyn, 2007; Xaba, 2003).

The average ProQol range for compassion fatigue (or secondary trauma resulting from compassionate work) ranges from 8–17. In the pre-test, participants recorded an average score of 33.33 – this signaled above average compassion fatigue among participants. The post-test average was lower (27.85), suggesting decreased compassion fatigue. Despite this decrease, participants continued to score in the above average range of compassion fatigue. To the best of our knowledge there are no current studies which document South African educator compassion fatigue and so it is difficult to comment on whether the high compassion fatigue of participants in our study is endemic to them or typical of South African educators or even typical of South African educators confronted by the challenges of the pandemic. Qualitative accounts of pandemic-related experiences of Life Orientation educators in KwaZulu-Natal (Bhana *et al*., 2006) and educators in Gauteng and the Free State (Theron, 2007) do suggest that some educators are fatigued by pandemic-related caregiving tasks as does a comprehensive review of schools as sites of care and support (Hoadley, 2007).

Participation in REds did not impact significantly on participant compassion satisfaction, burnout or compassion fatigue – this may be related to the small number of participants which confounds statistical computations. Nevertheless, the decreases in burnout and compassion fatigue scores and the increase in compassion satisfaction suggest that participants experienced some relief following participation in REds.

Qualitative results

The qualitative results emerging from the pre-tests will be presented first, followed by the results emerging from the post-tests. In summary, the pre-test results suggested limited resilience, whereas the post-tests results generally suggested nascent resilience, with themes related to altered perception and acceptance of the HIV-crisis, professional empowerment, and burgeoning community mindedness. There were, however, also some post-test results that suggested ambivalence towards the HIV-crisis. This section on qualitative results is concluded with findings from the reflection worksheets.

Pre-test results

Prior to their participation in REds, the participants came across as vulnerable to the challenges of the pandemic. There were limited themes of resilience. Participants regarded the pandemic as a '*death sentence*', more specifically one which they were powerless to alter. Many of them commented on inadequate knowledge with regard to transmission and prevention: ". . . *we had very little knowledge about HIV and AIDS. Even up to now people still lack information* . . ." All participants related negative emotion that threatened to overwhelm them: "*When I think of the future I feel like crying because of HIV and AIDS*". They all referred to the pandemic's negative impacts, including altered social lives, poor sleeping and eating patterns and declining spiritual faith. One participant commented "*I sleep badly, because even if I am not positive I think of those who suffer from that and die."* Participants generally experienced the pandemic as insidious because they witnessed its impact on their learners: "*If I see a learner suffering I just can't hold my tears"* and "*As an educator, you feel the learners pain and frustration.*" They reflected that it was not enough to take care of learners' academic growth, but that their learners needed them to provide psychological and sometimes physical care and that this left them feeling sad and drained.

There were strong overtones of despair, uncertainty and helplessness in most participant responses. Their negative experiences contributed to many participants being fearful: "*When I think of the future, I fear.*" In addition to fear, participants referred at length to grief and loss and also to feelings of disempowerment when they were helpless to save ill loved ones or aid learners. One participant explained "*You meet infected learners daily, and you are willing to help, but you don't know how."* Participants noted that they did not have the skills to cope with the pandemic's challenges and that nothing

they did seemed to make enough of a difference. As one participant said: "*You want to give help to learners, colleagues and it won't be sufficient.*" This contributed to some participants feeling overwhelmed and powerless with many wishing they could avoid the pandemic and its challenges: "*When things go wrong I feel like hiding myself.*"

Facilitator and observer reflections noted that the participants were initially grave and generally uncertain. They seemed overwhelmed by the pandemic's challenges. It appeared that most of the participants welcomed the opportunity to be able to open up about their experiences. In general the pre-test data symbolised negative educator perception and lived experiences of powerlessness and hopelessness that connoted vulnerability rather than resilience.

None of the pre-test data were surprising. What the participants in this sample related matched the typical profile of the affected educator with limited resilience as documented to date (Bhana *et al*., 2006; Coombe, 2003; Simbayi *et al*., 2005; Theron, 2005; Theron, 2007).

