

Formative evaluation of the STAR intervention: improving teachers' ability to provide psychosocial support for vulnerable individuals in the school community

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The article describes the pilot phase of a participatory reflection and action (PRA) study. The longitudinal investigation explores teachers' ability to provide psychosocial support within the context of HIV/AIDS following an asset-based intervention. The study ensued from our desire to understand and contribute to knowledge about the changed roles of teachers due to adversity in the community, specifically in relation to HIV/AIDS and education. The supportive teachers, assets and resilience (STAR) intervention was facilitated from November 2003 to October 2005 and consisted of the research team undertaking nine field visits and facilitating 20 intervention sessions (2–3 hours each), and 12 post-intervention research visits have been conducted to date. Ten female teachers were selected for participation through random purposeful sampling at a primary school in an informal settlement outside Port Elizabeth, South Africa. Data-generation included PRA activities, observation, informal interactive interviews, and focus group discussions. The data were analysed by means of inductive thematic analysis. We found that the teachers did not view vulnerability as being related to children or HIV/AIDS in isolation, but rather that their psychosocial support to children and the school-community was inclusive across a spectrum of vulnerabilities and services. We argue that teachers who are inclined to provide such support will fulfil this role irrespective of understanding policy or receiving training. We contend that teachers are well-positioned to manage school-based psychosocial support in order to create relevant and caring spaces for vulnerable individuals in the school-community.

Keywords: asset-based approach, capacity-building, intervention research, participatory reflection and action, psychosocial support, school children

Introduction

Traditionally, teachers function in a triadic relationship with parents and children, with the teacher's role being a facilitator of learning (Ferrara & Ferrara, 2005). However, social challenges such as those concerning HIV and AIDS have altered familiar

home and education circumstances and overturned parents' customary role as child-carers (Ross & Deverell, 2004; UNICEF, 2006; Jones & Sargeant, 2009). In the presence of HIV and AIDS, teachers' lives in the school environment are interwoven with children experiencing parental loss, changes in caregivers, chronic illness of family members, as well as distress due to poverty (Barolsky, 2003; Marais, 2005).

In the absence of parents' ability to perform their traditional tasks, the South African Department of Education has developed policy to help teachers to function in changed roles. However, a policy/practice conundrum exists. Although the policy entitled *Norms and Standards for Educators* (Department of Education, 2000) provides guidelines on a philosophical level, on a practical level teachers struggle to implement the abstract guidelines (Green, 2003; Robinson, 2003; Schierhout, Kinghorn, Govender, Mungani & Morely, 2004). Our study set out to determine whether an asset-based approach could enable teachers to function in a policy-prescribed pastoral role. The research objectives were governed by the need to enable teachers to provide psychosocial support (as promulgated by policy) to an ever-increasing pool of vulnerable school-going children.

Intervention research has proven to be an effective means of capacity development (Richter & Desmond, 2008; Theron, 2009). Similarly, a participatory reflection and action (PRA) approach provides a pathway where research and practice can meet (Chambers, 2008). Our longitudinal study focused on exploring teachers' ability to provide psychosocial support in the context of HIV/AIDS following an asset-based intervention. The study commenced in 2003 with 10 teachers from one school. The initial study evolved to include seven more schools and 70 other teachers, in two more South African provinces (with dissemination of the research having occurred for four of the sites). However, the focus of the article is on the pilot phase of the study, which was conducted from November 2003 to October 2005.

This article therefore describes the pilot phase of our ongoing supportive teachers, assets and resilience (STAR) intervention. The article is directed by the following question: Within the context of HIV/AIDS, how did teachers provide psychosocial support following the STAR intervention? The discussion lends insight into the

potential supportive role of teachers in an education system faced with multiple adversities, specifically in terms of psychosocial support concerning HIV/AIDS-related challenges. Based on the specific focus of this article, we do not report on the challenges that the participants (teachers) experienced in providing such support in their school-community; rather, our discussion focuses on the supportive acts they were able to initiate despite the challenges they faced.

Asset-based approach as the underlying philosophy

According to the asset-based approach, the focus falls on the utilisation of existing resources, assets, skills and abilities as a way of addressing community challenges (Kretzmann & McKnight, 1993). Ebersöhn (2008a) conceptualised the asset-based approach in terms of coping and resilience, emerging from multiple studies focusing on the deconstruction of the asset-based approach (e.g. Ebersöhn & Mbetse, 2003; Ebersöhn & Eloff, 2006; Eloff, Ebersöhn & Viljoen, 2007), and studies on coping and resilience (e.g. Ebersöhn & Eloff, 2003; Eloff & Ebersöhn, 2003; Ebersöhn, 2007 and 2008b; Ferreira, 2007 and 2008; Ebersöhn, Ferreira & Mnguni, 2008). The conceptualisation is informed by three systemic frameworks: Kretzmann & McKnight's (1993) asset-based approach to mobilising communities, the positive psychology constructs of Wright & Lopez's (2005) theory of human strengths and environmental resources, and Masten & Reed's (2005) view of resilience in terms of adaptational systems.

Ebersöhn (2008a) contends that when the asset-based approach is related to resilience, strengths are placed at the heart of interventions aimed at mediating adversity and facilitating resilience. Consequently, when individuals apply asset-based strategies in terms of such a 'resilience framework' to cope with hardship they are more readily able to restore subjective wellbeing (happiness) than if the coping-focus had not included a strength concentration. Ferreira (2008) conceptualises this strategy as 'asset-based coping.' In this way individuals are regarded as best placed to direct systemic coping beliefs, choices and behaviours for resilient outcomes.

A working assumption of the asset-based approach is that individuals are aware of and can identify internal and external resources, as well as deficiencies or barriers.

Considering resilience, Ebersöhn (2008a) as well as Theron (2009) posit the identified factors as systemic protective and risk factors, maintaining that individuals can access and mobilise particular identified strengths (i.e. protective resources) in order to cope with adversity (exacerbated by risk factors). As such, an asset-based view of resilience typifies individuals as motivated to realise and preserve a state of flourishing by means of strategies such as awareness/reflexivity, identification, accessing, mobilisation or self-regulation, and sustaining.

Consequently, the STAR intervention was developed around the following assumptions of the asset-based approach:

- The teachers' strengths formed the heart of the intervention;
- Teachers are best placed to direct systemic coping beliefs, choices, and behaviours for resilient outcomes;
- Individuals (teachers, children, community members) are motivated to realise and preserve a state of flourishing;
- A PRA intervention can mediate HIV/AIDS-related adversity;
- A PRA intervention can facilitate resilience by developing psychosocial support capacity among teachers; and,
- A PRA intervention recognises the presence of both protective and risk factors within the life-systems of individuals.

Psychosocial support and the pastoral role

South African education policy (DoE, 2000) emphasises the so-called pastoral role that teachers are expected to fulfil by, among other things, providing psychosocial support to children in the school environment. The teacher fulfilling a pastoral role embraces the concept of facilitation of learning holistically (Ogina, 2008; Theron, 2009) — thereby acknowledging the entwined nature of intellectual, emotional, social, spiritual and physical development in children. In this manner the community, citizenship and pastoral roles expected of teachers is likely to provide the necessary support to children (DoE, 2000). As such, the practical competences of the pastoral role consist of the demonstration of care, protection and interest in the holistic development of the child. The tasks related to these competences include a range of

child-related systems, which we align with associated systems in which children typically function (see Table 1).

Other than teaching and learning, the impact of HIV/AIDS seems to implore teachers to not only provide physical care (e.g. distributing food parcels, feeding ill individuals, and overseeing the intake of medicine), but also psychosocial support. Coping with AIDS-related bereavement seems different to coping with the loss of meaningful others to other diseases. Physical and psychosocial losses associated with the disease itself are plentiful. These losses include distress triggered by stigma, resulting worries in terms of discrimination and disclosure, and incidences of amplified anxiety. Factors such as these indicate the need for specialised psychosocial support. As dictated by the DoE policy alluded to earlier, teachers subsequently take on the role of counsellors to children who have lost loved ones.

On the one hand, one can argue that by virtue of their chosen profession, teachers possess certain characteristics that could enable them to offer psychosocial support.¹ Such supportive characteristics could include empathy, caring and supportive dispositions, interpersonal skills, and embedded knowledge of practices regarding death, grief and bereavement. On the other hand, however, teachers are mostly not formally trained as social workers, counsellors or psychologists. Therefore, teachers in all likelihood may lack the necessary competence to specifically deal with the array of psychosocial losses associated with HIV. Accordingly, we construe that: 1) HIV/AIDS compels augmented psychosocial support to children who are vulnerable because of the pandemic; 2) teachers are well-positioned to provide psychosocial support as stipulated by policy; and 3) teachers may benefit by enhancing their ability to provide psychosocial support.

Participatory reflection and action (PRA) intervention

Methodologically we employed a PRA design. We view PRA as an activist approach, during which the involvement of people who are directly affected by a certain phenomenon is encouraged (Chambers, 2008). As such, we encouraged the participants to think for themselves, contribute to their own learning rather than receive information from us, share their knowledge, and work together in order to

face the challenges implied by HIV/AIDS. We aimed at stimulating community awareness among the teachers, in turn encouraging them to take action when issues arose during discussions which could inevitably result in change. This implied a shift from viewing ourselves as outsider professionals who can provide information and advice (etic approach) to a focus on insider participation and understanding from an insider's perspective (emic approach) (Patton, 2002; Chambers, 2008). In line with the principles of PRA, we viewed the selected community's mode of living as the starting point, while recognising throughout the process the wealth of social indigenous knowledge that community members possess. We respected the participants as the experts who hold the key to any understanding and insight into their ways of psychosocially supporting community members within the context of HIV/AIDS.