Post-test results

Compared to the pre-test data, very different themes emerged in the post-test data. In general the participants projected and reported resilience, although some participants still noted that the pandemic and its challenges continued to be taxing. One participant summarised her post-REds attitude rather aptly: "*REds empowered me. I am resilient. Maybe I will bend, but I will not break.*" When the post-test data were analyzed thematically in terms of what might have informed educator resilience, or their 'bending but not breaking', the following themes emerged:

- ***Altered perception***
  In most instances, participants voiced an altered perception of HIV and AIDS that suggested a reviewed understanding of HIV/AIDS as a disease, rather than a death sentence, scourge or punishment: "*It has impacted me so much because I was able to consult my younger sister who is infected. I empowered her by giving her skills to acknowledge herself as a person who has a normal sickness like everybody who is ill. . . . Before I undergo REds programme I did not understand HIV and AIDS. I took it as a death sentence but now I do understand that HIV is a*

sickness like any other disease; the difference is that HIV has no cure." Implicit in this extract is the sense that understanding HIV as an illness encouraged advocacy and agency. A number of participants echoed notions of advocacy and agency, and added that their altered perception had facilitated more comfortable interaction with colleagues, learners, loved ones and acquaintances who might be HIV-positive and less prejudiced behaviour. In this regard a participant explained: "*It has taught me that people with HIV/AIDS are people like myself. They should be treated like all other people. . . I have also learned that people with HIV/AIDS need to be loved and supported*." Positive perception is typically associated with coping and resilience (Boss, 2006; Lazarus and Folkman, 1984; Potgieter and Heyns, 2006).

- ***Acceptance of an HIV-altered reality***
  Many participants voiced acceptance of an HIV-altered ecology: "*REds has made me realise that AIDS is there and it is real. It has thus given me the strength and opportunity to take care and to make sure that other citizens be aware of the pandemic.*" This acceptance was allied to a willingness to respond preventatively to the HIV-crisis, again implying agency. For some participants participation in REds encouraged acceptance of a professional reality altered by HIV/AIDS: "*REds lead me to accept the situation in my class and school".* Acceptance of this led to an altered perception of what it meant to be a teacher in the pandemic and a sense of being able to make a positive difference: "*As educators we are faced with learners who come from different backgrounds. Some infected or affected. So I have learned as an educator to accommodate them, know more about my learners so that they can feel free to discuss with me and I should offer help*". Acceptance of the status quo is thought to encourage resilience, especially when there is little possibility of affecting change. In such instances, acceptance is related to an internal locus of control, or a sense of one's power to make a difference despite the presence of ecological hazards (Donald *et al*., 2006; Edward, 2005; Hjemdal *et al*., 2006; Leadbeater *et al*., 2007; Masten and Reed, 2005). Given that the HIV-crisis is a social phenomenon over which educators typically have cursory (if any) control (Smit and Fritz, 2008), participant acceptance of the status quo and willingness to work meaningfully within this context is especially enabling.

- ***Professional empowerment***
  Professional empowerment related to participants illustrating a sense of competence to cope with the taxing demands that the HIV-crisis makes of many educators, including being able to teach HIV-prevention, counsel, advise, and practically support learners (e.g. with grants, uniforms, food packages). Most participants referred to being able to assist and support vulnerable learners and orphans via the acquisition or extension of knowledge and skills: "*It [participation in REds] has empowered me with the knowledge and skills to help the learners understand how to deal with other learners who are HIV positive. And even I myself have learned how to deal with the learners who are infected and affected.*"

  Increased knowledge (such as knowledge of referral networks, available grants, HIV transmission, rudimentary nursing of HIV positive individuals) and augmented skills (such as time management, bereavement skills, counselling skills) encouraged educators to feel empowered and competent: "*It gives me skills on how to go about with the learners who are affected; how to handle them emotionally and psychologically. I know how to manage time in terms of teaching because initially I used to just listen to problems, not knowing what to do with the problems encountered by learners but through REds I am able to solve them and know whom to contact, whom to refer a serious problem. It means a lot to me because I know whom to contact. I do understand how to counsel learners who are affected. REds empowered me as a person with skills*."

  For some participants the REds experience was associated with a sense of being able to cope with the multifaceted roles that confront educators in the age of HIV and AIDS, including amongst others preventative agent, caregiver and social worker (Cf. Table 1): "*In my professional capacity REds has changed me in such a way that learners and educators who are infected turned to accept their status and also have learned to live with it through my help; in short, REds has also changed my role as a teacher i.e. I've turned to be a social worker in a way.*" Whilst this change was generally interpreted in a positive way by participants, it included the potential to strain participants in ways similar to those noted by Bhana *et al*. (2006) and Hoadley (2007): "*I have been very concerned now of late about the lives those learners live in their different homes. Are they eating healthy foods . . . I also wanted to know whether they receive their grants . . . and if not I am always*

willing to help those children. I also brought my children's clothes and give them to those children who need them."