Overview of the intervention

In developing the STAR intervention we were guided by certain assumptions, namely: 1) that the selected community was coping with the challenges implied by HIV/AIDS by relying on available resources and existing assets; 2) that asset-based trends existed in the community's coping repertoires when we entered the research field; and 3) that PRA could be applied within (and together with) the particular school and teachers selected to participate in the STAR intervention. In accordance with the methodology of PRA, data-generation and data analysis occurred simultaneously.

Our pilot study was conducted during the period November 2003 to October 2005. The initial study gradually evolved into various sub-studies,² some of which are ongoing. The pilot study consisted of nine visits to the initial school, during which we facilitated 20 intervention sessions. To date, we have also completed 12 follow-up research visits with the aim of exploring psychosocial support capacity post-intervention. The phases of the pilot study are summarised in Box 1.

During phase one of the pilot study we obtained an overview of the community and explored the participants' general concerns and perceptions in regard to the context of HIV/AIDS. For this purpose, the participants engaged in activities to explore the

school-community in terms of its existing structures, resources and facilities. By compiling community maps (written and photographic) the participants noted available and potential resources. Based on these constructed community overviews, the participants then categorised the various components of their community maps as challenges, resources (assets) or potential resources (assets available but not yet mobilised). Thereafter they formulated potential ways to deal with the identified challenges by relying on the identified available resources by means of mobility maps (see Ferreira, 2008).

The second phase of the intervention was completed in response to the participants' need to improve their basic HIV/AIDS-related knowledge and competencies, as they wanted to acquire knowledge in order to psychosocially support others. Consequently, the second phase involved group discussions among the participants which focused on existing asset-based trends in their ways of coping and simultaneously providing support to others. Basic HIV/AIDS information was discussed; this pertained to dealing with HIV/AIDS-related conditions, nutrition, emotional support for persons with HIV, and how to deal with a parent or child infected with HIV — both in general terms and in the context of the classroom (cf. Ferreira, Ebersöhn & Odendaal, 2010).

During phase three the participants discussed latent assets (identified during phase one) that could be utilised to address some of the challenges facing the community. The teachers identified three potential psychosocial support initiatives, formulated action plans to initiate these, and monitored their progress. Subsequently, they established a school-based vegetable garden, support group, and information centre for HIV-infected/affected community members (Ferreira, Ebersöhn & Loots, 2008).

Phase four of the pilot study centred on the teachers' expressed need to acquire basic counselling skills to psychosocially support children and families affected by HIV. In response to their request, we introduced the participants to two counselling techniques, namely memory-box-making and body-mapping. Following the intervention, the teachers implemented these techniques with children and/or other community members, noting their experiences and the outcome of the processes.

During a subsequent field visit, the teachers reflected on these experiences (see Ebersöhn *et al.*, 2008).

Methods

We conducted our intervention research from an interpretivist stance as we aimed to gain understanding (*verstehen*) with regard to the lived experiences and personal worlds of the participants through their perceptions and interpretations. However, at the same time, we acknowledged ourselves as co-creators of meaning (see Terre Blanche & Kelly, 2002).

Sampling procedures

For the purpose of the STAR intervention, we relied on convenience sampling to identify one primary school to pilot the intervention. Our decision to work with teachers in a school is aligned with the notion that schools (and teachers specifically) can serve as nodes of care and support, and as access points through which communities can be supported (Giese, Meintjes, Croke & Chamberlain, 2003; Brooks, 2006; De Witt, 2007; Hoadley, 2007). The school is located near the Nelson Mandela Metropole in the Eastern Cape Province and situated in an informal settlement community, characterised by poverty, a high rate of unemployment, limited resources and high HIV prevalence.

After identifying the school, we collaborated with the principal to select 10 teachers (of whom nine were females) to participate in the pilot study. For this purpose, the principal employed simple random purposeful sampling (Patton, 2002). After the first phase of the intervention, the one male participant withdrew from the project, but arranged for another female teacher to replace him.

Data-generation and documentation

Table 2 provides an overview of the data-generation and documentation methods. Our choice of methodological strategies was guided by the principles of PRA (see Chambers, 2008). Thus we relied on open-ended methods that are visual, flexible and creative, and involve a cycle of interrelated activities. Table 3 provides a

summary of the PRA-based activities employed during the intervention (cf. Emmison, 2004; Chambers, 2008). By conducting intervention research, mirrored in a combination of strategies, we aimed to provide the participants with multiple lines of communication and a safe environment to share their perceptions on the sensitive topic of HIV/AIDS. Good rapport, frequent research visits and regular contact with the participants between our research visits seemingly encouraged honest contributions (cf. Leach, 2003; Litoselliti, 2003; Wilkinson, 2004).

Data analysis and interpretation

We employed inductive thematic analysis (Creswell, 2003), which commenced during the first phase of data-generation. As several researchers had been participating in the STAR project since 2003, multiple researcher-coders participated in the data analysis. At any given stage of the project, at least two researchers conducted thematic analysis, after which the identified themes were compared and collated. In this manner we could work with large amounts of detailed qualitative information in our attempt to identify core meanings in terms of themes, patterns, categories and interrelationships (cf. Mouton, 2001; Patton, 2002; Wilkinson, 2004).

The iterative process led to ideas for directions of further analysis, shaping patterns and themes, as well as emerging hypotheses and questions. Accordingly, our insights impacted on subsequent field visits, leading to further analysis and interpretations in terms of sorting, questioning and thinking, constructing and testing the preliminary ideas. Whereas the initial stages of data-generation provided us with new insights and guidance on where to go, later stages served to deepen our insights and to confirm or contest the patterns that seemed to have emerged (cf. Patton, 2002; Smith & Osborn, 2003).

In line with the underlying principles of PRA, the participants were involved with the data analysis. The participants provided feedback on preliminary themes and contributed to the data analysis and interpretation in various manners (cf. Chambers, 2008). First, the participants checked preliminary results in terms of the identified themes, during the focus group discussions. Second, the participants were involved in participatory analysis during mapping activities where they elaborated on and

analysed the maps they had constructed. Thus, the participants revisited their original maps of the community during several sessions during the course of the study, analysing and elaborating on these on each occasion.

Ethical considerations and study limitations

We respected the human nature of the participants by following the necessary ethical guidelines to ensure that they were not deceived, did not experience distress, were informed about the progress of the study, and knew that they could withdraw at any time (cf. Hayes, 2000; Babbie & Mouton, 2001). We obtained informed consent before commencing with the research. The participants were assured of the research team's commitment to the principles of confidentiality, privacy and anonymity of the information shared. The participants were also requested to respect the confidentiality, privacy and anonymity of any information shared by others. In addition, we took the necessary steps to protect the confidentiality of our sources, for instance by initially³ disguising or altering identifying information on photographs and when the interviews were transcribed, and by ensuring that our field journals, audio-tapes, transcripts and other data were kept in a secure environment. Representation ethics were addressed by consulting with the participants after themes had emerged, in order to ensure that the findings indeed reflected their voices and not ours (cf. Hayes, 2000; Oliver, 2003).

As our study involved only one school and 10 female teachers, the investigation had several limitations. First, the findings cannot be regarded as generalisable. However, in line with the interpretivist paradigm, the findings might be transferred to similar contexts, based on the rich descriptions and context provided. Second, it is possible that the findings could be gender-specific, as the participants were all females. Third, the findings might be nuanced by specific cultural values, based on the specific context and community involved. However, we strived to obtain and present the participants' perceptions and to clearly highlight the context and specificities of the participating teachers. Finally, differences between the participants and us (as researchers) posed distinct challenges in terms of language and educational level. In an attempt to address this challenge we relied on our own continual reflections and 'member-check' sessions with the participants.

Discussion

Five themes emerged from the pilot study, centred on the primary idea that the participating teachers displayed evidence of being supportive teachers within the HIV/AIDS realm.

Teachers willingness to take initiative and provide support

Based on our observations we typified the teachers as committed to providing psychosocial support to children both at school and within the community. We noted in our research journals: *'The school, principal and participants themselves are such great assets to the community'* (23 November 2003), and: *'The willingness of the participants to be part of the study and — even more important — make a difference in the community is truly remarkable'* (8 July 2004). In terms of behaviour, the participants demonstrated the necessary initiative to provide psychosocial support, reporting on incidences such as the following: *'What the teacher did is she gave him bread, a loaf of bread everyday'* (field visit 2, focus group 2; 23 January 2004).

Throughout, the participants conveyed an eagerness to participate, displayed enthusiasm to generate place-based support initiatives, and maintained high levels of energy in initiating and monitoring the identified psychosocial support projects. As the study progressed, the teachers confirmed awareness of their own abilities: *'I didn't know what I'm capable of doing, but you did make sure that I know what I can do...'* (field visit 6, focus group 4; 31 October 2004), and they showed confidence about their efforts: *'At least we are trying our best. We are trying our best, you know'* (field visit 2, focus group 2; 23 January 2004).

An awareness of their own abilities, increased levels of motivation, and feelings of enablement resulted in the participants confidently initiating and managing three school-based support initiatives (discussed later). Previous authors (Kelly, Ntlabati, Oyosi, Van der Riet & Parker, 2002; Kabiru, Njenga & Swadener, 2003) have emphasised the value of individuals being aware of their own assets and abilities,

which in turn may result in feelings of self-confidence, moving them to action and positively impacting on self-efficacy and personal wellbeing.