The above excerpts suggest that educator competence and resilience to professional challenges are intertwined, as suggested by Schulze and Steyn (2007). However, participants were candid that the keys to their empowerment lay in more than acquired knowledge and skills – empowerment was also partly in kinship with others, and in awareness of and access to supportive resources. In this regard, most participants noted that being with others and talking to others encouraged coping: "*REds made me realise that I cannot face AIDS alone. There are people who can help me."* Many participants felt better capable of coping with professional tasks because of heightened awareness of supportive resources within their communities and the sense of kinship that this provided. Their navigation towards and negotiation for resources that might aid them to cope with the challenges of the HIV-crisis is directly in line with more recent resilience theory that posits that people are inclined towards resilience when they are aware of and take advantage of accessible, protective assets (Ebersöhn, 2008; Ungar, 2008).

In summary, the above echoes themes that typified resilient mental health practitioners (Edward, 2005) and more resilient educators affected by the pandemic (Theron, 2007), specifically those of adequate expertise, skill and experience to tackle work demands; insight into professional roles, freedom to talk openly about confrontational issues and social networking.

- ***Community mindedness***
  The post-test data suggest that participants were community-minded and confident about their ability to support their communities following participation in REds. Whereas they were aware of learners, colleagues and loved ones who were affected and infected prior to REds, they were mindful that communities needed empowerment in terms of knowledge and skills following REds. One participant noted: "*It made me realise how really my community needs me."* Another said: "*REds has made me aware that . . . you have to play an important role in educating my children, neighbours, family members about the necessary skills on how to cope and treat both an infected and affected member in a family situation, community, church . . .*" Positive social orientation has long been associated with resilience (Friborg, Barlaug, Martinussen, Rosenvinge and Hjemdal, 2005; Werner, 2001), especially when such orientation includes empathy and a willingness to care.

Community-mindedness was expressed in tandem with a belief that participants could make a difference in their communities. For example, one participant noted: "*I have also learned how to help the people in the community that are infected and affected*" while another explained: "*REds has in fact changed my life as an educator able to reach children and help them. I am able to counsel them, especially those who are affected by HIV. And families are coming to me for more advices – in the community I am serving, I cope with [a] very difficult situation.*" It would seem therefore that participants considered reaching out to their communities because they felt they had the know-how. As noted above, a sense of personal control, agency and efficacy are associated with resilience (Donald *et al*., 2006; Edward, 2005; Hjemdal *et al*., 2006; Leadbeater *et al*., 2007; Masten and Reed, 2005).

Many participants were mindful of the community of teachers, both in their districts and in South Africa and reported that such an awareness had encouraged them to share what they had learned with them: "*As teachers we should have knowledge about this pandemic – that is why after REds we found that it was necessary to impact the knowledge we had gathered from REds to other educators.*" Other participants were aware that in the war on HIV/AIDS, educators need to stand together to be triumphant: "*I have decided to reach out to the community and help them to accept people who are HIV positive and not to neglect them. Let us not fight HIV and AIDS as individuals but join forces together – we will win."* Such community-mindedness echoes themes that typified resilient mental health practitioners and more resilient educators affected by the pandemic, especially in terms of finding meaningfulness in professional roles including making a difference to others (Edward, 2005; Theron, 2007).

- ***Ambivalent responses***

  Despite the generally positive responses, there were still post-test responses that connoted vulnerability. For example, one participant commented that the spiritual impact of the pandemic was "*I have hatred to man*". Another noted: "*Emotionally I feel sad and unhappy; I feel it is not happening. It is a dream."* Another said "*When I think of the future I become sad because of horrible things happening*." The responses suggestive of continued vulnerability were made by the same three participants and were interspersed with coping responses. For example, one of these three made the following positive comment later on: "*REds gave me hope for the future, no matter my circumstances"* and another

> *"I can manage my stress . . . REds helped me a lot to cope."* More recently researchers have begun to suggest that resilience is not an either-or construct, but might more accurately be interpreted as a continuum (Speakman, 2005; Ungar, 2008). In other words, most people are motivated towards resilience; some may just be at the lower end of the continuum, and this position may never be regarded as fixed (Leadbeater *et al*., 2007).

Reflections on REds

The reflections of the participants were predominantly laudatory. In general participants advocated that REds should be more widely implemented in order that multiple educators and communities might be empowered. They were vociferously in favour of REds being translated into indigenous languages. Some participants felt that REds content should be integrated into the curriculum of educators-in-training and of learners.