In line with their willingness to support children, the teachers' commitment extended to supporting the wider school-community. One teacher reported her conversation with a community member:

'But what made me so excited is the following day when she came, she didn't even have a tear on her eyes, and she said I came here to thank you. I didn't know that I could get help, even the nurses at the hospital prayed for me and said — Why did you take so long? And I told them it's only when I got information at the school, it's only now that I'm ready' (field visit 6, focus group 4; 31 October 2004).

The principal reinforced that the school, not only individual teachers, were willing and committed to the community:

'And this year we have declared that we are going to make a difference, and not in the classroom alone, but the communities. In the next five to ten years they must always remember that there have been the teachers in the year 2004 that have been very concerned with the plight of the communities in which we find ourselves in' (field visit 3, individual interview 3; 18 February 2004).

The stance towards psychosocial support within the community as declared by the participants and the school in our study correlates with Kretzmann & McKnight's (1993) view of schools/teachers as community-building assets and supportive structures in communities. Equally, this result provides empirical evidence for the notion of schools as possible nodes of care and support to communities (Giese *et al.*, 2003; Brooks, 2006; De Witt, 2007; Hoadley, 2007).

Supporting vulnerable children

The teachers supported vulnerable children on various levels. They identified vulnerable children by means of observation in the classroom, on the school premises, and beyond:

'We are helping these kids out of our own potential' (field visit 2, focus group 2; 23 January 2004).

'I would try and be a parent for that child...so that she will feel comfortable and she cannot feel that my mother is not here...I'm your mother, if you've got a problem come to me' (field visit 2, focus group 2; 23 January 2004).

In explaining their way of identifying vulnerable children, the teachers conceptualised their view of vulnerability by identifying the following significant behaviours as indicators: anxiety, sleepiness, concentration problems, decreased scholastic performance, isolating behaviour and sadness.

In addition to identification, the teachers established a referral base of available services (health and faith-based ones) linked to the school-community. They mentioned some examples:

'If they [i.e. parents as well as children] are sick, they can report at school; we phone ATICC [a local non-governmental organisation] so that he can send a social worker, someone to help them' (field visit 6, focus group 4; 31 October 2004).

'So I did tell my priest and the other church group members, and they give a lot of support. They give advice and emotional support' (field visit 4, individual interview 11; 7 June 2004).

Established networks enabled teachers to refer identified vulnerable children (and their kin) to existing services within the community. Examples of reported systemic support included support in terms of school fees, school uniforms, food parcels, applications for governmental grants, and psychological services.

The teachers also indicated their willingness to provide basic counselling as a means of psychosocial support: *'We are supposed to be counsellors'* (field visit 3, focus group 3; 19 February 2004). Echoing findings in studies where memory-box-making was used with vulnerable children (Eloff *et al.*, 2007), teachers found memory-box-making and body-mapping suitable for use as basic, first-level counselling in fulfilling their pastoral role. In this regard, the participants highlighted the value of teachers using basic counselling skills to support children:

'It isn't always easy for them to talk, but now it's easy...you tell them to write on that body-map their feelings or their stories' (field visit 9, focus group 6; 14 October 2005).

'It brings you closer to them, they trust you, they tell you something that you didn't ask.... They all talk freely...they are now open to me' (field visit 9, focus group 6; 14 October 2005).

The teachers specifically noted that using counselling techniques contributed to a warm classroom, enabled trusting relationships between teachers and children, and provided them with rich insight into the life-worlds of the children. These advantages correlate with the views of Morgan (2004) and Valentine (2004) who found that memory-box-making and body-mapping could facilitate communication and allow individuals to usefully express their perceptions, experiences, values and emotions — thereby opening a way towards receiving psychosocial support offered by teachers, for example.

Focus on support within the school-community

The teachers favoured a focus on giving support within the school-community. As a result of the intervention, the participating teachers divided themselves into three task teams and started three school-based initiatives to provide psychosocial support to the community at large. The initiatives included a vegetable garden on the school grounds, an information centre providing basic HIV/AIDS information, and a support group for members of the community. Based on monitoring and evaluation conducted during each field visit since the projects were initiated, these projects proved to be sustainable.

The vegetable garden project implies that HIV/AIDS-related adversity in poverty-stricken communities includes basic nutritional and economic needs:

'Now we haven't got money to buy food — now she's getting food from school, she's getting vegetables. I told her the way to eat...and I also told her to ask the clinic nurses to tell her more about what she is suffering from so that they can add more on what we have told her' (field visit 6, focus group 4; 31 October 2004).

In addition, the HIV/AIDS information centre and school-based support group seemingly addressed issues characteristic of a community facing HIV/AIDS-related illness and stigma (cf. Ogina, 2008; Theron, 2009).

The information centre at the school was established with the aim of providing basic HIV/AIDS information to children, teachers, parents and community members. Besides providing answers when questions arose, the participants in this task team established the practice of discussing HIV/AIDS-related issues at every parent evening. In addition, they presented activities and programmes on World AIDS Day in an attempt to raise HIV/AIDS awareness in the community. With regard to the support group, the participating teachers initially focused their support activities on home visits to vulnerable families, during which small food parcels were distributed and individuals were prayed for. As the study progressed several other support activities were included, such as the distribution of clothes, food, and advice in terms of medication and financial support. As the community became aware that teachers at the school were available to provide information and support, stigma and discrimination reportedly decreased in the community, resulting in individuals being more open to disclosure and to accessing available support.

The selected psychosocial initiatives would characterise the participating school as a health-promoting school, which refers to a school where the administration, teachers, parents, children, and outside agencies are mobilised in an integrated attempt to cope with challenges such as HIV/AIDS (Kelly *et al.*, 2002). One of the activities that Kelly *et al.* (2002) attempted in their study was the establishment of vegetable gardens at schools, as was the case in our pilot study.

The manner in which the teachers in our study initiated support corresponds with the recommendations of UNICEF (2006) concerning the role of schools and education systems in supporting vulnerable children within the context of HIV and AIDS. One suggestion is that schools might become focal points in communities or even so-called 'vulnerable children support centres,' where meetings could be held, support provided to caregivers, and where feeding schemes could be operated. The psychosocial support provided by the participants in our study mirrors this suggestion as, for example, the teachers obtained donations from outside organisations to provide vulnerable families with parcels (consisting of vegetables from the school garden, clothes and food supplements). The school principal described the school's

efforts: *'We are starting to get hold of the NGOs so that they can be given some clothes and the meals, and with the meal again it can make a difference to one's life'* (field visit 3, individual interview 3; 18 February 2004).

Utilising networks for delivering psychosocial support

The teachers established networks of psychosocial services delivery, which they increasingly utilised in their support endeavours. Systemically, the participants identified and accessed the knowledge and capacity of their school colleagues, such as the two life orientation subject teachers who were regarded as knowledgeable about HIV and AIDS. The teachers also identified their own strengths and abilities, situating themselves in appropriate positions in terms of the roles they fulfilled within the three support initiatives they helped to start up (see above). In relying on available strengths within themselves and the immediate system to support others, these teachers demonstrated the implementation of the asset-based approach.

In addition, the teachers partnered with school parents to provide psychosocial support within the community. Parents became increasingly involved, for example by assisting with maintenance of the vegetable garden and volunteering to assist in cleaning the school. Based on the parents' increased involvement at the school, a teacher remarked: *'We are a great team. We didn't know that in a school we can work together, parents and teachers like this'* (field visit 6, focus group 4; 31 October 2004). The work of Kelly *et al.* (2002) on the potential role of schools, teachers, parents and others in supporting vulnerable communities supports these teachers' choice to foreground networking in their support efforts.

As our study progressed, the participants started assisting community members in applying for a range of social development grants, for example by referring people in the school-community to apply to appropriate governmental and non-governmental contacts or institutions for financial support. During an individual interview, one teacher described this involvement:

'Then, if we find that this one can qualify for a grant, then we go, we just tell her — You do qualify for a grant, this type of a grant, you can go to hospital D — for

example. Then we write a letter and ask hospital D to help us with this person' (field visit 4, individual interview 10; 7 June 2004).

The multi-dimensional nature of psychosocial support provided by teachers

The teachers did not provide psychosocial support as an isolated entity. Their support addressed wide-ranging needs and utilised a broad base of resources. Psychosocial support was provided in terms of social, emotional, as well as spiritual/existential dimensions. Towards the end of the pilot study, one participant remarked:

'We are no longer educators now; we are community workers, because we are here to work in this community. And the parents are coming, are free now to disclose, they come in numbers to come and disclose their [HIV] status since they have seen that we are here...they come and disclose to us' (field visit 7, focus group 5; 27 July 2005).

The teachers provided social support by displaying non-discriminatory behaviour; for instance, they undertook home visits to vulnerable children, families and community members. Correspondingly, they indicated that they provided emotional support by means of regular contact, answering individuals' questions and discussing their fears. One teacher described their role: *'Then they could cope, because we were visiting them now and again, now and again...and we explained to them that they mustn't worry, that they can cope with the situation'* (field visit 3, individual interview 1; 19 February 2004). Additionally, the participants provided spiritual/existential support by means of prayer and the encouragement of existential meaning-making through religion: *'And I said to him — Pray, because you have strength and I'm sure you are going to be okay'*; another noted, *'Through the hope which we gave them...they can cope with the situation'* (field visit 1, focus group 1; 15 November 2003).