Participants suggested only two changes to the REds programme. Both related to cultural issues. They recommended that alternative taped relaxation exercises be found that made no use of a white, male voice and that the classical music used in relaxation exercises be replaced with African or gospel music.

The reflections of the facilitator and observer urged more changes than the participants did. They recommended that the pre- and post-test media (e.g. questionnaires; incomplete sentences) be shortened and specifically that the wording and format of the ProQoL be simplified; that session times be lengthened and that resilient, HIV-positive community members be invited to participate as voices of realism and encouragement for participating educators. They also suggested that REds might be logistically simpler if it were implemented in its entirety over a weekend, rather than for nine consecutive weeks. In the course of piloting REds, implementation dates had to be frequently altered to facilitate apparently last minute Education Department or school initiated activities.

Discussion

This discussion is prefaced by acknowledgement of the limitations of a pilot

study, especially one with a limited number of participants, and of the limitations of a pre-experimental design (Babbie and Mouton, 2007; Leedy and Ormrod, 2005). Furthermore the sample was fairly homogeneous (all participants were black primary school educators). Even though participants made causal inferences between their enhanced coping and REds, this cannot be exclusively proven, given this limited design and sample. Nevertheless, within the ambit of intervention research, the results (primarily the qualitative results) of this pilot suggest that participants reported greater confidence in their ability to cope with pandemic challenges, even though the degree of confidence differed from participant to participant.

A comparison between the pre- and post-test data suggests some enablement of participants and the emergence of resilient functioning: the participants projected that they were generally coping more positively with the difficulties of an HIV-altered reality. Emerging resilience could be seen in participant acceptance of a pandemic-altered teaching reality, an internal locus of control, emerging themes of professional enablement, awareness of and navigation towards available protective resources, a sense of self-efficacy and an other-mindedness. In a very real sense, the participants seemed to have developed confidence in dealing with the pandemic challenges and seemed to have reframed the HIV-riddled status quo as both manageable and an opportunity to reach out to others (Almedom, 2005; Edward, 2005; Rutter, 1985). In essence, the findings reflect more recent understandings of resilience as a process of dynamic interaction between a person placed at risk and the protective resources within her ecology (Leadbeater *et al*. 2007; Ungar, 2008). It would seem that as with other effective resilience-focused intervention programmes, REds succeeded in diminishing the impacts of a stressful situation (in this instance, the HIV crisis) and provided opportunity for positive education (e.g. accessible resources, HIV-prevention) and personal growth (e.g. skill development, group experience) (Masten and Reed, 2005; Leadbeater *et al*., 2007).

When the quantitative and qualitative post-test data are compared, the results corroborate one another. The above average work satisfaction scores and participant comments affirming commitment to learners and communities suggests that most participants were passionate about their profession, even though they functioned in a pandemic-altered context. The high compassion fatigue scores suggest that participants were very aware of the negative impacts of the pandemic on learners, loved ones and communities and that this strained these educators. Their awareness and caring involvement were born out by comments relating to their involvement with orphans, friends and

family. Their qualitative responses suggested that they felt more capable of being competently involved following participation in REds and increased knowledge of referral networks and augmented skills. The slight decrease in the post-test compassion fatigue scores may have been because of this growing confidence. Nevertheless, these scores and the few ambivalent qualitative responses suggest that participants continued to be challenged by the pandemic, both on a personal and professional level. One implication of this is that REds should be implemented more continuously than a one-off intervention and might enable participants more effectively if follow-up or recurrent interventions (e.g. bi-monthly) occurred. A second possible implication is that some participants might need more rigorous intervention than others and that such individual needs be accommodated, possibly by encouraging participants to initiate therapeutic relationships with local service providers. An alternative interpretation might relate to putting aside typically Western dichotomous thinking which suggests that people are empowered, or not. In this regard, the notion of a continuum of resilience (Speakman, 2005) is possibly more veridical. If participant responses were to be viewed from a more dualistic perspective (Wong *et al*., 2006b), then it becomes possible that participants who completed REds might be empowered *and* challenged; that enablement and (continued) distress might very well co-exist. Perhaps as researchers we need to accept this duality of human experience, but simultaneously strive towards enabling participants to develop and make the most of protective resources so that there is greater balance and/or progression towards mastery of challenging circumstances (Wong *et al*., 2006a).