Besides the abovementioned dimensions of psychosocial support, the teachers provided pragmatic support in response to poverty-related issues such as income-generation, nutrition, and material needs. They collaborated with relevant partners to offer economic/material support by providing resources such as vegetables, food parcels and clothing: *'She is getting food here at school....'* (field visit 6, focus group

4; 31 October 2004). In addition, the teachers sometimes provided health/physical support by providing advice in terms of health guidelines or referring people to health services in the community: *'The clinic, that's where they're going to get help'* (field visit 2, focus group 2; 23 January 2004).

Finally, the teachers began to offer support in the form of advocacy and basic information on HIV/AIDS issues when the need arose, as depicted in the following extract:

'The reason for this is when the information team [during parent meetings] tell them about it, then we put it on the programme. We then tell them that since they know nothing about HIV and AIDS, they can come to school to get help. The only thing that the teachers can give them is to give them help and to show them the right procedures to take and give them the advice, good advice; that's what the information team can do' (field visit 6, focus group 4; 31 October 2004).

Besides providing some HIV/AIDS information during parent meetings, the teachers planned structured events at school, for example on World AIDS Day, in an attempt to increase HIV/AIDS awareness in the community.

Conclusions

The discussion here has been structured around two ideas: insight into teachers' psychosocial support in their pastoral role; and, teachers' perceptions of viable areas of psychosocial support in terms of HIV/AIDS. The teachers who participated in our study, and thus were exposed to the basic principles of the STAR intervention and the asset-based approach, were able to carry out many pastoral tasks in the school-community (psychosocial support functions) as sanctioned in South African education policy (see DoE, 2000; Ross & Deverell, 2004; UNICEF, 2006; Jones & Sargeant, 2009). These teachers demonstrated a willingness and commitment to function in a pastoral role as portrayed by their eagerness to participate in the intervention, their enthusiasm in generating appropriate support initiatives and implementation plans, as well as their sustained energy in putting support projects into action (and monitoring these). The teachers' high levels of motivation and

involvement resulted in positive outcomes, which correlates with the outcomes of a community HIV-prevention initiative launched in the Western Cape Province as reported by the Department of Social Development (2002, p. 53): “Recognise that a lot can be accomplished with limited resources, as commitment and altruism are strong impulses that often produce incredible, useful results. Such actions should be encouraged.”

It is evident that the STAR intervention encouraged the teachers to initiate and sustain acts of psychosocial support in their school- community. As such, the STAR intervention holds the potential to encourage and facilitate teachers on a broader forum to offer support and to fulfil existing needs for care and support in communities heavily affected by vulnerability. In the same manner, the STAR intervention might be applied in other contexts, thereby enabling individuals in other walks of life to provide support by relying on available assets and resources in their immediate environment. This hypothesis, however, requires ongoing investigation.

In terms of psychosocial support to school children made vulnerable by a context of poverty and HIV/AIDS, the participating teachers chose to support children in a community-based way. The findings from our pilot study therefore provide some understanding of a group of teachers’ perceptions of useful and workable support when utilising community resources to address HIV/AIDS-related challenges. The participants’ choice to target the distribution of information demonstrates the continued lack of access to pertinent HIV/AIDS information in some communities (Eba, 2007). Likewise, the teachers’ focus on cultivating a vegetable garden at the school aimed to address the socioeconomic and health challenges synonymous with poverty in South Africa. And, their support-group initiative showed the general need to provide individuals with not only medical care but also psychosocial support in the context of HIV/AIDS. In this way, the teachers viewed vulnerability holistically, which subsequently generated support on multiple levels.

The findings of this study show that school teachers do not necessarily perform pastoral tasks in isolation. Some teachers seem to integrate, embody, or live the pastoral role as part of their teacher-being. It seems that the policy/practice

conundrum might be passé, as the teachers in our study did not provide psychosocial support primarily because of a policy requirement. More explicitly, the teachers who participated provided wide-ranging support as compelled by an atmosphere of vulnerability in their work environment. It seems probable that the teachers were aware of such needs in their community prior to the STAR intervention and that the exercise merely served as a catalyst to urge them toward action. In the same manner, other teachers or individuals outside the teaching profession might benefit from being exposed to the STAR intervention, which similarly may increase ground-level psychosocial support in their communities. The participating teachers demonstrated care, commitment, and motivation through networks and relationships aimed at establishing a more supportive environment. We posit that teachers who are inclined to provide support (of which psychosocial support forms a part) will do so irrespective of understanding policy or receiving training in this regard, with the possibility of such action being linked to strength-based interventions, such as STAR.

Furthermore, we found that the participants did not isolate school children as needing exclusive support. The participating teachers provided support to children by also supporting their families and the community. In this regard, the teachers preferred an approach to support that is characterised as family-centred, community-based, network-based, and collectively beneficial. Our findings give credence to the notion of schools as 'nodes of care and support.' Still, we suggest that the idea of schools as nodes of care and support might be enriched by viewing teachers' participation in pastoral tasks of care as a prerequisite if schools are to be the epitome of support.

Concerning the potential supportive role of teachers, we contend that teachers are well-positioned to manage school-based psychosocial support in order to create relevant and caring spaces for vulnerable individuals in the school-community. However, we do not view teachers as the sole providers of such psychosocial support. Instead, we reason that when school-based psychosocial support originates with teachers and is managed by them, additional relevant and caring spaces are created for vulnerable individuals. Teachers are well placed to prioritise psychosocial support initiatives in a specific school-community. Equally, teachers are positioned to establish and maintain relationships with community partners to provide appropriate

psychosocial support services. We claim that psychosocial support initiatives might result in suitable multisectoral care to mitigate vulnerabilities, as occurs within an education system faced with adversity.

Acknowledgments — We thank the following institutions for financially supporting the project: Educational Training and Development Sector Education Training Authority (ETDP SETA) (2003-2004), ABSA Foundation (2004), M&SST Trust (2005), NRF dissertation award (2007), University of Pretoria Research Development Programme (2007-2009), The Foschini group (2008-2009), Albert Wessels Fund, Toyota (2008), University of Pretoria Department of Community Engagement (2008-2010), NRF Incentive Funding for rated researchers (2009-).

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Table 1: Pastoral tasks related to systems in which children function

System	Pastoral tasks
Individual level	<ul style="list-style-type: none"> • Managing children’s wellbeing. • Addressing and supporting children in terms of counselling and career guidance. • Respecting children’s constitutional rights by acknowledging their uniqueness, individuality and special needs.
Classroom, playground and school environments	<ul style="list-style-type: none"> • Managing classes with authority, demonstrating compassion and fairness. • Enhancing gender equality. • Striving to direct children in terms of values based on human rights policy. • Accepting responsibility and ensuring children’s safety. • Participating in extramural activities.
Parents/caregivers	<ul style="list-style-type: none"> • Communicating and discussing children’s behaviour and progress with their caregivers.
Societal level	<ul style="list-style-type: none"> • Understanding and reacting to social and educational challenges in a community.

Table 2: Data-generation methods used in the pilot study

Research methods	Participants in the research phase	Documentation methods
Informal interactive interviews (see Sterk & Elifson, 2004)	With teachers throughout the pilot phase; with community members when needed	Audio-visual recordings; field notes; researcher journals
Participatory reflection and action-based intervention activities (see Table 3)	With teachers throughout the pilot phase	Audio-visual recordings; field notes; researcher journals
Focus group discussions (see Litoselliti, 2003; Wilkinson, 2004)	With teachers throughout the pilot phase	Audio-visual recordings; field notes; researcher journals
Observation as context-of-interaction (see Angrosino & Mays de Pérez, 2000)	Researchers’ observations of the research activities, the context, and the progress of the initiatives, throughout the study	Field notes; researcher journals; photographs of the settings and intervention processes; artefacts, etc.

Table 3: Participatory reflection and action (PRA)-intervention activities used with the teachers

Activity	Description
Do-it-yourself techniques	Participation-based activities guided by probing questions.
Group meetings and discussions	Facilitation of brainstorming activities and discussions about the community's way of utilising assets and resources in coping with HIV/AIDS.
Informal interaction	Focusing on interrelated discussions (e.g. during lunches).
Participatory mapping, diagramming and modelling	Creating maps and spatial diagrams to illustrate the layout of the community; the nature and extent of challenges, resources and potential resources; and the availability, accessibility and utilisation of available resources.
Participatory analysis, presentations, planning and monitoring	As part of the data analysis and monitoring phase.
Timelines and trend- and change-analysis	Implemented towards the end of the pilot phase, guiding the participants to reflect on events of the past as well as changes to date.

Box 1: Phases of the pilot study

- 1 – Exploration of the community in terms of general concerns, assets and resources to address HIV/AIDS-related vulnerability in the school-community.
- 2 – Improvement of teachers' HIV/AIDS knowledge and competencies in order to contribute to psychosocial support.
- 3 – Mobilisation of latent assets or resources for psychosocial support initiatives at the school.
- 4 – Focusing on psychosocial counselling skills for teachers (especially memory-box-making and body-mapping).

Notes

¹ Our study did not aim to explore this assumption.

² The co-researchers were Sam Bagherpour, Janna Beukes, Georgina Dempster, Karien de Jager, Melanie Joubert, Tilda Loots, Malize McCallaghan, Maria Mnguni, Viona Odendaal, and Hermien Olivier.

³ As the study progressed, the participants voiced their comfort with identifying information that formed dissemination of the findings, thereby providing informed consent to do so.