When participant reflections and projections are considered, their emerging resilience is associated with enhanced personal resources (e.g. increased knowledge, additional skills, personal change) and collective resources (e.g. awareness of community-based protective resources) and protective processes (accessing referral networks, speaking to others). The aforementioned are inherent to proactive coping (Wong *et al*., 2006a; Wong *et al*., 2006b) and comprehensive interventions aimed at encouraging resilience (Masten and Reed, 2005). Confidence in one's ability to cope with challenging circumstances heightens enablement and is embedded in knowledge, skills, resources and social networks (Edward, 2005; Heppner and Lee, 2005; Maddux, 2005, Masten and Reed, 2005). This suggests that future versions of REds should continue to encourage the awareness and development of inter- and intra-personal protective resources and processes. The latter might be emphasized by encouraging mapping activities of community resources (Ebersöhn *et al*., 2007).

As noted earlier, enablement and resilience are linked to the willingness to make the most of prevailing knowledge, skills, resources and social networks or to negotiate access to these (Carrey and Ungar, 2007a; Heppner and Lee, 2005; Hjemdal, 2007; Leadbeater *et al*., 2007; Schoon, 2006). This suggests that the empowerment of the participants in this pilot phase might have been partly due to their willingness to make the most of inter- and intra-personal resources that emerged in the course of their participation in REds.

In reflecting on further possible reasons why participants projected resilience, we conjecture that participant growth in resilience was likely due to the process of REds and not merely the content of REds. The process of REds included group-belonging, volunteer participation and participatory methods. All of these have been reported to facilitate enablement (Ebersöhn *et al*., 2007; Mitchell *et al*., 2005; Ross and Deverell, 2004, Smit, 2004; Theron, 2008).

The qualitative data generated by participants provided clearer signs of emerging resilience than the quantitative data. It is possible that the wording and format of the ProQoL (as reported by the facilitator and participant observer) might have confused the participants who were not English mother-tongue speakers. The opportunity to use mother tongue during the generation of qualitative data might have made it easier for participants to express empowerment and continued challenges more clearly.

In summary, the findings of this study reinforce contemporary resilience theory and contribute an understanding of how this theory can be put into enabling practice with educators impacted by HIV and AIDS. At the very least, educators who are placed at risk by the HIV-crisis require support that encourages altered perception and acceptance of the status quo, raises awareness of ecological resources that can be used to buffer the challenges of the HIV-crisis, forges community-mindedness and provides a sense of belonging to a group of like-minded educators.

The way forward

Participant recommendations regarding modification of REds were limited. We are aware that research participants often provide socially desirable responses (Mouton, 2008), but it is also possible that recommendations were limited because REds was specifically designed for educators in accordance with their reported support needs in the face of the pandemic (Coombe, 2003;

Theron, 2005). When interventions are designed for a specific population, the chances of participant empowerment are heightened (Mash and Wolf, 2005). The two recommendations that were made pertained to cultural sensitivity and cultural preferences and serve as a reminder that South African research needs to be meticulously sensitive to the realities of our multicultural society. Future REds facilitators should preferably be coached towards greater cultural sensitivity, especially given South Africa's cultural complexity.

The comments of both the facilitator and participant observer suggest that future rounds of implementation aimed at advancing REds development and concomitantly empowering participants and their communities should include altered logistical arrangements (possibly weekend-long implementation, depending on participant preference; shortened pre- and post-testing; simplifying ProQoL wording and format) and longer sessions. Participation by local, resilient and HIV-positive adults could potentially inspire participants and simultaneously further encourage community-participant interaction. In order to facilitate cultural compatibility, future facilitators should choose music and relaxation exercises that suit the culture of their participants. One possible way to address these suggestions is to adapt future REds to be even more participatory and include participants in decisions regarding the content and process of REds, prior to implementation. In this sense REds might facilitate immediate and practical experiences of empowerment.

Conclusion

REds is research in progress. The results from its first piloting suggest promising themes of participant resilience, and suggestions for logistical improvements. They also caution the need for heightened cultural sensitivity in terms of programme content. These results will inform future versions of REds, but may also serve to guide and remind other researchers and service providers working with educators affected by HIV and AIDS: of the importance of flexible logistical arrangements, increased use of participatory methods and heightened sensitivity to cultural preference.

As the results of ongoing rounds of implementations are gathered, an understanding of how to optimally modify the contents and process of REds and empower educators affected by the pandemic towards resilience will crystallize. This is essential as the ultimate goal of REds research is the enablement of educators to cope, resiliently, with the ongoing challenges of the HIV/AIDS.

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